

Understanding the Impact of Stigma

How the NYS Office of Mental Health is Addressing and Reducing Stigma

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

Stigma towards individuals living with mental illness still permeates our society today. Stigma remains a major reason individuals and families don't seek help when they are having emotional problems. The public stigma surrounding mental illness, often perpetuated by sensationalized media coverage, creates stereotypes that lead to discrimination in employment, education, housing, and other essential services. This discrimination can lead to self-stigma and shame for people living with mental illness, which in turn discourages them from addressing their issues or seeking out the treatment and assistance they need.

New York State is attempting to decrease stigma by implementing a robust effort to educate the public about the misconceptions of mental illness, while at the same time taking action to address the impact of discrimination resulting from stigma by holding insurance companies responsible for parity of services and supporting fair housing, employment, and education opportunities. Additionally, efforts being made today to educate our youth can really have an impact on how future generations perceive mental health and wellness thus further reducing stigma.



Ann Sullivan, MD

Stigma-based discrimination against people living with mental illness can take many forms, some overt and some more subtly embedded in our communities and our social systems impacting many different aspects of a person's life.

A particularly harmful overt stigma is the media portrayal of individuals with mental illness as violent and dangerous. We must work hard to educate the public and the media that individuals living with

mental illness are no more violent than anyone else, but unfortunately are more often the victims of violence.

More subtle stigma permeates many of the systems we live with every day, even in healthcare. For many years, health insurance companies have discriminated against people with mental illness by not covering mental healthcare treatment or medications in the same way they cover treatment for physical illnesses. While New York State has strong parity laws, which, together with federal measures, protect our rights by requiring most comprehensive health insurance plans to cover medically necessary mental health services in the same way they cover medical and surgical benefits, violations of these laws still occur. NY State monitors and works to correct any violations, and it is important for the public to let us know when this happens.

New York has a behavioral health ombudsman program called the [Community Health Access to Addiction and Mental Health Care Project \(CHAMP\)](#) which helps individual New Yorkers who are facing insurance obstacles due to parity violations to get the treatment they need.

Other systems where individuals with mental illness often face discrimination is in employment and housing - two critical components of the recovery process. [The NYS Office of Mental Health \(OMH\)](#) is partnering with community groups and organizations across the state to help educate individuals and families about their

rights and the laws that protect against housing and employment discrimination, including the [Fair Housing Act](#) and the [Americans with Disabilities Act](#).

Partnering with the community is essential when trying to change minds about mental health. OMH recently awarded seven grants to organizations across the state that are engaged in various activities to educate the general public about mental health, including targeted audiences, such as landlords, corporate employers, educators, the media, and healthcare workers, who are often unwittingly influenced by the stigma of mental illness.

As a result of community advocacy, a voluntary tax check-off program launched in NY state in 2016. This program allows NYS taxpayers to donate easily to the "Mental Illness Anti-Stigma Fund" when filing their NYS taxes. Our latest round of awards emphasized activities that provide innovative, culturally appropriate, and relevant approaches to reducing stigma in minority and underserved populations, which are often most impacted by false perceptions of mental illness.

In this very edition, we are partnering with Behavioral Health News as part of our public awareness campaign to reduce stigma. OMH is teaming up with [Mental Health News Education \(MHNE\)](#) publisher of Behavioral Health News, on several stigma reduction projects. With OMH's

see [NYS OMH on page 38](#)

Help change the conversation about mental health.

The New York State Office of Mental Health and *Behavioral Health News* are working together to reduce stigma.

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Overcoming the Stigma of Mental Illness: Peers Play a Critical Role

By Edwin Rosario
and Jose Cotto, LCSW
Institute for Community Living (ICL)

Sharing a lived experience may be the single most important tool we have to address the stigma of living with a mental illness, and the isolation of COVID only exacerbated how important it can be to have someone to talk with who truly understands.

Over the past two years, we all learned to keep a very close eye on mental health. We came to see just how much this pandemic affected our physical, emotional, and spiritual response to things that were once everyday occurrences.

Greater awareness has led to some very positive developments, including expanded funding of behavioral health services offered in different ways like telehealth, support for new, innovative programs and overall greater acceptance and understanding by the world at large. While there's much work still to be done to overcome the stigma of mental illness, it's clear no one is a stranger to the realities of mental health.

Another lesson of the pandemic has been a deeper understanding of the critical role of Peer Specialists and just how much they can help increase engagement in services so that resilience, recovery, and healing are more attainable. The unique relationship between a peer and a person receiving services allows for a healthy blurring of "professional" boundaries - the ultimate "human touch" - someone who has walked a similar path.

At [Institute for Community Living \(ICL\)](#), Peer Specialists play a critical role in achieving our whole health goals because they show from their own perspective the value of addressing physical and mental health together. ICL peers are valued partners in newer programs such as Shelter Assertive Community Treatment (ACT) Intensive Mobile Treatment (IMT) teams as well as longstanding programs like Transitional Shelters, Community Residences for Young Adults, Supported Housing, and Traditional ACT teams.

Through a new internship program, ICL began working recently with a local college as the field placement for Peer Specialists which can lead to a permanent position. Additionally, a revamped committee by and for Peer Specialists will enhance programming and provide support to our colleagues.

Peer specialists have become uniquely able to address stigma, particularly during the pandemic. About to celebrate his one-year anniversary at ICL, Eddie Rosario demonstrates just how valuable and valued Peer Specialists are today at ICL. He clearly has what it takes for this difficult but ultimately rewarding work.

I have come to believe through experience that whatever prevailing condition one is born into can be considered normal to the one who is experiencing it despite



Edwin Rosario

how it looks to the outside world. This belief is one of the main reasons why I have been so interested in promoting mental health and shedding light on the prevalent stigma around it that can go unnoticed to many. I can still remember specific moments in my life that helped shape and evolve my views around mental illness and even question the disparity that if we are all created equal then why aren't we all treated as such.

While growing up in various neighborhoods around Brooklyn, I quickly learned it was taboo to speak about mental health. And when it did come up, it was done so in a negative light. My first introduction to the sentiment around mental illness was as a young child playing with my peers in a park. We were all playing basketball and one of the kids made a simple mistake while playing which resulted in another kid telling the boy who made the mistake that he must be "crazy and from the G Building" and continued to make fun of him until it was time to go home. I was not aware that the G building was the Psychiatric Ward of Kings County Hospital until many years later but what I subconsciously learned that day was that it wasn't okay to fall into the category as someone from the "G Building" because in my neighborhood that would make you a target.

The older I got the more I would hear the term being used and I would cross paths with many more people wanting to ostracize and target people with mental health challenges. Neighbors would even celebrate and welcome those coming out of incarceration yet have a dismissive and sometimes silent regard for anyone that would be released from a mental institution. With all these observations and experiences, I still didn't question the status quo and social stigmas because in hindsight, I was like the metaphoric fish who was the last to know that it was in water.

Environment played such a huge role in shaping my world around mental health but so did entertainment. I remember as a teen turning on the radio and they would



Jose Cotto, LCSW

play rapper Biggie Smalls' song called "Suicidal Thoughts," a narration of the protagonist's struggle with holding and attempting to share the trauma, regret, and self-stigma they held internally, and I would bob my head in agreement without fully comprehending the gravity of his words. At the time those very words seemed normal to me because it was what I and most people were exposed to in our neighborhoods. The difference was that now someone of influence was disclosing it. I recall having a strong connection to the music and feeling a sense of relief knowing that I wasn't the only one with dark thoughts and emotions. Even though there was a visceral connection that I and many others had with Biggie's music, it was not enough of a motivator for anyone to begin having meaningful dialogue about it. In hindsight, I believe it planted a seed in my mind, normalizing the need to look for different outlets so that my struggles would no longer be internalized.

The role of mental health stigmas and its toll ended up revealing itself to me in a major way as a young adult. I still found myself holding many things in and felt like I was living a double life; in front of friends and family I would put on a smile, while inside I was suffering because I was too afraid to share and be judged. I would try to justify it by playing the hand that I was dealt which in other words dealing with my thoughts, feelings, and traumas on my own. My lack of clarity and fear led me to make some poor choices and unfortunately I wound up incarcerated. It was in prison that I noticed that many of the people I met there had mental diagnoses and were from neighborhoods similar to mine which didn't sit well with me.

Right before my eyes was the evidence of what not having enough meaningful dialogue, education, and awareness about mental health can lead to. For some, it was a vicious cycle of going from jail to hospital to shelter. I wanted this to change and grew very frustrated with the

institutions and even with society as a whole. Much like how the popular Rumi excerpt goes, "Yesterday I was clever, so I wanted to change the world. Today I am wise, so I am changing myself." I understood that expecting change from complex systems is okay but aiming to become the change that I wanted to see was even better. Upon my release, I decided to look for support for my own mental health and was fortunate to have met some amazing people that helped me in tremendous ways and guided me in deconstructing my own stigmas.

How did I get to where I am today, thriving as a peer specialist helping people rebuild their lives? It began when I shared my gratitude with a mentor and asked him how I could ever pay him back for his support; his words forever stayed with me. He said "Eddie, the best way to pay me back is by paying it forward" and with that encouragement I would eventually become a Peer Specialist at ICL. My experiences in this journey to my current life were birthed because of stigmas and have helped me understand that with healthy support anyone can turn their "mess" into a message and bless so many others just by openly sharing it. There's privilege in being able to say that I've overcome so many obstacles and find myself in a position to be able to give back. I was once in prison and now I'm working full time, living with a family I created; completing my Bachelor's Degree and planning to get my MSW. I'm living proof that anything is possible and that taking care of our mental health is vital.

I compare receiving mental health services to what the greatest athletes in the world receive from their coaches and teams. If the best of the best athletes can openly benefit from having a team of people supporting them to be their best, then so can we as humans when it comes to receiving mental health services for winning in life.

Edwin (Eddie) Rosario is a Peer Specialist on the ICL Shelter Assertive Community Treatment (ACT) Team where he uses his clinical skills and experience to provide high quality care to some of our most vulnerable. It is through his lived experience and training that he has grown to believe it's never too late for anyone to bloom. His mission is to share seeds of encouragement that will positively impact lives and inspire people to bloom wherever they plant themselves. Eddie has completed the Peer Training Program at Howie the HARP Advocacy Center and earned an Associate's Degree from Borough of Manhattan Community College with a focus on Liberal Arts. He is working on his Bachelor's Degree at Brooklyn College with the hope of pursuing a Master's Degree in Social Work. Aside from helping others, his greatest source of pride is being a father. Jose Cotto, LCSW is Senior VP for Residential Treatment at the Institute for Community Living (ICL).

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Intersectionality in Behavioral Health: Serving Those With Membership in Multiple Stigmatized Groups

By Kismyth Shuler, LCSW, Master
CASAC, Director of Integrated Services
The Guidance Center of Westchester

What are your social identities? How do you identify and how does the world see you? “Intersectionality, a term coined by legal scholar Kimberlé Crenshaw, emphasizes the “multidimensionality” of oppressed people’s lived experiences and recognizes how various types of oppression frequently coexist and intensify one another (Karmakar, 2022).” As part of my many intersecting identities, I identify as a Black cisgender woman. My identities are not independent of each other and overlap with who I am and how I am seen in the world.

Social stigmas can have a negative connotation and/or lead to discrimination against an individual or group based upon their social locations such as race, gender, religion, co-occurring disorders, disability, sexuality, and other identities. When we consider what intersectionality means, it is complex and is interconnected to social justice issues including, but not limited to, power dynamics and systemic oppression inclusive of disparities of wealth, health, education, experiences in the legal system, employment/wages, and access to resources. These disparities have significant and long-lasting impact to marginalized groups who are stigmatized based upon their intersectional identities and social location.

There is no one size fits all when looking at engagement and behavioral health treatment approaches which can either support those we serve or harm an individual’s overall well-being. Culturally aware, sensitive, and appropriate responses and approaches should be thoughtful and intentional. Approaches and interventions for a person who identifies as a cisgender, bicultural, female, can look different from approaches for a person who identifies as Black, gender nonconforming and differently abled. As we are reflective and cognizant of intersecting identities in historical, social, cultural, and political contexts, and are inclusive of an intersectional framework when in dialogue with stigmatized groups, we gain better insight to the experiences of these populations through their narratives.

Behavioral health services are not wrapped in a box with a bow. We serve a diverse population of community members who each have unique and complex experiences and needs, inclusive of historically and presently stigmatized groups. The expectation to conform to society’s Western culture, values, and beliefs of what behavioral health approaches and interventions should look like are not in alignment with the experiences of stigmatized populations. The impact to this primarily Western-



influenced homogenous approach is that we risk our efforts being out of alignment with the needs of stigmatized populations. Even further, we potentially leave a gap between the treatment needs and social justice problems that may be contributing factors to the individual and group issues within systems and structures that are broken and stigmatizing, leaving oppression and marginalization to continue to be perpetuated.

An intersectionality framework can have a meaningful impact and potentially better outcomes in behavioral health care. Through conversations with our clients and groups about how they experience the stigma of having intersecting identities, socio-politically and culturally, can provide validation, acknowledgement, inclusivity, and a deeper understanding of ways in which we can understand and support those individuals. Singh et al. (2020) suggests that intersectionality scholars inspire behavioral health providers to understand that using common theories can be harmful to clients with a dearth of awareness of cultural components around more influential and traditional theories.

The term epistemology is about how we know what we know. What are our ways of knowing? How do we know what the experiences of intersectionality are of stigmatized individuals and groups? We must be moved to think about systemic oppression, explore and be curious about the person and environment, recognize power imbalances, consider our own intersecting identities, consider our own power, privilege, and oppression that we hold and be culturally conscious. Hold courageous conversations inclusive of an individual’s intersecting identities and an awareness of any biases that may negatively impact those with whom we work. “It requires that social workers be vigilant, bold, and knowledgeable. It tells us that in order to serve for justice, one has to get to the heart of the matter” (Sulé, 2020). There is a narrative to be heard and explored. Accord-

ingly, Collins (2019) states intersectionality is about interconnections, reciprocity of engagement, and rapport building.

Let us consider health disparities within our healthcare systems. Social determinants of health have a negative impact on marginalized and stigmatized groups. Almeida et al. (2019) suggests that use of an intersectional assessment to inform ways in which social determinants of health determine overall wellness and health by using a decolonizing process and approach. Assessment of financial or economic stability, healthcare access and quality, environmental factors, food insecurity, housing, unemployment, cultural and social stigma, support networks, education, and literacy to name just a few. There is a cycle and theme of these social determinants of health that are experienced at a high rate by marginalized and oppressed populations. We tend to focus more on what is considered deficits of an individual rather than how systems in which these populations are engaged with continuously oppress, stigmatize and even pathologize. Within our healthcare systems as a whole, we need to do better with deconstructing and eradicating the stigma of those with intersecting identities and the experiences of being marginalized, oppressed, dismissed, devalued and unheard.

There are many interventions we can implore. Training is a critical aspect of bringing awareness, knowledge, tools and resources about intersectionality and application of the framework. While many may have heard the term intersectionality, many may not fully understand how to apply the framework and how to have discussions about intersecting identities and the impact socially, politically, or culturally it has on stigmatized groups and social justice issues that inherently are attached. I say, get comfortable with being uncomfortable.

Inviting and holding conversations in a learning and teaching environment, inclusive but not limited to, supervision spaces,

with our organizations leadership, speaking with community members, and with community partners about intersectionality, make it an inclusive conversation so that we can be thoughtful about decisions we make, policies we create, and utilizing practices that are supportive of stigmatized populations. If we are not talking about intersectionality, we are not addressing it. If we are not addressing it, marginalized groups will continue to experience of stigmatization. Hence, we become complicit in continuing to perpetuate stigmatizing oppressed and marginalized populations.

I will leave you with a quote from the late great inspiring Maya Angelou: “Do the best you can until you know better. Then when you know better, do better.”

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.

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Consumer Perspectives: Overcoming the Stigma Of Mental Health, Chronic Illness, and Homelessness

By Glenn, Rachelle, Robert, and Stephanie

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 four New Yorkers ranging in age from 39 to 62. We all receive support from [Services for the UnderServed](#) including housing, mental health services (therapy, medication management, and psychiatric rehabilitation), help preparing for and finding employment, and/or case management.



Stigma Causes Harm

We have all experienced stigma because of mental health challenges, chronic

illness, and/or homelessness. It has been really hard for all of us when people treat us differently because of what we're going through. Stigma has made us more

protective of ourselves and less trusting of others.

“After I went to the hospital, people looked at me differently, people stayed away from me, labeled me as crazy - everyone, including my friends and family. It made me standoffish and very private. I was very non-trusting of others. I didn't feel like anyone did anything that made me feel safe. Everybody pushed me away. I really wanted people to have an open mind, ask me questions, hear me out, listen to me to understand where I was coming from,” said Robert. “I was constantly thinking ‘What did I do wrong?! Was it my fault?! Are people right about me?’ I finally came to the realization that everyone goes through ups and downs and that has made me happier and more in tune with myself.”

Glenn said, “For me, the stigma around my HIV was the biggest thing I faced. People really didn't understand the virus

see Consumer Perspectives on page 14

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Stigma Is Being Used as a Political Weapon: Reject It!

By Michael B. Friedman, LMSW
Adjunct Associate Professor, Columbia
University School of Social Work

And many others have said it before but, as recent events make clear, we will have to say it again and again and again: **Mental illness is not the cause of mass murder in the United States.**

The continuing assertion by the political right that it is has become a core element of the vituperative and dangerous political division that besets the United States today. It is effective as political rhetoric because of the widespread misbelief that people with serious mental illness are violent and dangerous - i.e., because of continuing pervasive stigma about mental illness. In the hands of the political right, **stigma has become a political weapon.**

The mental health community, whether liberal or conservative on other issues, needs to conceptually disarm those who rely on the slogan that the problem of violence is mental illness, particularly those who refuse to confront guns as a major vector of death in the United States.

We need to continue to make the facts clear.

- People with mental illness rarely commit homicide, and few homicides are committed by people with mental illness.



About **5% of homicides are committed by people with psychotic conditions.**

- People with serious mental illness are far **more likely to be victims than perpetrators.**
- Most mass murders are committed by people who are not seriously mentally ill including:
 - Terrorists
 - Racists
 - Religious bigots

- People who commit purposeful acts of murder or manslaughter or who commit crimes that result in unintended deaths
- Perpetrators of domestic violence
- People seeking revenge
- And more...

It is notable that in its [Global Study on Homicide](#), the UN Office on Drugs and Crime recognizes multiple motivations for murder and divides homicides into 3 types: socio-political, interpersonal, and

criminal. But murder by people with psychosis is so rare that it is included only as a footnote.

- People with mental illness are far more likely to **take their own lives** than the lives of other people. This became an increasingly serious problem in the first two decades of the 21st century. [According to the CDC](#), the rate of suicide has increased 32% since the beginning of the century and is now roughly double the rate of homicide, which remained about the same from 2000-2019, but jumped about 30% in 2020 and apparently is continuing to rise.

In addition to repeatedly making the facts clear, mental health advocates need to resist the temptation to use recent increases in homicides, including mass murders, as a rationale for calling for improvements in America's mental health system. There are numerous reasons why there should be massive improvements; reducing murder is not one of them. Reducing suicide, yes. Increasing the capacity to provide and to get access to treatment for mental illness, yes. Improving the quality of available services, yes. Reducing fragmentation, yes. Addressing social determinants of mental illness, yes.

see Weapon on page 37



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Breaking Down Barriers to Using Social Determinants of Health Data

By David Bucciferro
Special Advisor, Foothold Technology
Vice-Chair, Electronic Health Record
Association

This is the time to use technology to overcome the barriers in integrating social determinants of health (SDoH) information into healthcare but ensuring that infrastructure and standardization is in place will be a joint effort.

If one were to think about individual health, you might think of the incredible advances in medicine that we have seen in the past 30 years. You could think about the use of new technologies that were only a dream 30 years ago. You might also think that an annual physical is the key to a person's health. Although all of these are important advances in medical care, they are only a very small part of the story. Medical care accounts for only 10%-20% of modifiable contributors to health outcomes for populations in the US (Magnan, 2017). You may wonder, how is this possible? The answer comes in the correlation between patient outcomes and social determinants of health.

Defining Social Determinants of Health

To better understand the influence of SDOH, it is important to understand what they are. The World Health Organization defines social determinants as "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life." Social determinants are non-medical factors that impact a person's health.

There are numerous ways to categorize social determinants. The CDC identifies 5 categories of social determinants: Eco-



omic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context. On the other hand, the Public Health Agency of Canada has identified 12 determinants of health as follows: Income and social status, Social support networks, Education and literacy, Employment/working conditions, Social environments, Physical environments, Personal health practices and coping skills, Healthy child development, Biology and genetic endowment, Health services, Gender, and Culture (2020).

Whatever definition we use, it is important to understand that there are a set or range of factors that are major influencers on the health status of individuals and populations. Regardless of one's age, there are complex interactions between social and economic factors, as well as between physical environment and individual behaviors. These factors and interactions come together to influence one's health.

For those in the behavioral health world, social determinants of health have always been at the center of the work that these providers do. They have developed community-based programs that address inequities and help people work, learn, and thrive in the community. For most behavioral health programs, social determinants have been at the core of recovery and rehabilitation for many years.

In recent years, there has been a growing recognition of the importance of social determinants. There have been some focused, while limited, efforts to address this critical component of the healthcare system. Through COVID-19 we have gained knowledge about social determinants that has helped to highlight the disparities in our healthcare system, which come as a result of racial, gender, and economic inequalities. However, for the most part, social determinants have not been as deeply integrated into medical care when compared to the behavioral health sector.

Integrating Social Determinants Data into Healthcare

As an industry, how can we be even more successful in identifying and incorporating these factors into healthcare treatment? I believe there are three factors that will help us integrate social determinants into healthcare: identification, access, and action.

1. Identification: It starts with identification. Identifying social determinants is not as simple as "just ask the person." Often, this information is not disclosed by an individual during a healthcare visit or during urgent care treatment. Even as social determinants have become more widely recognized as critical to an individual's health, the healthcare system as it's currently configured is not set up to fully identify an individual's comprehensive array of social determinants. What's more, clinical settings and reimbursement systems are not designed to identify and account for these factors. While there are pockets of successful efforts to integrate social determinants into the healthcare system, the system as a whole is still struggling to address social determinants.

2. Access: Access to social determinant information has been an ongoing issue. When thinking about the value of information, it is important to look at standardization, accessibility, and usability. Projects such as the Gravity Project have made great progress in creating standardized nomenclature and coding for many of the social determinants. Including social determinants as part of the latest USCDI dataset provides an avenue for interoperability and sharing of this information. Beyond having this information

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and how you could transfer it and I was very stigmatized. My mom would give me plastic forks and knives to eat with while everyone had silverware. They would scrub the toilet bowl after I used the bathroom. There was a real lack of education and disconnect, and it didn't work well for me. The reactions I got from my loved ones made me feel more rejected and I ended up just turning more to the streets and did more drugs as a way of dealing with things."

"I hate the fact that when people know you have mental health issues that they call you 'crazy.' I hate the stigma of 'crazy.' People don't understand your mental health and you feel like they don't understand you. I get into arguments with a lot of people because I know I'm triggered by the things they say, especially if someone calls me crazy, a liar, or an unfit mom. That triggers me and my reaction is to hit when I hear things like that. I hate being called those things but there's a stigma with bipolar depression and people think that you can't tell what is real," said Rachele.

"There is stigma when it comes to people with mental health having to acquire

housing and supports. Because of that I tend to not share much about myself," Stephanie said. "I think the biggest source of stigma came from me. I would beat myself up, saying I didn't want to take meds, I didn't want to go to treatment. I stigmatized myself a lot in that aspect. The way I looked at myself six years ago was I didn't need the help. I thought it was okay, I was really trying to be strong and was stubborn in telling people I didn't need help even though I knew I might. But the mind is an organ. It's like any other organ in the body, and if there is something wrong you need to treat it, and it needs to be taken care of and medicated; if there are symptoms, you need to treat it to be healthy. All of the same things that apply to other body parts apply to the mind because it is the powerhouse of the body. I finally realized that and I took the stigma off of myself."

Therapy Helped Us in Different Ways

Most of us have been aided by therapy; we've become more stable and made progress in our lives.

Robert said, "When I took therapy seriously it really helped me. I became more understanding of who I was and what I

was going through. S:US therapists listened with an open mind and gave good advice, especially at times I needed it the most. I was able to talk about anything and they didn't judge me. The advice and experience from them helped a lot. Therapy was a place to speak my mind and it helped me open up. Everyone was very receptive to listening to me and gave me genuine advice from a non-judgmental point of view, which was something I really needed."

"I appreciate having someone to go talk to when I'm having a hard time or need help. If people who live here start using (substances) again, they are able to talk to the counselor and say, 'Hey I can't stop using' and get the help they need by being able to go to detox or rehab - it's life-saving. When people are on their own, nobody is checking up on them and people are using and can be found dead, but here I feel safe because the staff checks up on me," said Glenn.

"Four years ago, I became a grandmother and things became clear. I didn't want my grandson to have the same problems I went through. And that was when I started really going to therapy because I didn't want that generational cycle to continue. I was staying away from people I care

about and so focused on the two people I'd lost (my two sons) that I didn't realize my relationships with my other kids were deteriorating. With therapy, I learned how to get through things, started looking for a job and practiced strategies to control my anger, like journaling, calling a counselor, and counting backwards. Whenever I called my counselor they would call me back quickly and I felt like I had so much support. It really helped that they had my back when I needed it," Rachele said. "Mental health is an important issue. People don't want to be in my community because they don't want to be crazy. But S:US can make you feel comfortable enough to talk to them. I didn't think I wanted to talk at first, just wanted to get something off my chest, but afterwards it made me understand that someone could understand me without bias and that will help you come back."

A Support System and Stability Are Essential for Mental Health

Experiences with mental health, chronic illness, and homelessness can make people feel alone. We all felt that way at

see Consumer Perspectives on page 36



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A Real and Present Danger in the Fight Against Stigma

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

By many measures we have achieved considerable progress in combatting stigma and its insidious effects. Persons who experience behavioral health challenges are now more inclined to pursue treatment without incurring the reputational risks they might have borne in prior years. We regularly encourage those in need of treatment to seek it, and we laud public figures who disclose their struggles with mental health or substance use issues. Public service announcements concerning the potential benefits of behavioral healthcare abound, and legislation has been enacted by the federal and state governments that requires insurers to offer comparable coverage for behavioral and physical health conditions (notwithstanding insurers' repeated failure to abide by such legislation and regulators' reluctance to enforce it). New York State recently distinguished itself as a leading combatant in the fight against stigma. It now permits its residents to allocate a portion of their income tax refunds to finance anti-stigma initiatives and requires primary and secondary schools to include mental health education in their curricula. As promising as these developments may be, they belie an enduring undercurrent whose momentum is poised to dismantle decades of progress.

The United States enjoys a dubious distinction among developed nations for its epidemic of violence. As of this writing, there have been 260 mass shootings in 2022, an average of 1.59 per day (Gun Violence Archive, 2022). Clarion calls to action echo across our landscape and a diverse array of potential correctives are proffered, although few find support among both sides of the proverbial aisle. There is one proposed "solution," however, that has garnered support from proponents of diverse political stripes. The identification of individuals at risk of violence, presumably as a result of undiagnosed and untreated mental illness, has unified a polarized body politic much as it has throughout our history. In invoking the specter of the "violent mentally ill," our policymakers have once again seized upon a politically expedient distraction from actual causes of mass violence and propagated a myth the recovery movement has labored for so long to debunk.

In a comprehensive survey of research on public sentiments toward individuals with mental illness, Pescosolido (2013) found evidence of decreasing stigma between 1950 and 1996 along select dimensions. The author's findings revealed increasingly nuanced and sophisticated views concerning the nature and etiology of mental illness among individuals surveyed along with a greater willingness to acknowledge their own mental health conditions. Survey respondents also evidenced a fourfold increase in their willingness to utilize mental health treatment throughout the period of analysis. These



Ashley Brody, MPA, CPRP

findings might suggest enlightened attitudes toward individuals living with mental illness, but they obscure a countervailing trend that has persisted, if not worsened, over time. Survey respondents' belief that individuals with mental illness possess a propensity toward violence increased throughout the period of analysis (Pescosolido, 2013). A full accounting of potential reasons for such persistent bias was beyond the scope of the author's investigation, but one cause was posited for which abundant evidence exists. The U.S. media reliably depicts individuals with mental illness as violent, and significantly more so than their counterparts in other developed nations (Olafsdottir, 2011).

Depictions of individuals with mental illness in our news media and popular culture might reinforce longstanding stereotypes and impede stigma mitigation efforts. For instance, an examination of viewers' responses to the depiction of a violent mentally ill character in a popular movie supports this hypothesis (Scarf et al., 2020). This study assessed participants' responses to a viewing of *Joker*, a film whose eponymous central character commits a killing spree after he is forced to discontinue treatment for a serious psychiatric condition. Study participants exhibited more negative attitudes toward individuals with mental illness after viewing this film as assessed by the Prejudice Toward People With Mental Illness (PPMI) survey instrument. The study authors concluded such depictions might deepen prejudice and discourage those who experience mental health conditions from seeking treatment. This is consistent with other findings concerning "self-stigma" that includes negative attitudes and internalized shame that persons with mental illness harbor about their own conditions (American Psychiatric Association, 2022).

Those who conflate egregious acts of violence with mental illness commit a grave error that perpetuates stigma and diverts attention from the actual causes of this scourge. Only 3-5% of violent acts are committed by individuals with mental health conditions (Knoll IV, James L., & Annas, George D., 2016). Other factors are significantly more pre-

dictive of violent behavior, and as researchers catalogue the commonalities among perpetrators of mass violence they converge on central findings. Perpetrators generally harbor extreme feelings of anger, often fueled by experiences of rejection and humiliation (Coalition for Smart Safety, 2022). A desire for revenge in response to actual or perceived maltreatment coupled with access to lethal means perfects this deadly recipe (Peterson & Densley, 2021). Simply put, if there were a bona fide correlation between the incidence of mental illness and mass violence, other nations would experience comparable trends. Mental illness is not unique to the United States. Mass violence committed with high-capacity assault rifles is.

Ashley Brody, MPA, CPRP, is Chief Executive Officer at Search for Change, Inc. For more information, email abrody@searchforchange.org or (914) 428-5600 (x9228).

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How We as Practitioners Can Foster Stigma

By Sa'uda K. Dunlap, LCSW,
Lisa Furst, LMSW, MPH,
and John Orr, MA, LMHC
Vibrant Emotional Health

Practitioners, despite our best intentions, may unconsciously foster stigma by downplaying or not recognizing the ways in which power dynamics, implicit bias, stereotypes, and lack of cultural humility can all build barriers to care.

To illustrate the stigmatizing potential of a practitioner's implicit bias, let's consider the following scenario:

Leila, a 16-year old Black youth, has been referred to your community mental health clinic by school personnel. She is one of four siblings, two of whom have the same father. Leila and her second oldest sibling have different fathers. Leila's mother married the father of her youngest two children. Over the past six months, Leila's mother and stepfather have increasingly argued about finances and other matters, and there has been a tense atmosphere in the home. Recently, Leila's mother filed for divorce from her husband. Leila has been nodding off in her classes and has been more irritable than is typical for her. She has been spending her lunch periods by herself and has snapped at her teachers several times, receiving detention on two occasions. After the first few meetings with Leila, she reports that her menstrual cycle was delayed by two weeks, and she thinks she is pregnant. A week later, during your next meeting with Leila, she reports that she had a false alarm and is not pregnant after all.

As you read about Leila's presenting concerns and history, what are your immediate thoughts? What assumptions are you making about this young person? What assumptions and judgments are you making about her family? Are any of the assumptions or judgments stemming from any bias or stereotypes associated with race, gender, or sexuality?

Practitioners are trained, ideally, to enter into the therapeutic relationship without bias. We are often taught that our knowledge of theories and conceptual models about human behavior supersede the lived experiences of people we are charged with providing care and mitigate the potential of practitioner bias when providing services. While this is taught to us as the ideal of practice, the reality is that we all have our own personal histories and social values that dictate how we perceive and process information. These internalized ideas and values contribute to implicit bias, defined as when we have attitudes towards people or associate stereotypes with them without our conscious knowledge (<https://perception.org/research/implicit-bias>).

As you continue to build a relationship with Leila, you learn more about her recent life circumstances. Leila reports that



Sa'uda K. Dunlap, LCSW

the stress of witnessing the constant arguing between her mother and stepfather led her to leave the house during the evenings, when the arguments were most frequent. Leila frequently sought comfort from one of her oldest friends, a young man she has known since elementary school. She began spending time with him in his room, talking about what was going on at home and her feelings about it. He listened to her without judgment. They grew close over the past six months. Their parents didn't question the amount of time they were spending together because they were longtime friends. They eventually had sex without using protection.

As you learn this new information, what are your immediate thoughts? What assumptions are you making about these two young people and their parents? Are you identifying any strengths and resources available to your client even as the challenges become clearer? What conclusions are you making based on this additional information?

Practitioners, despite their best intentions, may unconsciously foster stigma due to implicit bias. We are shaped by our upbringing and lived experiences. It presents itself in our journeys in therapeutic relationships with the people we serve. These biases also influence our experience of countertransference when working with our clients. While countertransference can be used to further our understanding of a client's internal struggles and interpersonal dynamics, we may find it harder to make therapeutic use of countertransference if we don't identify when our biases are affecting our clinical case formulations and interventions.

The scenarios likely brought up a number of emotions as you read and stopped to think about the questions that were posed. Implicit bias and negative attitudes toward certain groups of people impacts health care. Research shows that these unspoken biases can be changed, but first, one must recognize and actively work



Lisa Furst, LMSW, MPH

towards dismantling them. One model proposed by Jennifer Edgoose, MD, Michelle Quiogue, MD, and Kartik Sidhar, MD, aims to mitigate implicit bias through eight evidence-based tactics that is implicit. These tactics spell out the mnemonic **IMPLICIT**: **I**ntrospective, **M**indfulness, **P**erspective-Taking, **L**earning to Slow Down, **I**ndividuation, **C**heck Your Messaging, **I**nstitutionalize Fairness, and **T**ake Two.¹

Introspection is the deliberate quest to identify your own biases. An accessible means of doing so is through implicit bias tests such as those provided (without cost) by **Project Implicit**.

Mindfulness, a present-moment oriented approach to living and form of meditation with an abundance of online resources, is complimentary to this process as it increases self-awareness and can potentially reduce stress, shame and other challenging emotions that may arise through such inquiries.

Perspective-Taking, in this model, is more than hearing from your clients - it is the intentional and ongoing actions to expose and educate oneself to the thoughts and insights of people who have been marginalized or stereotyped. An easy access point is through the regular consumption of media that is generated from individuals and groups from different communities.

Learning to Slow Down is another intentional step that recognizes that part of caring for people means conscious consideration of the factors that may be affecting them - prior to meeting. By adding a short, reflective pause - no more than a minute or two - before your appointment, you can slow down and enter the space from a more informed perspective.

Individuation is the opportunity to see a person based upon who they are, not just

the group or community to which they belong. If we maintain a continuous and genuine curiosity about just who the person in front of is, today, we can consistently find ways to deepen connection.

Check Your Messaging refers to the reality that we live in a world where antiquated terms that were born from bias are still being spoken. This technique is a remedy as it guides professionals to use evidence to not only inform their work, but also their words. A helpful practice is to have an ongoing inquiry such as "How do I know this is true?" to analyze the meaning and origin of the things we say, especially the phrases that have been with us for a while.

Institutionalizing Fairness is the willingness to question the familiar and see if it still has a place in an equitable and inclusive future. Organizations have an opportunity - and an obligation - to modernize their policies and practices to be considerate of diversity, equity, inclusion, and justice.

Take Two is a recognition that we are continuous learners about an individual's culture and that humility, in this regard, can be healing, and can support the breakdown of potentially oppressive power dynamics. Power dynamics are always at play within any helping relationship, but adopting a stance of cultural humility and assuming that we are in a space of learning, rather than always knowing, helps to lessen barriers to connection between practitioners and the people they serve.

As mental health practitioners, we aren't perfect, and we are going to make mistakes in our practice. Ideally, we learn from them in order to deepen our ability to engage and support the people we serve. Recognizing our implicit biases and internalized stereotypes is a lifelong journey, and we have an obligation to continue on that journey as we strive to provide the highest quality services. The **IMPLICIT** tool, among others, can be one framework to guide our practice working with the diverse communities in New York State and beyond.

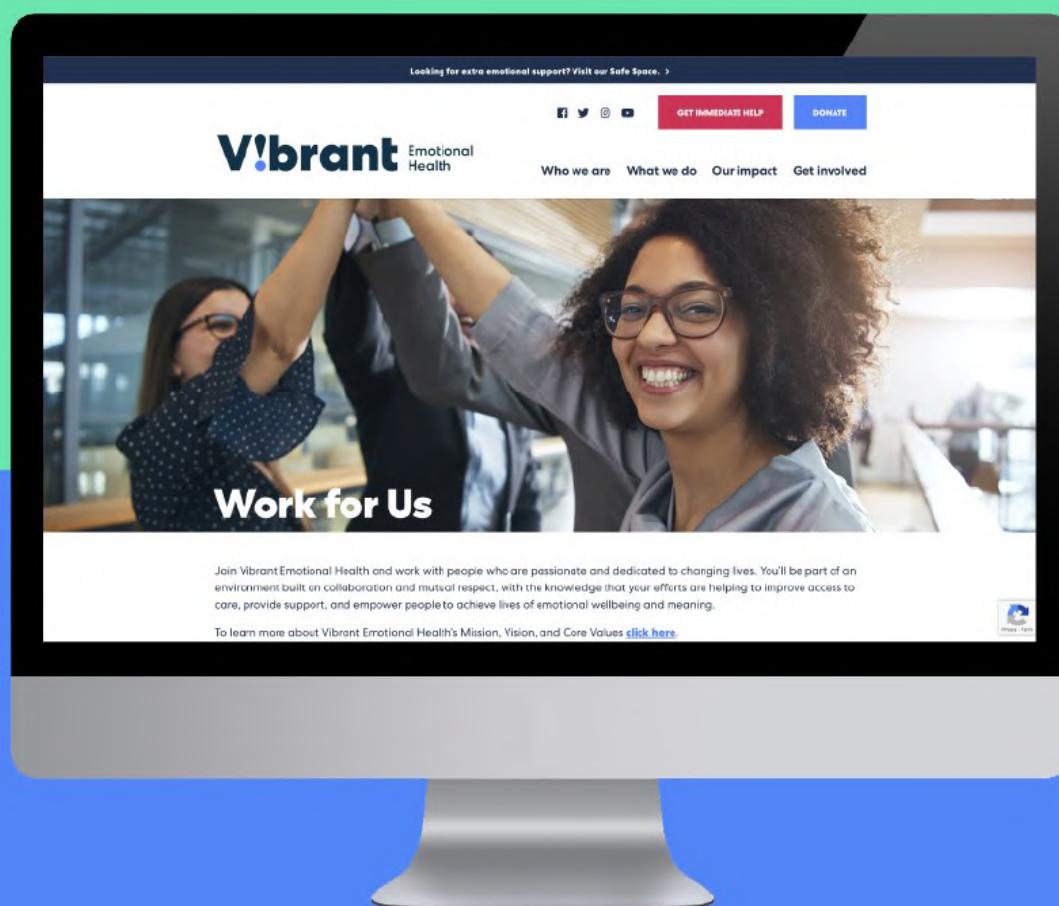
Sa'uda K. Dunlap, LCSW, is Assistant Vice President of Equity and Belonging, Lisa Furst, LMSW, MPH, is Chief Program Officer, and John Orr, MA, LMHC, is Vice President of Programs at Vibrant Emotional Health.

Footnotes

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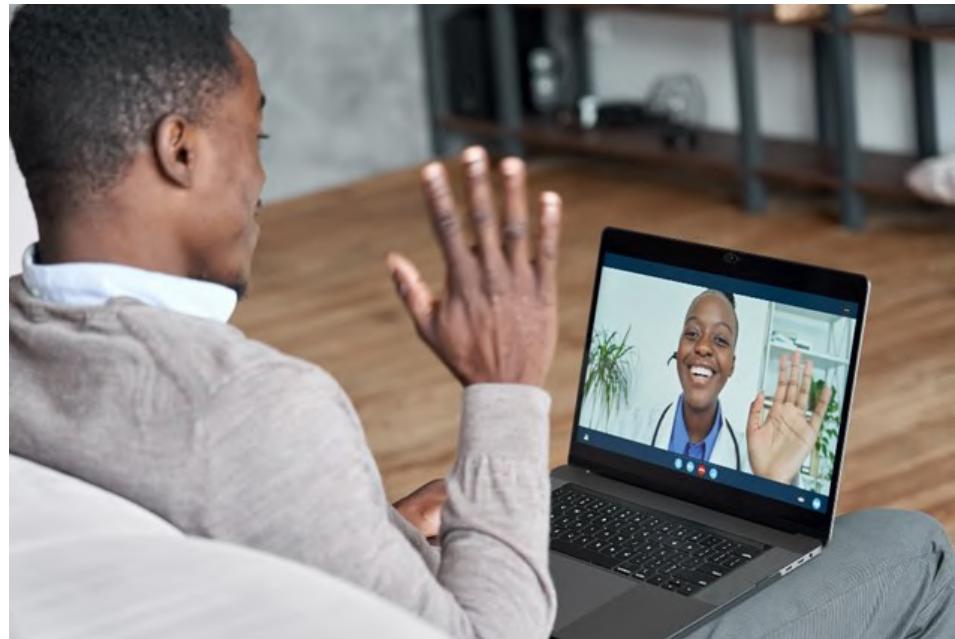
By Rachel A. Fernbach
and Jamie Papapetros
New York State Psychiatric Association

The Random House College Dictionary defines stigma as “a stain or reproach, as on one’s reputation.”¹ Dictionary.com adds to this definition “a mark of disgrace or infamy.”² In the context of mental health, stigma means a negative perception of mental illness, which has long served as a significant barrier to accessing essential mental health care and treatment. Stigma has been proven to be pernicious and damaging, both on a personal and societal level. In fact, experts have stated that “stigma and discrimination in relation to mental illnesses have been described as having worse consequences than the conditions themselves.”³

Stigma is based on fear and the demonization of mental illness and individuals with mental illness are often seen as dangerous and unpredictable. However, these fears are often unfounded. According to the National Center for Biotechnology Information:

*The public perception of psychiatric patients as dangerous individuals is often rooted in the portrayal of criminals in the media as “crazy” individuals. A large body of data suggests otherwise. People with mental illness are more likely to be a victim of violent crime than the perpetrator. This bias extends all the way to the criminal justice system, where persons with mental illness get treated as criminals, arrested, charged, and jailed for a longer time in jail compared to the general population.*⁴

Stigma can be divided into three categories: (1) public stigma, which includes negative or discriminatory attitudes among members of the public; (2) self-stigma, which includes an individual’s own negative attitude and feelings of shame; and (3) institutional stigma, which includes systemic policies of government or private industry that may result in limited opportu-



nities for people with mental illness.⁵ For individuals, the consequences of stigma include decreased hope, lower self-esteem, increased symptomatology, difficulties with social relationships, decreased likelihood of remaining in treatment and increased difficulties with work and productivity.⁶ Stigma contributes to the fact that more than half of those with a mental health condition go without treatment, according to Mental Health America.⁷

A 2019 survey conducted by the American Psychiatric Association found nearly half of workers are comfortable talking about mental health in the workplace with one-third worried about potential repercussions if they pursue mental health care.⁸ The survey also found only one in five employees are completely comfortable taking about mental health with colleagues and supervisors, while finding a generational divide as millennials are almost twice as likely as baby boomers to be comfortable (62% vs. 32%) with talking about mental health in the workplace. The survey also found most workers could identify a colleague in need and would be comfortable reaching out.

A few years later, the data shows continued progress. In 2020, the National 4-H

Council commissioned a survey with the Harris Poll, exploring adolescents’ experiences and perceptions related to mental health. Among the key findings: 81% of teens believe that mental health is a “significant issue” for youth; 64% believe living through the pandemic will have lasting impact for generations; 82% urged fellow Americans to talk more openly and honestly about mental health; and 83% agreed with the statement “It is important for people to take action with their mental health.”⁹

However, stigma is still a powerful force that inhibits access to care. Stigma regarding mental illness may be particularly strong among diverse racial or ethnic communities due to certain cultural beliefs or mores. For example, researchers in England found that children from Black, Asian, and Minority Ethnic backgrounds were less likely to access government mental health services and noted that “telepsychiatry has great potential to reduce the impact of stigma as service-users can access services discreetly.”¹⁰ Researchers also noted that “the rapid, widespread adoption of telehealth could be beneficial in reducing barriers between mental health service providers and Afro-

Caribbean adolescent users.”¹¹

Another community that often experiences difficulty accessing the mental health system is the farming and agricultural community in the United States. According to the Centers for Disease Control and Prevention, there is a high rate of suicide among farmers and agricultural workers.¹² In an attempt to address this problem, the Southern Illinois University School of Medicine and the Illinois Department of Agriculture as well as the Wisconsin Farm Center have instituted pilot programs for mental health hotlines and virtual counseling to reach farmers in need who may live a long distance from a treatment provider or who feel uncomfortable going to a mental health office in person. It appears that even having your car recognized in the parking lot of a mental health practitioner may be enough to dissuade an individual from seeking care.

In fact, the element of personal privacy inherent in telepsychiatry and other virtual mental health services may be a key component of its success. There is no question that confidentiality is essential to mental health treatment.¹³ However, where stigma is involved, privacy becomes even more important, both on a societal and personal level. Telepsychiatry is unique in that it can be furnished in a private location, such as a patient’s home, private office or even automobile. For those individuals unable or unwilling to visit a practitioner’s office, increased access to telehealth may be one piece of the puzzle to ensure that necessary care is delivered.

The good news is that the utilization of telehealth has been steadily climbing, even before the COVID-19 public health emergency. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA):

Implementation and use of telehealth as a mode of service delivery has been increasing in recent years. Between 2016 and 2019, use of telehealth doubled from 14 to 28 percent. This trend continued

see Telehealth on page 42



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On Self-Stigma and Employment

By Danielle Ramachandran, MS Ed, CRC
Program Director, Employment Services
MHA of Westchester

When we talk about stigmatization of people with behavioral health conditions in employment, many of us think of Equal Employment Opportunity disclaimers many companies place at the end of their job descriptions. Others would mention the Americans with Disabilities Act and name drop reasonable accommodations. Some of us may just have a long list of anecdotes of our participants being treated unfairly in hiring or firing. What we may not often think of is a very common, but considerably less discussed, source of stigma: individuals with disabilities themselves. Societal stigma and discrimination may dominate the discourse; however, for those with living with behavioral health conditions, one might argue that self-stigmatization is more impactful.

Research on self-stigma is gaining traction, as is the creation of formal resources for individuals and their supports to directly combat it. Attitudes towards one's own condition have been shown to predict a host of major negative affects if not addressed. Among those cited by Researchers Patrick Corrigan and Deepa Rao (2012) include "decreased healthcare service use, poor health outcomes, and poor quality of life." The authors also reference what is referred to as the "Why Try" effect, which very succinctly sums up the effects of self-stigma on employment outcomes in particular. They proffer this example: "Why should I seek a job as an accountant? I am not deserving of such an important position. My flaws should not allow me to take this kind of a job from someone who is more commendable." This sentiment is unfortunately a common one echoed by countless recipients of vocational rehabilitation services and functions as a self-imposed barrier to employment opportunities before a candidate even submits a single application.

In my work as a Vocational Rehabilitation Counselor, I have witnessed self-stigma play out in a curious phenomenon that is an uncomfortable reminder of how under-emphasized vocational aspirations are in our therapeutic work: the puzzled look on a person's face the first time they are asked about their work goals. Regardless of a specific diagnosis or level of support need, there is too-often genuine surprise at the mention of work. Skepticism can, however, give way to engagement and, on a good day, optimism.

Well-meaning but ultimately discouraging contributions from families, communities, and even healthcare providers have compounded legitimate concerns and fed existing self-doubt. While not unique to the behavioral health realm, it appears a



Danielle Ramachandran, MS Ed, CRC

disproportionate number of those diagnosed with a significant mental health condition have been cautioned that working is "too stressful" and may trigger an increase in symptoms. Similarly, people who receive Social Security or other benefits are warned that working will decrease or cut off their benefit. These cautions are just two of those often recited by those seeking employment support that are both incorrect and stemming from those in truly supportive roles.

While problematic on a number of levels, we are sending the message that investing in one's vocational growth is "not worth the risk" and more subtly, reinforcing that their condition is incompatible with success. This makes it increasingly important for us to challenge our own beliefs about the role of work in a person's recovery. As Researchers Phelan, Link, and Dovidio (2008) explain, self-stigma is not an inevitable result of receiving a "stigmatized" diagnosis. Across the field of behavioral health, several major approaches are emerging, including individual adjustment counseling work, manualized group approaches such as the "Ending Self-Stigma" program, Peer Service provision, and on a larger scale, NAMI's "In Our Own Voice" program (Corrigan, Rao, 2012).

As practitioners, we can intervene at the most basic level by opening the door to explicit discussions of self-stigma and examining our clients' internal narratives. The following is a brief example of a person whose most impactful barrier to employment turned out to be her own self-esteem:

Carol* was a 61-year-old, career-changer diagnosed with severe Major Depressive Disorder and referred for individual placement services. She struggled to maintain motivation in her job search, expressing near constant doubts about her potential, skills, and capacity to work. She worked with an Employment Specialist for several months with no progress and rejected every lead. The

Employment Specialist then re-focused their work on addressing her negative self-beliefs. As a direct result, Carol agreed to open up her job search to include positions which would require her to learn new technological skills. With encouragement and practical support, she went from having only pre-digital receptionist experience to landing a medical secretary position in a busy doctor's office and ultimately mastering her first electronic health record database! Of her experience, she said that despite having seen a number of therapists, psychologists, and doctors, "[employment services] just worked in a way that nothing else had" to reinvigorate her progress towards recovery.

We as behavioral healthcare providers are in an unparalleled position to support others towards greater agency and self-efficacy; examining our role in addressing self-stigma and calling attention to its influence is an essential way that we can bolster our clients' efforts not only towards employment but virtually any life goal they may be pursuing. It is also an important opportunity to change the discourse about work with our participants from an afterthought of

treatment to a viable source of growth and recovery.

* Name and some details have been changed for privacy reasons.

Danielle Ramachandran, MS Ed, CRC, is Program Director of Employment Services at MHA of Westchester.

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They Are Us

By Dr. Stephen J. Giordano, PhD
Commissioner, Director of Community Services, Albany County Department of Mental Health



Dr. Stephen J. Giordano, PhD

If the last two years have shown us anything it has shown us how resilient we are. It has also reminded us all just how vulnerable we can be. These are two important truths that are too often overlooked, forgotten, or denied. As we strive to build mental health awareness in our communities, it is more important than ever for us as leaders to be especially aware of these truths for, even though we appear to be healing from the pandemic's threat to our physical well-being (hopefully), we remain vulnerable to its wide-reaching impact upon our mental health and well-being now and into the future. And this should not be overlooked, forgotten, or denied - too much is riding on it.

As leaders, we must be continually taking the temperature of our communities asking how we got here, what are today's most pressing challenges, and where are we headed. When it comes to understanding the mental health challenges in a community, things get complicated pretty quickly because most don't want to think or talk about it because it's too uncomfortable and it cuts too close. As a society we seem to have made a secret agreement that mental health challenges happen to someone else and somehow believe that what we ignore will go away. In case you haven't noticed, this doesn't work even a little bit.

Most have heard by now the startling statistic that 1 in 5 will experience a diagnosable mental health condition in a given year. That likely means that someone in your immediate sphere - a friend, a loved one, a family member, a co-worker - is struggling right now and you may not even know it. But actually, you can and you should know it. And as leaders we must know it.

In order to steer the ship through choppy waters, and it doesn't get choppy than a global pandemic, we must recognize that the largest obstacle to effectively addressing the mental health challenges in our communities is not funding, it is stigma. Stigma leads us to overlook, forget, and deny the pain and suffering of our fellow community members. And most damagingly, it encourages us in our belief that mental health challenges hap-

pen to someone other than to us; it happens to "them."

The truth is that mental health challenges are insidious and they do not discriminate. Mental health challenges exist on a continuum for ALL OF US. To think otherwise leads us to diminish the reality of those we know and love. It leads us to demonize individuals when they are at their most vulnerable. And it denies a central truth about our human condition; life is hard, we all struggle at times and these struggles exist on a continuum. Some struggle more acutely than others, some struggle more chronically than others, and some struggle less than others, but we all struggle at times in our lives.

"Us/them" thinking is at the core of many of the societal challenges we face today and it is most certainly at the core of the problem of mental health stigma. The remedy, needed more than ever as we begin to emerge from the pandemic (hopefully) and begin to face the mental health aftermath, is striving each day to see yourself in "the other," seeing the common struggles, seeing the continuum that we are all on. Last I checked, this was the definition of empathy; a good thing to consider as we strive to build mental health awareness in our communities.

Dr. Stephen J. Giordano, PhD, is Commissioner, Director of Community Services, Albany County Department of Mental Health. Dr. Giordano can be reached at stephen.giordano@albanycountyny.gov.

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From the Desk of Dr. Max

Mansour (Max) Banilivy, PhD
Director of Clinical Training,
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Stigma and Mental Illness

By Mansour (Max) Banilivy, PhD
Director of Clinical Training,
Education and Internship Placements
WellLife Network

Stigma continues to be an obstacle for many individuals struggling with emotional health challenges. Seeking help for these challenges is additionally made more difficult with the limited quality of best practice resources. Stigma, whether community or self-based, inhibits many from even acknowledging their struggles. Not knowing where to find quality help adds to the complications.

As a nation and members of the behavioral health community, we need to make the goal of reducing the stigma of mental illness even more of a reality. Some improvements and changes have been made. However, much more awaits us as gatekeepers, stakeholders, and consumers. Quality service and upskilling the work force is a continuing necessity for all.

Stigma is perpetuated through lack of knowledge, stereotypes, blame, contact and prior experience, media portrayals, things we say, and costuming. Key factors in the cycle of stigma are labelling, social exclusion and discrimination.

We invite all to participate in the goal of continuing to reduce the stigma of mental illness and improving and enhancing the visibility of the resources available. To this end, **we ask that individuals and all agencies and organizations develop an Action Plan focused on what can be done to reduce the stigma.** Ask yourself what are three things I or my organization can do to educate and bring to awareness to the struggles of those with mental illness considering some of the above challenges. Perhaps this can start with education for all with regard to what mental illness is and is not. Public education can go a long way in SAVING LIVES.

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VOTED TOP WORKPLACE ON LONG ISLAND

Personalized Recovery Oriented Services (PROS) Clients Share Their Lived Experiences of Stigma

By Clinton Bryant, LMSW
Director, Personalized Recovery
Oriented Services
St. Vincent's Hospital Westchester

During the month of May, we at the St. Vincent's Personalized Recovery Oriented Services (PROS) program participated in the observance of Mental Health Month. The topic "Mental Health Stigma" was so timely in the face of current events taking place in our society. This particular discussion on mental health stigma came with three grounding questions that we addressed in our Town Hall during our Community Meeting.

- What is it?
- Who does it impact?
- How do we stop it?

Immediately upon posting flyers promoting our Community Meeting, our PROS participants began discussing stigma and processing this term in therapy classes and treatment groups. During our Town Hall, we wanted to capture the voice of the community on the topic of Mental Health Stigma. When discussing "What is Stigma?" many of the participants shouted out from their seats different factors from their earlier discussions: "It is the way that society measures some



Clinton Bryant, LMSW

people;" "It is a label that sets limits on people with mental illness issues;" and "It is really like a target used to point out people with mental illness."

As the discussion progressed it became clearer that feelings were evoked and emotional expression became apparent. One person said, "Yes, if you see how many T.V. commercials target people with mental illness and how confusing it is," another said, "the people in those commercials look so happy, like nothing is really wrong with them."

As the topic began to heat up, more of

the participants started to chime in with their thoughts. So when the question was asked, "Who does it impact?" a shout came from the audience, "It impacts everyone." The idea of educating and advocating was echoed by other clients. "We need to be able to talk about mental illness more to normalize it," said Jack. "You are not your mental illness," said Maria. "Don't put stigma on yourself," said David.

The conversations shifted with the role of media and the coverage of the recent mass shootings and how the reporting was further stigmatizing to people with mental health issues, Jason said, "they make you want to just hide your face because you know that is how they see you." These events were very much on the minds of clients at the town hall/community meeting.

Several clients spoke of their frustration with the ways in which tragedies such as the shooting in Texas are covered by national media and the ways government officials talk about them, with the implication that the shooter "must have had mental health challenges." Mary commented, "Mental health shouldn't outweigh the problem of an 18-year-old being able to buy guns," while Ellen said, "People with mental illness are more likely to hurt themselves than to harm other people." Bill said the media coverage creates the impression that "anyone with a mental illness could be a danger to society."

The conversation then moved to "How Do We Stop it?" Don said, "For yourself, you have to be the one to do something by helping others who may be experiencing the same problems." Elaine talked about educating others about mental illness, saying, "Mental illness is not a topic most people understand. It is not contagious and you can't catch it by caring about someone who has a mental illness."

When asked how they coped with the impact of stigma, Darcy responded, "I keep God in my life - it's so important to have a higher power." Don said, "Contribute to society, don't be closed off - do something to give back."

John spoke up about the need "to make resources more available to people who are closed off by the pandemic and their illness and suggesting that telehealth and Zoom classes were helping people who are struggling." "Don't just accept your diagnosis," said Anna, "educate and advocate for yourself."

For the PROS clients, their powerful and positive message in the face of stigma is: "Educate, advocate, don't just stand by, do something to make change."

Please note: Names have been changed to preserve client confidentiality.

Clinton Bryant, LMSW, is Director of Personalized Recovery Oriented Services at St. Vincent's Hospital Westchester, a division of Saint Joseph's Medical Center.

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Mental Health in Schools: Moving Stigma Out in the Open

By Scott Bloom, LCSW
Director of Special Projects & Initiatives
New York Psychotherapy and
Counseling Center (NYPCC)

Since the start of the pandemic, rates of psychological distress and chronic mental health issues among young people have increased. In New York, state officials estimate that one in five children ages 2-17 has one or more emotional, behavioral, or developmental condition while approximately 264,000 New York kids ages 9-17 have a serious emotional disturbance that substantially limits their ability to function (Kramer, 2021). Across the USA, 51% of 11-17-year-olds who participated in MHA Screening reported having thoughts of suicide or self-harm more than half the time, or nearly every day of the previous two weeks, totaling nearly 160,000 youth (MHA, 2022). From March to October of 2020, children’s visits to the emergency room for mental health conditions increased 31% for those 12-17 years old and also increased 24% for children ages 5-11 compared to the same period in 2019 (MHA, 2022).

As the pandemic continues, mental health agencies are faced with growing waiting lists, shortages of qualified mental health staff, and alarming rates of suicide ideation in their communities. These longstanding issues are compounded by the impact of stigma that saddles our troubled youth. It is rare that an adolescent will seek services at mental health programs or schools if stigmatization persists, and so it is imperative that stigma be addressed. By leveraging resources, modifying mental health messaging, and promoting wellbeing, schools can provide a safe space for youth to help them overcome stigma-related, psychological barriers to seeking support.

Stigma can be defined as negative, judgmental, and/or discriminatory attitudes toward mental health challenges and those who live with them (MHA, 2022). It



stems from myths, inaccurate perceptions and lack of information. Stigma is often a key problem for young people experiencing a struggle with their mental health as it prevents them from getting needed support from family, friends, and services. Sometimes seeking help can expose youth to the risk of discouraging, unsupportive reactions from others, especially surrounded by peers and family naysayers. This peer pressure can make someone less inclined to talk about what they have been going through. (Psyche, 2022). For many, the consequences of stigma can include: limited social engagement or greater social exclusion, decrease self-efficacy, and increase social isolation and withdrawal.

In contrast, taking the opportunity to talk about challenges with emotional and psychological issues has the potential to deepen relationships. Teens who share their experience often feel less burdened about having a “secret identity” and feel that they get to live more authentically. The act of sharing can also lead to the relief that comes from being truly listened to when feeling down or anxious, or a meaningful connection to other people or services that can provide help (Corrigan, 2016).

Anti-Stigma in Schools

It has been widely accepted that mental health programs in schools increase resiliency and help-seeking behavior, and has the potential to make seeking help a universal intervention for all. Schools are on the frontline for identification of at-risk or presenting behavioral health concerns and have become the logical point of entry to addressing student wellbeing (NCSMH, 2013). Only 43.3% of all youth diagnosed with a major depressive episode in 2019 received any mental health treatment. Of those who receive mental health services, 70-80% of youth received them at school (MHA, 2022).

Making services visible and available in schools not only increases access and follow-up for all, but also reduces the stigma associated with mental health problems. Stigma reduction starts with school-wide promotional activities that enhance positive social emotional skills of all students regardless of whether they are at-risk for mental health problems. Fostering more positive attitudes and beliefs surrounding mental health topics lessens the emotional burden of shame and stigma. This can be

done universally with age appropriate mental health education lessons and classroom-based social emotional learning (SEL) for all students.

One of the key domains in any school mental health program is community coordination and collaboration with community-based mental health and social service organizations that are familiar with the culture and language needs of diverse student and family groups within the school (NASBHC, 2007). Programs like [New York Psychotherapy and Counseling Center \(NYPCC\)](#) build capacity for the school community to address stigma in diverse ways. For example, leading experts in an informal, positive environment facilitate workshops for parents on current topics. Offering free trainings to school support staff increases equips them with the knowledge and interventions to address important emotional needs. Additionally, establishing Community Outreach Teams that links mental health services and resources to schools in high needs areas or creating anti-bullying coalitions that raise awareness and support schools’ communities with strategies to deal with bullying - these types of services not only extend the scope of resources and finite capacity of the school, but also normalize that mental health issues can be addressed without shame or discrimination.

Mental Health Literacy

Mental Health Literacy can be defined as *knowledge and beliefs about mental disorders that aid their recognition, management, or prevention* (Jorm, Korten and Jacomb, 1997a). Improving mental health literacy among youth in schools is a promising alternative in the fight against stigma. New York State recently passed legislation to add mental health education to existing curricula, requiring that mental health education is integrated at all school levels. With this expansion, it is expected

see Schools on page 44



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How the COVID-19 Pandemic Affects the Future of Behavioral Health Care

By Javier Favela
VP, Solutions Behavioral Health
and Integrated Care
NextGen Healthcare

“Out of all human events, it is tragedy alone that brings people out of their own petty desires and into awareness of other humans’ suffering. Tragedy occurs in human lives so that we will learn to reach out and comfort others.”

- C. S. Lewis

Throughout history, we have learned many of life’s most important lessons by pulling together in tragedy and the collective experiences that push us to the very limits of what we believe we can endure. The COVID-19 global pandemic pressed everyone - especially healthcare workers - to the brink of our physical, emotional, and mental well-being. For many of us, quarantine led to isolation and intense feelings of powerlessness, loneliness, and despair. No one was exempt. These experiences and emotions impacted adults and children alike, across all socioeconomic and demographic strata nationwide.

According to a Kaiser Family Foundation report, U.S. adults reporting symp-



toms of anxiety and depression increased from 11% to 41% during the pandemic.¹ More than 48% of adults aged 25 to 49, the age range that most closely represents the majority of healthcare workers, reported symptoms of anxiety and depression during the pandemic. This increase in stress and mental health concerns occurred at a time when both mental health and addiction services were in exceptionally high demand, needed desperately by

millions, placing an even great burden on a taxed system of care. Providers were burning out at unprecedented rates. Healthcare staffing shortages, initially due to physical illness and mental health concerns, as well as barriers to accessing services due to stay-at-home orders and other public health emergency-related restrictions, remain one of the most pressing challenges for behavioral health organizations nationally.

We have always struggled with behavioral health provider staff shortages in our country, and provider burnout has been a problem across all healthcare specialties and care providers. When the pressures of the pandemic added to these already taxed, limited, and relatively low-paid resources, even more providers chose to leave the field. As a result, access to mental health and addiction services rates have plummeted. According to the American Public Health Association, these provider and staff shortages impact an estimated 132 million Americans, with more than 6,600 mental health practitioners needed to fill vacancies.²

Even before the pandemic, a years-long contraction of services due to budget cuts and turnover were laying the foundation for this crisis. When it comes to addressing the complex issues associated with our behavioral health workforce shortages, no one can deny that burnout is a leading factor. The American Journal of Psychiatry reported in 2020 that 78% of psychiatrists surveyed self-reported burnout.³ There is a specific psychology to employee burnout. It can impact a person’s mental health and even lead to substance use.

see COVID-19 on page 39

How Mental Health Stigma Drives Suicide Risk

By Tony Salvatore
Director of Suicide Prevention
Montgomery County Emergency Service

The inter-relationship between suicide risk, mental illness, and stigma against mental illness is multi-faceted and strong. Both mental illness and suicide are highly stigmatized. The American Foundation for Suicide Prevention (AFSP) identifies mental illness as a significant risk factor for suicide. The Centers for Disease Control and Prevention (CDC) cite stigma associated with mental illness as a risk factor for suicide. When stigma provokes suicidality it becomes more potent and dangerous by joining with the stigma attached to suicide.

Suicide research and suicide prevention give considerable attention to mental illness as a suicide risk factor. This association is so robust that the World Health Organization (WHO) noted that it underlies one of the most prevalent myths of suicide, namely that “only people with mental disorders are suicidal.” This widely accepted misconception is itself stigmatizing to both persons with mental illness and those struggling with suicidality. Overstating the correlation between mental illness and suicide distorts public perceptions and may leave some feeling that their disorder has doomed them to suicide.



Stigma towards mental illness may be a significant contributor to the emergence of suicidal ideation, to the progression from thoughts of suicide to suicidal behavior, and, in some cases, to dying by suicide. The most compelling effects of mental health stigma that drive suicide risk are:

- The internalization of negative beliefs
- Social exclusion and isolation
- Loss of autonomy and community living
- Reduced social connections and support
- Diminished self-esteem and self-efficacy
- Hopelessness
- Shame
- Avoiding treatment of both health and behavioral health problems
- Inhibiting engagement with providers and treatment

- Exacerbation of mental illness symptoms

These factors affect persons with mental illness at the individual psychological level. In his text, *Why People Die by Suicide*, psychologist Thomas Joiner presents a theoretical model of suicide that show how these factors combine and interact to set the stage for a potentially lethal suicide attempt. Joiner’s model posits two conditions that contribute to such an outcome. One is an intense desire to die. The other is the capability to take one’s life.

Intent to die may be brought on by an individual’s belief that he or she is a burden to those they care about and who would be better off if he or she were dead. Intent also originates in the feeling that someone is socially disconnected from family or friends. Neither of these feelings need necessarily be true to generate a desire to die leading to suicidal intent. Mental health stigma may directly produce a sense of burdensomeness and disconnectedness to one’s support system that can lead to suicidal ideation and, in some cases, to suicidal intent.

Concerning suicide risk, self-stigma may be the most pernicious consequence of mental health stigma. Internalizing public stigma with the stereotyping,

see Suicide on page 49

A Cruel Irony: Less Mental Health Stigma but Fewer Behavioral Health Clinicians

By Seth Diamond, CEO
Westchester Jewish
Community Services

Mental health outreach is more prevalent than it has ever been before. Efforts to encourage people to ask for help are seen online, on television, on college campuses, and in corporate headquarters. Many are sponsored by governments, but businesses, educational institutions, and foundations have been the impetus for others. As a result, more people are coming forward than ever before to ask for mental health assistance. This unprecedented rise in requests is a triumph for all in the behavioral health community who have worked for decades to reduce the societal stigma surrounding mental health. But that triumph comes tinged with tragedy. At the very moment people are asking for help when the pandemic has put them under more stress than ever, we in the behavioral health community are struggling to meet that demand. The cruel irony of our current situation is that inadequate reimbursement rates for behavioral health work and low salaries in the field mean that, at just the point the stigma around mental health has decreased, there are too few clinicians available to meet the needs of those who are seeking help.

While, undoubtedly, some stigma about asking for mental health support exists in some communities, overall, there is a societal consensus that people should feel comfortable coming forward and asking for help. That hard fought progress in reducing the stigma around mental health treatment is reflected in a wide range of campaigns. New York City is sponsoring a [Mental Health for All People](#) to connect people to counselors and crisis hotlines. Chicago's [Un\[*\]Spoken](#) campaign works with those experiencing loneliness. Smaller communities have sponsored programs. Macon-Bibb Georgia, San Mateo County California, and towns in New Jersey all have similar efforts underway ([Axios, Mayor's Tackle Mental Health by Jennifer A. Kingston, May 13, 2022](#)). At [Westchester Jewish Community Services](#), we provide Youth, Teen, and Mental Health First Aid trainings in school districts, for first responders, and community organizations.

One would be hard pressed to find a societal institution less traditionally associated with mental health needs than the National Football League (NFL). But despite the machismo culture, players in the NFL recognized the need for mental health assistance. As a result, under a 2019 agreement between the League and its players, the [Comprehensive Mental Health and Wellness Committee](#) was formed. Each team is now required to have a behavioral health team clinician for at least eight hours a week. Seven teams employ someone full time. Players have made videos publicly discussing their struggles.

The National Football League is not the only sports environment where discussing



the need for mental health treatment has become more common. Tennis star Naomi Osaka, gymnast Simon Biles, and swimmer Michael Phelps have all publicly discussed their mental health challenges and supported efforts to connect people to help.

The United States military is, similarly, making strides to reduce the stigma associated with mental health. Major General Ernest Litynski has, with the Army's support, talked to troops around the country about his own struggles with mental health. He made a video about his challenges which was posted on the Army's Facebook page. ([The New York Times, A General Fights to Destigmatize Mental Health Issues: 'There's a Shame if You Show Weakness', by Jennifer Steinhauer, March 19, 2022](#)).

The rapid adoption of telehealth services, a byproduct of the pandemic, has also contributed to an increased comfort level with seeking emotional support. Before the pandemic, seeing a mental health clinician typically meant a trip to a physical office where people may have been concerned they would be seen in the office or in the parking lot. In smaller communities, some may not have wanted to talk to a therapist who regularly interacted with their family and friends in social settings. Telehealth has changed the parameters of treatment. In most cases, individuals no longer need to travel to be treated but can do it from their home or office. They can work with therapists outside their town with whom the chances of contact outside the session are limited. Some individuals may find further comfort in text messaging a therapist where there can be even more anonymous than in face-to-face encounters.

The reduced stigma around mental health treatment combined with new treatment modalities have given people suffering under the overwhelming stresses of the pandemic greater comfort in asking for mental health assistance. According to the American Psychological Association, over 80% of psychologists who treat those with anxiety disorders have seen an increase in demand for treatment of anxiety. Demand for treatment of depression is up

over 70% ([American Psychological Association, Demand for Mental Health Treatment Continues Increase Say Psychologists, October 19, 2021](#)). A survey conducted by The New York Times and Psychology Today of mental health professionals in every state showed 9 of 10 therapists said the number of those requesting treatment has increased ([Yahoo! Life, There's A Shortage of Mental Health Providers, Now What? by Isabel Burton, May](#)

[5, 2022](#)). Community agencies such as the one where I work, Westchester Jewish Community Services, have seen a huge rise in requests for services.

We should be proud that many more people, with our encouragement, have come forward to ask for help. But we are also aware that even before the pandemic there was a struggle to meet the needs of all who requested service. Now it is clear demand is far ahead of our ability to meet it. The National Council for Behavioral Health has stated that 77% of counties in the nation have severe shortages of mental health professionals. It is not uncommon for those in Chicago to wait a year to see a mental health specialist ([American Addiction Centers, We're Facing A Shortage of Mental Health Professionals, by Kerry Nenn, January 4, 2022](#)).

Our mental health system, particularly the community-based behavioral health network that is the essential provider of treatment in many locations, has suffered from years of disinvestment. For too long reimbursement rates for these providers from publicly provided health insurance languished. Fortunately, this year's budget contains a substantial investment in expanding a range of behavioral health services and increases the reimbursement rate for clinics. It is a needed first step in

see Clinicians on page 38

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HAS BEEN TRAUMATIC FOR SO MANY,
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Behavioral Health News Spotlight on Excellence: An Interview with Joseph Wilson, Peer Specialist at Services for the UnderServed

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 Joseph Wilson, a Certified Addiction Recovery Coach and Peer Specialist with [Services for the UnderServed](#) in NYC. Joseph details his work at the [Harlem Wellness Works](#) clinic to provide outreach and support for individuals living with mental illness and substance use disorders.

David Minot: Hi, 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 and behavioral health community. My name is David Minot and I'm the Executive Director of Mental Health News Education, the nonprofit organization that publishes Behavioral Health News and Autism Spectrum News. Our mission is devoted to improving lives and the delivery of care for people 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



[Watch the Interview](#) with Joseph Wilson from Services for the UnderServed

science-based education, information, advocacy, and quality resources in the community.

Today, we are speaking with Joseph Wilson, an experienced Certified Addiction Recovery Coach and Peer Specialist who has worked with Services for the UnderServed for the past four years. Joseph is a vital member of the SUS outreach team at the Wellness Works Harlem and Harlem satellite program. Joseph is also incredibly proactive in several community initiatives and has forged positive relationships with many community-based

partners. He began his career at SUS with the intensive mobile treatment team and transitioned to clinic services in 2018. Prior to joining Services for the UnderServed, Joseph worked for two years on both a part-time and a voluntary basis, lending his skills to group facilitation and patient advocacy within the New York City Hospital System.

Joseph, thanks so much for being here today!

Joseph Wilson: Thank you for having me today David.

David: Please tell us a bit about the program that you're currently working for.

Joseph: I work with Services for the UnderServed CTI Harlem Wellness Works clinic. We're a community health-based organization who provides outreach and in-clinic services for individuals with substance abuse and mental health - both co-occurring disorders.

David: Can you provide an overview of the Certified Community Behavioral Health Clinic (CCBHC)?

Joseph: Sure. So here, initially, we started off with services that were just geared towards substance abuse. But now recently, we've integrated an array of services that includes mental health providers, telehealth medicine, housing, vocational peer support, as well as community outreach treatment services.

David: I would love to hear about the hospital where you're working. Can you give an overview of that and how it connects back to the clinic?

Joseph: We collaborate with several city hospitals and community-based organizations to offer a collaborative service to transition individuals to the next level of

see Spotlight on page 40

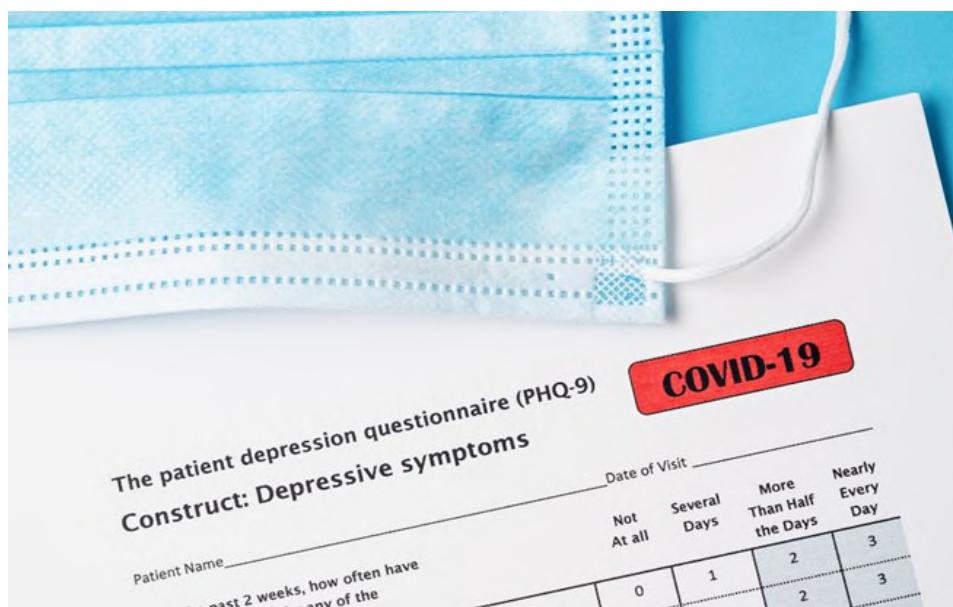
Depression Detection Has Never Been More Important: PHQ-9 Enables Clinicians and Patients to Track and Address Depression With Combined Physical and Emotion Symptoms Score

By Cindy Fox Aisen, PhD
Regenstrief Institute

The COVID-19 pandemic, armed conflicts, economic dislocations, and other concerns have affected mental health around the globe. Clinical depression, which affects 300 million individuals worldwide, is projected to increase.

With findings that are significant for both clinicians and patients, a large international study has shown that the most commonly used clinical measurement tool for depression, the PHQ-9, provides an easy-to-interpret single score of the physical and emotional symptoms that accurately indicates the presence (or lack of) and severity of the disorder, assisting in a diagnosis.

"You don't treat hypertension or diabetes without measuring and monitoring a patient's blood pressure with a blood pressure cuff or the hemoglobin the blood with an A1C test, said Kurt Kroenke, MD, a co-author of the new study, the developer of the PHQ-9 and a [Regenstrief Institute](#) Research Scientist and an [Indiana University School of Medicine](#) faculty member. "Similarly, with depression, you need to be able to measure and monitor the presence of both physical and emo-



tional symptoms and their severity.

"This study has shown that the free, easy-to-use PHQ-9, which can be administered in person, via telehealth or on a computer, provides a single, combined score of physical and emotional symptoms that is a good indicator of presence and severity of depression enabling both physicians and patients to track scores and respond appropriately."

The study found the PHQ-9's combined

physical and emotion symptom score to be accurate regardless of sex, age, and language of translation. PHQ-9 scores are based on patient self-rating of physical and emotional symptoms over the past two weeks including low mood, fatigue, sleep problems, inability to concentrate, loss of appetite and lack of interest in one's usual activities. The PHQ-9 employs a 4-point rating scale, from 0 for "not at all" to 3 for "nearly every day."

"By determining that the PHQ-9's single score of physical and emotional symptoms is a good indicator of presence and severity of depression, this study definitively shows that two scales, one for physical symptoms and one for emotional symptoms, with the ensuing need to somehow balance the two scores, are not necessary, making it easier evaluate and treat depression," said Dr. Kroenke, a father of the growing field of symptomology.

The 58,272 study participants came from seven countries — the U.S., France, Germany, Israel, New Zealand, Spain and Switzerland — completed the PHQ-9 in English, Spanish, French, German or Hebrew.

"[Is the PHQ-9 a Unidimensional Measure of Depression? A 58,272-Participant Study](#)" is published in the peer reviewed journal *Psychological Assessment*, a publication of the American Psychological Association. Co-authors, in addition to Dr. Kroenke, are Renzo Bianchi, PhD, of University of Neuchâtel, Switzerland (corresponding author); Jay Verkuilen, PhD, of City University of New York (U.S.); Sharon Tokter, PhD, of Tel Aviv University (Israel); Irvin Sam Schonfeld, PhD, MPH, of City University of New York (U.S.); Markus Gerber, PhD, of University of Basel

see PHQ-9 on page 38

Associative Stigma: An Unseen Force Impacting Mental Health Professionals and Service Users

By Philip T. Yanos, PhD
Professor, John Jay College,
City University of New York

Stigma toward people diagnosed with serious mental illnesses is a powerful force with pervasive impacts, some of which operate in subtle ways. In explaining the broad-reaching effects of stigma, Goffman (1963) asserted that persons who are “related through the social structure to a stigmatized individual...share some of the discredit of the stigmatized person to whom they are related.” Goffman suggested that there is an almost contaminative effect to the discrediting of stigmatized individuals that impacts those with whom they associate. This process, typically referred to as “associative stigma,” is generally thought of as applying primarily to the family members of people diagnosed with serious mental illnesses. There is evidence that family members often experience shame and family burden as a result of associative stigma (see Yanos, 2018, for review). Less frequently discussed, however, is the possibility that mental health professionals who work with people diagnosed with serious mental illnesses may also experience some degree of associative stigma, given the extent to which their lives are closely intertwined with those that they serve.



The way in which associative stigma might impact mental health professionals was explored in qualitative research I conducted with colleagues (Vayshenker et al., 2018) in which we asked 47 professionals who work with people diagnosed with serious mental illnesses about their feelings and interactions with community members in relation to their work. Participants discussed being frequently devalued, treated as if their work could be done by anyone (but would

not want to be), and avoiding discussion of their work with people outside of the field as a result. A telling comment came from one participant, who shared: “I had family members once tell me that I had the job that others didn’t want, like a garbage collector. They all laughed about it.” Others talked about being frequently asked if they felt unsafe in their work, reflecting the commonly-held negative stereotype that people with serious mental illness are violent.

Building upon these qualitative findings, we developed a measure called the **Clinician Associative Stigma Scale (CASS)** which includes subscales tapping four areas that were expressed in the qualitative study: negative stereotypes about professional effectiveness, discomfort with disclosure, negative stereotypes about people with mental illness, and stereotypes about professionals’ mental health. We hypothesized that scores on this scale would be significantly associated with “burnout,” a syndrome characterized by emotional exhaustion, disengagement from one’s work, and cynicism about one’s ability to help one’s clients. We administered the scale, along with scales of burnout and quality of service provision to a sample of 473 social workers, psychologists, and counselors who identified that they worked with people with a serious mental illness (Yanos et al., 2017). We found that nearly half of participants endorsed most of these types of experiences as occurring “sometimes,” and that associative stigma was moderately but significantly associated with burnout, especially its “emotional exhaustion” component, as well as lower self-assessed quality of care. In another study we conducted with partners in Indiana, we replicated these findings and also found that

see *Force* on page 49

A Paradigm Shift: Addressing Two Misrecognitions About the Stigma of Mental Illness

By Helen-Maria Lekas, PhD,
Suzanne B. Feeney, MBA,
Dhanushki Samaranayake, PhD,
Daniele Martino, MA,
Kerstin Pahl, PhD,
and Crystal Fuller Lewis, PhD

The stigma of mental illness has proven to be persistent and stubbornly immune to a wide range of stigma-reducing campaigns, programs, and interventions. The intensity of stigma varies by diagnosis, with depression and anxiety being less stigmatizing than, for example, schizophrenia and bipolar disorder. However, all deviations from what medicine defines as *mental health* or *normal mental status* bestow a negative label upon those diagnosed. Labeling a person as *mentally ill* has serious adverse health and psychosocial consequences, such as, exposing them to being discredited, ridiculed, blamed for their symptoms, hospitalized against their will, and excluded from opportunities in education, employment, or housing. As a society, we tend to attribute, if not justify, this differential treatment of those diagnosed to their potential dangerousness, unpredictability, and irresponsibility. We portray them as less reliable in their everyday interactions, their social roles, and as a financial and social burden, if not down-



right violent and dangerous. We have created and reproduced a cultural script, a collective story, that ascribes these characteristics potentially to all persons with a mental illness.

This process of labeling as different, assigning negative connotations to the label (i.e., stereotyping), separating “them” from “us” (i.e., otherizing), and, finally, depriving of opportunities and resources persons with mental illness is

the definition of stigmatization (Link and Phelan, 2001). Persons exposed to this process often *internalize* the *negative stereotypes* about their condition and *apply* them to themselves, and/or *anticipate* being treated as “less than” in their interactions with others. The recognition that a mental illness confers a discrediting status can lead to internalizing and anticipating stigmatization regardless of one’s interpersonal and social experiences.

Numerous deleterious health, psychological, and behavioral outcomes are associated with internalizing, anticipating, and/or experiencing stigma, including increased stress, social isolation and loneliness, a decrease in self-worth, concealment of one’s symptoms or diagnosis, and importantly, resigning to one’s symptoms and avoiding accessing and using mental health services because of shame and hopelessness (Corrigan, 2012). In essence, stigmatizing persons with mental illness amplifies their suffering and marginalization and further undermines their health, quality of life, and chances of recovery.

It is encouraging that, in the US, we have recognized the multifaceted harms inflicted by stigma. In the past three decades, there has been a significant increase in efforts to understand, measure, and intervene to reduce the stigma of mental illness (National Academies of Sciences, 2016). A review of the literature found that from 2004 to 2014, “on average, 36 measures of stigma have been developed *per year* since 2004” (Fox et al., 2018). Multiple stigma-reducing initiatives have also been launched by different organizations and systems, including the *stigma free* campaign of the National Alliance on Mental Illness. The social isolation and stress imposed by the COVID-19

see *Shift* on page 45

Drug Use Severity in Adolescence Affects Substance Use Disorder Risk in Adulthood

By The National Institutes of Health (NIH)

People who reported multiple symptoms consistent with severe substance use disorder at age 18 exhibited two or more of these symptoms in adulthood, according to a new analysis of a nationwide survey in the United States. These individuals were also more likely, as adults, to use and misuse prescription medications, as well as self-treat with opioids, sedatives, or tranquilizers. Published today in *JAMA Network Open*, the study is funded by the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health.

While use of alcohol, cannabis, or other drugs is common among adolescents, previous studies have suggested that most teens reduce or cease drug use as they enter adulthood. However, this study indicates that adolescents with multiple symptoms of substance use disorder – indicating higher severity – do not transition out of symptomatic substance use.

“Screening adolescents for drug use is extremely important for early intervention and prevention of the development of substance use disorder,” said Nora Volkow, M.D., director of NIDA. “This is critical especially as the transition from adolescence to adulthood, when brain



development is still in progress, appears to be a period of high risk for drug use initiation.” Dr. Volkow further discusses the findings and implications of this study in a [related commentary](#).

Researchers in this study argue that key knowledge gaps currently hinder the initiation of screening, diagnosis, prevention, and treatment efforts for teens with substance use disorders. For example, previous methods evaluating persistence of substance use disorder tended to treat substance use disorder as one broad

category, without looking at severity. They also failed to account for the possibility of polysubstance use, whereby individuals may use multiple drugs or switch the types of drugs they use as they grow older.

The NIDA-funded [Monitoring the Future](#) Panel study at the University of Michigan-Ann Arbor helped close this research gap by examining substance use behaviors and related attitudes among 12th graders through their adulthood in the United States. Since 1976, the study

has surveyed panels of students for their drug use behaviors across three time periods: lifetime, past year, and past month. In this study, researchers looked primarily at a subgroup of 5,317 12th graders first evaluated between 1976 and 1986, who were followed with additional surveys at two-year, then five-year intervals for up to 32 years, until they reached age 50. Among the respondents, 51% were female and 78% were white.

The research team examined the relationship between substance use disorder symptom severity at age 18 and prescription drug use, prescription drug misuse, and substance use disorder symptoms up to age 50 in these individuals.

To measure severity of substance use disorder symptoms in adolescence, researchers recorded the number of substance use disorder symptoms that participants reported in response to initial survey questions. These questions were based on criteria for alcohol, cannabis, and “other drug” use disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The researchers categorized substance use disorder symptoms into five levels of severity: exhibiting no symptoms, one symptom, two to three symptoms, four to five symptoms, and six or more symptoms. Symptoms included, but

see Severity on page 44

U.S. Law Enforcement Seizures of Pills Containing Fentanyl Increased Dramatically Between 2018-2021

By The National Institutes of Health (NIH)

Law enforcement seizures of pills containing illicit fentanyl increased dramatically between January 2018 and December 2021, according to a new study. The number of individual pills seized by law enforcement increased nearly 50-fold from the first quarter of 2018 to the last quarter of 2021 and the proportion of pills to total seizures more than doubled, with pills representing over a quarter of illicit fentanyl seizures by the end of 2021. The study also found an increase in the number of fentanyl-containing powder seizures during this time.

This study was published March 31st, 2022, in *Drug and Alcohol Dependence* and funded by the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health. According to the most recent Centers for Disease Control and Prevention data, the United States hit a record high in the number of overdose deaths ever recorded, estimating that nearly 106,000 people died from drug overdoses in the 12-month period ending in October 2021. This rise is largely driven by illicit fentanyl and other synthetic opioids.

Illicit fentanyl is highly potent, cheaply made and easily transported, making it a



profitable narcotic. While people may seek out illicit fentanyl intentionally, many people are not aware that the drug they are using – including heroin, cocaine, methamphetamine, or benzodiazepines – may actually be fentanyl, or has been adulterated or contaminated with fentanyl. Because fentanyl is about 50 times more potent than heroin and a lethal dose may be as small as two milligrams, using a drug that has been laced with fentanyl can greatly increase overdose risk.

“An increase in illicit pills containing fentanyl points to a new and increasingly dangerous period in the United States,” said NIDA Director Nora D. Volkow, MD. “Pills are often taken or snorted by people who are more naïve to drug use and who have lower tolerances. When a pill is contaminated with fentanyl, as is now often the case, poisoning can easily occur.”

Illicitly manufactured powder fentanyl has been a known adulterant in drugs [since](#)

2013, but the extent that fentanyl is found in counterfeit pills has been largely unknown. To address this question, a team led by Joseph J. Palamar, PhD, MPH, associate professor at the NYU Grossman School of Medicine and co-investigator on the NIDA-funded [National Drug Early Warning System](#) (NDEWS), analyzed data on drug seizures by law enforcement. The data were collected between January of 2018 and December of 2021 from the [High Intensity Drug Trafficking Areas](#) (HIDTA) program, a grant program aimed at reducing drug trafficking and misuse administered by the [Office of National Drug Control Policy](#) in which the [Drug Enforcement Administration](#) and the [CDC](#) play an active role.

Comparing data from the first quarter of 2018 with the last quarter of 2021, the team found that the number of seizures of pills containing fentanyl increased from 68 to 635, and the total number of individual pills seized by law enforcement increased from 42,202 to 2,089,186. Seizures of powder containing fentanyl also increased from 424 to 1,539, and the total weight of powder seized increased from 298.2 kg to 2,416.0 kg.

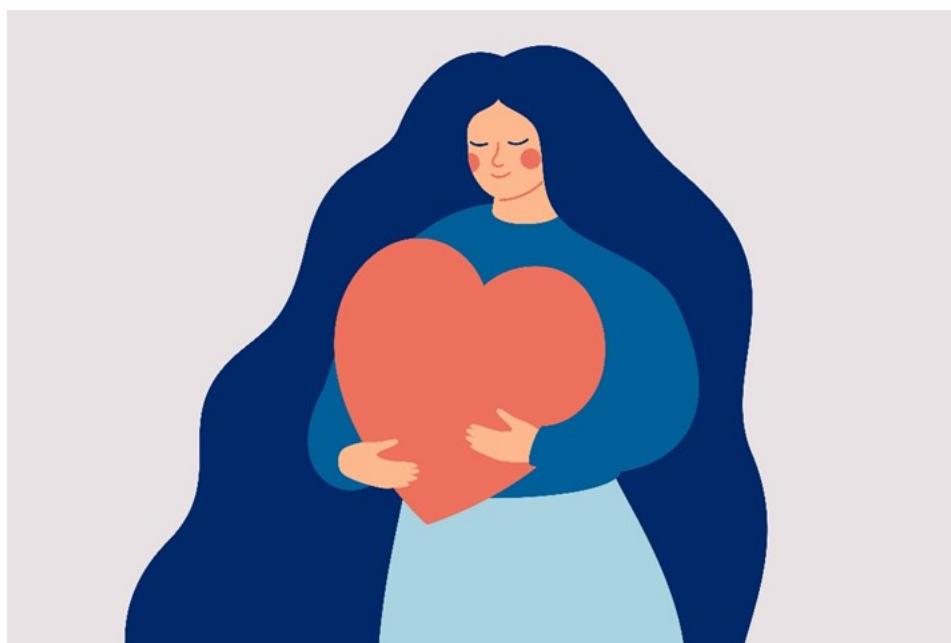
Unlike most survey data and surveillance systems which can be lagged for a year or more, HIDTA data are made

see Fentanyl on page 38

When Internalized Ableism and Stigma Intersect

By Amanda McDowell
Event Coordinator
NAMI-NYS (National Alliance for
Mental Illness, New York State)

In February of 2020, I received a letter from the government that I had been approved for disability payments. According to their records, I had been disabled with incapacitating, treatment-resistant depression since November of 2017. The Social Security Administration's definition of disability requires that you are unable to earn a certain amount of money due to a "physical or mental impairment(s) that is either: expected to result in death or has lasted or been expected to last for a continuous period of at least 12 months (SSA, 2021)." By that definition, I certainly fit the bill. I knew there was no moral value tied to whether I could make a certain amount of money or any money- whether temporarily or for the rest of my life. So why was I having such difficulty with the word "disabled," tortuously twisting my words to always refer to myself as "on disability," stopping myself from saying that one word that I thought would push everyone away? Over time, I would learn that the answer lay, like many things, at an intersection - the intersection between mental health stigma and internalized ableism.



Mental health issues hit me hard and early. By 13, puberty brought a diagnosis of depression, a prescription for an SSRI, and my first round of suicidal thoughts. Between mental illness and chronic migraines, participating fully in my life for long periods became challenging. After graduating high school, I went on to college, switching schools and career paths several times. I struggled to hold it together with depression, anxiety, chronic illness, and (though I didn't know it until I

was 35) severe ADHD, and getting my degree took ten long years. I would have years of stability - as a freshman at Gordon College with the roommate who became my best friend, or as a junior at SUNY Oswego where I began a relationship that would last eight years. As time went on after graduation, I found it more challenging to work and manage my life for long periods of time. In the 23 years since my diagnosis of depression as a teen, I've tried dozens of drugs and col-

lected a host of diagnoses - treatment-resistant depression, generalized anxiety disorder, PTSD, and ADHD. From 2014 to 2020, I was hospitalized six times and made one, blessedly unsuccessful, attempt to take my own life. I've tried ketamine and ECT. A new drug, a new type of therapy, or an inpatient stay would help - until it didn't.

After that attempt, I began a PROS (Personal Recovery Oriented Services) program, a day program for people with serious mental illness. I described it to people as "therapy college," where I could choose classes specific to my situation, with topics like symptom management, dealing with anxiety, or handling a crisis. It also allowed me to be with a group of people who knew what I was going through, at a time when I was most vulnerable. Eventually, I began to take small steps towards wellness, including things like getting out of bed, taking a shower, and leaving my house - steps that most people do every day without a thought, but for me, were massive. Would my fellow PROS classmates, whether or not they received disability payments, have considered themselves disabled? I think many of them would have said no because mental illness fluctuates. There can be years and even decades when a mental illness is well-controlled, or it can slowly

see Intersect on page 46

Understanding the Impact of Stigma: The Balance Between Choice and Accountability

By Larissa Breedlove, MFA
Senior Communications Specialist
EmblemHealth

In contrast to today's social media saturation, the burgeoning technology of the mid-2,000s was a time of comparative innocence. Similarly, candid conversations around mental health were virtually non-existent. Fewer than five years out of college, I'd recently been forced to resign from my journalism position after years of subtle but increasingly unmistakable difficulties: inconsistent performance, frequent absences and tardiness, and at times erratic behavior.

The high-octane grit of the newsroom was daunting. It's stereotypical for reporters to drink ample coffee to sustain the energy needed to meet tight deadlines and endure hours-long evening meetings. But after downing my fifth cup, the high of writing a half-dozen stories in a few hours often wore into an exhaustion so draining it felt as if all my energy had gushed out of my body at once, like air from a popped balloon. I was prone to leaving evening meetings early out of sheer fatigue. My relationships with my colleagues were also deteriorating.

Well into my tenure, my boss asked me to provide a note from a doctor stating I was fit to work. According to the Ameri-



cans with Disabilities Act (ADA), a medical exam revealing a "psychiatric disability" can only lead to a [job offer being rescinded](#) if "the person [wasn't] able to do the essential functions of the job without an accommodation and [couldn't] be reasonably accommodated, or [if] the disability [posed] a real safety issue." (In my situation, of course, I'd already been employed at length, but I surmise the essence is similar today.) In response to my boss's

request, I smiled, eager to appear both nonchalant and cooperative. "Absolutely," I said.

My psychiatrist wrote that while I had bipolar disorder, I was in treatment and capable of maintaining my position. The diagnosis was a surprise; for years I'd been diagnosed with depression and was only taking antidepressants. It should be noted that my psychiatrist and I never discussed changing medications at that

time, nor explored potential work accommodations, an ADA-granted right I wasn't familiar with then. Not long after I submitted the note, my boss asked me to resign. I blamed the experience on my own shortcomings and flummoxed employer, unable to fathom the larger systemic conditions at play. Now I realize the experience was also indicative of the deep stigma and discrimination surrounding mental health disclosure in the workplace.

When a recruiter contacted me about an airline role a few months later, I was eager to tackle something radically different. Though my new job was engaging, there was a catch: staff worked twelve-hour shifts, including overnights. We typically rotated on a monthly basis: one month working days (11 am to 11pm), the next month working nights (11pm to 11 am).

Not long after the new job started, I began dating someone who seemed emblematic of my improved life. On the surface, he was easygoing and unflappable. He also had a dedicated work ethic. In other words, he was everything I aspired to become. Best of all, though, he seemed to genuinely value my opinions, ideas, and outlook.

As our relationship progressed, my moods became more unpredictable. A perceived offense, however minor, could

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Coordinated Behavioral Care's Mission to Destigmatize Workplace Mental Health

By Emily Grossman, MA, CPRP,
Amanda Semidey,
and Dacia Barrington
Coordinated Behavioral Care (CBC)

When Emily Grossman began work as Training Institute Manager at Coordinated Behavioral Care (CBC), she had the same fear that had plagued her at the start of other jobs. As a person who is “out” about living with mental illness, she had always worried whether this new working environment would truly be supportive. She always did her best to be a conscientious employee but had experienced discrimination and stigma at some of her previous jobs.

Grossman had not experienced any symptoms of her mental illness in well over a decade. Yet, in work, she felt like she was sometimes placed under a microscope. As she recounts, “If I was having a bad day, I would experience my supervisors speaking to me, worried that my mental illness was the problem. They would say things like ‘are you speaking about this to your providers?’”

Grossman knew that other employees were not being asked questions like this, but she figured that this was an experience that she would have to live with to follow her heart and life mission. She had chosen



to not hide her diagnosis because she wanted to give credence to the idea that people living with mental illness can make real, positive contributions to society, and she also wanted to empower others to do the same. But she worried sometimes that this approach could hurt her career in the long run.

Grossman immediately established herself at CBC - developing the organization's Training Institute - and was pro-

moted to Training Director within a year. However, shortly after her promotion, she experienced a bout of anxiety, panic attacks, and depression. She tried hard to work despite these symptoms, but slowly felt like they were interfering. Her psychiatrist advised she take some time off.

Grossman worried tremendously about requesting time off for her mental wellbeing. She had worked hard to build her reputation at CBC and was concerned she

could lose her job, or at least prompt CBC to put her under that old, familiar microscope. However, neither thing happened. Her supervisor, Amanda Semidey, Senior Vice President of Quality, reassured Grossman that she was a valued employee and accommodations would be made to support her wellness and recovery.

As Semidey explains, “Despite no longer working with members directly, as a leader, I remain very much grounded and informed by my social work values. Just as clients are more than their diagnosis, employees are more than just their productivity. Before me was a competent and valued member of our staff, whose provider had deemed it necessary to take a medical leave. As a supervisor, I realized that despite how transparent Emily had been about her mental health journey, before me was an employee who had some trepidation about revealing current symptoms. First and foremost, I had only two questions, ‘What do you need me to know and how do I best support what you need professionally?’”

Semidey advises, “While operationally there are many logistics to manage in these matters, I would encourage leaders to prioritize the needs of their employee in that moment. Empower them to tell you what assignments they are most worried

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Internalized Stigma

By John Orr, MA, LMHC
Vice President of Programs
Vibrant Emotional Health

Stigma around mental health is not an unfamiliar conversation in professional circles and, thanks to the hard work of countless teams and individuals, stigma is becoming a more common conversation in our communities, albeit a recent conversation. Prior to this work, stigma didn't have a context to be recognized as such - it was more commonly the norm to respond with exclusion, condemnation or much, much worse. Whether actively or passively, a majority of us have inherited the burden of this unfortunate legacy and it can guide our thinking - as beliefs do every day - often without us knowing. When it does, we may find that amidst the storm we can identify our challenging symptoms as symptoms, but there is also something else affecting us, something that feels more factual than fleeting - the idea that we shouldn't be this way, that we are somehow wrong in our experience, and that it can't be discussed. These experiences are the manifestation of internalized stigma.

Recognition of this is often the first step in genuine healing and recovery. If you've ever felt like you couldn't share your inner experience, or if you have ever thought along the lines of “they/I shouldn't be that way...” it's worth considering



that you may have, with or without consent, internalized some stigmatized beliefs. After all, it was the norm in society to shame and condemn until only very recently. How could we not have been at least partially impacted? Thankfully, many of us are learning alternative, inclusive actions to counterbalance this. However, beliefs don't often change through external actions alone. Internal work needs to be done.

That internal step starts with a shift in context, a move from the personal to the collective. More specifically, this

means recognizing that we didn't choose this experience we are having, for if we had such a choice we would have chosen (and kept) happiness long ago. Suffering (and all the struggle that comes with it) isn't ours to personally claim and it isn't ours to outwardly shame - it's part of the human condition that nobody escapes.

If you're familiar with Dr. Kristin Neff's research around self-compassion, she and her team have shown that this shift in context is vital to our wellbeing. She suggests a mantra that can open the door

to meeting our experience in a more compassionate and helpful manner: “This is a moment of suffering. Suffering is part of life. May I be kind to myself in this moment” (Neff, 2002). Whether you use this example or create your own, this inwardly directed kindness opens the door to extinguishing internalized stigma, therefore creating more space and energy to directly approach the other parts of our experience. It can also help us to recognize that connecting with others - something internalized stigma blocks - is actually a safe and necessary endeavor, so long as we connect with those who care.

If we are contacted for help, we'd be similarly wise to remind ourselves of our shared humanity as underlying, stigmatized beliefs can quickly foster thoughts that drive limiting labels. In fact, one such label that can be limiting is “mental health,” which can be seen as positive, but it's not uncommon that the term is used in sentences like, “I'm dealing with my mental health.” Or, “It's a symptom of my mental health.” Even, “It's a mental health issue.” Such references are influenced, at least in part, by the burden of stigma as they create a context that mental health is something with a negative impact. It's not. Mental health is a catchall term that speaks to a shared trait within humanity, our baseline of wellbeing,

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There Is Hope

By Stephen Masiello, LCSW
Rockland Psychiatric Center
NYS Office of Mental Health

People with mental illness have long experienced prejudice and discrimination. To stigmatize someone is to regard them worthy of disgrace or great disapproval. For the individual who is struggling to maintain their overall health and wellness a stigma poses a barrier to them being a member of the community and to being able to love and fully accept themselves. The etiology of stigmas surrounding mental illness come from the misguided views that those individuals who have a mental illness are different than those who do not have one. Subsequently, society has stereotyped its views about mental illness and the way it impacts people's lives. Furthermore, the media also continues to perpetuate this belief by reporting news stories often linking those who have a mental illness with violent crimes. The American Psychiatric Association breaks stigma down into three distinct categories:

- **Public Stigma:** which involves the negative or discriminatory attitudes that others have about mental illness.
- **Self-Stigma:** which refers to the negative attitudes including internalized shame that people with mental illness have about their own condition.
- **Institutional Stigma:** which is systemic and involves policies of both governments and private enterprise that inten-



tionally or unintentionally limit opportunities for people with mental illness.

Public stigma often motivates individuals to fear, reject as well as avoid people who have a mental illness and as a result of these attitudes public stigma acts a pervasive barrier that prevents many individuals from engaging in mental health care and other mental health support activities. Additionally public stigma serves as the foundation for many of the systemic barriers that people with mental illness experience (Paracepe, 2013). During the COVID-19 pandemic we became familiar with the phrase "socially distant," however these actions have been occurring long before the pandemic started as many people would often distance themselves from

those who have a mental illness instead of welcoming them into the community.

Self-stigma occurs when people internalize the negative public attitudes and suffer and subsequently suffer numerous negative consequences. For example, if a person with a mental illness continues to hear things, such as he or she is dangerous, the individual will then believe they are dangerous which has negative implications on their self-worth and can lead to isolation resulting in a disconnect from the community and a reluctance to engage in services or pursuing personal goals such as employment or education. While it is not uncommon for people with mental illness to internalize it, there are individuals who are able to display a righteous indignation at the injustice of these

stigmas. These individuals have achieved a level of personal empowerment which they report being the catalyst to reducing self-stigma thus helping them achieve their life goals (Corrigan, 2012).

Institutional or structural stigma is stigmatization on a macro level often requiring legislative interventions to rectify. Unfortunately, all marginalized populations have experienced a form of structural stigma; for example, African Americans experiencing Jim Crow laws and same sex couples being unable to marry and openly show their love for one another. Additionally, it is these institutional prejudices that further perpetuate public stigma. These stigmas are also the driving force behind the social detriments to health and they must be addressed so that we can have an optimization of society (M.L., 2016).

Now that we have been able to identify and define the types of stigmas people with a mental illness experience, it is important to gain an understanding of the impact stigma has on those with a mental illness. Before we do that, I feel that it is important for you, the reader, to put yourself in the position of someone who has a mental illness. On one hand you are struggling internally. Perhaps you experience racing thoughts, an inability to concentrate, or auditory and visual hallucinations. You are in a state of torment and despair. The medications that you are prescribed often make you drowsy or make you appear that you are under the influence thus causing you shame. Perhaps you get so frustrated with prescribers

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Some Thoughts Regarding Stigma: The Often Silent Obstacle to Mental Health and Substance Care Among African Americans

By Tyffani Dent, PsyD and Lorna Hines-Cunningham, LCSW/R, ACSW
Black Women's Blueprint

The term stigma according to the Merriam Webster dictionary is Greek or Latin and indicates "a mark of shame or discredit." It most often refers to "a set of negative and often unfair beliefs that a society or group of people have about something." When addressing the concept of stigma within mental health, specifically within the African American community, one has to examine the historical factors that contribute to our mistrust of medical and behavioral health systems, the over-pathologizing of mental health within our community, and cultural beliefs about emotional wellness and where healing can come from. In addressing these causes of stigma around mental health and help-seeking behaviors, we can begin to effectively provide mental health services to those within a traditionally underserved community that has a demonstrated need for mental health services.



Essential Historical Facts Regarding African Americans and Stigma

History has justified the mistrust African Americans have for physical and mental health systems whose missions were allegedly to "do no harm." These

experiences have understandably resulted in a weariness around seeking services and, even when services are sought within the mental health field, mental health practices have been used to demonize and pathologize their experiences. (Bailey et al., 2017; APA, 2021.)

Beginning with the enslavement of Africans, the United States sought to pathologize African Americans and their understandable response to the inhumanity of slavery and to justify such treatment within society. During the 1840 census for example, so called researchers noted increased rates of insanity among freed Blacks in the north. This "research" was utilized to substantiate the need for African Americans to be enslaved reasoning freedom caused insanity among freed African Americans (Jackson, V., 2002). In 1851, Louisiana physician Dr Samuel Cartwright identified a mental disorder among slaves he called "Drapetomania, a disease causing Negroes to run away from their slave owners." Further, he felt the treatment intervention for slaves evidencing this so-called disorder was whipping (Ibid).

Under the guise of receiving medical care or advancing the field of medicine, African Americans have suffered from the Tuskegee Experiment in which African American males were deceived into not being treated for syphilis in order to study the disease's progression to the unlawful

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Jarod Stern, Senior Managing Director at Savills, Joins Mental Health News Education Board of Directors

By Staff Writer
Behavioral Health News

Jarod Stern, Senior Managing Director at Savills, has recently been approved to join the Mental Health News Education (MHNE) Board of Directors. Debra Pantin, CEO of Outreach and MHNE Board Chair stated, “Jarod has a wealth of experience serving the non-profit sector and his many ideas will certainly help us in guiding the future of MHNE.” David Minot, Executive Director of MHNE stated, “We are extremely excited to have Jarod join our Board. He brings with him a unique perspective as a member of the corporate community that will be an asset for MHNE in the coming years as we look to diversify our Board which is primarily made up of leaders from the mental health and substance use disorder communities.”

Jarod Stern joined Savills (then Studley) in 2006 after practicing law for six years. He has structured lease transactions for prestigious clients in the legal, fashion, education, financial and non-profit sectors. A member of Savills' National Law Firm and Tech Practice Groups, Jarod develops and implements customized and innovative real estate solutions for his clients that drive strategic growth and maximize business potential.

Over the course his career, Jarod has completed transactions totaling more than 5 million square feet on behalf of a diverse client roster. His creativity, client service and attention to detail was recognized in 2021, when he received the Deal of the Year Award from The Real Estate Board of New York for his work representing and “unionizing” 25 gem industry tenants in a group negotiation at 608 Fifth

Avenue. Jarod devised a novel rent formula not seen before in Manhattan real estate, which ensured an objective, fair, and ultimately successful process and outcome for all parties.

Prior to joining Savills, Jarod practiced corporate bankruptcy law at two high profile national law firms.

Jarod was awarded the Edward S. Gordon Memorial Award for the Most Ingenious Office Leasing Deal of 2021 - “A Gem of a Formula - Keeping an Industry in Place at 608 Fifth Avenue.”

Jarod’s professional affiliations include The New York State Bar Association, The New Jersey Bar Association, and The Real Estate Board of New York.

Jarod was educated at the University of Illinois at Urbana-Champaign where he received his BA in Political Science and attended New York Law School where he earned his JD.



Jarod Stern

The Transformative Power of Families Helping Families

By Matt Kudish, Executive Director
National Alliance on Mental Illness
of New York City (NAMI-NYC)

“I can now see that my loved one and their mental illness are separate.” I was fortunate to hear this powerful insight recently from one of NAMI-NYC’s participating family members. The National Alliance on Mental Illness of New York City (NAMI-NYC) is built on the transformative power of family-to-family interventions when it comes to caring for and supporting someone living with mental illness.

It’s remarkable what family-to-family interventions can achieve. By learning more about their loved ones’ mental illness, why they may behave in certain ways, and how to assist, caregivers create positive associations about their relationship and can approach it with more resilience.

Many studies have shown that the burden for caregivers of the elderly, people with disabilities, or those living with severe mental illness can be great. And while interventions may not change that burden, they can transform the caregiver’s ability to cope. Family-to-Family is among NAMI-NYC’s many free classes, support groups, Helpline, and other resources. It’s an 8-week class for families, significant others, and friends of people living with mental illness.

In an academic study of Family-to-Family, this program increased empowerment, knowledge, and coping skills as well as reduced stress among caregivers. In a phone interview, study participants were asked about their caregiving experiences. Among their negative experiences were managing difficult behaviors, stigma directed at them or their family member, and encountering problems with mental health services. Caregivers also



had positive personal experiences, including valuing the good aspects of their relationship with their loved one. After participating in the course, caregivers learned more about their loved ones' situation and reported more positive experiences. More positive associations reduced the caregiver’s distress and improved family functioning.

We know this works not only from the individuals and families we serve, but because we have had such experiences ourselves. Many of our staff and Board members are family members caring for a loved one with mental illness and being a part of the NAMI-NYC changed their understanding of mental illness and their lives. One of our longtime staff members, who has been with the organization for over a decade, was first recommended NAMI-NYC during a doctor’s visit with their relative. Although she was shy in this new environment, she took the Family-to-Family course and attended our Family and Friends support group. She kept coming back because she was with people who really understood what she was going through. With this learn-

ing and community around her, she came to the realization, “It’s hard for your family member to change the way they think because their brain won’t let them. We have to change the way we approach them.” Today, she is more understanding of her relative living with mental illness and knows it’s not their fault. These lessons were passed on when she persuaded her siblings and other family members to take the class. Today, she teaches that very class, Family-to-Family, offering the power of knowledge, family acceptance, and a better quality of life for everyone involved.

We are also fortunate to have Board Members who share such understanding from personal experience. One Board Member came to NAMI-NYC because of his son’s experience with psychosis. He and his partner didn’t know much about mental illness or what their son was experiencing. They were at the whim of the medical system. He felt helpless especially when his son was having an episode. Someone recommended NAMI-NYC. When he and his wife attended the Family-to-Family class, they came away with

tools to help their son and themselves. He learned about the stages of illness, what to expect, how to communicate through an event, and how to deescalate. He also learned how to listen to his son not with the intent to answer and resolve the problem, but to understand what he was going through. “NAMI-NYC has changed the relationship that I have with my son for the better. Instead of trying to tell him how to recover, I have learned to empathize with his recovery and how hard it is. It really allowed a lot more love, empathy, and understanding in our relationship. Our relationship became much better.”

Family psychosocial education not only reduces stigma, blaming, and misconception about mental illness, but can significantly reduce relapse and hospitalizations. In studies of inpatient settings, staff who communicated with family about a loved ones’ health, mental health, and discharge planning had higher aftercare involvement. Family phone calls and visits, family therapy sessions, and overall communication with staff improved follow-through on outpatient appointments. Taking this one step further, family-focused recovery means that family members not only help in their loved ones’ recovery but receive support themselves. When providers or community organizations talk to families about mental illness, it breaks through the shame families might feel, sparks conversation, and equips them with much needed caregiving tools.

Family involvement, much like in the Family-to-Family course, means greater understanding of mental illness and other critical information like how to identify warning signs, prevent hospitalization, and knowledge of available services. While much focus is often placed on people living with mental illness themselves, family-to-family interventions in

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standardized, we need to ensure that this information is readily available in a provider's workflow. Since providers at all levels of care are struggling to keep up with their workloads, systems must be designed to make social determinants data easy to access and utilize in clinical decision making.

3. Action: Last, but not least, action must be taken to successfully infuse SDoH information into healthcare. Most clinical settings and reimbursement systems are not designed to address these issues. The simple answer is to refer individuals to a program that can address social determinants. However, in practice, this is not as simple as it sounds. Again, being able to create a replicable workflow and reimbursement structure that allows for care coordination and follow-up is crucial. Being able to easily communicate between a referring practice and the service delivery agency is critical to minimize workflow disruption and improve referral success.

It's time for action. This is the time to use technology to overcome the barriers in integrating SDoH information into healthcare, in the same way that electronic lab or testing information is readily shared and utilized. It is also a time for creativity and community support in improving access to behavioral health resources and building up those resources.

Ensuring that infrastructure and standardization is in place for providers to efficiently collect, share, and analyze social determinants of health data will be a joint effort between government, industry organizations, and the private sector. But the benefits of making this data accessible are real and the opportunity is endless. This information placed in the hands of those who truly can make a difference would drastically improve individual and population health. It can help shed light on inequities in healthcare, enable better clinical decisions, and support predictive analysis. This is an opportunity for technology to make a difference and to



David Bucciferro

help create a healthier world.

David Bucciferro is Special Advisor, Foothold Technology and Vice-Chair, Electronic Health Record Association.

Foothold Technology offers behavioral health and Care Management software platforms to transform the way you care. We are a human services EHR company with deep roots in the behavioral healthcare world.

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some point. But reaching out to other people - whether that's family, friends, counselors, or S:US staff - has been a great help to all of us.

"The S:US staff are positive, caring, and loving people who show true concern for the tenants. They treat their work as more than a job and they do not look down on me. They have been sounding boards for me, they're my confidants and give me support. The staff helps and uplifts me," Glenn said. "I come from a Christian family, I gravitated towards my roots of church life and that helped me get grounded. That's been my source of energy, prayer, and meditations. Over the years it's been NA meetings, AA meetings, any time I'm going through something - ex addiction, food addiction, gambling addiction, mental health services like talking to a psychiatrist or therapist - I found places where I could get support."

"Before coming to S:US and in my early 20s, it was extremely isolating. I felt alone. Recently in the last year, I've reconnected with people (friends and family). They have had a more open mind, especially when I am showing them how good I'm doing and how much I've improved. I was able to show others that I was the same person as before my mental health issues, just wiser," said Robert.

"Since receiving services at S:US, I feel a lot more outgoing and more ambitious. I feel like I can achieve certain things when I put my mind to something. Being able to have a place where I call home and a roof over my head helped a lot. Having the stigma of being homeless in a shelter was very difficult, it caused me to be unstable. I really needed the stability that S:US gave me through housing," said Stephanie. "I've been thankful to be able to take my medications, it's very important to my mental health."

"I have been improving my relationships with my kids now; S:US cared about my kids and helped me rebuild those relationships. If it weren't for S:US, I would be locked up. I thank them for giving me the tools to walk away and go to a higher authority to deal with the situation. They helped me go to court and file complaints from people who were antagonizing me and they were really fighting for me. They call and check on me and my kids," said Rachelle. "If you can't talk to family or friends, you have to have a

support system because you cannot overcome mental health without a support system."

Messages for Others Experiencing Similar Challenges

We know there are many people who are going through things like we have. It's hard to see how things can get better when you're in it, so we have messages to share from each of us.

"You are not alone. Therapy works. If you're willing to be honest and give it your best shot, you'd be surprised how well it works," said Robert.

"I would like others to remain faithful because things work out as planned, when goals are set and put down on paper they really happen, like a vision board. If you're able to have a vision and a plan, if you remain focused it can happen for you, if you need to do better. That was my main goal," said Stephanie.

"I want people to know that there is help out there. Whatever you're going through, even living with HIV, S:US can help. S:US supports the neighborhood and they are there for your health: mentally, physically, financially. For individuals who are struggling, all you have to do is apply, abide by their rules and you can get better," said Glenn. "I want to let our youth know that even if they have HIV, they can live a long and healthy life. Chronic illness is not a death sentence."

"I want people to know that there is a support system and there are always people ready to hold your hand, give you a nudge, and say that they miss you," said Rachelle. "I want people in this situation to know they are not alone, reach out and even if you don't want services, just try it. Talk to someone, you will find something and help in some way, even if you don't want mental health, they can help you and you can continue coming back for more. Try it."

There's still a lot of stigma that people like us who have mental illness, chronic illness, or homelessness face every day. But we've found ways to overcome it and we know that other people can too. We appreciate organizations like S:US who are raising awareness, providing services, and helping to reduce stigma so we can lead stable, fulfilling lives.

For more information about Services for the UnderServed (S:US), visit www.sus.org.

Every Month is Mental Health Month at Behavioral Health News

Our mission is to combat stigma and educate the community about mental health and substance use disorders each and every day.

Please share our website with someone you know who is struggling:
www.BehavioralHealthNews.org

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Improving Help-Seeking and Reducing Stigma Through Public Messaging

By Jessica Zahn
Director of Marketing
NYS Office of Mental Health (OMH)

We know that mental health stigma can impact a person's willingness to reach out for help. They may be afraid of what others will think or feel ashamed that they're not "strong enough" to deal with a problem on their own. But we also know these thoughts are fueled by stigma, not truth. It's an issue the [NYS Office of Mental Health](#) is eager to combat and shift in our society today. Everyone needs support. We are human with complex needs and emotions. In fact, **1 in 4 of us will struggle with mental health this year.** But society has told us that we need to wage war with our minds on our own, and that is the impact of stigma.

But **there is hope.** We believe we can shift these thoughts and perceptions through public messaging and awareness. We know that consistent and effective



Jessica Zahn

public messaging can impact attitudes and behaviors over time. Just like a leaky faucet doesn't appear to have a big impact in

the moment, but over time, those droplets of water create a puddle, and maybe even a divot in the sink from the constant, repetitive impact. We know that creating a public messaging strategy using this "leaky faucet theory" can have a profound impact on the way people feel about mental health, the stigma surrounding it, and the perception of asking for help. However, the message itself is important. The way a message is perceived makes a major impact on the success of a public awareness endeavor. And this is where we need your help.

The Office of Mental Health has been planning a broad effort to improve help-seeking through a widescale public messaging campaign. We want your input on some of the mental health messaging that exists in the world today, so we can better shape our public awareness activities. We also want to understand your current view of stigma, mental wellness, mental illness, and help-seeking. This will help us climb the wall that is holding so many people back from getting the help they need and

deserve. This wall of stigma impacts us all, even those who work in the mental health field. So, whether you're a clinician, a program director, a person who receives mental health services, or someone who is just stumbling across this special edition of *Behavioral Health News* as a first-time explorer into the topic of stigma - **we have a job for you.**

Please consider taking 5 minutes out of your day to complete [this survey](#). Your answers will be anonymous and only collective data will be used to shape our future messaging strategy. You'll have the chance to weigh in on messages, design, and whether you'd share our sample graphics with your friends and followers on social media. In just 5 minutes **you can play a role in combatting stigma** and shaping NY's response to it in a major way.

Jessica Zahn is Director of Marketing at the New York State Office of Mental Health. For more information, email Jessica.Zahn@omh.ny.gov.

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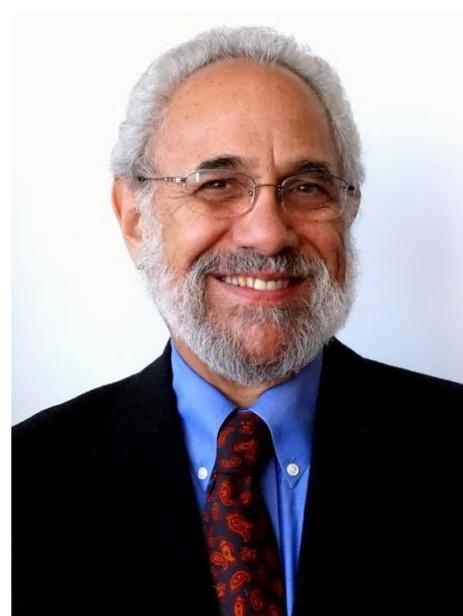
But improving the mental health system to reduce murder, maybe very slightly, probably negligibly - really no point.

In fact, calling for a better mental health system because of the rise of homicides undoubtedly results in reinforcing the misbelief that people with mental illness are to be feared because they are violent and dangerous. It results, that is, in reinforcing stigma.

Reducing the stigma of mental illness is among the most important improvements needed in America's efforts to help people with mental illness. It is needed to open the doors of the community and to provide opportunities to people with histories of mental illness who now suffer discrimination in housing, work, education, health care, and even access to houses of worship. Addressing stigma is also needed to reduce the shame that people with histories of mental illness often feel, shame that drives them into hiding and contributes to their reluctance to use mental health services that might help them.

And in the current climate I would add that addressing stigma is needed to remove a powerful political weapon - the frightening belief that people with mental illness are dangerous - from those on the political right who use it to rationalize their resistance to "common sense measures" - such as gun control - to bring down the horrifying rate of homicide and mass murder in the United States today.

Stigma about mental illness, from this point of view, is not just a problem for people with mental illness and their families. It has become a dangerous weapon in American politics, a weapon reinforcing



Michael B. Friedman, LMSW

ing the frightening divisions in American politics today.

The views expressed in this article are those of the author and are not necessarily those of Behavioral Health News or its publisher, Mental Health News Education.

Michael B. Friedman is a retired social worker who has worked in the field of mental health for over 50 years. He teaches mental health policy at Columbia University School of Social Work and serves as a volunteer social advocate as Chair of the Cognitive and Behavioral Health Advocacy Team of AARP Maryland. Michael's writings can be found at www.michaelbfriedman.com. For more information, please email mj395@columbiauniversity.edu.

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healthcare and other community settings can enhance care and quality of life for everyone.

Matt Kudish is the Executive Director of the National Alliance on Mental Illness of New York City (NAMI-NYC), a non-profit centering family and peer support for 40 years. Learn more at www.naminyc.org/findsupport or visit your local NAMI affiliate.

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reversing the trend. Commercial rates in New York State are, in many cases, even lower. The result is an inability to provide clinicians the salary their education, experience, and societal demand require for their services. Low salaries make it difficult at any time to retain clinicians, but this is particularly true now when salaries in many other fields are rising. Many clinicians are leaving for higher paying jobs and fewer young people, burdened with the high cost of their education and finding more attractive options elsewhere, are willing to work in community-based agencies. The result is a shortage that must seem particularly painful to those in our community who have seen pronouncements about the importance of treatment and now can no longer find it.

This burden of our inability to meet demand is particularly felt in communities of color. There, the needs, all exacerbated by the pandemic, are likely to be greater and providers, more typically dependent on low reimbursement from public and private insurance payments, have great difficulty retaining and attracting clinicians. In more affluent communities, individuals can pay privately and therapists, who charge higher rates, are more likely to be available.

As a society, if we champion the importance of mental health and seeking treatment, we should be prepared to meet that increased demand. Other-

**Seth Diamond**

wise, it is unfair to the brave people who come forward. We must support continued work to further encourage people to seek treatment and then invest in behavioral health treatment providers so they can provide that treatment.

Seth Diamond is CEO of Westchester Jewish Community Services (WJCS), one of the largest human service agencies in Westchester County, NY and the largest provider of licensed outpatient, community-based mental health services in the county. To learn more about WJCS, please go to www.wjcs.com.

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(Switzerland); and Elmar Brähler, PhD, University of Leipzig (Germany).

About Kurt Kroenke, MD

In addition to his role as a research scientist at Regenstrief Institute, Kurt Kroenke, MD, is also director of the Master of Science in Clinical Research program and a professor of medicine at Indiana University School of Medicine.

About Regenstrief Institute

Founded in 1969 in Indianapolis, the [Regenstrief Institute](#) is a local, national, and global leader dedicated to a world where better information empowers people to end disease and realize true health. A key research partner to Indiana University, Regenstrief and its research scientists are responsible for a growing number of major healthcare innovations and studies. Examples range from the development of global health information technology standards that enable the use and interoperability of electronic health records to improving patient-physician communications, to creating models of care that inform practice and improve the lives of patients around the globe.

[Sam Regenstrief](#), a nationally successful entrepreneur from Connersville, Indiana, founded the institute with the goal of making healthcare more efficient and accessible for everyone. His vision continues to guide

**Kurt Kroenke, MD**

the institute's research mission.

About IU School of Medicine

[IU School of Medicine](#) is the largest medical school in the U.S. and is annually ranked among the top medical schools in the nation by U.S. News & World Report. The school offers high-quality medical education, access to leading medical research and rich campus life in nine Indiana cities, including rural and urban locations consistently recognized for livability. For more information visit www.regenstrief.org.

NYS OMH from page 1

support, MHNE will publish two editions dedicated to the subject of stigma and stigma reduction. MHNE will also facilitate four 90-minute Roundtable Discussions featuring subject area experts, people with lived experience, government officials and representatives of community-based advocacy and provider organizations.

The roundtable discussions will help shape the anti-stigma messaging that we will use in future anti-stigma public awareness activities. This is critically important because to be effective, anti-stigma messaging must resonate with the target audience. For example, you can't usually grab the attention of young people and older adults with the same message or the same messenger. Messaging, and the messenger, must be tailored to the audience you are trying to reach, whether it's young people, older adults, people of color, immigrant communities, or residents

of rural parts of the state.

The roundtables will help us develop a roadmap to effectively reach different populations and reduce the stigma that may be directly impacting them.

Hope for the Future

Although stigma is still widespread, I believe the future holds great hope. One thing we've seen throughout the COVID pandemic is that people are more willing to talk about their mental health. This has certainly been the case with the [NY Project Hope](#) helpline (1-844-863-9314) which OMH implemented in March of 2020 to help people cope with increased stress and fears during the pandemic. More than 93,000 people have reached out to the helpline, the vast majority of whom have never sought out behavioral healthcare or advice.

We are also seeing the normalization of mental health issues among young people,

who are more willing to discuss their behavioral health concerns than were previous generations. I see it in my own grandchildren and their friends, who are being taught about mental health and wellness in their schools. They understand that mental health is as important as physical health, and they are more able to talk about stress, trauma, anxiety, depression, and other issues.

Young people who understand that mental health is as important as physical health are more likely to seek out support, and talk to their parents, teachers, or doctor when they are concerned about their own mental health. And hopefully, as they grow up, transmit that same message to future generations.

Recognizing that reaching and educating young people about mental health is an important step in combating stigma, OMH has been working with the State Education Department to help school districts across the state develop age-

appropriate curricula focused on mental health. We are also supporting school districts' efforts to create mental health clinics in their schools. To date, more than 1,000 such clinics have been created. And Governor Kathy Hochul recently authorized OMH and the Education Department to provide \$50 million in additional funding to school districts to improve student access to mental health services.

As the Commissioner of the Office of Mental Health, this gives me great hope for the future. Because as we educate all New Yorkers and help them understand that mental health is a critical aspect of overall health, they will be less influenced by stigma and fear, and more likely to seek out help if they need it. As former Surgeon General David Satcher said: "There is no health without mental health."

Ann Sullivan, MD, is Commissioner of the NYS Office of Mental Health (OMH). For more information, visit www.omh.ny.gov.

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available quarterly, allowing evaluation in almost real time. HIDTA also distinguishes between the presence of fentanyl in pill or powder form. Analyzing these data can therefore help identify trends in availability of illicit substances and act as a type of early warning system to shift public health education or interventional resources more quickly.

HIDTA data does not differentiate be-

tween fentanyl and its analogs, nor estimate the amount of fentanyl present in seized substances; however, given the small amount necessary for an overdose, the authors note that the presence of any fentanyl is an important indicator of overdose risk. People who purchase counterfeit drugs, such as illicit oxycodone, hydrocodone, or benzodiazepines may be at risk for unintentional exposure to fentanyl, which is associated with increased risk of overdose death. Further, people

who use these types of pills are less likely to have a tolerance built to opioids, and when coupled with the sedative effects of non-fentanyl opioids or benzodiazepines, may further increase risk of overdose and death.

"For the first time we can see this rapid rise in pills adulterated with fentanyl, which raises red flags for increasing risk of harm in a population that is possibly less experienced with opioids," said Dr. Palamar. "We absolutely need more harm

reduction strategies, such as naloxone distribution and fentanyl test strips, as well as widespread education about the risk of pills that are not coming from a pharmacy. The immediate message here is that pills illegally obtained can contain fentanyl."

The researchers emphasize that drug seizure rates are not direct measures of actual drug availability. However, the

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Employees are any company's brand ambassadors, so keeping them healthy - and supporting them in staying both physically and mentally healthy - is mission critical. For healthcare workers, absences whether due to physical illness, burnout, or mental health concerns have a profound impact on healthcare services access.

Expanding and Strengthening the U.S.
Behavioral Health Workforce

Congress has acted to address the behavioral health workforce shortage and has provided investments in the fiscal year 2022, including nearly \$225 million for behavioral health professional and paraprofessional education.⁴ With more than one-third of Americans living in a designated Mental Health Professional Shortage area, President Biden in his State of the Union speech, on March 1, 2022, committed to investing \$700 million in programs that provide education and training, scholarships, and loan repayment plans for clinicians committed to working in underserved communities.

In addition, the Centers for Disease Control and Prevention (CDC) is funding the Association of State and Territorial Health Officials (ASTHO) Public Health, Equity, Resilience, and Opportunity Program (PH-HERO), which aims to address workforce burnout, resiliency, and morale. The program is designed to create and support a culture of well-being and resilience within local, state, and territorial public health agencies to help reduce public health workforce mental health concerns, aid in hiring and retention efforts, and boost morale across the workforce.

According to ASTHO,⁵ the program is planned to include:

- Partnerships with national organizations, experts, and leaders in organizational change, leadership, and workforce development.
- Compiling models, approaches, and resources related to organizational wellness and resiliency, and assessing public health agency needs related to addressing burnout.
- Developing resources public health leaders can use to address worksite well-being, including assessment tools, training, and resource guides for workers, su-



Javier Favela

pervisors, and agency leaders.

• Pilot with up to five public agencies coaching and technical assistance to support the planning and implementation of an initiative to improve morale and burnout.

Behavioral health providers have several opportunities for intervention that can make an impact on both attracting talent and reducing burnout. The first is developing a culture of work/life balance, providing programs and tools for staff to support them in setting and respecting their work/life boundaries, fostering self-care, and consistently reinforcing that cultural norm. With continued access issues and staff shortages, it is tempting for administrators to keep piling unmanageable workloads on staff in the spirit of helping clients get access to critical services, but what unfortunately results is operating in "survival mode." Operating in survival mode leads to the burnout that we must work to prevent.

The other area where we can support providers and staff is by investing in technology that makes their administrative and documentation burden lighter through efficiency and automation, as well as tools to ensure that the care they are providing is high quality. With public-funded Medicaid and Medicare, the massive amounts of documentation and compliance requirements for payment can be

incredibly cumbersome. Fortunately, there is technology available that can reduce that burden substantially.

The combination of strategies that support team member well-being and work/life balance as well as adopting innovative technologies and automation to lessen the administrative burden on healthcare workers not only helps prevent burnout in existing team members but can also attract new talent. Demonstrating a culture that holds itself accountable to these ideals will go a long way to retain the best employees on your team.

Understanding the U.S.
Behavioral Health Workforce

President Biden's national mental strategy, as outlined in his 2022 State of the Union address, prioritizes strengthening system capacity to expand the supply and diversity of the behavioral health workforce. However, little is known about the current behavioral health workforce due to limited national data.

In March of 2022, the U.S. Department of Health and Human Services announced that the Substance Abuse and Mental Health Services Administration (SAMHSA) is supporting the development of a **Behavioral Health Workforce Tracker**, a new database of more than 1 million behavioral health providers.⁶

The George Washington University Fitzhugh Mullan Institute for Health Workforce Equity, with support from a 3-year grant from SAMHSA, developed a national database on the mental health and substance use disorder workforce. The database includes data on behavioral health physicians, psychologists, counselors, therapists, and advance practice providers. According to the Fitzhugh Mullan Institute for Health Workforce Equity, the goal of this database is to "provide evidence-based support for policy making and appropriate targeting of resources." The Behavioral Health Workforce Tracker will allow users to visualize the availability of behavioral health providers by geography, provider type, and Medicaid acceptance status.

Ensuring the United States has an adequate supply of behavioral health providers has never been more important. Before the pandemic, the rate of unmet need for behavioral health and substance use disorder services was already rising. The COVID-19 pandemic exacerbated this

need, particularly as it relates to the treatment and prevention of serious mental illness and substance use disorders. It is important that behavioral health provider organizations take a holistic approach to the ongoing well-being of their team members and employ technology solutions that reduce the administrative and documentation burden on providers and staff.

Javier Favela is VP, Solutions Behavioral Health and Integrated Care at NextGen Healthcare. For more information, please visit www.nextgen.com/1-bh.

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something each of us needs to balance from time to time as we make our way through life. Those times of imbalance may be driven by things that have names like anxiety, depression, and the like, but those aren't our mental health, those are the things that disrupt it.

Although stigma is an unfortunate occurrence, we now recognize it for what it is - a genuine barrier to care and community. As our work continues and we look to others to change their stigmatizing beliefs, it will support our aim of eradication if we first take the inward step and recognize our own limiting beliefs before focusing our attention in an outward direction. If we can see the ways we have been personally affected, we have the opportunity for greater connection, as it can help to drive commonality and avoid the occasional pitfalls of judgment and moral superiority that provoke defensiveness and close conversations. By supporting a positive context for mental health in our communities, it will no longer be defined by disruptions, rather, it can be seen as simply a part of our overall wellbeing. Organizations can model this with their employees - many of whom may already take "mental health days" (approved or not) - by allowing for health time to be inclusive of experiences beyond physical symptoms. Doing so reflects our best values and is also an investment in their longevity. But most of all we can remember that everyone is doing their best, and sometimes, life is still overwhelming. This isn't a failure or shortcoming, it's actually a disruption to the long-standing myth that we should be unaffected by life. If we



John Orr, MA, LMHC

succeed in our endeavor to eliminate stigma, everyone - not just some - will be able to finally say, "I'm strong because of my experiences, not because I'm without them."

John Orr, MA, LMHC, is Vice President of Programs at Vibrant Emotional Health.

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care when they're either in crisis, needing detox, or at the stage of change where they are ready to enter rehab services for inpatient treatment. So, we provide those transitions of care and we then link the patient, once they're returning to the community, back to our outpatient clinic CCBHC services at the Wellness Works clinic.

David: You are doing very important work to help people during a time of need. I think it would help to give a picture of what a day of engagement looks like for you. Can you walk us through the referral to engagement and then the connection back to clinics?

Joseph: Sure. One of the community-based providers or city-based hospitals would call or send us an email requesting support for an individual who has consented to receiving substance abuse services or substance abuse and mental health services. At that point, we would then check the demographics and then find means of contacting the individual. We call them "participants" and to try to shy away from calling clients or consumers. They are participants because we deliver a patient-centered approach and care and they are active participants in their treatment plan. So, we have an engagement. And at that point we assess their needs and their treatment options and then we would make a referral to a rehab, detox, or outpatient clinic or refer them directly to our clinic.

At that point, after the engagement, we will coordinate transportation with the agency that they're accepted to and then after we get all of the consents done, we would encourage them once we're ready for discharge or when they're speaking with a discharge planner to then reach back out to us for that linkage of care to make sure that they won't fall between the cracks from completion of treatment back to the community. So that's how it comes back full circle to the clinic.

David: Do you have a particular success story in mind from your work?

Joseph: Oh, yeah. I can provide you several! There is one where it's directly connected to the clinic and the services that we provide here and how a person's needs aren't just based on one factor - it's a holistic approach with several factors. It may be one thing that they may have needs for, but through engagement and building rapport, using skills like motivational interviewing, and that intention of peer support, we build a rapport. At this point, we have the participant feeling comfortable enough to then start really telling us about some of the real underlying needs that they may have. Sometimes it may stem from just one simple thing.

We had a participant who was coming to the clinic for services and engaging in mental health services as well as substance abuse counseling. But then as he started to engage with the vocational specialist, he ran into a barrier of not

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not listening to you that you decide to take matters into your own hands and stop taking your medications or perhaps you choose to self-medicate. Whichever direction you choose, you often feel that there is no hope, and you are a small boat being knocked around in the waves. Now imagine experiencing all this pain alone, imagine experiencing an inability to speak to neighbors, friends, family, or coworkers because you are ashamed and do not have the strength to cope with the prejudices and misconceptions society has against people with a mental illness. And as a result of these internal and external barriers, the individual with a mental illness is unable to live his or her best life (Corrigna, 2002).

There is hope and together we can combat the stigma of mental illness. While mental illness is very common, it continues to remain misunderstood, and these misunderstandings continue to make things very difficult for people who are living with mental illness. The National Alliance on Mental Illness brilliantly lays out a [nine-point plan on overcoming that stigma](#):

1. Talk Openly About Mental Health:

Everyone in this country knows someone or has personally experienced a mental illness, yet not everyone is so willing to talk about it. According to Mental Health America, about 20% of Americans or 50 million people have personally experienced a mental illness. However, over half of all adults in the United States go without mental health treatment. These statistics alone emphasize the importance of having a discus-

having a state ID. He had a city ID but not a state ID and was motivated to work. Initially, he was frustrated because of that barrier. But through the intentional peer support, and just making him feel comfortable and staying consistent, we were able to (after COVID) have him come into the clinic.

And we started working on some ways to overcome those barriers. I assisted him with obtaining an application in a waiver form for his green card, which he lost in the transition of moving from place to place, shelter to shelter. We filled out the application, which got sent back twice and stayed consistent. He called me about two weeks ago and told me that the \$450 fee was waived and the application was approved. Now he's just gone for his biometrics to do his fingerprint and then he will have his green card, which will allow him to go to DMV and get a state ID. Because we were able to assist him with that, now he's able to then get that ID to seek employment again. And now he can seek those vocational services that we provide.

And through that, we've gotten him to actually open up more - he's actively engaged in his treatment and he's coming to the clinic engaged and doing sessions regularly. Through any setbacks he stayed motivated. Even when his application was sent back, he stayed consistent with us because he knew he had that support. That's so important. This is an individual who doesn't have any immediate family in New York.



Stephen Masiello, LCSW

sion surrounding mental illness. Ad campaigns are great, but we must lead through action. Talking about thoughts and feelings should be cultural norm and should not be hidden away as if they were a burden.

2. Education: In my opinion education is the foundation for combating stigma because an educated society is a compassionate society. We must not only educate the community but we as clinicians must continue to educate ourselves so that we can provide culturally competent and individualized care to the people that we serve. The onus, however,

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And without you, he wouldn't be where he is now. That must be a good feeling.

Oh, of course. I mean, it's very satisfying. But you know, I do this from the heart to give back to the community providing services. It's about empowering Each One Teach One. I can help you overcome a barrier and then in the process of doing that teach something, motivate you towards something or another goal, encourage you to work on some things. It's a win-win.

David: You mentioned COVID. I'm curious, how did COVID impact what you do?

Joseph: As we all know, COVID impacted the world, let alone New York City, let alone our organization. But through strong leadership here at Wellness Work we were able to come up with a plan to still deliver services via telehealth. And that was an amazing thing because it afforded us the opportunity to actually be a little more consistent than we might have been when seeing the participants here on a regular basis. So now we're calling them and we're doing safety checks and wellness checks on a regular basis.

David: Telehealth was really fantastic to have during COVID. And I guess you are probably still using it.

Joseph: Of course, and we have combined it too. Sometimes the telehealth allows us

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must not solely be on the individual clinicians - agencies both public and private, for and nonprofit must invest in their staff as well as in their communities.

3. Change the language: Words matter and certain ways of talking about mental illness can and do alienate members of the community as well as continue to endorse the sensationalism of the media and further contribute to both stigma and discrimination.

4. Encourage equality between both physical and mental illness as the mind and body connection is constant. This concept is called "Parity of esteem" which means giving equal priority to both physical and mental illness. This is particularly important because individuals with severe mental illness are less likely to attend routine medical appointments and as a result of this their physical health deteriorates. As clinicians we must also remember that what is routine for us may not be routine for someone experiencing a mental illness so we must be there to support our consumers for them to take the necessary steps needed to attend medical appointments. Additionally, we as a mental health community must work to educate those working in the

physical medicine practices so that they can not only be more empathetic to our population but so they to have the ability to both screen for mental illness and have information to provide their patients on any appropriate referrals that they may need (Glew, 2016).

5. Show compassion for those with mental illness: Asking for help is difficult for everyone, not just people who have a mental illness. That is why we must do our best to provide non-judgmental understanding and support to people so that they know they have someone to turn to if they need help. It is important to also remember that sometimes a simple "hi how are you" can go a long way. Another added benefit of showing compassion is that it activates oxytocin which in turn makes us feel good thus boosting our own wellbeing.

6. Choose empowerment over shame: Please do not let the diagnosis dictate who you are. We are all a culmination of our experiences, and we must be sure to always give ourselves credit for what we have achieved even if it is small as it is the little things that matter the most.

7. Be honest about treatment: Let your mental health needs be known. For example, if you broke your leg, you would not go walking around, you would ask

for help. I encourage anyone who is reading this article to feel confident about asking for help. While it is important to ask for help it is equally as important to be honest with yourself. If you feel overwhelmed, as many of us are, its ok to just say no.

8. Let the media know when they are being stigmatizing: As a community we are strong. Let us stand together. Whether it is at community events or through media publications that we create. Let us show the people what the face of mental illness looks like; Everyone in this country has had mental illness affect them in one way or another.

9. Don't harbor self-stigma: Empower yourself and provide yourself with positive affirmations because we are all individuals capable of doing remarkable things.

In conclusion, the reality of mental health stigma is real, and it can be as damaging and as heartbreaking as any mental illness. While stigmas will not go away overnight, we can start by taking the steps needed so that they do not have to last a lifetime.

Stephen Masiello, LCSW, is a Social Worker at the NYS Office of Mental Health's Rockland Psychiatric Center.

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Telehealth from page 20

between 2019 and 2020, due in large part to the COVID-19 pandemic. Telehealth visits for mental health increased by 556 percent between March 11 and April 22, 2020.¹⁴

A 2021 survey conducted by the American Psychiatric Association found similar data.¹⁵ Nearly four in ten Americans (38%) used telehealth services to access care with a medical or mental health professional, a seven-percentage point increase from the fall of 2020.¹⁶ More than 80% of Americans have used telehealth services since the onset of the pandemic. Sixty-nine percent of survey respondents utilized telehealth through a video format while 38% used audio-only telehealth. The survey also found 59% of Americans would use telehealth services for mental health, and 43% plan to use telehealth when the pandemic is over. In addition, a 2021 survey conducted by NAMI found that 83% of survey participants were satisfied with telehealth and 79% stated that telehealth made it easier for them to access care.¹⁷

For many years, NYSPA has been advocating for mental health parity - equivalent coverage and reimbursement for the treatment of mental health and substance use disorders. This year, our efforts came to fruition and NYSPA's Government Relations Team of Richard Gallo and Karin Carreau of Carreau Consulting, along with other advocacy partners, led a successful effort to enact [telehealth payment parity](#) in New York State, a feat that only a dozen or so states have managed to achieve.

The enacted New York State budget for 2022-2023 included landmark legislation mandating reimbursement parity for coverage of telehealth services, effective April 1, 2022. This legislation requires payment "... on the same basis, at the same rate, and to the same extent the equivalent services... are reimbursed when delivered in person." The parity provisions will apply to the Medicaid program and to all insurers and health plans regulated by the New York State Insurance Law. The budget provisions also require that insurers maintain an adequate network of providers to meet the telehealth needs of the insured. Finally, the legislation requires the Department



Rachel A. Fernbach, Esq.

of Financial Services, in collaboration with the Department of Health, to conduct a study and issue a report by December 31, 2023, evaluating the impact of telehealth reimbursement parity during the first year. As the law currently includes a sunset provision for April 1, 2024, the substance of this report will be a factor in deciding if the law should be extended beyond 2024.

In a recent issue of the American Journal of Managed Care, Ellen Beckjord, a licensed psychologist and Associate Vice President of Population Health and Clinical Transformation at UPMC Health Plan, described the impact of COVID-19 on stigma as a "silver lining." She writes:

The best description of how the COVID-19 pandemic has affected stigma around mental health is not that it has lessened stigma, it's that COVID-19 has created an opportunity to lessen the stigma associated with mental health. COVID-19 has cracked stigma's armor; it's put a foot in the door that has, for so long, shut people off from seeking and receiving help for all kinds of mental health challenges. Keeping mental health in the shadows doesn't protect us from shame and embarrassment, it robs us of opportunities to observe - and celebrate - our resilience. Making real changes regarding how we approach mental health chal-



Jamie Papapetros

*lenges won't expose our weaknesses - it will expose our strengths. Embracing the need to tend to our mental health is an act of humanity and an act of love.*¹⁸

This is a sentiment that reverberates across the mental health professions. Despite the hardships of the pandemic, the exponential expansion of telehealth has truly been a silver lining. Telehealth is one of a variety of tools that society can utilize to reduce and eventually eliminate stigma. Telehealth reimbursement parity is a strong step in the right direction.

Rachel Fernbach, Esq. is the Deputy Director and Assistant General Counsel of the New York State Psychiatric Association. Jamie Papapetros is Research and Communications Coordinator at New York State Psychiatric Association's Government Relations Office.

Footnotes

1. The Random House College Dictionary. Rev. ed., New York City, Random House, 1998.
2. <https://www.dictionary.com/browse/stigma>
3. Thornicroft, Graham, et al. "Evidence for Effective Interventions to Reduce

grateful and humbled to have the support and have someone that he can relate to in this peer work. And that's another beauty and rewarding thing about this work that we do. When you do this peer work, you're able to share some stories of strength and resiliency to motivate us and to use that to elicit change.

David: I would imagine that you may have even formed some friendships and bonds with people and their experiences over time.

Joseph: Well, these rappers and therapeutic alliances, they never stop because recovery never stops - life doesn't stop. It's an ongoing process. You may need a lot of support today and a little bit tomorrow, but as long as the support is there, that's what bridges the gap.

David: What about some challenges that

Mental-health-related stigma and Discrimination." The Lancet, vol. 387, no. 10023, Mar. 2016, pp. 1123-32, [https://doi.org/10.1016/S0140-6736\(15\)00298-6](https://doi.org/10.1016/S0140-6736(15)00298-6).

4. <https://www.ncbi.nlm.nih.gov/books/NBK537064/>

5. <https://www.psychiatry.org/patients-families/stigma-and-discrimination>

6. Id.

7. <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf>

8. <https://www.psychiatry.org/newsroom/news-releases/about-half-of-workers-are-concerned-about-discussing-mental-health-issues-in-the-workplace-a-third-worry-about-consequences-if-they-seek-help>

9. <https://namicny.org/mental-health-stigma-and-the-impact-of-the-pandemic/>

10. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8035970/>

11. Id.

12. <https://investigatmidwest.org/2020/12/08/long-distances-and-stigma-telehealth-seen-as-way-for-farmers-to-access-needed-mental-health-assistance/>

13. <https://psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/principles-medical-ethics.pdf>

14. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf

15. <https://www.psychiatry.org/newsroom/news-releases/New-Nationwide-Poll-Shows-an-Increased-Popularity-for-Telehealth-Services>

16. Id.

17. <https://www.nami.org/Support-Education/Publications-Reports/Survey-Reports/2021-Mood-Disorder-Survey>

18. <https://www.ajmc.com/view/contributor-covid-19-and-stigma-about-mental-health-a-pandemic-silver-lining>

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the ability to be able to assess someone that may need in-person services by doing a video call via Zoom or Teams. We can then put eyes on a participant who may have not seen someone so quickly. So that allows us to do a real thorough wellness check via telehealth services.

David: What are some of the highlights of the work that you do as a Peer?

Joseph: A lot of highlights are being able to see a participant at the pre-contemplative stage or in crisis mode then seeing that participant excited and motivated after the engagement and a few days of support, if it's a few days, then to see them return to the clinic. It's just so rewarding, it's self-rewarding. It is just a validation of the important work we do

Another example just today from the community outreach. A gentleman came to the clinic today and reached out to us just from our community outreach efforts without connection with MTA. By doing community outreach, he was able to contact us looking into services. And we assessed his needs and determined that detox would be a good fit for him at that particular time. He was ambivalent, but we engaged, stayed consistent, and the next day he went to treatment.

I got a call three days later with a discharge plan. And now back to your first question, it came full circle because they called us wanting to know the address and to schedule an appointment.

He showed up today for an appointment and for some more engagement around some of his needs and we were able to share some community-based resources that can support his housing needs and his employment needs. He was just so

you have had to face?

Joseph: Just drawback from the patient themselves. And that's normal. We overcome those barriers and challenges with consistency, positive reinforcement, and validations. And having someone that's providing non-judgmental support that is patient-centered, that is sometimes what makes the difference given those barriers and challenges. It helps because they feel that they have somebody to walk with through tough challenges.

Peer specialists sometimes face our own challenges as well. Sometimes you find a participant who might be saying, "It's ok, it's alright. We're gonna get through it Mr. Wilson, it's alright." So, it's two way street.

David: If you had a wish list, what do you think could be added to this program to

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send me into a tailspin of anxiety or rage. I once described my reaction to any slight like this: imagine someone pricking your arm with the tip of a knife. To me, that prick could feel like a machete hacking to the bone.

“I never know what kind of mood you’re going to be in when I pick up the phone,” my boyfriend said months later in the middle of our crushing, perhaps inevitable break up, with a wistfulness that sucked my breath away. My lability was no longer something I could dismiss as a quirk. It was now an urgent problem to solve.

For a long time, I believed having bipolar disorder meant meeting every benchmark. A frequently cited example was spending money in excess or traveling on impulse; neither described my behavior. I now understand the spectrum of many health conditions, including my diagnosis, bipolar II, which is characterized, in part, by hypomanic periods that never reach full mania. I changed psychiatrists and reconnected with a therapist I’d seen intermittently for years, immersing myself in the work necessary to process the grief of my breakup and recover a fractured sense of self.

By then I was struggling more at work. My psychiatrist recommended I work strictly day shifts. When I shared this information with my supervisor, they sat back and asked, “What is bipolar disorder?” I’d never anticipated they’d be un-



Larissa Breedlove, MFA

familiar with the condition itself. They were, however, empathic. I was offered a role in the records office with standard office hours.

The journey toward finding an effective combination of medications was frustrating and uncertain, but close to a year following my breakup, I had a successful treatment plan. I also found a better fit back in journalism. Though my symptoms became less severe, the familiar challenge of uneven performance persisted. Over

the next four years, I changed employers three times.

I landed my current role in healthcare communications after a short lay off. For the first time, my leaders are mentors. My supervisor is a frank and nurturing person whose humor and authenticity has been a welcome shift from previous experiences. Before the pandemic, our team was allowed to work from home up to twice a week. Today our remote environment is permanent.

For me, remote work is a good fit. In addition to saving the time and energy once spent on a two-hour roundtrip commute, I’m able to counter my periodic insomnia by sleeping later in the morning. These additional hours can make the crucial difference between an average day and one riddled with episodes. While I sometimes contend with a boisterous cat and the distraction of home life, my current schedule has generally lowered my stress and increased my productivity.

When I disclosed my condition to my boss after a high-volume period at work, there was, gratefully, no wrinkled brow of concern. Instead, my boss asked if there was anything I needed. “Nothing,” I said. My boss’s fair, respectful and compassionate treatment - as well as their familiarity with basic mental health issues - was sufficient.

While stigma against mental health conditions has been reduced through bolder dialogue in recent years, there are still challenges. As a white woman of privilege, I’m lucky to have the financial

means and cultural acceptance that allows me to access quality mental health treatment, including an expensive out-of-network psychiatrist. A major problem surrounding mental health care is equity, especially in underprivileged black and brown communities.

A common myth about having a mental health condition is that it may reduce accountability. Earlier in my career, there were moments when my diagnosis felt like an excuse. Over time through treatment, I was able to build effective tools to better self-manage my condition. This again underscores the necessity of ensuring a person with a mental health condition has access to ongoing quality, affordable mental health care, which in turn enhances accountability, most vitally to oneself.

It’s also reasonable to consider that traditional accommodation may not always be possible within certain industries and roles. This makes the case for even more transparent conversations around mental health treatment, which can help a person living with a mental health condition make more informed choices. Ultimately, this can empower them to thrive - meaningfully and on their own terms.

The views expressed in this article are those of the author and do not represent her employer’s view in any way.

Larissa Breedlove, MFA, is Senior Communications Specialist at EmblemHealth.

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about as they likely know their job and deliverables better than you. If possible, partner with them in the transition of their assignments so that they don’t feel supplemental, but integral to the process. Promptly recruit your HR Department for additional support and resources. Reassure your employee that a mental health leave is a medical leave and employers are accustomed to managing medical leaves as a routine part of business. Employees who can truly step away from work for personal time off; whether that is for vacation or a medical leave, typically return rested and refreshed. Supporting staff to do so is simply good for office morale, as staff feel valued for their contributions and understood as a person who is more than just their job title.”

Grossman began with a week off, but it became evident to her that she might need more time. She felt so grateful when HR Director Dacia Barrington told Grossman to carefully determine the length of time needed. To Barrington, this was a very important thing to do. As she explains, “There used to be this idea in times past that employees needed to leave anything considered ‘personal baggage’ outside the workplace, but that made no sense then and still doesn’t. Every employee is an individual, a whole person and that whole person is who walks through the door every day. If HR/workplace practices and policies don’t sustain the whole person, what exactly is the point of those policies and



Emily Grossman, MA, CPRP

practices? Furthermore, as an employer in the behavioral/mental health sector, how can we advocate for practices which contribute to the overall wellness of our participants but fail to do so for our staff? If any employee has a physical ailment and needs restorative time, we provide that - why should we not take the same stance when our employees require the same for mental health needs? Local, state, and federal guidelines with regards to granting leave set a minimum threshold leaving flexibility for employers looking to extend the time to employees. All accommodations

should prioritize the employee’s wellness and do so in a manner that is equitable and without prejudice, thereby fostering a workplace culture where discussions about mental health are embraced. In Emily’s situation, providing the time she needed made sense from a humanistic perspective, a productivity perspective, and frankly, it was just the right thing to do.”

As a result of the medical leave, Grossman’s acute symptoms subsided, and have not flared up since. She has felt more productive than ever. This experience was one of many that led Grossman to realize that CBC was different from past employers, having built a culture of support around its employees living with mental illness. Not only did Grossman feel supported in her time of need, but she also noticed that she and other colleagues who were open about their mental illness were truly valued for what they could contribute to the organization based on their lived experience.

As Grossman says, “I was encouraged to weave my experiences with the mental health system into my trainings where my opinions as a person with lived experience have been valued and appreciated, and I see the same for any colleagues who are open about their previous mental health challenges.”

Grossman believes that if more companies respectfully treated their employees with mental illness as she has been treated by CBC, they would see an increase in loyalty, retention, and initiative. “So many times, people feel like they need to hide their diagnosis from

their employers for fear of discrimination. So, when problems arise, they feel that they must come up with excuses. The stress of this can weigh greatly on a person’s already fragile mental health.” One survey showed that 68% of people worry that telling an employer could negatively impact their job security, and that while 50% of employees experienced a mental health struggle, only 1/3 told their employer.¹

Additionally, companies suffer. In one survey by Mindshare Partners, 61% of workers said their productivity was affected by their mental health.² Thus, there is a high cost for companies when they neglect creating a more inclusive culture of support for employees with a mental illness.

It’s been a year now since Grossman returned to work following her month of recovery, and she feels empowered to be back doing what she loves at CBC. To Grossman, the whole experience is an affirmation that she selected the right employer.

Emily Grossman, MA, CPRP, is Training Director at the CBC Training Institute. Amanda Semidey is Senior Vice President of Quality and Dacia Barrington is the Director of Human Resources at Coordinated Behavioral Care (CBC).

Footnotes

1. <https://www.shrm.org/hr-today/news/all-things-work/pages/mental-illness-and-the-workplace.aspx>

2. Ibid.

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that the entire school community will be more adept at openly discussing mental health challenges, which, in turn, positively impacts youth ability to seek help.

The stigma of mental illness is embedded in our lives and comes in many forms. Using words like *crazy*, *nuts*, *weird*, *what's wrong with you* or *insane* - can make people feel ashamed, hurt, and prevent them from receiving help. Students are already grappling with multiple stressors - defining their identities, coping with conflicts that might be happening at home, community violence, racial barriers, and heightened social anxieties - using disparaging language about emotional needs exacerbates the situation (Dillard, 2019). Generalizable terms like *stress* and *stressed out*, *nervous*, and *feeling down*, are more suitable. Integrating mental health literacy into school culture ensures we are using the right words to describe the various components of mental health.

Effective school mental health requires the involvement of many partners, with varied professional backgrounds, often working across sectors and disciplines. At times, differences in language and understandings can interfere with an integrated approach to care. It is helpful to work towards shared meanings across the school and with partner organizations. This includes stopping the use of stigmatizing language and educating others about its impact.

Staff members' knowledge, beliefs and attitudes about mental health can influence their work with students. Professional training in this area should begin with basic mental health awareness and stigma reduction. Staff's views on mental health form the basis for how they operate as confidantes, role models, and enablers of support. It is recommended that when staff hears stigmatized language: it should be



Scott Bloom, LCSW

identified, educate why it may be harmful, and replace the language with something more acceptable (MHTTC, 2021).

Closing Thoughts

Investing in mental health promotion and prevention results in cost savings by reducing or eliminating the need for more expensive intensive services. Furthermore, interventions like mindfulness techniques in the classroom, discussions about the stigma associated with mental illness, and student lead presentations on the importance of healthy coping strategies can decrease stigma and promote well-being for both students and staff. Students need to be healthy enough to learn, and teachers need to be healthy enough to teach. Creating a stigma-free environment where the mental well-being of all is valued and fostered is essential to helping youth feel safe and accepted.

Scott Bloom, LCSW, is Director of Special Projects & Initiatives at the New York Psychotherapy and Counseling Center (NYPCC). For more information, call (347) 352-1518 or email SBloom@nypcc.org.

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Teen Mental Health

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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ND Volkow, EM Wargo. [Association of Severity of Adolescent Substance Use Disorders and Long-term Outcomes](#). *JAMA Network Open*. DOI: 10.1001/jamanetworkopen.2022.5656 (2022)

Severity from page 30

were not limited to, substance use resulting in a failure to fulfill major role obligations and repeating substance use even when dangerous to health.

Approximately 12% of surveyed teens indicated "severe" substance use disorder, defined by this study as reporting six or more symptoms. Among this group, more than 60% exhibited at least two symptoms of substance use disorder in adulthood - an association found across alcohol, cannabis, and other drug use disorders. By comparison, roughly 54% of teens reporting two to three symptoms - indicative of "mild" substance use disorder - had two or more substance use disorder symptoms in adulthood. Higher severity of substance use disorder symptoms at age 18 also predicted higher rates of prescription drug misuse in adulthood.

Overall, more than 40% of surveyed 18-year-old individuals reported at least two substance use disorder symptoms (across all substances). More than half of the individuals who were prescribed and used opioids, sedatives, or tranquilizers as

adults also reported two or more symptoms at age 18. This finding underlines the importance of strategies to increase safety and properly assess a potential history of substance use disorder symptoms when prescribing controlled medications to adults.

"Teens with substance use disorder will not necessarily mature out of their disorders, and it may be harmful to tell those with severe symptoms that they will," said Dr. Sean Esteban McCabe, senior author of this study and director of the Center for the Study of Drugs, Alcohol, Smoking and Health at University of Michigan. "Our study shows us that severity matters when it comes to predicting risk decades later, and it's crucial to educate and ensure that our messaging to teens with the most severe forms of substance use disorder is one that's realistic. We want to minimize shame and sense of failure for these individuals."

The authors note that more research is needed to uncover potential neurological mechanisms and other factors behind why adolescents with severe substance use

disorder symptoms are at increased risk of drug addiction and misuse in adulthood. Characterizing possible causes of more severe substance use disorder could help improve understanding of vulnerability to chronic substance use and help make prevention and treatment strategies more effective.

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 <https://www.nida.nih.gov>.

About the National Institutes of Health (NIH)

NIH, the nation's medical research agency, includes 27 Institutes and Centers

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pandemic also presented stigma-reducing opportunities by raising awareness of widespread pandemic-related depression and anxiety; thus, normalizing these conditions. The stubborn persistence of stigma of mental illness is therefore puzzling. We suggest that there are two fundamental and interrelated aspects of the stigma of mental illness that we have overlooked and that contribute to its enduring nature and limited effectiveness of stigma-reducing efforts.

First, the stigma of mental illness is *intersectional*, that is, other statuses a person has alongside their diagnosis of mental illness, such as race, ethnicity, gender, social class, age, or housing status interface with their mental illness status and generate different stigma experiences. For example, although they might share the same diagnosis (e.g., bipolar disorder) a young Black American (henceforth Black) man who is poor and lives on the street is exposed to more extensive stigmatization than a young White non-Latinx (henceforth White) middle-class woman who is stably housed. The stereotypical notions of dangerousness, unpredictability, and irresponsibility that are often associated with mental illness are more likely to be ascribed to the young Black man because of the intersection of his race, gender, age, social class, and housing status, compared to the young White woman. Racist and classist attitudes, explicit or implicit, among the public, and the persons and institutions that interact with the young Black man will likely be activated and result in stigmatizing interpersonal and institutional experiences for him. Hence, he will be exposed to three intersecting systems of stigmatization, exclusion, and oppression, namely, racism, classism, and the stigma of mental illness. The young White woman's intersecting statuses of race, gender, class, and housing stability, however, afford her privileges that protect her from and thus reduce the stigma of mental illness.

Exposure to stigmatizing reactions of different intensity also influence processes of internalizing and anticipating stigma. For example, the young Black man may be more likely than the young White

woman to internalize and anticipate stigma and, in turn, engage in behaviors that undermine his well-being (e.g., self-isolating or avoiding services) to protect himself from further stigmatizing reactions. Yet, since he navigates the world by inhabiting all his potentially stigmatizing intersecting statuses, we must recognize that he might be attributing his stigma experiences to one or more of his statuses and not assume that he considers his diagnosis the primary source of stigma. Therefore, when we administer a "stigma of mental illness measure," it is unclear whether we are measuring stigmatizing experiences, perceptions, attitudes towards mental illness or other intersecting statuses that we associate with mental illness.

With a few recent exceptions (Holley et al., 2019; Morrow et al., 2020), mental illness stigma research, interventions, and programs have not adopted a truly intersectional perspective that recognizes the different types of -isms (e.g., racism, sexism, classism, and heterosexism), that is, the systematic processes of exclusion or privilege that interact and generate vastly different stigma experiences among persons with mental illness. We suggest a change in terminology that will sensitize us to this feature of stigma, that is, to always refer to the *intersectional stigma of mental illness* instead of the stigma of mental illness.

Second, the intersectional stigma of mental illness *operates at the institutional level* as well as the intrapersonal, interpersonal, and structural levels. Most of the stigma-reducing efforts have focused solely on the intrapersonal and interpersonal levels. For instance, we have interventions for strategic disclosure of one's diagnosis and psychoeducational and contact interventions to increase public and provider understanding of and familiarity with persons with mental illness. To a lesser extent, we have also designed laws and policies to protect persons with mental illness from systematic exclusion from educational, employment, and housing opportunities to address stigma on the structural level. Yet, we have overlooked the stigma that operates on the institutional level, that is, in mental health organizations, specialized residential facilities, clinics, emergency departments, and

hospitals. Whether these institutions stigmatize persons they serve can be directly gleaned from their operating policies and written regulations. For example, asking patients' preferred pronouns in a mental health clinic is an institutional policy that reduces the intersectional effects of genderism and mental health stigma.

We also advocate for the importance of examining unwritten policies and routine ways, in which care is provided that become part of "how things are done" in different institutions. These regularities in staff and provider behaviors can result in stigmatizing practices in ways that are unintentional and go unrecognized by practitioners. For instance, the language providers typically use to describe patients' behaviors (for example, labeling patients as *noncompliant* or "frequent flyers" when they have numerous readmissions) has the potential to stigmatize patients. The decision to flag patients' electronic health records for *agitation* can bias providers, stigmatize patients, and increase the use of physical or pharmacological restraints. Moreover, it is safe to assume that these stigmatizing labels and practices weaved into the routine workings of institutions are more likely to impact patients facing multiple intersecting forms of "-isms," such as, Black, Indigenous, and People of Color, poor patients, those who are homeless, or who identify as LGBTQ+. To fully understand the stigma experiences of persons navigating mental health institutions and design effective interventions, we must collect extensive data on how institutions might contribute to and reproduce intersectional stigma, regardless of staff or provider consciously held attitudes and intentions. Recognizing the intersectional and institutional manifestations of the stigma of mental illness can bring about a paradigm shift and contribute to meaningful reduction in stigma.

Helen-Maria Lekas is a Research Scientist in the Social Solutions and Services Research division at the Nathan S. Kline Institute and is a Research Associate Professor at NYU in the Department of Psychiatry. Crystal Fuller Lewis is the director of the Social Solutions and Services Research division at the Nathan S. Kline Institute and is a Research Scientist and is a

Research Associate Professor at NYU in the Department of Psychiatry. Kerstin Pahl is a Research Scientist in the Social Solutions and Services Research division at the Nathan S. Kline Institute and is a Research Associate Professor at NYU in the Department of Psychiatry. Daniele Martino is a Research Coordinator in the Social Solutions and Services Research division at the Nathan S. Kline Institute. Suzanne Feeney, MBA is Director, Institute of Program and Policy Innovation at the NYS Office of Mental Health (OMH), and Dhanushki Samaranyake, PhD is Director, Thought Leadership, Institute of Program and Policy Innovation at OMH.

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increase in fentanyl-related drug seizures coincides with increasing synthetic opioid-related overdose death rates. These data also corroborate data from the [DEA National Forensic Laboratory Information System](#) showing a steady increase in fentanyl seizures in recent years, even across the earlier parts of the COVID-19 pandemic. For additional NDEWS research and reports, visit <https://ndews.org>.

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make it better?

Joseph: Some more funding is one wish! More staffing too. And what I mean by that is just more individuals who are passionate about this work, who decide to go into this field for whatever reason but for the right reasons and are willing to really make a difference in someone lives. That's one of

"To address the overdose crisis, you need real-time, high-quality drug surveillance data to inform the public health response," said Linda B. Cottler, Ph.D., M.P.H., principal investigator of NDEWS, and last author on the paper. "Through collecting and sharing data on drug use trends as we do through our NIDA-funded NDEWS, we aim to guide strategies to curb the overdose crisis of today, while also keeping our eye on the horizon to prepare for the problems of tomorrow."

my biggest passions. This is why I continue to do this work every day. I give 110% every day to fill those voids - at least I try to.

David: I really admire the work you do. You're saving lives. And with your own life experiences, you're able to relate to these participants. And I'm sure it is a lot more meaningful and powerful in some instances coming directly from you versus just hearing from doctors and other staff.

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 <https://www.nida.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. Visit www.nih.gov.

Services for the UnderServed. It's been such a pleasure to speak with you!

Joseph: Thank you, I'm humbled. I appreciate you appreciate your time.

For more information about Services for the UnderServed, please visit SUS.org and stay tuned for our next installment of the Behavioral Health News Spotlight on Excellence Series.

Joseph: Of course. Sometimes, you find a patient that may be so resistant to treatment, to progress, or to change that it may not be until that point that they do have peer engagement - that you see some change or motivation.

David: It has been wonderful to learn about the important work you're doing and I really commend you for devoting your life to helping those in need, working with

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or suddenly worsen. But what matters more than our ability to work and earn money is how our illness affects our everyday lives, and it is here that the disabled and mental health communities intersect.

While I was clearly doing the best thing for myself, I struggled to speak about it, even to friends and family. So much of our worth in society is tied to our work, and without a job, I could no longer hide the severity of my mental illness. I squirmed with awkwardness talking to a family friend or meeting an acquaintance at a grocery store. What had I been up to lately? Cue the verbal gymnastics. And dating? Forget about it. Friends reminded me that I was funny, smart, loving, brave - a wonderful person and a great catch, and depending on depression's grip that day, sometimes I believed them. Even as I felt like I was healing and ready to meet someone, the first thing I would tell a potential match was a disclaimer: here are all the possibly scary and off-putting parts of my situation, so leave now if you can't handle that. I was so convinced that disability and mental illness were such a central part of who I was as a person that I didn't allow anyone to get to know the rest of me - my insatiable curiosity, love of language, a penchant for horrible puns, my deep affection for animals - all the large and small details that make up a human being. A human being entirely separate



Amanda McDowell

from, and more than, their illness.

Later, learning about social justice led me to the disability rights movement and the concept of internalized ableism. Lauren Presutti, writing for The Christopher and Dana Reeve Foundation, puts it this way: "Internalized ableism is when we project negative feelings onto ourselves. This happens when we start to believe how society labels disability as inferior. We start to believe the stereotypes. Internalized ableism occurs when we are so heavily influenced by the stereotypes, misconceptions, and discrimination against people with disabilities that we

start to believe that our disabilities really do make us inferior (Presutti, 2021)." I was struck by this idea because it was so similar to something I was already intimately familiar with - the stigma surrounding mental health. I realized that stigma, like ableism, is a disability rights issue. We get so many messages from society and the media about why mental illness is bad, violent, scary, and shameful, and it's so easy to turn that in on ourselves. Stigma and internalized ableism are about shame - that there's something irretrievably wrong with us, that we have to hide - our struggles, our victories, our accommodations to make everyday life easier, our hard-won wisdom - all so that we don't fit into a "crazy" stereotype. Both stigma and internalized ableism live smack dab in the middle of the "shoulds" - I should be able to get ready and leave my house without panicking, I shouldn't struggle and need help with basic tasks, I should be able to pull myself out of this funk. Both issues amplify each other - I had difficulty talking about my disability at all, but it was even more challenging because my illness is mental rather than physical. I realized that stigma, like ableism, is a disability rights issue - and we should treat it like one.

In March, I started working at the [National Alliance for Mental Illness in New York State \(NAMI-NYS\)](https://www.naminy.org), a mental health non-profit that values the peer-run model and offers classes and support groups run

by people with mental illness and their loved ones. In fact, I became aware of NAMI by taking one of those classes six years earlier. During the interview, I shared that I was seeking to transition off disability and return to work, and rather than being a deal-breaker, I was told that what I was doing was admirable. Now I work somewhere where my lived experience with mental illness and disability is a strength rather than a liability. Being open about my struggles in an attempt to help or advocate for someone else is the best way I've found to confront the stigma and ableism that, for so long, I reflected back onto myself.

Amanda McDowell is Event Coordinator for the National Alliance for Mental Illness, New York State (NAMI-NYS). For more information, email amanda@naminy.org, call (518) 631-5068, or visit [naminy.org](https://www.naminy.org).

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manage their symptoms and condition(s). Treatment allows individuals to live a fulfilled and productive life.

The biggest stigma associated with mental health treatment during adolescence is medication usage in children. Most parents worry that medication used to treat mental health conditions affects a child's development and causes a reduction in their expression of emotions. Additionally, parents believe children are overmedicated for simple behavioral problems (Pescosolido et al., 2007). Psychiatric medication is often viewed as a quick fix or the "easiest option." These stigmas are not true.

The research and studies completed by scientists and mental health professionals help to inform physicians on safe medication usage and dosage. It also aids in creating supported federal guidelines on the medication. Research may also conclude simply that more research is needed, which is equally valuable. If the psychiatric medication were to affect a child's development or cause mood side effects, it would be noted in that research. It is im-

portant when parents are considering medications to ask their pediatrician what the medication is treating, the most common side effects, and any essential information regarding the prescribed medication.

Medication is not the solution to every problem, and it is sometimes not the best option. Furthermore, medication is one part of the equation. Typically, medication is used in conjunction with other mental health treatment options such as therapy. Similar to a sprained ankle, a doctor provides medication to reduce swelling and relieve pain, and that alone may not be enough to heal the ankle; an individual may need occupational or physical therapy to help strengthen the body. The same can be said for the mind and mental wellness therapy. Therapy or psychotherapy may be needed in addition to medication to help strengthen or heal the mind.

As easy as it is to create a stigma, it is just as easy to dispel. It is important to have positive conversations about mental health with children. It will help reduce the stigma associated with mental health and allow children to be open

about any concerns they have about their mental health. Parents and other adults cannot read a child's mind but they can help them feel more comfortable with sharing how they feel. Help children receive the care and support they need by educating yourself and those around you. It takes everyone to help reduce the stigma associated with mental health because mental health affects everyone at every age.

To contact the Missouri Mental Health Foundation, please send your email to Tynesha.hardin@missourimhf.org, or call (573) 635-9201, or visit www.missourimhf.org for more information.

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about identity and its relationship to power. Originally articulated on behalf of Black women, the term brought to light the invisibility of many constituents within groups that claim them as members, but often fail to represent them.” **Intersectional stigmatization** takes into account additional marginalized and privileged group membership of individuals with MI/SUD (Fox et al., 2017). It includes but is not limited to: housing status (Petrovich & Cronley, 2015), military service (Tanielian & Jaycox, 2008), homophobia (McLaughlin et al., 2010), structural racism (Lukachko et al., 2014), weight stigma (Puhl & Heuer, 2010), ethnicity (Yang et al., 2014), cultural betrayal trauma (Gómez & Gobin 2020), white fragility (DiAngelo, 2018), carceral involvement (Hansson & Markstrom, 2014), health equity tourism (Lett. Et al., 2022), socio-economic status (Buckmen et al., 2022), religion (Pfaff et al., 2021), ageism (Evans, 2018), accent discrimination (Freynet & Clément, 2019), ableism (Kattari, 2020), know-your-place aggression (Mitchell, 2018), biphobia (DeLucia, R., & Smith, N., 2021), gender-based discrimination (Vigod & Rochon, 2020), insurance disparities (Livingston, 2013), immigration status (Barajas-Gonzalez et al., 2022), and structural violence (Winter & Leighton, 2001).

We start off the “Effects of Stigmatization” section of our curriculum with the quote, “We argue that stigma is in fact a central driver of morbidity and mortality at a population level (Hatzenbuehler, Phe-lan, & Link, 2013).” In other words: if we do not target stigmatization directly, we, at best, worsen outcomes and, at worst, stand by while clients, community members, and even our own colleagues die because of it. The pre-COVID life expectancy was 10-25 years less for people experiencing MI/SUD than for people without MI/SUD, even though the top five causes of death were the same (Firth et al, 2019; Walker et al., 2015) with people experiencing MI/SUD less likely to receive evidence-based treatments for heart disease, stroke, asthma, and diabetes (Druss et al., 2010).

Since the pandemic started, there is evidence that people with schizophrenia spectrum disorders have an increased mortality due to COVID compared to those who do not have those disorders (Nemani et al., 2021), and that minoritized individuals are



Gretchen Grappone, LICSW

more likely to die of COVID than white individuals. Specifically, Indigenous individuals 3.3 times, Pacific Islanders 2.6 times, Latinx/Hispanic individuals 2.4 times, and Black individuals 2 times more likely (www.apmresearchlab.org/covid/deaths-by-race). COVID-related stigma is prevalent, is driven by anti-Chinese discrimination, and is also experienced, to a lesser extent, by people who work in the health professions (Gutierrez et al., 2022). COVID has also coincided with 100,000 overdose deaths in 2021, the largest amount ever in the U.S., with the highest rates among Black and American Indian/Native Alaskan individuals (Ahmad et al., 2021).

The stigmatization of people who use substances is not the sole cause of overdose deaths, but it likely plays a significant role. Stigmatization limits access to life-saving medications for people with opioid use disorder based on “non-medical, non-scientific grounds” (National Academies of Sciences, Engineering, and Medicine, 2019) and overcoming stigma is identified as one of the fundamental components needed to improve access to opioid use disorder treatment (Yang et al., 2019). Substance users are viewed as violent, manipulative, and unmotivated by many health professionals (Boekel et al., 2013) and this can result in perceived and self-stigma, causing people to drop out of SUD treatment (Brener et al., 2010).

Established evidence shows that harm reduction (HR) strategies save lives, lower risk for Hepatitis C Virus & HIV infection,



Jayden Carr, BS

and increases access to both health and social services for individuals who use substances, but the stigmatization of HR strategies stops its use due to negative attitudes about substance users, health professional burnout, and emotional/behavioral distancing from recipients of services (Knaak et al., 2019). People who inject drugs may internalize these negative views and behaviors, causing them to avoid using sterile syringe sources (Rivera et al., 2014).

While people with SUD experience higher levels of stigma than other diagnoses (Pescosolido, 2013), all individuals who experience stigmatization are at risk for negative emotional, social, and vocational outcomes (Shrivastava et al., 2013) and at increased likelihood of suicidality (Mayer et al., 2020). The structural criminalization of MI/SUD, especially toward Black people, results in increased risk for harm - even death - at the hands of law enforcement (Jordan et al., 2021). Individuals who do not have insurance and use emergency rooms to access care for MI/SUD may encounter staff who are at an increased risk of stigmatizing behavior since, by the nature of their work, they see only people when they are in crisis (Thornicroft et al., 2008). Clinicians in community mental health centers who experience stigma by association are more at risk for burnout and decreased job satisfaction (Verhaeghe & Bracke, 2012), highlighting stigma as a workforce development issue that is crucial to address as agencies struggle to hire staff amidst an

increasing need for services.

There are countless other studies documenting intersectional stigmatization. If we did not include representation from a specific minoritized identity or study that you would like us to include in our assessment and intervention article in the upcoming Winter 2022 Issue of *Behavioral Health News*, please reach out to us and let us know. We look forward to presenting what we refer to as the “good news” part of our curriculum and sharing promising practices and our own experiences helping hospitals, community mental health centers, and state agencies target intersectional stigmatization at structural, clinical, and community levels.

Gretchen Grappone (she/her/hers), LICSW, Gretchen Grappone Consulting grappone@ggrappone.org. Positionality: Gretchen is white, gay, cisgendered, and has lived expertise of depression. Jayden Carr (he/him/his), BS, jaydencarr354@gmail.com. Positionality: Jayden is African-American and lived expertise of anxiety and depression.

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* View the complete list of references at www.behavioralhealthnews.org/acknowledging-the-effects-of-intersectional-stigmatization/.

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and immoral use of the uterine cells belonging to Henrietta Lacks and the fact that she too was denied informed consent and adequate compensation for the use of her cells (www.hopkinsmedicine.org).

Current Experience of African Americans and Accessing Mental Health Care

According to the Centers for Disease Control, in 2019, suicide was the second leading cause of death for African Americans ages 15 to 24. In addition, research indicates that adult Blacks and African Americans are more likely to have feelings of sadness, hopelessness, and worthlessness than their Caucasian counterparts (CDC, 2019). Coupled with the disproportionate emotional and financial impact of the COVID-19 pandemic on Black and other marginalized communities, the need for mental health services by those within the Black community are not in question. However, only 37% of African Americans with mental health concerns receive treatment (www.nami.org/mhstats).

Obstacles to Seeking Mental Health Care Within the Black Community

We must not neglect the extent to which African Americans engage in self-stigmatizing with respect to accessing mental health and substance abuse services. We have heard common statements such as: "It's just the blues. We don't do therapy. Seeing a therapist is a sign of weakness. It will look bad on my record if I saw a therapist and that prevents me from getting a job. It is a poor reflection on my family. Remember Tuskegee and Henrietta Lacks."

Many African Americans who may be suffering from major depression describe their symptoms simply as being "down" while experiencing debilitating symptoms such as despair, sadness, insomnia, hopelessness, helplessness, guilt and for others, anger, agitation, and physical symptoms such as physical pain and headaches. Some seek relief by self-medicating leading to addiction to alcohol and other substances.

For many who are religiously or spiritu-

ally focused, the concept of church/faith being a place for healing cannot be ignored (McRae, 1998). There is a false belief that seeking mental health services somehow indicates a lack of faith.

For other African Americans there is a misalignment of mental health and wellness as being "crazy." Research indicates that depictions of negative stereotypes related to mental illness shown within the media does not help this erroneous perception (Rossler, 2016). Even more recently, the attribution of school shootings and other violent acts to "mental illness" likely reinforces this belief.

When addressing concepts of emotional health/wellness within the community, there is a belief that seeking mental health services is only for those whose mental health concerns are keeping them from functioning at an optimal level. Even in this definition of optimal, the belief of "pushing through" can contribute to minimizing significant difficulties in functioning.

As a nation, as we become clear in our understanding of what traumatic experiences exert in our mind, body and spirit, African Americans may have the tendency to deemphasize childhood experiences of sexual, physical, and experiences of neglect and maltreatment. The insistence of "resiliency" in the face of trauma often does not permit "time" or understanding in addressing trauma through therapy.

Although African Americans would benefit from receiving mental health services, there are several access barriers to good mental healthcare in addition to those related to stigma. These barriers include the following:

1. The lack of mental health professionals who are of color
2. The lack of mental health professionals who are culturally informed and practice from a cultural humility perspective
3. The lack of community focused mental health care, including an end to the Community Mental Health model of care
4. Lack of access to services due to no or inadequate insurance coverage among African Americans as well as failure of services to be located within

their communities

5. A tendency to over-pathologize the mental health presentation of People of Color within the field. (Bell CC et al., 2015), which can contribute to ineffective interventions/poor outcomes

Where Do We Go From Here?

To better serve the needs of African Americans seeking mental health services, consider the following:

1. Stigma associated with mental health services must be addressed at all levels, including policy, Mental Health Associations, local government, community, and much more.
2. Increase mental health literacy and awareness by providing accurate and culturally informed knowledge about mental illness, preventions and recognizing signs and symptoms. Consider Mental Health First Aid Training in a variety of community venues. It demystifies mental and substance abuse challenges.
3. Ensure that treatment interventions being used have been demonstrated to be effective with the community being served. There is enormous heterogeneity in the Black community. Although rooted in African American cultural and healing practices, interventions must still be diverse and incorporate client needs at all intersections of their identities.
4. Engage in ongoing required training of clinicians, supervisors, agency leadership, Boards, etc. to increase their cultural understanding while practicing cultural humility.
5. Provide services with their community in collaboration with systems/organization they trust, i.e., churches, social and civic organizations. This includes addressing the concept of "God and a therapist" as being beneficial versus mutually exclusive concepts.
6. Identify barriers to accessing services by making mental health services affordable, multidisciplinary, and available.

Tyffani Dent, PsyD, is Senior Director of Learning and Program Strengthening and Lorna Hines-Cunningham, LCSW/R, ACSW, is Consultant, Technical Advisor, and Psychotherapist, at Black Women's Blueprint. For more information, email Dent-Education@Blueprintny.org, Hines-Cunningham-lornahc876@optonline.net, and visit www.blackwomensblueprint.org.

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discrimination, and prejudice it entails amplifies shame, guilt, and other negative feelings. The resulting self-assessment further confirms beliefs that one's life has no value, meaning or purpose and that ending it would relieve others of the heavy emotional load it places on them.

The effects of mental health stigma can also extenuate the other component of Joiner's model, the capability to die by suicide. In order to complete suicide, one must overcome the inborn resistance to lethal self-harm. The capability for suicide is acquired gradually through adverse life experiences that enhance an individual's tolerance to circumstances that may cause pain or harm. This lessens the aversion to danger to self that deters suicidal behavior.

Mental health stigma can put an individual with mental illness in positions that weaken their resistance to self-harm. Chief among these is discouraging treatment adherence, which can cause emotional, psychological, and physical harm. Repeated and extended episodes of treatment nonadherence can gradually increase vulnerability to other forms of self-harm, including suicidal behavior.

Stigma can further the onset of the ability to end one's life by impeding crisis intervention help seeking. If ongoing sui-



Tony Salvatore

cidal ideation is not checked, it can progress from vague thoughts of suicide to the specifics of how to suicide. Ruminating on a suicide plan lowers resistance to self-harm. Once the threshold from suicidal thinking to suicidal action is crossed, the risk of dying by suicide rises significantly. This occurs because the stigma accruing to suicide merges with mental health stigma and creates a risk multiplier for more dangerous self-injurious behavior.

Protective factors against suicide may be another casualty of mental health stig-

ma. These are personal characteristics that moderate risk and make it less likely that individuals will become suicidal or die by suicide. Mental health wellness, the state of wellbeing that enables individuals to manage stress and effectively function in their lives and community, is an example of a suicide protective factor. Wellness is also an example of a personal defense against suicide that the corrosive action of stigma can undermine.

Other protective factors that may serve as buffers against suicidality in individuals with mental illness include:

- A sense of purpose, optimism, and self-esteem
- Good coping and problem-solving skills
- Strong connections to friends, family, and community support
- Access to mental health care and treatment adherence
- Supportive relationships with care providers
- Resilience and being adaptive to change

Each of these factors is susceptible to the negative impact of mental health stigma. Of course, at the same time the presence of these factors, particularly in com-

binations of two or more, can counteract the influence of stigma as well as the possible emergence of suicidality.

Recovery is another powerful personal suicide prevention resource negatively affected by stigma, which undoes everything that is gained. Stigma compromises wellness, overrides good coping mechanisms, and causes extreme stress. It brings anxiety, depression, and panic. It generates emotional pain and shatters feelings of control and safety. Stigma can substantially impede recovery and the obstruct the benefits it offers as a disincentive to suicidal thinking.

Ameliorating suicide risk must be a more prominent part of the rationale for combating stigma towards mental illness. Anti-stigma efforts may have a number of positive objectives and outcomes, but they can go further. They can help blunt suicide risk by addressing the suicidogenic aspects of mental health stigma. This would show the full measure of the debilitating influence of stigma on those with mental illness, their family members, their providers, and on the community as a whole.

Tony Salvatore is Director of Suicide Prevention for Montgomery County Emergency Services in Norristown, PA. For more information, visit www.montcopa.org/2838/Emergency-Services

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scores on the CASS were also significantly associated with job dissatisfaction among mental health workers in the public sector (Yanos et al., 2020).

Some might question whether associative stigma should really be a concern to the mental health field given that its effects are much less impactful than the effects of the stigma that is directly experienced by people diagnosed with serious mental illnesses. However, we believe that there is evidence that how professionals *respond* to associative stigma affects not only them, but how they interact with diagnosed individuals as well. For one, burnout has been demonstrated to impact a range of client-level outcomes (see Yang & Hayes, 2020, for a review), including client engagement in treatment. This might occur because clients can tell when professionals are burned out and not putting their hearts into their work, and then "vote with their feet" by not showing up for services. We further speculate that interactions with clients can be impacted by associative stigma in ways that could impact the internalization of stigma among clients themselves. This can operate via subtle mechanisms in the ways that professionals communicate with clients when they are experiencing burnout, such as being overly critical. These behaviors can lead clients to feel ashamed of themselves and deepen beliefs that they are incapable of succeeding in pursuing their recovery goals.



Philip T. Yanos, PhD

What can be done about associative stigma? There has yet to be any research on this topic, but evidence from the study of supervision suggests that quality supervision can help. Research suggests that some aspects of quality supervision, potentially including encouraging exploration and selective self-disclosure (for example, in which a supervisor shares examples of experiencing and coping with associative stigma), can help to decrease burnout among community mental health practitioners (Knudsen et al., 2013), so it is plausible that exploring associative stigma in supervision may act to mitigate its effects. We encourage providers to talk about associative stigma with each other and to consider how it might affect their interactions with their

clients. In addition, we believe knowledge about the recovery model (which emphasizes hope and personal choice) can help to protect against the effects of associative stigma. Although we have not directly studied the relationship between recovery model exposure and associative stigma, other research I have been involved with indicates that knowledge about recovery among clinical psychology trainees strongly predicted less endorsement of stigma (both negative stereotypes and intended social distance) among the trainees (O'Connor & Yanos, under review). This therefore suggests that greater attention to teaching the recovery model within social work, psychiatry and psychology training programs will benefit future clinicians as they move into the field and protect them against the corrosive effects of associative stigma.

Philip T. Yanos, PhD, is a Professor at John Jay College, City University of New York. To contact Dr. Yanos, email pyanos@jjay.cuny.edu.

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