The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred) and no references, tables, or figures. Send material to the column editor, Francine Cournos, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032.

Holocaust Survivors' Home

Some 500 psychiatric inpatients in Israel are known to be survivors of the Nazi Holocaust. Many of them have been hospitalized continuously for 20 to 50 years. Most of these patients received diagnoses of chronic schizophrenia, with no special attention given to the historical circumstances related to their psychiatric symptoms and disabilities.

In response to the need for a different approach to this population, a unique home for such Holocaust survivors was opened on February 1, 2000, adjacent to the grounds of the Beer Ya'acov Regional Mental Health Center in central Israel. The entire facility is planned for 100 residents, who are housed in three buildings. Each building is a separate one-story structure with its own small kitchen and communal dining room. Each resident room has its own toilet and shower and houses two patients. Activities at the home include psychodrama, exercise, music therapy, and a weekly cinema club.

Directed by a professional social worker, the home is staffed 24 hours a day by nurses and nurses' aides trained in geriatric and psychiatric nursing. A social worker and an occupational therapist support this staff, and a psychiatrist and an internist on call from the regional center usually visit the home every weekday.

One turning point in defining this program as a "home" rather than an institution came on the occasion of the first major Jewish holiday in our setting, the Jewish festival of Passover, on April 19, 2000. Passover is celebrated with the seder, a ceremonial dinner and collective recitation of the ancient Israelites' enslavement in Egypt and the subsequent exodus. The seder meal is traditionally a family experience, often charged with high emotions. Family members meet with other relatives whom they may not have seen for some time, and they often recall deceased relatives.

Many of the survivors in our home have no relatives, and they all have a personal history profoundly disturbed by inhumane and systematic physical and psychological torture. Although staff members were apprehensive about having a seder, most of the patients participated in the communal singing and religious ceremonies and partook in the festive meal.

The case of Ms. A is an illustrative example. Born in 1927 in Hungary, Ms. A was raised by a foster family in Budapest. She was forced for economic reasons to leave school and begin working as a maid at the age of 14. Ms. A was 17 when the Nazis began rounding up Jews in the Budapest ghetto in 1944, and she was able to survive as a prostitute. The rest of her story is not clear. It is known that she immigrated to Palestine and was a soldier in Israel's War of Independence. After the war she never married or adjusted to normal life.

Before she was released to the Holocaust Survivors' Home, she had been hospitalized for 40 years in a crowded, privately owned institution. Usually introverted, she was diagnosed as having residual chronic schizophrenia. Ms. A blossomed at the seder. She read the story of the Exodus, she sang, and she seemed to express emotions long dormant, remembering things "as they were."

We believe the Holocaust Survivor's Home could be a useful model for patients who are displaced survivors of catastrophic events, have severe mental illness, and require continuous care.

Baruch N. Greenwald, M.S.W.
Arnest Shvindelman, M.A.R.N.

Mr. Greenwald, M.S.W., is professional director and Mr. Shvindelman is head nurse of the home. For more information, write the authors at Holocaust Survivors' Home, P.O.B. 1, Beer Ya'acov, 70350, Israel (e-mail, baruchng@yahoo.com).

The August Aichhorn Center for Adolescent Residential Care

Among adolescents, admission to residential treatment facilities in New York State is reserved for those who have severe emotional and behavioral problems, including antisocial and self-destructive behaviors that require virtually constant supervision. Such facilities are usually the only placement less restrictive than incarceration or total institutionalization. All potential referrals to residential treatment facilities are screened for need by a state-mandated preadmission certification committee, which is the only final referral source for admissions.

In 1991, the August Aichhorn Center for Adolescent Residential Care opened a residential treatment facility in Manhattan that provides an extensive array of services to its adolescent residents. The center's policy is to accept all referred youths who are 12 to 16 years of age, and who have been certified by the New York City preadmission certification committee, without further screening except for Medicaid-required documentation.

Residents almost invariably have been placed in a large number of institutional settings before admission. There are no exclusion criteria and no bases for administrative discharge or transfer to another facility. The program was designed and is operated as a last-resort placement for adolescents who cannot be managed anywhere else.

The facility is located in a specially designed six-floor brownstone in a residential neighborhood. It accommodates 32 residents in four living

units—three with eight single bedrooms and one with four doubles—and it includes school, recreational, clinical, administrative, and support space. The design and operation of the facility, along with the staffing pattern of about 86 full-time equivalents, including 46 child care workers, permits continual, intensive supervision.

Living units are intended to be the residents' homes. The unit leader is a parent substitute and is responsible for all aspects of daily life for the residents and for supervision of the unit's child care staff. The facility's clinical staff—therapists, teachers, and others—are consultants to the unit leader. This system is modeled on a community living arrangement, in which outside professionals may advise the family, but final decisions are made by the parent.

Although it is sometimes necessary to hold children who become agitated, the facility has no seclusion or special care rooms, and mechanical restraints are not used. The center's small size and urban location afford ample opportunity for supervised or independent access to the city's multiple mainstream educational, recreational, and cultural resources as well as for participation in ordinary daily activities such as shopping. Well-stabilized residents may begin attending public high school part-time, and eventually attend full-time.

One of the justifications for such intensive services is the hope of keeping these youths out of the criminal justice system, but little is known about the impact of care in a residential treatment facility on this outcome. In 1997, with support from the Child Welfare Fund of New York, the center initiated a prospective longitudinal study of this question among all of the discharged residents at that time—a total of 52 persons. These former residents had been in the center for periods ranging from three months to four years.

Because of the highly selected nature of this population, comparison with general norms of achievement would have little meaning. Therefore, we included a control group of 52 adolescents who had also been referred to the August Aichhorn Center but who did not actually enter the facility for reasons unrelated to their diagnosis or to admission policies and procedures, such as a lack of a bed at the center at the time.

We looked at arrests that occurred at any time after the study subjects' 18th birthdays by submitting the names and birth dates of all 104 subjects to the New York State Office of Court Administration (OCA) and requesting a computerized check of adult criminal court records for all 13 downstate New York counties. At the time of the inquiry, the average age of both groups was 21.5 years; the mean time since discharge for the "alumni" group was 55.4 months.

OCA reported that 51 of 104 subjects had an adult arrest record. However, even after one discharged youth who was readmitted to the center was excluded from the analysis, the proportion of alumni with arrests (20 of 51, or 39 percent) was significantly smaller than the proportion in the control group (31 of 52, or 60 percent; $\chi^2 = 4.28$, df=1, $p<.05$).

This early finding suggests that the August Aichhorn Center's residential treatment program may serve to reduce the high rate of adult criminal convictions among high-risk youths with severe emotional and behavioral problems.

Bernard Horowitz, Ph.D.
Michael A. Pawel, M.D.
Patrice O'Connor, R.N.

Dr. Horowitz is a researcher with Child Welfare Research in New York City. Dr. Pawel is executive director of the August Aichhorn Center for Adolescent Residential Care and assistant professor of psychiatry at the College of Physicians and Surgeons of Columbia University. Ms. O'Connor is quality improvement coordinator at the August Aichhorn Center. Send correspondence to Dr. Pawel, August Aichhorn Center, 23 West 106th Street, New York, New York 10025 (e-mail, map6@columbia.edu).

New York State Office of Mental Health Trauma Initiative

In May 2000 the New York State Office of Mental Health (NYSOMH) established a trauma unit in its chief medical office, signaling the high priority of routine trauma assessment and treatment in New York's public mental health system. The unit is an outgrowth of the agency's trauma initiative, which is described below along with efforts to involve service recipients, clinicians, administrators, researchers, and policy makers.

The trauma initiative began in 1995. It was inspired by the work of the Center for Mental Health Services, including the first national forum on women, mental health, and violence in 1994. The initiative was also a response to pressure from consumer-advocates and to a growing body of research.

Researchers had already shown that although individuals receiving treatment for serious mental illness often have a history of childhood sexual and physical abuse, they are seldom asked about their traumatic experiences. Moreover, publicly funded mental health programs offered no trauma services. In New York State, it was clear that no single policy directive or administrative action could effectively retool the large and complex mental health service system. Rather, an incremental mobilization effort was indicated.

As a first step, NYSOMH issued a statement acknowledging the high rates of childhood abuse among adult recipients of mental health services and the need to develop routine assessment procedures and appropriate services. Next, an implementation plan was developed to improve services for survivors of trauma who have psychiatric disabilities. The plan laid out a road map for the work ahead and encouraged service providers to join the effort.

The next step in the trauma initiative was to develop local leaders. To this end, a statewide committee on trauma was established to advise NYSOMH. Formation of the committee created opportunities for interested clinicians, service recipients, and administrators to share information and support. An electronic bulletin board was established to disseminate information about the initiative as well as literature and program information.

The commissioner of NYSOMH directed state psychiatric centers to convene trauma work groups to identify opportunities for improvement at the facility.

Funding was provided to a nonprofit agency to facilitate the development of local trauma networks. NYSOMH established a small fund to support local training programs.

In partnership with the in-house design and printing department of NYSOMH, Trauma Initiative Publications was formed. It published the *Trauma Assessment and Treatment Resource Book*, which is a compilation of assessment forms and program descriptions of trauma services offered by state and local mental health providers. Trauma Initiative Publications has also published manuals for group models submitted by mental health providers. Thousands of copies of these resource books have been distributed.

After a forum was held on trauma and mental health issues, a report was issued and widely disseminated. The report included local research data, accounts of personal experiences of mental health service recipients, and clinical observations made by providers. Trauma initiative staff gave presentations on trauma and mental health issues to state and local audiences. Common themes included the prevalence of trauma histories; the connection between trauma and established priority populations, such as those with dual diagnoses of mental illness and substance abuse and those who are violent or self-injuring; and the consistency of trauma services with the larger agency mission, which is to promote recovery and decrease the use of high-intensity, high-cost psychiatric services such as emergency and inpatient treatment.

To date, the accomplishments of the trauma initiative include receiving priority status for state funding for new programs; an annual statewide training conference featuring national and local experts; partnership with heads of county mental health departments; and the inclusion of a mandatory training program for all direct care staff as part of NYSOMH's core curriculum. All state psychiatric centers now routinely screen for trauma history. A trauma screening form will be included in the agency's new automated record system. Many state hospitals and several local programs offer trauma services ranging from psychoeducational programs to safety skills groups to individualized trauma treatment.

Current efforts include a targeted children's trauma initiative, increased training in working with men who are traumatized, and the development of programs for trauma survivors with psychiatric disabilities in forensic programs. More than 1,100 mental health care workers and recipients attended our annual clinical training conference in 2001, demonstrating the potential for successfully raising awareness and interest in trauma issues through this type of initiative.

Janet Chassman, M.B.A.

Ms. Chassman is director of the trauma unit of the New York State Office of Mental Health, 44 Holland Avenue, Albany, New York 12229 (e-mail, jchassman@omh.state.ny.us).

Psychiatric Services Invites Submissions By, About, and For Residents and Fellows

To improve psychiatric training, to highlight the academic work of psychiatric residents and fellows, and to encourage research on psychiatric services by trainees in psychiatry, *Psychiatric Services* is introducing a new feature—a continuing series of articles by, about, and for trainees. Submissions should address issues in residency education. They may also report research conducted by residents on the provision of psychiatric services.

Avram H. Mack, M.D., will serve as the first editor of this series. Prospective authors—current residents, fellows, and faculty members—seeking advice about the appropriateness of a topic should contact Dr. Mack at the Department of Child and Adolescent Psychiatry, New York State Psychiatric Institute, Unit 74, New York, New York 10032; avram_mack@hotmail.com.

All submissions will be peer reviewed, and accepted papers will be highlighted. For information about formatting and submission, see Information for Contributors in the August issue, pages 1119–1120, or visit the journal's Web site at www.psychiatryonline.org. Click on the cover of *Psychiatric Services* and scroll down to Information for Authors.