

BEHAVIORAL HEALTH NEWS

YOUR TRUSTED SOURCE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER

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EDUCATION, INFORMATION, ADVOCACY, AND COMMUNITY RESOURCES

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The Behavioral Health System: Challenges Past, Present, and Future

Mental Health in America: Looking Back with Pride and Ahead with Hope

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

In the early 1970s at the height of deinstitutionalization in New York, I worked at a psychiatric rehabilitation program on the West Side of Manhattan that primarily served people who had been in state psychiatric hospitals for 5, 10, 20, even 40 years. Each week I went to Manhattan State Hospital to meet patients who might be willing to visit our program. The hospital was isolated on an island in the East River and was composed of three tall, foreboding cement structures that looked very much like buildings in Stalin's Soviet Union. Ironically, they had been built in 1955 at about the same time that New York State passed the first community mental health act in the United States.

Patients who were brought to the hospital first went to an admissions area where they were stripped, searched, deloused, showered, given a cursory physical examination that included rectal and vaginal exams, handed shabby hospital clothing - rudimentary dresses or pants and shirts - and then taken to a locked ward. The



doors were opened using skeleton keys of the kind frequently featured in horror movies to create a sense of the ominous. Inside the ward, they found a barracks style dormitory with fifty cots, placed fairly close together. There were some small private rooms, but they were reserved for patients being rewarded or for those too disturbing or dangerous to be close to other patients for an entire night.

There was a nurses' station that overlooked the sleeping area on one side and the so-called "day room" on the other. That was the room where patients ate their meals and spent their days dozing off in chairs or pacing the floor, unless they were lucky enough to go to the modern rehabilitation facility across the campus, which was very much underused because people eligible for it were also

eligible for discharge - the priority in that period of history. The wards were generally understaffed and the personnel undereducated and underpaid. Physical, sexual, and verbal abuse of patients both by other patients and by staff was, if not common, not nearly as rare as it should have been.

The patients who were discharged either went home to live with their parents or siblings or to adult homes or to live in squalid often dangerous rooms in the slum areas of the city. Adult homes were the subject of repeated scandals in the years after deinstitutionalization, as were the single-room occupancy apartments where many lived among very poor people, people addicted to drugs, sex workers, pimps, and petty criminals. People with serious mental illness were easy prey and too frequently were victims of assault, sometimes murder. These people relied on meagre, monthly public assistance benefits which didn't go very far. They could frequently be found begging for cash, food, and cigarettes, which they also retrieved from the sidewalks for a few drags or to collect tobacco to roll their own.

There were some treatment facilities in the community in the early 1970s. There

see Hope on page 35

Behavioral Health News Spotlight on Excellence: An Interview with Johana Lizarraga, Program Coordinator of Outpatient Substance Use Services at Outreach

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 Johana Lizarraga, a Program Coordinator of Outpatient Substance Use Services at Outreach in NYC and Long Island. Johana details her work with the Spanish speaking Latin community as a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) where she is changing the world through healing, recovery, and advocacy for those who truly need it.

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 in the behavioral health community. My name is David Minot and I am the Executive Di-



[Watch the Interview](#) with Johana Lizarraga from Outreach

rector of Mental Health News Education, the non-profit 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, sub-

stance use disorder, and autism while also supporting their families and the professional communities that serve them by providing a trusted source of science-based education, information, advocacy, and quality resources in the community.

Today, we are speaking with Johana Lizarraga, Program Coordinator of Outpatient Substance Use Services at Suffolk Avenue for Outreach. Outreach is a non-profit organization that provides life-changing drug and alcohol abuse treatment and training services in New York City and Long Island.

Johana, thanks so much for being here with us today!

Johana Lizarraga: Thank you for having me!

David: How about we start by having you tell us a little bit about your role as Program Coordinator at Outreach and maybe provide an overview of the services provided there.

Johana: Sure. I would like to start by mentioning that it's perfect that we're having this conversation now because September is National Recovery Month. I think it would be helpful to start by providing a

see Spotlight on page 36

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Table of Contents

The Behavioral Health System: Challenges Past, Present, and Future

- 1 [Mental Health in America: Looking Back with Pride and Ahead with Hope](#)
- 4 [Transforming New York State's Behavioral Healthcare System](#)
- 8 [Consumer Perspectives: Regaining Hope in Our Future](#)
- 10 [45 Years Within Human Services: Where We Go From Here](#)
- 12 [Recognizing the Root Cause of What Ails Us](#)
- 16 [Mental Health Parity in New York - How It Started, How It's Going](#)
- 18 [Updating Language and Design to a Modern Healthcare Approach](#)
- 19 [Future Technology Solving Treatment Centers' Challenges of the Past](#)
- 22 [COVID Turned Behavioral Healthcare for Older Adults on Its Head](#)
- 23 [50-Year-Old Organization Reflects on its Achievements and Future](#)
- 26 [The Evolution of the Behavioral Health Model](#)
- 28 [For One Mind, Too Many Silos](#)
- 31 [Another Call for Quality Improvement](#)

Addressing the Healthcare of New Yorkers

- 1 [Spotlight on Excellence: An Interview with Johana Lizarraga](#)
- 27 [Creating a Social Justice Action Framework](#)
- 29 [A Trauma-Informed Approach to the 1115 Waiver](#)
- 17 [Better Together: Addressing Challenges by Working Together](#)

Health and Wellness in the Workplace

- 20 [Employee Mental Health Benefits in the Private Sector](#)
- 21 [Clinician Burnout in a Community Mental Health Setting](#)
- 24 [From Dr. Max: The Impact of Employee Depression in the Workplace](#)

In the News

- 14 [The 988 Suicide & Crisis Lifeline: Building a Crisis Care Continuum](#)
- 26 [Alarming Increase In Opioid Overdoses in Central New York](#)
- 28 [Methadone Overdose Deaths Declined Between 2019 and 2021](#)
- 29 [Marijuana and Hallucinogen Use in Young Adults](#)

Editorial Calendar

Winter 2023 Issue

The Impact of Behavioral Health on Families

Deadline: December 13, 2022

Spring 2023 Issue

Stigma: How We Can Make a Difference

Deadline: March 16, 2023

Summer 2023 Issue

Serious Mental Illness: History and Challenges Ahead

Deadline: June 14, 2023

Fall 2023 Issue

Substance Use Disorder Treatment, Prevention, and Recovery

Deadline: September 14, 2023

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Office of
Mental Health

Innovative Programs are Transforming New York State's Behavioral Healthcare System

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

As we recover from the COVID Pandemic, we must look forward to the future and the critical issues our behavioral health care system will need to address. We know that over 40% of New Yorkers will have a mental health impact from this pandemic and we are seeing over twice the number of our youth dealing with anxiety and depression. We have to transform our system to provide access to prevention, treatment, and wellness across the lifespan, meeting the needs of all New Yorkers as we move forward.

In this article we will discuss these three urgent goals: 1) prevention; 2) ready access to treatment and support systems; 3) ongoing wellness for all ages. As the [New York State Office of Mental Health \(OMH\)](#) considers the development of new programs and investment of funding in our ongoing services, these three goals are in the forefront.

However, they cannot be accomplished without assuring equity, inclusiveness, and focused integrated care in all that we do. Our focus must be on timely access to integrated treatment which is culturally appropriate and is responsive to the voice of the people we serve. We must also ensure that residents of New York State are able to engage in treatment when and where it is needed and that it is available to our most vulnerable populations. And while we have begun this very important work, we have much more to do, and need our communities and providers to join with us.

Finally, we will begin to tackle the profound impact that our workforce shortage has had on all our programs and services. We simply must inspire current and future generations to join us in this incredibly rewarding work.

Focus on Prevention and Wellness

Early and effective prevention begins in a pediatrician's office and in the neighborhood school. New York State Govern-



Ann Sullivan, MD

nor Hochul's funding support has expanded Healthy Steps, a primary prevention program that places a mental health worker in a pediatrician's office to work directly with families and youth who are at risk or having emotional issues. We are also expanding the NYS Trauma-Informed Network to recognize and address the range of experiences that may be trauma-inducing for young children and their families, including the pandemic. On the adult side, the Collaborative Care Program seeks to identify and treat commonly occurring mental health conditions such as depression and anxiety in the primary care setting.

OMH has also significantly increased investments made to school districts across the state. We license nearly 1,100 school-based satellite clinics to help address the mental health needs of children and improve the learning environment and will soon announce funding awards totaling \$3.4 million that will help create an additional 136 satellite locations. We have also issued awards to 26 schools in high needs school districts to develop and implement comprehensive prevention and mental health plans.

The [Mental Health Association of New York State](#) was also awarded \$2.5 million this year to further develop the Mental Health Resource and Training Technical Assistance Center. The Center is focused on assisting New York State schools to incorporate mental health in the K-12 health curriculum, enabling future generations of youth to understand mental health as a critical part of their total health and wellbeing.

Over 1,700 New Yorkers still tragically die by suicide each year. OMH's Suicide Prevention Center of New York (SPCNY) continues to provide school and community-based trainings that educate on suicide risk, warning signs, and response. SPCNY has recently launched initiatives to improve wellness and resiliency for veterans and first responders and will soon be awarding funding to non-profit agencies or tribal organizations serving at-risk youth and/or young adults across the state.

And finally, Project Hope is a statewide response to the trauma of the pandemic and has reached over a million New Yorkers with outreach and counseling focused on healing and resiliency from the impact of the pandemic. It is the largest ever mental health crisis counseling across the state, focused on helping New Yorkers through the pandemic and beyond.

Focus on Access to Treatment: Helping Those in Crisis

The implementation of 988 was a watershed moment in the history of crisis and behavioral health care in the United States. It is an opportunity to rapidly reach millions in emotional distress while de-stigmatizing help-seeking. Through our innovative crisis initiatives, New York State has begun paving the way as a national leader in the statewide development of a coordinated crisis response system during this pivotal point in time. Over the past two years, we have been working closely with a diverse stakeholder group of individuals with lived experience, advocates, county mental health agencies, law enforcement, state agency partners, and others who have informed the development of our

crisis system. OMH has prioritized the statewide development of crisis services and is dedicated to ensuring equity, access, and inclusion for all individuals and at-risk groups, including youth, rural populations, BIPOC communities, and LGBTQIA+ individuals.

The vision for these initiatives safeguards the individuals' choice to receive crisis services according to their own preferences and in the communities in which they live. Crisis care offers the opportunity for stabilization and wellness at the level of intervention a person feels they need in that moment. With the 24/7 telephonic triage and crisis counseling available by the 13 NYS 988 Contact Centers, Mobile Crisis Response Teams, development of 12 Intensive Crisis Stabilization Centers and 12 Supportive Crisis Stabilization Centers, Crisis Residential Programs, Comprehensive Psychiatric Emergency Programs (CPEPs), and other community services and supports, individuals will be able to access the help they need quickly and in a supportive and caring environment.

Each crisis stabilization center for example will provide fully integrated substance use and mental health treatment and support and will have intensive involvement of peer services. Throughout the crisis system, staff will be trained in equity, inclusion, and engagement of each individual and family. We will also be strengthening our clinics and certified community behavioral health centers to provide ongoing care as needed, and reopening community hospital beds that were temporarily off-line during the pandemic.

But we cannot forget the most vulnerable individuals living with mental illness on the streets across our state. Governor Hochul has initiated the creation of new Safe Options Support (SOS) teams to work closely with these individuals and meet their needs. This year's state budget includes more than \$11 million, which will increase to \$21.5 million full annual to develop 20 new SOS teams with a multi-disciplinary team of 10 staff to reach

see Programs on [page 33](#)



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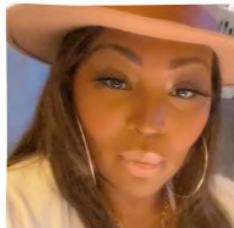
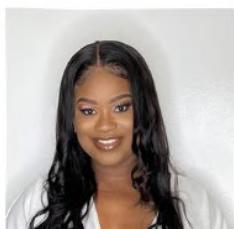
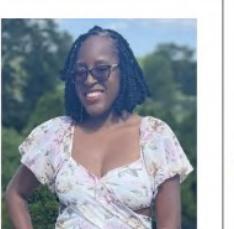
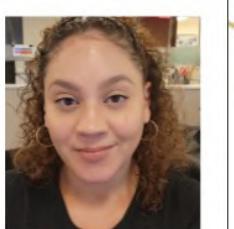
Employee Excellence Awards

2022

Every day ICL's 1,250 staff members come to work ready to help our clients lead their best lives. The ICL team is made up of not only the hardest working people but the kindest and most compassionate.

While we appreciate the dedication and skill of everyone who works at ICL, each year we recognize 25 special individuals who to put it simply -- go above and beyond. Regardless of the challenges, they continue to do what it takes – to meet the complex health and mental health needs of adults, children, and families across the five boroughs of New York City.

These 25 employees exemplify the core values of ICL and we thank them for their profound impact.

 <p>Amin Othman In Reach Clinician SIBN Adult Supported Housing</p>	 <p>Carmen Toledo Peer Specialist Bushwick ACT Team</p>	 <p>Danielle Clarke Program Supervisor II Brooklyn TAP</p>	 <p>Dominique Roberts Behavioral Health Specialist II Queens IMT</p>	 <p>Elizabeth Isidor Sr. Housing-Benefit Spvr. New Life Shelter</p>	 <p>Hattie Parnell Case Manager Supervisor Tillary Street Shelter</p>	
 <p>Judith-Ann Reuben Program Director Brooklyn Supported Housing</p>	 <p>Sonia Munro Clinical Supervisor Rockaway Parkway Center</p>	 <p>Karenlisa Depanfilis Work Service Coordinator All Shelters</p>	 <p>Lai Chung-Tam Registered Nurse Joselow House</p>	 <p>Lotoya White Program Assistant The Crotona</p>	 <p>Maralee Thomas Direct Support Professional East 170th Street</p>	
 <p>Marlyn Reynolds Program Director HUD IPS-HASA-HOPWA</p>	 <p>Nadine Smith-Payne East 170th Street</p>	 <p>Neikia Foster DSP I East 225th Street</p>	 <p>Trishana Davis Administrative Assistant Brooklyn Supported Housing</p>	 <p>Phillip Saunders Maintenance Supervisor Facilities</p>	 <p>Rashmi Koti SharePoint Developer IT</p>	
 <p>Rebecca Louisia Substance Abuse Specialist Strive & Thrive</p>	 <p>Roosevelt Hewitt Recreational Specialist Tillary Street Shelter</p>	 <p>Sabrina Betances Senior HR Coordinator</p>	 <p>Sharon Kingwood Director of Facilities Eldert Lane Shelter</p>	 <p>Sonia Daley Peer Specialist IMT Richmond Team</p>	 <p>Sonia Lessey Direct Support Professional I Pacific Street</p>	 <p>Willie Dockery Overnight Counselor East House</p>



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Consumer Perspectives: Regaining Hope in Our Future

By David D., David T., and Robert

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 New Yorkers in our 30s, 40s, and 50s who have overcome a lot of obstacles in our lives and made progress in achieving stability with help from S:US. We're each experiencing challenges such as homelessness, post-traumatic stress disorder (PTSD), depression, an eating disorder, substance use disorder, and two of us are living with HIV.

Previous Challenges Knocked Us Down

Everyone has challenges to overcome,



but we really struggled with significant crises that knocked us down and kept us from living our best lives.

"When I first came to S:US, I was sui-

cidal, I was hospitalized for an eating disorder, and I was dealing with a lot of family issues. I was on the verge of giving up before I turned 30," said David T. "I've been

dealing with PTSD for a long time. Feeling a lot of past trauma, I've never taken care of - S:US has been very good at helping me work on that. I'm also a former drug user. I've maintained sobriety through S:US and I'm very appreciative of that."

"My wife passed away in my hands, she couldn't breathe, and she died. It turns out that she had a blood clot in her lung. She said she was dying, and I was asking her why, I thought she was going to be fine. I called the ambulance because she kept saying she was dying and then she seized. I gave her mouth-to-mouth, but she died. We were together for 29 years and I never left her side. After she passed, I felt like I was going crazy and was very sad, lonely, and volatile. I kept thinking about unusual stuff, like getting into fights. S:US helped me. They talked to me and got me the help I needed. I appreciate them forever. I am still going through pain and I still hurt but I'm not volatile like I was," said David D.

see Consumer Perspectives on page 37

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45 Years Within Human Services: Reflections and Where We Go From Here

By Frank L. Bird, MEd, BCBA
Executive Vice President
and Chief Clinical Officer
Melmark

I have had the privilege of working within the field of autism over the past 45 years. For 24 of those years, I have been honored to work at Melmark, a multi-state human service provider with premier private special education schools, professional development, training, and research centers, currently in Massachusetts, Pennsylvania, and North Carolina. At Melmark I have been able to apply my knowledge and experience with organizational behavior management to influence advancements in all areas of programming and service delivery including strategic planning, curriculum, and instruction, staff development, research, and written publications. I currently serve as the Executive Vice President and Chief Clinical Officer at Melmark.

Throughout my career, the individuals I have met and worked with have taught, inspired, and changed me. I have been most impressed with the perseverance shown by people who are leaning to live and learn to overcome obstacles they face as they navigate their disability, sometimes on their own, and often with the support of family members, loved ones and community help-



Frank L. Bird, MEd, BCBA

ers. I have learned to be a better educator, clinician, administrator, and advocate. Frequently I have been asked “why” I chose to work within human services and my response is simple: “There is no greater satisfaction than supporting individuals who deserve a chance to learn to become more independent and have the opportunity to a life that is purposeful and satisfying.” There is no doubt they have given me a sense of purpose in my career and life.

As my professional role has changed over the years, my primary focus has remained to deliver and advocate for autism services for those most impaired: children and adults with the highest acuity, individuals with accompanying co-morbid mental health diagnoses, and severe challenging behaviors. Through my work over decades with hundreds of professional colleagues as models and mentors, I have become more attuned to the needs of each individual involved in the highly specialized care offered by clinicians, schools, and human service agencies across the country.

Proudly, my professional knowledge and expertise has contributed greatly to the deinstitutionalization movement, advocating for the transition of people with disabilities from public or private institutions, such as psychiatric and state hospitals or settings where they had received contingent shock therapy, to home or community-based settings. Along with my esteemed colleagues at Melmark, I continue to design and improve evidence-based services such as our state of the art private special education schools, adult day programs, community houses and supportive vocational opportunities for hundreds of individuals who were previously defined as unable to be served in community settings.

My early experience as a young direct

care clinician working overnights certainly informs my work as a senior clinician and administrator at Melmark, an organization that embraces care and compassion, evidence-based practices, best outcomes, a highly skilled workforce, integrity of service delivery, and diversity, equity, and inclusion for all. I have met amazing direct support professionals who have chosen to enter a field that unfortunately is always challenged by underfunding and a lack of public understanding for the necessity of complex care and the value of service provided.

I have had the opportunity to support and mentor countless young professionals and provide them with recommendations for how they can approach their role. Helping to shape them and learning from them as they become strong ethical leaders within the field is both inspiring and satisfying. I offer a few thoughts below to you as a reader of this article and hope you will consider adopting these values in your everyday experience.

Never Underestimate the Importance of
Care and Compassion

The mission and vision of every human service organization needs to start by highlighting the care and compassion for

see Reflections on page 30



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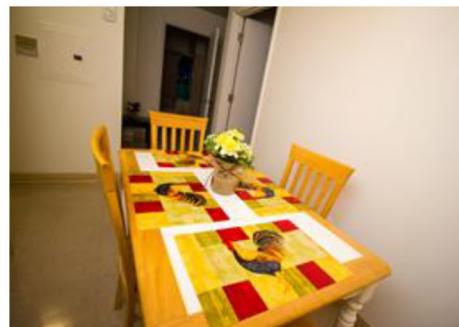
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Recognizing the Root Cause of What Ails Us

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

Our behavioral healthcare system has navigated innumerable challenges in pursuit of its overarching aim to alleviate human suffering. Ostensible improvements in treatment protocols and related technologies, sociocultural developments (specifically those that promote a greater understanding and acceptance of individuals afflicted with mental health and substance use conditions), and a movement toward “whole person” (i.e., integrated) care are merely a few of the advances that should have produced measurable progress toward the aforementioned aims. But this has not occurred. Our collective psychological health and psychic wellbeing have deteriorated significantly in recent decades. Although a certain share of this trend may be attributed to the enduring COVID-19 pandemic and its ancillary effects, an increasing incidence of anxiety, depression, substance abuse, and other leading manifestations of psychosocial distress preceded the arrival of the novel Coronavirus. Why? In short, the behavioral healthcare system has failed to address (and in some instances to even acknowledge) the root causes of our suffering. In doing so it has effectively ig-



Ashley Brody, MPA, CPRP

nored centuries of wisdom that, if properly understood and applied, might yield immeasurably greater improvements in public health.

At the turn of the 20th Century, Émile Durkheim, the figurative father of sociology, posited various precursors to suicide in his seminal treatise on the subject (Durkheim, 1897). His writings have been thoroughly scrutinized and inspired an impressive body of polemics. Some regard his conclusions with skepticism and

contempt. Few, however, would dispute his leading assertions that social disintegration and the dissolution of institutions through which meaning and purpose are derived figure prominently in the existential woe that underpins much of our suffering. Durkheim’s insights emerged in concert with (and likely in response to) the worst depredations of the Industrial Revolution that rent the social fabric that had entwined families and communities for centuries. The Industrial Revolution undoubtedly ushered in an epoch of technological “progress” and the rise of capitalist values that transformed the national and global economies, but it also marked the demise of an agrarian lifestyle to which humans had been acculturated for nearly 10,000 years. This lifestyle, though arduous and inequitable in many respects, fostered activities and values consistent with our biopsychosocial needs. Inhabitants of agrarian societies enjoyed an intimacy with nature, cooperation toward common goals, and opportunities for rest and rejuvenation that largely disappeared with the emergence of factories (Barth, 2001).

Subsequent developments in the American economy throughout the 20th and 21st Centuries have done little to mitigate the depersonalization that characterized the Industrial Era. The factories that once dominated our landscape have been supplanted by an amorphous “Information” economy reliant on increasingly advanced telecommunications technologies that foster communication at the expense of genuine human connection (Hunt, Marx, Lipson, & Young, 2018). Furthermore, these technologies tether many of us to our workplaces in ways we could not have imagined scarcely a decade or two ago, effectively blurring (if not altogether eradicating) the boundaries between our personal and professional lives. Recent analyses of this trend confirm its deleterious effects. A rising incidence of professional burnout and general workplace dissatisfaction may be attributed, at least in part, to employees’ inability to separate themselves from their workplaces and to enjoy periods of rest and rejuvenation essential to optimal health (Becker, Belkin, & Tuskey, 2018). Perhaps not surprisingly, a Gallup poll administered in June, 2013 revealed 70% of Americans either “hate” their jobs or have “checked out” of them (Lopez, 2013). This finding emerged seven years before the onset of the COVID-19 pandemic and its well-documented effects on the national economy, most notably an unprecedented volatility in labor markets characterized by some as the “Great Resignation” (Gulati, 2022).

Our relationship with work is surely not the only determinant of our collective emotional health and wellbeing, but we cannot underestimate its extensive repercussions. Many of us commit a substantial share of our waking hours to professional obligations, and nearly all of us depend on our jobs for financial stability. This is prima facie evidence of its primacy in our lives, and it logically follows that the economic upheaval we have experienced in recent years (especially during and as a partial consequence of the COVID-19 pandemic) should produce widespread

distress. For many, this distress manifests as anxiety, depression, substance abuse, and other “conditions” that fulfill corresponding diagnostic criteria (Witteveen & Velthorst, 2020). In *Deaths of Despair and the Future of Capitalism*, authors Anne Case and Angus Deaton explore this in considerable detail and offer a compelling critique of the state of the American economy as described above. They suggest it fuels many of the societal ills our behavioral healthcare system is now charged to treat (Case & Deaton, 2020). Their analysis focuses primarily on the plight of the working class whose wages and way of life have been upended by seismic changes in the national and global economies that preceded the pandemic. A core tenet of their findings, however, is applicable to other rungs of the socioeconomic hierarchy. Globalization writ large has isolated us from each other and from many of the pillars through which we derive meaning, purpose, and fulfillment. The demise of families, communities, and spiritual institutions, among many others, has left us wanting for much that cannot be supplied by the workplace (Heymann, 2006).

In consideration of the complex sociohistorical and economic factors in which human suffering (and, more tragically, “Deaths of Despair”) unfolds, modern treatments may be viewed as palliative in nature insofar as they alleviate symptoms but fail to address their root causes. And as much as we lament a dearth of behavioral healthcare resources that impedes access to treatment, we must also acknowledge fundamental limitations of the healthcare system. Simply put, counseling, medication, and other hallmarks of conventional behavioral healthcare cannot resolve structural impediments to optimal health whose etiology is primarily socioeconomic in nature.

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

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see *Root Cause* on page 30



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The 988 Suicide & Crisis Lifeline: Playing a Vital Role in Building a Crisis Care Continuum

By Susan Smyre Haire
Marketing and Communications Manager
Vibrant Emotional Health

Ease of access to crisis care and a lack of funds to sustain operations of local, backup, and specialized crisis centers have long posed tremendous challenges to our behavioral health system. But on July 16, 2022, the nation went some way towards addressing that with the transition to the new, easy to remember three-digit access code: 988. [Vibrant Emotional Health](#), the nonprofit administrator of the [988 Suicide & Crisis Lifeline](#) (988 Lifeline, and formerly the National Suicide Prevention Lifeline), which is funded by [SAMHSA](#), announced with the change, that “Hope has a new number!”

988 Lifeline is far more than just a number. The change has brought needed awareness to mental health access, reduced the stigma that can be associated with seeking support, and allows more people to quickly seek and access crisis support. 988 Lifeline builds on the model of local centers connecting callers to community services. The 988 Lifeline plays a critical role in being the front door to a responsive and comprehensive continuum of crisis care across the country.

The 988 Lifeline serves as a universal entry point to free, confidential service which is available 24 hours a day, seven days a week. Anyone experiencing suicidal, substance use and other mental health or emotional crises can now reach a trained crisis counselor by calling or texting 988



Susan Smyre Haire

and chat is available at 988lifeline.org.

The 988 Lifeline provides emotional support for people in distress, reducing suicides and mental health crises, and providing a pathway to well-being for all. Numerous evaluations by independent research teams have shown that the 988 Lifeline centers are effective in reducing the emotional distress and suicidality of persons contacting their service.

The network is designed to [route calls through a national number to local centers](#), allowing callers to be connected to community services when needed, but with the security of a backup network to handle times of volume surge. All 988 Lifeline counselors complete extensive training allowing them to listen to callers with empathy, work to understand what callers are experiencing, provide support, collaborate on ways to feel better and connect callers with any needed help or resources as needed.

As the administrator of the 988 Suicide & Crisis Lifeline since its inception, and now the administrator of the 988 Lifeline, Vibrant has long championed the need to enhance capacity for the Lifeline, recognizing it historically has been under-resourced and underfunded for many years. With the recent unprecedented funding that allows for the expansion of the crisis center network, an improved infrastructure is now a reality.

In 2021, SAMHSA announced over \$282 million in investments for 988 implementation (and another \$150 million announced in 2022). \$177 million of the 2021 funds were made available to Vibrant as the administrator of the Lifeline. These funds are now being used to fund crisis centers in the Lifeline network, which includes the national backup network, chat and text network, and a Spanish subnetwork, as well as the continued development of the infrastructure and services needed to support 988.

Funding is also used to establish outreach, partnerships, and services for enhancing access to crisis care for historically marginalized populations at higher risk of suicide, including persons from Tribal Nations, Black and Brown communities, as well as persons with functional disabilities. In September 2022 and as part of a \$7.2 million dollar pilot funded by SAMHSA, 988 Lifeline is providing persons under the age of 25 with the option of connecting with a counselor specifically trained on issues often faced by LGBTQ+ individuals. Individuals wishing to access specialized LGBTQ+ counseling

will be connected to the subcontracted service provider during the hours of 3PM to 2AM ET daily by chat and text, and 24/7 by phone.

The network expansion is the largest single expansion of capacity in Lifeline's history, growing the number of crisis centers offering nationalized services and increasing workforce capacity and response for phone, chat, and text services.

These recent and timely investments have already resulted in a substantial increase in the number of answered calls, chats, and texts, even while volume has increased. In August 2022, the first full month following the national 988 code rollout, the network experienced a 45% increase in overall volume compared to August 2021 - ultimately meaning the 988 Lifeline is already reaching more people.

Lifeline backup and nationalized services are an important and proven component of ensuring a mental health safety net, particularly when there are demand surges. While meeting these surges in the past, this expansion will help to meet the growing demand for these services.

This historic transition to 988 Suicide & Crisis Lifeline will promote help seeking and increase awareness and accessibility to this life-saving resource. The 988 Lifeline is a vital mental health safety net for all in this country, and it is just one part of a larger crisis continuum that will need sustainable investment to continue to meet the need.

Susan Smyre Haire is Marketing and Communications Manager at [Vibrant Emotional Health](#).

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Mental Health Parity in New York - How It Started, How It's Going

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

Picnics and Pizza: The fight for mental health parity - equal coverage and reimbursement by health insurers of mental illnesses and conditions - has been long and challenging. In the 1990s, the National Picnic for Parity became a grassroots movement in support of parity. The group hosted spirited rallies around the country where politicians, advocates, individuals, and families came to share ideas and experiences and garner support for parity in legislation and policies affecting behavioral health benefits. An August 1, 1998, article in *Psychiatric Times* describes a typical scene: "Despite threatening skies on a Sunday afternoon in late May, about 2,000 people gathered in New York City's Bryant Park for the fourth annual picnic given by National Picnic for Parity, a broad-based coalition of mental health providers, consumer groups, legislators, and other advocates interested in achieving parity for mental illness."¹

Sadly, just a few years later, in 2001, a 12-year-old boy named Timothy O'Clair from Schenectady, NY took his own life. The O'Clair family's health insurance plan provided only limited mental health coverage, and as a result, Timothy did not receive the care and treatment he needed. Following significant advocacy by the newly formed Timothy's Law Coalition, a new mental health mandate bill called Timothy's Law was introduced in the state legislature and became the new focus of the parity movement in New York.

When the legislature was in session, members of the Timothy's Law Coalition embraced a new strategy they called Pizza for Parity. Once a week, pizza pies with one slice of pizza missing were sent to legislators in their Albany offices. The missing slice was intended to represent coverage of mental health, which was the final piece of the puzzle, the missing piece of the pie. In other words, there is



Pizza for Parity, featuring former NYS Senator Joseph Bruno and Richard Gallo, NYSPA Government Relations Advocate

no true health and well-being without mental health. You can't have one without the other.

Timothy's Law

The watershed moment finally came when Timothy's Law was signed into law in late 2006 and made permanent in 2009. For the first time ever, healthcare insurance policies and HMO health contracts written in New York were required to include benefits for the treatment of mental illness. Timothy's Law requires all group health plans to provide coverage for at least 30 inpatient days of treatment and 20 outpatient days of treatment for all mental health diagnoses that are covered by the health plan provided to New York State employees and their families, which covers essentially all mental illnesses. In addition, employers with more than 50 employees are required to provide full coverage for schizophrenia, psychotic disorders, major depression, bipolar disorder, delusional disorder, panic disorder,

obsessive compulsive disorder, and bulimia and anorexia.

Federal Parity Law

In 2008, Congress passed the federal Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA and its implementing regulations prohibit health plans that offer mental health or substance use disorder (MH/SUD) benefits from imposing upon MH/SUD benefits any financial requirement or treatment limitation that is more restrictive than the financial requirements and treatment limitations imposed upon medical and surgical benefits under the same plan. The term "financial requirement" means copayments, coinsurance, deductibles, and out-of-pocket maximums.

Under MHPAEA, there are two types of treatment limitations: (i) quantitative treatment limitations, which impose limits on number of inpatient days or outpatient visits; and (ii) nonquantitative treatment limitations (NQTs), which include all

other types of limits on the scope or duration of treatment. Examples of NQTs are medical management, utilization review, fail-first policies, criteria for coding/claims processing, and reimbursement rate calculation methods. The federal law applies only to large employers with more than 50 employees. Small employers with 50 employees or less are not covered by the federal parity law but are covered by Timothy's Law.

Circular Letters

In 2009, following the enactment of the federal parity law, the New York State Insurance Department (now known as the Department of Financial Services) issued Circular Letter No. 20. This directive to insurers acknowledged that the combination of Timothy's Law and the federal parity law would significantly expand mental health and substance use disorder benefits for many New Yorkers. The Department confirmed that the federal parity law in combination with the state mandate would require certain employers in the state to provide full parity with respect to visit limits, inpatient days of coverage, copayments, coinsurance amounts, deductibles and in and out-of-network coverage. In addition, Circular Letter No. 20 confirmed that New York's minimum requirement for outpatient coverage of substance use disorder benefits was now fully expanded into a requirement for parity in outpatient and inpatient coverage of substance use disorders.

Not long after, the Department issued Circular Letter No. 17 (2010), which was crafted after the [New York State Psychiatric Association \(NYSPA\)](#) reached out regarding the refusal of some plans to cover evaluation and management (E/M) claims submitted by psychiatrists. E/M codes are the codes most commonly used by all physicians when evaluating and treating patients. Circular Letter No. 17 prohibited insurers from limiting the types of Current Procedural Terminology[®] (CPT) codes that it accepts from psychiatrists to codes

see Parity on page 37



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Better Together: Addressing Challenges by Working Together

By Stephanie Madison, LMSW, The Mental Health Association of Rockland and Charlotte Östman, LCSW-R, The Mental Health Association of Westchester

Positive growth as a result of navigating challenges and building resilience is a basic tenet of the behavioral health care world. It's the journey through which we support clients; it's how clinicians and other staff flourish in their professions; and it's how we, as organizations, adapt.

As agencies, change as a response to challenge enables us to address gaps in care that can be filled by innovative new services or ways of working. It also fuels us as we make improvements in service delivery and infrastructure, and ultimately, it is what helps us become stronger behavioral health care providers.

At The Mental Health Association of Rockland (MHAR) and The Mental Health Association of Westchester (MHAW), change is underpinned by our commitment to our clients. It is that promise - to identify and address the needs of our community while continually seeking to improve access to care - that has brought our two agencies closer than ever.

It is with great pleasure we share that The Mental Health Association of Rockland and The Mental Health Association of Westchester filed an intention to merge with the New York State Attorney General this summer. Building upon decades of working together in different capacities, our intention to merge organizations is a natural step in our evolution as two Mental Health America affiliates with nearly 150 years of combined experience.

Together, we have faced many of the challenges experienced in the mental health care sector. Together, we have emerged stronger and better positioned to care for our community as individual organizations. And together, we will create a united force in which we have more resources, talent, and experience to expand and improve our services to better support the greater New York region.

Our partnership spans decades and has only grown closer in the last 10 years. When we were faced with what we believed to be the largest transformation the Medicaid system has experienced - and all the challenges that we expected to come with it - we banded together with several other agencies to form a learning collaborative. United under the name of Coordinated Behavioral Health Services, our group recognized that by sharing resources, experiences, data, and ideas, each of our agencies would benefit - and so would our clients. We ultimately became a Behavioral Health Independent Practice Association or IPA.

Since its inception, the number of agencies involved in our IPA has grown and fluctuated as we addressed challenges such as leveraging value-based care contracts. We also recognized value in working with primary care partners. With a comprehensive approach to holistic, whole person care, we began working with Sun River Health, a Federally Qualified Health Center, to form an additional



IPA, CBHCare. Through CBHCare, we formed the first, and for many years only, value-based contract for behavioral health services in all of New York with our business partners at MVP.

Throughout this time of transformation, our work has been enriched by working alongside agencies we admire, from whom we can learn, and those with values that mirror our belief in resilience, recovery, and respect.

It is through working with each other - and not in competition with each other - that we became certain of an emerging truth: we are stronger and better together.

MHAR and MHAW are individually successful as organizations, offering a menu of complementary supports and services. But together, we are better positioned to meet the many challenges we, and other similar organizations, face: building a stronger workforce; strengthening funding and infrastructure; creating opportunity to be more creative and innovative; and advocating for policy change.

By merging our workforces, we have the opportunity to build a deeper bench and utilize our resources optimally in order to better support staff. This has become imperative in recent years as the mental health needs of our communities have intensified, making the work more challenging. Creating a workplace culture that focuses even more strongly upon employee wellness, professional development, diversity, inclusion, and equity will now be a reality.

Upon approval and completion of our merger, our new entity is expected to be the second largest Mental Health America affiliate in the country. Our increase in size and scope will be advantageous - as it relates to serving a wider community with improved access to quality care as well as for advocating for regulatory reform with a stronger, louder voice. With greater financial sustainability also comes increased ability to compete on larger playing fields, potentially with for-profit organizations.

As a larger agency, we will also have access to opportunities that separately may not have been attainable, including pilot and demonstration projects, further expansion of CCBHC, and bundled payments for services with managed care organizations.

and affordable, we need more competitive rates from commercial insurance and incentives for innovation and value to both clients and payors. For-profit providers must be held to the same standards as state-funded programs or those restrictions must be relaxed or eliminated for all. So much emphasis has been placed on policing not-for-profits that they have been forced to shift energy and resources from service delivery to chasing denial of reimbursement, compliance and maneuvering an ever increasingly complex set of regulations, billing requirements and data reporting that differ from program to program. Eliminating some redundancy and enjoying some economy of scale will help us to become nimbler and more efficient in these areas. As we expand our reach and size, we have a louder voice and stronger influence over how value can be measured and how policy is determined.

A challenge we experience as separate agencies and expect to continue navigating in the future as a merged entity, is better implementation of integrated care. Just as we break down the siloes between our organizations and work toward becoming one agency with a larger menu of supports and services, we remain hopeful that governing bodies, too, will reduce seemingly counterintuitive regulations

see Together on page 39

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Updating Mental or Behavioral Health Language and Design to a Modern Healthcare Approach

By Brooke Martin, AIA, NCARB, CCHP and Cassey Franco, AIA, LEED AP Dewberry

More and more today, mental health care is accepted as an optimal course of action for millions of people. Those seeking care anticipate restorative outcomes. As recently as thirty years ago, mental health institutions were referred to in derogatory terms. Many of these secure institutional facilities at that time were created for patients who would end up staying indefinitely due to the inability to obtain approval for release. Today, we refer to these facilities as mental and behavioral health facilities, psychiatric hospitals, outpatient treatment centers, or crisis centers - to name a few - depending on the facility's intended operation and its clients' treatment needs. Over time, a stigma has been attached to the abusive mental health practices used up until 1967, when the Lanterman-Petris-Short Act of 1967, ended the practice of institutionalizing patients against their will. As asylums closed across U.S. between 1967 and 1994, the justice system began to inherit portions of the population with mental health or behavioral health needs. Due to inability to find proper placement or treatment facilities, detention centers were



Brooke Martin, AIA, NCARB

slowly becoming the largest mental health institutions.

To challenge the status quo, reviewing and changing terminology is necessary to bring dignity, health, and wellness to patient care, to remove barriers from access to care, and to give better understanding to evidence-based practices and treatment. Updated facility language does not only exist to remove derogatory connotations,



Cassey Franco, AIA, LEED AP

but it also shifts to align with modern, best-practice approaches for mental or behavioral healthcare that emphasize providing patients with the self-confidence and active role in their treatment towards recovery and stability. With the foundation of correct terminology, results include improved treatment descriptions, room names, wayfinding that eases stress, and facility names that are

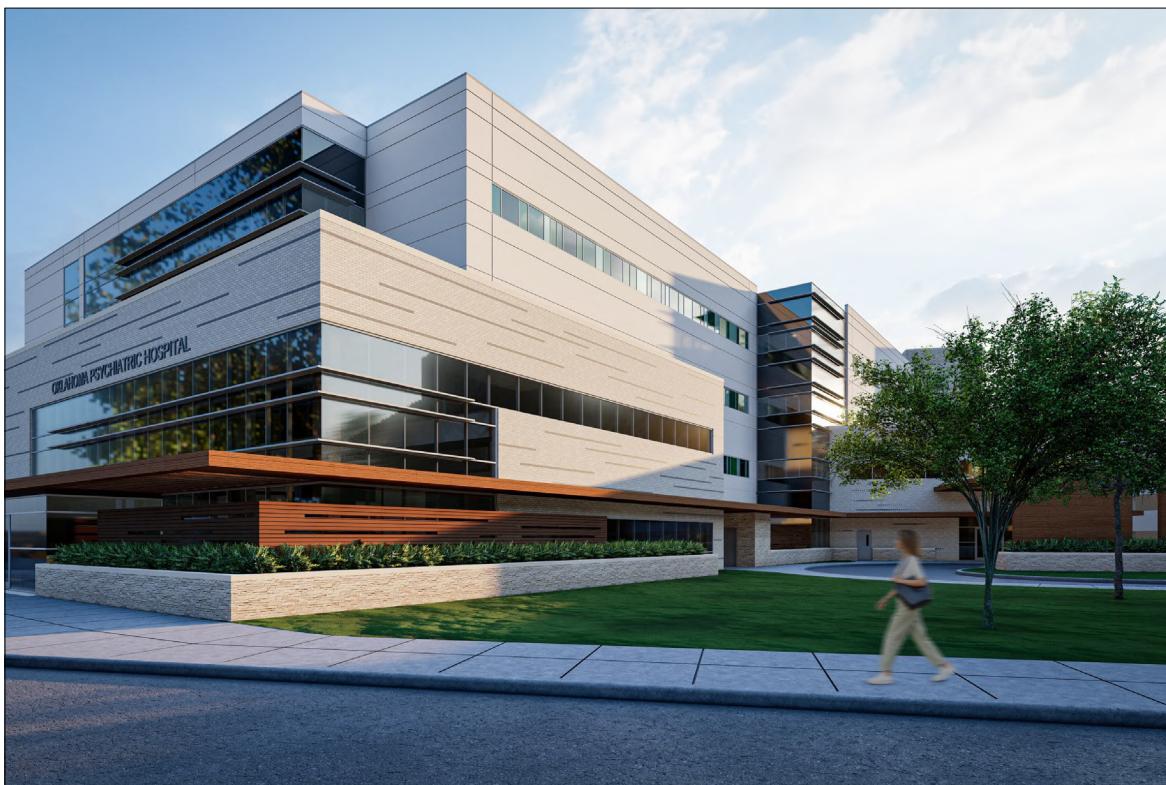
inviting versus anxiety-inducing. These improvements allow a much healthier and normative environment. Cumulatively, there is one goal in mind: the successful treatment of the patient or client and to destigmatize and decriminalize mental and behavioral health.

Person-First Versus Identity-First Language

Language updates also apply to how we refer to individuals with mental or behavioral health needs. Our industry is shifting to focus on using person-first language, which is a linguistic approach that puts a person before a diagnosis. Identity-first language describes a person in the context of a disability, medical condition, or cognitive difference. In the past, an identity-first language example would be calling a person "a schizophrenic," whereas in the push for change to de-stigmatizing person-first language today, this person would be described as an "individual who lives with schizophrenia." These simple but important updates to language allow us to avoid identifying or defining patients by their condition. Each patient is valued and should be spoken to with dignity.

Currently, there is no legislated change for terminology or standardized

see Modern on page 38



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Pictured Above: Oklahoma Psychiatric Hospital, Tulsa, Oklahoma

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How Technology of the Future is Solving Treatment Centers' Challenges of the Past

By Kirk Monroe, MBA, CPA
Chief Executive Officer
Lightning Step

Mental health and addiction service providers encounter struggles every day, whether it's a challenge facing a patient or confronting the stigma surrounding the value of addiction rehabilitation. There are institutional obstacles including rising costs with stagnated administrative support. Tack on human resource shortages, insurance coverage management hoops, patient, and rehabilitation advocacy, and the list goes on and on.

Over the last few years, being hit with a pandemic has only amplified the accumulation of challenges that treatment facilities face. Today, we are seeing mental health disorders on the rise. According to the [American Psychological Association](#),¹ there is a 29% increase in addiction numbers, depression and anxiety have surged by 74%, and the rise of trauma and stress-related disorders has skyrocketed by 51%. That translates to an increase in the demand for public health support and increased caseloads for most organizations.

Providers are struggling to overcome the hurdles, but they continue to rise above them because the purpose calls louder than the problems.



Kirk Monroe, MBA, CPA

Alongside a group of other treatment center operators, I decided the future of behavioral health facilities needed to be comprehensive and there had to be a solution to overcome the fragmented market and offerings. That's why in late 2015 we set out to solve some of these issues using innovative technology to allow treatment center operators to focus less time on solving manual problems and more time

on patient care. Today, we're proud to say [Lightning Step](#) is the only comprehensive enterprise software created by treatment professionals for all levels of care and in-house medical billing.

What Lightning Step's technology platform uniquely does is integrate Customer Relation Management (CRM), Revenue Cycle Management (RCM), and Electronic Medical Records (EMR) into one comprehensive management platform - ultimately streamlining efficiencies and giving treatment center operators and facilitators their much-needed time back. Lightning Step's CRM involves all data required before a patient arrives for intake. This includes referral, management, and communication, call tracking metrics, inquiries, admissions, and admission activities. Our EMR eliminates the need for paperwork and having to manually enter data repeatedly across platforms, creating a care continuum. And Lightning Step's RCM promotes simplicity and productivity by integrating insurance claims, invoices, and automated payment plan processes as well as point-of-service payment. Gone are the days of calling an insurance company each time you see a patient because the data entered will generate throughout their stay. Lightning Step makes it easier to collect clinical, treatment, and payments without the hassle of calling insurance companies, inputting data multiple

times, or searching for client information. Having an automated workflow eliminates the high probability of human error from manual data entry and saves the treatment center staff time and headaches of the past.

Provider organizations do not have the time, money, or resources to develop their own enterprise software solutions, so they settle for the same substandard output. On the other hand, our clients say that Lightning Step allows them to no longer worry about separate database systems, optimizing work from their staff so they can provide the highest quality care to their patients and family. With this platform, all treatment team members see the benefits of harnessing technology to ensure a streamlined back-end process to focus their attention on remission and recovery.

Each health facilitator understands that data must be collected for each patient and then input data individually to monitor progress and submit claims. Each minute spent repetitively adding data to a unique software is a minute away from a patient. As part of the job today, computers tend to get most of the operator's attention. The benefit of this data-driven world is a deeper insight into patterns and analytics created from this information. All organizations need to be able to tell

see Technology on page 39



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Employee Mental Health Benefits in the Private Sector: Workplace Programs and Hiring Policies

By Joann Mundin, MD
Psychiatrist

According to a recent study by Mental Health America, about fifty million Americans are experiencing some kind of mental illness. Each year, major depression affects more than 8% of about twenty-one million American adults. No matter a person's origin, age, status, line of work, or other personal characteristics, mental illness can affect anyone. Whether or not you know it, some of your employees are currently experiencing mental health problems.

Employers should foster a positive work climate where staff may perform at their highest level and take pride in their accomplishments. Giving employees access to health insurance to address concerns about their mental health or usage of drugs is one way to foster a positive work environment. Making these decisions in advance will allow for changes to health insurance coverages. Then, you can make modifications to ensure your insurance provides enough coverage for mental health.

Legislation Regarding Mental Health Insurance Coverage

Health insurance programs generally cover services for behavioral and mental health. Regardless, it's always a good idea to confirm the coverage specifics. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 was created to compel insurers to treat mental health treatment equally with treatment for physical health issues.

What Fundamental Change Was Introduced in MHPAEA in 2008?

Large group health plans were prohibited by the Mental Health Parity Act of 1996 (MHPA) from placing annual or lifetime dollar restrictions on mental



Joann Mundin, MD

health benefits that were less favorable than any such limits on medical/surgical benefits. The MHPAEA maintains the MHPA provisions and adds additional protections, the most important of which is extending the parity criteria to substance use disorders.

What You Should Know About MHPAEA

MHPAEA mandates that insurance providers refrain from placing additional restrictions on addiction or mental health therapies that are less favorable than the restrictions on other healthcare services. For instance, if sessions for other health concerns are not restricted, an insurer cannot impose a cap on the number of counseling sessions reimbursed. Copayments for mental health services have to be comparable to those for other specialized services, such as inpatient care.

Benefits of the Affordable Care Act

According to the Affordable Care Act, mental health problems are covered by all health plans on the government-run health insurance marketplace. Additionally, the

ACA forbids insurance providers from refusing coverage due to pre-existing diseases and mandates that they provide preventative care. Most employer-sponsored health plans comply with the ACA and provide coverage for mental health care.

Accessing mental health care can get complicated due to factors like:

1. Long waits for appointments for intake
2. Lack of in-network medical professionals in the employee's area
3. Being unable to leave work to attend appointments
4. Appointments with high copayments
5. Hospitalization or inpatient care is unaffordable due to high deductibles

Examine the group insurance plans you intend to provide and any additional prescription drug benefits to be sure that cost won't be a barrier to receiving care. Training managers and human resources professionals should be considerate of employees who require time off to obtain mental health or drug abuse treatments.

Why Is It Essential to Provide Your Employees With Mental Health Coverage?

Employees are more vulnerable to burnout or other mental health issues with the regular job and life changes brought on by the pandemic. Employees who are experiencing mental health issues are probably less focused and less involved with their coworkers and their work, and their productivity at work may suffer as a result. You want your staff to be able to meet your expectations for efficiency, work quality, and customer service. The majority of employees want to live up to those standards as well. Still, occasionally they want extra support to make sure they are in the correct frame of mind to com-

plete their personal and professional duties. This is where various mental health therapies like psychotherapy, medication, and outpatient care come into play.

Employee dissatisfaction can also hurt your company's culture as a whole. When a small subset of employees is unhappy, it might spread and lead to other workers losing interest in their work. Although mental disorders like depression or anxiety are not contagious like the flu, they might cause a lack of involvement or unfavorable attitudes toward the firm if left untreated. Promoting a great culture also involves demonstrating your concern for your employees through your benefit plans. An investment in your workforce and organizational culture is improved health insurance, including mental health care for your personnel. It is important from both a business and a personal standpoint. You should do your best to prevent insurance coverage from adding to the stigma around mental illness and substance misuse, which makes it difficult for people to access mental health care.

How to Make Sure That Your Employees Have Access to Mental Health Care

You want to make it simple for your staff to get mental health care. Consider these when you're thinking about mental health care:

Review documents related to health care

- Look at the health insurance plans you are currently providing. Do all of them offer coverage for mental health services? Do the available programs in your area offer adequate in-network behavioral healthcare providers? Do you provide at least one plan with affordable copays? Companies routinely offer plans with low monthly premiums but large deductibles and copayments; these are ideal for workers who do not frequently utilize healthcare services. However, plans with smaller copays and somewhat

see Workplace on page 38



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Addressing Clinician Burnout in a Community Mental Health Setting During the COVID Pandemic

By Jessica Bonumwezi, PhD,
Russi Soffer, PsyM,
and Elana Spira, PhD
Westchester Jewish Community
Services (WJCS)

More than two years into the COVID pandemic, we are probably all familiar with the term “burnout.” According to the literature, burnout is defined as a syndrome resulting from one’s profession that is comprised of three dimensions of symptoms: fatigue and emotional exhaustion, a low sense of personal accomplishment or performance, and a feeling of depersonalization or cynicism (Maslach & Leitner, 2016).

Countless research articles and news reports have highlighted the mounting crisis of burnout during the COVID pandemic, especially in healthcare workers. While burnout was a significant concern before COVID, the burnout crisis only exploded once the pandemic began due to a myriad of factors, including increased work hours, clinicians feeling the same sense of personal vulnerability as experienced by their clients, reduced social contact, and severity of client concerns. Since the pandemic began, healthcare workers have reported decreasing job satisfaction, adverse mental health outcomes and, for many, the intent to leave their professions. With an influx of referrals on an already overtaxed mental health system, mental health professionals are particularly at risk for becoming “crispy fried.” A recent advisory by the U.S. Surgeon General called attention to this issue, urging healthcare organizations to make efforts to assess and respond to burnout among their staff (U.S. Department of Health & Human Service, 2022).

At Westchester Jewish Community Services (WJCS), one of the largest providers of licensed, community-based mental health services in Westchester County, NY, we assumed the challenge of measuring burnout in our clinical staff and taking steps to address it. To assess clinicians’ needs, our research team conducted a survey one year after the start of the pandemic and achieved a response rate of about 70% ($N = 61$). The abbreviated version of the Maslach Burnout Inventory (MBI-9; Maslach, 1993) and select items from the Compassion Fatigue Satisfaction Self-Test (CFS; Figley, 1999) were used to assess symptoms of burnout.

One standout finding from this survey was that 70.6% of clinicians at WJCS reported high levels of burnout in at least one of the three facets of burnout (emotional exhaustion, reduced personal accomplishment, and depersonalization). Specifically, 45% of clinicians reported experiencing emotional exhaustion and 59% experienced a reduced sense of personal accomplishment. More than one-tenth of respondents, 11.5%, reported high levels of depersonalization or cynicism. Although 51.5% of respondents reported often feeling weak, tired, and run down from their work, the majority (80%) reported that they were able to manage all



clients on their caseload without significant feelings of compassion fatigue. On the positive side, it was encouraging to learn that, despite overwhelming high rates of burnout, the majority of clinicians (92%) reported feeling emotionally connected to others in their lives.

Survey findings were shared with WJCS’s leadership team and presented to the clinicians in an effort to obtain more in-depth, qualitative feedback that may not have been fully captured in the survey. This additional feedback was obtained in two ways. First, reactions and comments were solicited in 30- to 60-minute discussion forums in staff meetings across the agency. During these meetings, clinicians emphasized the main concerns driving their burnout: time pressures, productivity expectations, increased work hours, excessive time spent on screens due to telehealth, tedious administrative tasks, and a culture (perhaps inadvertently) rewarding overworking. Clinicians were also given an additional survey to collect ideas for how to rectify high burnout levels and improve the quality of work in their positions at our agency.

After reflecting on the data that was collected, our efforts shifted to learning about interventions to address burnout. We reviewed the literature for evidence-based approaches to approach burnout effectively in behavioral health settings. With the help of the leadership team, we brainstormed several feasible recommendations for agency staff and presented preliminary ideas to clinicians, generating ideas and additional suggestions that were then shared with the leadership team to further identify and hone action steps.

Action steps were organized into three categories: increasing awareness about burnout (among staff members as well as leadership and supervisors), improving access to resources, and fostering social and emotional support for clinicians. The first category included goals related to reducing stigma about burnout so that clinicians would learn to recognize it in themselves and feel comfortable obtaining support from supervisors and colleagues, reinforcing the need for self-care, and shifting the overall agency culture to be

more sensitive to the needs of clinicians. The second category encompassed action steps such as improving access to clinical resources and trainings (e.g., lists of engaging telehealth activities for youth, additional trainings in evidence-based treatments used at the agency given by WJCS or outside partners), and resources to assist with other stressors that might be encountered (e.g., increasing awareness

about and effectiveness of employee assistance services and existing WJCS grief groups for clinicians who have lost clients). We also worked with our clinics to set up informal check-in times with coworkers (e.g., drop-in hours held by supervisors where clinicians could stop by), increased our efforts to express gratitude to our staff (e.g., emails from supervisors and shout-outs from team members recognizing stand out performance by clinicians), and worked on giving more advanced notice for wellness events, such as seminars on nutrition and stress management.

The final process was implementation of these action steps in collaboration with the leadership team. The action steps that were considered most feasible and/or most urgent were prioritized (e.g., establishing regular check-ins to monitor burnout and provide burnout-related consultation at all staff meetings, protecting consultation time from counting against productivity, providing additional time for administrative tasks when necessary, providing scheduling resources, such as sample schedules, reducing productivity requirements, etc.). Continuous discussion with various staff members was sought at various points to share progress, collect

see Burnout on page 34



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How the Pandemic Turned Behavioral Healthcare for Older Adults on Its Head

By Nancy Harvey, LMSW
Chief Executive Officer
Service Program for Older People

The past three years have brought about the greatest transformation in behavioral healthcare practices that I have seen in four decades.

I have served as Chief Executive Officer of **Service Program for Older People (SPOP)** for 33 years. We provide community-based behavioral healthcare for adults ages 55 and older in New York City. Our programs include a New York State-licensed Article 31 Clinic, which offers outpatient therapy, psychiatry, and medication management, and a Personalized Recovery Oriented Services (PROS) program, which offers group-based support for adults with serious mental illness. We serve 2,000 adults each year, and our client population is overwhelmingly low-income, isolated, and frail.

During my tenure, SPOP had already evolved from a neighborhood agency to a city-wide resource with clinic satellite sites throughout Manhattan, the Bronx, and Brooklyn, relationships with the leading hospital systems in the city, and a partnership with the New York City Department for the Aging to provide mental health services on-site at high-need older



Nancy Harvey, LMSW

adult centers. We had also garnered expertise in aging and mental health, and we had developed a robust program of workplace and community-based training for those who work with an older population.

As we all know, everything changed in March of 2020. The most immediate and far-reaching change was the emergency coverage of public-payor coverage of telehealth for behavioral health services, including sessions by telephone. SPOP was one of the first agencies in the metro-

politan New York area to transition fully to telehealth, and our clients experienced no interruption of service. We supplied equipment to all staff, provided training to clients and staff in the use of our HIPAA-compliant Zoom platform, and re-assigned staff to make check-in or update phone calls to all clients.

Telehealth has had a profound impact on the way we work - for our client population it has been a tremendous success, with easy access to services without the challenges of inclement weather, transportation, or frail health - but it is just one of the ways we adapted. We also remained in close contact with our community partners and used this time to develop strategies to meet unprecedented demand and increasingly complex needs in the community.

We quickly realized that we needed to rethink the role of our frontline staff, including front desk staff, intake staff, and schedulers. We assembled a team of bilingual staff to serve as ad hoc telehealth trainers and tech support for clients. Our intake department updated its resource guide and made certain that frontline workers were prepared to assess incoming calls, identify urgent or emergency situations, and connect people to other services in the community, particularly emergency meals, and medical care. As we became aware of the tremendous pressure our clinicians were experiencing, we created a structure in which each client was matched with a frontline staff member, with instructions to call this contact with all inquiries other than therapy-related issues. Finally, we created a Client Navigator position within our intake department to provide enhanced support for new and established clients.

This experience has been transformational. Our frontline staff have developed new skills and report that their work is more varied and gratifying. Most important, clients have a point person who is available during business hours, and incoming clients are connected promptly to other community-based services to support aging in place.

The pandemic coincided with one of the worst periods of race relations in the country in recent years, and during this time we experienced a dramatic increase in PTSD and other disorders associated with racism and lifelong discrimination. For many older adults who were already struggling with loss and grief, isolation, substance misuse, or depression, this compounded their psychological needs, often creating a situation where clients were unable to untangle one challenge from another. We used this as an opportunity to create a Clinic Anti-Racism Lens Initiative, with a goal to improve clinic practice and create a more inclusive environment for staff and clients. We have created a library of resources and a series of training workshops at the intersection of aging, discrimination, ageism, disability, racism, and diversity, which we offer to all of our clinicians. In addition, we updated our treatment plan to incorporate and community and cultural strengths, and our psychosocial assessment was expanded to include questions about cultural background and identity, culture-specific coping

skills, religion, and spirituality. The outcomes include expanded clinical skills for our staff and a more culturally-responsive therapeutic approach.

Older adults were disproportionately impacted by the pandemic, with many continuing to suffer from unresolved grief, isolation, depression, and other disorders. Our professional community was also impacted, and we have seen a worrisome increase in resignations or early retirement, often as a result of compassion fatigue or burnout. We have responded to this urgent challenge by expanding our training program to include workshops focused on self-care specifically for those who work with an older population, as well as community-based trainings for clergy and lay leaders in the faith community, public library patrons, and diverse programs that serve older adults, with a goal to expand the knowledge base and provide support for those working in the field.

We recognized that, while telehealth enabled most clients to engage fully in the therapeutic process, there were others who needed to return to in-person sessions. We reopened our offices as soon as it was safe to do so, and we developed a paradigm to assess each client and determine the optimum ratio of in-person and virtual sessions, taking into consideration the client's treatment plan, transportation needs, and medical condition.

Finally, we have expanded our roster of therapy groups, with a goal to provide social interaction and support rapid engagement with clients during periods of high demand. This project has been a great success, with new groups on such topics as managing chronic pain, long-term grief, decluttering, mindfulness, recovery, or skills training.

One silver lining of this experience has been a broader conversation about behavioral health and a general reduction in stigma or fear of treatment. We find that older adults are more open and receptive to treatment than ever before. This "normalization" of behavioral health awareness and treatment is all to the good of our profession and the society overall.

I expect that we will continue to build upon the work of the past three years. I look forward to developing new strategies and community partnerships to reach those who are most isolated and vulnerable, and to finding new ways to provide treatment and other services that enable older New Yorkers to live independently.

Nancy Harvey, LMSW, has served as the Chief Executive of Service Program for Older People (SPOP) in New York City since 1990. During her tenure SPOP has grown from a neighborhood-based agency primarily serving homebound seniors to a regional resource for affordable mental health care for adults age 55 and older. A graduate of the State University of New York system, she holds a B.A. from SUNY New Paltz and M.S.W. from SUNY Albany. She has been an advocate for increasing access to geriatric mental health care in the region and has developed outreach

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50-Year-Old Organization Reflects on Its Achievements and Hopes for the Future

By Barbara Faron
Chief Executive Officer
Federation of Organizations

This year, Federation of Organizations is celebrating the 50th anniversary of its incorporation as a not-for-profit by the parents of people with serious mental illness and/or developmental disabilities. Fifty years ago, these parents dreamed of changing the system. That has certainly come true! We can see the difference by reading recent articles with headlines like, “UnitedHealthcare Selects Behavior Health Startups...,” which discuss yet another telehealth startup delivering behavioral health and substance use services remotely to the general public. Times certainly have changed!

Before the late 1960s/early 1970s, when the deinstitutionalization movement started, the nexus of treatment for mental illness and developmental disabilities was the institution. People were institutionalized, often with little differential diagnosis, and sent to one of the large hospitals located across New York State. At the height of the institutional movement there were 90,000 people living in psychiatric hospitals statewide. These institutions provided stable employment with a steady income and retirement benefits to local people, which were not available in other sectors in many parts of the state. Irving Goffman, a sociologist, described this system very well in his early-1960s book, *Asylums*. The institutions supported local economies, and all was well with the world until the escalating cost and dubious results of this system became apparent.

Deinstitutionalization began and accelerated, fueled by the advent of effective psychopharmacology and the liberation ideology of the 1960s. In the institution-based phase, treatment consisted of long-term institutional care. In that era, parents were blamed for, or at least considered a major factor in, their children’s mental illness. There was talk of schizophrenogenic parenting. Recovery was not a concept. Stabilization on medication and lifetime institutional care was seen as the best outcome. Family members organized parent groups to bring enrichment activities such as holiday parties into the hospitals. Sometimes people could be discharged into Family Care, a system overseen by the state, where people were placed with families in the community who were paid a fee to care for them - like adult foster care.

At first, 2/3 of the people released from hospitals were sent back to their families of origin. There were few community resources, and the family groups focused on advocacy to divert resources to community-based services. At one point, as I remember, 80% of the mental health dollar went to the institution-based state system and only 20% to the community-based providers, which were now serving all the people who had been released from the institutions. There has been a long struggle, which still goes on, to divert resources to the community from the institutions, which are still important to



Barbara Faron

local economies in some regions of the state.

This brings us to 1972, when some of these family groups centered in the institutions united and founded Federation with the purpose of advocating for investment in community resources. In its early stages, Federation focused on advocacy and preferred to spin off new organizations that would incorporate separately and take responsibility for program operation. It was in this phase that Federation advocates were responsible for the creation of such agencies as FREE, Transitional Services of Long Island and New York, Rockland Hospital Guild, and Project Real, which flourished and continue to serve the community today.

While continuing to advocate for the establishment of community-based services, Federation maintained its commitment to people still living in institutions. The family groups continued to bring resources to the hospitals, usually in collaboration with the hospital’s director of volunteer services. For many years, Concerned Citizens of Creedmoor operated a snack bar that employed hospital patients, working with Creedmoor vocational rehabilitation staff, to prepare people for eventual outside employment.

In the late 1970s, still committed to bringing resources into hospitals, Federation’s board received a grant from the Corporation for National and Community Service (a Federal agency then called ACTION) to sponsor a Foster Grandparent Program (FGP) in Suffolk County. This was the first program operated by Federation as it transformed itself from an advocacy coalition to take on program operation. FGP provides low-income seniors volunteer opportunities working with children at risk. Foster Grandparents receive a stipend and other benefits that cannot be considered income under Federal law. True to its mission, in addition to placements in schools, daycare centers, and other community sites, Federation was pioneering in its effort to bring Foster Grandparents into psychiatric institutions. At that time there were still children’s units in major Long Island psychiatric

centers: Central Islip, Pilgrim, Kings Park, and Sagamore, a children’s hospital. Seniors were recruited and placed in these settings. The effort was very successful and continued until the children’s units were shut down, when the volunteers were moved to community sites.

With FGP’s success and the increasing pace of deinstitutionalization, Federation’s board looked to another Federal program funded under the Older Americans Act: the Senior Companion Program (SCP). Here the focus of the senior volunteer was other seniors, providing friendly visiting and assistance with community access to homebound frail elderly individuals. By this time many older people with long histories of psychiatric hospitalization had been released into adult homes in Suffolk County. These were people who had spent large parts of their lives living in psychiatric hospitals, often moving from one to the next and ending up in Suffolk, a place with which they were unfamiliar. Most spent their days around the adult homes with little stimulation, punctuated with monthly visits to the clinic for medication management. Some people attended day programs or sheltered workshops, but life was lived mostly in the closed circle of former mental patients and outpatient treatment.

In 1981, funded by the Office of Mental

Health, Federation put a special spin on SCP by hiring people who themselves had long histories of psychiatric hospitalization as Senior Companion volunteers. They would reach out to their peers and be role models for the possibility of recovery. Federation hoped that Senior Companion volunteers would provide socialization and peer support in the adult homes and assist residents in utilizing community resources such as public transportation, libraries, and recreational activities. For the first time, inspired by a strength-based perspective and based on peer support and self-help, the possibility of recovery and community engagement was brought to people who had been relegated to community-based institutional care. The success of our recovery-oriented approach and the inspirational work of our peer volunteers impacted greatly on the existing service delivery system, and Federation grew as resources were directed to community services.

For 50 years, inspired by the experience of family members and peers, Federation has developed a network of services supporting recovery from mental illness and community integration for people with disabilities. We have helped pioneer the transformation of the mental health

see *Future on page 34*



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From the Desk of Dr. Max

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



The Impact of Employee Depression in the Workplace

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

Although the impact of emotional health challenges is well documented in the literature, its impact and consequences for the workforce and the work environment is ever increasing and prevalent during the COVID-19 pandemic. Four out of ten adults reported symptoms of anxiety and depression during the pandemic. Seventy-eight percent experienced additional stress and about 56% have reported increased worries about their future.

Depression Affects 7% of the Workplace Population

Most, if not everybody, is aware of this feeling called depression and its range of consequences and unique manifestations amongst different individuals. According to SAMHSA Center for Depression and the Workplace, about 16 million or roughly 7% of the population may be suffering from depression. Early symptoms may be evident in adolescence and the 20s onto mid to late adulthood. Anyone may suffer from the consequences, but women experience and report it more than men.

It is noteworthy that about 50% of this group does not seek treatment according to the American Psychiatric Association. The cost to the employers is more than 44 billion dollars and this does not take into account the emotional consequences to the individual and their families.

How is Depression Manifested in the Workplace?

Listed below are some of the obvious and not so obvious changes in the individual:

- Withdrawing from the group or team - isolation
- Becoming indifferent or apathetic - not taking pleasure in work
- Delaying, procrastinating, and lower productivity
- Having problems with concentration, becoming scattered and/or somewhat absent-minded
- Feeling tired often
- Low motivation and underachievement
- Impact on relationships by different

reactions or becoming short tempered/negative

- Higher absenteeism

Typical Signs Associated with Depression

The above indications will accompany some or all of the other typical signs that are usually associated with depression:

- Feeling sad
- Suicidal thoughts
- Feelings of worthlessness
- Sleep and appetite problems
- Irritability, tearfulness, and may be anger or argumentativeness
- Not future-oriented
- Physical complaints and/or worsening of current medical conditions
- Increased use of prescribed medication, alcohol, and drugs

Over the past decade some workplace strategies have developed recognizing the impact of emotional health and work/life balance on the health of the organization, productivity, retention, and job satisfaction. Lack of recognition, work stress, burnout, inequality, poor working conditions, and leadership and communication problems are identified as some of the factors for employers to pay close attention to. "Clinical depression has become America's most costly illness left untreated. Depression is as costly as heart disease."

Steps Employers Can Take

- Awareness and education
- Promoting early recognition
- Address stigma by open and direct discussions

Educating managers, supervisors, and directors goes a long way in addressing this sensitive and vital conversation about work/life balance, conflicts, stress, and other signs that may be evident to address without infringing on individual privacy. Employee Assistance Programs (EAPs) are part of the plan but cannot be the only resource.

In view of months of September/October recognizing Suicide Awareness and Depression Screening, it is prudent

see Depression on page 39



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VOTED TOP WORKPLACE ON LONG ISLAND

The Evolution of the Behavioral Health Model: 24/7, Walk-Ins, and Crisis and Stabilization Centers

By Charles Madray
VP for Health Systems
and Community Programs
Samaritan Daytop Village

Our communities are in crisis. Mental health and substance use disorders are affecting communities nationwide from all levels of society, without regard for political affiliation, economic status, age, cultural origin, or educational level. Furthermore, the impact of the crisis is particularly acute for the impoverished and people of color.

Behavioral health disorders are common, recurrent, and often devastating to families and communities. It is estimated that half of the individuals who experience a substance use disorder have a co-occurring mental health disorder - and vice versa (National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration, 2018).

The Growth of Co-Occurring Substance Use Disorder and Mental Health Issues

The Centers for Disease Control and Prevention estimates that in 2021, there were more than 107,000 opioid overdose deaths, a nearly 15% increase from 2020, which previously held the record for overdose deaths in a 12-month period.

Among the afflicted were health professionals who provided the services and treatments they in turn would require. In a recent Morbidity and Mortality Weekly Report, 8% of American public health personnel reported at least one mental health issue.

Other surveys reveal a similar rise of behavioral health issues among New York State's approximately 20.2 million resi-



Charles Madray

dents. According to the New York State Office of Mental Health:

- More than 1 in 5 New Yorkers have a mental disorder
- 1 in 10 adults and children have serious mental health challenges that affect work, family, and school life
- The total cost of mental illness is more than all cancers

The issue has been a financial burden on the social services sector and criminal justice system.

In New York, unhoused persons living with mental health costs the city over \$58,000 in health care, corrections, and shelter services.

Mental health and substance use disor-

ders often run in families, suggesting that these conditions may be inherent and that specific genes can be identified as risks. Additionally, environmental factors, such as stress or trauma, can cause genetic changes passed down through generations and may contribute to the development of a mental health or substance use disorder (University of Southern California (USC) Schaeffer, 2018).

A 2018 study by USC Schaeffer showed that individuals living with mental health disorders are more likely to be jailed than treated. The impact has had a heavy financial burden on the State's correctional system. Incarcerating individuals (instead of treating them) is costly - at a price tag of more than \$500 million.

Fortunately, these two behavioral health disorders are treatable - and many recover. Behavioral health service providers can attest to the fact that it is far better to treat both disorders together rather than separately.

Effective evidence-based treatment often includes both medication-assisted treatment and behavioral therapy. However, experience shows that treatment needs to be individualized based on age, substance misuse, and other co-factors.

No two individuals are alike and the same holds true for their treatment plans. But with skyrocketing numbers of people requiring care, there is a growing number who believe their behavioral health needs are not being met.

Consequences of Not Receiving Care

More than 20 million people are dependent on alcohol and/or drugs, yet only one in ten is accessing treatment (National Institute on Drug Abuse (NIDA), 2010). Often, individuals desperate for treatment must wait days, weeks, and even months

for an appointment. The consequences are often dire when the window of opportunity is missed.

According to NIDA over 33% of adults report having a mental health or substance use disorder. However, less than half receive treatment. The main drivers for this phenomenon are:

- Shortages of providers
- Access to facilities offering services
- Gaps in reimbursement
- Cost of care
- Lack of housing
- Fractured families
- Poorly integrated system

According to the National Alliance on Mental Illness, more than 50% of people with at least one mental health disorder have not received treatment in 2020. Without treatment, mental illness may continue to be significantly debilitating, potentially leading to adverse consequences, and diminishing the individual's quality of life.

Delays can endanger the chances that a person denied treatment will access a pathway to recovery. And too often, the result of delayed treatment is overdose and death.

The primary reasons individuals do not seek treatment are fear and shame. Stigma is real for those suffering from mental health and substance use diagnosis, and it needs to be addressed from a Federal,

see Evolution on page 40

State Department of Health Warns the Public in Central New York About Alarming Increase In Opioid Overdoses

By The Office of The Governor
of New York State

On August 26, 2022, The New York State Department of Health has been made aware of a rapid increase in opioid-related overdoses in the Central New York region. Other areas of the state should also be aware and take precautions. These overdoses are likely linked to fentanyl, which is a powerful opioid that is often added to other drugs like heroin, as well as, cocaine, crystal methamphetamine and illicitly manufactured pills, including benzodiazepines and other psychostimulants like Molly and MDMA.

Fentanyl is 50-100 times stronger than heroin and has contributed to an increase in opioid overdose deaths in recent years. Nearly half of all overdose deaths in New York State now involve fentanyl. The public and providers are encouraged to recognize the signs of

overdose and take advantage of the resources available through the [Opioid Overdose Prevention Program](#) to help those in need.

"Cases of overdose are on the rise in Central New York, but we can make each overdose less likely to be fatal," State Health Commissioner Dr. Mary T. Bassett said. "Fentanyl has made all street drugs more dangerous and non-opioid drugs like methamphetamines can be fatal, too. I carry naloxone, just in case. And I urge everyone never to hesitate to call 911."

Opioid overdose signs and symptoms include slow or shallow breathing, uneven or no breathing, blue or purplish-black lips or fingernails, unresponsiveness, and unconsciousness. The signs and symptoms and characteristics to identify a methamphetamine overdose include agitation, chest pain, irregular or stopped heart, high body temperature and seizure.

Recently, Dr. Bassett [announced a statewide pharmacy standing order for na-](#)

[loxone](#) that began on Monday, August 15, 2022. Naloxone is a medication that can be easily administered to block the effects of opioids allowing a stricken person to regain consciousness and resume normal breathing. Providers, the public, and family members of those suffering with addiction are encouraged to obtain naloxone and become familiar with its administration.

Through the State Health Department's [Naloxone Co-payment Assistance Program \(N-CAP\)](#), insured individuals have co-payments of up to \$40.00 covered by the State resulting in no cost or lower out-of-pocket expenses. Individuals and family members are also encouraged to keep these simple guides handy, in case of an emergency: [How to Use Nasal Naloxone for Opioid Overdose](#) or [Emergency Response for Opioid Overdose](#).

Individual who use opioids or other substances, as well as their loved ones, are also encouraged to create [an overdose prevention safety plan](#). Support for creating an overdose prevention plan is offered

at Opioid Overdose Prevention Programs [across the state](#). Family members can also check the [Community Calendar of Opioid Overdose Trainings](#) for an overdose prevention training session to learn how to identify and respond to an opioid overdose, and be trained in how to administer naloxone. And test strips are also available to help identify other substances that may be contaminated with fentanyl.

New Yorkers looking for support with their substance use, or whose loved ones are seeking help, can find help and hope by calling the State's toll-free, 24-hour, 7-day-a-week HOPEline at 1-877-8-HOPENY (1-877-846-7369) or by texting HOPENY (Short Code 467369).

Feeling stressed by the COVID-19 pandemic? You are not alone. Call the NY Project Hope Emotional Support Helpline 7 days a week, 8am-10pm at 1-844-863-9314 or visit <https://nyprojecthope.org>.

This press release originally appeared [here](#).

Creating a Social Justice Action Framework For a NYC Social Service Provider

By **Jorge R. Petit, MD**
President & CEO
Services for the UnderServed

As one of the largest providers of community-based human services and housing in the state, the [Services for the Underserved \(S:US\)](#) team of over 1,800 dedicated staff serve over 38,000 New Yorkers each year. For more than four decades, S:US has served individuals and communities who face many complex and intersectional issues compounding with poverty and socioeconomic needs such as people who have lost their homes, people with mental illnesses and substance use disorders, people living with HIV/AIDS, people with autism and other developmental disabilities, survivors of domestic violence and veterans. Most of the persons served are people of color and come from diverse cultural backgrounds from predominantly black and brown communities and neighborhoods disproportionately impacted by social and health inequities.

S:US' core mission of driving scalable solutions to transform the lives of people with disabilities, people in poverty and people facing homelessness is predicated on embracing the solutions that contribute to righting societal imbalances and ultimately creating opportunities for all. At the heart of what we do is a firm commitment to righting the disparities caused by racial discrimination, bias and health inequity and eradicating these within our practices and programs to help us move towards true social justice.

Since starting in this role as President and CEO six months ago, I have come to better understand that S:US must fully and intentionally engage in social justice actions in ways that extend beyond the more traditional actions of a community-based social services organization. My goal is to develop a clear social justice action framework for the work we do and organize S:US to be a leader in the sector and truly deliver on our mission of transforming the lives of the people we serve and the communities we are in.

It is imperative to first define what is meant by social justice from the perspective of a not-for-profit social service provider. According to the American Public Health Association,¹ social justice is the view that everyone deserves equal rights and opportunities - this includes the right to good health. We also need to call out the systemic and racial inequities that exist, especially health inequities that negatively and disproportionality impact black and brown communities. A widely used definition of health equity is the one developed and used by the Robert Wood



Jorge R. Petit, MD

Johnson Foundation: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."² With these definitions as context, at S:US we are currently expanding our social justice action framework of what we are doing and need to do in order to eradicate these societal imbalances, starting with the following four action areas.

Access to Health/Behavioral Health Care

As a community-based health and human services organization, we need to offer timely and high quality medical, dental, pharmacy, mental health and substance use disorder supports, treatment, rehabilitation, and recovery services. At S:US we offer an array of [supports and services](#) on a continuum from care coordination and outreach to intensive community-based programming like ACT, SOS, and Pathway Home™ Teams as well as rehabilitation/habilitation programming, in order to meet an individual where they are at while providing the needed person-centered care and stability on their road to recovery. Based on recent data, the use of mental health services is very low; approximately a third of individuals with serious mental illness are not receiving mental health services (within the past year). According to SAMHSA, as a whole and specifically in NYC, non-Hispanic White individuals are more likely to use mental health services than non-Hispanic Black or Hispanic individuals and these inequities have been further exacerbated

by COVID-19.³

Relatedly, in a recent RAND publication,⁴ providers surveyed reported serious challenges in offering integrated services for individuals with serious mental illness given the current fragmentation in care that exists when people are receiving services from multiple sources, lack of bidirectional communication among systems of care, and barriers to navigating these complex systems. Additionally, recipients of services reported challenges connecting with a provider who they felt would understand them as well as difficulties in finding information on how to seek services. S:US is embarking on a transformative reorganization by launching a Total Quality Roadmap Initiative as well as embracing an Integrated Service Delivery of Care Model in order to provide a seamless, no-wrong door access to all needed health and behavioral health services as well as all the social determinants of health offerings within our portfolio.

Access to Affordable Housing

As a provider of choice for so many vulnerable New Yorkers, we need to continue to provide a roof over one's head and foster safe communities with access to green spaces and needed community amenities. Housing is at the core of everything we do. Without the stability of a home, it's harder for families to stay together, harder for people to find employment, challenges can completely overwhelm, and life can quickly spiral out of control. At S:US, we envision a city where everyone has a roof over their head and has an equal opportunity for a healthy, productive life within a vibrant community. Most importantly, our vision mandates we deliver services of equal quality, whether it be to one individual or to thousands. By addressing the complex circumstances of each individual, we change lives, improve neighborhoods, and help break the cycle of poverty for future generations of New Yorkers.

As part of the effort to house our most vulnerable citizens and decrease the homeless census, S:US develops and operates both supportive housing and affordable housing for low-income individuals. Our housing is especially intended for those whose circumstances have left them in need of a stable home. Each night, S:US provides [housing](#) and [shelter](#) to more than 4,500 people. S:US' Housing Portfolio consists of 120 buildings owned, managed, or leased in New York City. S:US has developed 19 Low Income Housing Tax Credit (LIHTC) buildings with 1,139 units of supportive and low-income housing owned and operated by the organization, and currently has 1000+ units under construction. We also current-

ly have an additional 800+ units in our LIHTC development pipeline. We are committed to continuing to grow our housing portfolio equitably and ensure that housing is a basic right.

Education/Employment/Workforce

Developing educational, vocational, and meaningful employment opportunities for persons served as well as recruiting, retaining, and nurturing a diverse, qualified, and committed workforce is another major pillar in our social justice action framework. Establishing a diverse, equitable, inclusive organization where the voice of a person served is factored in and prominent at all levels, creating space for belonging, is mission-critical. S:US is committed to maintaining a racially diverse and culturally inclusive workforce throughout the agency from leadership to maintenance staff. S:US prioritizes hiring individuals from the communities we serve. We do this by posting new positions with trade associations and networking groups for BIPOC (Black, Indigenous, People of Color), such as the Association of Black Social Workers, to recruit a more racially diverse staff. The majority (91%) of our staff identify as BIPOC. We value this diversity among our agency leadership and Board.

Food Security

S:US is also deeply committed to ensuring an equitable, participatory food system by supporting the food security of the people we serve and elevating their voices and power within food system work. By food security, we mean universal access to adequate nutritious, affordable, and culturally/personally appropriate food. Food security encompasses more than just access. Being food secure means having food available, having access to that available food, having that access and availability be stable over time, and having the tools and knowledge to use the food to meet nutritional, dietary, cultural, and personal or household needs. Our social justice action framework is anchored in our commitment to address food insecurity and hunger. S:US [Urban Farms](#) functions as an innovative supplement to the supports we offer to the individuals and families we serve, using horticulture as a tool in improving wellness outcomes and in helping our clients to achieve their personal and professional goals. Urban Farms provides therapeutic horticulture, nutritional programming, and employment opportunities through workshops, field experiences, and stewardship for our

see Framework on page 41

***The Behavioral Health Community
Has Many Vital Programs and Services to Help You During Times of Crisis
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For One Mind, Too Many Silos

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

In the worlds of advocacy and policy making, there are sharp distinctions drawn among Alzheimer's (and other dementias), mental illness, and substance use disorders. This results in separate, distinct, and insular fields of policy and practice, often referred to as "silos."

Frankly, I've never understood the imagery. Are we talking about grain silos in farm country or nuclear silos in secret locations? Whatever the source of the metaphor, what is meant by "silos" is that they are insular fields with inadequate communication, coordination, and collaboration. The result is not good for people with co-occurring disorders.

In my view, it's time for a change, not just by promoting more and more inter-agency councils, but by moving towards real integration of both policy and practice.

There are good historical reasons why a field of cognitive disorders - dementia and cognitive impairment - split off from the field of treating mental illnesses. The population of state hospitals prior to deinstitutionalization was 30% older people, mostly with "organic brain syndrome" as it was often called at the time.¹ Deinstitutionalization could not be the same for them as for people with greater functional capacity. At that time, there was also an erroneous diagnostic distinction between "organic" and "functional" conditions of the mind. "Organic" meant that there were observ-



Michael B. Friedman, LMSW

able problems in the brain on autopsy; "functional" meant that it was psychological rather than physical.

In the mid-20th century, psychoanalytic theory prevailed when it came to psychological matters.² This emphasis on intra-psychic conflict was an additional reason for the separation of the fields of mental illness and dementia. It also contributed to the emergence of a separate field for substance abuse, actually to two separate fields - "drug" abuse and alcohol abuse.

In addition, as the populations of state hospitals began to decline, Medicaid was created, and it funded nursing homes but not long-term psychiatric hospitals.³ The movement of people with organic brain

conditions to nursing homes made considerable sense both clinically and financially, but the simultaneous transinstitutionalization of people with serious and persistent mental illness to nursing homes became a scandal.⁴ It was wisely discouraged, but with unfortunately insufficient housing and other community-based alternatives.

The separation of dementia, mental illness, and substance use disorders carried over to outpatient services, which split between adult medical day care in the long-term care system and various forms of clinics, day treatment, and rehabilitation programs in the mental health and substance abuse fields.

Thus, the schisms emerged between treatment for people with so-called "brain disorders" and for those with mental and/or substance use disorders, lately referred to as "behavioral health" disorders.

This is obviously a false trichotomy. Over the years, mental illnesses and substance use disorders have increasingly been understood as brain disorders with powerful psycho-social dimensions.

For example, research studies have made it entirely clear that virtually all people living with dementia will at some point during their progressive cognitive decline also have behavioral disorders - generally referred to as "neuro-psychiatric symptoms" - including anxiety, depression, psychosis, substance misuse, behavior problems, etc. 98% is the number reported in recent research.⁵

We also know that mental and substance use disorders are frequent precursors of the development of dementia.^{6,7} In fact, they may be the early phases of as yet unnamed conditions

of the mind that begin with psychiatric symptoms and end with an admixture of cognitive and behavioral health disorders.

We also know that there is considerable co-occurrence of mental and substance use disorders.⁸

So, to put it simply, because cognitive, mental, and substance use disorders commonly co-occur, people are potentially subject to multiple silos even though each has just one mind.

What difference does this make for policy?

It suggests to me that we ought to reconceptualize policy and service systems from the standpoint of the unity of the mind rather than a fictitious fracturing. "Person-centered" care, which is frequently called for as the essence of improved care, should not be understood as person-centered dementia care OR mental illness care OR substance use care. It should be understood as care of each person's mind.

Ideally, systems of care should be remade emphasizing early identification and intervention with entry into a compassionate continuum of care rather than into non-communicative and competitive "silos."

The continuum needs to be the commonly noted mix of crisis, inpatient, outpatient, residential, rehabilitation, health, family support, community education, and care management services.

But as currently structured, these elements are not adequately integrated. And they are not adequately responsive to the social problems that people confront -

see Silos on page 41

Percentage of Overdose Deaths Involving Methadone Declined Between January 2019 and August 2021

By The National Institutes
of Health (NIH)

National data indicate COVID-era treatment expansion was not associated with harms, add evidence to support take-home treatment for opioid use disorder,

The percentage of methadone-involved overdose deaths relative to all drug overdose deaths declined from January 2019 to August 2021, according to a new study. Access to methadone, a medication to treat opioid use disorder, was expanded at the start of the COVID-19 pandemic to allow more patients to take home doses, rather than visit a clinic daily. These data indicate that broader access to treatment was not associated with harms. While drug overdose deaths both with and without methadone increased in the month of March 2020, overdose deaths that did not involve methadone continued to increase in the months after the policy changes, while overdose deaths involving methadone held steady.

Published on July 13, 2022, in JAMA

Psychiatry, this study was a collaborative effort led by researchers at the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health, and the National Center for Injury Prevention and Control, part of the Centers for Disease Control and Prevention.

In 2021, provisional data from CDC estimate more than 107,000 people died of a drug overdose, with 75% of those deaths involving an opioid. The overall rise in overdose deaths is largely attributable to the proliferation in the drug supply of illicit fentanyl, a highly potent synthetic opioid. A key component of the federal government response to the overdose crisis is expanding access to medications for opioid use disorder. However, only 18% of people with opioid use disorder receive medication as treatment. Though the benefits of providing safe and effective medication for opioid use disorder are well-known, decades of stigma against treating substance use disorders with medication has contributed to minimal reach.

"Treatment is an essential tool to stop the addiction and overdose crises, but it is vastly underused," said NIDA Director

and senior author, Nora Volkow, M.D. "This evidence adds significant weight to the argument that effective treatment for substance use disorders should be offered in an accessible and practical way that works for people who need it."

In the United States, methadone for the treatment for opioid use disorder can only be provided through federally certified opioid treatment programs, where most patients are required to visit a clinic in-person, on a daily basis, in order to get their medication. For decades, this requirement has been identified as an often-insurmountable barrier to access and retention for this treatment, particularly for people trying to balance employment, childcare, and other needs. The requirement presented unique challenges during the COVID-19 pandemic, as accessing in-person treatment became limited due to concerns about exposure to COVID-19. In order to ensure continuity of care for individuals receiving methadone treatment, on March 16, 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) allowed states to request exceptions to provide up to 28 days and 14

days of take-home methadone for stable and less stable patients, respectively.

To assess the impact and potential harms of these policy changes, investigators used data from January 2019 through August 2021 from the CDC's National Vital Statistics System, a national mortality database. Researchers calculated monthly drug overdose deaths without methadone, monthly drug overdose deaths involving methadone, and the percentage of overall overdose deaths involving methadone. They then assessed whether there was a shift in outcomes before and after the methadone take-home policy change in March 2020. They did this through interrupted time series analyses, a method of evaluation for large scale public health interventions with well-defined starting points.

Researchers found that non-methadone-involved overdose deaths increased by an average of 78 more deaths each month before March 2020, increased by 1,078 deaths during March 2020, and then continued to increase by an average of 69

see Methadone on page 34

A Trauma-Informed Approach to the 1115 Waiver: A Critical Ingredient for Success

By Jenna Velez, LCSW
and Tricia Williams
Coordinated Care Services, Inc.

Despite an increasing recognition and surge of evidence that trauma is pervasive and has significant negative health consequences, the traditional healthcare system has not yet been configured in a way that is adequately responsive to this knowledge. Conversely, the system creates barriers to implementing upstream prevention efforts and relies on costly treatment interventions when predictable healthcare issues emerge. As Dr. Robert Anda, Co-Principal Investigator of the Adverse Childhood Experiences (ACEs) Study at the CDC, says, “What’s predictable is preventable.”

While the healthcare system can do its part by routinely screening for ACEs, recognizing signs of trauma, and treating the subsequent health issues, it’s not enough to wait until the need for treatment arises, particularly when we understand the root causes. If we recognize that a calcium deficiency contributes to osteoporosis and that osteoporosis often results in costly surgeries and decreased quality of life, we expect the healthcare system to support reimbursement structures for prevention (i.e., calcium supplementation). This approach not only improves outcomes but reduces overall costs. The disconnect the healthcare system must find a way to disrupt is that prevention methods for toxic stress are often not medical in nature; there is no vaccine for trauma and



Jenna Velez, LCSW

toxic stress. But, given that there are significant, long-term health outcomes associated with toxic stress, it makes sense that the healthcare system would invest in efforts to prevent it.

Health and behavioral health care pro-



Tricia Williams

viders have experienced the frustration of this disconnect, as traditional reimbursement structures have not supported provider incentives to implement this type of whole-person care. A provider working with a pregnant woman, who is

living in unsuitable housing, experiencing food insecurity, and exposed to interpersonal violence will be reimbursed for vaccinations and routine healthcare, essential components of the maternal/prenatal health. However, the community-based organization (CBO) that addresses the family’s poverty and safety has also provided services that will significantly impact the healthcare outcomes without that same reimbursement support. Moreover, similar scenarios often play out in areas where a CBO is inadequately funded or doesn’t exist at all. This example, one of the countless ways in which alarming racial, disability-related, and economic health disparities emerge, highlights how crucial it is to prioritize health equity measures at a systemic level.

New York State is poised to address these disparities associated with the delivery of care through the 1115 Waiver, which would transform Medicaid payment structures to support the integration of social care and health care. One of the four subsidiary goals of the waiver is to build a more resilient, flexible, and integrated delivery system that reduces racial disparities, promotes health equity, and supports the delivery of social care.¹ The proposed waiver includes an explicit focus on increasing health equity amongst the most vulnerable and underserved populations. The state has a structured plan for implementation, with a significant role for providers and CBOs in making the work happen.

see Success on page 32



Marijuana and Hallucinogen Use Among Young Adults Reached All-Time High in 2021

By The National Institutes
of Health (NIH)

Marijuana and hallucinogen use in the past year reported by young adults 19 to 30 years old increased significantly in 2021 compared to five and 10 years ago, reaching historic highs in this age group since 1988, according to the Monitoring the Future (MTF) panel study. Rates of past-month nicotine vaping, which have been gradually increasing in young adults for the past four years, also continued their general upward trend in 2021, despite leveling off in 2020. Past-month marijuana vaping, which had significantly decreased in 2020, rebounded to pre-pandemic levels in 2021.

Alcohol remains the most used substance among adults in the study, though past-year, past-month, and daily drinking have been decreasing over the past decade. Binge drinking (five or more drinks in a row in the past two weeks) rebounded in 2021 from a historic low in 2020, during the early stages of COVID-19 pan-

demic. On the other hand, high-intensity drinking (having 10 or more drinks in a row in the past two weeks) has been steadily increasing over the past decade and in 2021 reached its highest level ever recorded since first measured in 2005.

“As the drug landscape shifts over time, this data provides a window into the substances and patterns of use favored by young adults. We need to know more about how young adults are using drugs like marijuana and hallucinogens, and the health effects that result from consuming different potencies and forms of these substances,” said National Institute on Drug Abuse Director Nora Volkow, M.D. “Young adults are in a critical life stage and honing their ability to make informed choices. Understanding how substance use can impact the formative choices in young adulthood is critical to help position the new generations for success.”

Since 1975, the [Monitoring the Future](#) study has annually surveyed substance use behaviors and attitudes among a nationally representative sample of teens. A longitudinal panel study component of MTF conducts follow-up surveys

on a subset of these participants to track their drug use through adulthood. Participants self-report their drug use behaviors across three primary time periods – lifetime, past year (12 months), and past month (30 days). The MTF study is conducted by scientists at the University of Michigan’s Institute for Social Research, Ann Arbor, and is funded by NIDA, part of the National Institutes of Health.

Data for the 2021 survey were collected online from April 2021 through October 2021. Key findings in the young adult group include:

Marijuana Use: Past-year, past-month, and daily marijuana use (use on 20 or more occasions in the past 30 days) reached the highest levels ever recorded since these trends were first monitored in 1988. The proportion of young adults who reported past-year marijuana use reached 43% in 2021, a significant increase from 34% five years ago (2016) and 29% 10 years ago (2011). Marijuana use in the past month was reported by 29% of young adults in 2021, compared to 21% in 2016 and 17% in 2011. Daily marijuana use also significantly increased during these

time periods, reported by 11% of young adults in 2021, compared to 8% in 2016 and 6% in 2011.

Hallucinogen Use: Past-year hallucinogen use had been relatively stable over the past few decades until 2020, when reports of use started to increase dramatically. In 2021, 8% of young adults reported past-year hallucinogen use, representing an all-time high since the category was first surveyed in 1988. By comparison, in 2016, 5% of young adults reported past-year hallucinogen use, and in 2011, only 3% reported use. Types of hallucinogens reported by participants included LSD, MDMA, mescaline, peyote, “shrooms” or psilocybin, and PCP. The only hallucinogen measured that significantly decreased in use was MDMA (also called ecstasy or Molly), showing statistically significant decreases within one year as well as the past five years – from 5% in both 2016 and 2020 to 3% in 2021.

Vaping: Nicotine vaping in the past month increased significantly among young adults in 2021 despite leveling off

see 2021 on page 32

Reflections from page 10

our consumers and their families. At times I have had to remind my colleagues and peers why they chose a career within human services. I have met established clinicians or administrators who are caught up in their own success (research, publications, and promotions) and temporarily forget or minimize the value of care and compassion. At Melmark, we have an organization-wide practice of starting every meeting with "Mission Moments," or sharing observations that highlight the successes of those we serve. This practice is one of my favorites as it helps to keep me centered in my daily work.

**Create a Clinical Environment
That Values Evidence-Based Practices**

We have the opportunity to change lives by teaching new skills whether it be how to communicate needs or wants, become more independent within a work site, learn new daily living skills, access the community, develop social relationships, and establish new strategies to adaptively respond and cope with challenges. In order to be efficient and effective, we must look to the sci-

ence and research when implementing supportive strategies for change and improvement.

Fidelity, Fidelity, Fidelity

As often as possible, I remind myself and other clinicians that we are only as effective as our ability to assess the fidelity of what we say we are doing. It is critical to evaluate systems of operation to determine effectiveness. There are times we need to pivot and make data-informed decisions for improvement in service delivery.

Learn From Those You Serve

Early on in my profession, I realized that the people I serve are influential and responsible for how successful I could be in the human service field. I think we can all look back and remember a teaching moment when the people we served taught us an important lesson or responded in a manner, which then led us to generalize this skill to other individuals, which in turn created more opportunities for success. Our consumers are our teachers, and we must look to them to make us better leaders while informing decisions to improve their lives and the lives of others in our community.

Advocate and Educate

More than ever, we need everyone's voice to educate and advocate in ways that will positively influence our future. There are many competing interests and needs for our legislators to consider and therefore it is imperative that we raise our voices in a collective way for our needs to be heard and we must be united in our messaging. The services we provide are only as good as our front-line staff. The COVID-19 pandemic and the current workforce crisis has magnified the reality of that statement. We need to speak and advocate for those who cannot speak for themselves. We must insist that our government support the needs of the most vulnerable amongst us, and the skilled staff who support them.

Maintain Your Standards of Excellence

Despite the challenges you will face ranging from underfunding, a hiring and staffing crisis affecting direct care human service agencies, and a widespread lack of understanding of the highly specialized service needs of those we serve, do not sacrifice your professional standards. It is critical that you define and establish your expectations in operational terms, which

will enable you to assess and evaluate your performance as a professional and as an organization.

It is my privilege to work among a community dedicating their lives to serve others living with intellectual disabilities and mental health concerns as they overcome challenges and obstacles. My advice is to remain steadfast and committed to those you serve and always be proud of what you do and how you do it. Our world deserves your presence, your commitment, and your expertise!

Frank L. Bird, MEd, BCBA, is Executive Vice President and Chief Clinical Officer at Melmark, Inc, and founder of Melmark New England and Melmark Carolinas. He is responsible for developing and overseeing clinical policies and practices, integrity, and resources across divisional settings. He has extensive experience in community-based human service delivery systems, having developed more than 80 programs in support of children and adults with intellectual and developmental disabilities, autism, acquired brain injury, and mental illness. He has a successful clinical history working with individuals with severe behavior disorders and his evidence-based practices have been published and presented at national conferences.

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Root Cause from page 12

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Another Call for Quality Improvement

**By Thomas Grinley, MBA, CMQ/OE
Program Planning and Review Specialist,
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of Health and Human Services**

Twelve years ago, Dr. Anthony Weiss and I presented a paper to the Healthcare Division of the American Society for Quality. We made a call for quality improvement in behavioral health and argued that, in general, what passed for quality improvement was really about compliance. We were echoing a call for quality improvement made by The Institute for Healthcare Improvement in their 2006 reports *Crossing the Quality Chasm* and *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. In that report, they called for action from “clinicians, health care organizations, purchasers, health plans, quality oversight organizations, researchers, public policy makers, and others to ensure that individuals with mental and substance-use health conditions receive the care that they need to recover.” The report also observed that there are many studies demonstrating the gap between what is known to be effective and what is actually delivered. It was also observed there is a gap in research between what is efficacious and what is effective. However,

Reese et al (2014) point out, “continuous outcome feedback may be a viable means both to improve outcomes and to narrow the gap between research and practice.”

However, it does not appear that much has changed since then. Kilbourne et al. (2015) found “the overall quality of mental health care has hardly improved since publication of these reports and, in some cases, have worsened over time.” To be sure, most organizations now have some sort of quality improvement plan in place as called for by a myriad of stakeholders. Yet, stakeholders, for the most part, are still measuring compliance. A typical quality audit is looking for process measures. Patel et al (2015) in their analysis of quality measures found that seventy-two percent were process measures. Kilbourne also stated, “Only a few studies have linked quality of care process measures to improvements in patient functioning and clinical outcomes, calling into question the validity of these measures.” We mentioned above the observation of a gap between what is known to be effective and what is delivered. This is also a process measure. We need to take it a step further and ask if what is delivered achieves the desired results. As Funk et al. (2009) point out, failure to deliver quality services is essentially a violation of basic human rights. However, the authors also point out, “poor quality of

care can be substantially redressed through concerted and systematic quality improvement strategies.”

At the same time, we also see many missed opportunities for quality improvement; seclusion and restraint for example. It is generally agreed that the use of those interventions must be reduced if not eliminated. The use of these interventions lends itself perfectly to root cause analysis. Root cause analysis can assess whether the intervention was called for and what could be done differently. It can inform training efforts and work toward reducing the use of seclusion and restraint. We recently participated in a quality audit of the use of seclusion and restraint in children’s programs. The audit looked to see if the proper forms were filled out and communicated timely to all stakeholders. There was no attempt to look at the appropriate use of the intervention or efforts to reduce the use of seclusion and restraint.

The Centers for Medicare and Medicaid Services (CMS) announced a video series titled “Teach me clinical quality language.” While it sounded promising, it was simply about more process measures that could readily be gleaned for electronic health records. CMS also provides guides for quality measures in inpatient psychiatric hospitals. Again, mostly process measures based on claims data. The Substance Abuse and Mental

Health Services Administration announced quality measures to “help states and behavioral health clinics assess treatment and document performance.” Again, they were mostly process measures. For example, one measure looked at how many people with schizophrenia were prescribed and remained on antipsychotics. Nothing whatsoever on how antipsychotics were combined with other treatment modalities or what progress toward recovery was made by those prescribed antipsychotics.

We must pay more attention to Donabedian’s (2005) model for improvement. He identifies three components to improvement- Structure, processes, and *outcomes*. Quality improvement based on outcomes is primarily what is missing in our current system. The ACT Academy (2021) pointed out that process measures “reflect the way your systems and processes work to deliver the desired outcome.” In other words, process measures are not a bad way to start but we still need to measure if they are actually producing the outcomes we are looking for. The ACT Academy also pointed out, “According to Donabedian, outcome measures remain the ‘ultimate validators’ of the effectiveness and quality of healthcare.” The ACT Academy explains further:

It is important to have both process and

see Improvement on page 32

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Success from page 29

With the intent of improving the overall health and wellbeing of individuals and families that have been marginalized and traditionally underserved, an equity-focused, trauma-responsive approach must be woven through every aspect of the service delivery system. Approaching the work through the lens of trauma-responsiveness will provide the ideal foundation for meeting the stated goals, integrating what we know about trauma's impact with prudent action steps. As the system moves to support this integration, providers can strengthen this foundation in preparation. We know there are ways in which the traditional policies and payment structures created a disincentive to implementing some aspects of a trauma-informed, equity-focused approach. If we look at these challenges and can reframe them as opportunities, innovation can flourish.

It is well documented that disparities in health outcomes exist for members of racial and ethnic communities, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, members of rural communities, and those impacted by poverty. This became even more glaring

during the COVID-19 pandemic, as rates of death and illness were higher amongst non-White individuals.² Promoting health equity requires that we understand the root causes of this type of disparity and remove obstacles to achieving better outcomes. An equity-focused approach requires a foundation of trauma-awareness, just as a trauma-informed approach requires an emphasis on equity. They are not competing initiatives, but rather interconnected conceptual frameworks that dig beneath the surface to understand how community and environmental factors contribute to harm amongst marginalized segments of the population.

Trauma-responsive, equity-focused organizational change is an endeavor that is ongoing, seeking to understand and respond to all the factors impacting both those receiving care and employees. It is an approach that acknowledges that the healthcare system has and continues to re-traumatize individuals by removing choice, power, and safety, and then makes transparent efforts to prevent this re-traumatization. Though much of this information is not novel, it can be overwhelming for organizations to determine where to start. Using a standardized assessment measure, such as the Trauma-Responsive Understanding Self-Assessment Tool

(TRUST), can provide a snapshot in time of how well organizations are implementing trauma-informed care practices across SAMHSA's 10 implementation domains. The TRUST allows organizations to view aggregated survey results from their leadership and staff, as well as receive reports and recommendations for Trauma-Informed Care practices. Organizations in NYS can access the tool and associated recommendations at no cost.³

The most important factor in addressing and preventing trauma is the presence of supportive, nurturing relationships. As such, CBOs have a strong track record in building these relationships with the individuals and families they serve and have an opportunity before them to prepare for meaningful engagement and participation in meeting waiver goals. There is no pathway to success without this, as we need to resist reverting back to the medical model that prioritizes treatment over prevention and social care. Simultaneously, provider organizations need to be strengthening their partnerships with CBOs, creating an alignment of goals and objectives, be prepared for regional health planning, and be responsive to market changes in the system. Ensuring that there is a voice at the table for CBOs and their constituents highlights the trauma-informed principles

of collaboration and restoring power.

Adopting a trauma-informed approach positions organizations to remain adaptively flexible and responsive to their staff and consumers' needs amidst a system that is persistently in flux. Approaching this current transformation with an eye toward equity means intentional restoration of power to the communities that have historically been disenfranchised, not just understanding, but responding to the voices of those with lived experience. Achieving the goals of this waiver demand this paradigm shift.

Jenna Velez, LCSW, is Sr. Consultant of System and Practice Transformation and Tricia Williams is Director of 1115 Waiver Planning and Technical Assistance at Coordinated Care Services, Inc., www.ccsi.org

Footnotes

1. https://www.health.ny.gov/health_care/medicaid/redesign/2021/docs/2021-08_1115_waiver_concept_paper.pdf
2. <https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/coronavirus-infection-by-race/faq-20488802>
3. <https://trust-survey.com/Landing>

2021 from page 29

in 2020 during the earlier part of the pandemic. The continued increase in 2021 reflects a general long-term upward trend: in 2021, nicotine vaping prevalence nearly tripled to 16% compared to 6% in 2017, when the behavior was first recorded.

Prevalence of marijuana vaping in the past month among young adults had significantly dipped in 2020 but returned to near pre-pandemic levels in 2021. Since 2017, when marijuana vaping was included in this study, past-month prevalence has doubled – from 6% in 2017 to 12% in 2021.

Alcohol Use: Reports of binge drinking by young adults – defined as having five or more drinks in a row in the past two weeks – returned to pre-pandemic levels in 2021 after significantly decreasing in 2020 (32% reported in 2021, versus 28% in 2020 and 32% in 2019). High-intensity drinking, defined as having 10 or more drinks in a row in the past two weeks, was at its highest level since it was first measured in 2005, reported by 13% of young adults in

2021, compared with 11% in 2005. However, past-month and past-year alcohol use, and daily drinking have been on a downward trend in young adults for the past 10 years. For example, in 2021, 66% of young adults reported alcohol use in the past 30 days, a significant decline from 70% recorded in 2016 and 69% in 2011.

The study also showed significant decreases in past-month cigarette smoking by young adults and non-medical use of opioid medications in the past year (surveyed as “narcotics other than heroin”) compared to 10 years ago. Both substances have been declining steadily in use for the past decade. Additional data from the 2021 MTF panel study include drug use reported by [adults 35 to 50 years old](#), [college/non-college young adults](#), and among [various demographic subgroups](#).

“One of the best ways we can learn more about drug use and its impact on people is to observe which drugs are appearing, in which populations, for how long, and under which contexts,” said Megan Patrick, Ph.D., a research

professor at the University of Michigan and principal investigator of the MTF panel study. “Monitoring the Future and similar large-scale surveys on a consistent sample population allow us to assess the effects of ‘natural experiments’ like the pandemic. We can examine how and why drugs are used and highlight critical areas to guide where the research should go next and to inform public health interventions.”

View more information on the [methods](#) behind MTF panel study data collection and how the survey adjusts for the effects of potential exclusions [in the report](#).

Results from the related 2021 MTF study of substance use behaviors and related attitudes among teens in the United States was released in December 2021, and 2022 results are upcoming in December 2022.

For more information on substance and mental health treatment programs in your area, call the free and confidential [National Helpline](#) 1-800-662-HELP (4357) or visit www.FindTreatment.gov.

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, 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.

This article was originally published [here](#) on August 22, 2022.

Improvement from page 31

outcome measures as they connect the theory of change to your expected outcomes. If you measure just outcomes, you cannot be sure the changes actually occurred in practice and therefore cannot link the improvements to outcomes. If you measure just process, you cannot be sure if the outcomes have changed, and the aim(s) achieved and therefore there is the risk that the process improved but the outcomes did not.

Are there any attempts to measure outcomes? We see annual reports on satisfaction with behavioral health services. Year after year, we see that individuals like their clinician but are not satisfied with outcomes. The same results, year

after year, suggest an obvious area for quality improvement yet we see no efforts to dig deeper into the meaning of these survey results. Many states, and Canada, use the Adult Needs and Strengths Assessment (ANSA), which could readily lend itself to outcome measurements. However, when we see the same narrative copied from year to year, we have to question the validity, if not the reliability, of this instrument.

The Substance Abuse and Mental Health Services Administration (SAMHSA), based on the National Quality Strategy, created the Behavioral Health Quality Framework (2021). It too calls for “a quality measurement framework that can be used to guide and hold entities jointly accountable for improving care access

and outcomes.” This framework found 1,400 different quality measures used by federal programs. However, it also found that “those focused on BH care, rely heavily on metrics and non-standardized quality measures, limiting use for benchmarking and value-based payment models,” and that, “Current BH quality reporting efforts are burdensome and limit resources for improving and measuring aspects of BH care most meaningful to different levels of the delivery system.”

It seems that we are not alone in recognizing the need for a renewed call for quality improvement in behavioral health.

Patel et al. (2015) suggest the reason for the focus on process measures is that most “quality” measures are based on administrative claims. They also suggest that is

because it is easy and less burdensome. Again, however, these process measures do not capture the clinical outcomes necessary for true quality improvement. Again, we go back to Donabedian's model that calls for process measures but also outcomes. Australia has mandated the use of standard outcome measures since 2000. Is it more difficult than gathering process measures? Yes, but it can be done and must be done for true quality improvement.

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Programs from page 4

thousands of homeless individuals. These teams remain engaged with an individual as they access treatment, support services, and permanent housing. Addressing the very challenging time of transition and ensuring that people have the support of professionals with whom they have formed a relationship can make all the difference.

Access to Care:**Supporting Children, Youth and Families**

Families need access to intensive services in the community, focused on helping families and youth grow and thrive. OMH has recently created the first-in-the-nation Assertive Community Treatment (ACT) teams specially designed for youth, building on the success of the traditional ACT team in which adults who have been unable to engage in traditional forms of mental health treatment are served by a multi-disciplinary team of professionals who meet with clients in community settings. We have adapted the ACT treatment model to serve children between the ages of 10 and 21 and their families. The teams will provide services and support in the home and community settings and allow young people who are at risk of entering residential or inpatient psychiatric treatment to receive

services while remaining with their families and in their communities. We are developing 20 Youth ACT teams statewide, which covers 29 counties and will serve approximately 835 children and their families.

Increasing numbers of youth and families are in serious, crisis post pandemic. Expanding Intensive Outpatient Programs and Partial Hospitalization Programs serving children provides additional opportunities for community-based treatment, so children remain in their homes and with their families while receiving a higher level of care. We have funded Family Peer Support Services to ensure that the needs of families are met at any stage in their journey whether they are first identifying mental health needs or experiencing significant challenges.

Additional support for children and families allowed for significant expansion of the Home-Based Crisis Intervention programs for children which provide short-term, intensive, in-home crisis intervention services to a family in crisis. We are expanding these teams to serve 2,640 families each year, doubling the current volume.

Finally, statewide expansion of On-Track NY, our state's First Episode Psychosis Program focuses on assisting young adults who have a recent onset of psychosis to continue their educational and vocational goals and live their hopes and dreams.

**Access to Care:
Developing Our Workforce**

Throughout the pandemic our mental health workforce healed New Yorkers with skill, compassion, and incredible dedication. With the growth in need for mental health services we are facing an unprecedented workforce shortage.

With the help of our Governor and federal funding we were able to provide bonuses and other incentives to mental health workers, and urgent recruitment and retention initiatives. This year's Governor's budget also included a 5.4 % cost of living adjustment (COLA) for our not-for-profit workforce that was critically needed. The budget also included funding for the development and expansion of peer services throughout our system of care.

The Budget also includes \$9 million for a new Psychiatrist and Nurse Practitioner loan repayment program, and we are working with SUNY and other Universities on a pipeline for engaging students in our work including fellowships, traineeships, and specialized certificate programs in our community colleges.

We are also working to grow the diversity of our workforce in all the above initiatives and are developing programs to help individuals advance in their learning and professions.

We need to work together to attract, engage and retain our future workforce for the long term.

Looking to the Future

Innovation, new ideas and new services, plays a critically important role in healthcare and our ability to reach, engage, and help people. Post the pandemic we are focusing on prevention, integrated wellness, and rapid access to quality services. We need to ensure that these services are equitable and inclusive and serve all New Yorkers and especially our most vulnerable populations. Our new Vital Signs Dashboard which uses Medicaid data broken down by race, ethnicity, gender, and region is one tool to assist us in understanding and responding to the healthcare disparities experienced by different groups.

There are many critical services we have not focused on in this article such as safe and supportive housing, employment and education, intensive rehabilitation, and recovery services, expanded peer and family advocacy, and many more that OMH focuses on daily to ensure that individuals living with mental illness can lead full and productive lives.

As we emerge from this pandemic, we have learned a great deal and we also know we have much to do throughout our healthcare system. Together with our dedicated workforce and the individuals, families, and youth we serve we can accomplish great things!

Ann Sullivan, MD, is Commissioner of the NYS Office of Mental Health (OMH).

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Methadone from page 28

more deaths each month after March 2020. Methadone-involved overdose deaths experienced a similar increase in March 2020 (increased by 94 deaths). However, the trend in number of deaths per month before and after this initial uptick remained stable, and the percentage of overdose deaths involving methadone declined at similar rates before and after the take-home policy change, declining from 4.5% of overdose deaths in January of 2019 to 3.2% in August 2021.

Taken together, these findings indicate that the modest increase in methadone-involved overdose deaths in March 2020 was likely a reflection of the overall spike in overdose deaths driven by illicitly produced fentanyl and not an outcome of the take-home policy change. Mirroring findings from smaller studies, these national data provide evidence that

the expanded opioid treatment program take-home methadone policy change established in March 2020 was not associated with increases in methadone-involved overdose deaths, despite marked increases in overall overdose deaths during the study period. Coupled with other studies that have demonstrated positive benefits related to these policies, the authors note that these findings can inform decisions about permanently expanding take-home methadone from opioid treatment programs.

“The goal of health policy should be to promote health and reduce harm, and our goal in conducting studies like this is to ensure that those policies are based on the best available scientific evidence,” said lead author Christopher M. Jones, Pharm.D., Dr.P.H., acting director of the National Center for Injury Prevention and Control at the CDC. “Projects like this also underscore the important findings

that can emerge when we collaborate across agencies under a common mission, as we continue to work together to address the overdose crisis.”

For more information on substance and mental health treatment programs in your area, call the free and confidential National Helpline 1-800-662-HELP (4357) or visit <https://www.findtreatment.gov/>.

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, 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.

This article was originally published [here](#) on July 13, 2022.

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Burnout from page 21

feedback, and shape the interventions to be most effective. This ongoing process between leadership and clinician feedback resulted in creative solutions to further inform change. For instance, clinicians pointed out to us that despite reductions in productivity requirements (based on their feedback), their caseload sizes still meant that they had to manage many cases. This forced us to go back to the drawing board and think of additional ways to reduce caseload sizes, such as the use of maintenance groups for stable clients and the use of risk stratification measures in providing care.

Upon reflection of this initiative in follow-up meetings, clinicians consistently expressed that the experience of having their voices heard was the most important byproduct of this effort. Clinicians noted

that the invitation to openly share their concerns helped counter the sense of hopelessness commonly found in clinicians experiencing burnout. Just knowing that the agency leadership was invested in their wellbeing was helpful. While some might argue that the discussions and surveys were additional tasks for staff members to complete, clinicians provided overwhelmingly positive feedback that the collaborative nature of this process was immensely helpful. They noted their appreciation for their involvement in the process and open communication, which led to more attention being cast on clinician challenges, including large caseloads and high productivity requirements. These conversations highlighted areas in which further work and collaboration is needed.

Although we cannot be certain that our results generalize to all clinicians in behavioral health settings, they do echo nu-

merous other findings from the literature concerning levels of burnout among healthcare workers during the pandemic. We do feel certain, that this process helped us begin an important conversation and identify vital action steps that have started to make key differences for our clinical staff.

Jessica Bonumwezi, PhD, and Russi Soffer, PsyM, are Psychology Fellows and Elana Spira, PhD, is Director of Research at Westchester Jewish Community Services.

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Future from page 23

system from an institution to a community base and championed the goal of recovery and community participation over surrendering to long-term disability isolation.

Now, in 2022, Federation serves up to 7,000 people annually in communities of Nassau, Suffolk, Brooklyn, Queens, Bronx, and Manhattan. We serve people with chronic illness, families/individuals living in poverty, and people aging in the

community. Our newest initiatives in development include 3 Safe Option Support (SOS) Teams in Queens and Brooklyn, an integrated mental health/SUD Certified Behavioral Health Clinic, 2 Intensive Crisis Residences, OASAS clinic, expansion of Narcan training on Long Island and New York City, telehealth access to recipients of soup kitchens, and our most recent award from SAMHSA to develop a mobile SUD treatment team serving LBGTQ+ individuals. We are also devel-

oping 2 large affordable housing projects in Brooklyn and Far Rockaway. We continue to transition individuals out of adult homes to scattered site supportive housing. We also are serving individuals who are aging in place in supported housing.

Looking to the future, Federation will continue to focus on ability rather than disability. We remain committed to developing and implementing evidence-based interventions and programs in response to need. Our goals include expanding our affordable

housing projects, establishing an integrated wellness clinic, expansion of crisis services, and looking into geographic expansion.

As we celebrate our 50th anniversary, we salute the pioneering family advocates who did so much to change the system and look forward to further enhancing the health and lives of the people we serve in the future. Please visit us at www.fedor.org for more information.

Barbara Faron is Chief Executive Officer of Federation of Organizations.

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Hope from page 1

were two state clinics for the West Side, for example, one on 110th Street at the top of the district, the other on East 17th Street, another part of the city. For the most part these clinics prescribed and/or distributed medications after brief monthly, medication management visits with people who had credentials or were training to be psychiatrists, but mostly were not very good at what they did. Many of them did not speak English. The medications were mostly first generation phenothiazines or Haldol. Their side effects of obesity, apathy, sexual dysfunction, and tics and tremors (tardive dyskinesia) were common. The Parkinsonian side effects were treated with drugs that controlled shaking but also probably had counter-therapeutic side effects.

Have I painted too bleak a picture? Perhaps a bit. Many of the people who were discharged blended into the general population and managed on their own or with the help from family and friends. And many of those who were in chronic states of severe, long-term mental illness were helped to avert acute psychotic episodes, which often included angry, screaming unforgiving voices and unrelenting delusions. Despite their chronic psychoses and very limited social skills, many had friends and found some pleasure in life. Some of them became active members of rehabilitation communities such as Fountain House or The Bridge, where I worked. Almost all of them were happy not to be in the hospital, a fate that they feared because of terrible experiences many of them had had there. So, most of them were better off in the community than in the hospital. But overall, their lives were challenging, to put it mildly.

This is the past that we can proudly say we have put behind us.

The transformation began in the mid-to-late 1970s as journalistic exposés revealed the very poor quality of life and treatment of people who had been discharged from, or were no longer admitted to, state hospitals.

Legislators were alarmed. For example, Senator Frank Padavan, who chaired the NYS Senate's mental hygiene committee, held hair-raising hearings on the West Side and elsewhere and pushed through legislation to support the development of community residences for people with serious mental illness or developmental disabilities.

At the same time the National Institute of Mental Health developed a model for community support programs (CSP) that was adopted in NYS in 1978. This model was built on recognition that state hospitals - however poorly they did it - did provide a place for people with serious, disabling mental illness to live; provided food, clothing, and other essentials; provided physical health care; provided social contacts; and even - until it was outlawed as

exploitation in the early 1960s, provided work. The CSP model wrapped these supports together in the community by calling for supportive housing; adequate public assistance, rehabilitation; crisis, outpatient, and inpatient treatment in local facilities; and case management to coordinate care. (The model also noted the need for better physical health care, but due to the fragmentation of funding for physical and behavioral health services, that did not happen for the most part, which is one reason for the low life expectancy of people with serious mental illness.)

The past 45 years have been largely devoted to incremental implementation of the concept of community support with modifications and improvements that have resulted in 100's of thousands of supportive housing units, great expansion of rehabilitation, significant expansion of outpatient services largely funded by Medicaid, and what I called in a [recent article in Behavioral Health News](#) "the triumph of recovery." Some state hospitals have survived the process of deinstitutionalization, but they are smaller, better, and offer a more diversified range of services than in the days when they were huge, overcrowded, and understaffed facilities isolated out in the country largely cut off from the rest of the mental health system.

In addition, families of people with serious mental illness, who at one time were disparaged as the cause of their progenies' mental illness, have become a powerful voice in the world of mental health advocacy.

People with mental illness have also risen from being disdainfully regarded as people who cannot speak for themselves to advocates who speak strongly, loudly, and intelligently for themselves. And they are becoming valued members of the mental health workforce as peer advocates, providers, administrators, and public officials.

Over the past four+ decades, the public mental health system has also changed in several additional, important ways. It is now more responsive to the needs of people with mental and/or substance use disorders who are not disabled but who need treatment to salvage their lives. It has placed a significant priority on the mental health needs of children and adolescents, whose needs went largely unrecognized in public policy until the early 1980s. And, at the same time, there was some recognition of the special needs of people of color (then called "minorities"), who were then and still are underserved in comparison to Whites. Efforts to reduce these disparities via affirmative action and building cultural competence have not been as successful as we hoped for, but treatment of people of color has become far better than the segregation of the races that dominated the system until the passage of the Civil Rights Act in 1964.

Since the advent of CSP, the realization

also has grown that substantial numbers of people with serious mental illness cannot or will not come to settings labeled as mental health programs for service. It is critical to go to them in the community rather than sitting in offices waiting for them to arrive and angrily throwing them off the rolls when they do not. Assertive community treatment is growing as a way to reach out to and engage people who may benefit from behavioral health services if they are provided in home and community settings.

In addition, crisis services are now being remodeled with the development of a [national 988 crisis intervention number](#), the shift away from reliance only on police to respond to severe psychiatric crises, and the development of crisis centers as alternatives to emergency rooms. And there have been some changes to the criminal justice system - such as mental health courts - to divert people with mental illness who commit minor crimes away from jails and prisons.

All of this and more has taken place through persistent advocacy for incremental improvements. We can take pride in this.

But it needs to be said, over and over again, that there is much more that needs to be done to improve our nation's behavioral health systems.

Obviously, I left out of my historical account of improvements the growth of homelessness and of the numbers of people with serious mental and/or substance use disorders in jails and prisons. Some, of course, argue that these shameful facts reveal that the move from an institution-based to a community-based mental health system was a dreadful historical mistake. I do not agree. I believe that homelessness was more the result of gentrification and the consequent loss of housing for poor people and the result of cuts to eligibility for disability benefits than the result of reducing the size of the state hospitals. And I believe that the increase in the numbers of people with serious mental illness in jails and prisons reflects criminal justice policies designed to put minor offenders - particularly drug users - behind bars for excessively long times.

But the debate about whether the system needs to move in the direction of more, longer-term, and more mandated inpatient service or to more rapid expansion of community services is critical to resolve in the coming years.

And there's much more that needs doing. More housing is needed. Public assistance needs to be secured for the future. Criminal justice reform needs to go further. The capacity of the service system needs to be increased, especially with the development of a larger and more competent workforce. Access to services needs to improve. The quality of services also needs to improve, including better translation of research findings into practice. Fragmentation within the mental health

system, between the mental and substance use service systems, and between physical and behavioral health needs to be reduced. We've talked about that, since the 1960s. Time to get it done. In addition, stigma needs to be reduced. And, at the heart of all possibility for change, is funding. Without money policy talk is empty rhetoric. There's too much of that.

The details of all this would take volumes. I just want to mention three areas that I think are particularly important - (1) reducing disparities, (2) addressing social drivers of mental illness and health, and (3) changing systems of response to problems of the human mind from blind silos of mental illness, substance use, and dementia to integrated systems rooted in understanding the unity of the mind.

- The rise of "anti-racism" and its criticism of the mental health system for its past abuses of people of color is offering important insights into race and mental health. Hopefully, these insights will lead to greater success in reducing disparities than previous efforts of affirmative action and cultural competence.
- The psychological fallout of the pandemic highlighted the power of the so-called "social determinants of mental health." Treatment alone and biomedical research alone, will not reduce the prevalence of mental disorders or adequately improve the quality of life for people with cognitive and/or behavioral health disorders. The role of the mental health system in addressing societal conditions that breed mental illness or support mental health needs to be resolved sooner rather than later.
- Finally, I think we need to get serious about addressing the co-occurrence of mental disorders, of mental and substance use disorders, and of behavioral and cognitive disorders. We will need to shake up the established order to do that. But if we don't do it, we will remain trapped in organizational structures that may be better than they once were but still are not good enough.

I often quote Robert Frost when I talk about America's mental health system because we have much to "look backward to with pride" and much to "look forward to with hope." But we have "many miles to go before we sleep."

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. His writings can be found at www.michaelbfriedman.com. He can be reached at mf395@columbiauniversity.edu.

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Spotlight from page 1

background of Outreach. Outreach first started in 1979. The organization's mission has always been to build healthier lives and meet the needs of the community we serve. We've evolved through the years and have been able to open multiple locations. We have some in Queens, Brooklyn, and in Long Island. The Outreach headquarters is located in Richmond Hill, where we provide outpatient services and have the [Outreach Training Institute](#). We have another location in Ridgewood, which offers services for adolescents and it's residential treatment. We have another one in Greenpoint that provides outpatient services. We have a few locations in Brentwood on Crooked Hill Road that provides adolescent residential services, outpatient services, and where we have another Training Institute - which I actually attended and was able to get my CASAC there. At the same location, there is a recovery residence for women. And we also have an Outreach Recovery Center at Pilgrim State where they provide outpatient and community residential services for men and veterans and an MAT hub. We have another location in Bellport which provides outpatient and day rehab. There is another location one in Roosevelt, which is our newest one, called the Outreach REACT Center where they provide outpatient services. And of course, we have left Suffolk Avenue which is the location where I currently work where we offer outpatient services. We also offer services in Spanish and English for men and women over the age of 18. At Suffolk Avenue we have a parole track, a DWI

track, a MICA program, we offer peer services, parenting, anger management, and evening and morning groups. We are also a component to the women's CR. And we are connected to Sun River Health, which is a van that provides medical services to our clients here. So, we do a lot!

It's a lot. But, if we look into what I do as a Program Coordinator at Outreach, you never really know what's happening day-to-day. Working in this field keeps you on your toes. It's always exciting because you're not going to be bored, I can tell you that much. We manage crises here. Sometimes when I come in, I have to deal with medication issues. Or I'm answering emails and handling what to do if there's somebody's calling out. I also run groups. I also do individual sessions because, as a Program Coordinator, I carry a small caseload with about 10 to 15 clients. I run reports, attend trainings, host events representing Outreach, and things like that. So, I have the best of both worlds. I have the management position as well as keeping the connection with the clients and still being a clinician.

David: You mentioned you attended the training institute where you got your CASAC. Can you tell us a little bit more about your personal journey that led you to choose this career and how you got here?

Johana: Of course. I migrated from Peru in 1998 when I was seven years old, having to learn a different language. I graduated from Brentwood High School, went to Suffolk Community College, and then attended the Outreach Training Institute.

I spent a year at the training institute and was able to get my CASAC-T. I did my internship at Outreach - I've always been here! I've been here for about nine years now. After my internship, I started out Outreach as a secretary in 2012. While I was a secretary, I attended the community college and at the same time did the Outreach Training Institute. So, I was doing double schooling and working at Outreach part time while I was a single mom as well. I completed that, did my internship here, and went to Stony Brook University. I was hired as a part time than a full timer counselor here, where I helped grow the Spanish track for the Latin community.

At some point, we had about five clinicians that offered Spanish services, which was amazing. But then, COVID hit, and things became a little bit more challenging for us. During COVID, I think everyone went through a little bit of a crisis where you were questioning what you're doing. I ended up losing my father due to COVID. After having a discussion with the director, I took some time off because I really needed it. I'm an only child and I'm very close to my mom, dad, and my daughter. When I was going through a very hard and difficult time, I was able to get support I needed from my team members at Outreach. They asked me, "What is it that you really want to do?" So, after taking some time off, I came back - not that I left the job, but I just took a little bit of like a vacation time to just recuperate and get my thoughts together. And I realized this is truly what I want to do. And you know, they have a great program. They offer tuition reimbursement here. They said, "You should go back to school! We support you." I attended online classes at New Hampshire University, where I completed my bachelor's in psychology in 2021. I'm now attending Adelphi for my master's in social work.

I started off as something as simple as a Secretary to now a Program Coordinator here at Outreach. And I realized that after going through like multiple challenges, my passion is working in this field because I realized that, despite the rough days, making an impact in someone's life that leads to change is truly my passion. We all have a voice. And I think that it's our duty as a community to learn to utilize it for those who fear to utilize their voice, and I think together, we can create change and definitely save lives.

David: You are certainly changing lives with your important work! Is the work that you do primarily with the Spanish speaking Latin community?

Johana: Yes. When I first entered, I started working with women and then, because I spoke Spanish, we figured why not offer those services in Spanish, right? I've pretty much always served the Latin community. And it's been challenging for this community. Treatment hasn't always been accepted by this community - it has been rejected because there's so much taboo around it. Because of that, it has definitely been challenging to work with them, I would say, but it's also been very rewarding to be able to see the outcome of the change - of planting that seed.

David: What are some specific challenges that you and others in the field serving the Latin community have had to face? You

mentioned the stigma and the taboo and getting past that I'm sure is part of it.

Johana: It is. But also, I think there aren't enough opportunities for people to obtain their education in this field - there isn't a lot of promotion of it. And, you know, I've noticed that the younger generation who are coming into this field are not always fluent in the language, which is an issue. The people who migrate to this to this country, it's almost like they're leaving everything behind, including the language or they're forced to learn another language, and they're not teaching their children their native language. It's challenging sometimes when we get people who apply for a position and I'm speaking to them in Spanish and they're not fluent - so they're not going to be able to serve that community. And I can't stress enough that there aren't enough clinicians who speak the language and can serve our communities. There are so many people that have decided to leave the field. I had mentioned earlier that we had five clinicians and now we are down to just two. And the stressful part about it, I believe, is the large caseload. I want to serve everyone. I was actually saying that to a group the other day, that I wish we could have so many more clinicians. But because of COVID, we had to reduce the quantity of people we serve in a room. We used to have group rooms of 15 people where now we had to reduce that to six.

David: So, you are meeting in person - it's not just all virtual?

Johana: Yes, we do everything in person. We do offer telehealth if it's needed, but because we deal with people who are mandated, it's better to have them in person.

David: So how receptive do you think the Latin community is now versus in the past to receiving help for substance use disorders and mental health issues?

Johana: I think that there's definitely been a change. I've noticed that, when I first started, the substance was only alcohol - there was no such thing as marijuana, cocaine, crack, heroin, or anything of that nature, at least in Long Island where I was located. And it's now so much more broad. They're more open to talking about the trauma and the issues that led them to the U.S. and what they've tried and the feelings and emotions around all of this. I think that after COVID, there's so much more promotion of mental health, that they're more open to it. And you know, there's implementation of the trauma screen and all of these things that really trigger further conversations, not just the substance use disorder that they're coming for. It's now so much more and it's combination of everything. It started out as just alcohol, and now it's everything.

David: Is there something in particular today, September of 2022, that is really pervasive in the Latin community as really a big issue?

Johana: I think for the Latin community, it's heavier on the alcohol and the cocaine, whereas for English speaking tracks, it's heavier on marijuana and opiate use.

Outreach's Wellness Clinic is Open!

Serving adolescents as young as 12 to adults, Outreach's substance use disorder (SUD) program in Richmond Hill, Queens, is introducing a **co-located mental health clinic**.

- ✓ Hybrid telehealth and in-person care available.
- ✓ Intake by appointment (same day or next day appointments are available). Telehealth and in-person options are available.
- ✓

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Richmond Hill, NY 11418

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see Spotlight on page 39

Parity from page 16

specifically designated as “psychiatric.” Insurers must accept and initiate processing of E/M codes from any physician, including a psychiatrist, for the treatment of mental, nervous, or emotional disorders or ailments. This was yet another step forward in achieving parity in coverage of the treatment of mental illness.

Parity Implementation

Despite significant gains over many years, the struggle for parity is still not over. NYSPA and other advocates continue to address the need for full implementation and enforcement of the parity statutes. To assist in this fight, in 2018, New York State established CHAMP, an independent health insurance ombudsman program for substance use disorder and mental health care.² CHAMP educates and assists New Yorkers in accessing treatment and insurance coverage for substance use and mental health treatment. Free to the public, CHAMP helps with investigation and resolution of complaints and violations of the parity laws.

Also, in 2018, NYSPA championed the Mental Health and Substance Use Disorder Parity Report Act, a state law that requires health plans to implement formal parity compliance plans along with regular reporting to the state. Recognizing the need for enhanced transparency and accountability in parity compliance, the Legislature passed this bill by a near unanimous vote in both houses. This legislation directs the Department of Finan-



Rachel A. Fernbach, Esq.

cial Services to collect data from insurers on rates of utilization review, prior or concurrent authorization, adverse determinations, percentage of claims paid on an in-network and out-of-network basis and network adequacy in order to determine compliance with federal and state parity laws. The data is then analyzed and used to prepare regular compliance reports.

Finally, the 2019-20 New York State Budget included a comprehensive overhaul of the New York Insurance Law in order to eliminate discrimination in coverage of care and treatment for behavioral health conditions. These new provisions, called Behav-

ioral Health Insurance Parity Reforms (BHIPR), include coverage for *all* mental health conditions, substance use disorders and autism spectrum disorders, as defined in the most recent edition of DSM or ICD. BHIPR also established certain restrictions on the use of prior authorization by plans and requires insurers and health plans to post information about their in-network providers of mental health and substance use disorder services, including whether the provider is accepting new patients.

Ongoing Advocacy Efforts

Insurance carriers continue to engage in utilization review of claims for behavioral health services, including pre-payment review, claims denials and post-payment audits. While health plans are legally permitted to limit covered benefits to only medically necessary care and treatment, some utilization review efforts appear to be conducted solely in connection with claims for mental health treatment or are more restrictive and more stringent than medical necessity reviews of treatment for non-behavioral health conditions. NYSPA continues to work to assist its members as these reviews continue. NYSPA staff regularly write letters to insurers and interface with government regulators on behalf of our members.

Another troubling parity issue that impacts both providers and patients is reduced access to care resulting from inadequate reimbursement for mental health and substance use disorder services. In the out-of-network context, without adequate reimbursement, patients may be unable to

pay out-of-pocket for their care and may be forced to discontinue treatment. In this way, inadequate reimbursement acts as a barrier to care because the quality of an out-of-network benefit is measured by the reimbursement that the patient will receive under the terms of their health plan. In some cases, reimbursement may be so low as to effectively constitute no benefit at all.

Unfortunately, inequities in reimbursement and utilization review for behavioral health services continue to negatively impact access to care. Even though we now have powerful and comprehensive federal and state laws requiring parity, the fight for parity continues on a new front - full implementation and enforcement of the rules already in place. NYSPA will continue to work on behalf of our members and the larger mental health community until inequitable treatment of mental health is a truly a thing of the past.

Rachel A. Fernbach, Esq., is Deputy Director and Assistant General Counsel of the New York State Psychiatric Association and incoming Chair of the Mental Health News Education, Inc. Board of Directors.

Footnotes

1. www.psychiatrictimes.com/view/picnic-parity-grows-nationally

2. CHAMP, a joint program of the New York State Office of Mental Health and the New York State Office of Addiction Services and Supports may be reached at (888) 614-5400 or ombuds@oasas.ny.gov.

Consumer Perspectives from page 8

“I lived on the streets for a long time. I was hospitalized for substance use many times. I was eligible for an S:US housing program because I had been homeless and had a psychiatric diagnosis and medical issues,” said Robert. “The last five to six months have been a real challenge for me. I had been suffering from panic attacks and acute paranoia and I ended up in the hospital again. I had a lot of restlessness and problems with anger. Mental health has been a real challenge. I just need people to check in and to make sure I’m doing okay. It’s nice to have S:US staff check on me. They are really caring and follow-up on what they say. They actually just sit down and listen to you and let you talk; to me, they are helping me out a lot. I really appreciate S:US.”

We’ve Grown and Made Progress

Things have changed a lot for all of us - whether it’s the past few years or even just the past couple of months. We’re all working on our sobriety, we are housed, and we’re on a journey to stabilize our mental health.

“From 2017 to now, I’ve experienced major changes, especially because I was an addict and now, I’m sober. I am forcing myself to go to therapy even on days when I don’t want to. Everything has been overly emotional, but I’ve been starting to see more stability in my life. S:US has been helping me with taking medication. I feel like my PTSD and OCD went down tremendously since taking my meds. Talking with my therapist weekly also is a huge help,” said David T. “S:US got me

into more intense therapy for my eating disorder and helped me get in touch with my family. When my grandmother died in November, it was a really dark time for me. I was having a lot of issues with panic attacks. Coming to the clinic was a saving grace. I utilized the tools they gave me to get through the grief and I started coming to programs, it helped make me a stronger person. Through the help of my therapist, substance use counselor, and peer specialist, I have been able to maintain a healthy lifestyle.”

“I’ve grown a lot. I used to feel like I didn’t care too much about stuff. I was not in the right state of mind, not taking medication, I wasn’t going nowhere. I had depression, self-loathing doubt, suicidal thoughts, I was fighting with people. Since S:US has helped me, I’ve been on my way to a clearer, better, more sober path. Before when I had been to places other than S:US, I didn’t feel like it helped, they just sent me to the hospital and let me go but I had to figure it out on my own. S:US has stayed with me,” said David D.

“I have lots of challenges still, but I’m making progress. I go to groups, I attend meetings, I talk with my case workers and my therapist. I used to be a heavy drinker, but I quit drinking and quit smoking. I’ve been in this home for five years, which is the longest I’ve been in one place, as I’m used to moving from here to there a lot. I still struggle with issues and I’m working on them,” said Robert. “S:US services could’ve benefited me earlier. I always tried to do things on my own, but if I had these supports all along, I would’ve been able to be a lot more stable, do a lot more, and could’ve gotten hooked up with a lot

of more agencies. Mentally I would’ve been a lot more stable. I think it would’ve helped me get stable and stay stable a lot longer.”

Support Systems Save Lives

Connecting with other people is an essential part of life. When we get down, we need our support system to keep us afloat. The three of us don’t have many people we can go to, but S:US has helped us tremendously.

“I was living with my wife, then I had to leave when she passed away. I was worried about ending up on the street. S:US helped me get an apartment and get support,” said David D. “When I needed someone to talk to, when I felt like being violent to myself or killing myself or someone else, S:US staff came and talked to me, and they listened. They came and never let me go since then. That really helped.”

“S:US also helped with my career as a writer. I was HIV-positive and just got out of a homeless shelter into an apartment, but I didn’t know how to function and be patient. Now I feel very centered. I actually want to live now; I didn’t have that sense before. I was so alone before. I think about how that place saved my life. I honestly don’t know where I would be right now, I’d probably still be an addict somewhere. I’m really grateful for the team I have. They are saving lives, for people with addiction,” said David T.

“It’s nice that S:US staff come see me. They help me to stabilize. I don’t have a lot of people that visit, just having S:US staff visit and them talking with me helps me to sort out things that I need to sort

out. They are a great support network; they have helped out a lot. I’m graduating from one level to another level and as a reward they got me a bike, so now I bike all over the place,” said Robert.

Messages for Others Experiencing Similar Challenges

We’ve all been in difficult, dark places and we have messages to share for other people who may be losing hope. Don’t give up. You can get your life back on track. There is help for people like us - we are regular people too.

“It’s never the end,” said David T. “When I first came to S:US with all of my issues, they made it very clear that this was a transition period, and it wasn’t permanent. There was a light at the end of the tunnel, I probably need a few more years of therapy still but they really helped me through very difficult moments.”

“You can’t take this life for granted. You never know who is going to be there and who is not. Don’t do drugs. Stay in school. I can’t read or write and I’m 48 years old. It’s hard because I can’t read my grandkids a story. I definitely regret not staying in school,” said David D. “What’s helping me most is my mother and my sister.”

“It’s been a long journey. People with mental illness and physical problems, we are people too. We are just like everybody else. I’m a survivor. I’m very resilient. And the big thing is that I want to be treated like anybody else,” said Robert.

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

Modern from page 18

terminology across the industry for conditions or patients. We must choose to be proactive in the use of a person-first terminology. To help foster positive change in the design industry, the focus must shift towards creating equality and equity within design, including how spaces are formed, how they are named and operated, and how operations and occupants are described. In doing so, designers can bring respect and dignity to patients, clients, and staff. This movement removes barriers when accessing care and lessens patient and client anxiety in the overall process. It helps support the paradigm shift from, "What's wrong with you?" to "What happened to you and how can we help?"

Designing a Welcoming Patient/Client Experience

To coincide with updates in healthcare language, architecture and interior design professionals are updating the way they design mental and behavioral health facilities. One primary area of focus is implementing clear and inviting interior, exterior, and wayfinding signage. Designers should work to consider the sensory reaction to a space. Typically, people experiencing mental or behavioral health issues are either hyper-sensitive to their environment or have sensory impairment. Design considerations are important, such as how welcoming each space is, what the path of travel from the parking lot to the reception area looks like, the design of corridor circulation, and dignity/privacy versus security and safety within patient rooms.

Identity-First Examples	Person-First Examples
Disabled person	Person with a disability
Autistic person	Person with autism/person on the autism spectrum
Intellectually disabled person	Person with an intellectual disability
Addict	Person with a substance use disorder

Examples are taken from [thesaurus.com](https://www.thesaurus.com)

Designers can employ several design strategies to make patients and clients feel welcome, including:

- Normalized ligature-resistant furniture, fixtures, and equipment
- Appropriate acoustics in all facility spaces
- Warm, natural, and stress-reducing materials and finishes that can be easily sanitized
- Expansive windows/daylighting
- Connection to nature, including gardens, walking paths, and natural features
- LED lighting with options for individualized control/circadian rhythm programming

Additionally, one growing design innovation is to create sensory spaces for patients and staff to relax and decompress or proactively excuse themselves. These spaces are used for mindfulness, not for isolation or punitive institutional actions. Sensory spaces typically have soothing

colors, artwork, comfortable furniture or materials, changeable light settings and colors, music, and some include water soundtracks or monitors with guided decompression or breathing exercises.

Embracing the Approach in a New Facility

Our team is currently designing the New Psychiatric Hospital in Tulsa, Oklahoma, which will be a leading crisis center in the area. The Oklahoma Department of Mental Health and Substance Abuse Services is embracing a design approach that reduces the stigma surrounding mental health. This facility is being designed so that spaces feel warm and welcoming for their patients. Ideally, as patients become more comfortable and trusting of their environment, they will open more fully to their treatment plans and actions.

Rethinking the Way We Think and Communicate About Healthcare

The U.S. mental or behavioral healthcare system is slowly adapting to the

modern world, but there is still much to be done. Changing how we look at mental health and behavioral health patients, updating our language and terminology, and improving our design strategies will have a profound impact on both the patient/client experience and their recovery process. When we speak with dignity for others, we offer them respect and value and support our vulnerable populations.

Brooke Martin, AIA, NCARB, CCHP, LEED Green Associate, an associate and project manager based in Dewberry's Peoria, Illinois, office, has 17 years of experience. She has a passion for justice architecture, and focuses on supportive, trauma-informed, intentionally humane design that supports positive, treatment-focused outcomes within skill-building and learning environments and integrating functions that fit within a community's continuum-of-care. Martin can be reached at bmartin@dewberry.com.

Cassey Franco, AIA, LEED AP, is a senior architect based in Dewberry's Tulsa, Oklahoma, office, has nearly 30 years of experience in design of healthcare facilities. She works to bring functionality, constructability, and aesthetics to her projects and has a passion for implementing transformative designs for restorative outcomes. Franco can be reached at cfranco@dewberry.com. For more information, visit www.dewberry.com.

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Workplace from page 20

higher premiums are typically better suited for employees who need services like weekly therapy sessions, routine psychiatrist visits, and ongoing medication. You want to offer your staff insurance options that they can genuinely afford to use. Pay close attention to your deductible, inpatient treatment expenses, and copays for mental health appointments.

Should you go with HMO or PPO? It is hard to choose between HMO and PPO plans because each has advantages and disadvantages for the insured. There may be employees who would prefer the choice to join an HMO if your company is operating in an area where HMO health systems are standard. However, you should make an effort to avoid presenting an HMO as the only choice.

Pick a PPO if you must stick with a single insurance company or plan. The choice of healthcare providers is more flexible with PPO insurance, and recommendations are often not necessary to

see a mental health professional. This is crucial for persons seeking mental health services because successful mental health treatment depends on the patient locating a therapist, psychiatrist, or institution they feel at ease. One system, and its particular set of treatment practices, cannot meet everyone's specific needs in a field as complex and personal as mental health, so it is somewhat understandable that some large HMO healthcare systems have come under fire in recent years for the quality of their mental health services.

Can an employer refuse to hire or fire candidates or employees for mental health issues? Because a person has a mental health issue, an employer cannot mistreat them. This includes firing, refusing a job offer, a promotion, or requiring them to take time off.

An employer is not required to employ individuals who represent a "direct threat" to safety or hire or maintain workers in positions they are unable to fulfill. However, when determining whether a person

can do the job or if they constitute a safety risk, an employer cannot base their decision on misconceptions or preconceptions about their mental health condition. Before denying employment due to a medical condition, an employer must prove that a person cannot perform the essential functions of the position or pose a serious risk to others' safety.

The importance of employee assistance programs - Employee assistance programs (EAPs) are becoming more and more common as a means of helping employees, including support for addiction recovery and mental health care. EAPs facilitate access to expert assistance for mental health issues, addiction rehabilitation, legal aid, and directories for finding child and eldercare services. EAPs frequently cover a small number of employee counseling sessions. These programs are an excellent approach to offer additional help, but they should not be used in place of comprehensive mental health coverage under your employer's health insurance plans.

Closing Thoughts

One of the most crucial actions you as an employer can take to encourage employee wellbeing in the workplace is to offer proper mental health insurance coverage. You should create a welcoming and supportive work environment and encourage staff members who need support to seek treatment from mental health professionals. Employee access to mental health care can also be aided by providing flexible leave and time off policies, EAPs, and an atmosphere of open communication.

Joann MUNDIN, MD, is a board-certified psychiatrist who has been in practice since 2003. She is a Diplomate with the American Board of Psychiatry and Neurology and a Fellow with the Royal College of Physicians and Surgeons of Canada. Currently associated with [Mindful Values](https://www.mindfulvalues.org), she provides assessments and treatment for patients with severe mental illness. For more information, email dr.mundin@mindfulvalues.org.

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Together from page 17**Stephanie Madison, LMSW**

amongst themselves in order to better serve the whole person.

We recognize the old adage that tells us we can't be all things for all people. We also recognize that people need - and deserve - choices in their care. But we are certain we can be among the best at what we do, for those we serve - and that we are better together.

Stephanie Madison, LMSW, serves as

**Charlotte Östman, LCSW-R**

President/Chief Executive Officer of The Mental Health Association of Rockland (MHAR). Charlotte Östman, LCSW-R, serves as Chief Executive Officer of The Mental Health Association of Westchester (MHAW). To learn more about MHAR, please visit mharockland.org or call (845) 267-2172. To learn more about MHAW, please visit mhawestchester.org or call (914) 345-5900.

Pandemic from page 22

strategies in partnership the NYC Department for the Aging, NYC Office of Mental Health and Hygiene, Mount Sinai Health System, New York-Presbyterian hospital system, SAGE/Services and Advocacy for GLBT Elders, VISIONS/Services for the

Blind and Visually Impaired, and dozens of other organizations. She is a member of the Board of Directors of The Coalition for Behavioral Health Agencies in New York City, where she also serves as Chair of the Healthy Aging Committee.

To learn more about SPOP please visit www.spop.org or call (212) 787-7120.

Spotlight from page 36

That's the difference that I've seen.

David: This is clearly a stressful job. How do you and your colleagues handle the stress and avoid burnout as substance use disorder counselors?

Johana: We're very fortunate to be able to offer supervision - we have individual supervision on a weekly basis. We also have case conferences, which is where we all get together once a week for about an hour and a half (sometimes we go over a little bit) on a weekly basis. We also have a great team. I'm very fortunate to work with such a great team. We have three supervisors here. Our doors are always open and we talk to each other. I think that is the best thing to do if you've had a really heavy session, you can go in and talk to someone about your feelings. You can talk about what you're feeling if there's some countertransference going on. We also encourage self-care. Outreach gives us personal days and days off sometimes. If you feel like you're overwhelmed, we encourage you to take a day off and do something for yourself. Personally, I take therapy. I have a therapist I see every week and have been doing so for years. That's been very helpful for my own growth and my personal self-care - she encourages me to go out and do things I love.

David: It sounds like you have a supportive family at Outreach.

Johana: Exactly! We eat together. That's another thing, we eat together when we're stressed. It's maybe not the best coping skill, but we'll say, "Are we ready to order tacos today?"

David: We've talked about some of the challenges and the stress that you grapple with. Can you share some of the highlights that come with your work?

Johana: For the people that get into this field, it's really because you're passionate about helping others. But for me, it's also about being able to see the progress, no matter how small it may seem. You're planting the seed for someone, you're doing this change, you are helping others get to where they need to be. People who come here are mandated and I can't sugarcoat that. And sometimes that can be a little bit of a challenge because we struggle to get them to want to see the help that they need. There's a difference between seeing somebody who wants help versus somebody who doesn't know how to ask for it. It's not that they don't want it, they just don't know how to ask for it or they don't really know that it is an issue in their life. Engagement is something huge for us and we get pushed back.

The other day, I was talking to someone about the difficulty of realizing that you

Technology from page 19

the story of a client's success through data. A chart should be evaluated at a glance, from intake to discharge including all payments and insurance or Medicaid coverage. The provider can take this data and help create a solution specifically for the patient from day one of employing technology. The future of healthcare lies in the utilization of technology. Lightning Step Technologies partners have over 100 years of collective experience in the psychiatric and substance abuse treatment field as operators, clinicians, front-line staff, and accountants. This distinctive background allowed us to formulate a software platform that is designed specifically for the evolving rehabilitation services market.

The top priority of any behavioral health facility is superior measurable client services. For those of us that have been closest to the fire, we understand clients are fighting their own battles

with mental health and addiction. Understanding that treatment center operators need to focus their time on increased patient care and not sitting behind a computer is critical. That's why there is a vital need to integrate technology into facilitators' daily operations to minimize problems of the past and overcome challenges of the future.

Kirk Monroe, MBA, CPA, is Chief Executive Officer of Lightning Step. For more information on how Lightning Step can help solve your challenges, reach out to us through our website at www.lightningstep.com.

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Depression from page 24

for all entities to explore and examine ways they are addressing emotional health versus physical health as a benefit to their employees. Sadly, depression accompanied by suicidal thoughts can result in lethality.

Mansour (Max) Banilivy, PhD, is Director of Clinical Training, Education, and Internship Placements at WellLife Network.. Please send your comments and questions to Dr. Max at max.banilivy@welllifefenetwork.org.

Resources

- [The Substance Abuse and Mental Health Services Administration \(SAMHSA\)](https://www.samhsa.gov/)
- [American Psychological Association](https://www.apa.org/)
- [Mental Health America](https://www.mentalhealthamerica.net/)
- [Depression.org](https://www.depression.org/)
- [The National Suicide Prevention Lifeline: Call 988](https://www.nationalsuicideline.org/)

really can't do this on your own. As much as you want to think you can, you really can't and getting there is a little difficult but it's also rewarding. It's rewarding to see that, wow, it took us this long to get to the conversation of, "You know what, maybe I need this." I always say, "I'm not here to tell you the answer. I'm here to help you find the answer. Whatever that means for you."

David: It must be really gratifying to see the progress for people from when they're really struggling to eventually feeling empowered to take steps to improve and make changes. Of course, the road to recovery will continue to be an ongoing process, but you are helping them to reach certain milestones and directing them down the right path so that they may continue to make progress in their lives.

Johana: Right. And just because something means something to me doesn't mean it's going to be effective for them. It's really about providing person-centered care and working with them to achieve their goal, whatever their goal is.

David: I'm sure every situation is different.

Johana: Absolutely.

David: With the workforce shortage, you mentioned the difficulty of filling positions for Spanish speaking clinicians and counselors. Can you provide a message of inspira-

tion and hope for people who are considering a career as a counselor working with people living with substance use disorders?

Johana: I can say that this field is a growing field - there's so much need for the services. You will have multiple opportunities - there are so many agencies who provide different tracks or different things that you may be interested in. I think it's really important to remember that it's really about changing one person at a time. My biggest message would be that the substance use field is challenging. It takes a special individual to want to go on a journey with a powerful meaning to change the world through healing, recovery, and learning to advocate for those who truly need it.

David: That's really a nice message. You're really making a difference in people's lives and making a positive impact on the overall community. I think that's a good place to stop. I really value our time together and I want to thank you for taking the time to talk with me. It's been such a pleasure to speak with you.

Johana: Same! Thank you for having me here.

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Evolution from page 26

State and City level. Failure to address stigma and the resulting shame will delay successful outcomes.

The devastation caused by the mental health and substance use crises has taken its toll. Now more than ever, we need creative and innovative strategies to make an impact.

In recent years, New York State and City providers, communities and government officials have joined together to create new behavioral health models that individualize treatment for varying patient types. These new models operate on a grassroots level with partners from the community.

City-Backed Short-Stay Treatment Model

New York City pioneered Support and Connection Centers, an entirely new behavioral health model. Support and Connection Centers provide an alternative to avoidable emergency room visits or criminal justice interventions. The patient receives an introduction to available treatment options while having their immediate health needs addressed.

Each of these community-based Centers offer short-term clinical and non-clinical services for people with mental health and substance use needs. Stays are voluntary for individuals - who we refer to as "guests" - and last no more than five days.

Support and Connection Centers promote individualized, person-centered engagement and stabilization, and offers community-based linkages to follow-up care. The goal is to provide immediate treatment and support and offer appropriate long-term or outpatient care. For many guests, the Support and Connection Center is their first experience with healthcare, social services, and recovery professionals.

Each Center has an interdisciplinary staff of mental health, substance use, peer recovery, and social service experts who provide:

- Screening and assessments
- Counseling services
- Short-term case management
- Links to ongoing health and social care
- Medically supervised substance use withdrawal services
- Access to naloxone
- Support from certified Peer Recovery Specialists

In addition, guests can access other on-site services to fill basic needs such as food, showers, laundry, and overnight shelter.

The facility does not operate as a walk-in clinic, shelter, or treatment program. All guests who arrive at the local Support and Connection Center are referred by a community outreach team run by the New York Police Department and B-HEARD.

In New York City, B-Heard teams consist of criminal justice, medical, and mental health professionals from the NYC Police Department, Fire Department's Emergency Medical Services, and NYC Health + Hospitals. Team members determine whether the individual should be escorted to the Support and Connection Center or if the case requires a different direction.

The Health Department developed the Support and Connection Center program model in consultation with NYC-based behavioral health service providers Samaritan Daytop Village and Project Renewal, along with feedback from community members and experts.

This innovative program model is currently being operated at two locations:

1. Bronx Support and Connection Center
Operated by: Samaritan Daytop Village
Location: 3050 White Plains Road, Bronx, NY 10467
Partnering with the 47th Police Precinct
2. East Harlem Support and Connection Center
Operated by: Project Renewal
Location: 179 East 116th Street, Harlem, NY 10029
Partnering with the 25th Police Precinct

Each Center has the capacity to serve up to 25 people per day - a projected total of 2,400 people per year at a cost of \$10 million annually over 10 years.

State-Funded 24-Hour-Stay Crisis Clinics

In July 2022, New York State Governor Kathy Hochul announced \$75 million in funding to open nine new Crisis Stabilization Centers throughout New York State as part of the State's comprehensive crisis response plan. The award was a collaboration grant from the New York State Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS).

As 24/7 operations, Crisis Stabilization Centers provide evaluations, care and treatment to any adult, child or adolescent experiencing a behavioral health crisis. In this model, community members can voluntarily enter the Center and request immediate medical attention for an acute mental health and/or substance use crisis.

Unlike the Support and Connection Center, patient stays are limited to 24 hours. However, during that time, an interdisciplinary team tends to patients' varying behavioral health needs, connects them to a peer recovery volunteer, and provides linkages to community services.

Currently, there are plans to create two distinct types of Crisis Stabilization Centers: Supportive and Intensive.

1. Supportive centers target patients at risk of a mental health or substance use crisis that cannot be managed without on-site support. In these cases, the center provides voluntary peer recovery support and 24/7 stabilization services.
2. Intensive centers focus on patients with more acute behavioral health symptoms who require urgent treatment. Staff offer all services including medication treatment, peer recovery support, and 24/7 stabilization.

These Centers will be jointly licensed by OMH and OASAS under Article 36 of the Mental Hygiene Law. Samaritan Daytop Village was awarded \$1.4 million per year for five years to implement and operate a Center in Rockland County. Currently, the State is working to add a total of three Crisis Intervention Centers in New York City and the Capital Region.

Next Steps: Educating, Training and Funding

We can find inspiration by New York City and State's targeted action plans. However, we should consider further expanding on their examples. By thinking outside of the box, we can uncover new ways to treat the untreated and prevent the preventable.

In the early 1980's, the HIV epidemic demanded creative ideas to promote awareness and educate communities at every level in every community. In response, a new treatment model was developed and implemented called the ETF (Education, Training, and Funding) Model.

As a result of the ETF model, communities across the state began to see and hear massive numbers of public service announcements. Funds were funneled toward training and education, including billboards and TV/radio/transit advertising. Both health providers and medical payments were increased through enhanced health insurance reimbursement rates.

A more recent success story demonstrates a feat once thought impossible: We reined in Medicaid costs, thanks in part to the ETF Model, through the creation of the Health Homes model. Health Homes

eased providers' ability to deliver and coordinate care. More patients received care, and costs were reduced.

Just two and a half years ago, the pandemic was another example of the ETF Model in action. Free vaccines, numerous vaccine clinics in partnership with local healthcare institutions and governments, online scheduling of vaccines, frequent print and broadcast PSAs, and webinars were several examples. Where would we be today if we did not educate the public and offer free testing and vaccines?

Finally, we are embracing the ETF Model to curb today's behavioral health crisis. Program models such as the Support and Connection Centers and Crisis Stabilization Centers are perfect examples of this. These programs will allow us to expand access, integrate care, diversify services, strengthen the workforce, and reduce unnecessary costs overall.

Much has been done but we still need to fund for additional Prevention, Treatment, and Recovery Support and Management. We must also continue to embed innovative health centers within communities and do so with the support and financial backing of State, City, and local governments.

As we embrace our future, we can make an impact if we continue to work together to overcome the current mental health and substance use crisis.

Charles Madray is VP for Health Systems and Community Programs at Samaritan Daytop Village.

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Framework from page 27

network of more than 70 community farms and garden spaces throughout New York City. Urban Farms programming also includes distribution of farm and garden harvests. The 2021 seasonal yield included 8,700 lbs. of fruit, vegetables, and culinary herbs (the equivalent of 7,250 meals) with an estimated market value of \$43,500 provided free-of-charge to program participants and S:US housing residents.

All individuals served by S:US earn less than the median income in NYC. The vast majority of individuals and families are dependent upon some form of public assistance, including Social Security Disability Insurance, Medicare/Medicaid, Temporary Assistance for Needy Families and rental assistance, and SNAP benefits. During a 2018 program assessment that surveyed 224 residents from S:US supportive housing, many persons served at S:US indicated some degree of food insecurity. See Table 1: Health Outcomes Demonstration Project.

To further our efforts at eradicating food insecurity, S:US staff - responding to the needs of the people we serve, their families and the larger community - undertook the development of Community Fridges and Lending Libraries. This year, we launched community fridges in Brooklyn and Bronx communities in need where we work and live in. We plan to open more of these valuable resources as we continue to find other locations where we know there is a need.

We also launched an internal Food Security Resource Hub to assist our staff and the people we serve on how to find and access food security resources.

These are just a few of the critical areas - access to quality, timely health and behavioral health supports, services, and treatment; employment opportunities for all as well as having a diverse, equitable and inclusive workplace of choice; safe, dignified, beautiful affordable and supportive housing;

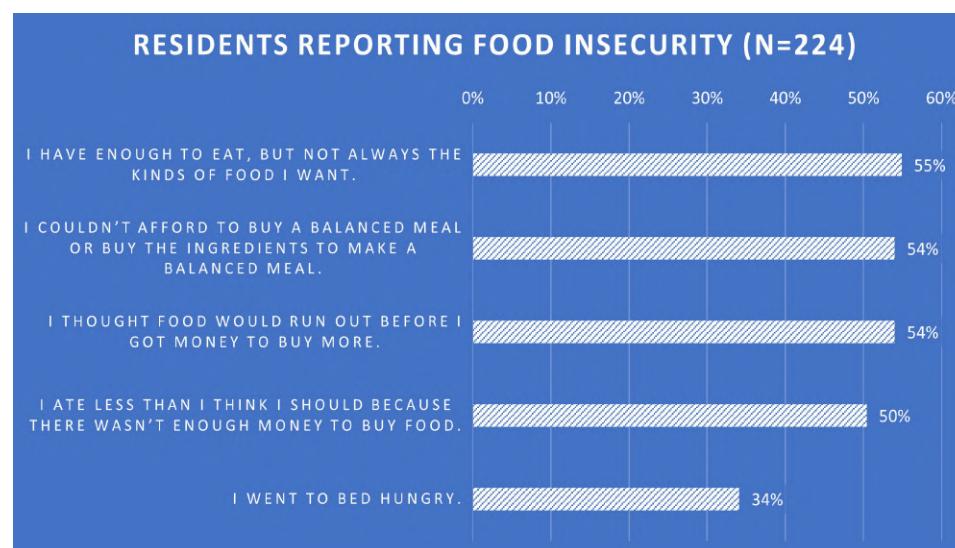


Table 1: Health Outcomes Demonstration Project

and food security - that we must impact and ultimately eradicate as we address social injustices and other systemic barriers that have negatively impacted our communities. Truly, our purpose is to transform lives, improve neighborhoods, and boost future generations. Because no New Yorker should struggle alone when we can all stand together.

Jorge R. Petit, MD, is a community psychiatrist and the President and CEO for Services for the UnderServed (S:US). S:US drives scalable solutions to transform the lives of people with disabilities, people in poverty, and people facing homelessness: solutions that contribute to righting societal imbalances. Founded in 1978, S:US works with more than 37,000 individuals and their families every year to create pathways to rich and productive lives by offering housing, employment, skills-building, treatment, and recovery services.

Prior to joining S:US, Dr. Petit was the President and CEO for Coordinated Behavioral Care (CBC), a not-for-profit organization dedicated to improving the quality of care for individuals with serious mental illness, chronic health condi-

tions and/or substance use disorders, through a Health Home, an Independent Practice Association (IPA) and an Innovations Hub.

Dr. Petit was the Regional Senior Vice President for New York State for Beacon Health Options and before that was the Founder and President of Quality Healthcare Solutions, a consulting firm that provided training and consulting services for healthcare systems including community-based behavioral health agencies, hospital systems, and local and state regulatory entities. He was the former Associate Commissioner for the Division of Mental Hygiene in the New York City Department of Health and Mental Hygiene.

Dr. Petit has been the primary lead on several large-scale grant-funded implementation projects including: Integrated Care Models to Improve Health Outcomes and Reduce Poverty funded by the Robin Hood Foundation; the Depression Care Management in Primary Care funded by Forest Laboratories; the Behavioral Health Care Collaborative (BHCC) funded by NYS OMH and the BHCC expansion grant funded by NYS OASAS.

Silos from page 28

including racial and class disparities and inadequate housing, income, family support, community acceptance, protective services, and more.

As a result, people, especially older people, are too often shuttled between, or shifted from, one system to another without regard to the continuity of their lives. Despite decades of talk about integration of care, we still fit people to the system rather than vice versa.

The pursuit of the ideal, of course, is often elusive. But it really is not far-fetched to believe that at the very least the long-term care system can and should develop expertise in serving people with co-occurring cognitive and behavioral health conditions and that the fields of mental illness and substance misuse could and should develop expertise in serving people who also have, or will develop, cognitive impairments.

All of this also suggests that advocates for the various silos ought to make an effort to work together to promote better lives for people with cognitive and/or behavioral health disorders.

Yes, that's hard to do when there is such intense competition for limited resources. But for the sake of the people who have problems of the mind, it needs to happen. Advocates to meet the needs of people with dementia should acknowledge and confront the fact that these people also often have mental and/or substance use disorders. And advocates for people with mental disorders need to confront the fact that as they age this population is increasingly likely to develop dementia. And advocates for a humane approach to substance misuse should acknowledge and confront the fact that the population they care about is at high risk for dementia and/or mental illness.

To say it again, each person has just one mind. Multiple silos reflecting the intricacies of the human mind may have been historically useful. But it is time now to focus far more on its unity.

This article was originally published by the National Coalition on Aging. [Treating Dementia, Mental Illness, and Substance Use Disorders: The Need for Better Integration \(ncoa.org\)](#)

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Dr. Petit sits on the board of Primary Care Development Corporation (PCDC) and Mental Health News Education (MHNE); is a Distinguished Fellow in the American Psychiatric Association (APA) and a member of the Committee on Psychiatric Administration & Leadership in the Group or the Advancement of Psychiatry (GAP) as well as a member of the National Council for Mental Wellbeing's Medical Director Institute.

*Dr. Petit is the author of *Handbook of Emergency Psychiatry and The Seven Beliefs: A Step-by-Step Guide to Help Latinas Recognize and Overcome Depression* and the recipient of the Schiff Community Impact Award from The Jewish Board, the 2017 Greater Good Honoree, Corporate Social Responsibility Award, 2018 Heritage Healthcare Organizational Leadership Award and the Community Partnerships Award, Virtual Community Partners Award from Federation of Organizations (FOO), Crain's New York Business 2022 Notable LGBTQ Leader, and City & State 2022 Nonprofit Power 100.*

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