Behavioral Health News

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SPRING 2022 EDUCATION, INFORMATION, ADVOCACY, AND COMMUNITY RESOURCES VOL. 9 NO. 4

Understanding Treatment and Recovery Models of Care

The Triumph of "Recovery"

By Michael B. Friedman, LMSW
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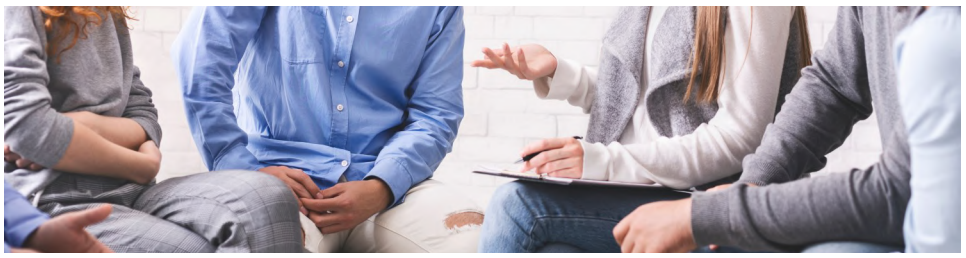

By the early 1970s, just a few years after aggressive deinstitutionalization began, it became clear that merely keeping people with serious and persistent mental illness out of the hospital and in the community was not enough. It was not even enough to make sure that they got good psychiatric treatment (not that it happened often). To have a decent life, people who had been discharged after years in state hospitals or who had been "diverted" from admission to state hospitals needed more. They needed a place to live that was safe and tolerably comfortable. They needed to have enough money to get through a month without having to panhandle at the end. They needed to have people in their lives who cared about them and who they cared about. They needed to have something interesting and pleasurable to do beyond hanging out on the streets of their neighborhoods. They needed opportunities for education and work. They needed to have access to good medical care.

But that's not what they had. I worked on the Upper West Side of Manhattan for the first 6 years of the 70's. The people I worked with lived in shabby, often dangerous single room occupancy hotels. They got very poor psychiatric treatment that relied on excessively high doses of drugs like Thorazine. The support they got from welfare was barely adequate for those who were incredibly frugal; for those who wanted an occasional nice meal or a drink with friends, life was not affordable. They often scrounged for cigarette butts on the sidewalks and panhandled for a few extra bucks so they could eat at the end of the month. Family life was often difficult, friends hard to find. They were mostly not welcome in mainstream settings. The shabbiness of their dress and other trappings of severe poverty as well as idiosyncratic behavior set them apart. Even houses of worship were not welcoming.

To make it right, in 1977 the federal

see Recovery on page 14

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Summer 2022 Issue
Understanding the Impact of Stigma
Deadline: June 15, 2022

Fall 2022 Issue
The Behavioral Health System: Challenges Past and Present
Deadline: September 16, 2022

Winter 2023 Issue
Stigma: How We Can Make a Difference
Deadline: December 13, 2022

Spring 2023 Issue
The Impact of Behavioral Health on Families
Deadline: March 16, 2023

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Peer Professionals and the Important Role They Play in the Recovery Process

By Ann Sullivan, MD
Commissioner
NYS Office of Mental Health (OMH)

When two people have something in common, it creates a bond that allows for meaningful discussions and a trusting relationship. This is the foundation of Peer Support and the reason for its success. Peer professionals share the knowledge, skills and information they've learned from their own experiences living with mental illness to help others reach their recovery goals.

The work of Peer professionals complements the work done by therapists, case managers, and other members of a treatment team. Numerous research studies have indicated that Peer professionals can play a significant role in improving health and wellness, because of their ability to build trust, form one-to-one relationships, and give hope to others. Peer professionals know what the struggle is like because they've overcome the same challenges and can understand the thoughts and feelings of people going through recovery or caring for child with social and emotional challenges.

As the mental health system becomes increasingly more responsive and person-centered, Peer professionals are playing a key role because of their cultural understanding and ability to provide education in a community setting. Recognizing the important role Peer Supporters play, New York was the first state to establish a Civil Service title for "Peer Specialists" and these peers were among the first to be certified and qualify for state and Medicaid reimbursement.

The New York State Office of Mental Health recognizes and endorses the certification or credentialing of three types

Ann Sullivan, MD

of Peer professionals, including Adult Peer Specialists, Family Peer Advocates and Youth Peer Advocates, to work throughout the adult and children's mental health system. A key qualification for a Peer professional is "lived experience" which typically includes living with, or being impacted by, conditions such as health or behavioral health conditions, substance use, or other system challenges.

Lived experience gives Peer professionals a deep level of understanding and insight into a recovering individual's experience. Their experience of learning to grow and thrive, while facing similar challenges, puts them in a position to share meaningful lessons learned in a way that individuals can view as highly credible. Family and Youth Peer Advocates are specially trained to work closely with young people and families who are struggling with mental health or addiction issues. They provide support and hope to youth and their families as they navigate the mental health care system.

There is widespread recognition that peer delivered engagements can play a significant role in improving health and wellness. Published studies cited by such organizations as Substance Abuse & Mental Health Services Administration, (SAMHSA), Health Resources & Services Administration (HRSA) and Centers for Disease Control (CDC) have consistently indicated that Peer Specialist services have improved outcomes for individuals dealing with Substance Use Disorder, health, or mental health, challenges.

OMH's plans to reinvest in community-based programs and services to increase availability and access to mental health supports, and our reinvestment plans for every region of the state include utilizing Peer professionals in expanded crisis intervention programs and mobile intervention teams, as well as Assertive Community Treatment (ACT) teams. Peer professionals work in a wide variety of settings, including residential facilities, community-based services, emergency departments and psychiatric units, Faith-based organizations, and health programs.

The Role of Peer Specialists in OnTrackNY

One of OMH's most successful programs is OnTrackNY, and the involvement of *Peer Specialists* is a major reason for this success. OnTrackNY is an innovative treatment program for adolescents and young adults throughout the state who have had unusual thoughts and behaviors, or who have started hearing or seeing things that others don't. OnTrackNY helps people achieve their goals for school, work, and relationships.

Peer Specialists work as partners with the young people in the program to support them as they make meaning of their experiences and build the lives they wish to live. The role of Peer Specialist is embedded into the OnTrackNY clinical treatment team. Their work is best explained through these 12 role responsibilities:

Outreach & Engagement: Reaching out to young people and their families in order to introduce them to the unique benefits of working with the program;

Relationship Building: Developing relationships with young people that include connecting around their shared mental health experiences and other aspects of their personal lives;

Embracing Creating Narratives: Helping young people understand life experiences such as psychosis;

Co-Creating Tools for Success: Collaborate with young people to support them in strengthening self-awareness, building life skills, and clarifying their personal visions.

Supporting & Partnering with Families: Working with young people to define family involvement within the program, then working to share perspectives and have open dialogues;

Making OnTrack Better: Partnering with current and former program participants to learn about their experiences to ensure that the OnTrackNY program is best serving Participants, their families and the community at-large;

Bridge Building: Serving as a bridge between OnTrackNY team members and

see Peer Professionals on page 16

Navigating the Road to Recovery: An Art and a Science

By Jose Cotto, LCSW
Senior Vice President/Residential Services, ICL - Institute for Community Living

Defining recovery is all-encompassing – it may be recovery from mental illness, substance use, trauma, losses – and as we've recently learned – from the effects of a pandemic. Most often it is thought about as a journey toward regaining something that was lost or returning to a former state. In behavioral health, we take the definition a step further: Recovery is about helping a person realize a vision of themselves they did not think possible and derives from the belief that everyone is capable of living their best life even if circumstances or history make it difficult for a person to believe. That is why at its very core – recovery is about hope.

Here are some basic assumptions about the process of recovery: We know that there is no one recovery: Each person's journey will look – and feel – very different. For some, the slightest gains allow them to feel better and feel like themselves again. For others, it may take much more work and time to get to that place.

Recovery as Common Thread

While I worked in a variety of settings earlier in my career, it has been in my almost ten years at ICL that I have come to appreciate a much broader and holistic understanding of recovery.

I've been part of nearly every area of services at ICL (and there are many, with more than 100 distinct programs across the five boroughs). Through this work, I have come to a much greater understanding of the complexity of recovery thanks to being part of a community of people working together to ensure that - as our mission states – "people get better with us".

At ICL, recovery is integral to every program– whether at Community Residences, Supported Housing, Assertive Community Treatment (ACT) Teams, Intensive Mobile Treatment Teams or Mental Health Clinics. While each program may look different on the surface, they share the goal of improving a person's well-being, enhancing their safety and bringing them closer to a more satisfying and fulfilling life. All of these goals are encompassed in a program's particular approach to recovery tailored to specific life experiences, ages, and health status.

Recovery is even spelled out in the central principles that guide the work we do throughout ICL It's part of what we commonly refer to as TRIP – an acronym for treatment that is Trauma-Informed, Recovery-Oriented, Integrated, and Person-Centered.

Jose Cotto, LCSW

Linking Physical and Mental Health

What has further enhanced ICL's appreciation for recovery are the two latter parts of that acronym – Integrated and Person-Centered care.

ICL serves about 15,000 people every year - people of all ages, facing problems related to mental illness and substance use; many of their challenges are the result of larger social and economic conditions that have plagued communities of color for generations – conditions like poverty, chronic homelessness, and lack of access to quality, reliable health care.

Incorporating the effects of these social determinants of health into our work has further enhanced how we look at recovery. What we've come to appreciate at ICL – along with other mental health practitioners and institutions around the country -- is that recovery is only successful if it is grounded in an understanding of and respect for the entire life experience of a person. Referred to as whole person/whole health (or integrated) care – whatever it's called, we know that this approach needs to be part of any recovery process.

At ICL, whole person health is the lens through which we look at every individual who comes to us for help. And each person is an active participant – that's why we do biannual healthy living surveys to make sure that what we are doing is working. Since this survey was instituted about seven years ago, each year about 97% of people receiving mental health services tell us they are feeling and doing better and are more connected to community. These are key markers of success on the recovery journey.

Use What Works

What modality works best in recovery? When asked what practice models inform my work – one-on-one, group or community -- my answer is always the same: I am a social worker and take from different models what has the most promise and meets the needs of the individual (family, group or community).

Let's say I'm working with a 20-year-old young adult transitioning out of foster care into an ICL Community Residence and being served by an ACT team. My decision about a modality will be led by the person, their specific situation and circumstance. For example, I might use a Strengths-Based language approach to introduce myself, have small talk to help make the individual feel more at ease. Like a good social worker, I may throw in a couple of ice breakers that are age appropriate and - hopefully - "cool" enough.

Once they are feeling more comfortable, I might use evidenced-based practices such as Motivational Interviewing to determine what parts of their life they're prepared to make changes in. At that point, I might engage in Person-Centered Planning and partner with them to develop goals and objectives and possible interventions. I would do this carefully as this might be the first time the person feels they are in the driver's seat, on their road to recovery.

If there's an event the person wants to heal from but isn't quite ready to face, we can tap into Narrative Therapy and call the event something that's less triggering. I might also pull from Cognitive Behavioral Therapy and assign worksheets to help them better understand the impact of their thoughts and how to restructure unhealthy patterns of thinking. And in the end, I might leave them with a transitional object (Object Relations Theory) to remember our relationship when they might need a tangible reminder.

A resource I've found very useful in developing strategies to support recovery is SAMHSA's Recovery Model's ten guiding principles that include culture, relational, holistic, hope and peer support. These principles were created to bridge mental health and substance use disorders, providing more treatment options.

Culture is one we often take for granted: We've learned a lot about the impact of culture in recent years as the conversation about race has come more to the surface. We have to continually assess the interaction of culture and treatment delivery. When we're being conscious of the role of cultural identity in a person's life, we're conveying much-needed respect. Relationship is another principle I hone in on as it can significantly help the person tap into their own motivation and create change. In other words, your relationship with them can be the impetus for change.

Access a Variety of Services

Regardless of what model you're utilizing, to serve the complexity of medical and mental health needs of people, having a place that offers many services under one roof is ideal. We've been fortunate at ICL to have a convenient internal resource: our East New York Health Hub that opened a few years ago. Having a wide range of health, mental health, and community support in one location has greatly enhanced access to care *and* knowledge, for people seeking and those delivering care. And recovery is part of all services offered there.

One of the first things you will see on entering the Hub is a primary care clinic operated by the Community Healthcare Network (CHN). The clinic represents a carefully developed partnership between CHN and ICL that gives concrete meaning to the link between physical and mental health (something we as mental health providers have long understood and the rest of the world came to appreciate during COVID).

In addition to primary care, you'll find many other resources at the Hub like housing support, access to healthier foods and the benefits of improved lifestyles, as well as a continuum of therapeutic services including individual and group therapy, care coordination, and mobile treatment teams. And we offer additional supports that we know are critical to achieving better health and open up new avenues toward recovery, like an active art studio and an outdoor garden to spend time in.

Where there isn't an accessible physical center for services like the Hub, then we have to get more familiar with – and collaborate with – various community resources. At times, it may feel almost impossible given our workloads and time pressures, but it will pay off to visit local organizations and help people receiving care at ICL benefit from other organizations as well.

Ensuring a Strong Future

This pandemic is not going anywhere as far as our communities are concerned and the impact will be felt for decades. As practitioners, we remain committed to the possibilities of recovery – for all people to get better, do better, and live better. This continues to motivate us to keep doing the work together – so every person who seeks help, gets closer to leading a more independent and fulfilling life.

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A commitment to recovery is at the heart of everything we do.

It all started with a downtown residence in Brooklyn for people living with mental illness - one of the first in the country.

Today ICL offers a citywide network of more than 100 housing and support programs - all grounded in a whole person/whole health approach to care.

Thank you to our 1300+ staff for their extraordinary commitment and for never giving up on anyone.

Together with all of our community partners, we'll continue to build a healthier New York for all.

It's been an incredible journey and we've only just begun...

Institute for Community Living
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Evolution and Innovation in Care

By Shawna Marie Aarons-Cooke, LCSW-R, CASAC2, Senior Vice President of Programs, The Guidance Center of Westchester, an Affiliate of Access: Supports for Living

As a newly licensed master social worker, I began my career in a health center of a major New York City hospital system in 2007. Addiction and substance use, mental health, and comprehensive medical care were all provided within the center. Joining The Guidance Center of Westchester (TGCW) 12 years ago, I learned first-hand the challenges nonprofit community-based organizations face when attempting to address the complex co-occurring needs of individuals and families.

When I initially joined TGCW, I provided comprehensive assessments as well as individual, family, and group psychotherapy as part of a multidisciplinary team in our New Rochelle children and families clinic. The team included clinicians from a variety of disciplines: social work, psychiatry, psychology, marriage and family therapy, mental health counseling, and creative art therapy. I worked with children as young as four years of age and adults well into their 80s. I loved the opportunity of engaging a diverse group of individuals who each had unique presentations, needs, and challenges.

Shawna Marie Aarons-Cooke

Very different from a program within a hospital system in New York City, the ability to integrate medical care was much more complicated in a smaller nonprofit social services organization. Negotiating medical care meant developing relationships with numerous medical providers or falling short in being able to effectively engage program participants in their medical care. For those with challenges related to alcohol and substance use, other clinicians and I were making linkages to substance use treatment and recovery programs. However, in some cases that meant a person would have their mental health needs served in one program or agency, addiction needs served in another program or agency, and medical needs also served elsewhere – an ongoing challenge for service providers who specialize in either mental health or addiction.

Fortunately, TGCW operates substance use treatment programs including medication assisted treatment, as well as supported housing programs for individuals struggling with mental health conditions and/or addiction. Each of the substance use programs has medical staff and services which enable primary care services to be provided as part of their treatment. TGCW also established two evidence-based integrated treatment and recovery-oriented services programs: Personalized Recovery Oriented Services (PROS) in 2011 and Assertive Community Treatment (ACT) in 2018. Both programs integrate medical, mental health, and addiction care in addition to providing family, vocational, and housing supports. Health Home Care Management services, established in 2016, is yet another resource TGCW provides to support integrated medical and behavioral health care.

There is a saying around our offices, "If there's a need, we have a program for that!" From co-locating mental health and addiction programs to integrating mental health, addiction, medical care, and additional supports, TGCW has evolved to support the full range of complex co-occurring needs of those who seek our services.

The culmination of the agency's evolution to become a Certified Community Behavioral Health Clinic (CCBHC) organization in 2020 reflects the "no wrong door" of comprehensive care that is truly needed to provide whole person care and supports. Today as a SAMHSA CCBHC expansion grantee organization, TGCW provides 24/7 access to services via a toll-free hotline 1.888.TGCW.CAN (888-842-9226) as well as walk-in hours at locations in Mount Vernon and New Rochelle. This centralized engagement and access to services is one small step to innovate behavioral health treatment and recovery. Throughout the organization we have trained more than 30 team members to become Certified Alcohol and Substance Abuse Counselors (CASACs), ensuring comfort and skill among our already multidisciplinary team of clinicians to address co-occurring mental health and addiction needs of our program participants. TGCW also obtained integrated licenses from the

see Care on page 29

Early Childhood Mental Health Clinic: Unmasking Social-Emotional Needs in Young Children

By Iva Jenkins, LCSW
Director of Early Childhood Behavioral Health Services, The Guidance Center of Westchester, an affiliate of Access: Supports for Living

Think about this: a child who turned 5 years old in March 2022 will have spent 60% of their young life in the age of COVID. Most, if not all, of the child's active memories will be a time when traveling outside the home means wearing a mask. They were told that masks keep them safe; masks protect us; masks mean that we care about other people's health and safety, too. Their first school experiences, if they had them, are all in the era of COVID.

As indoor mask mandates are being lifted, how is a young child - whose entire conscious recollection of life involves wearing a mask in public - supposed to process the "new," sometimes mask-less world? How are they to interpret some people wearing masks and others not?

As an adult, we may welcome getting back to the "new old" ways; a child may have a harder time understanding it. As odd as it may seem, they may feel a loss of security, control, and comfort.

Parents and caregivers may see children exhibit a variety of behaviors: complaints of stomach aches or other pains when plans involve leaving the home; a regression with toileting, sleeping, or eating habits; acting out; crying for "no" reason; or other uncharacteristic behaviors.

Iva Jenkins, LCSW

Masks, however, are just one example of something which may cause very young children to exhibit symptoms of anxiety and trauma. We are living in a day when startling events from around the world are broadcast into our homes. While the troubles may be half a world away, they feel close to home.

Young children also pick up on the stress of the adults in their lives. Children may not know about the economy, inflation, or escalating gas and food prices, but they do know when their parents or caregivers are worried. Divorce rates are also rising. While this has long been a cause for behavioral issues in children, because families have spent so much time together during the pandemic, children may be more exposed to quarrels and bickering between the adults.

Too often, parents are at a loss when it comes to identifying their child's social-emotional development and assessing behaviors. Parents aren't sure what is typical versus what may need a little guidance and coaching. And then they don't know where to go for help. This is why The Guidance Center of Westchester (TGCW) opened the only OMH-licensed mental health clinic solely dedicated to the needs of young children (up to 5 years old), their siblings, and their families.

With a history rooted in supporting children and families, TGCW is particularly well positioned as an important resource for families when it comes to behavioral health care needs. Our clinical team consists of early childhood behavioral health specialists (LMSW and LCSW), and we are able to provide services in English, Spanish, and Portuguese.

We strive to provide families with the tools to handle inevitable setbacks and challenges of life in a safe, constructive way, now and in the future; decrease behaviors that interfere with learning; increase the child's ability to manage and regulate feelings and behaviors; improve social/emotional skills, build resiliency, improve self-esteem, and encourage self-regulation; improve family relationships so that the child feels safe and secure; increase positive interactions and communication between parent and child.

We provide evidence-based treatment and group treatment modalities:

· Child Parent Psychotherapy (CPP), an intervention model for children aged 0-5 who have experienced traumatic events or mental health, attachment, or behavioral challenges. The central goal of CPP is to support the parent-child relationship to restore and protect the child's mental health

· Play Therapy, a specialized way to gain needed insights into behavior. Through Play Therapy a child explores emotions and deals with unresolved trauma or behavioral issues using games and other play materials. Children learn new coping skills and how to redirect inappropriate behaviors.

· Family and Sibling Support helps improve communications skills, facilitates

see Unmasking on page 20

Mental Health is Essential to Stability

By Diana, El-Quan, Herman, Jesus, Luis, Noelle and Socorro

This article is part of a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The authors are served by Services for the UnderServed (S:US), a New York City-based nonprofit that is committed to giving every New Yorker the tools that they can use to lead a life of purpose.

We are seven New Yorkers ranging in age from the 20s to the 70s. We all have a variety of behavioral health needs and have benefited from S:US programs such as housing assistance and supported housing, crisis respite, care coordination, substance use treatment and recovery clinics and services, therapy and other mental health services, supported employment, and peer-to-peer support. Some of us have been homeless, some have had mental health crises, and some have overcome substance use to drugs and alcohol.

We believe very few individuals are unaffected by mental illness and substance use. Because S:US provides the support we need and through our work together, we believe we can recover, lead productive lives, and move past our challenges.

Mental Health is Essential to Stability

We all have mental health disorders – whether it be anxiety, depression or anger management issues. Being able to support our mental health is key to finding stability in all areas of our lives.

Noelle struggled with a crisis situation and was starting to shut down. "I have generalized anxiety disorder and I suffer from panic attacks. If my anxiety levels are too high I go into crisis mode and cannot function well. The Crisis Respite Center has been just that – a respite. It has been great to be able to have time to rest and reset a bit here. Before I came here, I was experiencing physical challenges that were overshadowing my mental health issues and not allowing me to put in the psychological work I needed to. The respite helped me to lift my head up again and get back into more of the activities I'm used to doing," said Noelle.

El-Quan experienced multiple hospitalizations and wasn't very good about taking his medication. "Since getting help from S:US, I learned a lot about my diagnosis, and reconnected with my family and friends – which I found hard to do before. With my mental health under control, I have been able to keep a job (working with my family) and I hope to get a new job. I live with my grandparents. I'm doing well now," said El-Quan. "I don't let myself fall into negative thoughts and patterns. I keep busy with photography and writing. Writing has been a positive outlet, getting my ideas and thoughts out and being able to express whatever I'm feeling has been helpful."

Jesus came to S:US from a local hospital. S:US helped transfer him out of the hospital and into a shelter. "I was in the hospital, scared of going out and getting help. One thing that helped me was that S:US would escort me to services that I needed and I felt safe doing that. It was a difficult transition between the hospital and the outside world – going outside was really hard for me but they helped me overcome that. I was slowly able to attend appointments and use public transportation on my own, and I've been successful in using coping skills they taught me," said Jesus. "I was also finally able to save up money from my part-time jobs and my student internship. I visited my mother in the Dominican Republic for the first time in ten years! I also got reconnected to college courses, received my associate's degree, and have been accepted to a bachelor's program. I'm waiting on supported housing – that will really help me focus on school and work."

Luis was diagnosed with alcohol dependence and has been able to identify

see Stability on page 39

Today's Treatment Models Use All the Tools in the Toolbox

By Peter Provet, PhD
President and CEO
Odyssey House

Treatment for substance misuse begins before someone walks through the doors of a rehabilitation center asking for help. It starts when a person acknowledges their life is out of control – or controlled by a drug of abuse – and harms themselves and potentially others.

Denial, conscious and unconscious, is the primary defense used by a person with substance use disorders (SUDs). One of the founding principles of self-help approaches, including AA, NA, and many residential treatment models, is that people with SUDs are reluctant to seek and commit to a course of treatment.

But it is also well documented that the positive power of the community encourages and allows for sustainable change and growth. The Community-as-Method model has saved the lives of hundreds of thousands of people and continues to be an effective, low-cost model of care today.

At Odyssey House, we support the self-help model of care across our residential, outpatient, supportive housing, and recovery services. For 55 years, we have provided a continuum of services that engage, stabilize, and prepare people to rejoin society as functional parents, spouses, workers, and citizens. While we are proud of this legacy and its contribution to the health and well-being of thousands of Americans, we are equally proud of the innovative enhancements to the evidence-based treatment models we incorporate into our program services.

Peter Provet, PhD

Integrated Service Model

Recent enhancements in our treatment services build on the foundational approach that people with chronic substance use disorders need long-term support that addresses addiction in conjunction with other challenges, including mental and physical health problems, poverty, homelessness, and discrimination. It's an approach that sees an individual as a whole person with interrelated challenges and circumstances that require multiple services.

Examples of our whole-person approach are woven throughout our services and start in our admissions unit. It does not matter how the person is referred - through the courts, detox centers, homeless shelters, family, or harm reduction services - our process of engagement and developing a treatment plan starts immediately.

We are acutely aware that our ability to bring people into treatment and start stabilizing their lives can mean the difference between life or death for those abusing potentially deadly opioids or other drugs of abuse.

The Urgency of Opioid Treatment

Last year, drug-related overdoses claimed the lives of more than 100,000 people. Each of those deaths was preventable and a tragic loss and waste of human potential. The toll is shocking: over 500,000 deaths attributed to opioids since the mid-1990s.

The causes of the opioid epidemic are understood, in part, to have been fueled by the aggressive marketing and misleading promotional information of OxyContin's potent addictive properties by Purdue Pharma and other pharmaceutical companies and distributors of synthetic opioids. Their drive for profits laid waste to communities already suffering from economic decline and societal challenges, undermined legislative efforts to control ballooning prescriptions, and paved the way for illicit and cheaper opioids, including heroin and fentanyl, to find new markets.

Integrating Harm Reduction

Treatment agencies were, and continue to be, on the front lines of this epidemic. As early as 2015, we began training staff and clients to use naloxone to reverse a suspected opioid overdose. We embraced this life-saving harm reduction approach and incorporated it into our treatment model along with medication-assisted

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Recovery from page 1

government developed the Community Support Program (CSP) with an emphasis on housing, income support, rehabilitation, and case management. The states followed.

But even CSP was not enough, in part because it couldn't happen fast enough and in part because in practice the focus of community support was limited to helping people stay in the community safely and to filling their daytimes. Something more was needed.

Two primary ideas emerged— "quality of life" and "recovery". And, speaking metaphorically, a quiet battle ensued between these concepts. In the end "recovery" won. It is interesting to think about why.

The concept of "quality of life" actually emerged first as the ultimate goal of the community support program. Somewhat later, Anthony Lehman, a brilliant psychiatrist, developed a way to measure "quality of life" that had several critical domains—life satisfaction, living situation, daily activities, family, social relations, finances, work and school, legal issues, and health. Quite comprehensive and an extremely useful guide both for (1) clinicians who understood their responsibility to be not only to limit symptoms of illness but also to promote a decent quality of life and for (2) policy makers trying to design and finance systems of care that enabled people with serious mental illnesses to live as well as possible.

"Quality of life" had great appeal to many mental health professionals,

Michael B. Friedman, LMSW

including me. I thought then, and still think, that it was great progress to move from focus merely on clinical condition to an effort to build systems of care that addressed the most fundamental needs in people's lives.

But at the same time, people with mental illnesses began to speak for themselves. I personally learned most from Ed Knight through private conversations about his experiences in hospitals where he was informed that he had no hope of becoming the PhD in sociology that he became and where he found more help from fellow inmates than from the mental health professionals until one of them supported his vision for himself. Ed did not deny that he had a mental illness, and he used medication. But he insisted that he "used" it, and not that he took it. It was his choice and a tool to achieve his goals. He was actively helping himself not being passively compliant. Ed was particularly clear that the diagnostic system of the time essentially defined "schizophrenia" (his diagnosis) as a hopeless condition and that people who recovered from schizophrenia often were then re-diagnosed with one or another condition from which it was believed to be possible to recover.

I was also personally influenced by Patricia Deegan whose wonderful lecture and essay, "A Conspiracy of Hope", defined a new perspective on life with severe mental illness.

Ed and Pat, or should I say Drs. Knight and Deegan were among the leaders of a movement of people with histories of mental illness that insisted that they be addressed as "people with" not as an amorphous mass "the chronically mentally ill". They insisted that they did not need professionals to speak for them, that they could speak for themselves. They made clear that people with persistent mental illnesses had human aspirations—for relationships, for activities they found satisfying and meaningful, for acceptance in mainstream society, and for recognition in the mental health community. And perhaps most importantly they insisted on hope.

The advocates for "quality of life" did not seem to get this. Here is Anthony Lehman's opening sentence to his classic article on evaluating quality of life, "Evaluating the well-being of *the chronically mentally ill* has become crucial to revising our national plans for serving them in the wake of three decades of deinstitutionalization." (Emphasis added) "The chronically mentally ill"—there it is, the amorphous mass of the hopeless.

In contrast, here is William Anthony from his early and definitive article on recovery, "Recovery is … a *deeply personal*, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the *development of new meaning and purpose in one's life* as one grows beyond the catastrophic effects of mental illness." (Emphasis added).

Anthony makes it clear in this article that the advocates of the community support program and of "quality of life" have it right. Treatment alone cannot make a life. But he adds that addressing concrete needs for housing, income, relationships, and activity also are not enough to make a life. Something else is needed. Something "deeply personal", a re-making of personal goals, the discovery of meaning.

Some mental health professionals, I among them, have had reservations about using the word "recovery" to name a process that can include living with continuing mental illness. Isn't that a misleading term for those people for

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The Adolescent Therapeutic Community: An Integrated Model of Care

By John Venza, LCSW-R, LMHC
VP Residential and Adolescent Services Outreach

I was once told early in my career that the Therapeutic Community (TC) takes an hour to explain but a lifetime to master. The traditional Therapeutic Community model has saved countless lives over the past several decades featuring a therapeutic milieu that uses the community as the healer and peers as role models as its cornerstone pieces (G. De Leon, 2000).

Originally designed for adults, the success of the model paved the way for adaptations to fit the needs of special populations such as adolescents which is perhaps the most challenging stage of development in the life cycle. Many developmental tasks must be accomplished for the young person to make a healthy shift from being a child, to a young adult who has individuated and separated from their parents. Given the complexities of this life stage, when a young person experiences consequences from substance use and mental health disorders, the treatment must be specialized to meet their needs.

Outreach opened their first adolescent treatment facility in 1984 with a program design based off of the traditional Therapeutic Community. Over the past 38 years, the agency has dedicated resources to evolving a highly specialized model of care that integrates both Therapeutic Community constructs with adolescent development.

Realizing most teenagers possess little intrinsic motivation to stop their substance use and the accompanying lifestyle, the addition of parents into the program design is paramount. Essentially, if we don't have the parents on board, we will be hard pressed to get the adolescent to engage. By having parents in a *parallel treatment process* through a comprehensive array of family services, treatment outcomes for teenagers improve. Working with the parents, we shift the entire family system to increase the likelihood that gains achieved by the teen in treatment will be sustained after they return home after treatment.

Peer relationships during adolescence become extremely important as a source of support and reassurance. Unfortunately, these powerful bonds can become destructive when substance use and other risk behaviors enter the picture. Normative social development becomes delayed and even arrested as substance use progresses and mental health worsens. The adolescent therapeutic community features peers as role models who are substance free, in recovery and nurturing pro-social relationships. The program design strategically allows new members to enter an environment where pro-social behavior

John Venza, LCSW-R, LMHC

garners acceptance and feeds the adolescent's desire to fit in and belong. The young person now has the opportunity to assimilate into a community of their peers who value their recovery and positive behavior.

The integrated model must provide age appropriate services to meet the adolescent's developmental needs in each life domain. The evolution of the TC over time allowed for the integration of highly specialized mental health services so adolescents with co-occurring mental health disorders may be treated under one roof (NIDA, Principles of Effective Treatment, 3rd Edition, 2018). Additionally, services include a full day of school on-site, individual and group therapies addressing both SUD and Mental Health, family, vocational/educational, and physical health.

While I could go into great detail about the clinical services, I choose to highlight a core belief that serves as the common denominator to all these services. We must remember the population being served, teenagers! They are young, full of life and have a strong desire to be with their friends and have fun. While treatment involves a great deal of work, making treatment and recovery fun is a key variable in a successful program for adolescents. Making services fun is not mutually exclusive with being clinically effective. The creativity and energy of the adolescents will provide great insights and ideas for making treatment for teenagers life-changing while being fun. Adolescents always love when they can have input into programming, formats, and events occurring in the treatment milieu as it appeals to their emerging autonomy.

While traditional talk-therapy still has its place in the TC, adolescents will surely shut down if the service delivery is not creatively diversified. To improve engagement and retention with teens, there must be an integration of a variety of multi-modal therapies. Drumming circles, music therapy, creative art therapy, yoga, and meditation to name a few. These formats are both fun and healing which is exactly what we want as we put teenagers on the journey of recovery. After decades of work at Outreach, the clinical team recognizes adolescents seem to learn best by hands-on approaches than the traditional didactic deliveries. The more that an adolescent equates recovery with being something they can have fun in, the greater the chance they stay engaged in recovery support activities after the residential treatment episode has ended.

It is so important to remember adolescent culture is pop culture. It changes all the time. This is both the challenge and exciting part of working with adolescents as we must continue to evolve the therapeutic milieu to be effective with the kids of today. Adolescents are very perceptive and if they believe the adults working the TC are not current in their understanding of the adolescent world, it will be hard to achieve credibility and trust with the young person.

My final thought is this, if you are creating an adolescent TC, ensure that the staff are of course talented clinicians, and also that they are strong educators. Another attribute not often mentioned is staff should be "good actors". Teens will be more receptive to adults that adjust their delivery styles just as an actor assumes different acting roles. To each individual teenager, the staff must assume a delivery that allows the adolescent to be willing to listen to what the staff has to offer. Remember, adolescents are in the process of separating and individuating from their parents. The last thing they will entertain is another adult that feels more like another parent. They will however enjoy a strong therapeutic alliance with an adult that is relatable and sees them as a unique individual through a person-centered lens.

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participants to help facilitate their recovery related goals, as well serving as a bridge to the broader community;

Group Facilitation: Facilitating participant and family groups, playing an equal role in the planning and preparation, as well as in the administrative and organizational duties;

Community Mapping: Developing a strong awareness of resources available in their region and familiarize themselves with organizations, agencies, businesses and public programs in order to support participants and their supporters;

Influencing Team Culture: Emphasizing the perspectives and experiences of participants, highlighting the holistic view of each individual and holding space for their understanding;

Team Communication & Collaboration: Maintaining open and frequent communication with the team to ensure integrated and cohesive services and regularly collaborate with all other team roles in order to best serve participants;

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Connection as Treatment: The Healing Power of the Community Center

By Ruthanne Becker, MA,
Dillon Browne, LMSW, and
Jordania Estrella, LCSW-R, CASAC-G
Sterling Community Center

Humans are social beings by nature. While our level of socialization differs from person to person, the great majority of people have emotional and psychological needs that are best met by interpersonal engagement. In a healthcare system defined and often enhanced by outcome measures, evidence-based practices, and centered around a combination of hospitals and professionally run clinics, it's easy to miss the significance of the "unglamorous" community center. Unglamorous both because of the images too often evoked from the past, in which individuals who were frequently overmedicated spent the day smoking cigarettes and sitting around, as well as due to a strong preference for the inherent predictability of the clinic and its psychotherapy groups. By comparison to a traditional clinic, the community center's seemingly inefficient use of time, focus on connection and recreation, and almost chaotic energy can seem dated. However, underlying the community center model is a concept so basic, it underpins our society - the inherent human need for community and connection. While the calm, professional clinical environment can provide effective treatment, the humble community center remains an extremely effective vehicle for forging community and social connection upon which a robust recovery journey can develop.

In his book *Together: The Healing Power of Human Connection in a Sometimes Lonely World*, former surgeon general Dr. Vivek H. Murphy writes, "Medicine for my parents was all about relationships... built by listening. Insurance companies would protest their spending more than the approved fifteen minutes… but [they] understood that to truly listen… you had to meet people where they are…. however long it takes." Community centers remain an ideal space to allow supportive staff to meet people where they are, provide healing support, and facilitate the development of connection and community, however long it takes. Too often, connection is seen as a consequence of proper treatment, rather than a precondition to recovery. Dr. Murphy writes, "It's clear that loneliness serves a vital function by warning us when something essential for our survival – social connection – is lacking." People do not become more connected by "recovering," they begin their recovery, in part, as a result of building (or rebuilding) connections. In traditional psychotherapy, this connection comes in the form of therapeutic relationship, whereas in a community center, it takes the form of traditional friendships. While both relationships have value, it is those natural supports, such as friendships, that best promote resilient recovery.

The Mental Health Association of Westchester's (MHA) Sterling Community Center (SCC), located at 29 Sterling Avenue in White Plains, New York, is far more of an idea than a structure; it's a place where people are welcome, regardless of where they are in their own recovery. For a community center to fulfill its promise, it must open its doors to the same people who society too often neglects. This means being open to behaviors that might be outside the norm and addressing community issues through an empathetic and situational lens rather than relying on the safety of established rules and consequences. The community center is a model of acceptance, equality, and inclusion, even when exclusion might be an easy solution to common challenges. People frequently come to SCC after being rejected while trying to form connections and seeking to remain part of a community in traditional social settings. At SCC, the experience of belonging and connection offers a healing invitation. Our Community Center becomes a unique space at which folks can struggle, make mistakes, and learn without risk of exclusion. Many gain a level of social connection from daily employment, but if their behavior ventures outside of the established social standard, they might rapidly find themselves without a valued role and connection.

Unless there are active and acute safety concerns, any person 18 years of age or older with a behavioral health diagnosis is welcome to join SCC. To ensure community mental health is effective and inclusive, there must be a level of support with generally open doors, which is accessible to those with limited information and potentially no existing resources. SCC fills this need: it can be the first place an overwhelmed individual with a new diagnosis walks into; it can be the connection to other needed services; and it can remain as constant as the individual who works through various levels of support. In contrast to traditional clinic, SCC relies on grants and is able to open its doors to individuals regardless of their insurance type or status. Frequently, folks require assistance navigating complex social benefits system, but they also often require benefits (such as insurance) before receiving assistance. SCC does not require insurance and welcomes anyone who walks in, at any stage of their lives. Ensuring each person receives treatment at the appropriate level of support is important to providing quality services. Transitioning between "various levels of care" can make it difficult to form long-term friendships and ties – elements that have been identified as key components of successful recovery. Through each phase and level, SCC remains an integral component of the treatment and support paradigm, in whatever capacity the person chooses.

Early in a recovery journey, one may attend daily groups and activities at SCC, utilizing the hours and days between psycho-therapy sessions and groups. During this time, they might be using SCC as a safe space to test out concepts discussed in therapy and finding mutual support in the environment. As one progresses, the amount of time spent at SCC, as well as how that time is spent, also evolves. SCC can become a source of support in a job search, with available technologies such as computers, Wi-Fi, and peer supporters to build needed skills. Even when someone has advanced in their recovery, they may find a place at SCC as a participant volunteer, group facilitator, or just a social drop-in. This space can also serve as a sanctuary for those seeking time and space to reflect in a calm and welcoming environment with connection to additional resources, if needed. It is up to the person, rather than the staff, when and how they choose to utilize the SCC space.

The question isn't which is more effective, the clinic or the community center, but how they may collaborate to build a comprehensive and effective support system. A number of clinic offices share space with SCC, giving participants access to both professional care and SCC's open, relationship-building social setting. This approach considers the whole individual, addressing both immediate and long-term goals for connections, relationships, and natural supports. The outcomes are unique and significant; SCC has seen generations of

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understanding of the behavioral issues, teaches how to resolve conflicts in a healthy way, and provides siblings with a safe space to verbalize their own feelings and reactions.

· Parent Groups provide support on accepting and understanding their child's social-emotional issues.

Early intervention in addressing any challenges is the key to positive, long-term outcomes. Our early childhood mental health clinic is currently open two evenings a week. We have 15 children enrolled and a waitlist. We have hired an additional clinician and plan to expand our hours to include additional evenings and Saturdays. You can learn more at www.TheGuidanceCenter.org.

The Guidance Center of Westchester is part of the Access Network - a group of agencies led by Access: Supports for Living. Together, the nearly 2,200 staff of the Access Network provide support to more than 17,000 adults and children with mental health and substance use needs, developmental disabilities, children and families facing challenges, and those who need support with housing and employment across New York's Hudson Valley, the five

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Pediatric Behavioral Health Urgent Care: An Innovative Model of Care for Children and Adolescents

By Rachel A. Fernbach, Esq.
Deputy Director and Assistant and General Counsel
New York State Psychiatric Association

The Cohen Children's Pediatric Behavioral Health Urgent Care Center ("BH Urgi"), located on Long Island, NY, is an alternative treatment setting for school-aged children and adolescents ages 5 through 17 in need of urgent mental health support. BH Urgi is intended to provide urgent or same-day intervention for children and teens who need urgent psychiatric care and treatment but may not necessarily need to be seen in a hospital emergency room. There is also a community-embedded version of this model called the Behavioral Health Center ("the Center"), which expands on what BH Urgi can provide, provides collaboration with local school districts, and provides additional services to students and school staff alike. BH Urgi and the Center represent a unique model of care for children and adolescents that enhances access to care and quality of care and should be replicated in other communities.

The following are excerpts of a conversation with Vera Feuer, MD, Associate Vice President, School Mental Health and Director, Pediatric Emergency Psychiatry and Behavioral Health Urgent Care at Northwell.

How was the idea for the center first conceived and how long has it been in operation?

Cohen Children's Medical Center, located in New Hyde Park, NY, and a part of the Northwell Health system, has operated its Behavioral Health Urgent Care unit since 2017. The unit was established through state funding with the goal of avoiding unnecessary emergency room visits and hospitalizations for children and adolescents experiencing mental health crises. However, this program was limited in the amount of care coordination and bridging services it was permitted to provide.

Rachel A. Fernbach, Esq.

In 2019, following two student suicides, a local school district reached out to Northwell administrators to see if something similar to the BH Urgi program could be established in Southern Nassau County. In 2020, a free-standing, outpatient behavioral health center was opened in Rockville Centre, staffed by a child psychiatrist, a mental health counselor, and a medical assistant. This past July, a second location was opened in Mineola, New York. The Mineola location is staffed with child and adolescent psychiatrists, behavioral health counselors, care coordinators, administrative assistants, and front desk staff who are bilingual in English and Spanish. Both locations offer flexible schedules to accommodate patients in crisis who may need to be seen urgently.

Why is behavioral health urgent care such a valuable resource for children and adolescents in need?

The treatment needs of children and adolescents requiring psychiatric care and treatment can vary widely. Often, youth experiencing a mental health crisis end up visiting the emergency room at their local hospital because no other appropriate options are readily available, and resources can be difficult to access. This can result in additional burdens on the health care system as well as long wait times and extra stress for the patient and family. The Center is designed to address this very issue and ensure connection to the next level of care. Traditionally, there have been few standards governing emergency behavioral health care for children and adolescents. In the past, there were challenges establishing a link between emergency room visits and follow-up outpatient care and treatment. Professionals also began to recognize that children and families needed a different environment - one that was familiar, pleasant and accessible, reminiscent of a pediatrician's office.

What unique services does The Center provide?

The central role of the Center is assessment, including a focused mental health evaluation and determining any immediate safety concerns or other needs. Following initial assessment and evaluation, the goal of the program is to link patients with community-based mental health treatment in their area, including psychotherapy, psychiatry and case management services.

Patients and families may be referred to Northwell clinics, non-Northwell clinics, private clinicians, subspecialty clinics, or group practices. The plan is for patients to be connected with care in the community as quickly as possible, so they are not lingering or left without resources. Past data has shown that the best results occur when a follow-up visit takes place within one week following a crisis visit. If more than one week passes, the follow up rates are extremely low because you lose momentum. The Center works to link patients and families with care in the community as quickly as practicable to ensure follow up and continued care. In the interim, the Center's team will provide in-person bridging care or telephone follow-up until communication is established with a provider in the community.

The Center also coordinates care and collaborates with the referring school, pediatrician, outpatient provider or case manager and communicates findings and recommendations where appropriate. The goal is to break down silos and improve communication between schools, community providers and our team and to support and educate families. The key is guiding parents and children to recognize problems as they occur and providing assistance and intervention before it escalates to a crisis.

How do school districts partner with The Center?

Local school districts are able to use their state funding and select the Center from a list of services available through Nassau BOCES. Partner school districts receive exclusive, emergency access to the Center for their enrolled students as well as bridging care, case management services, consultative support, professional development activities and community education for students and families.

How are children referred to the Center?

The Center is available for referrals from partnering school districts, community providers and children and families. School districts are an important referral source for the Center as children spend a significant amount of time in school, making teachers and school personnel an excellent resource for referring children that may need evaluation and treatment. Families in need may also call the Center directly to obtain services if they feel their child needs to see a child psychiatrist or needs a connection to care.

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The Integration of Treatment and Recovery: Special Considerations for Working with Children

By Crystal Taylor-Dietz, PsyD
Devereux Advanced Behavioral Health
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Devereux Pennsylvania Children's
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Historically, the term "recovery" was commonly associated with substance use/addiction services and was popularized in the United States through Alcoholics Anonymous (AA) (Witkiewitz, K., et al., 2020).

Beginning in 1939, AA published materials highlighting recovery as a personal journey toward not only abstinence, but also increased well-being and overall functioning. As psychiatric care in the U.S. became deinstitutionalized in the 1970s and 1980s, definitions of recovery for psychiatric illnesses became more common.

Over the last decade, researchers and behavioral health providers have moved toward an integrated definition of recovery that includes mental health and substance use, and they are prioritizing recovery as an essential focus of care. The Recovery Science Research Collaborative published a study in 2019 defining recovery as, "an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness (Ashford, R.D., et al., 2019, p. 5)."

The Substance Use and Mental Health Services Administration (SAMHSA) also has moved toward a standard definition of recovery that encompasses substance use and mental health as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, p.3)." SAMHSA's definition also includes four principles that are important factors for successful recovery:

- Health (emotional, physical)
- Home (adequate housing)
- Purpose (engaging in daily activities/ having resources to be productive)
- Community (supportive social/familial relationships)
- Individual-Centered Approaches

In the past, treatment-oriented/medical models of care focused on the individual and symptom reduction but did not address the process for increasing overall well-being and functioning in society (Jacob, 2015).

Today, recovery-oriented models of care focus on the individual and their treatment, while also prioritizing the role of family/caregiver involvement in treatment and the ongoing work outside of treatment needed to function in all areas of life. Devereux Advanced Behavioral Health's Philosophy of Care integrates the core principles of individual-centered and recovery-oriented approaches, while also focusing on the utilization of the most current and effective evidenced-based treatments (EBTs). Considered the gold standard of behavioral health treatment delivery, EBTs were developed in the 1990s (Cho, et al., 2019), and are now widely implemented across all levels of care for use with children and adolescents to address specific behavioral health challenges. The reason: Children and adolescents are at unique stages in their psychosocial development that require specific considerations for their treatment and recovery in order to meet the individual and caregiver's needs.

Crystal Taylor-Dietz, PsyD

Molly Stubbs, LPC

Utilizing EBTs for Our Youth

When determining the use of EBTs for children and adolescents, best practice considerations emerge in the research. Special attention should be given to ensuring a well-rounded diagnostic evaluation is completed (Lee, et al., 2021). In a study by Lee, et al. (2021), research showed that providing an EBT appropriate for a child's primary diagnosis revealed the most robust improvement in treatment outcomes and clinician/ caregiver's perception of symptom improvement, highlighting the need for thorough and accurate diagnosis when initiating treatment (p.8).

While it is common practice for an individual to receive a diagnosis upon completion of an initial clinical assessment, it is imperative that providers reassess this diagnosis to ensure an individual receives the most effective treatment available. In addition, research shows a strong correlation between increased caregiver involvement with an EBT and improved treatment outcomes for youth (Okamura, et al., 2020).

In a study related to delivery of trauma-focused cognitive behavioral therapy, youth and their caregivers reported improvements in communication, validation and family functioning (Okamura, et al., 2020). It also was noted that too much emphasis on using EBT-specific language was a turn-off for caregivers, underscoring the importance of providers delivering treatments in authentic ways, free of professional jargon (Okamura, et al., 2020). In addition, the use of empirically validated outcome measures allow for increased understanding of progress in treatment.

DBT Revisits the "Life Worth Living Goal"

Dialectical behavior therapy (DBT) is one of Devereux's most widely used EBTs and is implemented across the country in a variety of settings including residential treatment facilities, outpatient and acute hospital settings.

While traditional treatment-oriented models of care focus on symptoms and their presentation, DBT revisits the concept of an individual's "life worth living goal," which, essentially, is the vision of creating a life that is no longer compatible with the idea of suicide or other high target behaviors. The "life worth living goal" looks at living a life of balance (Linehan, 1993, p. 124).

Comprehensive DBT includes coaching as an intervention that assists with living a more balanced life. Through frequent access to DBT therapists, individuals can receive coaching for in-the-moment support to engage in more skillful behavior, generalize skills and improve quality of life. In a traditional recovery-oriented model, coaching may be akin to a recovery coach or to an AA sponsor. Coaching marries recovery/treatment models, allowing for both change and acceptance of one's behaviors, while also focusing interventions to reduce symptoms and ineffective behaviors.

DBT via Telehealth

As the COVID-19 pandemic escalated in the U.S. in March 2020, Devereux

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A Case for the Discerning Application of Treatment Models: Proceed with Caution

By Ashley Brody, MPA, CPRP
Chief Executive Officer
Search for Change, Inc.

In recent decades we have witnessed a proliferation of models for the treatment of behavioral health conditions, many of which enjoy robust evidence bases that support their application in accordance with overarching principles and intended outcomes. In many respects, we inhabit a "Golden Age" of behavioral healthcare that promises new pathways to recovery for individuals experiencing emotional distress and a broad array of psychosocial challenges. This differentiates the present from preceding eras characterized by a reliance on ad hoc treatment interventions employed by practitioners of diverse theoretical backgrounds. Such interventions were often informed by paternalistic or clinician-centric philosophies that viewed conformity with established social norms as the primary hallmark of "success" in the treatment process.

The Recovery Movement and others that elevate persons above pathology have enabled us to adopt a more expansive view of human suffering - one that regards those entrusted to our care as more than mere constellations of symptoms or sums of discrete parts. We now understand Social Determinants of Health (SDoH), Adverse Childhood Experiences (ACEs), and other progenitors of post-traumatic stress must be addressed if treatment is to be truly person-centered and effective. Recent developments in the sociopolitical sphere continually remind us of enduring inequities (and egregious injustices) perpetrated against Black, Indigenous, Persons of Color, and other marginalized populations that must be similarly addressed lest the behavioral healthcare establishment remains complicit in perpetuating such inequities.

A casual observer uninitiated in the intricacies of our healthcare system would be forgiven for concluding it has finally achieved some measure of enlightenment in its treatment of the human condition. Indeed, the value and import of select advances are beyond dispute. Most are no longer solely a product of theoretical consensus but the result of painstaking research that rests on a presumed bedrock of empiricism and purportedly leads to conclusions of proven validity and reliability. In short, the tools of the natural science trade are now operating in realms once characterized as nothing short of pseudoscience. This has produced lasting benefits for the behavioral healthcare industry and the vulnerable individuals who depend on it. The consistent application of

Ashley Brody, MPA, CPRP

evidenced-based practices (and dissemination of supporting information to practitioners, service recipients, their family members, and other stakeholders) is foremost among the tangible advantages of this movement. But it also poses grave hazards. McIntyre (2002) enumerates a variety of liabilities associated with the unwavering application of "proven" treatment models that promise to ameliorate specific manifestations of human distress as assessed by the presence of particular symptoms. He cites gaps in the research base (particularly as they relate to the treatment of individuals of diverse racial, ethnic, and geographic backgrounds) that perpetuate disparate treatment and associated inequities. He also cites enduring resource limitations that preclude the timely or consistent application of emerging practices to recipients in urgent need, and he echoes other authors who admonish practitioners against unduly strict adherence to models that inadvertently exclude elements of experience inconsistent with the diseases or conditions for which they were developed. Hyman (2010) describes this challenge as one of "reification" through which various practice guidelines and heuristics become concretized and rigidly applied in a manner that fails to account for the innumerable contextual variables' characteristic of human experience. Although this author's critiques are directed largely at the system through which behavioral health conditions are classified, they may be similarly applied to treatment approaches formulated to address conditions enumerated in classifications of questionable validity. He specifically suggests our Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) have achieved acceptable levels of interrater reliability (i.e., consistency of application across practitioners) but fall short of capturing the full panoply and nuance of human experience integral to validity. Treatment models predicated on a nosology of suspect validity are, by corollary, similarly suspect.

Another author addresses this in simple and succinct terms. Kinderman (2014) writes, "We need to place people and human psychology central in our thinking." He espouses approaches that account for myriad factors that influence mental health and wellbeing including biological processes, SDoH, and life circumstances in general. Thomas Insel, a psychiatrist and former Director of the National Institute of Mental Health, advocates a more expansive view that acknowledges limitations inherent in traditional healthcare (Insel, 2022). He reminds us only a modest share of health outcomes should be attributed to healthcare. The lion's share is governed by socioeconomic and other factors (i.e., one's "station" in life). Borrowing language from a colleague who serves exceptionally vulnerable individuals (i.e., homeless persons with behavioral health conditions), he places "the three Ps" ("people, place, and purpose") at the forefront of the recovery process. That is, for human suffering to be transformed it must find support from others, a place (or sanctuary) to facilitate healing, and a mission or purpose. Emerging Alternative Payment Models (APMs) and other innovative approaches to whole-person care have begun to compensate providers who address the three Ps and other SDoH, but this trend is neither widespread nor

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worked swiftly to provide individual and group telehealth sessions for many programs, including DBT.

Through the use of telehealth, Devereux's clinicians were able to engage with individuals and caregivers without the barriers of transportation or demanding schedules. The availability and access of both families and clinicians increased as telehealth offered more flexibility. In addition, the Office of Mental Health and Substance Abuse Services published updated best practices on the delivery of services via telehealth to assist clinicians in providing the most effective level of involvement.

Taking special consideration for the numerous challenges people with mental health challenges faced as a result of the pandemic, providing telehealth services also increased Devereux's geographical access to the most vulnerable populations who otherwise might not have had access to DBT in their local communities. This train of thought is known as highlighting the dialectic (Linehan,1993).

It is of value to note that while individuals of color are widely known to have

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Virtual Care Platform Supports Text-Based Mental-Health Research Program for Transgender and Nonbinary Participants

By Dr. Keith Dressler
Chairman and CEO
Rhinogram

Reaching individuals with information designed to help with anxiety and depression can be difficult, especially when they're in rural areas. Consistent, fast internet is still not available in many of these areas, so text-messaging outreach is highly preferred (about 95% of US residents have a cell phone with text capabilities).

That's exactly the type of program Assistant Professor Douglas Knutson, PhD and his researchers in the Counseling and Counseling Psychology Program at Oklahoma State University (OSU) began piloting last year. The program provides transgender and nonbinary individuals with an affirmative cognitive-behavioral intervention for anxiety and depression.

Creating interventions that can be delivered electronically, but still contain a human touch and are responsive to client needs is challenging, according to Dr. Knutson. The first iteration of his program used Google Voice for text messaging and was highly manual, involving multiple Excel spreadsheets to track participants and their progress within the program (referred to as a "protocol" by researchers).

The system was far from ideal. Fielding text messages from multiple individuals simultaneously on days the program was open to participants was stressful. Automating messages for participants or potential enrollees to receive after hours was awkward at best. Program management was also difficult, with pertinent information scattered across multiple data sources.

The final straw came when Google Voice began setting limits on how many text messages program researchers could send in a row without a response before being labeled us spam. (The program involves sending multiple informative texts back-to-back at times.)

Dr. Knutson began looking for other solutions, finding a few but only one virtual care platform that had all of the features he sought. "I found this team to be incredibly responsive and engaging," says Knutson. "I was further hooked by the fact that the product has a really engaging interface that met our needs all in one place, instead of having to cobble together all those spreadsheets and platforms."

User Friendly, HIPAA Compliant

The second iteration of the program used the new platform to exchange more than 6,000 messages with an expanded number of participants during a five-month period. The students absolutely love the platform, according to Dr. Knutson. "In the first iteration of the study, they found interacting with participants an exhausting process," he says. "Now, they're excited to begin again when they return to school in the fall."

Dr. Keith Dressler

Not only is the platform's interface user friendly, but the research team received an unprecedented level of support during training and startup. "The training we received was completely tailored to our needs," says Dr. Knutson. "The support team selected the pieces we would need and was available and engaged throughout the process," he says, adding that his group was up and running within a week of finalizing the contract.

The platform's HIPAA compliance is another critical factor. "Not many text messaging services seamlessly integrate the HIPAA security component," Knutson says. "Our new platform allowed me to designate that the required consents have been endorsed by the participant. Other products pale in comparison with those capabilities."

The platform is ideal for setting up projects that involve multiple participants at various stages of the protocol, multiple coaches rotating in and out throughout the day, and a number of interaction types. Students log on when they arrive at the clinic and can immediately see which protocol stage each participant is at and engage accordingly. At peak study times, a single research assistant was able to exchange an average of 97 (relatively complex) messages per hour with multiple participants.

The project's templates are labeled by the message number and the day within the protocol (e.g., Day 2). Says Dr. Knutson: "The platform allows us to create such strong organization within its system that the workflow dictates itself based on what's unread and how the person is located within the system. We can easily accomplish tasks as a team by picking up where others left off."

Automated Content Reduces Administrative Burden

Administratively, the platform is head and shoulders above the project's previous system. For example, Dr. Knutson used to have to quickly text back potential participants and then be available in the project lab to get them set up in the program. "Now, it just automatically texts applicants a link to a screening survey to determine their eligibility," says Dr. Knutson. "All of that automated content reduces the burden on me." He estimates he spends four hours a week less on the program than during the first iteration.

There's also reduced concern about participants not getting the information or attention they need. "The students aren't responsible for keeping everyone in the loop," says Knutson. "Now, we're able to centralize that information, helping us keep distressed and highly engaged participants from going unmonitored."

So, it's no surprise that Knutson leans heavily on the platform as he writes grants for future iterations of the project. "The platform increases the feasibility of our projects and demonstrates that we're capable of doing them at this university," he says.

Dr. Keith Dressler is Chairman and CEO at Rhinogram, and can be contacted at dr.d@rhinogram.com.

Peer Professionals from page 16

Ongoing Professional Development: Participating in opportunities for enhancing understanding and abilities to support them in their work. This can include trainings, webinars, workshops, conferences and networking events for Peer Specialist staff.

Peer Specialists are playing an increasingly important role in the recovery process of people living with mental illness. The services they provide have been shown to promote positive health and recovery outcomes, including reduced inpatient service use; enhanced relationships with providers; better engagement with care; higher levels of empowerment and hope for recovery; and improved ability to manage continuing health and wellness. As an added benefit, many Peers report that contributing to the lives of others helps them in their own recovery process.

As more healthcare providers learn about the impact of Peer support, opportunities and career paths will grow and expand. We at OMH are very excited to be at the forefront of the Peer movement and we look forward to expanding access to Peer services.

Ann Sullivan, MD, is Commissioner of the New York State Office of Mental Health (OMH).

Recovery, Hope and Resilience During the Pandemic

By Jonathan Keigher, PhD
Vice President, Chief Clinical and Compliance Officer, New York Psychotherapy and Counseling Center

As one of the largest providers of outpatient mental health services in New York State, New York Psychotherapy and Counseling (NYPCC) works together with tens of thousands of New Yorkers facing mental health challenges. NYPCC embraces a recovery-oriented, trauma-informed model of community mental health care that supports the individual in their recovery journey. Mental health recovery is a person-driven process of change through which individuals improve their health and wellness, strive to reach their full potential, and lead independent lives. NYPCC clinicians assist and inspire people to move forward with their recovery in a safe and affirming environment that respects self-determination. During the first contact with a person, NYPCC clinicians facilitate discussion of the person's recovery goals, seek to understand the person's resiliency, strengths, coping skills and resources that can be brought into action during the treatment process, and appraise their level of hope.

Hope, a belief that mental health challenges and conditions can be overcome, is fundamental to recovery. Hope is an essential element of mental health treatment, and many successful therapies deliberately build hope as part the therapeutic process (Weis & Speridakos, 2011). Having hope for the future also helps build resilience. Resilience is the ability to withstand adversity, bounce back more quickly after adverse experiences, and to learn and grow from difficult experiences. A person's capacity for resilience in the face of adversity and a belief that they can resolve their mental health challenges highly correlate with successful living and positive mental health outcomes (Wu, 2011; Griggs, 2017). Hope provides individuals with will, determination, and a

Jonathan Keigher, PhD

perception of empowerment that permits them to reach their recovery goals. When hope or resilience is lacking, it must be instilled. Hope and resilience do not simply come from a person's internal strengths but can be fostered and nurtured by supporting and accepting the person, making them feel valued and appreciated. While hope and resilience often develop during the psychotherapeutic process, they can also come from strengthening relationships with family, friends, peers, and faith.

Now more than ever, instilling a sense of hope and building resilience are crucial for the persons NYPCC serves. During the last two years, the COVID-19 pandemic transformed the mental health landscape by improving access to care through telehealth and drawing new attention to the mental health system as soaring rates of mental health symptoms emerged. In October 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared that the pandemic-related deterioration in child and adolescent mental health is a national emergency. COVID-19-related social isolation, school closures, and economic distress have disproportionately affected Black, Indigenous, and people of color (BIPOC) communities, whose levels of suicidality, depression, anxiety, loneliness, and drug overdose increased (Friedman et al., 2021; McKnight-Eily et al., 2021; Bray et al., 2021). As the pandemic drags on, psychological stressors, economic distress, and health disparities combined with waning hope and resilience negatively impact communities of color. The mental health and addiction challenges that emerged as a major health crisis during the pandemic will likely continue far beyond the pandemic, generating an increased need for trauma-informed services and comprehensive, community-based recovery systems of care.

While the pandemic impacted mental health and changed healthcare delivery, NYPCC's core belief in recovery remains unchanged. As an agency, we continue to assist people to succeed in life and improve their health and wellbeing. We have focused on developing a responsive, recovery-focused system of care that evolves with the needs of the communities we serve. During the early years of the opioid epidemic, NYPCC implemented harm reduction approaches to care. Clinicians educated the community on overdose prevention and initiated the dispensing of naloxone in the community. Recognizing the urgent and growing need to address co-occurring mental health and substance use disorders in an integrated and person-centered manner, we recruited therapists, psychiatrists, and administrators experienced in substance use treatments. Most recently, in response to an identified community need in Brooklyn, NYPCC sought and received approval to open an OASAS-licensed substance use disorder outpatient program that will further our recovery mission.

To help persons achieve complete health, NYPCC focuses not only on mental health symptoms, but promotes physical health integration and social wellbeing. Poor mental health is a risk factor for chronic physical conditions, and many people treated at NYPCC present with complex co-existing conditions and many negative social determinants of health. During COVID-19 as structural drivers of health inequities increased, BIPOC communities with preexisting health conditions and negative social determinants of health were disproportionately impacted. To address disparities in the communities we serve, NYPCC clinicians work with individuals to remove barriers to their physical health care and use Medicaid data to identify persons lacking routine physicals and follow up care of complex medical conditions. NYPCC care coordinators connect individuals to primary care physicians and specialists, assist with housing, food insecurity, unemployment, education needs, and other social determinants of health. Maximizing positive social determinants of health creates opportunities to enhance protective factors and reduce risk factors for mental and physical health.

At NYPCC, individuals and their families are empowered in the process of healing and achieving health. By focusing on recovery and operating with the universal expectation that trauma has occurred, NYPCC clinicians bring safety to treatment by helping individuals increase control over their own lives while building hope and resilience.

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OnTrackNY: An Early Intervention Program to Interrupt Psychosis

By Sarah Fisher, LCSW
OnTrack Team Leader
WJCS

A year ago, 21-year-old Christine* started hearing voices saying terrible things about her. She wondered 'why doesn't anyone around me admit to hearing them?' And now people have started to spy on her, through her phone. Her parents were upset that she wasn't able to contribute to the household since she kept losing her jobs because of these people. They seemed to go everywhere with her, bringing her down.

Christine had been to the hospital twice and had gone to a Partial Hospitalization Program– with groups focused on teaching skills to help her feel better – but the voices and the spying distracted her from learning anything. Her new therapist told her the voices were in her head and her family was pressuring her to "act right." Nobody seemed to know what to do except give her medication, which made her gain weight and sleep too much. She was starting to feel hopeless that she would ever get her "old self" back.

Christine is one of many young people who have experienced their First Episode Psychosis (FEP).

Schizophrenia occurs worldwide, with an annual incidence 15.2 per 100,000 and is one of the top leading causes of disability, according to the Global Burden of Disease Study in 2016. The illness usually develops between ages 16 and 25; for men it typically occurs younger than women. It accounts for 25% of all hospital beds and for 40% of all long-term care days. It also accounts for 20% of all Social Security benefits, costing the nation up to $65 billion per year.

A cycle typical for young people experiencing their FEP starts with symptoms of schizophrenia being viewed through societal stigmas: social withdrawal, poor self-care (such as not paying bills, not showering), responding to internal stimuli (like laughing or talking to themselves), sleeping at odd hours, paranoia (putting tape over their phone camera or pulling the shades to prevent people from spying on them), and uncharacteristically odd behaviors, among other symptoms cause them to be labeled pejoratively. It is frightening for families to see their loved ones acting and thinking differently and, in their increasingly alarmed concern, they are usually at a loss for what to do and most others around them don't know either, including many therapists and other mental health providers. Out of desperation, families end up bringing their symptomatic children to an emergency room, a psychiatric hospital, or sometimes they even call the police. The young person will typically stay at a hospital, be put on medications that help a little, and then go to an outpatient therapist or Partial Hospital program, only for the cycle to repeat when symptoms inevitably increase, with the same stigma and not knowing what to do.

OnTrackNY (OTNY) a coordinated, specialty care program seeks to interrupt this cycle by intervening as early as possible after the FEP. It offers the young person (ages 16-30) on the Schizophrenia Spectrum multiple services to choose from, all geared toward their individualized needs and goals and promoting recovery from their illness. The ultimate goal is to help them get back "on track" into the world, to pursue their goals in the areas of school, work, hobbies, passions, as well as to promote long-term recovery, ultimately limiting their disability.

Sarah Fisher, LCSW

The OnTrackNY program at Westchester Jewish Community Services (WJCS) is funded by the Office of Mental Health (OMH) and SAMHSA's (Substance Abuse and Mental Health Services Administration) Healthy Living Grant. WJCS's program is one of 22 teams throughout New York State, and is located in our Peekskill and Hartsdale clinics WJCS's team provides office and community-based services to those in Westchester, Putnam, Rockland, and lower Dutchess counties.

OnTrack uses non-clinical language with participants and their families to help them address, for instance, "unusual thoughts" and their "mind playing tricks" on them. OnTrack's shared-decision model is based on research studies funded by the federal government that demonstrated positive outcomes for people with FEP, such as the RA1SE program studies (Recovery After an Initial Schizophrenia Episode), which sought to change the trajectory and course of Schizophrenia through coordinated and aggressive treatment in the earliest stages of the illness, with an emphasis on minimizing any disability.

The WJCS OnTrack team consists of multidisciplinary staff, including an Outreach and Recruitment Coordinator who helps figure out if the program is a fit for individuals, Primary Clinicians who works on the participant's goals and coping skills, a Prescriber who collaborates on medication and medical goals, a Nurse who helps with overall health goals, a Peer Specialist who works with people from their own lived mental health experiences, and a Specialized Employment and Educational Specialist who works on the participant's school and employment goals. The participant picks which team members would be the most helpful to meet their goals and may use them all or only team members who can help them toward their recovery goals. Flexibility of team members is an important part of any individual's plan; for instance, clinicians may meet with a participant multiple times in a week to help them through a difficult time.

OnTrack's guiding principles are: limiting disability as a central focus, the individual acquires skills and personalized supports necessary to optimize recovery; Shared Decision-Making which facilitates recovery where the participant's preferences are integrated with team member's recommendations; and a Culturally Competent interpretive framework of symptoms, signs and behaviors, as seen in families and societies.

As an OnTrackNY participant said, "what's been good about the program is...hearing the counselors talk and saying this is not defining who you are, this is an event in your life. You can still get on with your life. You know, there may be some differences, but you can still do it."

*pseudonym

To learn more about the WJCS OnTrackNY program, please visit https://www.wjcs.com/services/mental-health/ontrackny/.

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Schizophrenia is one of the top 15 leading causes of disability worldwide (Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet. 2017 Sep 16;390(10100):1211-1259. PMID:28919117)

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Financial costs associated with schizophrenia are disproportionately high relative to other chronic mental and physical health conditions, reflecting both "direct" costs of health care as well as "indirect" costs of lost productivity, criminal justice involvement, social service needs, and other factors beyond health care (Desai, PR, Lawson, KA, Barner, JC, Rascati, KL. Estimating the direct and indirect costs for community-dwelling patients with schizophrenia. Journal of Pharmaceutical Health Services Research, 2013 Jul;4(4):187-194. doi/10.1111/jphs.12027/epdf)

About 100,000 adolescents and young adults in the US experience first episode psychosis each year.(https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis)

Treatment for Opioid Use Disorder in Jail Reduces Risk of Return

By The National Institutes of Health (NIH)

Almost two-thirds of people currently incarcerated in the U.S. have a substance use disorder. Many struggle with opioid addiction. Opioids include prescription pain relievers, heroin, and powerful synthetic versions such as fentanyl that are driving record numbers of overdose deaths.

Medications used to treat opioid use disorder—also called MOUD—can reduce cravings and symptoms of withdrawal. MOUD include buprenorphine, methadone, and naltrexone. However, few jails and prisons offer these evidence-based treatments.

Studies have shown that giving medications for opioid use disorder in jail or prison can reduce the likelihood of a return to opioid use or an overdose after release. Whether drug treatment can also reduce recidivism (reoffending and returning to jail or prison) hasn't been known.

Researchers led by Drs. Peter Friedmann at Baystate Health Medical Center in Massachusetts and Elizabeth Evans from the University of Massachusetts performed a comparison between two rural jails in the state. The jails were located in adjacent counties with similar rates of recidivism at the start of the study. One, in Franklin County, introduced buprenorphine treatment in 2016. The other, in Hampshire County, didn't offer the treatment until 2019.

The team compared rates of recidivism between the two facilities for men with opioid use disorder who were released into the community. They tracked the men between 2015 and 2019. The study was funded by NIH's National Institute on Drug Abuse (NIDA) through the Helping to End Addiction Long-term (HEAL) Initiative. Results were published on February 1, 2022, in *Drug and Alcohol Dependence*.

Overall, 469 men in the two jails had a diagnosis of opioid use disorder: 197 in Franklin County and 272 in Hampshire County. More than 90% of those in the Franklin County jail received MOUD, most often buprenorphine. In contrast, none of the men in the Hampshire County jail received drug treatment for opioid use disorder.

All men who re-entered their community through mid-2019 were followed for at least one year. During follow-up, fewer than half (48.2%) of men who had been in the jail that offered drug treatment were rearrested or reincarcerated, compared with 62.5% of men released from the jail that didn't offer MOUD.

This trend held after accounting for other factors that increase the likelihood of recidivism. These included the number of prior arrests and whether people were first arrested as a juvenile or adult. Overall, after adjusting for such factors, men who received MOUD while incarcerated had an estimated 32% lower risk of recidivism.

"Studies like this provide much-needed evidence and momentum for jails and prisons to better enable the treatment, education, and support systems that individuals with an opioid use disorder need to help them recover and prevent reincarceration," says NIDA director Dr. Nora D. Volkow.

The men included in the study were relatively young and mostly white. The researchers are currently performing further studies of MOUD in both urban and rural jails. These are following more diverse populations, including women and people of color.

This NIH Research Matters article was originally published here on February 8th, 2022.

Offering Buprenorphine Medication to People with Opioid Use Disorder in Jail May Reduce Rearrest and Reconviction

By The National Institute on Drug Abuse (NIDA)

A study conducted in two rural Massachusetts jails found that people with opioid use disorder who were incarcerated and received a medication approved to treat opioid use disorder, known as buprenorphine, were less likely to face rearrest and reconviction after release than those who did not receive the medication. After adjusting the data to account for baseline characteristics such as prior history with the criminal justice system, the study revealed a 32% reduction in rates of probation violations, reincarcerations, or court charges when the facility offered buprenorphine to people in jail compared to when it did not. The findings were published in *Drug and Alcohol Dependence*.

The study was conducted by the Justice Community Opioid Innovation Network (JCOIN), a program to increase high-quality care for people with opioid misuse and opioid use disorder in justice settings and funded by the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health, through the Helping to End Addiction Long-term Initiative, or NIH HEAL Initiative.

"Studies like this provide much-needed evidence and momentum for jails and prisons to better enable the treatment, education, and support systems that individuals with an opioid use disorder need to help them recover and prevent reincarceration," said Nora D. Volkow, M.D., NIDA Director. "Not offering treatment to people with opioid use disorder in jails and prisons can have devastating consequences, including a return to use and heighted risk of overdose and death after release."

A growing body of evidence suggests that medications used to treat opioid use disorder, including buprenorphine, methadone, and naltrexone, hold great potential to improve outcomes among individuals after they're released. However, offering these evidence-based treatments to people with opioid use disorder who pass through the justice system is not currently standard-of-care in U.S. jails and prisons, and most jails that do offer them are in large urban centers.

While previous studies have investigated the impact of buprenorphine provision on overdose rates, risk for infectious disease, and other health effects related to opioid use among people who are incarcerated, this study is one of the first to evaluate the impact specifically on recidivism, defined as additional probation violations, reincarcerations, or court charges. The researchers recognized an opportunity to assess this research gap when the Franklin County Sheriff's Office and the Hampshire County House of Corrections, jails in two neighboring rural counties in Massachusetts, both began to offer buprenorphine to adults in jail, but at different times. Franklin County was one of the first rural jails in the nation to offer buprenorphine, in addition to naltrexone, beginning in February 2016. Hampshire County began providing buprenorphine in May 2019.

"There was sort of a 'natural experiment' where two rural county jails located within 23 miles of each other had very similar populations and different approaches to the same problem," said study author Elizabeth Evans, Ph.D., of the University of Massachusetts-Amherst. "Most people convicted of crimes carry out short-term sentences in jail, not prisons, so it was important for us to study our research question in jails."

The researchers observed the outcomes of 469 adults, 197 individuals in Franklin County and 272 in Hampshire County, who were incarcerated and had opioid use disorder, and who exited one of the two participating jails between Jan. 1, 2015 and April 30, 2019. During this time, Franklin County jail began offering buprenorphine while the Hampshire County facility did not. Most observed individuals were male, white, and around 34 to 35 years old.

Using statistical models to analyze data from each jail's electronic booking system, the researchers found that 48% of individuals from the Franklin County jail recidivated, compared to 63% of individuals in Hampshire County. As well, 36% of the people who were incarcerated in Franklin County faced new criminal charges in court, compared to 47% of people in Hampshire County. The rate of re-incarceration in the Franklin County group was 21%, compared to 39% in the Hampshire County group.

Additional analysis showed that decreases in charges related to property crimes appeared to have fueled the 32% reduction in overall recidivism.

The Massachusetts JCOIN project, led by Dr. Evans and senior author Peter Friedmann, M.D., of Baystate Health, is performing further research on medications for opioid use disorder in both urban and rural jails across more diverse populations, including women and people of color. The investigators are examining the comparative effectiveness of the U.S. Food and Drug Administration-approved medications for opioid use disorder in jail populations, and the challenges jails face in implementing them.

"A lot of data already show that offering medications for opioid use disorder to

see Buprenorphine on page 40

Crisis Intervention: Is the Field Ready?

By Joyce Wale, LCSW
Regional Executive Director,
Behavioral Health, UnitedHealthcare

The comments below are those of Joyce Wale, LCSW and do not reflect the opinions of United Healthcare or others.

The New York State Office of Mental Health should be commended for their leadership and insight into the need for a comprehensive behavioral health system that is equipped to respond to psychiatric crises for all New York state residents. The NY State Governor and Legislature should also be recognized and thanked for their commitment of adequate funds allowing for the enhancement of the existing crisis intervention resources. Existing psychiatric or substance abuse crisis response services include interventions such as toll-free hotlines, county based mobile crisis services, crisis residences that allow for prolonged stays, suicide prevention programs, psychiatric evaluations at designated emergency rooms, specialized Community Psychiatric Emergency Programs, and inpatient hospitalizations on psychiatric units in general hospitals or at hospitals designated specifically for psychiatric services. The New York Offices of Mental Health (OMH) and Addiction Services and Supports (OASAS) are leading a statewide expansion of crisis services to include the development of crisis stabilization centers. There will be two types of crisis stabilizations centers developed, Supportive Crisis Stabilization Centers (SCSCs) and Intensive Crisis Stabilization Centers (ICSCs). Both types of centers will offer a safe and supervised environment that is available 24 hours a day, 7 days a week where individuals can receive support for up to 24 hours while experiencing an acute mental health or substance abuse crisis. These resources will create the opportunity for rapid intervention while avoiding the need for more intensive levels of treatment.

Joyce Wale, LCSW

While NY State policy leaders and legislative decision makers are recognizing the need for prevention, immediate intervention, and follow-up, I must ask: has the concept and utilization of crisis intervention and stabilization been understood and accepted by multidiscipline behavioral health teams?

We live in a risk aversive society where decisions are often influenced by the potential outcomes if a client in crisis is not evaluated in an emergency room. Often, families engage law enforcement as their loved one has refused all services and so they can feel safe in the community progress has been made and continues to expand to include mental health professionals in law enforcement activities.

In order to better develop the resources and improve our outcomes, we must ask:

Is there a scientific way to know when an individual is beginning to show signs of distress? If so, can we identify the optimal time to intervene? How can we use people with lived experience to quickly engage individuals in crisis at an early stage to facilitate appropriate intervention? How can we better educate and support families so they can more effectively utilize the crisis system, so it becomes a form of treatment leading to recovery and not simply a respite for the individual and family? Are medical students and psychiatric residents learning to understand alternatives to hospitalization and effectively access crisis intervention services?

Now is the time to find answers and solutions to those questions to facilitate improvements in our provision of care while the State expands crisis services. Regardless of an individual's mental wellness or distress, everyone, including myself, is affected by the efficacy and effectiveness of our current behavioral health system. I do not need to experience a psychiatric crisis to understand and value the importance of these services.

There has never been a better time to develop a robust transformation from the existing system to one that offers a simple yet effective array of crisis services that are easy to access. To make this shift, it is crucial for us to start with our training programs to improve our understanding the appropriate utilization of crisis services as an alternative to emergency room services. We need to utilize our scientific resources and knowledge to better understand effective timing and interventions. We need a better understanding of the legal resources available such as Kendra's Law. Kendra's law provides for court ordered services based on clinical criteria for need. This insures ensure adequate and effective care for individuals refusing services. Have other states developed more effective services and strategies, what can we learn from them?

It is inevitable that reflection on this subject will lead to more questions than

see Crisis Intervention on page 34

Recovery and Inclusion: A Viewpoint in Retrospect

By Fredrick Hodges, LCSW, MC-G

Currently we are faced with a delicate dance, between saving lives and promoting and perpetuating a zombie underclass. Tens of thousands are dying from drug overdose each year. Those who are living in addiction inflict on the society, higher healthcare costs, crime rates and human services costs. The eternal question of disease vs willful indulgence still persists. The medical model lacks the reach to inspire recovery via etiology and logic. The therapeutic community and its approach is seen as outmoded. Self-help remains the most effective pathway.

Abstinence as a goal is waning in the face of the call to save lives, championed by the harm reduction movement. Language is the new focus, fortunately this could be our salvation. The umbrella of "Recovery" in its embracing of all pathways has provided cover for many new provocative and controversial approaches, including recovery centers, "safe consumption sites" or "Overdose prevention sites." The language of Recovery in all instances and pathways indicates direction and progression. Words like "improvement," "potential," and "reduction", indicate direction and an impact on "Dysfunction."

A focus on the reduction of dysfunction in any area, physical, emotional, sexual, familial, financial, relational, etc. should be considered "recovery," and not be negated by the consumption of any substance, legal or illicit. Alternative foci give rise to divisive debates about the authenticity of an individual's recovery due to continued use of illicit substance or use of a supportive pharmacological agent. The DSM 5 terminology evolved from "dependence" and "abuse to use" and "use disorder," implicitly recognizing use without dysfunction. Ideas about who is in recovery and who should celebrate that recovery should also evolve.

Fredrick Hodges, LCSW, MC-G

When I learned about the fact that formal treatment services only served 1 out of 10 people who needed help, I knew that a strategy to increase inclusion was indicated." Although 20.8 million people (7.8 percent of the population) met the diagnostic criteria for a substance use disorder in 2015, only 2.2 million individuals (10.4 percent) received any type of treatment" (Surgeon General's Report on Alcohol, Drugs and Health 2016).

The goal of "abstinence" was the first barrier to a more inclusive view of recovery. Many individuals who continued to use substances while improving their lives would avoid stating they were in recovery or would hide their use. This diminished what would be visible support of the recovery movement for fear of the stigma attached with "relapse," another obsolete pejorative term. Recovery was typically seen as an all or nothing proposition.

The outcry from the community to save lives, opened the door to a wide range of interventions and a reexamination of approaches. The initiative to bring Recovery as "person-centered, life skills enhancement" to the community via peers as an interface is growing in popularity. Unfortunately, there is some confusion that I feel compelled to address. All peer services don't qualify as Recovery Services, simply involving a peer does not qualify a service as a recovery service. Peer support is essential in the process of recovery. Peers must be involved in teaching life skills, to qualify as providing Recovery Services.

The focus of Recovery services is the restoration of self-image, voice and pursuit of best self and the maximization of life potential. This is accomplished by teaching life skills. Peer Services is a bridge between the recoveree and the community. Peer services always provides support but does not always include life skills education.

This demarcation is provided not to create a silo, but to make clear the necessary elements to qualify services provided as being Recovery services. In my limited 8-year exposure to Recovery Services, I see the restoration of voice through the teaching of life skills, as the core of Recovery Services.

In order to be successful, the Recovery movement must move to a measurement of success based on recovery, of positive relationships, and of functions on a social, physical, vocational, psychological and familial level, without regard for the continued use of substance, whether prescribed, legal or illicit. Hopefully this will foster an atmosphere of inclusion, measuring recovery by the reduction of dysfunction and "harm."

Fredrick Hodges is a person in long term recovery for 30+ years. He is the

see Inclusion on page 34

Making Addiction Treatment More Realistic and Pragmatic: The Perfect Should Not Be the Enemy of the Good

By Dr. Nora Volkow
Director, National Institute on Drug Abuse (NIDA)

Last year saw drug overdose deaths in the U.S. surpass an unthinkable milestone: 100,000 deaths in a year. This is the highest number of drug overdoses in our country's history, and the numbers are climbing every month.

There is an urgent need for a nationwide, coordinated response that a tragedy of this magnitude demands. Recent data from 2020 shows that only 13 percent of people with drug use disorders receive any treatment. Only 11 percent of people with opioid use disorder receive one of the three safe and effective medications that could help them quit and stay in recovery.

The magnitude of this crisis demands out-of-the-box thinking and willingness to jettison old, unhelpful, and unsupported assumptions about what treatment and recovery need to look like. Among them is the traditional view that abstinence is the sole aim and only valid outcome of addiction treatment.

While not using any drugs or alcohol poses the fewest health risks and is often necessary for sustained recovery, different people may need different options. Temporary returns to use after periods of abstinence are part of many recovery journeys, and it shouldn't be ruled out that some substance use or ongoing use of other substances even during treatment and recovery might be a way forward for some subset of individuals.

Reduced number of heavy drinking days is already recognized as a meaningful clinical outcome in research and medication development for alcohol addiction. Clinical endpoints other than abstinence, such as reduced use, are now being considered in medication trials for drug use disorders. This could facilitate the approval of a wider range of medications to treat addiction, as well as open the door to medications that address symptoms associated with it, such as sleep disorders and anxiety. The existing medications methadone, buprenorphine, and naltrexone have proven to be effective at reducing relapse risk and improving other outcomes in patients with opioid use disorder, but more options could benefit more patients. And medications to treat other drug use disorders are needed.

Temporary returns to drug use are so common and expected during treatment and recovery that addiction is described as a chronic relapsing condition, like some autoimmune diseases. Yet these setbacks may still be regarded by family, friends, communities, and even physicians as failures, resetting the clock of recovery to zero. Patients in some drug addiction treatment programs are even expelled if they produce positive urine samples.

Healthcare and society must move beyond this dichotomous, moralistic view of drug use and abstinence and the judgmental attitudes and practices that go with it.

There are still many unknowns about the different trajectories that recovery may take, but stereotypes should not guide us in the absence of knowledge. Research in the field of nicotine addiction shows that a person's first cigarette after a period of abstinence raises the risk of returning to their pre-treatment use pattern but does not always have that outcome. Research on the consequences of returning to opioid, stimulant, or cannabis use after a period of non-use is still needed, but there is little evidence to support the assumption—reinforced in movies and TV shows—that a single return to drug use following on a one-time loss of resolve will automatically lead the individual straight back to their former compulsive consumption.

Medicine can perhaps learn from the recovery world, where a distinction is increasingly made between a one-time return to drug use, a "slip" or "lapse," and a return to the heavy and compulsive use pattern of an individual's active addiction—the more stereotypical understanding of relapse. The distinction is meant to acknowledge that a person's resolve to recover may even be strengthened by such lapses and that they need not be catastrophic for the individual's recovery.

A return to substance use after a period of abstinence may also, in some cases, lead to less frequent use than before treatment. Such a trajectory has been identified in research on drug and alcohol treatment outcomes in adolescents. For some drugs, any reduced use is likely beneficial: Less frequent illicit substance use means less frequent need to obtain an illicit substance and fewer opportunities for infectious disease transmission or fatal overdose. It may also increase the likelihood that a person can be a supportive family member, hold a job, and make other healthy choices in their life.

But as long as treatment is only regarded as successful if it produces abstinence, then even one-time lapses can trigger unnecessary guilt, shame, and hopelessness. If an individual feels like they are bad, weak, or wrong for taking a drink or drug after a period in recovery, it could potentially make it more likely for those slips to become more serious relapses. As it now stands, even a slip can produce a positive urine sample or force the honest patient to self-report a return to

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Overcoming Silos to Create Better Service Delivery

By Rola Aamar, PhD
Senior Clinical Effectiveness Consultant
Relias

Over the past two decades, overcoming the silos of clinical practice that predominate how we provide care has become one of the biggest obstacles that healthcare has tried to tackle. Chronic mental, medical, or substance use conditions rarely occur independently, yet the majority of options offered for treatment of these conditions operate in separate settings, with varying frequency, and sometimes with differing payment models. While these conditions do require distinct specialists for appropriate care, a major limitation to treatment is created when the specialists are not provided the resources to collaborate on treatment planning. When patients have access to multiple areas of treatment concurrently, the outcomes of treatment improve and patient quality of life increases.

A major barrier to collaborative treatment practices is how competent a provider feels in assessing and navigating the presenting condition. For example, many behavioral health or medical providers may underdiagnosis substance use conditions due to limited confidence in successfully assessing symptoms. This often results in a process of referring out for conditions beyond a provider's primary area of expertise, rather than bringing trusted experts into the existing patient-provider relationship and treatment process. This places the responsibility for treatment on the individual rather than on the healthcare system and creates a barrier to care for under-resourced populations.

The solution? Integrated care. Growing in popularity over the years, integrated care has become an established best practice in healthcare delivery models. When implemented properly, integrated care offers the ability to bring experts from a variety of fields into the same treatment and recovery plan. This allows providers to create treatment options that give patients easy access to a variety of providers who work together on shared treatment goals rather than working in parallel to one another.

Understanding Integrated Care

There is a strong case to be made for addressing concurrent conditions through collaborative treatment approaches. So strong, in fact, that two of the best funded agency types (Federally Qualified Health Centers (FQHCs) and Certified Community Behavioral Health Clinics (CCBHCs)) operate on the premise of providing medical, behavioral, and substance use services concurrently via a collaborative team. And the benefits of integrated care have been documented extensively in the literature.

Rola Aamar, PhD

The reality, however, of implementing integrated care in currently-existing healthcare systems has proven to be a challenge. New processes for triaging cases need to be developed to properly assess all conditions and hiring more staff is required to support the increased workload. Efforts to integrate care become even more complicated when we consider that integrated and collaborative care require a considerable amount of upskilling in cross-departmental subject matter.

Truly integrated care is not simply placing services in the same building. It requires an intentional effort to understand each individual's co-occurring conditions of needs and then provide the appropriate mix of resources to address those needs. This means that integrated care must become a daily practice, not just a set of logistical decisions made in executive board rooms. To achieve this, you need buy-in from all staff members – from clinical directors to providers to support staff.

Social Determinants of Health and the Case for Integration

Considering that implementing integrated care is not a simple process and that it often requires a significant financial investment, what are the long-term benefits of pursuing integrated care versus maintaining the status quo of treatment and recovery services? The answer lies in our growing understanding of the social determinants of health.

Social determinants of health have been a hot topic for quite a while, but the logistics of being able to provide treatment in a way that addresses each domain of health have eluded organizations that operate using siloed approaches to care. A challenge that siloed organizations experience when attempting to address social determinants of health is that there is plenty of awareness created around what social determinants of health are and how to assess for them, but then organizations often stop short of taking appropriate action on them. This leaves staff and administrators with a lot of questions about why treatment outcomes are not improving.

Challenges around creating resources that can address social determinants of health may stem from long-held ideas about "staying in our lane", specifically not interfering with issues that were outside of the scope of care that certain organizations provide. But with the growing understanding of the impact of moderating factors, such as food security and community support, comes the opportunity to be more involved in advocating for all the resources necessary for successful treatment and recovery.

When considering the ability to provide thorough recovery and treatment services through integrated care, organizations will find that they are afforded more experts with more community connections that can facilitate actions to address social determinants of health. Moreover, staff can include securing access to resources such as safe housing, vocational training, and stress management into their treatment plan.

Needs of Current Healthcare Systems

Healthcare systems that decide to transition siloed treatment and recovery services to an integrated care model face considerable challenge, including:

- transitioning payment models
- navigating the logistics on implementing new policies and procedures
- cross-training staff to build a base of knowledge that allows for interdepartmental collaboration

By their nature, healthcare systems are transactional. Specifically, most healthcare organizations are heavily dependent on fee-for-service models that limit the amount of access to a variety of services for a single diagnosis. Even organizations that are the most advanced in implementation of value-based payment models still rely on some fee for service payments. Fee-for-service models make integrated care difficult, if not impossible, to maintain.

It is widely known that the most successful integrated care organizations, CCBHCs and FQHCs, are supplemented through grant funding, which makes many of the services provided through those agencies possible. Steady and consistent transitions away from fee-for-service models to value-based payment models will be key in expanding and sustaining integrated care sites.

It should be noted that the developments of policies and procedures necessary to be successful as an integrated care organization will vary for each organization. However, a common thread across all organizations is the need for an expanded workforce. This will ultimately include hiring more staff and increasing training across all staff to better prepare them for the types of services that will be delivered.

Also, most integrated care organizations need to create new service lines (e.g., crisis services, on-site lab, peer support, MAT services) or expand existing service lines (e.g., care coordination and case management). Successful integrated care organizations will also prioritize building or growing their reporting infrastructure so that they can report on program and quality outcomes.

Finally, successful integrated care organizations require staff that have been properly cross trained in the different service areas offered. One purpose of cross-training is to create a team that feels confident in the ability of all members. Cross-training also helps staff operate with a shared foundation of knowledge. This allows providers to understand that while their expertise may be in either medical, mental health, or substance use treatment, that treating co-occurring conditions means managing the conditions at the same time alongside colleagues with the expertise needed to help the patient.

More importantly, it encourages each staff member to understand the value that other departments bring to the treatment process and encourages focusing on building a treatment plan that includes all components of care that a patient may need. Cross-training and upskilling are two of the strongest tools that organizations have for developing staff members that feel confident in bridging the gaps in care an individual may experience and giving them what they need to have a meaningful treatment experience.

Rola Aamar, PhD, is currently the Senior Clinical Effectiveness Consultant at Relias for behavioral health.

Limits of Self-Management in Mental Health

By Max Guttman, LCSW
Mental Health Therapist
Private Practice

Self-management teaches consumers of mental health treatment and people struggling with a mental health condition to eliminate all obstacles in your chosen path to recovery. The success of a person making true lasting gains in their recovery hinges on your capacity to identify immediate and long-term problems in your path to recovery, and in doing so, also produces and creates new and permanent solutions before your mental health issues become new and problematic complications in your treatment.

So, how does this translate into practical steps? I recommend:

1. Being proactive with communicating with providers, case managers, and allies in your recovery.

2. Don't be afraid to be a so-called nuisance to your treatment team. In the end, your health matters. So, a few extra phone calls when you know your mental health may be in jeopardy is more important than presenting as 'together' and 'high functioning'.

3 Get to know who your point person is and stay connected to their care of service until you are stable enough to coordinate your own care during a psychiatric emergency and are well on your way to your recovery.

Max Guttman, LCSW

4. Familiarize yourself with the mental health system in your area and surrounding geographical location.

5. Registering and applying for entitlements on account of your mental health condition may be critical in having the freedom you need in your life and accommodations to truly be attentive to your self-care and recovery.

There are always more resources available for you if you connect with key players in the systems that serve your special needs group. There may be qualifying hoops to go through and steps ahead of you, so start early and be prepared for delays. These systematic delays and red tape you must go through will likely reduce the potential for gaps in your treatment.

Remember, your commitment to care for yourself, adherence, and radical acceptance will be vital to preserving your belief in a positive outcome for the future. It's easy to disbelieve in your own recovery if you aren't sticking to your treatment plan and completing your objectives in a reasonable time frame. So, expecting good results and positive gains in your recovery when you aren't focused on your treatment and adhering to the recommendations of your providers can potentially put you at risk of an unexpected relapse, when a simple understanding of the risks and benefits of your treatment path will put you in range of your goals.

At some point during your recovery, you may believe insurmountable odds are pitted against your chances of success. This may be the aftermath of poor decisions on your part or the introduction of a new situation you are hurled into which was poorly planned and misunderstood in its power to derail your recovery plans. In these cases, no amount of planning ahead and insight into your clinical picture can abate the perfect storm of new and unpredictable contributing factors putting you at risk of relapse. I term this type of clinical situation mental status free fall and the emergent need for immediate help. In these cases, experiencing some relief from your symptoms isn't in the immediate future.

Self-management of your symptoms may not be realistic either, and you may be confronting a toxic chain of events, which will ultimately put your recovery in jeopardy of definite failure. In the wake of such global distress to your overall mental status, I recommend a simple and easy plan to implement during these crises and persistent loss of possibly self-control and capacity to problem solve or create solutions for yourself.

While self-management talks a lot about repairing decision-making before things get out of control, things can and will err regardless of our behavior. Taking comfort in the inevitable loss of our gains to date and radically accepting a loss or drop in mental status may be what's necessary to start over again.

So, instead of exhausting all your resources for one unattainable last goal, regroup, because these very resources will be moot and a waste of energy if you get hurt. I have seen first-hand patients barricade themselves in their apartments to avoid hospitalization and this is never the answer. There is a function in failure. Nobody is beyond starting over unless you are ready to give up on your recovery altogether. So, hit the refresh key in your life and sit back as your worldview resets, wait, and hope next time things will be different.

Utilizing Recovery-Oriented Cognitive Therapy When Treatment-Oriented Care is Not Leading to Recovery

By Kristin Rodriguez, LCSW
and Cameron Searle, PsyD
South Beach Psychiatric Center

Recovery-Oriented Cognitive Therapy (CT-R) was originally developed by the Beck Institute to promote recovery and resiliency in individuals with a diagnosis of schizophrenia, but it can be applied broadly to individuals with various challenges. The Beck Institute describes CT-R as "highly collaborative, person-centered, and strengths-based and focuses on developing and strengthening positive beliefs of purpose, hope, efficacy, empowerment and belonging" (Beck Institute, 2021)[1], making it a great treatment option for our facility where we have a percentage of patients with treatment refractory illnesses who have had poor response to traditional treatments. CT-R is a treatment that centers around recovery.

CT-R starts with connecting with the individual to identify a point in their life when they were doing better. This could be done by connecting them to an interest they had at the time. For example, music they enjoyed listening or even dancing to, cooking a meal, playing a sport, etc. Once the interest is identified, therapist and individual work together to explore their feelings and identify the meaning or value behind this feeling. CT-R aims to help the person identify their aspiration such as to feel connected, helpful, capable, and/or more energized. When in this adaptive mode, treatment focuses on finding ways to build and strengthen connection and motivation through repeating these activities and exploring the meanings behind them to link the meaning to the action.

What Is It?

CT-R utilizes a Recovery Map which can serve as a guide for treatment (Beck Institute, 2021)[2]. Individuals and therapists can work collaboratively to complete. Recovery Maps start with identifying interests and ways to engage the person as well as the beliefs that are triggered when they are active. They will identify goals and aspirations, how it would feel to accomplish these goals, and the meaning behind them. Maps also identify challenges that may interfere with accomplishing these goals. These challenges can be behavioral or the beliefs they hold about themselves. The last step is to identify strategies to create positive actions, finding purpose and building resilience.

As CT-R is recovery based and centered on the participant's input and interests it also allows for a multi-disciplinary approach. The participant may connect with a specific therapy aide or a night shift nurse that they open up to or who observes them when they are most activated. Using this team approach and implementing CT-R within the milieu increases the chances for initial engagement and maintenance over time.

How Is It Done at SBPC?

In 2018 the NYS Office of Mental Health (OMH) selected South Beach Psychiatric Center (SBPC) to pilot CT-R. SBPC is a New York State OMH facility in Staten Island, NY that provides intermediate level inpatient and outpatient services to adults and adolescents with severe and persistent mental illness living in western Brooklyn and Staten Island.

Staff at SBPC completed initial training in person with the Beck Institute and then continued with bi-weekly meetings with Beck Institute consultants to review cases and get guidance for implementing the treatment. The treatment was piloted on 2 inpatient units, the inpatient day program, and the outpatient transitional living residence. In 2021 the facility did a new training to expand to staff representing the other inpatient and outpatient units to help implement the treatment facility wide. Outcome measures are taken using an instrument developed within the OMH system called the Indicators of Participation Scale [IPS]. Staff are asked to rate the participants from the time of recovery map development and at 3-month time points. The IPS is a general measure of activity to see if the participant is increasing connection with treatment. When a participant is ready for discharge and is being referred to one of our own outpatient programs we hold a meeting to share information about this person and what was effective/ineffective with the outpatient team to continue their progress using the CT-R model for treatment.

Initially, clinicians targeted participants who have shown treatment resistance to medication and/or therapy interventions with longer lengths of stay. Once identified, specific cases were presented during team consultations. Through consultation, recovery maps were completed to help guide the treatment along the CT-R model. From the map, we initiated participant specific activities.

One woman had an interest in crocheting. Staff began by allowing her to show them how to crochet, giving her the role as teacher and expert. This grew into a group with several peers and staff learning to crochet on a regular basis. Another woman had an interest in baking. She struggled with connecting with staff and peers. Staff worked with her and were able to identify some recipes she liked.

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CBC Board Announces Appointment of New President

Staff Writer
Behavioral Health News

The Coordinated Behavioral Care (CBC) Board has selected Pamela Mattel, LCSW-R as the new President & CEO of CBC. Pamela will replace Jorge R. Petit, MD who has skillfully led CBC for the last 4+ years. Pamela is a healthcare leader with over 38 years of non-profit experience, most recently as the Executive VP/Chief Operating Officer at Institute for Community Living (ICL) overseeing a large portfolio of Behavioral Health and Care Coordination, Supportive and Transitional Housing, and Intellectual and Developmental Disabilities services. Pamela was the Chief Program Officer at Public Health Management Corporation in Philadelphia, as well as the Executive VP/Chief Operating Officer at Acacia Network in the Bronx.

Patricia Bowles, CBC Board Chairperson announced, "Pam Mattel's appointment is an amazing opportunity for CBC and its network of community-based providers to continue to grow, innovate and improve care, especially in view of the many new initiatives contained in the Governor's budget. It is our hope that along with hospitals, community health care and social service providers, as well as other key stakeholders, we will develop new models of care and new partnerships which not only will improve outcomes but reduce the health disparities that have been exacerbated by the Covid 19 Pandemic. Pam is up to this task."

Pamela Mattel, LCSW-R

"Now more than ever, vulnerable New Yorkers need CBC's strength, innovation, and a diverse network with its proven record improving health and wellness to thousands. Together, we will move forward leveraging our vision, resources and mission driven commitment resulting in greater health equity and enhanced services for the people we serve. I look forward to working with the talented Board of Directors, CBC Staff, network agencies as well as our colleagues in government, hospitals and Health Plans," said Pam Mattel.

Pam's leadership will catalyze and propel CBC's network of leading behavioral health and care management providers to continue to advance our field on behalf of communities across New York City and the larger metropolitan area.

Coordinated Behavioral Care (CBC) is a provider-owned and -led organization consisting of a Medicaid Health Home (HH), an Independent Practice Association (IPA), a Training Institute (TI) and an Innovations Hub which incubates new program models, such as Pathway Home™, and emerging technology-assisted care solutions.

CBC leverages community partnerships to coordinate integrated medical and behavioral health interventions that, coupled with a specialized emphasis on social determinants of health, promote a healthier New York. CBC brings together over seventy community-based health and human services organizations which provide access to quality treatment, housing, employment and other needed services.

The Department of Health and Human Services Announces Funding For Substance Use Treatment and Prevention Programs

By The Substance Abuse and Mental Health Services Administration (SAMHSA)

The Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA), is announcing two grant programs totaling $25.6 million that will expand access to medication-assisted treatment for opioid use disorder and prevent the misuse of prescription drugs. By reducing barriers to accessing the most effective, evidenced-based treatments, this funding reflects the priorities of HHS' Overdose Prevention Strategy, as well as its new initiative to strengthen the nation's mental health and crisis care systems.

"Every five minutes someone in our nation dies from an overdose," said Secretary Becerra. "This is unacceptable. At HHS, we are committed to addressing the overdose crisis, and one of the ways we're doing this is by expanding access to medication-assisted treatment and other effective, evidenced-based prevention and intervention strategies. We're also traveling the country to listen and learn about new and innovative ways HHS can support local communities in addressing mental health and substance use. Together, through our Overdose Prevention Strategy and National Tour to Strengthen Mental Health, we can change the way we address overdoses and save lives."

Following President Joe Biden's State of the Union address earlier this month, HHS kicked off a National Tour to Strengthen Mental Health in an effort to hear directly from Americans across the country about the challenges they're facing and engage with local leaders to strengthen the mental health and crisis care systems in our communities. This funding announcement is part of this new initiative, which is focused on three aspects of the crisis Americans are facing: mental health, suicide, and substance use.

"This funding will enhance efforts underway throughout our nation to get help to Americans who need it," said Miriam Delphin-Rittmon, Ph.D., HHS Assistant Secretary for Mental Health and Substance Use and the leader of SAMHSA. "Expanding access to evidence-based treatments and supports for individuals struggling with opioid use disorder has never been more critical. Strengthening the nation's prescribing guidelines to prevent misuse is equally critical." The two grant programs are:

- The Strategic Prevention Framework for Prescription Drugs (SPF Rx) grant program provides funds for state agencies, territories, and tribal entities that have completed a Strategic Prevention Framework State Incentive Grant plan or a similar state plan to target prescription drug misuse. The grant program will raise awareness about the dangers of sharing medications, fake or counterfeit pills sold online, and over prescribing. The grant will fund a total of $3 million over five years for up to six grantees.

- The Medication-Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant program provides resources to help expand and enhance access to Medications for Opioid Use Disorder (MOUD). It will help increase the number of individuals with Opioid Use Disorder (OUD) receiving MOUD and decrease illicit opioid use and prescription opioid misuse. The grant will fund a total of $22.6 million over 5 years for up to 30 grantees. No less than $11 million will be awarded to Native American tribes, tribal organizations, or consortia.

Anyone seeking treatment options for substance misuse should call SAMHSA's National Helpline at 800-662-HELP (4357) or visit findtreatment.gov. Reporters with questions should email media@samhsa.hhs.gov.

More information on the National Tour to Strengthen Mental Health is available at https://HHS.gov/HHSTour.

This article was originally published by the Substance Abuse and Mental Health Services Administration (SAMHSA) here.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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Office of Mental Health (OMH) and the Office of Addiction Supports and Services (OASAS) in two of our clinic programs and have collocated OMH and OASAS clinics in our headquarters.

The process of becoming a CCBHC has also enabled TGCW to provide mobile crisis response and engage in innovative initiatives. In New Rochelle, TGCW is the behavioral health provider for a newly established Opportunity Youth court. In Mount Vernon, TGCW collaborates with the Mount Vernon Police Department for co-response, homeless outreach, and linkages to behavioral health supports. As we continue to expand our wrap around services, I am comforted in knowing that TGCW can and does support the full age range and complex co-occurring needs of individuals and families, including education, career/vocational needs, housing, in addition to treatment and recovery, as well as access to medical care.

The Guidance Center of Westchester is part of the Access Network – a group of agencies led by Access: Supports for Living. Together, the nearly 2,200 staff of the Access Network provide support to more than 17,000 adults and children with mental health and substance use needs, developmental disabilities, children and families facing challenges, and those who need support with housing and employment across New York's Hudson Valley, the five boroughs of New York City, and Long Island.

Shawna Marie Aarons-Cooke, LCSW-R, CASAC2, is Senior Vice President of Programs at The Guidance Center of Westchester, an affiliate of Access: Supports for Living. Please visit our early childhood website: www.TheGuidanceCenter.org/earlychildhood.

Secretary Becerra Kicks Off National Tour to Strengthen Mental Health

By U.S. Department of Health & Human Services

Following President Joe Biden's State of the Union Address, Health and Human Services (HHS) Secretary Xavier Becerra kicked off the National Tour to Strengthen Mental Health in an effort to hear directly from Americans across the country about the behavioral health challenges they're facing and engage with local elected officials and leaders to strengthen the mental health and crisis care system in our communities.

"The pandemic has not only taken a physical toll on all of us, but also brought on greater behavioral health challenges for everyone," said Secretary Becerra. "From small towns to big cities, I'll be traveling nationwide with members of my leadership team to meet with people who have been hit particularly hard, and partnering with local leaders to find ways to save lives in our communities. The Biden-Harris Administration will continue to deliver on our promise to build back better – and healthier."

As President Biden launches a whole-of-government strategy to transform mental health services for all Americans, Secretary Becerra is leading HHS to address the mental health challenges that have been exacerbated by the COVID-19 pandemic, including substance use, youth mental health, and suicide. Building on work that agencies and offices across the Department have already been doing, Secretary Becerra and HHS leaders will hit the road in a concerted effort to deliver on the Biden-Harris Administration's priorities to tackle these challenges.

Over the next few months, Secretary Becerra will make announcements on new initiatives and various resources provided by HHS, such as increasing the number of behavioral health professionals and community and behavioral health support workers in underserved and under-resourced communities, expanding pediatric mental health care access through telehealth services, and the transition to 988: America's Suicide and Crisis Lifeline. Through meetings with partners, local leaders, and elected officials across the country, the Secretary will highlight the work HHS is doing and also take time to listen and gather ideas about ways to partner with states and communities to strengthen mental health services, and what more the Department can do.

The term "behavioral health" refers to the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

Provisional data from the Centers for Disease Control and Prevention (CDC)'s National Center for Health Statistics indicate that there were an estimated 100,306 drug overdose deaths in the United States during the 12-month period ending in April 2021, an increase of 28.5 percent from the 78,056 deaths during the same period the year before. To combat this crisis, Secretary Becerra announced the release of the new HHS Overdose Prevention Strategy, designed to increase access to the full range of care and services for individuals who use substances that cause overdose, and their families.

Even before the COVID-19 pandemic, mental health challenges were common, with 1 in 5 adults experiencing a mental illness in any given year. Mental health challenges were the leading cause of disability and poor life outcomes in young people, with up to 1 in 5 children ages 3 to 17 in the United States having a mental, emotional, developmental, or behavioral disorder.

Additionally, from 2009 to 2019, the share of high school students who reported persistent feelings of sadness or hopelessness increased by 40 percent, to more than 1 in 3 students. The share of high school students who seriously considered attempting suicide also increased during this period, by 36 percent. The pandemic only exacerbated youth mental health challenges. In December 2021, the U.S. Surgeon General Dr. Vivek Murthy issued a new Surgeon General's Advisory to highlight the urgent need to address the nation's youth mental health crisis.

"Our country faced a mental health pandemic long before the COVID-19 pandemic began, and it was exacerbated by the traumatic effects of the past two years. That's why, last December, I issued a Surgeon General's Advisory on protecting youth mental health – because it will take policy, institutional, and individual changes alike to reframe and address this crisis with the urgency it deserves," said Surgeon General Vivek Murthy. "I am grateful to Secretary Becerra and the Biden-Harris Administration for recognizing this, and for their commitment to work with communities across the country to strengthen and protect mental health."

According to the CDC, in 2020, suicide was among the top 5 leading causes of death for people ages 10-64. Suicide was the second leading cause of death for people ages 10-14 and 25-34. Some groups have higher suicide rates than others. Among the highest rates are American Indian/Alaska Native and White populations, veterans, people who live in rural areas, and young adults who identify as lesbian, gay, or bisexual.

The National Tour to Strengthen Mental Health will also promote health equity and prioritize hearing from diverse voices. The Secretary will travel to traditionally underserved communities and hold conversations in spaces and places that are under-resourced. As the Secretary leads

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To End the Drug Crisis, Bring Addiction Out of the Shadows

By Dr. Nora Volkow
Director, National Institute on Drug Abuse (NIDA)

When I was six years old, as I was having dinner with my mother and three sisters, my mother received a telegram. She broke down crying as she read it. Her father - my grandfather - had died. In her grief, she locked herself in her room and would not let me console her. The memory of my inability to relieve my mother's suffering still haunts me.

My sisters and I were led to believe that our grandfather had died of a heart attack. It was only decades later, when I had already been an addiction researcher for several years and my mother was herself dying, that she revealed the truth: My grandfather had had an alcohol addiction. Unable to stop drinking, he had taken his own life in a final moment of futility and shame.

Overwhelmed by this revelation, I asked my mother, "Why didn't you tell me until now?" Her response was that she did not want me to lose respect for him or love him less.

My mother knew that I had devoted my life to understanding the neurobiological effects of chronic substance use. She had seen me speak about addiction as a disease of the brain and not a character defect. Of all people, I was someone she should have been able to speak to openly about why and how her father died. Yet, for her, the stigma of addiction and suicide was more powerful than the scientific understanding I was trying to bring to medicine.

Things have not changed much since that day. As a society, we still keep addiction in the shadows, regarding it as something shameful, reflecting lack of character, weakness of will, or even conscious wrongdoing, not a medical issue warranting compassionate medical care. Unfortunately, many in the medical profession harbor this mindset.

In fact, stigma remains one of the biggest obstacles to confronting America's current drug crisis.

Last year alone, more than 96,000 people in the United States died from overdoses - usually from opioids but also increasingly from stimulants - and the pandemic worsened an already dire public health crisis. If you have not lost a family member or friend to drug or alcohol addiction or its consequences, which include diseases like cancer, you likely know someone whose family has suffered such a loss. Additionally, untreated substance use exacerbates many other health conditions or interferes with their treatment.

The direct and indirect health effects of drug and alcohol addiction are so numerous and devastating that they are considered root causes of the declining life expectancy in our country.

What the Science Tells Us

Science has shed much light on addiction. We now understand that changes in brain networks needed for self-regulation cause substance use to become compulsive in some individuals - despite their best efforts to decrease or stop use. We are also gaining an understanding of the genetic, developmental, and environmental factors that cause susceptibility to drug experimentation and to the brain changes underlying addiction.

For instance, data from a large longitudinal study of adolescents funded by the National Institute on Drug Abuse in close partnership with other National Institutes of Health entities have provided insights into the adverse effects of poverty and adversity on the developing brain, including neurobiological changes that make drug use and addiction more likely.

On the positive side, prevention research shows that providing targeted interventions to families with low incomes or lacking social supports can avert - or even reverse - these neurobiological changes. What's more, decades of research on brain signaling systems have demonstrated that even once addiction takes hold, it is still reversible and recovery is achievable.

Unfortunately, stigma limits the impact of this knowledge and the reach of our tools.

The Role of Stigma

Stigma pervades medicine, policy, and communities.

Medical schools until recently offered little or no training in screening for or treating substance use disorders because, for many years, addiction was not seen as a medical problem. Even now, when medical systems offer treatment, it may be limited or inadequate. Among dedicated addiction treatment programs, fewer than half offer medications, which is tantamount to denial of appropriate medical care, according to a National Academies of Sciences, Engineering, and Medicine report.

Insurers are often reluctant to cover addiction treatment, including medications for opioid use disorder, and coverage is limited when it is provided. Inadequate coverage puts these life-saving treatments out of reach for many people who need them. Stigma also prevents the use of medications in most justice settings - even though at least half of incarcerated individuals in the United States have a substance use disorder, often an opioid

see Shadows on page 40

How Peers Contribute to Treatment and Recovery on CBC's Pathway Home™ Care Transition Team

By Angelo Barberio, MA, CASAC II, Coordinated Behavioral Care (CBC) and Maynor Alas, Samaritan Village

Community-based care management services are vital in helping New York City's most vulnerable members navigate an evolving healthcare landscape. CBC's Pathway Home™ (PH) program is an evidence based multidisciplinary care transition intervention, tailored to walk side by side members from institutional setting back to their communities, providing emotional and practical support every step of the way. Pathway Home™ specializes in care transitions from a variety of institutional settings such as State Psychiatric Centers, Adult Homes, Hospital Inpatient Units, and transitional living residences. Pathway Home's™ unique approach builds trust and rapport to mutually design a transition plan while inpatient, segueing into intensive supportive community-based visits. Through modelling and active linking from the PH multidisciplinary team, members strengthen skills for independence and take active ownership over their healthcare needs. The multidisciplinary team is comprised of Licensed Mental Health Clinicians, Case Managers, Registered Nurse, and Peer Specialists. Pathway Home™ utilizes several evidence-based practices such as Critical Time Intervention (CTI), Harm Reduction, Motivational Interviewing, and Peer Support. Peers are those with shared lived experience of mental illness, substance use, or homelessness who utilize disclosure to engage, develop, and strengthen rapport with the members.

This article highlights the important peer role within CBC's Pathway Home™ team including the influence on the care team relationships and member/provider relationships. It's well known that the peer is meant to build a connection using disclosure and comradery to establish a safe space for recovery, wellness, and growth. Traditional multidisciplinary teams have established robust structures for community-based services but often have limited experience in adopting a meaningful place for peers. The mental health clinicians provide clinical and therapeutic support and registered nurses use medical expertise to provide health education and linkages to medical care. However, the peer specialist position, can feel vague and arbitrary. The function of the peer specialist is inconsistent across providers and has been challenging for peers to establish their legitimate role in a care team.

Peer Amongst Peers

The perspective of an individual with lived experience is an important team-based tool just like a nurse providing a medical perspective to inform the team around physical health. Some members have histories of poor experiences in care and when offered services may find that these past experiences are a negative anchor and decline services. Staff desensitization, compassion fatigue, and burn-out create unintended therapeutic relationship barriers. The peer helps to remediate and heal this by building the member and team connection. They purposefully share their own experience of receiving care with the goal of increasing the intervention's acceptance. The peer's perspective on the receiving end of empathy fatigue can point this out to team members and remind them that the individuals have valid experiences and voices.

In a more active way, the peer will use language to help guide the Pathway Home™ team. In their training, peers are encouraged to use conversational speech rather than clinical language. This is with good reason as the peer embodies the person-centered approach especially in the language they use when discussing a member. Established clinical language is a refined and convenient short-hand form to communicate information in a field where time is limited, but it has its deficits, e.g., stigma, lack of clarity, barriers to empathy. There are so many ways to reframe a mental health experience, to shed preconceived notions and stigma that are often associated with them. The peer specialist, who has first-hand knowledge of how language impacts treatment, is

see Team on page 34

NY State Governor Hochul Appoints Debbie Pantin, MHNE Chair, and Anne Constantino to NYS Opioid Settlement Board

By The Office of The Governor of New York State

On March 19th, 2022, New York State Governor Kathy Hochul, after signing legislation expanding the Opioid Settlement Board from 19 members to 21 members, announced her two appointments to the Board.

"As we make our comeback from the COVID-19 pandemic, we must commit to also mitigating the impact of the opioid pandemic New Yorkers have endured for many years," Governor Hochul said. "That is why I am appointing Anne Constantino and Debra Pantin, two dedicated and qualified public servants to work with me in delivering results to improve prevention, treatment, and recovery for New Yorkers who need our support."

Anne Constantino has been appointed to the Opioid Settlement Board**.** Ms. Constantino is the President & CEO of Horizon Health Services and has worked at Horizon since 1986 where she began as Chief Operating Officer. As CEO, Ms. Constantino has seen an expansion of services in Western New York. As a result of the expansion, Horizon Health Services have grown and become one of the largest providers of mental health and addiction treatment and support services providers in Western New York. Ms. Constantino is a proud Western New Yorker, having graduated from Buffalo State (BA) and SUNY Buffalo (MS). Ms. Constantino is active in her community and on multiple boards such as: Amherst Chamber of Commerce, Executive Committee member: NYS Addiction Services Providers, Executive Committee: Coalition for Community Services, A Network of New York SUD treatment agencies.

Debbie Pantin, MSW, MS-HCM

Anne Constantino, BA, MS

Debra Pantin has been appointed to the Opioid Settlement Board**.** Ms. Pantin is the President & CEO of the Outreach Development Corporation located in Richmond Hill, New York. As CEO, Ms. Pantin focuses on using her 30 years of experience in the substance abuse and mental health treatment field. By trade, Ms. Pantin is a social worker by trade who has an extensive background in uplifting communities and improving outcomes. While working as CEO of VIP Community Services in the Bronx, Ms. Pantin was able to help oversee unprecedented growth in agency operations. Funding was raised from $21 million to $30 million under her watch. MS. Pantin is President of the Alcoholism and Substance Abuse Providers of New York State (ASAPNYS) and is the Chair of Mental Health News Education's Board of Directors. She participates in numerous national, state and local boards, and was previously the Co-Chair of the Substance Abuse Treatment Committee for the Coalition of Behavioral Health Agencies.

The New York State Association of Counties (NYSAC) made three recommendations for appointment to the Opioid Settlement Board that are currently being reviewed.

This article was originally published here on March 18, 2022.

HHS Announces Nearly $44 Million to Strengthen Mental Health and Substance Use Services for Populations at Risk for or Living with HIV/AIDS

By The Substance Abuse and Mental Health Services Administration (SAMHSA)

Today, the Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA), announced three funding opportunities to strengthen mental health and substance use services for individuals at risk for or living with HIV/AIDS. Totaling $43.7 million dollars, the funding opportunities reflect the Biden-Harris Administration's commitment to providing accessible, evidence-based, culturally appropriate substance use prevention, treatment, and recovery services to all as part of HHS's new Overdose Prevention Strategy. Funding will be awarded in the fall.

"We remain committed to providing people at risk for, or living with HIV/AIDS, with the support and services they need to thrive – no matter who they are or where they live," said Health and Human Services (HHS) Secretary Xavier Becerra. "This funding will ensure people who simultaneously face mental health and substance use challenges - and are at risk for or living with HIV/AIDS - will receive the support and treatment that they need."

"We must increase supports and services for those who are at risk for or living with HIV/AIDS and have mental health and substance use needs," said Miriam Delphin-Rittmon, PhD, HHS Assistant Secretary for Mental Health and Substance Use and the leader of SAMHSA. "This means connecting them to easy-to-access, culturally appropriate prevention, treatment, and recovery services."

The grants, which are being deployed to help underserved communities, are supported by the Minority AIDS Initiative and align with the Administration's priority of health equity. The funding targets areas of the country with the greatest disparities in HIV-related health outcomes and aligns with the National HIV AIDS Strategy.

The three grant programs are:

· Substance Use Disorder Treatment for Racial Ethnic/ Minority Populations at High Risk for HIV/AIDS: This program increases care for racial and ethnic minority individuals with co-occurring substance use and mental health challenges who are at risk for or are living with HIV/AIDS and receive HIV primary care and other services. This grant will fund up to $30.5 million over five years for up to 61 grantees.

· Substance Abuse and HIV Prevention Navigator Program for Racial Ethnic Minorities: This program provides training and education around the risks of substance use and HIV/AIDS, as well as the integration of a range of services for individuals with HIV/AIDS. The program uses a navigation approach - working through community health workers, neighborhood navigators, and peer support specialists – to expedite services for these populations. This grant will fund up to $4.5 million over five years for up to 18 grantees.

· The Minority AIDS Initiative - Service Integration: This program reduces the co-occurring epidemics of HIV, Hepatitis, and mental health challenges through accessible, evidence-based, culturally appropriate treatment that is integrated with HIV primary care and prevention services. The grant will fund $8.7 million over four years for up to 18 grantees.

Anyone seeking treatment for mental health or substance use issues should call SAMHSA's National Helpline at 800-662-HELP (4357) or visit findtreatment.samhsa.gov.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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Behavioral Health News Editorial Calendar

Summer 2022 Issue
Understanding the Impact of Stigma
Deadline: June 15, 2022

Fall 2022 Issue
The Behavioral Health System: Challenges Met, Challenges Ahead
Deadline: September 16, 2022

Winter 2023 Issue
Stigma: How We Can Make a Difference
Deadline: December 13, 2022

Spring 2023 Issue
The Impact of Behavioral Health on Families
Deadline: March 16, 2023

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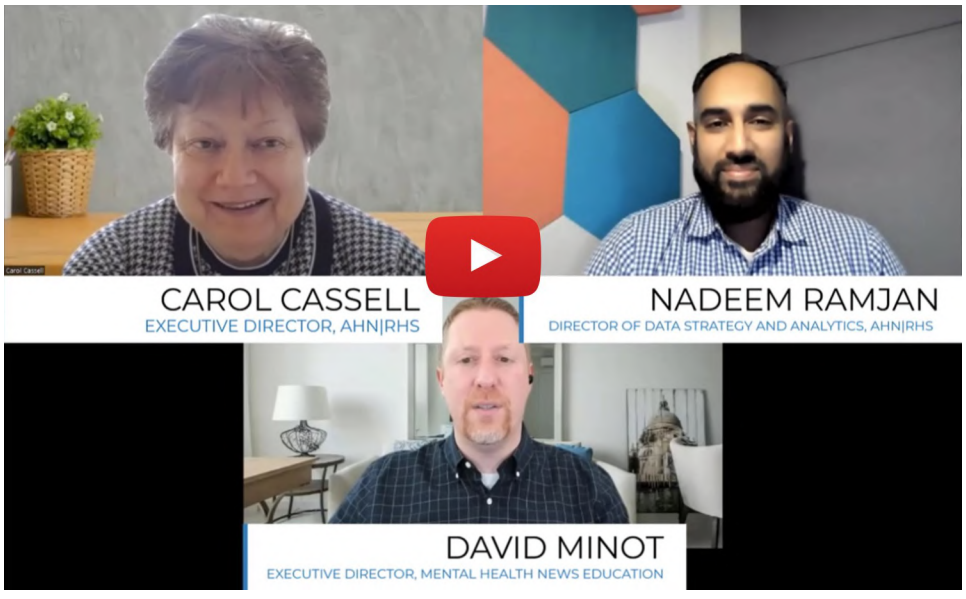
Behavioral Health News Spotlight on Excellence: An Interview with Carol Cassell and Nadeem Ramjan From Advanced Health Network & Recovery Health Solutions

By Staff Writer
Behavioral Health News

David Minot, Executive Director of Mental Health News Education, the non-profit organization that publishes Behavioral Health News, interviews Carol Cassell, Executive Director, and Nadeem Ramjan, Director of Data Strategy & Analytics at Advanced Health Network & Recovery Health Solutions (AHN|RHS). Carol and Nadeem detail their work to help behavioral health providers understand the value of a data-informed culture and its positive impact on the entire care continuum.



Watch the Interview with Carol and Nadeem from AHN|RHS

David Minot: Hello, and welcome to the Behavioral Health News Spotlight on Excellence series, where we feature exceptional leaders and innovative healthcare solutions that are raising the standards of care in the behavioral health community. My name is David Minot and I am the Executive Director of Mental Health News Education, the non-profit organization that publishes Behavioral Health News and Autism Spectrum News. Our mission is devoted to improving the lives of individuals living with mental illness, substance use disorder, and autism while also supporting their families and the professional communities that serve them by providing a trusted source of science-based education, information, advocacy, and quality resources in the community.

Today, we are speaking with Carol Cassell, Executive Director, and Nadeem Ramjan, Director of Data Strategy & Analytics at Advanced Health Network & Recovery Health Solutions, otherwise known as AHN|RHS, operating in affiliation. AHN & RHS work together with the shared goal of improving the health and wellness of individuals experiencing behavioral health disorders, often further complicated by medical and social determinants of health issues. AHN|RHS is a network comprised of almost 50 New York State OMH & OASAS licensed agencies providing comprehensive community-based services to individuals and their families experiencing behavioral health issues throughout the five boroughs of NYC and Nassau and Suffolk counties in Long Island.

Working as a team, Carol and Nadeem have been busy gathering quality metrics data from their member agencies and have worked to put this data in a format that is actionable and visualized so that providers can easily determine where there are opportunities for improvement and where they are doing well. With their impressive visual reports, they are helping providers understand the value of a data-informed culture and its positive impact on the entire care continuum.

Carol and Nadeem, thanks so much for being here today.

Carol Cassell: We're happy to be here. And I look forward to sharing our learning as we're learning on this journey, and hopefully can share that with others as we go forward here.

David: Let's start out by telling us about the Advanced Health Network and Recovery Health Solutions and the services that are provided.

Carol: Our providers represent both

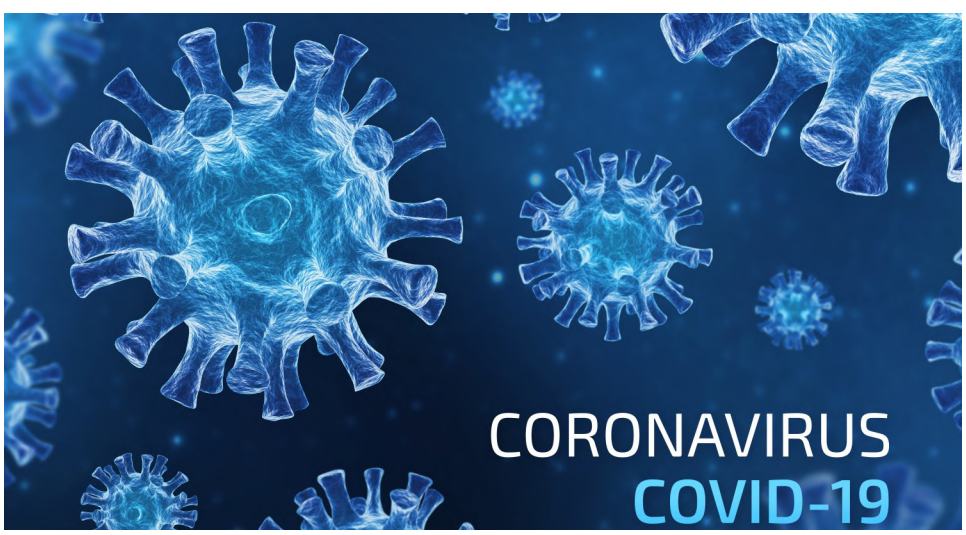
see Spotlight on page 35

Knowledge, Attitudes, and Practices Related to Prevention of COVID-19 Among New York State Behavioral Health Employees

By Kavita K. Trivedi, MD,
Valerie Deloney, MBA,
Brad Hutton, MPH,
Mark Graham, LCSW,
and Jorge R. Petit, MD

The COVID-19 pandemic has resulted in more than 79 million cases of confirmed infection and over 963,000 deaths in the United States.[1] The pandemic has also resulted in increased levels of adverse mental health conditions, substance use and suicidal ideation.[2] The reported prevalence of anxiety and depression increased three and four-fold, respectively, over prevalence in 2019.[2] Public health measures such as workplace and school closures, physical distancing, forgoing gatherings, testing, and contact tracing have increased isolation and exacerbated existing mental health conditions.

Mental and behavioral health providers have been impacted as well. Researchers from the University of Maryland conducted a survey of 137 mental health providers in the US about how the pandemic has impacted their clients, their services, their own stress and mental health, and what resources they need. Eighty-two percent of respondents reported the pandemic had negatively affected their ability to serve clients and that they are experiencing burnout and fatigue.[3] Even before the pandemic, an over-strapped mental health care system has struggled to meet patient demand for services leaving over 100 million people without appropriate access to needed behavioral services.[4]



Coordinated Behavioral Care (CBC), a not-for-profit organization representing over 60 community-based behavioral health providers in New York City, has been working to help address these unmet behavioral health needs. Through funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), CBC has been working with the behavioral health workforce across New York State to understand and address their personal and professional experiences with COVID-19. CBC partnered with Trivedi Consults to design and conduct a survey of their behavioral healthcare providers to identify knowledge, attitudes, and practices related to COVID-19.

Methods

The survey was designed to capture providers' knowledge and beliefs about the pandemic and the COVID-19 virus, as well as individual and community behaviors, and views and perceptions of COVID-19 vaccination. Responses were collected between February 3, 2021, and February 13, 2021. Approximately 1,585 persons statewide received the survey, 90 completed it, for a 5.7% response rate.

Results

Respondents were majority female (74%) and diverse in age range. Most respondents live outside of New York City. Sixty-five percent hold an advanced degree or doctorate (see Table 1, Demographics).

COVID-19 Prevention Behaviors

Ninety-three percent (84) of respondents reported members of their community wear face coverings and physically distance, and 99% (89) reported that individually they always wear a face covering when entering a public place.

Most respondents were cautious in interactions with people outside their households (see Table 2, Interactions with Others). Sixty-three percent (57) reported feeling unsafe getting a drink or meal in an indoor restaurant or bar. Seventy-six percent (68) reported they felt unsafe using

see COVID-19 on page 37

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What other programs does The Center offer?

The Center provides community education, including a webinar series for families, a newsletter and professional development programs for school staff. Upcoming webinar topics include Bouncing Forward: Resilient Parenting, Addressing Stress and Trauma in Families, Substance Use in Children and Adolescents, ERASE the STIGMA-A Family Event, and Mental Health in LGBTQ Youth.

Rachel Fernbach is the Deputy Director and Assistant General Counsel for the New York State Psychiatric Association.

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consistently applied across payers and their covered populations. Insel suggests nothing less than a "reframe[ing of] what we mean by care" is necessary if we are to bridge the gap between current service delivery and reimbursement practices and their intended outcomes.

Progress in any field of inquiry is fraught with detours, dead ends, and missteps, most of which are recognized as such only in hindsight. Inasmuch as psychiatry (and human services generally) boasts that loftiest of aspirations - an understanding of the surpassing complexities of the human mind and behavior – errors and repeated course corrections are inevitable. This does not invalidate emerging treatment models and the evidence bases on which they rest, provided practitioners are appropriately discerning in their application. To paraphrase Johann Jacob Löwenthal, a preeminent 19th Century chess player, mastery is marked by the judicious violation of general principles. The application of treatment models must be similarly judicious – and even violative of core tenets at times – if it is to be truly masterful in mitigating human suffering.

Ashley Brody, MPA, CPRP, Chief Executive Officer, Search for Change, Inc., may be reached at (914) 428-5600 (x9228) or abrody@searchforchange.org.

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solutions but maybe, we don't need all the answers, maybe we simply need one or two solutions. The development of crisis stabilization centers may bring us one step closer to that. The behavioral health community is full of thoughtful and compassionate problem solvers, who better to include in brainstorming and development of solutions than those individuals?

Joyce Wale began her career in high school, where she started her school's Social Action Committee and volunteering at health and human services organizations. Her dedication led her to obtain both a bachelor and master's degree in Social Work, with honors. Ms. Wale worked in Child and Adolescent Behavioral Health programs at both the direct clinical services provision as well as administration in clinic, residential and day treatment services. With an extensive clinical and administrative program background, she went on to direct a National Institute of Mental Health State Planning grant in New Jersey. Moving up quickly to take over the leadership of the State's Child and Adolescent Mental Health Service's while continuing to serve as the Project Manager/ Principal investigator of the multi-year planning grant.

The lack of direct clinical work led Ms. Wale to establish a small clinical private practice In addition Ms. Wale taught at a university level and served in various capacities on the Board of Directors for the NJ State Chapter of the Mental Health Association. She served on a variety of legislative and NY State Committees while leading the New York City Health & Hospitals Corporate Behavioral Health Services. Under her leadership was the implementation of AOT, the development of numerous services across the city as well as establishing roles for peer leadership and published multiple articles on service delivery. She is a fellow with the NY Academy of Medicine and the Vice President of the Board of Directors of the Institute of Behavioral Healthcare Improvement.

Currently Ms. Wale is the Northeast Reginal Executive Director for Behavioral Health at United Healthcare Community. In this role she has oversight of the Insurance Companies' Health and Recovery Plan, Mainstream and Essential Health Plan Behavioral Health services. Additionally, she oversees the public sector Behavior Health services in the northeast. She is passionate about including individuals with lived experience in service delivery and administration. She may be reached at joyce.wale@uhc.com.

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former Assistant Director of the OASAS Bureau of Recovery Services, and lead for the 31 Recovery Centers in New York State. Mr. Hodges has had a career in human services spanning 30 years including OMH, Non-Profit residential treatment and over 21 years at OASAS in Regional Office, Enforcement, and recovery Services. You may reach Mr. Hodges at Hodgie3351@outlook.com.

References

U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016. (pg. 1-8)

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best placed to guide the team in broadening their vernacular by circumventing stigmatizing language and activities. Through dialogue and a person-centered approach, the peer minimizes repetitive language, energizes the team, and reminds colleagues of basic truths; *we do not have issues, we have challenges, we do not have weaknesses, we have barriers, we are not clients, we are members.*

Bridging the Member/Provider Dynamic

Building trust between a member and their various healthcare providers is innately challenging. A common issue is the power imbalance between members and their providers. The provider who takes on the role of expert often results in member's self-doubt and acquiescence. Unfortunately, and unintentionally, that dynamic can breed distrust and create an "us vs. them" dynamic where the provider is perceived as ill-intended. This is exacerbated in times of crisis that end with an adverse event such as hospitalization where members experience the process as punitive and/or threatening. A core element of the peer role is to validate member feelings, experiences, and circumstances. They connect to members and establish trust that encourages discussion about the recovery journey. While other disciplines can provide validation and use disclosure, the peer role is invaluable, as it involves trust through mutuality.

The peer embarks on a conversation fostering a different kind of relationship. They share their stories and actively listen in return. There is reciprocity, transparency, and mutuality to provide comfort in situations that can feel very isolating. In other words, it's an organic conversation between two people. *I am not a clinician; I am not here to assess you. I know how scary being hospitalized can be, I've been there too. Let's see how we can put our heads together and figure out how to best support you.* The hope is to build trust which encourages the member to be more open to sharing their concerns with treatment and their requests about how to move forward.

When this conversation takes place on a psychiatric unit, (a common occurrence with Pathway Home™), education and advocacy can then play a key role in building trust. Residing in an inpatient unit can be traumatic in its own way and elicit mixed emotions. Sometimes a member needs more clarity on their discharge plan, doesn't understand their rights as a consumer, or is too afraid to ask questions. The peer can help bridge that gap by being a trustworthy person that provides feedback, clarity, and suggestions based on their own experiences in treatment. This knowledge then allows the peer, along with the PH team, to advocate for the member and provide education.

Implications for the Field:
Sharing with Intention

The behavioral health sector has focused on increasing awareness and education on person centered care, strength-based language, and ensuring members are the drivers of their own recovery. The peer specialist role was/is most prepared for this movement. When utilized well the peer specialist both assists the member and equally important educate staff from other disciplines. The lived experience and the comradery are just the tip of the iceberg when it comes to the underlying context and plethora of care that a peer specialist can provide. The peer has a story, the member has another, both are equally valid, and they can learn from each other, guiding others within the healthcare system through their humanistic lens.

Angelo Barberio, MA, CASAC II, is Director, Pathway Home™, at Coordinated Behavioral Care, Inc. (CBC). Maynor Alas is a Peer Specialist/Care Manager, Pathway Home™, at Samaritan Village. For more information about Coordinated Behavioral Care, inc. or Pathway Home™, please visit our website at www.cbcare.org. For more information about Samaritan Village, please visit our website at www.samaritanvillage.org.

NYS Office of Mental Health Announces Funding to Strengthen Suicide Prevention Efforts for Veterans and Uniformed Personnel

By The New York State Office of Mental Health

The New York State Office of Mental Health (OMH) recently announced funding for a new initiative to strengthen resiliency and suicide prevention efforts among military Veterans and uniformed personnel, including law enforcement officers, firefighters, emergency medical service members, and corrections officers.

The program is called CARES UP (Changing the Conversation, Awareness, Resilience, Empower Peers, Skills Building/ Suicide Prevention for Uniformed Personnel) and was developed by the New York State Office of Mental Health's Suicide Prevention Center (OMH SPCNY).

OMH Commissioner Dr. Ann Sullivan said, "CARES UP will provide much-needed mental wellness support to first responders, uniformed personnel, and military Veterans – all of whom are at an elevated risk for suicide compared to the general population in New York State. CARES UP programming will support resiliency and wellness among our veterans and uniformed personnel and will ultimately save lives and protect our communities."

New York State Division of Veterans' Services (DVS) Director Viviana DeCohen said, "The funds from the CARES UP program will provide life-changing and life-saving services not only for our Veterans and their families but for our companions that serve for the safety and protection of our communities. This program ensures that New York keeps its promise to care for those who served our State and Nation not only with the challenges they may face upon their return home but any obstacles which may arise throughout their lives."

Division of Homeland Security and Emergency Services Commissioner Jackie Bray said, "Our first responders and veterans face levels of stress and trauma

that most of us never see. We have a responsibility to take care of the people who spend so much of their time taking care of us. The CARES UP program provides resources directly to local agencies so they can offer critical services and wellness programs to their employees and retirees that are sorely needed. Thanks to Governor Hochul's leadership this critical issue is not only getting attention but also getting the resources it deserves."

Division of Criminal Justice Services Commissioner Rossana Rosado said, "Training law enforcement officers is key to DCJS's mission. From the state's Basic Course for Police Officers to its Trauma Resources and Unified Management Assistance course, the agency has made police officer health and wellness a priority. We are grateful to our partners at the Office of Mental Health for their work in developing CARES UP to ensure that all uniformed personnel have access to resources and support that will help then prioritize their mental health."

Funding for Veterans' Agencies

The awards include $210,000 for three Veteran-serving organizations:

- Tioga County Veterans' Service Agency
- WNY Heroes, Inc.
- The PFC Joseph P. Dwyer Veterans Peer Support Program of Rensselaer County

The funds will be used to increase participation in a model national program called the Expiration of Term of Service Sponsorship Program (ETS-SP). This program assists service members and Veterans as they shift from military to civilian life by connecting them with a local volunteer peer sponsor. The program focuses on the first year of post-military life, a timeframe associated with high rates of homelessness, criminal justice involvement, alcohol and substance use, unemployment, and suicide among Veterans. Using peer-reviewed, evidence-based best practices, ETS Sponsors are trained and certified to build relationships and resiliency.

Governor Hochul announced as part of her 2022 State of the State agenda that New York State would help ensure the presence of ETS Sponsors in every county, to provide support for transitioning Service Members and Veterans. The New York State Division of Veterans' Services has worked with partners across the state and at the federal level to recruit ETS Sponsors – including through the coordination of training sessions that are available both online and in-person. Already, more than 150 New York State residents have completed the training to serve as ETS Sponsors. Any New Yorker interested in becoming a sponsor in their community can sign up here.

Funding for Uniformed Personnel

Additionally, $960,000 has been awarded to 12 Uniformed Personnel organizations (including fire departments, emergency medical services, law enforcement, and corrections departments). Grant funding will support resiliency and wellness programming as well as peer to peer training for grant sites, with the goal of increasing protective factors and reducing mental health problems faced by uniformed personnel. Awardees include:

Corrections Departments

- Albany County Sheriff's Department
- Suffolk County Sheriff's Department
- Allegany County Sheriff's Department
- Emergency Medical Services
- Clifton Park & Halfmoon Emergency Corps
- Colonie EMS Department

Fire Departments

- City of Olean Fire Department
- City of Watervliet Fire Department

Law Enforcement

- Village of Mamaroneck Police Department
- Albany County Sheriff's Office
- Erie County Sheriff's Office
- Port Chester Police Department
- Town of Clarkstown Police Department

OMH has also produced a CARES UP webinar series titled "First Responders Behavioral & Mental Health Wellness: Lessons from the Field" featuring Drew Anderson, Ph.D., FF/EMT, an Associate Professor of Psychology at the State University of New York at Albany. The videos, available on the SPCNY website, explain why first responders are at an increased risk for behavioral and mental health issues. This series helps viewers understand protective factors that boost behavioral and mental wellness and can help first responders identify those around them who are struggling with mental health issues.

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mental health and substance use inpatient detox/rehab, residential, outpatient, and recovery programs across the five boroughs of New York City and all of Long Island with multiple locations including close to 50 providers and over 200 locations with several upstate serving about 50,000 patients annually. Where we've been focused on, we often hear people say, "Data is the asset of the future." But what does that mean?

Because we all collect a lot of data, whether we collect it through our EMRs, assessments, and care plans. But how do we take that data and really transform it into a way that it becomes actionable and measurable to support what we do every day. The competitive advantage that we're looking for is to get paid for the incredible work that our providers provide every single day. It's an investment. If the data is an asset, an asset has to be managed and invested in and there's investment through cultural change - a cultural change being with people, processes, workflows, and technology itself. It starts with (and we sometimes take this for granted) what data we collect, where we collect it, how we collect it, and then how we summarize it in a way that we can then publish it and have it visually actionable so that decision making can occur.

As we've worked with some of our providers, we've discussed how we make the data we have collected visually useful and actionable at an executive level, at a management level, and at a staff level. It's frustrating to staff when they're collecting data and they don't have an appreciation for how their data is really informing care coordination plans, quality improvement efforts and the like. That investment is a significant one that we've been supporting our providers in.

The other piece that we are working on as a data-informed culture is to bring together medical data, mental health data, substance use disorder data, and social determinants of health data in a way that we can package it, visualize it, and utilize it to inform our quality improvement efforts, our care coordination activities, our contracting, and our grants. We're fortunate that we're emerging with all this data but making it actionable is where we're focused. We have built a robust business intelligence platform that we'll share more with you - Nadeem has been leading that effort .

We've also learned from the healthcare community as a whole that a referral management solution would be helpful. Too often emergency rooms, hospitals, physicians in the community might identify the need but they don't know where and how to refer. And so, we have built a platform that supports that data flow. The other piece not to be taken lightly is addressing consent management because in this space of mental health and substance use, while we all are familiar with HIPAA, there are additional consent requirements because of the nature of the data that we have worked on to help our providers best manage. And then all of that, moving towards management of grants, bundled payments, incentive programs, and visualizing the data. So, we're working with our providers on quality measures, performance improvement, ad hoc reporting, care-coordination, bundled payments, and clinical viewers and we look forward to sharing some of that with you.

David: Why should providers support the transformation to a data-informed culture?

Carol: It's their future that is going to be predicated on making informed decisions focused on certain population cohorts. So, if we build the data warehouse by bringing in all of this data from these multiple

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sources, we've been able to define population cohorts in terms of those who have complex needs - complex needs being a population cohort where they have a medical condition combined with mental health, substance use disorder, housing or employment concerns that requires a different level of care management/care coordination than someone who might just present with a substance use disorder or alcoholism. In building this data warehouse, we brought in all this data; we've collected it, we've normalized, and we've standardized it so that we can, through actual data analytics, look at retroactive practices - what their performance is and meeting HEDIS metrics, what their performances in 30 day, 60 day, and 90 day engagement periods.

We've also started to develop comparative analytics so that if you and I are both in the same space, how is my performance vs. your performance and what shared learning can come from those best practices that we're deploying is measured in the analytics. We are now also starting to move into predictive analytics because where we can intervene earlier by engaging individuals where they're not presenting repeatedly at the emergency room - that's where we want to get. We really want to focus more on the prevention in the recovery along with just treatment. Again, we're looking at how do we visualize it from looking at cohorts; provider cohorts, population cohorts, whether it's individuals who have come out of the justice system or the veteran's cohort. Because how we engage with these populations are different and they should be because we want to be patient-centered and person-focused. And then, again, supporting the providers in how we optimize their EMRs in the PSYCKES database that New York State provides to our mental health and substance use providers. I'm very passionate about that. In my background, I've worked with implementing EMRs in hospitals, for primary care physicians, and for the behavioral health community. It's one thing to implement it but it's another step to optimize all the functionality and capabilities that exist in that EMR. So, as we're helping our providers and building that data from culture, we're actually helping them optimize the investments that they've made in their technology platforms and also helping them on their consent-management.

David: Can you provide some details on what AHN|RHS is doing to support its behavioral health providers?

Nadeem Ramjan: We're all quite familiar with the standard HEDIS metrics. What we've tried to do is to peel back the layers and say, "How can we identify why patients are not adhering on certain metrics?" We want to peel back the layers to get to actionable data. But in doing so, we want to be able to leverage the existing data collection tools. Sometimes you find our new project and then we say, "Let's build a survey tool to get that data" or we take all types of approaches which can create a lot of administrative burden. So, one of the strategies we have employed is to look at existing data collection tools and squeeze as much value out of them as possible. On the right, here are some metrics we've built internally, which start to tell the true story of which patients we need to focus our attention on. For example, we have an AMA report where we're able to track patients that don't complete treatment and we look at patients who are staying less than 30 days, shown in red. We take this information, we drill down with the providers, and we look for the commonalities among the patients that are not staying the minimum 90 days as recommended by various programs. And then lastly, we built an entire suite of SDOH measures. One of them is here, where we look at patients who, when they come in for treatment, they're unemployed, and by the time they leave, they have some level of employment. So, in doing this, we're able to look at the non-traditional data, but utilize the existing data sources that are there to again build deeper insights into why we're not able to move the needle on certain metrics.

Carol: We have another example to share, which builds upon the PSYCKES reporting that the state has built the infrastructure for and our providers are working with.

Nadeem: So here we show an example where we have some data that is perhaps dated; it's not as real time as we'd like it to be. However, it doesn't mean we can't utilize it. And so, what we have here is an example of a trended report where we've trended about two and a half years' worth of data. And it tells a really strong story where, if the provider, for example, is not improving on a measure over a period of two years, then definitely they need to look at some new methods, some new engagement techniques to employ with their populations.

We trend data over time to show how providers are doing and we also compare them against their peers. We do some ranking reports where we rank our mental health outpatient providers against each other, our SUD providers, those that have those that are Certified Community Behavioral Health Clinics (CCBHCs) those that are inpatient. And we also rank them with respect to how they're doing on measures, compared to their peers, and we do it in a blinded way so there's no feelings of highlighting people. What this data shows is that if you are, for example, "the worst" among your peers, what often is the story is that you are dealing with a far more complex population. So that also helps them as they engage with different grant applications and MCOs to say, "Look, I'm not able to perform as well as my peers because I'm dealing with a much more complex population set. What can I do here? And what help can you offer me, so I can improve the care that's being delivered."

Carol: Our next example is with population health.

Nadeem: We try to empower providers so that we're giving them data at the PHI level, at the patient level, building registries and so forth. But then we also do work at a population health level, and we span such a wide range and have so many locations and providers. So, we pulled together demographic data, medical data, mental health, substance use, and SDOH. We pulled together all this data so we can tell the full story of what's going on with the patient. We look at clusters. You can see over here, we have some examples of some geo mapping we've done. This is really trying to get into this space that is getting more attention now, which is to be more neighborhood-focused.

A lot of grants that are coming out now ask you to focus on a collection of contiguous zip codes in a specific region. We drill down on that and we say, "These folks have high rates of diabetes, they also have high unemployment rates, and they also suffer from depression." So, we're able to combine all this data so we understand the population. And then on the lower right, we try to make sure that we're also being culturally sensitive. We look at data, both public and internal, to see what the ancestry of the folks in those regions is so that, again, we're being culturally sensitive. This is an example where we tried to pull all the data together in one place and put it together in one presentation so that, as we're applying for grants or for targeting populations, we see all the factors that are affecting people in a specific region. But certainly, a patient in the South Bronx would have a different set of needs then one perhaps in Western Suffolk County. And that's exactly what we find as we do these types of analyses.

Carol: For the next example on where we are utilizing these analytics, we are pleased to share that we have initiated a pilot project with HealthFirst called "Walk With Me." This is a medication-assisted treatment (MAT) program. We spent about three years developing a clinical model and we have built a program that embraces a patient-centered approach that captures data for what's termed as wraparound or add-on services; services that are not billable today but are a means of having better engagement of the individual in the program. And so, it's a pilot program to test how this bundled payment approach supports a clinical model, all supported by data; data that gets captured, gets gathered, and summarized. We are just now rolling it out. We anticipate that in about a year, we'll have sufficient data we can learn from so that we can then modify this program as we go forward.

Nadeem: To summarize the work we do, in terms of supporting our providers, we've spent a significant amount of time on consent-management. And one of our guiding principles we have is trying to make sure we find solutions that don't create administrative burden for both our providers as well as the patient. And so, we've leveraged existing consents that have been well-vetted within New York State and we've trained our providers, through a series of webinars, on how to implement those consents while also helping them build scripts so they can clearly communicate what the patient is consenting to. That's been a great success, I would say. There's no conversation we have about improving care that doesn't involve consent. So that's something that you really have to have a clear strategy and focus around if you want to help improve patient care and break down barriers with data silos.

In terms of quality management and reporting, we show some examples of some reports that we've created at the population health level as well as at the provider level. We share performance reporting with our providers on a quarterly basis so they can look at how they're doing and if they're adhering to goals with respect to different grants that they're a part of. For data visualization, similarly, we leverage existing tools that are available at the state level and create visualizations on an ad hoc basis to again support the management of various grants.

We look to optimize their use of the EMRs across our IP. We have 15 different EMRs and we work with all of our providers to help them make sure that they're making use of the data that is there. This leads to a lot of shared learnings because as we become experts in different EMRs, we're able to show our providers how you can use these two or three reports and basically answer 80% of the questions you have. And again, as we also have this wide network of MH and SUD, we are able to come together, form workgroups around specific initiatives using learnings from specific providers and then sharing it across the board - so everyone in the IPA benefits.

Lastly, we are working towards this goal, which is a goal for everyone in data and in healthcare, to break down silos into interoperability. We have strategic partnerships with specific vendors that we've hired in the IPA that will support interoperability so that if a patient moves from the outpatient setting to the residential setting, the outpatient provider can see which meds their patients are receiving. So, we break down those barriers, again leveraging our vendor relationships and strategic partnerships so that we can have data flowing between providers even if they have different EMRs. I think that's really critical because, while it's easy to focus on data visualization, sometimes providers just want a simple, one line statement in their EMR: "Did the patient pick up their meds?" or "What meds were they prescribed?" We support that as well to have better patient care, break down silos, and hopefully see better outcomes for our patients.

David: You are certainly doing a lot to support for providers, they are lucky to have you! What have you learned throughout this journey?

Carol: That's a great question because it is a journey. And as I shared in my opening comments, we all think that we have data and that data is just magically going to transform itself into these reporting capabilities that's going to help us in our day to day management and our strategic leadership but it's not that easy. What we've learned, or what we've confirmed, is that the build of a data warehouse is a journey. All this data coming in needs to be normalized and standardized and it takes time to do that.

We've also learned that in the build of the data warehouse, not everyone captures data in the same way. Also, how you capture data and how I capture data can look very different. I might ask questions very thoroughly and capture a lot of data points and my colleagues may not. So, the data capture is an operational investment that really requires orientation and education of the workforce in terms of why it's important and how it's going to be used.

And then there is an investment in the infrastructure itself. There is a lot of data that gets captured. And what we've learned, and what we've had to do through our shared learning with our providers,

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is to prioritize and focus on what matters. What we don't want to do, as the cliche goes, is to be managed by the data but rather manage the data so that we are prioritizing and focusing on those key data points and data elements that, when made actionable, will help contribute to improvement in care, improvement in quality, and will support the ongoing funding that's needed to make the investments in the interventions, the workflows, the processes, the resourcing, and the technology that's required. In the end, what we're about is improving the lives of those who are receiving mental health and substance use services. That's the summary - it's a journey. It's an investment in people, technology, workflow, and infrastructure. It is a change of culture to be data-informed and data-driven where we manage the data going forward.

Nadeem: I think you said it well that it's really a journey. And we're so happy with the partnerships we have with our providers. We always try to meet them wherever they are and remain focused on what we can achieve today rather than focusing on something that is going to take years and years. Taking a phased approach is critical when it comes to data. We've been able to lay that out through all the collaboration we have with our providers, making sure we're listening to what they're saying and providing them with the greatest value for the data. We make sure that we're not just producing data for the sake of dashboards but making data that's actionable, relevant, and again, barrier free where we're not creating a burden for them. We're doing whatever we can today and then laying out a path for the future for things that are much needed like interoperability.

Carol: I would add to that the way we put data visualizations together is that we take it out, we'll get feedback and we get their input in terms of what metrics matter or what data matters. It is a collaborative, shared learning and development culture that we are building. And because of that, it really comes down to trust. There are many questions about the data and if it can be trusted. That trust comes from the engagement with the leadership of the organization, getting their input and their feedback on what's important and how we can make it available. It comes from the workforce, those who are collecting the data, and learning how their data is being used to management.

Trust in the data and in a data-informed, culturally-driven organization. It's making data a part of almost every meeting; how it's being used and worked with. And then the processes; how is the data captured and at what level of detail is it captured? And then, as those processes are defined, it's looking at the technology. It's the enabling technology that supports the capture of the right data at the right time by those who are skilled to

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the subway. Ninety-four percent (85) reported they would fully participate in contact tracing if diagnosed with COVID-19.

Discussion

This small survey of behavioral health providers in New York City in February 2021 during the COVID-19 pandemic signals overall capability in seeking and interpreting scientific information. The rates at which respondents selected answers that reflect current scientific understanding of the virus and disease, and the consistency with which they were able to do so across topics, shows frequent engagement with and comprehension of multiple sources of scientific information. For almost all questions that assessed knowledge about COVID-19, transmission, high-risk activities, and vaccination, at least 90% of respondents marked answers that aligned with scientific consensus and current recommendations.

On people's minds is the question of what should change or improve based on the experience of the COVID-19 pandemic in preparation for "next time," which is all but assured. For decades, infectious diseases experts have warned of factors that increase the likelihood that society-disrupting pathogens will emerge and spread rapidly widely[5] - factors that are all the more prevalent today. In our preparation for the next epidemic or pandemic we should fortify communities by identifying champions for public health and building multidisciplinary partnerships and collaboratives to support and implement public health interventions.

Conclusions

Studies show a high rate of confidence and trust clients have in their behavioral health providers, who also frequently are clients' main connections to healthcare.[6] This survey demonstrates behavioral health professionals' skills in seeking out scientific sources, keeping up with evolving research and guidance, and interpreting it accurately. Their work is ongoing to guide clients through managing safe behaviors during the COVID-19 pandemic, but as the country considers how to improve the US public health infrastructure and plan ahead, it is important to identify ways to leverage behavioral health specialists' scientific fluency and trust from clients.

As explained in a recent article from *Health Affairs*[6], efforts should be made to link behavioral health groups to public health agencies both for the purposes of pandemic planning and preparedness for future events, as well as to build vaccine confidence, so that when the "next time" happens, they are ready to serve as a temporary arm of the public health infrastructure. In turn, it is important for organizations such as CBC to continue to remain a trusted resource in providing pandemic information to their members, to remain agile and nimble in pivoting to support the membership during an emergency, and to continue adjusting messaging, training, and information flow based on the latest science and the community's needs. This survey highlights the critical importance for the development and delivery of needed training for the behavioral health workforce and thereby, their vulnerable clients, to address real-time knowledge gaps particularly important during a pandemic.

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Footnotes

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Gender			**Race or ethnicity**		
Female	67/90	74.4%	White	56/90	62.2%
Male	21/90	23.3%	Black or African American	20/90	22.2%
Non-binary	2/90	2.2%	Multiple race or other	7/90	7.8%
Age			Hispanic or Latinx	5/90	5.6%
45-54	21/90	23.3%	Asian	2/90	2.2%
55-64	21/90	23.3%	American Indian, Alaska Native, Native Hawaiian, other Pacific Islander	0/90	0.0%
35-44	20/90	22.2%	**Education**		
25-34	19/90	21.1%	Advanced degree	53/90	58.9%
>65	7/90	7.8%	College	26/90	28.9%
18-24	2/90	2.2%	Doctorate	5/90	5.6%
Location of residence			High school	3/90	3.3%
NA – I live outside of NYC	53/89	59.6%	Technical certification	3/90	3.3%
Brooklyn	13/89	14.6%	Some high school	0/90	0.0%
Queens	13/89	14.6%			
Manhattan	6/89	6.7%			
The Bronx	4/89	4.5%			
Staten Island	0/89	0.0%			

Categories of people in my "bubble" (those with whom I do not adhere to pandemic precautions like face coverings and physical distancing)		
Household members	80/90	88.9%
Family members who live in other households	30/90	33.3%
Close friends	17/90	18.9%
People who I know are tested often	5/90	5.6%
Friends of friends, if outdoors	4/90	4.4%
Colleagues I see throughout the week	4/90	4.4%
Patients or clients	2/90	2.2%
People I exercise with	1/90	1.1%
Other	4/90	4.4%
Number of people in my "bubble" (those with whom I do not adhere to pandemic precautions like face coverings and physical distancing)		
<5	62/90	68.9%
6 to 10	21/90	23.3%
11 to 15	3/90	3.3%
16-20	2/90	2.2%
>20	2/90	2.2%
In the last 30 days, I have attended a gathering with people from outside my household without pandemic precautions (indoor or outdoor)		
No	83/90	92.2%
Yes	7/90	7.8%
Don't know	0/90	0.0%

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the Administration's efforts to ensure equitable access to health care, HHS will continue working across the Department and in partnership with other agencies to close behavioral health disparities and invest in comprehensive treatment, early intervention, prevention, and recovery support services for all Americans.

The Secretary also intends to bring with him a message of hope – because in the face of startling statistics, there are prevention strategies that work and stories of resilience that should be shared. For example, providing 24/7, free and confidential support to people in crisis works – numerous studies have shown that the existing SAMHSA-funded National Suicide Prevention Lifeline helps thousands of people overcome crisis situations every day. The transition to 988 in July will make it more accessible.

Secretary will work with partners and elected officials across the country to address the nation's mental health and behavioral health crises, which have been exacerbated by the COVID-19 pandemic. Photos and videos of the National Tour to Strengthen Mental Health stops will be available at: HHS.gov/HHSTour.

Tour stop details will be announced in the coming weeks and throughout Spring 2022.

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boroughs of New York City, and Long Island.

Iva Jenkins, LCSW, is Director of Early Childhood Behavioral Health Services at The Guidance Center of Westchester, an affiliate of Access: Supports for Living. You may reach her at (914) 613-0700 x7031 or by email at EarlyChildhood@TheGuidanceCenter.org.

Please visit our early childhood website: www.TheGuidanceCenter.org/earlychildhood.

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capture the data so that it can then be gathered, summarized, and visualized in a way that leadership can lead the culture of the organization to be data informed and data driven and demonstrate that to those external partners that we are the quality driven provider - in our case the AHN|RHS network - that services want to be provided and be received from.

David: This has been very informative, and I had no idea that so much is being done with data to help these provider agencies improve their services and improve outcomes. It's wonderful what you guys are doing at AHN|RHS. Thank you both so much for your time today to share your impressive work with the Behavioral Health News readership!

Carol: And thank you for the opportunity of sharing this story because data is something that we all need to make an investment in, learn from, grow with, and share with each other. So, we thank you for the opportunity to share our story.

For more information about the work Carol and Nadeem are doing at Advanced Health Network and Recovery Health Solutions, please visit www.AHN-RHS.com and stay tuned for our next installment of the Behavioral Health News Spotlight on Excellence Series.

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whom severe mental illness persists?

Perhaps, but doesn't talking about improving the quality of life for "the chronically mentally ill" have a ring of hopelessness about it?

At the dawn of the 21st century "recovery" won the day. A presidential commission created by George W. Bush and chaired by Michael Hogan, with powerful input from Roslyn Carter, the former first lady, focused on the potential for people with mental illnesses to lead lives that they found satisfying and meaningful. In part this meant focusing on those who would recover in the ordinary sense, people who no longer have symptoms of mental illness. In part this meant focusing on those people who rose to leadership positions in the mental health community despite continuing struggles with severe mental illness, people like Pat Deegan and Ed Knight among many others. And in part this meant recognizing the possibility of good lives for people still disabled by mental illness.

The Commission voted for a "recovery-oriented" system; it voted for hope as well as for a comprehensive system of care and treatment.

During the first two decades of the 21st century, sad to say, housing development has fallen short, income support has been barely adequate, finding high quality treatment has remained difficult, acceptance by mainstream society has remained limited, and people with severe mental illness continue to die younger than the general population.

But the lives of people with histories of mental illness have improved, not enough for sure but improved. And they have become powerful spokespeople for themselves. They are now called "peers" and have become helpers as well as the helped. Patricia Deegan's conspiracy of hope has spread to those who organize and manage the nation's mental health system. It is not total victory for people with histories of severe mental illness, but it is a triumph for "recovery."

Michael B. Friedman, LMSW is a retired social worker who continues to teach at Columbia School of Social work—via Zoom—and who has become the volunteer chair of The Cognitive and Behavioral Health Advocacy Team of AARP Maryland.

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drug use, which can then trigger the judgment and punitive policies of their treatment program or the law as well as trigger the personal sense that they have failed again and there is no hope for their recovery.

Another deleterious effect of equating treatment success with abstinence and drug use with treatment failure is that some people with SUDs are unready to give up substances completely. In fact, this is one of the main reasons people who could benefit from addiction treatment do not seek it. Although it may not be ideal or optimal, treating an opioid or methamphetamine use disorder even while a person continues to use cannabis or alcohol would be a net individual and public health benefit.

Realistically and pragmatically addressing addiction requires that we not let the perfect be the enemy of the good. Right now, we need all the good we can get. It also means offering supports for people with SUD that protect against the worst consequences of drug use. Syringe-services programs reduce HIV transmission and offer people an entry point into treatment; naloxone distribution to people who use opioids and their families reduces overdose fatalities. Neither of these measures increase drug use in communities that implement them, as critics often worry.

Other harm-reduction modalities being studied include personal drug-testing equipment like fentanyl test strips, as well as overdose prevention centers—places where people can use drugs under medical supervision, which are in operation in other countries and, as of late November, are available in New York City. Such services could potentially help mitigate some of the risks associated with lapses and relapses, such as heightened risk of overdose due to lost tolerance. The latter currently accounts for many fatal overdoses after people with an untreated opioid use disorder are released from prison, for example.

Drug addiction is a chronic but treatable disorder with well-understood genetic and social contributors. It is not a sign of a person's weakness or bad character. Continued or intermittent use of drugs, even by people who know they have a disorder and are trying hard to recover from it, must be acknowledged as part of the reality of the disorder for many who struggle with it. Just as we must stop stigmatizing addiction, we must also stop stigmatizing people who use drugs as being bad or weak, and instead offer them support to help prevent addiction's most adverse consequences.

Nora D. Volkow, M.D., is Director of the National Institute on Drug Abuse (NIDA) at the National Institutes of Health. NIDA is the world's largest funder of research on the health aspects of drug use and addiction.

Dr. Volkow's work has been instrumental in demonstrating that drug addiction is a brain disorder. As a research psychiatrist, Dr. Volkow pioneered the use of brain imaging to investigate how substance use affects brain functions. In particular, her studies have documented that changes in the dopamine system affect the functions of frontal brain regions involved with reward and self-control in addiction. She has also made important contributions to the neurobiology of obesity, ADHD, and aging.

This essay was published by Health Affairs on January 3, 2022.

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his triggers and patterns in his life that have motivated him to self-medicate. In his journey of healing and sobriety he discovered the additional medical challenges of diabetes and hypertension. "I'm trying to find a balance of health and wellness. I'm doing alright now. I always go to my programs (three days a week) and am doing well. That has made me feel good. At my programs, I talk about things that happen and how I feel. The staff interact with me and it's nice. They are able to tell me this is this, that is that, you're doing fine. They keep supporting me and I like them – now I'm doing things right, things are right for me right now. The way that I'm going is good enough – I can't ask for no more. I'm grateful for everything that I have," said Luis. "I've been in S:US housing for more than five years. I don't like to go out too much, and staying in my home is good for me. I'm not a young man any more – I'm going to be 70 years old so it helps to have the support."

Diana said that utilizing all the services that S:US offers for people with disabilities has been a great experience and transformational for her as an individual. "I have been able to learn to become a better person and to be more self-sufficient. I am very glad to be a part of the S:US family," said Diana. "I love living at my S:US residence. I have my own studio apartment where I can have guests and come and go as I please. I'm very grateful to have my own place because I have a roof over my head and a place to sleep every night. That has made a big difference in my life."

Social Connections are Important

This pandemic has been isolating and we've experienced additional challenges that make it hard to connect with people. But connections are important for everyone and talking with other people who've been where we are has been a lifeline. Building community helps us find activities that keep us busy and teach us new skills.

Herman came from a hospital to the Assertive Community Treatment (ACT) program. S:US' ACT teams deliver comprehensive mental health treatment to individuals who have a mental illness that seriously impairs their functioning in the community. ACT delivers treatment to people in their homes, shelters, parks and anywhere else they happen to be living, engaging them in a sustained relationship that leads to recovery. "ACT helps me with medical services, medication management, and talk therapy either at home or via phone once or twice a week. They keep me stable," said Herman. "I miss my other social connections; I used to spend three hours a day at a community center to play dominos with my friends. But ACT helps and keeps me connected with other people."

"Having someone to speak to that was not family helped with my recovery. The S:US staff cares, they asked questions to make sure I'm okay. They asked if I needed support with anything every time they spoke to me. They helped a lot with medication management. Before I came to S:US, I wasn't very good at keeping up with my meds but now I have been staying on top of it," said El-Quan.

"The women's group where we talk with each other about issues we were going through and learn from others who were going through the same thing was really helpful and I learned from others' mistakes," said Socorro.

"I used to live on the streets after my sister kicked me out of the house. I was homeless and ended up staying in a shelter. S:US helped me get this apartment and welcomed me with open arms. I'm doing really well here. I go out every day to the S:US Brooklyn Clubhouse (a place for people with mental illness to get training and build community). At the Clubhouse, they teach me how to use computers, all different things – how to make copies, how to scan stuff, how to get a new job, how to cook. They teach me a whole lot. The people at the Clubhouse were especially supportive in telling me that I'm doing a great job. They spoke of my progress and that I'm doing very well, so hopefully I'll be able to get a job soon," said Diana.

Don't Give Up

We've all experienced ups and downs, progress and setbacks. Some of us overcame substance use, after many attempts. We kept going until we found what worked for us.

"I went to a lot of other places that didn't help, but S:US provides tools and resources for whatever you are going through. Staff gave me tools and techniques, breathing exercises, and they rewarded me when I did things well. I thought I was never going to recover from addiction. And it was so hard. Every time I would fail, S:US would give me new techniques to help me succeed. They never gave up on me," said Socorro. "I couldn't believe all the support and genuine care that the staff showed me. After 30 years, I really never thought I'd be able to do it. But I did it in less than a year, thanks to their support! They even helped me find housing, which helped me get my life back on track. They still call me even though I've completed the program four years ago – telling me about breathing techniques and they helped with writing letters to support me in getting a job. It's allowed me to live a normal sober life and I recognize that this is the best feeling in the world."

Messages for Others
Experiencing Similar Challenges

We want other people who are experiencing similar challenges to know that if we could do it, you can too. There are services to support you and people and organizations like S:US who will help.

"Don't give up, there is hope, you can do it. At first you won't feel like you can and when you start it is like the end of the world and you can look for a thousand excuses, but your life will be better," said Socorro. "Love yourself because you're important. Don't let anyone tell you otherwise."

Diana shared, "Being homeless is not easy. Recovering from alcohol and drugs is not easy – going to AA groups and rehab and getting help is important."

Herman said, "Don't give up and try to stay as stable as possible because that will help in your journey. Try to stay positive."

El-Quan said, "There are people out there that will listen and help you along your journey in any way that you need. That's what the ACT team has been doing for me. You're not alone out there. If you feel like you're alone, the ACT team would be perfect. I'm really grateful to them for giving me a helping hand. I'm so appreciative of that and I look forward to the future."

"Don't give up – always know that God has something good for you even if you're struggling now. You may be going through a difficult time, but you can get through and overcome it. Find a purpose to do things, then you will find purpose in your life," said Jesus.

"It would've been nice to know about this place/these services sooner. I had a few incidents where I went into crisis when I was younger and knowing that this place existed and accessing these services would've helped me out a lot and could've put me back on course before things got out of hand. I want people to know that these resources are out there and can help. I'm really happy S:US exists," said Noelle.

We are thankful for the support we receive from S:US and wish everyone knew about these resources. Housing and support for our mental health has allowed us to stabilize our lives and get on paths to lead lives of purpose. We may still have challenges, but we know we are not alone. We are hopeful for the future.

Resilience from page 22

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Center from page 17

individuals walk through its doors and has provided a space for lifelong connections to blossom. The Sterling Community Center has witnessed the formation of numerous lifetime friendships and at least one marriage, as well as the development of many participants' careers, families, children, grandchildren, hobbies, and passions. These long-term, natural ties are what make the community center model so special and beneficial to the recovery process.

Ruthanne Becker, MA, is the Senior Vice-President of Rehabilitation Services, Dillon Bowne, LMSW, is the Coordinator of Peer and Recovery Services, and Jordania Estrella, LCSW-R, is the Chief Clinical Officer at Sterling Community Center.

Buprenorphine from page 24

people in jail can prevent overdoses, withdrawal, and other adverse health outcomes after the individual is released," said Dr. Friedmann. "Though this study was done with a small sample, the results show convincingly that on top of these positive health effects, providing these medications in jail can break the repressive cycle of arrest, reconviction, and reincarceration that occurs in the absence of adequate help and resources. That's huge."

The Helping to End Addiction Long-term Initiative and NIH HEAL Initiative, are registered service marks of the U.S. Department of Health and Human Services. This article was originally published by the National Institute on Drug Abuse here.

About the National Institute on Drug Abuse (NIDA):NIDA is a component of the National Institutes of Health, U.S. Department of Health and Human Services. NIDA supports most of the world's research on the health aspects of drug use and addiction. The Institute carries out a large variety of programs to inform policy, improve practice, and advance addiction science. For more information about NIDA and its programs, visit www.drugabuse.gov.

About the NIH HEAL Initiative: The Helping to End Addiction Long-term Initiative, or NIH HEAL Initiative, is an aggressive, trans-NIH effort to speed scientific solutions to stem the national opioid public health crisis. Launched in April 2018, the initiative is focused on improving prevention and treatment strategies for opioid misuse and addiction and enhancing pain management. For more information, visit: https://heal.nih.gov.

About the National Institutes of Health (NIH): NIH, the nation's medical research agency, includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical, and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.

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Cognitive from page 28

She worked with staff to bake cookies, again becoming the teacher and the expert by showing the staff how to follow the recipe. She was then able to take this further by contributing to a facility bake sale. She volunteered to help and was able to hear the compliments about her cookies.

One participant was difficult to engage in both inpatient and outpatient units. Outpatient staff learned that he had an interest in music and wanted to get a cell phone. After showing him how to use the phone and access YouTube he started to share more about his history of going to raves and rave music. He has shown significant improvement, starting to connect more socially by showing others the videos he is watching and interested in and agreeing to attend community trips with the residential staff which he had not previously participated in.

Another participant was very quiet, did not interact socially, and needed a lot of encouragement to remain compliant with medication. Through brief and friendly interactions with staff and offering him coffee he eventually shared that he is a strict vegan and couldn't drink it with milk. He has since been offered black coffee and accepted it and has been willing to engage in brief conversations with staff, sharing more about his decision to be a vegan and recently sharing that he would be interested in bowling. The residence is now planning a trip for the group to go bowling.

Another participant shared an aspiration of becoming a famous football player. Staff worked with him to ask more questions and understand the beliefs of his aspiration. The meaning behind wanting to be a part of a team was to feel like he belonged as he had no family connections at that time. Additionally, he wanted the respect and the recognition of others- connecting to his wanting to be famous.

In our CT-R group, participants would take turns as the group "barista" helping to make coffee or hot chocolate for group members as the group had identified that some caffeine, or at least a hot beverage, would be energizing and activating for them. This led to group members sharing memories associated with coffee or hot cocoa (ex- Grandma making hot cocoa on a snowy day) and building connections amongst the group members. Other ways we have engaged participants to be active include throwing a football or frisbee out in the courtyard and selecting a song to listen to/play the music video for and get participants to dance along.

What's Next?

If treatment-oriented care does not lead to recovery, the two can be integrated into a recovery-based treatment model such as CT-R. CT-R can be adapted to both inpatient and outpatient settings. It is not diagnosis specific and therefore can be broadly applied to a variety of people. One of the benefits of this treatment is that it permits participants to be the guide and direct treatment to recovery based on their own interests and values.

The next step for our and other OMH facilities will be to include more staff as The Beck Institute implements their next training initiatives. Continued consultations with Beck Institute will focus on more in-depth exploration of how to apply CT-R. Lastly, another initiative is a "Train the Trainer" program with the Beck Institute for the goal of making CT-R internally self-sustainable within the facility.

For more information about South Beach Psychiatric Center, visit omh.ny.gov/omhweb/facilities/sbpc.

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Shadows from page 30

use disorder.

What's more, many communities fail to provide harm-reduction measures, such as syringe services programs and the overdose medication naloxone, out of a moralistic - as well as factually incorrect - belief that those measures encourage illegal drug use.

Even when treatments and other supports are available, people with addiction may not seek them, fearing the judgments of those around them and the discrimination they routinely experience in the health care system. Patients are often hesitant to disclose their substance use to their physicians.

This contributes to the tragic reality that fewer than 13% of people with an illicit drug use disorder received any treatment for their addiction in 2019 and just 18% of people with opioid use disorder received one of the three safe, effective, and potentially lifesaving medications that could facilitate their recovery. The proportion of people with alcohol addiction who received medications is even lower: 3%.

Government policies, including criminal justice measures, often reflect - and contribute to - stigma. When we penalize people who use drugs because of an addiction, we suggest that their use is a character flaw rather than a medical condition. And when we incarcerate addicted individuals, we decrease their access to treatment and exacerbate the personal and societal consequences of their substance use. What's more, drug laws are disproportionately leveraged against Black people and Black communities, driving societal and health disparities.

The aura of illegality affects the treatment of people with addiction. For example, some treatment programs expel patients for positive urine samples, as if relapse were not simply a known symptom of the disorder and a clinical signal to adjust the treatment approach but instead actual wrongdoing.

Prescribers of addiction medications are themselves monitored and subjected to strong limitations that don't apply to other medications - or even to the same medications in different circumstances, such as prescribing buprenorphine for pain. Such oversight tacitly signals that there is something suspect about these treatments and the people who receive them.

Help and Healing

Stigma's damaging effects go well beyond impeding care and care-seeking. Painful social and emotional effects like rejection, isolation, and shame - internalized stigma - drive drug-taking to alleviate one's suffering, leading to a vicious cycle. It was internalized stigma that led my grandfather to end his life.

Research supports the lesson I learned firsthand in my own family - that stigma is not alleviated solely by educating people on the science of a disease. Partly, it requires facilitating contact between a stigmatized group and the wider community. If people with substance use disorders can share their experiences, then empathy and compassion can begin to replace judgment and fear.

For that to happen, addressing stigma must be a central prong of our public health efforts. If we're going to end the current addiction and overdose crisis, we must treat combating stigma as no less important than developing and implementing new prevention and treatment tools.

We need a large-scale social intervention to change public attitudes toward addiction and people who have the disease. Besides ensuring proper training and the resources needed to help patients with substance use disorders, we need to seriously reconsider policies - not only laws but regulations and practices in health care and other settings - that promote viewing substance use as wrongdoing. And we must make it safe for patients and families to discuss addiction and remove the shame that interferes with its treatment.

This article was originally published on February 2nd, 2022, and can be found here. This article was also published by AAMCNews on November 2, 2021.

Nora D. Volkow, MD, is Director of the National Institute on Drug Abuse (NIDA) at the National Institutes of Health. NIDA is the world's largest funder of research on the health aspects of drug use and addiction.

Dr. Volkow's work has been instrumental in demonstrating that drug addiction is a brain disorder. As a research psychiatrist, Dr. Volkow pioneered the use of brain imaging to investigate how substance use affects brain functions. In particular, her studies have documented that changes in the dopamine system affect the functions of frontal brain regions involved with reward and self-control in addiction. She has also made important contributions to the neurobiology of obesity, ADHD, and aging.

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treatments (MATs) such as methadone, buprenorphine, and Vivitrol, primary medical services, the education and prevention of sexually transmitted diseases, relapse prevention techniques, and other harm reduction methodologies.

All dormitory floors in our residential centers, communal areas, staff lounges, and medical centers have naloxone kits prominently displayed and easily accessible, as do our admissions and administrative offices, supportive housing, and outpatient and recovery centers. Executive staff and members of the Boards of Trustees have also been trained on its administration.

Clients entering treatment receive training on identifying signs of potential overdose, safely and quickly administering naloxone, and reaching out to EMS or other first responders to further assist in the critical situation of a suspected overdose. Clients are provided with overdose reversal kits when they leave the treatment environment for work, family, or court visits. Over the last seven years, we have made thousands of naloxone kits available to clients and staff in residential and outpatient treatment.

Our approach to treatment and recovery recognizes that addiction is a chronically relapsing disorder. Meeting clients where they are is the only way to engage them in the complex process of lifelong recovery. Providing social supports that include education, housing, harm reduction, and other services is essential for long-term recovery.

On-Site Health Services

We offer clients in our residential and outpatient programs access to MATs and primary medical and behavioral health services. It's an integrated approach that follows every client from initial engagement via street outreach or an admissions referral to placement in an appropriate program following a detailed medical and psycho-social assessment.

The operation of co-located Federally Qualified Health Centers (FQHCs) on-site at our two primary residential treatment centers in East Harlem allows us to quickly diagnose any medical or psychiatric issues impacting a client's ability to engage fully in substance use disorder services. The professional clinical staff works closely with the physicians and other medical personnel in the clinics as partners who cooperate as a person-centered team focused on a client's whole treatment experience.

This partnership is essential for meeting the service needs of our clients who often enter treatment with undiagnosed or neglected health issues. During the COVID-19 public health emergency, the ready accessibility of primary health services allowed us to quickly develop infection control measures, roll out an effective vaccination and testing system for clients and staff, and expand MAT services for a growing population of clients with opioid use disorders.

Some of the enhancements we made in response to Covid-19 kept everyone safe during the public health emergency. They also support and help clients progress with their treatment goals. Key among these are online and telehealth services for outpatient clients, court appointments, and other external appointments.

Power of Positive Peers

Extending recovery into the community through a network of peer supporters helps people in early recovery navigate the challenges of maintaining a healthy lifestyle. This support system is especially crucial for individuals who abuse opioids which, because addiction is a chronically relapsing disorder, are at heightened risk of overdose if they should misuse.

To give clients the best chance of maintaining their recovery, Odyssey House developed a peer navigator system that:

- trains people in recovery to be mentors for participants served by our Outpatient Center in the South Bronx;
- provides community support services for older adults.

Peer navigator services were funded by the federal Substance Abuse and Mental Health Services Administration and the New York State Office of Addiction Services and Supports. These community-based initiatives align with our residential treatment approach, emphasizing self-help, MAT compliance (where indicated), health and wellness education, and resources, including harm reduction protocols.

Moving Forward

As treatment evolves to include MATs, health and wellness components, art and exercise, formerly seen as "ancillary" services, have become central to our recovery mission.

Clients and tenants from all walks of life eagerly participate in art projects, finding purpose and beauty in creative expression. Exercise is central to all clients' health and rediscovery of physical strength and well-being. Whether lifting weights and practicing yoga in one of our on-site gyms or running outside and competing in our Annual 5K race or the NYC Marathon (where over 600 clients, staff, and volunteers have completed the race in the past 15 years), exercise is a central part of recovery at Odyssey House.

Peter Provet, PhD, is President and CEO at Odyssey House. For more information, visit www.odysseyhousenyc.org.

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statistically significant treatment outcomes when offered an EBT (Lee et al., 2021). Providing opportunities for underserved families to engage in an EBT through telehealth is an important, future consideration of behavioral health treatment providers.

Fidelity is Key

Devereux's process for the implementation of evidence-based practices is helpful to ensure treatments are conducted to fidelity. In addition to regular integrity and fidelity monitoring, Devereux also utilizes HIPAA-compliant technology to record and display daily behavior data for individuals in the organization's care. This is used by treatment team members to customize treatment/recovery goals and therapeutic strategies to meet the unique needs of each child/family. Access to real-time behavioral data also serves as consistent outcome data, which can allow for more targeted and accurate teaching/coaching of the skills necessary for successful recovery.

In conclusion, best practices in the behavioral health field promote an integrated system of care that prioritizes the use of EBTs, while also delivering services and resources necessary for empowering individuals and families during recovery.

Special considerations are needed when treating children and families/caregivers within this structure to ensure thorough and ongoing diagnostic assessment, consistent caregiver engagement with EBTs, and accessible services to underserved populations.

While all EBTs are considered gold standards for care, thought should be given to EBTs that focus on the generalization of skills outside the treatment setting to support recovery goals and principles. Systems for monitoring fidelity to EBTs contribute to recovery by ensuring a high quality of care is met and providing data that can assist with targeted interventions to support individuals, caregivers and stakeholders with the recovery process.

Devereux Advanced Behavioral Health is one of the nation's largest nonprofit organizations providing services, insight and leadership in the evolving field of behavioral healthcare. Founded in 1912 by special education pioneer Helena Devereux, the organization operates a comprehensive network of clinical, therapeutic, educational, and employment programs and services that positively impact the lives of tens of thousands of children, adults – and their families – every year. Focused on clinical advances emerging from a new understanding of the brain, its unique approach combines evidence-based interventions with compassionate family engagement.

Devereux is a recognized partner for families, schools and communities, serving many of our country's most vulnerable populations in the areas of autism, intellectual and developmental disabilities, specialty mental health, education and child welfare. For more than a century, Devereux Advanced Behavioral Health has been guided by a simple and enduring mission: To change lives by unlocking and nurturing human potential for people living with emotional, behavioral or cognitive differences. Learn more: www.devereux.org.

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For more information on Devereux Advanced Behavioral Health, visit www.devereux.org.

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