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

Community Mental Health in the Northern Marianas

Some years ago, I visited a colleague who was living in Saipan in the Northern Mariana Islands, which is a self-governing United States commonwealth located in the western Pacific Ocean. I felt attracted to the innate generosity of the people, challenged by the unmet needs that I saw for mental health services, and stunned by the beauty of the verdant foliage contrasting with the cerulean sky and turquoise sea. I decided to relocate there. As a general psychiatrist with credentials in addiction, forensics, traumatology, and administration, I found numerous ways to fit in and to apply my skills and knowledge.

For the past three years, I have been working as part of a newly established team dedicated to developing culturally appropriate community care for people with severe mental illness. We started out by trying to identify every individual with serious mental illness who was homeless or at risk for homelessness. We offered treatment to them, and we continue to approach those who do not currently want treatment. We've also directed our efforts to the education of clients, their families, and the community—through village meetings, Friday-night potluck dinners, appearances at health fairs, and promotion on radio and television—to encourage acceptance of treatment and to reduce the stigma associated with mental illness.

A major constraint on community mental health is the recruitment and retention of professionally and culturally competent staff. We have worked with existing resources by starting to develop a network of supervisory support for the numerous members of the clergy of several denominations who already counsel mentally ill people in the community and by forming alliances with local healers. We hope these activities will become part of providing comprehensive, collaborative, and socially acceptable interventions.

We are now planning a network of residences for chronically mentally ill patients, with varying intensity of treatment and supervision. We have begun to train nursing staff in the smaller islands so that facilities there can directly serve their own severely mentally ill populations. It has been very rewarding to begin developing the type of mental health system that we've come to think of as the standard of care on the mainland of the United States within the cultural context of Micronesia.

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Transpersonal Psychiatry at a VA Medical Center

A transpersonal care program has been developed at the Veterans Administration Medical Center in San Francisco to provide mental health care to veterans for whom spirituality is a significant focus in their lives. Traditional psychiatry has often ignored or pathologized religious and spiritual issues. Transpersonal psychiatry recognizes spiritual growth as an essential part of psychological health.

This program, which was founded at the medical center in 1995 by John F. Hiatt, M.D., has provided mental health services to 100 veterans. Currently 50 clients are participating in a variety of treatment modalities. They include individual psychotherapy, medication clinics, and group therapy; among the therapy groups is one for people with less developed ego strength. Veterans in the program who need primary care or substance use treatment receive such services elsewhere in the medical center; however, most participants in the transpersonal care program receive all their treatment under its auspices.

The program recognizes that human consciousness is evolving, and clients' issues are framed in this context. Many clients who are struggling to find meaning at midlife have benefited from group work that addresses spiritual concerns.

The program focuses partly on the meaning of life experience, illness, and health to the client. Characterological problems, existential issues, and psychotic experiences can all be effectively addressed in this framework. Veterans with posttraumatic stress disorder have learned to experience control over their anxiety through grounding and centering meditative techniques. For others, recognizing the transformative aspects of psychotic experiences has been an important part of their postpsychosis integrative work.

Breathing exercises and visualization are used to help clients access nonordinary states of consciousness in order to facilitate psychotherapy and spiritual development. Meditative practices develop clients' capacity for introspection and self-analysis by training their attention, which enhances and facilitates psychotherapy. Studies suggest that quiet breathing with prolonged expiration reduces the rate of nerve-cell firing in the amygdala, which may lower levels of subjective anxiety. Clients use a visualization technique to still the mind and allow a spontaneous image to arise into awareness. The client regards the image with nonjudgmental attention and then explores it. Guided imagery therapy employs a client's own internal imagery to uncover and resolve emotional conflicts.

The program receives referrals from throughout the medical center, including the program for homeless patients, the psychiatric day treatment center, the HIV clinic, the nursing home and hospice program, and the psychiatric consultation-liaison service. Providers are asked to screen their clients for spiritual interests, concerns, and practices.

The transpersonal care program makes a distinction between religion and spirituality and does not incorporate any particular religious system into its approach. It has been well received by the veteran population and is growing. The program is also involved in teaching psychiatric residents and medical students.

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Community Psychiatry Pilot Projects in Ukraine

In May 1998 I traveled from Canada to Ukraine to spend a month as a volunteer psychiatrist for the American Jewish World Service—to consult with the director of the Zhitomir Psychiatric Hospital, assess mental health services in the region, and suggest improvements. I spent two weeks visiting all the psychiatric facilities in the area, was allowed to see whatever I wanted without restrictions, and had an outstanding translator.

The Zhitomir hospital, which is just outside the city, has several old buildings housing 700 patients in conditions reminiscent of past asylums. Facilities were quite primitive and crowded, and treatment was primarily custodial. Patients were treated kindly by staff, and I saw no evidence of abuse or of incarceration of political prisoners. However, activities for patients seemed minimal, and most sat looking bored.

Similar bleak conditions characterized the 400-bed Regional Psychiatric Hospital Number 2, near the Byelorussian border. The most upsetting place I visited was an *internad,* or boarding home, which was a farm two hours' drive from Zhitomir. One hundred and sixty women lived in this facility that had one physician and offered minimal "treatment." Patients rarely had visitors or a chance to integrate into society. The pervasive public attitude about psychiatric patients seemed to be "out of sight, out of mind." Patients were sent to hospitals or boarding homes and tended to remain there, as almost no community services existed. The best facilities were outpatient clinics in Zhitomir, which were well staffed and looked more user friendly.

Psychiatrists received only about a year's training. Many mentally ill patients who did not fulfill *DSM-IV* criteria for schizophrenia were diagnosed as having that disorder, and affective disorders were underdiagnosed. Psychiatrists were also required to treat patients with mental retardation or with epilepsy along with the mentally ill.

What I was shown as psychotherapy seemed more like activity therapy or psychoeducation. Psychotropic medication was inadequately used. Often neuroleptics were prescribed for nonpsychotic patients. Dosages were often on the low side due to lack of drugs, and medications were frequently discontinued due to lack of funds. Yet often several neuroleptics were given when one would suffice. The drug prescribed might depend greatly on what was available. Our newer antidepressants were seldom obtainable, and laboratory monitoring was rare. It was frustrating to see patients lack the benefits of simple, common remedies.

The psychiatrists were unfamiliar with the concept of multidisciplinary teams. Nurses were available, but were not highly trained in psychiatry and basically carried out orders. Psychologists provided some testing and specific therapies. There were no social workers. Self-help groups were almost nonexistent. I met with a group of patients' relatives who were organized to provide mutual support, but not to promote political action or public awareness of mental health concerns.

The common themes I heard were that there was not enough money, the government needed to provide more, and the government was not to be trusted. People did not have the concept of helping themselves. There was no association for physicians, although a psychiatric association had recently been formed.

Before leaving, I met several times with the director and staff of the Zhitomir hospital and described in detail the outstanding differences between Canadian and Ukrainian psychiatry, including the Canadian emphasis on multidisciplinary teams and community treatment rather than hospitalization. The hospital director and I met with the local director of social welfare, initiating possibile ongoing collaboration.

We also agreed on two pilot projects. The Zhitomir outpatient dispensary would select 20 difficult-to-treat patients with a chronic psychotic illness such as schizophrenia. They would receive the proper neuroleptics, including long-acting depot medications, and would attend the dispensary twice a week for drugs, monitoring, and activities with mental health personnel. The staff would assist patients with any current family, personal, or social problems. To assess the project, simple data would be collected after six months and one year. A similar project would be carried out in nearby Novograd.

Such endeavors are unique in Ukraine. They emphasize community care, mobilization of patients, and regular, uninterrupted pharmacological regimens. They involve a multidisciplinary team and, one hopes, relatives and community organizations.

I have maintained e-mail contact to keep the projects on track and have obtained donations of depot medication from a manufacturer. The problems facing Ukraine are enormous, but the people I met were hopeful and motivated to make improvements. They are accustomed to sacrifices. I hope I can return to witness their progress.

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