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FALL 2013 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 1 NO. 1

Perspectives on Behavioral Health

The Future Of Behavioral Healthcare in New York State

By Arlene González-Sánchez, MS, LMSW
Commissioner, NYS Office of Alcohol and Substance Abuse Services (OASAS)

Arlene González-Sánchez, MS, LMSW

The future of behavioral healthcare in NYS is promising and full of great opportunity. While we understand that the future of all Medicaid care being managed creates some anxiety for providers, Governor Cuomo's Medicaid Redesign Team (MRT) recommendations ensured that the NYS behavioral health agencies OASAS and OMH would lead the development of this future managed care system. Today truly is a new day for the addictions field. Our future will be shaped by ensuring that our vision for addiction and recovery services is strongly recognized as New York begins implementing the national healthcare reform agenda. This will bring us new and exciting opportunities, new partners, new models of care and new challenges that we will need to work together to meet.

A New Vision: Our vision is fully integrated treatment where behavioral health and physical health are valued equally and patient-directed recovery goals are supported through a comprehensive and accessible service system. We will need to work to ensure this vision drives addiction

see The Future on page 14

A New Era In New York's Behavioral Health System

By Kristin M. Woodlock, RN, MPA
Acting Commissioner, New York State Office of Mental Health (OMH)

Kristin M. Woodlock, RN, MPA

On his first public appearance after the 2010 election, Governor-Elect Andrew Cuomo visited Manhattan Psychiatric Center on Wards Island, New York City. During this visit, the Governor-Elect made clear the priorities which he hoped would define his administration; the provision of high quality services, such as mental health, for vulnerable New Yorkers and the balancing of New York's budget. In July, as the New York State Office of Mental Health (OMH) released a plan calling for the creation of fifteen Regional Centers of Excellence and a statewide expansion of community based services, these priorities were given life for people with a mental illness and their families.

OMH has a long history of groundbreaking service provision, dating back to the opening of the Utica Asylum in 1843. Since then, New York has pioneered mental health treatment, research and policy implementation in a way which has positively impacted the current modes of behavioral healthcare in the United States and throughout the world. However, our structure is fundamentally flawed

see New Era on page 54

Preventing Mental Illnesses and Substance Use Disorders

By Adam Karpati, MD, MPH
Executive Deputy Commissioner for Mental Hygiene, NYC Department of Health and Mental Hygiene (DOHMH)

Adam Karpati, MD, MPH

The New York City Department of Health and Mental Hygiene (DOHMH) has a unique mandate in our City to prevent illness and disability. How does this mandate translate to our work in behavioral health? This inaugural publication of *Behavioral Health News*, with its focus on the interconnectedness between mental health, substance use, and physical health challenges, provides an opportunity to highlight prevention approaches to mental illness and substance use and how we at DOHMH incorporate these approaches into our work.

"Prevention" in behavioral health can be interpreted broadly; many of our services and programs are designed to prevent or reduce disability, and consequently to promote resiliency and recovery. But in this discussion, I will focus on those strategies that aim to avoid the development of behavioral health problems in the first place, or to reduce the progress of early illness or behavior into more serious forms.

Early Intervention for Psychotic Illness: Following a "first-episode" of psychotic illness such as schizophrenia, which often occurs in young adulthood, the course of remission and relapse can be unpredictable. Often, individuals develop significant disability. But evidence has accumulated over the past several decades that intervening early in the course of schizophrenia and related illnesses can change this negative trajectory and produce sustained remission. Specialized treatment, including low-dose medication prescribing, counseling, family therapy, and supported education/employment, are emerging as critical components to achieving the best outcomes. Unfortunately, as with most mental illnesses, years often go by between the time symptoms develop and when individuals begin receiving sustained care. So the challenge is two-part: identify, engage, and support young people experiencing a first episode of psychosis and provide them with specialized, comprehensive care. The New York State Office of Mental Health is supporting the development of new clinics specializing in this area, and we at the NYC DOHMH are developing an initiative to work with hospitals to support individuals who are admitted with first-episode psychosis and link them to care. This is exciting work, especially because it represents a prevention approach to serious mental illness.

Opioid Misuse and Overdose: We are in the midst of a national epidemic of prescription painkiller misuse and its consequences

see Preventing on page 50

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Table of Contents

Behavioral Health News
2013/2014 Theme and Deadline Calendar

Winter 2014 Issue:

"Substance Use Prevention and Treatment Services"

Deadline: October 23, 2013

Spring 2014 Issue:

"Perspectives on the Transition to Managed Care"

Deadline: January 23, 2014

Summer 2014 Issue:

"Housing and Employment: How Are We Doing?"

Deadline: April 23, 2014

Fall 2014 Issue:

"Integrative Health Care"

Deadline: July 23, 2014

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It's About Time

By David Woodlock, President and Chief Executive Officer, Institute for Community Living (ICL)

Back in the height of what was called the "Humane Care" period, state hospital institutions took care, to the limits of their abilities, of the full spectrum of people's needs. While one can certainly look back and question the quality of the care and the enormous personal consequences of long term hospitalization, it is also true that mental healthcare, physical medical care, nutrition and work were part of the tapestry of better institutions.

As our field evolved and we came to realize the terrible personal costs people paid by spending such long periods of time in institutional settings and with the advent of Medicaid and Medicare, government began to organize itself differently. Over time silos of disability-specific agencies emerged to create, fund, regulate and monitor select portions of the human experience. Those of us who have been in the human services world for a while have decried this artificial segmentation of the service system. Phrases like "cross systems kids" or "multiply dually diagnosed" became common place. Our inability to address individual needs in a more comprehensive way had dire consequences for many.

Unfortunately, many of those discharged from mental institutions during deinstitutionalization did not receive proper access to the medication and rehabilitation services they needed and, instead, ended up on the streets, homeless. Even to this day, an estimated 30 to 50 percent of homeless people in the U.S. suffer from mental illness.

Deinstitutionalization brought with it the promise that individuals with mental illness could adjust to everyday life and live without stigma in their communities, albeit with the assistance of dedicated social workers, psychiatric rehabilitation, and other forms of support. Recent changes in mental health policies that promote managed care and Whole Health programs live up to that promise and will benefit not only those with mental and behavioral problems, but society as a whole (http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html).

The Whole Health Model

There has been a paradigm shift in the way we think about and treat those with mental health-related issues. In the past, if an individual was a substance abuser, then treat their addiction. If a person was homeless, find them a place to stay. Each issue was dealt with separately, through various agencies that often did not coordinate or communicate with one other. Navigating the maze of departments and resources was hard enough for those without mental health issues and extremely difficult for those with them. The system was both inefficient and ineffective as many of the people who most needed help didn't get it and simply gave up, resulting in high mortality rates and a high instance of chronic illness among them.

David Woodlock

Today, the trend is shifting from treating mental health issues in separate "silos" to a more integrative Whole Health approach that focuses on treating all aspects of an individual's life—mental, physical health and substance abuse.

This Whole Health approach demonstrates that problems—and their solutions—are interrelated. Drug addiction, joblessness and homelessness often go hand-in-hand. Rather than treating each issue separately, treat them simultaneously. Instead of going to different departments for different resources, coordinate all efforts through a central source. For example, while working on a person's addiction, help them find suitable accommodations, get them job skills training, and, when ready, help them find employment. If they have a family, help them get public assistance or find them a free children's lunch program to ensure proper nutrition.

The Whole Health approach goes beyond recovery to empowering individuals to learn more healthy behaviors, make better choices, and to lead a fulfilling life. Programs like ICL's Healthy Living that teach individuals how to follow and lead more healthy lifestyles, develop a skill, or tap into a hidden talent, provide the positive reinforcement that is needed to improve lives.

Also integral to the Whole Health approach is to address the underlying causes of recurring behavioral problems and identifying the strong connection between a person's upbringing, their behavior, and their physical well-being.

The ACE Study: The Consequences of Adverse Child Trauma

Often, those who experience mental and social disorders have also been affected by adverse childhood experiences or (ACE). A groundbreaking study of 17,421 individuals over a 17-year period by Dr. Vincent Felitti, of the Kaiser Permanente Department of Preventive Medicine in San Diego, CA, found that adverse childhood experiences were linked to every major chronic illness and social problem in the U.S. ACEs can include: sexual, verbal and physical abuse, one or both parents who are mentally ill, alcoholics, incarcerated, or victims of domestic violence, the loss of a parent through divorce or abandonment, and or emotional and physical neglect.

Children who experience ACE often mask their feelings of fear, shame, and anxiety by turning to drugs, alcohol, violence or other seemingly self-destructive behaviors for solace. Understood in the context of their trauma, these behaviors can often be explained and seen as strengths; and the individual recognized as a survivor rather than a victim. The more adverse the childhood experiences, the greater the risk of medical, mental, substance and social problems as an adult.

"The biological impact of ACEs transcends the traditional boundaries of our siloed health and human services systems," says Dr. Robert Anda, a researcher at the CDC who participated in the ACE study. "Children affected by ACEs are more likely to become adults with behavioral, learning, social, criminal, and chronic health problems."

With proper training and support, individuals can learn to break the continuum of emotional distress and develop positive mental and health behaviors. This is especially true for children where early intervention, or the lack thereof, can have an enormous impact on that person as an adult.

What's needed is an integration of the educational, mental health, and other public systems to share knowledge and resources and replace past fragmented approaches. By identifying and breaking the cycle of ACEs, behavioral health professionals can help individuals and families turn their lives around, and help reduce the costs of healthcare, social services, and other support areas significantly (Stevens, Jane, "The Adverse Childhood Experiences Study—the largest public health study you never heard of," Huffington Post, October 4, 2012).

Managed Care Organizations: Improving Care, Reducing Costs

It is estimated that the top one percent of patients consume one-fifth of all healthcare costs and the top five percent consume one-half. However, recent initiatives have shown that improving the quality of care through managed care programs is actually a very effective way to reduce health care costs, especially for high-need, high-cost individuals with complex behavioral issues and chronic conditions. One such effort is the New York State Medicaid Redesign Team (MRT). Launched in 2011, MRT is a collaborative effort to reduce the state's Medicaid costs while enhancing the health of participants, and has broad support among the healthcare stakeholder community. So far, the state has cut $4 billion in Medicaid expenditures while adding 154,000 to the Medicaid rolls and getting high marks for the quality of its managed care programs (http://www.health.ny.gov/health_care/medicaid/redesign).

Nationally, the Affordable Care Act (ACA) provides funding for care management programs for high-need, high-cost Medicaid beneficiaries. In New York State, this funding was used to help launch a three-year Chronic Illness Demonstration Project (CIDP) to test new strategies to improve health care quality and control spending for Medicaid's highest-need, highest-cost populations. Six providers throughout New York State were selected to participate, among them the Institute for Community Living.

> *"The changes taking place today in the behavioral health profession are as dramatic and game-changing as deinstitutionalization was in the 1960s and 1970s."*

Using a Whole Health "managed care" approach (not just managed costs) consisting of nurses, social workers, and peer specialists (who experienced issues similar to those whom the program attempts to help) searching the streets, homeless shelters, veterans fairs, and drug clinics for targeted high-need, high-cost individuals. Once enrolled, a "care manager" coordinated with a team of physicians, social workers, behavioral health providers, and others all with the goal of ensuring that each participant was given access to all the services needed to stay healthy, out of the hospital, and off the streets, and the reduced cost of such should be viewed as an added bonus that allows for wider distribution of services to a greater population in need.

This managed care model has not only improved the quality of care for participants—who account for about half of the state's $54 billion annual Medicaid expenditures—but lowered costs by reducing preventable hospitalization and emergency department use. Best practices from New York's CIDP initiative offer valuable lessons to other cities and states across the country. In December 2012, with additional funding available from the Affordable Care Act, New York launched plans to extend case management services to nearly one million of its five million Medicaid beneficiaries, using the CIDP as a model.

Furthermore, as the Institute for Healthcare Improvement (IHI) notes, new designs must be developed to simultaneously pursue three dimensions, which they call the "Triple Aim": improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

Organizations and communities that attain the Triple Aim will have healthier populations, in part because of new designs that better identify problems and solutions further upstream and outside of acute health care (http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx).

Recently, I became the President and CEO of the Institute for Community Living (ICL), one of the six providers who participated in the New York CIDP pilot program, and I have seen first-hand how the application of integrative Whole Health,

see Time on page 54

Intentional Peer Support: Using a Crisis as an Opportunity for Growth and Change

By Lauren D'Isselt
Program Director
Manhattan Crisis Respite Center

In January 2013, Community Access, in partnership with the NYC Department of Health and Mental Hygiene, launched the first alternative to hospitalization program in New York City. Called a crisis respite center, the new program has several unique features that, compared to "treatment as usual," radically transform the experience for people in a psychiatric crisis, as well as the staff who work in this setting.

First impressions are important, and the respite center was designed to offer a welcoming environment for people needing a "respite" from the unrest in their lives. First, there is no reception desk. All visitors are greeted at the front door by a peer worker. In addition, institutional lighting and furniture have been replaced with comfortable residential furnishings. And the program is small--limited to seven people, leaving plenty of time for one-on-one discussions, small groups, and, when needed, solitude. Finally, our "guests" are free to come and go on their own accord.

While the physical plant is critical in establishing an atmosphere for healing and reflection, the most important aspect of the program is the carefully choreographed interaction between the staff and guests. For this, the respite center—and the companion peer-operated support line— has adopted a truly revolutionary model of care known as Intentional Peer Support (IPS).

IPS is grounded in a simple concept that is transformative in its execution. IPS views "the crisis" as an important opportunity to learn, grow and heal. To do this, there is no attempt to "stabilize" the guest, or offer advice on how to better manage a future emergency. These "risk management" techniques are replaced by a process of learning and sharing between the peer staff and guests. It requires staff with a special gift for empathy, but also a lot of training.

Like all respite center staff, I was trained intensively in the principles and methodologies of IPS by Shery Meade, its creator and developer, along with her long-time collaborators, Chris Hansen and Beth Filson. The initial training lasted a full week and was part workshop, rite of passage, and bonding experience: a compelling mix of lecture, presentation, role play, discussion and video. Shery and her colleagues made a tremendous training trio. The model and the training process have evolved and been refined by real world experience for over two decades.

The Community Room at the Crisis Respite Center

As with the respite center itself, IPS is both innovative and reflective of broader and long-term changes within behavioral healthcare as the system struggles to replace expensive hospital-based care—which often comes with high recidivism rates—with something more effective.

The last several months have been instructive and inspiring to see IPS in at work. As the examples below will illustrate, I have been given a richer context in which to consider my previous professional roles as a case manager, for several years, and as an administrator at a licensed housing program.

There are three principles of IPS: (1) Learning versus Helping; (2) Relationship versus the Individual, and, (3) Hope and Possibility versus Fear. These are the prisms through which we see the work, a collaborative partnership vested in hope and promise that allows for possibility.

There are four tasks of Intentional Peer Support. They are: (1) Connection, which refers to the need to create a genuine rapport between the participant and peer worker. (2) Worldview, which asks the worker to consider the perspective of the person, what is their perspective and beliefs and how did they come to hold them? (3) Mutuality, meaning shared responsibility for honest communication between staff and participants. And, (4) Moving Towards, which means always moving the participants towards a better way of being closer to where they want to be.

I see these tasks as grounding points to orient oneself to the guest (as we call people who come in to stay at the respite) or support line caller, beginning with making an initial connection and then charting together an aspirational and proactive plan for the future. The three principles then guide and direct the worker to keep on track.

I've found that these approaches have much in common with how I used to try and work as a case manager: namely, to be respectful, supportive and honest. At least, that is, until it comes to "mutuality." That is where it really starts to get interesting.

In most therapeutic settings there is some kind of "filter" that strains the information that goes to a patient: conclusions and reflections about a client, and, perhaps most sacrosanct of all, the professional's own story, thoughts, and feelings. These are absolutely unavailable to the patient. Intentional Peer Support is quite different. As IPS trainer Chris Hansen often used to say: "*nothing about us without us*" – "clinical" conversations should always be inclusive in the company of the guest. In practice, this requires that all conversations with other treating professionals or family members be conducted with the guest's consent and with him or her present.

More deeply felt by me, and a real change, is the possibility that in a professional clinical setting I can now show that I too am moved in the course of an interaction with a participant, or that if reminded of something painful in my own past hearing the story of a guest, that I would be permitted to share this and be thereby enriching the encounter for both of us. This is truly a different experience compared to traditional mental health care.

Mutuality also directs us to share when we feel in some way uncomfortable or unsafe in our interactions with a guest or caller, thereby maintaining an expectation of accountability. There is no emotional or psychological filter or professional distance at work—concerns are not dumbed-down or spoon-fed but shared in a clear, caring and respectful way.

One thing I find myself repeatedly tripping over is the use of the word "peer." While it is useful when describing the groundbreaking features of this model, emphasizing our peer workforce feels a bit like continuing some kind of apartheid (separate and unequal). If an employee is competent to do the job it is my preference to call them, simply, a *professional*, which significantly broadens the future career opportunities for these skilled and well-trained staff members.

To provide a real world example, I asked my staff to share their experiences of Intentional Peer Support in action. These two are particularly illuminating:

I received a call from a gentleman identifying himself as Mark. He began by asking for a male to speak to. I told him there wasn't presently a male peer available and asked if he wanted to talk a little with me and he could let me know what his

see Peer Support on page 8

If you are experiencing an emotional crisis,
There is an alternative to hospitalization or the emergency room.

CRISIS RESPITE CENTER

Stays are from one to 14 days, with at least two staff present at all times. Maximum of seven guests allows us to provide an array of highly focused supports, including:

- Peer support
- Wellness self-management
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- Creative arts
- Meditation and relaxation techniques
- Linkage to medical and psychiatric supports

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The Importance of Self-Care and Staff Care for Mental Health Professionals

Mary Pender Greene, LCSW-R, CGP
President
MPG Consulting

Dr. Francis Peabody one wrote: "The secret of the care of the patient is caring for the patient." We must practice self-care in order to prevent becoming "Wounded Warriors."

Adversity is one of the primary reasons people seek help, and it is the mission of the mental health professional to provide guidance to those who are suffering. But some of the long-term consequences of working with individuals in crisis is stress, burnout and compassion fatigue.

Mental health professionals are a constant witness to a wide range of emotions, such as anxiety, sadness, grief, fear and anger. Giving too much can take its toll. It is not a flaw, but rather, a hazard of the role. As such, there is a great need for mental health professionals to practice self-care. It is crucial they listen to their own body's cues, which often warns when rest, relation and extended downtime is needed. Learning to recognize these complex symptoms of compassion fatigue can prove priceless:

- A persistent feeling of sadness, anxiety, or emotional emptiness
- Constant sensations of hopelessness, pessimism, or helplessness
- Problems concentrating, remembering, or making decisions
- Diminished energy levels
- Feeling constantly fatigued

Caring for Staff

Mental health professionals need both supervision and mentorship. Bernard & Goodyear (1998) defined supervision as an evaluative relationship between a senior and junior member of the profession whose purpose is to "enhance the professional functioning" of the supervisee. According to the authors, supervisors are the culture carriers for the profession and are responsible for directing and nurturing the development of the supervisee's skills and professional identity.

Supervisees who have unrealistic expectations for themselves and others are more apt to experience stress and burnout. This is why being open and presenting yourself as a whole human being with shortcomings and doubts is so crucial to the development of new clinicians. It helps them to prepare them for the realities of the profession. This relationship will set the stage for their future. Be real, and offer them what you wish you had at the start of your career.

Helpful Hints

- Seek to understand supervisees as whole, complex people.
- Don't limit your focus to just work issues.
- Let supervisees know that they're seen as a whole person.
- Understand that supervisees are not just an extension of your role.
- Keep an eye out for signs of stress, burnout, or compassion fatigue.
- Share both approval and concerns.
- Talk about the times when you've had doubts.
- Be open to hearing mistakes.
- Share your own mistakes.
- Reiterate that lessons are learned from mistakes.
- Be honest, clear, and direct about expectations.
- Make "office politics" a regular part of your discussions.

Modeling Self-Care

As supervisors, it is imperative that we model and encourage staff self-care. It is important to help workers to develop a preventive maintenance plan to lessen the effects of secondary traumatic stress – which ultimately leads to burnout and compassion fatigue. Due to the major changes in the profession over the last decade, there is an increased number of traumatized patients, more diverse populations, shorter terms for treatment, new fiduciary responsibilities, and new outcome measures. We must serve clients despite our own personal losses and fears, a hostile political climate, and a major loss of funding.

Like effective clinical work, effective supervision must be taught. However, new supervisors often get promoted to meet an organizational need and may not be trained for their new assignment. While all clinicians receive training during their education, most new supervisors begin to supervise with little or no supervisory training.

Things to Remember

- The quality of the supervisee's future leadership skills is closely-related to the quality of the supervision they have received.
- Experienced leaders need continuing education and supplemental training in order to meet new challenges.
- Collaboration with peers is a career-long process.
- Encouraging and modeling self-care is essential.
- Supervisees need a plan to avoid burnout and compassion fatigue.
- Maintaining wellness should be a regular part of supervision.
- It is important to assess yourself and your organization for signs of stress.
- Strategies for positive change and healing must be created and shared.

Leading By Example

We can't be personally falling apart and serve as an example of what good self-care is all about. As clinical leaders, we carry many responsibilities and roles. But our primary role is the care and development of our supervisees. There is a parallel process between our own needs, the needs of our supervisees, and the needs of the people we serve. We all need:

- *A peaceful work environment:* We spend the largest part of our lives at work, and therefore our work environment reflects us.
- *Good supervision:* For seasoned professionals, this might take the form of consultation.
- *Coaching:* We all need help in flushing out ideas about our own missions.
- *Professional development:* We all need to think about our goals and next steps.
- *Mentoring:* Mentorship comes in many forms and helps to keep our spirits and hopes alive.
- *Recognition:* We need recognition no matter where we are in our profession – we need it emotionally for ourselves and we need to give it to others.

Practicing What We Preach

Working with the younger staff reminds me that work/life balance is what we must strive for. New clinicians must be clear that if they want a life, they must be mindful of this balance. Work-life balance allows us to:

- Nurture ourselves
- Be nurtured by others
- Cut down our risk for burnout
- Avoid compassion fatigue
- Rejuvenate
- Continue to offer our best to clients/ constituents

Money

The compensation issue is paramount for mental health professionals. We need to continue to advocate for higher staff salaries with government, contractors, and funders. In our society, our value continues to be equated with money. Care of staff requires that appropriate salary be allocated to maintain a decent standard of living, and to attract – and keep – talented individuals in the profession.

One of the greatest lessons I've learned is that collaboration is the key to success. We need to partner with clients and not just provide for them. We need to collaborate with other institutions and groups so no one is working alone. When we work together we can create a wider array of services, and do this more cost effectively. We do not have to work in silos and reinvent the wheel. Our greatest asset is ourselves – the mental health workforce. We must care for our leaders as well as our staff so we can offer our very best to those we serve.

Peer Support from page 8

comfort level was. He hesitated, but agreed to try. He shared he was "morbidly obese" and that he lived with a great deal of depression, anxiety and shame about his weight. He spoke about being "so alone" and that although he desperately needed to, talking about his feelings to anyone felt impossible to him. He explained that he "didn't feel like a man" if he admitted to others the shame, embarrassment and insecurity he felt daily. In using IPS, I shared with him that I also struggled with body image, and that I knew what it was like to feel discomfort, disgust, shame, and self-hatred at being in your own skin and to have no one to talk to who can truly understand that specific, constant pain. He broke down briefly, saying that not only was he shocked that someone could relate (he just "assumed" I would not be able to), but no one had "validated his pain" before. I told him I had felt the same way for a long time, only to finally realize that no one could ever possibly understand or validate my pain if I refused to risk sharing it with others. Mark spoke of having considered support groups, but had not sought that out. At the end of the call, he said he felt better and was more hopeful that there could be others that could relate to his situation. He said he realized he was alone because he kept himself alone and things could perhaps change for him with his depression if he reached out. I gave him the number for LIFENET for support group resources. He said he was so appreciative of the support line, glad he called, and thanked me. I told him the hours we were available and encouraged

see Peer Support on page 19

Mary Pender Greene, LCSW-R, CGP

Mary Pender Greene, LCSW-R, CGP is a psychotherapist, clinical supervisor, career/executive coach, trainer, and consultant with 20+ years of experience and a private practice in Midtown Manhattan. She is a thought leader in the social services industry, recognized for her novel ideas on coaching and mentoring. Mary works with individuals, couples and organizations. She coaches and supervises therapists, and helps them to start and build their practices. She helps clinicians to enhance their psychosexual awareness and gain skill in addressing sexual expression in clinical practice.

Mary also works with organizations to enhance clinical capacity and improve leadership development. The MPG Consulting team brings to organizations a wide range of experience as clinicians, trainers, managers, and organizational consultants in mental health, child welfare, and other settings. The team enhances clinical capacity and performance by offering training and consultation on:

Evidence-Based Treatment Models • Building Mental Health Capacity in Child Welfare Programs
Individual/Group Coaching for Workers, Supervisors, Managers & Executives
Team Building • Clinical Team Conferencing • Recruitment of Culturally Competent Staff
Customized Training/Workshops/Supervision on Providing Culturally Sensitive Services to Males of Color

Mary's background includes executive management roles at The Jewish Board of Family Services in NYC. She gives inspiring keynotes and has been honored many times for her professional contributions. Mary has a popular blog on Tumblr and is frequently quoted in the press on mental health and business topics.

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Healthcare Reform: The New School Lunchroom

By Marlowe Greenberg
Founder and CEO
Foothold Technology

What does the new healthcare environment have in common with a high school lunchroom? Many Behavioral Healthcare providers have been experiencing anxiety as they hear and read about all the fundamental ways their work, organizations, and very lives are about to transform. "It's all going to change," and "Hospitals are going to be our payors now," and "Health Homes/ HIEs/RHIOs/ACA/ACOs are going to put us out of business," and so on. It's worth pulling apart some of these strands to see what we're really talking about.

A big question in our field has always been how we can use our resources to drive outcomes more efficiently. Today, in all likelihood, you provide services using a combination of funding streams. Probably most of your revenue ultimately comes from Medicaid or Medicare, and probably you are being paid on a fee-for-service basis. Additionally, it's safe to assume that you've been trying to make the work you do ever more efficient and effective, and basically, trying to do more with less. For the most part, you've thought of your organization as a self-contained unit. Sure, you get referrals from other organizations and sure, you're a big part of the communities in which you work. But generally, this conversation has been about how your organization can drive outcomes more efficiently to sustain itself.

Marlowe Greenberg

It's your context that's changing. Almost all the new ideas, projects, experimental payment structures, and acronyms are built around the idea that providing real care for people who don't have the resources to pay for care themselves is going to require multiple specialized providers—the entire community—to work together. It's the community that will be providing care now, not the individual organization. It's you, and the hospital, the shelter down the street, the DD organization across town—everyone. That is why you are suddenly feeling like you need to care about what your local hospital is doing and how it will affect you. That is why this process feels like finding a seat to eat your lunch on the first day of high school. You don't know the angles, don't know who your friends are, and don't know who's nice and who's a bully. You are now part of a web of organizations that offer a wide range of healthcare services to a particular population, and you are going to need to figure out how to work in that context.

The truth, though, is that this is less about changing how you operate than it is about changing how you relate to other service providers. Primary care's "integration" with Behavioral care is not a physical, organizational integration. Rather, it's a data integration that allows each care provider—Primary or Behavioral—to leverage the information being collected by all the other providers in a person's life. At Foothold Technology, we've been working steadily to provide a range of tools that enable providers to do two broad but crucial things: 1) Share clinical data safely and in real time with other providers in your community, and 2) Tell your story with solid support from the objective clinical data in your Electronic Health Record (EHR). These two "new" ideas address the vast majority of the changes that are currently coming at you. In both cases, they're about finding a way for you to be financially sustainable and to become a crucial part of the care network in your community. In both cases, they will enable us to address the fundamental challenge posed by the small number of dual or multi-diagnosis individuals who utilize a vastly disproportionate percentage of the monies available for care.

Put bluntly, keeping Behavioral Healthcare recipients out of the ER when they would be better served by calling or visiting you is the key to all the Healthcare Reform that comprises our current national conversation. By using an EHR that enables you to share data with your local hospital and fellow BH providers while enabling you to tell powerful stories about the value you bring to your local community within this larger national conversation, you will have done nearly all you need to do to survive and thrive in our new world.

The Three A's of a Successful Agency

By David Bucciferro
Senior Advisor
Foothold Technology

In a time of diminishing resources and ever-changing regulations, today's providers are entering a new era of care characterized by increased oversight activity and a shift in service delivery from volume-based to value-based, among other changes. Success in the new environment will require more complex methods of documentation, and a new approach to management incorporating a special focus on three A's: Accountability, Accessibility, and Affordability. Providers will need to be accountable to more people and in new ways than ever before. As a result, they will need to promote accessibility (as appropriate) to a large array of data, and be able to obtain this data in a means that is affordable. An electronic data management system is critical to accomplishing these goals.

Accountability is defined as meeting the obligation to report, explain, or justify something in a responsible, answerable, explicable way. Administrators, managers, practitioners and staff at all levels of the organization must be aware of the lines of accountability, and determine the best ways to measure it for both external and internal needs. For external requirements these metrics may be predetermined, but for internal ones, metrics need to be developed and used as a tool in agency and outcome management. Data alone is not the key to success, though: you'll also need the ability to analyze and present it. Raw data may satisfy some of your external needs, but you'll need to link the right pieces of data together to create information that tells a story and helps you make informed clinical and administrative decisions.

David Bucciferro

Whether examining your accountability to services recipients, families, your Board of Directors, staff, State or Federal government, or other stakeholders, a set of quality useful metrics need to be developed and the data obtained to calculate these metrics. *Accessibility* is the degree to which you can make your data available to as many relevant people as possible. Questions to ask about your data are: "Is it Easily Entered? Easily Retrieved? Easily Understood? Easily Used?" It's critical to know who needs access to your data: direct care workers, senior administration, billers, supervisors, consumers, community members, regulators, and others. Then you need to know for each group how they want to access the data: whether on a desktop computer or mobile device, in real-time or report-based, and whatever other factors are relevant. Mechanisms and procedures need to be developed that ensure key staff has access to and knowledge of the system so they can review the data on an ongoing basis.

All of this must be accomplished in a manner affordable to the agency. Affordability is based on an assessment of the cost of action versus the cost of inaction. Can your agency find the dollars for an Electronic Health Record (EHR)? In this new climate of Health Information Exchange, the more pressing question is: "Can you afford not to have an EHR?" Investigate the consequences of not having a data management system, and find ways to help defray the costs. Consider State and Federal grants, philanthropic opportunities, and the potential for increased revenue a quality EHR/data management system can create. Lost accreditation, lost business lines, loss of funding or reduced rates are real possibilities without the ability to provide data to those to whom you are accountable.

Change is here, and it's happening rapidly. Data Interoperability is not just nice—it is mandatory as the nation embraces Health Information Exchange. A functional EHR is critical to applying the Three A's because it will place at your fingertips the information you'll need not only to sell yourself to the funders and system overseers externally, but to provide the wisdom to guide your clinical and operational decisions internally, ensuring success for your agency.

Focus on Integrated Treatment (FIT)

By Nancy H. Covell, PhD, Associate Director and FIT Project Director, Center for Practice Innovations at Columbia Psychiatry, New York State Psychiatric Institute

Person-centered recovery and treatment includes understanding a person's individual strengths and challenges. For many, the path to recovery includes addressing both mental health and substance use disorders; however, historically, treatment settings offering help with both have been difficult to find. For example in 2007, 5.4 million adults in the U.S. had a co-occurring mental illness and substance abuse disorder (COD), yet only 10% received treatment for both (Substance Abuse and Mental Health Services Administration (2008). Results from the 2007 national survey on drug use and health: National findings (Office of Applied Studies, NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD).

Individuals who have co-occurring substance use and mental health disorders who are not able to address both experience significant difficulties including greater rates of hospitalization, homelessness, incarceration, and violence (Drake, R.E., & Brunette, M.F. (1998) Complications of severe mental illness related to alcohol and other drug use disorders, in Recent Developments in Alcoholism: Consequences of Alcoholism: Vol 14. Edited by Galanter M. New York, Plenum). These negative experiences interfere with recovery.

Nancy H. Covell, PhD

When both disorders are addressed, however, individuals can achieve and sustain recovery. The integrated approach emphasizes people setting their own recovery goals and the key role of peers in the recovery process. In fact, research has shown that integrated treatment reduces negative consequences and treatment costs, and promotes individuals' recovery, independent living, and employment (Drake RE, McHugo GJ, Xie H, et al. (2006) Ten-year recovery outcomes for clients with severe mental illness. Schizophrenia Bulletin, 32, 464-473).

Recognizing a critical need for better integration of care, the New York State Offices of Mental Health (OMH) and of Alcoholism and Substance Abuse Services (OASAS) created a joint task force on co-occurring disorders. The joint task force developed a number of recommendations to increase to provision of integrated care throughout New York, including core competencies for treatment staff. As a follow up, OMH and OASAS provided funding to the Center for Practice Innovations (CPI) to create web-based training and distance implementation supports to promote uptake of integrated treatment. CPI supports OMH's mission to promote the widespread availability of evidence-based practices to improve mental health services, ensure accountability, and promote recovery-oriented outcomes for consumers and families. CPI also offers free tools and supports through learning collaboratives, webinars, phone calls, and a resource library to help programs implement integrated treatment.

The Focus on Integrated Treatment (FIT) Initiative began in the fall of 2009 when CPI released the first 10 online training modules developed to help practitioners, supervisors, and agency leadership learn the skills necessary to treat people with co-occurring mental health disorders. As of today, staff from participating programs in New York State can access 39 modules which cover a variety of topics including screening and assessment, stage-wise treatment, tobacco dependence treatment, cognitive-behavioral therapy, motivational interviewing, and more. Individuals that complete 29 modules covering basic, intermediate, and advanced practitioner competencies can earn the Integrated Mental Health/Addictions Treatment Training (IMHATT) certificate signed by both OMH and OASAS Commissioners. Over 15,000 practitioners in programs across the care spectrum in NYS have taken advantage of the free training and implementation supports in this initiative, and many more are joining every day (over 100,000 modules have been completed to date and over 600 individuals have earned the IMHATT certificate thus far).

CPI is beginning to assess whether the training and implementation supports are increasing the availability of integrated treatment throughout New York State. Indeed, programs are reporting that they have implemented key components of integrated treatment and have begun to embed the core competencies within their policies and procedures. With continued implementation, we hope that increasing numbers of people will have access to care that addresses their whole person and facilitates recovery.

CPI continues to develop additional modules in other areas such as wellness self-management (which includes attention to both behavioral and physical health), suicide prevention, Assertive Community Treatment, and supported employment. CPI is also developing videos and modules for consumers and their families. To view one of these modules (e.g., "Becoming Tobacco Free") or for more information, please visit http://practiceinnovations.org/.

Co-authors of this article also include, Paul J. Margolies, PhD, Associate Director, Forrest P. Foster, MSW, Implementation Specialist, and Luis O. Lopez, MS, HSBCP, Implementation Specialist, at the Center for Practice Innovations at Columbia Psychiatry, New York State Psychiatric Institute.

An Experienced Social Worker's First Natural Disaster

By Susan Weigele, ACSW Social Worker, Nassau County Office of Mental Health, Chemical Dependency and Developmental Disabilities Services

The call went out, "Are you ready to roll?" This was the question that my director at the Nassau County Office of Mental Health, Chemical Dependency and Developmental Disabilities Services (the Office) asked me the day before Hurricane Sandy hit Nassau County as we prepared to make our rounds to the Office of Emergency Management and the shelters that would be opened to accommodate evacuees. I replied "Yes," and, although mildly anxious, I reassured myself that I had fulfilled all of the disaster mental health planning activities, that I was calm in emergencies, and that I love to work hard.

And hard work it was. First, being in the role of both disaster victim and responder was stressful. Like my fellow responders, I was separated from loved ones who sheltered in place in homes that were without power and vulnerable to falling trees. Traffic lights were inoperable and driving was perilous; and due to the lack of access to gas because of the shortage, I was preoccupied with running out of gas. Communicating with loved ones was inconsistent and unpredictable; land lines were not working and cell phones could not be charged due to prolonged power outages.

Second, working in and sleeping in shelters was physically taxing. Shelters are after all, usually gymnasiums and there should be no expectation for comfort. The temperature was usually cold, the lights bright and intrusive, and the noise level high. Mental health responders were always on the move and the most available seating was on the floor, sitting next to an evacuee's cot while speaking with them. And sleep was restless to say the least.

Third, the work itself is challenging. I was trained in Psychological First Aid and after thirty-two years as a social worker I felt confident in my clinical abilities. However, I learned that after a few days in a shelter, "information" trumps empathy and emotional intelligence is the most valuable asset. "Do you know where my mail is being forwarded to?" "Are the buses running south of Sunrise Highway?" "Is my house still standing?" "Where am I going to live?" "How do I get my medication?" "When is the psychiatrist coming?" "How am I going to get to my methadone clinic?" "Do you know if there is power at my house?" "How long will the shelter be open?" Evacuees were very appreciative of mental health responders' kindness; and I know that our efforts served to give comfort and hope to those we served, however, the lack of access to information caused many evacuees to feel frustrated. As a remedy, we dedicated much of our time to gathering as much credible, real time, information as we could. If they could articulate it as such, I think the consensus statement of evacuees might be, "We appreciate that you are kind and supportive and good listeners, but what we still need is concrete, specific, information."

Another challenging aspect of working in shelters came in assuring that the evacuees received the needed "commodities" or "amenities." "I am cold, can I have another blanket?" "My baby is one week old; can you get me a bottle warmer?" "Could I borrow a pair of reading glasses?" "I would like to take a shower – do they have towels?" "My back hurts from sleeping on the cot – do they have pillows here?" "I have been wearing these clothes for ten days. Can you bring in some clothes for me?"

In the event of a disaster, the number one goal of a shelter is to provide safety, food and water, and in the event of supply shortages items may be rationed. But the limitations and restrictions on procuring items such as the aforementioned caused many us responders to feel limited in their ability to respond in the desired manner. As for me, it exacerbated the survivor guilt I felt every evening when I left the shelter. In response to these "commodity challenges," mental health responders engaged in traditional community organizing and advocacy work.

Sound stressful? It was, but it was not all bad. The Office and its provider agencies have a culture of responsiveness among practitioners, and respond they did. Over 100 mental health responders deployed to ten shelters, for as long as fifty days; and at the largest shelters covered overnight shifts. The camaraderie, cohesion and dedication of responders was inspiring and made me feel proud to be a part of our treatment provider system. There was a tremendous sense of home town spirit and desire to do the best for

see Disaster on page 54

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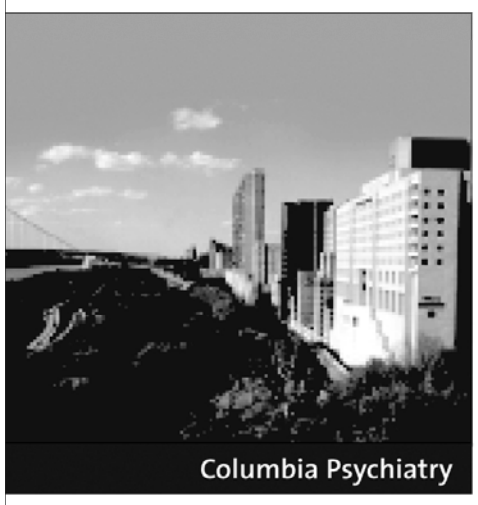
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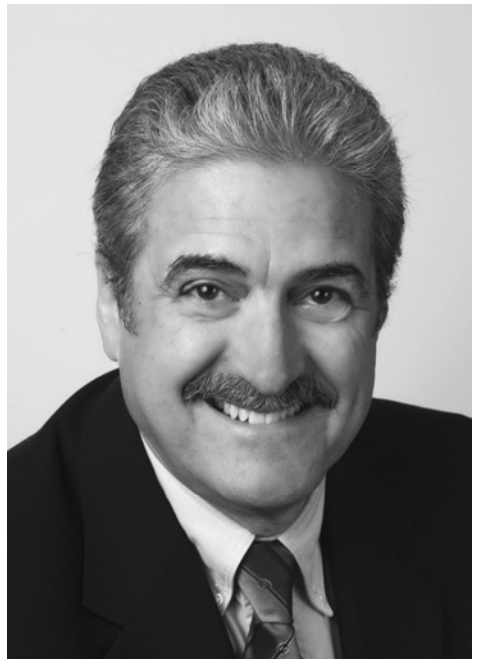
Integrating Dialectical Behavioral Therapy (DBT) And Co-Occurring Disorder Treatment at Four Winds Hospital

By Jonathan Bauman, MD, LFAPA
Chief Medical Officer
Four Winds Hospital

Four Winds continues to be a leader in mental health care as we are now well into our fifth year of applying Dialectical Behavior Therapy to our Co-Occurring Disorder treatment. The Co-Occurring Track, one of two treatment tracks in our Adult Inpatient Program, offers a structured program for patients with co-occurring psychiatric and substance abuse disorders. It is designed to meet the mental, emotional, and spiritual needs of our patients by focusing on the dignity and strengths of each person as they struggle with the symptoms and behaviors that have led them to hospitalization.

Patients with co-occurring disorders (formerly known as dual diagnosis) are affected by both psychiatric disorders (mood, anxiety, traumatic stress and psychotic disorders) plus substance abuse (alcohol, opiates, cocaine/stimulants, benzodiazepines, etc.). Many of these patients may try to recover from one problem and unknowingly neglect the other. Often one disorder is "blamed" for the other. These patients present specific diagnostic and treatment challenges since symptoms of both problems can overlap and/or mask one another. Proper treatment requires that both disorders be addressed simultaneously in an integrated process.

Our program consists of two substance -abuse groups daily that are led by masters-level CASAC's and licensed therapists. These groups are both educational and therapeutic and include CBT, relapse



Jonathan Bauman, MD, LFAPA

prevention, coping skills, information about co-occurring disorders, and other relevant topics. An in-hospital twelve-step (Alcoholics Anonymous) meeting is held seven days a week. Patients also participate in DBT skills groups to enhance their ability to use skills instead of substances to cope with emotional discomfort. The skills groups include Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effective.

A fifth skill, Walking the Middle Path, is integrated into the teaching that occurs in these groups. This skill is particularly useful in counteracting the black and white, either/or thinking that can make recovery, and life, so difficult. Walking the Middle Path requires becoming mindful of when thinking has become dichotomous and learning to appreciate the kernel of "truth" in seemingly contradictory points of view. Patients with co-occurring disorders, as well as mental health practitioners, can sometimes get hung up on whether they have either a mental disorder or a substance use disorder, and whether one or the other should be treated first. Walking the Middle Path replaces the "chicken or the egg" question with the "chicken and the egg." A common example of this is patients with bipolar disorder and substance abuse. Both disorders need to be treated simultaneously in an integrated fashion if treatment is to be successful.

Adult inpatient team members do many of the same skill-strengthening assignments given to our patients. This helps staff with the important task of accepting and validating the challenge of behavioral change, and understanding that given their circumstances, patients couldn't be any other way. It also helps staff be better able to help our patients define "target behaviors" and the skills necessary to deal with them. Target behaviors may include substance abuse, intentional self-harm, suicide attempts, dangerously risky behavior, binging, purging, promiscuity, gambling, avoiding treatment, stopping medications, etc.

Patients learn to identify the target behavior(s) that led them to come into the hospital, along with the triggers and circumstances that resulted in the target behaviors. The process by which this chain of events is identified is called a Behavioral Chain Analysis. Helping patients identify the links in the chain and learn alternate behaviors (skills) to manage the progression of events more skillfully is essential to helping them improve their lives one day at a time. The transformative power of the program lies in the dance, of sorts, between acceptance and change, the central dialectic in Dialectical Behavior Therapy. Accepting that our patients are doing the best they can, while also recognizing that they must change in order to have a life worth living, enhances self-acceptance and motivation.

Medication management is a vital part of treatment for patients with co-occurring disorders. Abuse of substances can interfere with prescribed medications, increasing the risk of relapse of the psychiatric condition, which may further increase the abuse of substances. Our team of experienced psychiatrists practices state-of-the-art psychopharmacology to address co-occurring psychiatric problems, such as depression, panic disorder, PTSD, bipolar disorder, and psychotic disorders. If necessary, careful medical monitoring helps patients withdraw from substances. Medical staff members are versed in helping patients walk the "middle path" between accepting the need for medication while also accepting personal responsibility for working on skills to create a life worth living.

As we live through ongoing change in our healthcare environment, there is one thing that we believe is certain: incorporating DBT has strengthened Four Winds Adult Inpatient Co-Occurring Program and makes the program transformational experience for our patients.

Dr. Bauman is Assistant Professor of Psychiatry and Behavioral Sciences at the Albert Einstein College of Medicine.

The Future from page 1

policy in New York State.

New Opportunities: Federal and State changes through the Affordable Care Act and Governor Cuomo's Medicaid Redesign Team have and will continue to provide many opportunities to strengthen addiction service and will bring needed addiction screening and intervention to many patients who are currently unidentified and untreated. We have already seen how we can work together and use these opportunities to strengthen addiction services. Together we have already successfully advocated for: (1) Ensuring that addiction services are included in the Essential Benefit Package, (2) Achieving policy to ensure that Mental Health and Substance Abuse services are managed with parity to other health conditions, and (3) Activating a Behavioral Health subcommittee to inform the design of the managed addiction benefit within the overall Medicaid Redesign.

Working Together: Together there is more for us to do and more opportunities to pursue: (A) We need to build on our past success and use new opportunities to secure a place for addiction screening and referral to treatment in the mainstream of health care, (B) We need to ensure that the people on the front lines of the medical system learn to ask the relevant questions and screen for substance abuse. The OASAS Medical Director has been, and will continue to, meet with the medical directors of hospital Emergency Departments and Comprehensive Psychiatric Emergency Departments to continue our progress towards this goal, (C) We will have new opportunities for care coordination, (D) We want everyone we serve to receive good care coordination, a peer to help bridge treatment and recovery, greater recovery supports, and an improved quality of life, (E) We want to reduce expensive hospital stays by getting people into treatment and giving them the support they need to recover, (F) We want to use Care coordination, arriving in the form of Health Homes, to help us save money on crisis admissions and emergency room visits, and (G) We will then reinvest these savings to improve people's health in the long-term.

The Future with Medicaid Managed Care: As the State moves towards a fully managed Medicaid system we understand that we have to be careful and provide protections during this transition. So OASAS has, and will, continue to take action to do just that. We succeeded, with inclusion in the final 2013-14 NYS Budget, in putting into place a number of significant transitional protections: (1) First, managed care will have to reimburse providers at established APG rates for two years, (2) Second, they will have to reimburse providers for the services provided by CASACs, and (3) Third, they will have to include providers in their networks when they have a treatment relationship with the patients in their plans.

Additionally, we will make sure that the state segregates and separately tracks behavioral health spending from physical health spending. Most importantly, OASAS will regularly and carefully monitor how the plans manage the SUD benefit.

The transition to a managed system also provides us with opportunities to further develop innovative patient-centered and recovery oriented services that providers and OASAS have considered for many years but were unable to achieve in a fee for service environment. We will seek approval from the federal Centers for Medicare & Medicaid Services (CMS) to allow providers to treat people outside the four walls of their facility, in recovery-oriented settings in the community. We will seek approval to offer services such as housing support and pre-vocational training for the high-need individuals who frequently use inpatient services. We will also seek approval so that clinical services provided in all treatment settings are reimbursable by Medicaid. That includes clinical services in our Intensive Residential Treatment programs.

We will continue to work with our partners at DOH and OMH to ensure that our patients receive the best possible integrated treatment. We will also have new partners, including: behavioral health organizations; health plans; health homes; and, health and recovery plans. Our new partners may have different vantage points or perspectives but we all have the same goal of providing patients with access to excellent care. Together with our new partners we will ensure that we achieve our common goal; that patients have access to all of the resources currently available and that we build new services; new models and new opportunities for community based recovery.

We will have an opportunity to redesign services to fit with a more modern, patient–centered and recovery oriented continuum of care that is attractive to patients and payers alike. This will require a rethinking of some of our models including the Intensive Residential Treatment model. Our Intensive Residential Treatment programs vary a great deal in terms of length of stay, completion rates, and costs—and in the services they offer. Currently, New York State has one of the largest Intensive Residential Treatment

see The Future on page 46

Total Wellness: The Key to Behavioral Health

By Peter Provet, PhD
President & CEO
Odyssey House

The term "behavioral health" is often used to describe the connection between behavior and the health and well-being of the body, mind, and spirit. Substance use disorders, mental illness, homelessness – these are all behavioral health problems that need a multi-faceted treatment approach. The path to recovery requires us to see the connection between substance abuse and related problems and to take the necessary steps to address these issues in a comprehensive and effective way. That is why Odyssey House provides high quality, holistic treatment impacting all major life spheres: psychological, physical, social, family, educational, and spiritual.

Established in 1967, Odyssey House is a nonprofit behavioral health care organization with a mission to provide comprehensive and innovative services to New Yorkers struggling with substance use disorders, mental illness, and homelessness. With 10 substance abuse, mental health and supportive housing facilities located in East Harlem and the South Bronx, Odyssey House provides a range of direct and supportive services, including residential and outpatient substance abuse treatment, trauma-informed services, case management, primary health care, dental care, mental health care, supportive housing, recovery coaching, housing assistance, vocational and educational support, and more.

Treating the Whole Person

At any one time, Odyssey House is home to more than 1,000 men, women, and children. Some of these residents are young mothers who enter treatment with their children, seeking a drug-free life for themselves and a brighter future for their families. Older men and women come into treatment to break a lifetime habit of addiction, while teens are attempting to get back on track and succeed in school and at careers. For all of these clients, Odyssey House provides a chance to recover from addiction and mental illness and, along with that, to experience the psychological and physical well-being that comes with recovery.

Throughout all programs, Odyssey House provides holistic care with wrap-around services. Recognizing that there is no "one size fits all" treatment model, Odyssey House does not simply place clients in housing or treat them for their substance use disorders or mental illness. We provide ongoing, personalized support to teach daily life skills, reunite families through NYC Administration for Children's Services mediation and family therapy, attend to educational needs

Peter Provet, PhD

through GED preparation and classes, and care for the body through our health clinics and on-site gym facilities.

This complete continuum of care stabilizes clients and puts them on the path to lasting independence. Through Odyssey House's licensed medical clinic and dental clinic, clients of all programs are able to access a range of health care services, giving our clients a crucial opportunity to manage their health before their conditions degenerate into an emergency situation.

Managing Mental Illness

Men and women suffering from mental illness are especially prone to substance abuse. The effects of addiction combined with the challenges of chronic mental conditions can be devastating, isolating these men and women from family, making it almost impossible for them to lead productive lives in the community, and often rendering them homeless.

At Odyssey House, case managers and counselors enhance treatment in our supportive housing communities with intensive mental health services and coaching in life skills ranging from personal hygiene to financial management. Up to 250 residents, most referred from city and state psychiatric facilities, partake in supported community living plus group therapy, medication management, vocational counseling and job training—all part of preparing themselves to take control of their lives and re-enter the community.

When the time comes, Odyssey House helps these men and women make the difficult transition into permanent housing. Residents in treatment attend workshops that teach such real-life skills as budgeting, making rent payments on time, and grocery shopping. Once participants have successfully completed the workshops, a placement specialist helps them find affordable housing, accompanies them on interviews with landlords, and helps negotiate rental contracts. In this way, Odyssey House helps break the cycle of relapse and homelessness.

Beyond Treatment

At Odyssey House, recovery is more than just sobriety. Recovery includes engaging in regular physical activity, taking responsibility for your health, and expressing yourself creatively.

Research shows that exercise not only improves cardiovascular function and has other physical benefits but can also elevate mood, alleviate stress, and even improve brain function. Exercise makes us feel better, both mentally and physically, and that is why physical fitness is such a big part of the Odyssey House experience.

Facilities are equipped with exercise equipment and weights, and residents are encouraged to enjoy yoga, Pilates, basketball and other team sports. Especially popular is Run for Your Life, a program that brings residents of all ages together several times a week in New York's Central Park to walk or run. Many clients also choose to participate in marathons and other races.

Creating art provides a way to access and express feelings, and helps relieve a sense of isolation. Residents at all Odyssey House facilities are encouraged to express themselves through art and writing, and also enjoy readings, film screenings, and museum visits. The Odyssey House Art Project engages residents in painting, sculpture, and other forms of expression. Every year, works by these residents are showcased in the Haven Art Gallery, occupying a handsome, light-filled space in an Odyssey House facility on East 121st Street in Manhattan.

These activities provide residents with a chance to develop relationships with one another, improve their self esteem, gain control over their bodies, and get a change of pace from the strenuous, day-to-day routine of recovery. Most important of all, they introduce residents to yet another component of a richer, fuller, more satisfying substance-free life.

When You're Feeling Hopeless - Don't Ever Give Up
There is a Caring Behavioral Health Community Out There to Help You

"Behavioral" Health: What a Difference a Word Makes!

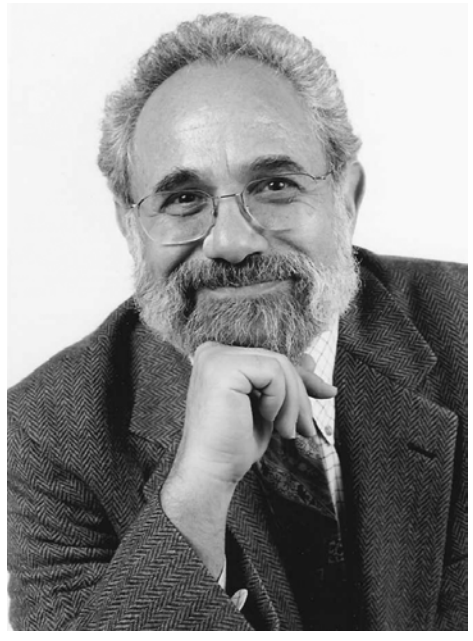
By Michael B. Friedman, MSW
Mental Health Policy Advocate

Mental Health News is now *Behavioral Health News*. It will now be reaching out to the fields of alcohol and substance abuse services and planning to expand its subject matter to include information about these fields in addition to the field of mental health. This is an exciting development that, I think, will enable *Behavioral Health News* to serve as a platform for discussions of vast changes in public policy that are now underway.

The name change obviously follows a trend that has gathered momentum over the past decade for "mental" health organizations to become "behavioral" health organizations. For example, The National Council of Community Mental Health Centers is now The National Council of Community Behavioral Healthcare, and The Coalition of Voluntary Mental Health Agencies is now the Coalition of Behavioral Health Agencies.

Why is this shift in terminology taking place? Let's start with a bit of history.

Until the 3rd quarter of the 20th century "mental health" referred to all diagnosable mental conditions, including addictive disorders and, arguably, developmental disorders. For example, until the mid-1970's there was a single Department of Mental Hygiene in New York State. It



Michael B. Friedman, MSW

was responsible for services for people with mental illness, "mental retardation" (as it was known at that time), alcoholism, and addiction to illegal substances. In 1977, this department was divided into four cabinet level departments—the "Offices" of mental health and mental retardation and the "divisions" of alcoholism, and substance abuse, which were subsequently merged into an Office of Alcoholism and Substance Abuse.

Similar restructuring took place around the country, reflecting changes that had already taken place in the field. Families of people with intellectual and developmental disabilities (as they are now known) worked hard to get out from under the control of psychiatry and other mental health professions. They did not regard developmental disabilities as mental illnesses and had little regard for the usefulness of mental health professionals for their family members.

The fields of alcoholism and substance abuse also worked to get out from under the control of psychiatry and other mental health professions. By the 1970s there were profound differences between the views, practices, and personnel of "mental health" and those of alcohol and substance abuse services. One difference was that mental health practitioners by and large were professionals with university degrees and other formal professional training and credentials. The dominant providers in the field of addictions were recovering from alcohol and drug dependence, who believed that professionals were not only not necessary but were also potentially harmful. Why? Because mental health professionals tended to believe that treatment should either be an effort to uncover the inner psychological root causes of addiction or should involve providing medication, while addiction providers generally believed that behavior had to be changed immediately with the help of other people with addictions and a higher power. They also were generally opposed to using substances to treat substance abuse. Immediate abstinence was their fundamental goal.

We tend to talk these days about the "silos" of mental health and substance abuse as if this was just some dumb thing that happened thoughtlessly, but in truth the silos (a metaphor I have never understood) reflect the profound disagreements that existed, and to some extent still exist, between mental health professionals and the people who led efforts to address substance abuse—whether alcohol or illegal substances.

The schism between the fields of mental health and substance abuse worked out pretty well in the politics of public policy and public service, but it was not an idea that captured the minds and hearts of large employers and health insurance companies that needed to make decisions about the extent to which they should cover mental as well as physical conditions. To them an addiction was a mental health condition—if it was a health condition at all.

By the early 1980s, managed care organizations were beginning to develop a market among employers and health insurance companies for the management of access to mental health services, including services for addictions. As far as I know, it was these companies that coined the term "behavioral health."

see Behavioral Health on page 50

Mental Health News Education, Inc. Welcomes New Board Members

Staff Writer
Behavioral Health News

Excitement has been steadily building for this premier issue of *Behavioral Health News*. So you can imagine our added excitement when it was just announced that two very prominent leaders from the substance use community have been elected to our Board of Directors. That is, to the Board of Mental Health News Education, Inc., (MHNE) the nonprofit organization that publishes *Behavioral Health News*.

They are Debra Pantin, MSW, Chief Operating Officer at Palladia, Inc., and Joseph Krasnansky, LCSW, Vice President and Chief Program Officer at the Lower Eastside Service Center.

Dr. Peter D. Beitchman, Chairman of the MHNE Board of Directors and Executive Director of The Bridge stated, "We are extremely honored to have Debra and Joe join our Board. They are both well known leaders of the substance use community. Their participation on our board will play a vital role in our newly expanded mission of providing mental health and substance use education to the community. Their knowledge of the substance use and mental health community will add a balanced perspective to the content of *Behavioral Health News*."

Debra Pantin earned her MSW degree at Hunter College School of Social Work

Debra Pantin, MSW

Joseph Krasnansky, LCSW

and her BA at SUNY College, Purchase, New York. Debra has been with Palladia (formerly the Project Return Foundation) since 1987. Prior to her current position as COO, Debra served in key positions in charge of housing, outpatient and centralized services, clinical support services, and more. Her professional affiliations include the NASW, NYS-ASAP, the NYC Intra-agency Task Force, the NYC Drug Court, NYS-OASAS Workgroup and Committee, Coordinated Behavioral Care (CBC), the Coalition of Behavioral Health Agencies, and the NYC BHO Detoxification Work Group.

Joseph Krasnansky earned his MSW at NYU School of Social Work and his BA from the New School for Social Research. He received his Post Graduate Training at the New York Center for Psychoanalytic Training. Joe has been VP and CPO at the Lower Eastside Service Center (LESC) for the past seven years, and has held other key positions at LESC since 1987 including: Chemical Dependence Programs at the New York Downtown Hospital, and Opioid Recovery and Methadone Treatment Services at LESC. Prior to his current years at LESC he has held other positions at the Children's Aid Society, Jewish Child Care Association, NYS Psychiatric Hospital and at Columbia Presbyterian. Joe has also conducted a private clinical practice since 1979. His affiliations include the NYS Society of Clinical Social Workers (NYSCSW), the NASW, the Coalition of Behavioral Health Agencies, and serves on multiple committees of the Committee of Methadone Program Administrators (COMPA), and the National Institute of Drug Abuse - Clinical Trials Network. Joe is also known for his many clinical and policy presentations.

Ira Minot, LMSW, Executive Director of MHNE and Publisher of *Behavioral Health News* stated, "I am so excited that Debra and Joe have joined our Board of Directors. They are both held in such high regard by their colleagues in the substance use and mental health communities. I know that *Behavioral Health News* will greatly benefit by the knowledge, expertise, leadership and guidance they will bring to our organization."

Behavioral Health Transformation: ASAP Provides Vision and Leadership

By John J. Coppola, Executive Director
The New York Association of Alcoholism and Substance Abuse Providers (ASAP)

The New York Association of Alcoholism and Substance Abuse Providers, Inc. (ASAP) is committed to influencing public policy so that substance use disorders and problem gambling prevention, treatment, and recovery services providers and the people they serve have the best opportunity to succeed. Toward that end, ASAP has worked to position itself strategically to influence policy change and its implementation and, at the same time, to help services providers make the changes necessary to achieve desired outcomes and to thrive while doing so. We are working with the Governor, who has invited our participation, and we are working with numerous state agencies to achieve a transformation of services delivery that is of a magnitude not previously experienced by persons working in the field.

Relative to policy change, ASAP has been working with a diverse network of advocates and stakeholders, the New York Coalition for Whole Health, to ensure that behavioral health services are included as a core component in emerging healthcare models and in policies that are developed as NYS implements healthcare reform. Simultaneously, NYS is moving forward with Medicaid redesign, development and implementation of the NY Health Benefit Exchange, transition from a fee-for-service model to managed care, integration of behavioral health with primary healthcare, implementation of health homes, and a variety of additional innovations and transformations including reorganization and transformation among state agencies. ASAP staff and members are actively participating with advisory

John J. Coppola

and decision-making workgroups in each of these areas. We are working to ensure that people with substance use and problem gambling disorders have access to the prevention, treatment, and recovery services they need and that services providers are able to thrive as they work to help those in need. ASAP sees the value of working collaboratively with consumer and family groups and with advocates from a range of services delivery systems to ensure that new policies respond to our collective needs.

To help services providers make the changes necessary to achieve desired serves outcomes and to ensure implementation of a sound business model, ASAP has initiated a major technical assistance initiative. We are developing Learning Communities, Transformation Workgroups, and a technical assistance team comprised of experts from a cross section of content areas to help services providers learn as much as possible about the emerging environment, assess the need for organizational transformation, and help them implement the necessary changes with support from expert technical assistants. ASAP invites behavioral health providers from across NYS to participate in our Learning Communities and to participate in the work of our Transformation Workgroups. For additional information, contact Ashley Behrle at ABerhle@asapnys.org.

ASAP intends to provide *Behavioral Health News* readers with updates about our systems transformation work relative to public policy and implementation. Please feel free to reach out to us with questions and recommendations for future articles. ASAP is pleased to be a catalyst in the transformation of this publication as it transitions to *Behavioral Health News* and we are committed to making the transformation a success.

ASAP Makes Commitment To *Behavioral Health News*

According to Ira H. Minot, LMSW, Executive Director of Mental Health News Education, Inc., the nonprofit organization that publishes *Behavioral Health News*, "The New York Association of Alcoholism and Substance Abuse Providers, Inc. (ASAP) was very supportive during our transition from *Mental Health News* to *Behavioral Health News*. In early discussions with John Coppola, ASAP Executive Director, he encouraged our Board to move forward with the transition and offered his support. John will be a regular contributor to *Behavioral Health News* and has promised to assist in our work to ensure strong content addressing substance use disorders and problem gambling prevention, treatment and recovery."

ASAP is responsible for providing vision and leadership to organizations and individuals who work to provide effective substance use disorder and problem gambling prevention, treatment, and recovery support services in communities across New York State. With close to 200 agency members and a Board of Directors that includes representatives from every regional and statewide coalition or association of substance use disorders services providers in the State, ASAP is the voice of the substance use disorders services field. ASAP's membership includes programs from rural, suburban, and urban communities; not-for-profit and for-profit corporations; prevention, treatment, and recovery support services providers; professional development and research; organizations ranging from very small to quite large; and individuals working in the field or wanting to support the work being done by addictions programs. In addition to a comprehensive range of substance use disorder and problem gambling services, ASAP members also provide primary healthcare, mental health services, housing, alternatives to incarceration, peer support, recovery coaching, social services, employment and vocational services, care coordination, and more. ASAP is the largest state association of substance use disorders services providers in the U.S.

We encourage readers to reach out to us with requests for articles and other content covering addiction specific issues. We appreciate the support and contributions made by ASAP to this first issue of *Behavioral Health News* and we look forward to future contributions from ASAP staff and members.

Peer Support from page 8

him to call again if he wanted.

And:

The first time I had kitchen duty with a guest, I took it upon myself to prep most of the food and also assist with serving the dish and clean-up. When the guest came down, she was very eager to help, but not much was left to be done. The guest ate the dinner, but was visibly a bit sad. I remembered her cultural background as being one that places great importance on sharing food and hospitality. I brought this up, and acknowledged that I assumed it would be nice of me to take care of most of the prep, and asked if she would like to be more involved next time and she talked about the joy she finds in "feeding others." After this, the time we set aside for dinner preparation and serving was when she was most engaged in the program, lively, talkative, and happy. Being with this guest was truly a treat since then, as she was able to share many of her favorite dishes with staff and fellow guests which, in turn, has aided in the recovery of others as well.

Intentional Peer Support allows a person in crisis the opportunity to discover a new role that is simply not possible in traditional clinical settings. As I have experienced, this process can truly lead to lasting changes in the lives of the people we help, and ourselves. To learn more about Intentional Peer Support visit www.intentionalpeersupport.com.

BEHAVIORAL HEALTH NEWS DESK

NYS's Governor Cuomo Launches Emergency Tracking System To Locate Patients During Emergencies and Evacuations

By the Office of New York State Governor Andrew M. Cuomo

Governor Andrew M. Cuomo today announced that New York State is launching a statewide emergency tracking system to ensure the safety of patients and residents when healthcare and human services facilities are forced to evacuate as a result of a natural disaster.

The New York State Evacuation of Facilities in Disasters System (NYS e-FINDS) is a secure, confidential, fast and easy-to-use system to provide real-time access to patient locations. The system will be in place for the 2013 hurricane season, with training for providers beginning next week.

"In the event of an emergency, it is vital that family members, hospitals and nursing home staff can quickly find loved ones and patients if evacuations occur," Governor Cuomo said. "Protecting the safety of vulnerable populations is always our top priority and this new system will serve as a critical emergency resource for all major health care and human services facilities."

During Superstorm Sandy, more than 13,000 patients and residents were evacuated from State-regulated and State-run facilities, including more than 7,100 from

Governor Andrew M. Cuomo

hospitals and nursing homes. When these storms struck, there was no statewide system in place to track vulnerable patients and residents who had to be transferred to alternative locations due to flooding, power outages or damage to facilities.

NYS e-FINDS will provide patient tracking to hospitals, nursing homes and adult care facilities overseen by the Department of Health; state developmental centers and many certified residential homes overseen by the Office for People With Developmental Disabilities; residential treatment programs overseen by the Office of Alcoholism and Substance Abuse Services; state psychiatric facilities and licensed residential programs overseen by the Office of Mental Health; supportive housing overseen by the Office of Temporary and Disability Assistance, and juvenile justice facilities operated by the Office of Children and Family Services.

Under this new system, all facilities will use barcode wristbands pre-printed with the facility name for all patients and facility residents, except for facilities such as substance abuse treatment programs where confidentiality requires that facility names be excluded. Patient and resident locations can be updated and tracked using hand-held scanners, mobile apps, or paper tracking (if power and/or phones are out of service).

The establishment of NYS e-FINDS follows the recommendation of the NYS Ready and Respond Commissions, and was based on close collaboration with outside organizations, including the Greater New York Hospital Association (GNYHA).

Kenneth E. Raske, President of the Greater New York Hospital Association, said: "New York's hospital community strongly supports the development of a patient tracking system that will improve the evacuation process and ensure that family members and key response agencies can track the location of patients during emergencies. We applaud New York State for its leadership in analyzing the region's response to Superstorm Sandy and identifying ways to improve evacuations, the safety of those sheltering in place, and the ability to protect our most vulnerable populations."

Daniel Sisto, President of the Healthcare Association of New York State, said: "The response of the provider community to Super Storm Sandy was historic in its magnitude and demonstrated again the irreplaceable role played by our care delivery system, especially in times of disaster. Notwithstanding this incredible response, we learned things that can be improved upon; and, regrettably, we learned again that there will always be a potential crisis for which we must always be prepared. We therefore applaud the Governor and the Department of Health for creating this initiative that will help us respond in the future with even greater coordination and effectiveness."

Harvey Rosenthal, Executive Director of the New York Association of Psychiatric Rehabilitation Services, said: "NYS e-Finds will provide a state-of-the-art electronic method to help ensure that New Yorkers with disabilities continue to be

see Tracking on page 22

New York State Office of Mental Health Announces OnTrackNY

By the New York State Office of Mental Health (OMH)

The New York State Office of Mental Health (OMH), in collaboration with The Center for Practice Innovations at Columbia Psychiatry, The New York State Psychiatric Institute, and The Research Foundation for Mental Hygiene, is pleased to announce the availability of *OnTrackNY*.

OnTrackNY is an innovative, evidence-based team approach to providing recovery-oriented treatment to young people who have recently begun experiencing psychotic symptoms. These symptoms may include unusual thoughts and beliefs, disorganized thinking, or hallucinations such as hearing or seeing things that others don't. *OnTrackNY* helps young adults aged 16 to 30 with newly-emerged psychotic disorders achieve their goals for school, work, and relationships.

"Schizophrenia usually emerges in young adulthood and puts the young adults it strikes at huge risk of going off track. *OnTrackNY* is all about helping young people stay in school

or stay employed while learning how to manage their illness. By intervening early, we'll help people to take control of their health and to maintain wellness. Schizophrenia can emerge within any family, which is why *OnTrackNY* teams will be open to all New Yorkers with emerging psychosis suggesting schizophrenia. Our goal is to help these New Yorkers get back on track, reduce suffering, and have productive, fulfilling lives." said Kristin M. Woodlock, Acting Commissioner of the New York State Office of Mental Health.

OnTrackNY will follow principles of care which include shared decision making, youth friendly and welcoming environments, and flexible and accessible recovery oriented services. The program will serve young adults with psychoses suggesting early schizophrenia, within one year of the onset of their psychotic symptoms, regardless of treatment received during that time.

Four partner agencies in the downstate region have been awarded funds for staff, training, and technical assistance. These partner agencies were identified in collaboration with County mental health departments. They are: Kings County Hospital Center; the Mental Health Association of Westchester; North Shore Long Island Jewish Hospital; The Washington Heights Community Service Center at The New York State Psychiatric Institute.

OMH has invited Lisa Dixon, MD, MPH, Director of the Center for Practice Innovation at the New York State Psychiatric Institute, to direct the implementation and further develop its provision statewide. Dr. Dixon is the principal investigator of the RAISE (Recovery After Initial Schizophrenia Episode) Connection

see OnTrackNY on page 50

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The Tradition of Excellence Continues at Wurzweiler School of Social Work

By Carmen Ortiz Hendricks, DSW, ACSW
Dorothy and David Schachne Dean
Wurzweiler School of Social Work
Yeshiva University

Wurzweiler School of Social Work at Yeshiva University is a nationally and internationally recognized School of Social Work. Located in Washington Heights and in Midtown Manhattan, the School is accessible to all five boroughs as well as Long Island, New Jersey, Westchester and even Connecticut. When it opened in 1957, Wurzweiler was the first School of Social Work under Jewish auspice. It is grounded in the values and ethics of the social work profession, values of diversity, inclusion, human rights and social and economic justice, and "Tikun Olum" which means "repairing the world" in Hebrew. The faculty and student body reflect the diversity of New York City, and the School is engaged in a Wurzweiler Community Partnership to recruit more BA level workers from Washington Heights to the MSW program thus professionalizing many community-based agencies in the area. Wurzweiler is accredited by the Council on Social Work Education through to 2017.

For almost 60 years, the School's mission has adhered to a distinct set of values—excellence of teaching and learning, cultural competence, professional ethics and values, scholarship, social justice, and the importance of service to individuals, groups, and communities. Wurzweiler has educated MSW and PHD social workers who have gone on to outstanding careers as clinicians, supervisors, managers, administrators, researchers, educators, and legislators. MSW students choose from concentrations in advanced clinical practice with individuals & families, clinical group work, and community organization practice. Wurzweiler students can choose to obtain one of five certifications: Certificate in Jewish Communal Service (CJCS), Certificate in the Practice of Gerontology (CPG), Certificate in Child Welfare Practice (CCWP), Certificate in Social Work Practice with the Military (CSWPM), and the newest Certificate in Jewish Philanthropy (CJP). The certificates allow graduates to market themselves as having a modicum of expertise in a career direction of their choosing. The new Certificate in Jewish Philanthropy is unique among other fund raising training programs. Its graduates will be well-positioned to assume critical development positions in Jewish organizations. It is a training program focused solely on addressing the acute shortage of qualified fund raisers in the Jewish community. It integrates classroom instruction on the art and science of fund raising with internships and professional coaching. It also explores the Jewish philanthropic tradition through textual study of primary sources on core Jewish values.

Carmen Ortiz Hendricks, DSW, ACSW

Wurzweiler's Doctoral Program is one of the largest doctoral programs in social work in the country. Initiated in 1968, over 200 graduates have received doctoral degrees, and many of them, like Dean Carmen Ortiz Hendricks, have earned the Doctor of Social Welfare (DSW) degree. Since 2000, Wurzweiler has been approved by the New York State Department of Education to offer the PHD in Social Welfare. The core of all educational programs at Wurzweiler lies in its mission to prepare students to undertake competency-based practice in the profession of social work at the direct practice, middle and upper management levels and in teaching and research. The PHD Program prepares scholarly practitioners who represent this core concept. Unlike many other PHD programs, Wurzweiler's program is grounded in practice. PHD students are expected to have an MSW degree, and to be employed in a social work position during their studies. This reflects the need for doctoral students to maintain their involvement in social work practice and to link the academic knowledge learned in the classroom to their practice. Wurzweiler is also planning to offer a fully on-line PHD program in the not too distant future.

Wurzweiler claim to fame is that it is what it says it is. There is a strong commitment to maintaining small class sizes with classes capped at 20 students and practice classes hold no more than 15 students. The individualized attention students receiver inside and outside the classroom is unique to social work programs in New York City. Wurzweiler has flexible study options with classes held daytimes, evenings and Sundays: on-line course offerings; and a midtown evening option at 33rd Street and Lexington Avenue. There are full-time, part-time, BSW Advanced Standing, 16 month Accelerated and a Summer Block Program options as well as a joint MSW/PhD program. Wurzweiler has dual degree programs offering an MSW/JD with YU's Benjamin Cardozo Law School and an MSW/Divinity Degree in conjunction with Yale Divinity School.

The Wurzweiler office of field education maintains relationships with over 100 social service agencies in the tri-state area and globally. Field placement agencies are selected for their diversity, quality of service to the community, learning opportunities, expertise of supervisors, and eagerness to collaborate. Wurzweiler has partnerships with the American Jewish World Service, the Peace Corps and City Year that broaden outreach to the global community. Field education is the heart of social work education and the signature pedagogy. That is why field work and classroom work go hand in hand in the education of a social worker. Social work is not just academics but it involves concurrent hands on experiences with individuals, families, groups and communities.

The faculty at Wurzweiler produces world renowned research published in major peer-reviewed field-related publications. They have expertise in a wide range of areas including working with military families, elderly, child welfare, Jewish communal service and Latino communities; clinical practice, group work and community practice; hearing impaired infants, women with Lupus, and end of life decisions; and faculty excel in cutting edge research methodologies, field education, and cultural competence in social work education and practice. Eight faculty are Fulbright Specialists and traveled to England, Israel, and South Africa to teach and consult. One faculty member is currently the editor-in-chief of Families in Society, the premier professional journal in social work. Other faculty serves on editorial boards, community boards and commissions.

Wurzweiler's MSW and PHD graduates are leaders in social service agencies around the world, and in professional organizations like the National Association of Social Workers, Council on Social Work Education, Society for Social Work and Research and the International Association of Schools of Social Work. Wurzweiler's Dean currently serves as Chair of the Commission on Accreditation for CSWE. Wurzweiler alumni are the best advertisement for the School, because more applicants are referred by alumni than by any other form of recruitment including Wurzweiler's website, open houses, and newspaper ads. Wurzweiler takes great pride in the contributions of alumni to improve the lives of vulnerable populations throughout the world. Alumni lead major Jewish agencies and federations around the U.S., Canada and Israel. They are leaders in health care, mental health/behavioral health care, addictions, disabilities, education, veterans' affairs, elder care, child welfare, forensics, and Jewish communal service. Alumni represent Wurzweiler in whatever arena of practice they are in.

Wurzweiler is recognized around the country and the world, in both secular and public forums, as a leading producer of scholarship and of graduates who are skilled social work practitioners, well-trained in ethical precepts. Several categories are repeated throughout the curriculum, namely, knowledge of social work values and ethics; bio-psycho-social -spiritual theories; social diversity and cultural competence; policy analysis and critique; organizational structures; and professional practice as a life-long learning experience.

Join the Wurzweiler community and become the finest social worker the world has known.

For more information about our programs go to www.yu.edu/wurzweiler or call 212-960-0810. Wurzweiler continues to accept applications for the Fall, 2013 semester.

Tracking from page 20

connected to vital services and supports that are especially critical in times of disaster. This very smart and strong response can give us all some greater confidence in our ability to respond and provide continuity of care to our community members during such emergencies."

State Health Commissioner Nirav R. Shah, M.D., M.P.H., said, "Patients and health facility residents are our primary concern when a disaster occurs and it is imperative that we be able to know their exact location even amidst the chaos when patients and health facility residents need to be relocated due to damage and power outages. Governor Cuomo has taken decisive action in the wake of natural disasters to improve our State's emergency preparedness and response capabilities, and the NYS e-FINDS is an important tool that will greatly enhance patient safety when an emergency situation occurs."

New York State Division of Homeland Security and Emergency Services Commissioner Jerome M. Hauer, said: "By implementing NYS e-FINDS, Governor Cuomo has applied a sensible and critically important mechanism for tracking patients during emergencies, which is another level of preparedness that will contribute to the safety and security of our state's most vulnerable population during events such as Superstorm Sandy."

Kristin M. Woodlock, Acting Commissioner of the New York State Office of Mental Health, said: "The Office of Mental Health is committed to the safety of children and adults who receive treatment in our hospitals. During times of emergencies our care will be enhanced through this confidential, reliable protocol."

Kristin M. Proud, Acting Commissioner of the New York State Office of Temporary and Disability Assistance, said: "This new system will help ensure the safety of vulnerable populations who are forced into shelters because of an event such as Superstorm Sandy. We have seen first-hand the obstacles of serving New Yorkers in these emergencies and are confident that this system will address these challenges as well as help other family members stay aware of their loved ones' situations."

Courtney Burke, Commissioner of the New York State Office for People With Developmental Disabilities, said: "Events

see Tracking on page 47

— The NYSPA Report —
A Salute to *Behavioral Health News*

By Barry B. Perlman, MD
Director, Department of Psychiatry
Saint Joseph's Medical Center

The New York State Psychiatric Association (NYSPA), the state affiliate of the American Psychiatric Association, applauds and congratulates the Board of Mental Health News Education, Inc. for its decision to broaden their publication's mission to address issues related to alcohol and substance abuse as well as mental illness. The publication's new name, *Behavioral Health News*, serves to announce that broadened horizon.

The decision to advance the publication's content areas comes at a time when the clinical need to address the challenge of the co-occurring disorders of mental illness and alcoholism/substance abuse is being recognized by psychiatric physicians and other clinicians as well as New York State's Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS) and federal agencies such as SAHMSA (The Substance Abuse and Mental Health Agency). The American Psychiatric Association (APA) and its state affiliates, such as NYSPA, have long advocated for integrated services and for the recognition of the need for Parity insurance benefits covering the full spectrum of mental illness and addiction diagnoses. The national coalition of advocacy organizations, among which the APA assumed a proud leadership role, saw its long time goal realized with the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in October, 2008. Psychiatrists viewed the federal Parity Act as the culmination of a long fight for equitable treatment for those with mental illness and addiction disorders in the mold of other civil rights struggles in our country's history. With the passage of MHPAEA, the challenge now is to realize its goal by achieving full implementation despite resistance from the behavioral health insurance industry.

The APA recognizes, as do state and federal agencies, that these disorders are biologically based and socially influenced. As a consequence, they cannot be treated in isolation, one from the other. The epidemiologic data describing the prevalence rates of mental illness and substance use disorders and the frequency with which they co-occur are compelling. SAMHSA reports the following statistical findings. Forty-five million Americans suffer with mental illness of which 11 million are found to have serious and persistent mental illness (SPMI) and 8.9 million have co-occurring mental illness and substance use disorders. Almost 21 million persons are believed to have substance abuse disorders. While 44% receive care focusing on one or the other disorder, only 7.4% receive care addressing both problems and a whopping 55.8% are receiving no treatment at all. It also has been found, based on an analysis of Medicaid data, that those with co-occurring disorders are disproportionately costly and demonstrate higher levels of

Barry B. Perlman, MD

socially unacceptable behavior such as violence. Furthermore, much of the higher medical cost is attributable to increased rates of medical illness including diabetes mellitus, hypertension, and cardiac illness, among others.

With the attention of responsible federal and state governmental agencies and of professional societies, such as APA and NYSPA, focused on the important matter of mental illness, substance abuse, and medical disease co morbidities, the treatment landscape is rapidly evolving. These transformations are occurring at the same time that the requirements of the Accountable Care Act (ACA) are taking effect. The greatest change is poised to occur in 2014 when millions of Americans will gain access to affordable health care. Building on existing health insurance vehicles such as commercial insurance, Medicare, and Medicaid the ACA will extend benefits through the newly created healthcare exchanges and an extension of Medicaid to a newly defined low income group in states such as New York which have chosen to participate. It is noteworthy that the Parity protections conferred on persons requiring care for mental illness and substance use disorders by MHPAEA is to be categorically preserved in the benefit design of these new health insurance products. Along with enrollee expansion will come an increased reliance on an ever more "managed" system with the goal of containing costs. Given the checkered history of enrollees' experience with managed care and especially in the face of the resistance of behavioral managed care companies to full compliance with MHPAEA, consumers and professionals will need to remain vigilant and push in a variety of ways to assert the rights embodied in the law.

What are the steps being taken? In NYS Governor Cuomo initiated a Medicaid Redesign Taskforce to address the issues of the need for better integrated care and control of costs, among others. Several of its work products include the formation of Health Homes, initially funded largely through federal funds, to improve the environment for the delivery of integrated care. Collaborative efforts between the OMH and OASAS, such as the "no wrong door" approach have the goal of making access to mental health and addiction services easier. Going forward it is anticipated that the system is likely to transition from the current model of parallel, stove piped care to truly integrated care. Such a step forward would be presaged by regulatory change establishing unified service licensure of providers.

Aware of research findings on prevalence rates of substance use disorders and on the need for improved treatment of those with addictions, The American Academy of Addiction Psychiatry was founded in 1986, making it a new psychiatric subspecialty. Fellowships in addiction psychiatry began to emerge, the American Board of Psychiatry and Neurology took note and in 1997 established a subspecialty "Certification in Addiction Psychiatry," a testament to the increasing recognition of the importance of that field. Today there are more than 45 such programs with many of them in the NYC metropolitan region. Psychiatric trainees, recognizing the need for more holistic treatment approaches to the care of those with dual diagnoses of mental illness, especially SPMI, and addiction are increasingly enrolling in addiction fellowships after their general psychiatric training to broaden their base of expertise.

Recognizing the complexity of mental health, addiction and medical illness care, the need for practitioners well versed in providing such treatment within integrated systems is evident. At national and state levels the healthcare system is in a state of unimaginable flux. How it will play out hangs in the balance. What is clear is that the decision to transform *Mental Health News* into *Behavioral Health News* is right on the mark. The community needs a publication which will report on these changes and their impact on consumers, their families, and the professionals who serve them – and I believe *Behavioral Health News* will be there to meet the challenge!

Barry B. Perlman, MD is the Director, Department of Psychiatry, Saint Joseph's Medical Center with campuses in Yonkers and Harrison, New York, and is a past president of the New York State Psychiatric Association.

Leaders Gather to Celebrate the Premier of *Behavioral Health News*

Staff Writer
Behavioral Health News

The speaker at the lectern began his remarks with, "Hello everyone and welcome. Thanks so much for joining us as we celebrate the upcoming fall premier of the new *Behavioral Health News*." His name is Dr. Peter Beitchman, Chairman of the Board of Mental Health News Education (MHNE), the organization that publishes both *Behavioral Health News* and *Autism Spectrum News*.

The Behavioral Health News kickoff event was held at Palladia, Inc. on June 12, 2013. Sponsors of the event included the New York State Office of Mental Health (OMH), the New York State Office of Alcohol and Substance Abuse Services (OASAS), The New York City Department of Health and Mental Hygiene (DOHMH), The New York State Association of Alcohol and Substance Abuse Providers (ASAP), and The Coalition of Behavioral Health Agencies. In attendance at the event were many leaders of New York's mental health and substance use provider organizations, as well as other

Peter D. Beitchman, DSW

leading representatives from treatment and advocacy services.

The idea for *Behavioral Health News* has been on the drawing board for the past two years. Along the way MHNE convened a *Think Tank* committee which included: John Coppola, MSW, Executive Director of the New York State Association of Alcoholism and Substance Abuse Providers, Debra Pantin, MSW, Chief Operating Officer, Palladia, Inc., Joseph Krasnansky, Vice President and Chief Program Officer, Lower Eastside Services Center, Hillary V. Kunins, MD, MPH, Assistant Commissioner, NYC Department of Health and Mental Hygiene's Bureau of Alcohol and Drug Use, Adrienne Marcus, PhD, CASAC, Executive Director, Lexington Center for Recovery, and Steven Rabinowitz, Director, OASAS, Downstate Field Operations. Additional members of the committee from the MHNE Board of Directors included: Carmen Collado, LCSW, Assistant Executive Director, JBFCS, Alan Eskenazi, MA, CPHQ, Chief Executive Officer, Holliswood Hospital, and Jorge R. Petit, MD, President, Quality Healthcare Solutions Group.

According to Dr. Beitchman who is also Executive Director of The Bridge in NYC, "*Behavioral Health News* will combine the worlds of mental health and substance use which have become increasingly interconnected as they have also become with our clients. In addition, government is increasingly thinking about the behavioral health sector as a whole, certainly in New York State with the BHO's and transition to managed care."

According to Ira Minot, LMSW, Founder and Executive Director of MHNE, "We envision *Behavioral Health News* covering the areas of practice, policy, and research. We will provide a vehicle for providers to share successful models in providing not only integrated mental health and substance use services, but also the integration of behavioral health with primary care, health homes, and health and recovery plans (HARPS)."

Following in the footsteps of MHNE's award-winning *Mental Health News*, the new quarterly publication will provide vital news, information and education about mental illness and substance use disorders to its uniquely diverse audience of consumers, families, treatment professionals, and service providers. The publication's content is expected to be of the highest level, with the formation of a new Editorial Board - made up of some of the leading minds from the fields of mental health and substance use.

Photo Gallery of Attendees From Our Kickoff Event

Staff Writer
Behavioral Health News

We would like to thank everyone who attended our *Behavioral Health News* kickoff event. We tried to take photos of everyone, but may have missed a few of you - please let us know. Unfortunately, some that were taken did not come out. Here is an index of the 61 best photographs taken at the event.

#1 Renee Sumpter, LCSW-R, CASAC, Vice President Behavioral Health, Addiction, Research & Treatment Corp.

#2 Ramón M. Rodriguez, Esq., Special Assistant to Commissioner, Arlene Gonzalez-Sanchez, and Director of NYC Operations, NYS Office of Alcohol and Substance Abuse Services (OASAS)

#3 Phillip A. Saperia, CEO, The Coalition of Behavioral Health Agencies

#4 Joseph Krasnansky, Vice President and Chief Program Officer, Lower Eastside Service Center; and John Coppola, Executive Director, New York Association of Alcoholism and Substance Abuse Providers (NYS-ASAP)

#5 At the podium addressing the audience is John Coppola, Executive Director, New York Association of Alcoholism and Substance Abuse Providers (NYS-ASAP)

#6 At the podium addressing the audience is Trish Marsik, Assistant Commissioner, New York City Department of Health and Mental Hygiene (DOHMH)

#7 At the podium addressing the audience is Anita Appel, LCSW, Director, New York City Field Office, NYS Office of Mental Health (OMH)

#8 At the podium addressing the audience is Hillary V. Kunins, MD, MPH, Assistant Commissioner, New York City Department of Health & Mental Hygiene

#9 Bernadette Lewis, Executive Assistant, Palladia; and Lenard J. Hébert II, Executive Director, Reality House

#10 John Tavolacci, LCSW, CASAC, Executive Vice President & Chief Operating Officer; and Jeffrey R. Savoy, LCSW, CASAC, Vice President, Director of Clinical Support Services, Odyssey House

#11 At the podium addressing the audience is Phillip A. Saperia, CEO, The Coalition of Behavioral Health Agencies

#12 Judith Omidvaran, Autism and Mental Health Advocate, and MHNE Board Member

#13 Robert Germaine; and Jose Caraballo, Senior Director of Community Services, Palladia

#14 Jonathan P. Edwards, LMSW, Training Specialist, Parachute NYC

#15 Suzanne B. Feeney, MBA, General Manager, Medicaid Public Sector, Optum Health speaks with Mark Hurwitz, President and CEO, Palladia

#16 Deborah Witham, LMSW, JD, Chief Program Officer, VIP Community Services

#17 David Minot, BA, Associate Director, Mental Health News Education, Inc.; and Mary E. Hanrahan, LCSW, Government Relations Specialist, NY Presbyterian Hospital - Psychiatry

#18 Carmen Collado, LCSW, Assistant Executive Director, Jewish Board of Family and Children's Services (JBFCS); and Peter D. Beitchman, PhD, Executive Director, The Bridge

#19 Trish Marsik, Assistant Commissioner, NewYork City Dept. of Health and Mental Hygiene; and Ira Minot, LMSW, Executive Director, Mental Health News Education, Inc.

#20 Dr. Peter Beitchman, Chair of the Mental Health News Education, Inc. Board of Directors,; Barbara J. Felton, Parent Advocate; and Ira Minot, LMSW, Executive Director, Mental Health News Education, Inc.

#21 Steven Rabinowitz, Director, OASAS, Downstate Field Operations; and Ramón M. Rodriguez, Esq., Special Assistant to Commissioner, Arlene Gonzalez-Sanchez, and Director of NYC Operations, NYS Office of Alcohol and Substance Abuse Services (OASAS)

#22 Constance Y. Brown, MPA, Vice President, Community and Government Relations, Institute for Community Living; and Stella Pappas, LCSW, ACSW, Executive Director, Optum Health, NYC Behavioral Health Organization

#23 David Minot, BA, Associate Director, Mental Health News Education, Inc.; and Peg Moran, LMSW, Senior Vice President, FEGS Health and Human Services System (FEGS)

#24 Debbie Pantin, MSW, Chief Operating Officer, Palladia; and Scott Kellogg, PhD, Assistant Professor, NYU Department of Psychology

#25 David Minot, BA, Associate Director, Mental Health News Education, Inc.; and Isobelle Surface, SVP & Director of Communications, Odyssey House

#26 Sharon Dorr, AVP of Homeless Services, Palladia; and Susan M. Ohanesian, LCSW, ACSW, CASAC, Senior VP and Chief Clinical Officer, Daytop Village

#27 Elaine DuBissette, JD, Vice President, Residential Services, Daytop Village; and Sharon Dorr, AVP Homeless Services, Palladia

#28 Barbara Feldmann, LCSW, CASAC, Clinical Director, Parallax Center, Inc.; and Mary-Allison Mays, Community Relations Representative, Realization Center

#29 Mary-Allison Mays, Community Relations Representative, Realization Center; and Joan Montbach, PhD, Vice President, Policy and Communications, Palladia

#30 David Minot, BA, Associate Director, Mental Health News Education, Inc.; and Lucas Matthiessen, LCSW, CASAC, Director of Field Operations, Catholic Charities Neighborhood Services

#31 Jose Caraballo, Senior Director of Community Services, Palladia; and Lenard J. Hébert II, Executive Director, Reality House

see Gallery on page 31

Gallery from page 26

#32 Milta Vega-Cardona, Director of Development, Reality House; and Ira Minot, LMSW, Executive Director, Mental Health News Education, Inc.

#33 Audwin Edwards, Sr. Vocational Counselor, Behavioral Health, Metropolitan Hospital Center; Lolita Silva-Vazquez, MA, LMHC, VP Quality Improvement, Lower Eastside Service Center; and Valerie C. Walters, MBA, President & CEO, Lower Eastside Service Center

#34 Members of the Mental Health News Education, Inc. Board of Directors: Constance Brown, Mary Hanrahan, Peter Beitchman, David Minot, Barry Perlman, Peg Moran, Janet Segal, Ira Minot, Carmen Collado, Alan Eskenazi, and Jorge Petit. Other Board members who arrived later and are not in this shot were Judy Omidvaran, and Jonathan Edwards.

#35 Palladia Staffers Back: Frederica Felder, and Angela Doonachar; Front: Mercedes Romero, and intern Casey Fromm

#36 Nilda I. Ruiz, Chief Financial Officer and Nancy S. Brinn, LMSW, Chief Operating Officer at QVCMH for J-CAP speak with Mark Hurwitz, President & CRO of Palladia

#37 Mark Hurwitz, President & CEO, Palladia, Anita Appel, LCSW, Director, NYC Field Office, NYS Office of Mental Health; and Peter D. Beitchman, PhD, Executive Director, The Bridge

#38 Dr. Peter Beitchman, Chair of the Mental Health News Education, Inc. Board of Directors, introduces Ramón M. Rodriguez, Esq., Special Assistant to Commissioner, Arlene Gonzalez-Sanchez, and Director of NYC Operations, NYS Office of Alcohol and Substance Abuse Services

#39 Jim Mutton, LMSW, Director of Residential Services, Project Renewal

#40 Anita Appel, LCSW, Director, NYC Field Office, NYS Office of Mental Health; Alan Eskenazi, Chief Executive Officer, Holliswood Hospital; and Roy Wallach, Senior VP Marketing & Development, Liberty Behavioral Management Corp.

#41 David Minot, BA, Associate Director; and Ira Minot, LMSW, Executive Director, Mental Health News Education, Inc.

#42 Suzette Stewart, Administrative Assistant, Palladia

#43 Ira Minot, LMSW, Executive Director, Mental Health News Education, Inc.; and Constance Y. Brown, MPA, Vice President, Community and Government Relations, Institute for Community Living

#44 Hillary V. Kunins, MD, MPH, Assistant Commissioner, NYC Department of Health & Mental Hygiene; Joshua Rubin, Executive VP & COO, MHA of NYC; and Mary E. Hanrahan, LCSW, Government Relations Specialist, NY Presbyterian Hospital - Psychiatry

#45 Michael Wernham, Community Healthcare Liaison, Optum Health

#46 Dr. Richard Juman, Professional Voices Coordinator at TheFix.com

#47 Pat Johnson, Assistant Vice President Asset Management, Palladia

#48 Joan Salmon, LCSW-R, Senior Director of Clinical Services, Fortune Society

#49 Roy Wallach, Senior VP Marketing & Development, Liberty Behavioral Management Corp.

#50 Ronald Williams, President & CEO, New York Therapeutic Communities

#51 Janet Z. Segal, LCSW, Executive Vice President, Four Winds Hospital, and member of the MHNE Board of Directors

#52 Barry B. Perlman, MD, Director of Psychiatry, St. Joseph's Hospital Yonkers

#53 Ann Marie Bove, Deputy Director, NYC Field Office, NYS Office of Mental Health

#54 Reinaldo Diaz, MSW, CASAC-T, Outreach Specialist, Substance Abuse Division, Albert Einstein College of Medicine

#55 Susan Weinreich, Award Winning Artist and Mental Health Advocate

#56 Christopher Smith, PhD, Director of Adult Services, NYS Office of Mental Health, NYC Field Office

#57 Mitchell Netburn, JD, President and CEO, Project Renewal

#58 Ira Minot, LMSW, Executive Director, Mental Health News Education, Inc.; and Anne G. Katz, Vice President Private Banking, Capital One Bank, and Former Board Member, Behavioral Health News

#59 Jorge R. Petit, MD, President, Quality Healthcare Solutions Group; and Mark Hurwitz, President & CEO, Palladia

#60 Carmen Collado, LCSW, Assistant Executive Director,, Jewish Board of Family and Children's Services (JBFCS); and Peg Moran, LMSW, Senior Vice President, FEGS Health and Human Services System (FEGS), both are also members of the MHNE Board of Directors

#61 Debbie Pantin, MSW, Chief Operating Officer; and Sally Bernstein, Assistant Vice President of Planning and Capital Development, Palladia, Inc.

We Wish to Express Our Deep Appreciation
To Everyone Who Attended Our Kickoff Event

We Know We Did Not Get Everyone's Picture
But We Still Greatly Appreciate Your
Participation Just The Same !!

Suicide Prevention: Creating an Agency-Wide Response

By Amy Dorin, Peg Moran, and Ellen Stoller, FEGS Health and Human Services (FEGS)

FEGS Health & Human Services, a large and diverse organization serving 100,000 individuals annually, provides a full array of behavioral services through community based treatment, rehabilitation, care coordination programs and residential and housing services to over 25,000 people a year. We have grown increasingly concerned about people for whom dying by suicide seems to be a solution. In August 2012, FEGS launched a multi-pronged Suicide Prevention Initiative with the New York State Office of Mental Health’s Suicide Prevention Center as a key partner. The purpose of the initiative is to become a suicide alert community, committed to caring for people with thoughts of suicide. Our primary goals are: to learn more about people who have thoughts of suicide; to lower the annual number of deaths by suicide and suicide attempts.

As reflected in the significant media attention, suicide prevention is a major concern in our society. More than 35,000 people in the United States die by suicide each year and it is the third leading cause of death in young people. Every day approximately 90 Americans take their own life. According to a recent article in The New York Times, the rate of suicide among middle-aged Americans has increased nearly 30 percent since 1999. Individuals that suffer from mental illness are at even greater risk, a driving force behind the suicide prevention initiative at FEGS.

Creating a suicide alert environment, an organizational culture where it is okay to talk about your thoughts of suicide without fear of being judged, blamed, or shamed, and where a call to 911 is not the only response, challenges our way of thinking and practice. Talking directly about suicide is difficult; in fact, it is not the way many Behavioral Health professionals have been trained. Staff is more likely to ask a person at risk if they are thinking of hurting themselves - not if they are thinking of killing themselves. Couple that indirect (fearful) approach with the feelings that people with thoughts of suicide often have - that their thoughts are bad, wrong, or that their thoughts go against their religion or their culture. In addition, after a person who has been hospitalized is stabilized, he/she is released back into the same environment with many of the same stressors still before them.

FEGS is moving toward our goal of becoming a suicide alert community through training AND research. Using the Suicide Prevention Center’s best practices called ASIST (Applied Suicide Intervention Skills Training) and SafeTALK, 350 FEGS staff has already been trained. Because suicide prevention is an issue for our entire community, not just for people with mental health diagnoses, our goal is to train staff throughout FEGS including those who work with youth in schools and across our Family Services operations.

FEGS’ research partner, the Columbia University School of Social Work, has launched a Suicide Prevention Research Program, (SPRP) under the leadership of Dr. Dana Alonzo, Ph.D., Associate Professor. The SPRP, of which FEGS is a member, is committed to developing new initiatives in the arena of suicide prevention and to developing collaborations with community providers. Dr. Alonzo believes that maintaining people in treatment helps to mitigate the risk for suicide. She has developed STEPS, Strengthening the Treatment Engagement of people at Risk of Suicide, a new intervention, which will be implemented in FEGS treatment programs and evaluated as to its impact on reducing suicide attempts and suicide. Funds provided by the New York State Office of Mental Health, through the New York State Mental Health Association will enable a feasibility study of the intervention which we hope will become the standard of care.

FEGS is especially proud that the Suicide Prevention Center of New York has recognized our agency as a 2013 SPCNY Excellence in Suicide Prevention awardee. Suicide prevention is a priority that we all must share.

Amy Dorin is Senior Vice President, Behavioral and Community Health, Peg Moran is Senior Vice President, Residential & Housing Services, and Ellen Stoller is Associate Vice President for Professional Development & Consumer Affairs, FEGS Health & Human Services (FEGS).

From Isolation and Despair to Engagement and Activation: The Peer Support Specialist's Role in the Behavioral Health Care System

By Sue Bergeson, Vice President Consumer and Family Affairs Optum

Peer coaches are individuals in recovery from a behavioral health condition who are trained to use their lived experience to help others on their journey to recovery. They do this by offering support, promoting engagement and facilitating activation. Optum's Whole Health Peer coaching program is one of many programs emerging across the country that give new hope to people living with behavioral health conditions. These programs offer community-based Peer Support Services and promote recovery. For example, when Optum implemented the Peer Bridger model, first created by the New York Association of Psychiatric Rehabilitation Services (NYAPRS), in its Tennessee and Wisconsin PeerLink programs, the support of peer coaches helped consumers reduce the amount of time spent in inpatient care due to acute symptoms:

- Enrollees in the Tennessee Peer Link program showed a significant decrease of 39% in their average number of acute inpatient days
- Enrollees in the Wisconsin Peer Link program showed a significant decrease of 34% in their average number of acute inpatient days

A recent testimonial from an Optum Whole Health Peer Coach illustrates the type of services provided and the important role that these individuals are able to have in the lives of others.

I was asked to meet with Mr. West (not his real name) who was deeply depressed. Mr. West lives daily with severe pain. He was often negative in perspective and irritable in attitude. Mr. West permitted me to briefly introduce myself and the Optum Whole Health Peer program. When I asked him if I could come to see him in person he barked back, "If you can do something about my pain, come on over." I reminded him that I am not a doctor or a nurse, but I would commit to work hard with him to help him find ways to improve his pain.

During our visit, I asked Mr. West to describe to me what life was like with such severe pain in his leg. He described himself as hopeless and often felt that there was no purpose for living. He wondered if he could ever walk again. I discovered that beneath Mr. West's gruff presentation, he had a wonderful sense of humor. We have a motto that we share and talk about often "We will never give up"!

Through Whole Health Peer strategies and support, Mr. West developed a willingness to talk about his condition and schedule appointments with specialty physicians. After careful consideration, Mr. West elected to have leg surgery. He is recovering and has realistic hopes of walking again. With renewed hope and a less self-centered focus, Mr. West began to share with me his successful career as a skilled auto mechanic. He is enthusiastic about someday becoming a mentor for high school students learning auto mechanics. Mr. West is choosing life and wants to share his talents with others. He has developed relationships with neighbors and has a network of friends who enjoy sitting on the porch talking every evening."

— From the Optum Whole Health Peer Coaching program

In the case described above, Mr. West felt isolated and was experiencing a number of physical and psychological challenges. The Whole Health Peer Support Specialist who worked with him was able to provide outreach and engage Mr. West in a recovery-focused approach to his care that addressed both his physical and emotional well-being. This helped Mr. West achieve activation, which occurs when an individual has the necessary knowledge, skills, hope, and confidence to proactively manage their own health. As a result, Mr. West experienced improved mental and physical well-being as well as a renewed sense of hope for the future. Greene et al (2012) have shown a direct link between patient activation and improved quality of life and health outcomes. People who are activated are more likely to have received preventative health services. They are also less likely to smoke or have high a high body mass index (BMI). Also, they are less likely to have been hospitalized or have received services from a hospital emergency department.[1]

Peer services can benefit a wide range of consumers and have been included as part of behavioral health treatment throughout the country for many years. Family-to-family coaches or navigators have been used to help families of children with emotional difficulties manage the often confusing and confounding health care system. Addiction Recovery coaches have been used both in person and over the phone to support sobriety. The Veterans Administration has used peer coaching as part of its behavioral health treatment program since 2006. The Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration (SAMHSA-HRSA)

see Peer Support on page 49

Merging Legal, Clinical and Medical Issues For the Most Effective Treatment Outcomes

By Deborah Witham
Chief Program Officer
VIP Community Services

Drug courts began in Miami-Dade County Florida started a maverick program to combine rehabilitative substance abuse treatment within the justice system sanctions. Since that time, 2,743 drug courts have been developed across the country. This was a progressive initiative that has proven to be successful in that 75% of participants do not re-offend[1] very likely because the model recognizes addiction as a disease that requires treatment as opposed to a crime or a lack of willpower.

In spite of these progressive goals and impressive outcomes, there seems to be a disparity in how drug court participants who are opiate dependent receive treatment. In many courts, the participant is not allowed to utilize medication supported recovery as a treatment method and are required to taper completely prior to completing their mandate.

It begs the question of how a progressive judicial system meant to decrease criminal activity through treatment would prevent participants from taking part in a form of treatment that could support their recovery. An even larger question is whether the decision to maintain someone on medication supported recovery should be taken from the treating physician and placed in the hands of a judge.

Since its implementation in the 1960s Methadone treatment has proven to be an effective treatment method for those who are opiate dependent. A Treatment Outcome Perspective Study (TOPS) conducted by Condelli and Dunteman showed that clients on long term methadone demonstrated a reduced heroin use rate from 100% to 40%.[2] Moreover, the Drug and Alcohol Services Information System (DASIS) report shows that those maintained on methadone are two times more likely to be employed than those who are not.[3]

With an almost 50 year proven track record of success, one must wonder what the clinical and medical implications might be for those forced to abandon this form of treatment. For one, research shows that those who taper from methadone have upwards of an 80% rate of relapse within one year of tapering from methadone.[4] This relapse will then likely lead to further dangerous consequences as rates of HIV infection increase 1.5 times for every 3 months someone is out of methadone treatment.[5] In addition, SAMHSA and OASAS have worked together with treatment providers to greatly increase and improve services and accountability provided in methadone programs, eliminating the "cop and go" model many still ascribe to this form of treatment. Thus when a client is forced off of methadone they lose additional recovery supports; including clinical groups, individual counseling sessions, peer to peer support, medical and psychiatric services as well as a daily structure and routine critical to maintaining a life of recovery.

As addiction leaders we must question the legal implications of mandating individuals off of methadone and whether the courtroom is the place to make what is essentially a medical and clinical decision. In fact, Judge Karen Freeman, the Director of the National Drug Court Institute wrote a letter to her drug court colleagues imploring them to "examine their own personal opinions and biases" and how when she did her research she understood "the use of drugs to address opiate addiction was often necessary to assist clients in their efforts to sobriety" and was a "matter of life and death."[6] Her words speak to continued opportunities for improved outcomes when two long-standing evidence-based practices collaborate to promote treatment and recovery.

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Scan Predicts Whether Therapy or Meds Will Best Lift Depression

By The National Institute of Mental Health (NIMH)

Pre-treatment scans of brain activity predicted whether depressed patients would best achieve remission with an antidepressant medication or psychotherapy, in a study funded by the National Institutes of Health. "Our goal is to develop reliable biomarkers that match an individual patient to the treatment option most likely to be successful, while also avoiding those that will be ineffective," explained Helen Mayberg, M.D., of Emory University, Atlanta, a grantee of the NIH's National Institute of Mental Health. Mayberg and colleagues report on their findings in JAMA Psychiatry, June 12, 2013.

"For the treatment of mental disorders, brain imaging remains primarily a research tool, yet these results demonstrate how it may be on the cusp of aiding in clinical decision-making," said NIMH Director Thomas R. Insel, M.D.

Currently, determining whether a particular patient with depression would best respond to psychotherapy or medication is based on trial and error. In the absence of any objective guidance that could predict improvement, clinicians typically try a treatment that they, or the patient, prefer for a month or two to see if it works. Consequently, only about 40 percent of patients achieve remission following initial treatment. This is costly in terms of human suffering as well as health care spending.

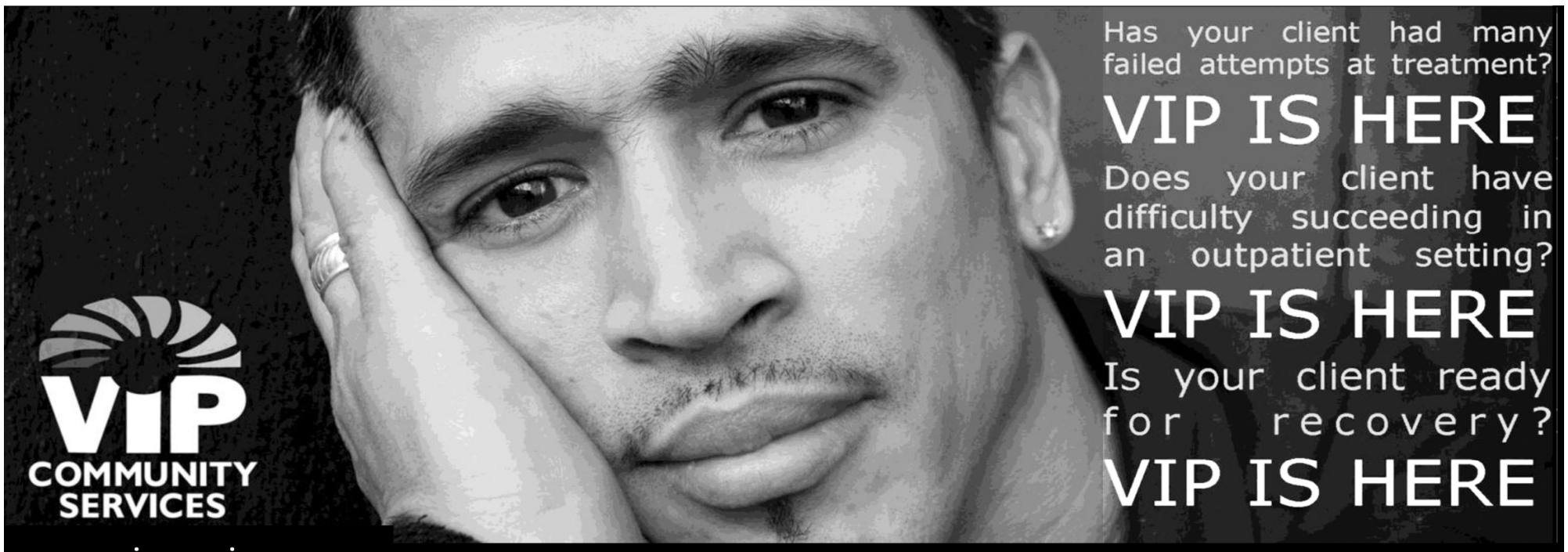
Helen Mayberg, MD

Mayberg's team hoped to identify a biomarker that could predict which type of treatment a patient would benefit from based on the state of his or her brain. Using a positron emission tomography (PET) scanner, they imaged pre-treatment resting brain activity in 63 depressed patients. PET pinpoints what parts of the brain are active at any given moment by tracing the destinations of a radioactively-tagged form of glucose, the sugar that fuels its metabolism. They compared brain circuit activity of patients who achieved remission following treatment with those who did not improve.

Activity in one specific brain area emerged as a pivotal predictor of outcomes from two standard forms of depression treatment: cognitive behavior therapy (CBT) or escitalopram, a serotonin specific reuptake inhibitor (SSRI) antidepressant. If a patient's pre-treatment resting brain activity was low in the front part of an area called the insula, on the right side of the brain, it signaled a significantly higher likelihood of remission with CBT and a poor response to escitalopram. Conversely, hyperactivity in the insula predicted remission with escitalopram and a poor response to CBT.

Among several sites of brain activity related to outcome, activity in the anterior insula best predicted response and non-response to both treatments. The anterior insula is known to be important in regulating emotional states, self-awareness, decision-making and other thinking tasks. Changes in insula activity have been observed in studies of various depression treatments, including medication, mindfulness training, vagal nerve stimulation and deep brain stimulation.

"If these findings are confirmed in follow-up replication studies, scans of anterior insula activity could become clinically useful to guide more effective initial treatment decisions, offering a first step towards personalized medicine measures in the treatment of major depression" said Mayberg.



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The Recovery Movement in New York State

By Laura Elliott-Engel, MA, CASAC-G, LMHC, CARC, President Friends of Recovery New York

What an exciting time to work in behavioral health! Practitioners are in a new frontier of best practices based upon significant research that provides a growing understanding about brain disease and appropriate interventions in behavioral health and recovery. The growing strength and influence of people in sustained recovery informs a philosophy that there are multiple pathways to recovery and that no door is a wrong door.

In the spring of 2008, over 75 recovering individuals and family members came together and within three months had incorporated Friends of Recovery New York. The founding Board developed an advocacy mission that no policy should be made without us and that "nothing about us without us" can drive any decisions that impact the recovery community. A short time later the National Parity Act and the Accountable Care Act both passed. This confluence of events created another opportunity to affirm that addiction and mental health disorders are treatable and would be covered by insurance with parity with other medical services.

Laura Elliott-Engel, MA, LMHC

Incorporation of coverage for addiction and mental health disorders within primary health further indicated that new opportunities would and could emerge for alternative services such as peer services and nontraditional access points.

Friends of Recovery New York seized upon these opportunities and focused on training Recovery Coaches and trainers of Recovery Coaches to provide a voluntary, paid workforce of peer coaches that would be available to mobilize responsively to the new opportunities. We have now collectively trained over 750 coaches in New York State along with an additional 80 trainers.

The access points for recovery are multiple and layered. Recovery Coaching intervenes with the criminalization of people's behavior that results from brain diseases. Coaching meets individuals in their own space with their own needs. Coaching assists in the development of action plans fully developed by the individuals. Peer coaches are viewed as a genuine resource for individuals who may not find or want traditional treatment options. There also is the possibility of screen and referral services through the health home/medical model that is emerging in NYS.

As a person in sustained recovery who has become a practitioner and then an administrator in the addiction field, my world view has been significantly influenced by the new alternatives available for community resources and to individuals seeking help. Community recovery resources such as coaches joining with the mental health advocate/peer movement has clearly impacted the public policy discussion about the right to have available services.

The most significant component for many with this New Perspective on Health is the opportunity for those in recovery to proclaim their recovery, to move out of the shadows and to address issues of discrimination and stigma. The opportunity to engage families and provide hope and instructive assistance is growing and remarkable. Recovery is foundational to achieving success. Certainly my recovery allowed me to achieve an advanced degree and to serve clinically and administratively in rural underserved settings.

Comrades instead of competitors are created because of the mutual commitment on the part of mental health and addiction peers to provide guidance and support to achieve recovery. The acknowledgment that medication is available and effective also has further reduced barriers for comrades, not competitors, in recovery. These are the direct consequences of the new health perspective that includes the right to care.

These new health perspectives also raise anxiety and uncertainty. We have a structural outline, but resources and employment opportunities are still limited. We need to join our voices and develop policy and strategies for training, standards and skills development to continue to influence the direction that health practices travel.

Laura Elliott-Engel, MA, CASAC-G, LMHC, CARC, is also the Executive Director of the Council on Addictions Recovery Services, Inc. located in Olean New York.

Beacon Partners with NAMI-NYC to Educate Plan Members

By The National Alliance on Mental Illness of New York City (NAMI-NYC)

Beacon Health Strategies (Beacon) is undertaking a groundbreaking public/private partnership with the National Alliance on Mental Illness of New York City (NAMI-NYC) on a pilot project that will promote and engage NAMI services for Beacon plan members in the New York City metro area.

To promote that engagement, the pilot program will provide education on mental illness in general, and specifically, the importance of accessing community-based services. Measurement of the program will be two-pronged: Beacon and its partners will measure the impact that the NAMI services have on participating members' knowledge of dealing with mental illness and the subsequent use and success of community-based services to support independent living.

The target population is plan members who have recently or previously been diagnosed with a serious mental illness and could benefit from NAMI services to advance their recovery objectives. NAMI's peer-led programs, whose participation is voluntary, will augment the behavioral health services already available under member health plan benefits. The project which began in June will connect NAMI-NYC's programs to participants, with community-based courses on mental health topics as follows:

Wendy Brennan

NAMI Basics, an education program for parents and other caregivers of children and adolescents living with mental illness, is taught by trained leaders who themselves are the parents/caregivers of children with mental illness. Its goals include giving basic information for effective caregiving, helping the parent/caregiver cope with the impact of mental illness, and providing tools to assist in making the best decisions for the child's care.

NAMI Peer-to-Peer is a unique program for people with serious mental illness that focuses on wellness and recovery. It is taught by a team of individuals who are living with mental illness.

"This is a singular opportunity for Beacon to partner with NAMI in a local market," said Beacon's CEO Timothy Murphy. "It is exciting to discover how a concerted effort at community-based outreach can improve the quality of life for people who live with mental illness and their families."

Wendy Brennan, NAMI-NYC Metro's Executive Director, added, "Beacon cares about individuals who are impacted by mental illness and recognizes the need to expand community-based services. They also understand the importance of incorporating the consumer voice in treatment."

NAMI will administer surveys before and after the intervention to measure the courses' impact on knowledge about mental illness, medications, stress management techniques, and wellness management skills. Additionally, Beacon will work with NYU's McSilver Institute for Poverty Policy and Research to assist with data analysis and review of members' subsequent service utilization. The two groups will assess any correlation between the use of NAMI services and the improved use of outpatient and preventive services to support community living.

Founded in 1996, Beacon Health Strategies is a leader in behavioral health care management services for Medicaid, Medicare and commercial populations, serving more than 8 million enrollees with a presence in 21 states and the United Kingdom. Accredited by both URAC and NCQA, Beacon's success is derived from its member-centric and locally administered managed care services, active integrations of members' medical and behavioral health care needs, innovative clinical programming, and customized solutions for every health plan partner.

NAMI-NYC is a grassroots organization that provides support, education and advocacy for individuals and families of all ethnic and socio-economic backgrounds who live with mental illness. As the largest affiliate of the National Alliance on Mental Illness, NAMI-NYC works collaboratively with stakeholders in the community to educate the public, advocate for legislation, reduce stigma, and improve the mental health system. NAMI-NYC provides support, education, and advocacy throughout the New York metropolitan area on behalf of families affected by mental illness and their loved ones – all free of charge to the public.

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Treating Youth with Sexual Aggression: Stopping Predators? Or Meeting Needs?

By Ivan Kruh, PhD, Coordinator, Juvenile Starting Over Program, Westchester Jewish Community Services

For the last three decades, the Juvenile Starting Over (JSO) program at Westchester Jewish Community Services (WJCS) has been treating Youth with Sexual Aggression (YwSA). It is the only community-based program in the area specially designed to help these young people cease their problematic sexual behaviors and lead more functional lives. Over these thirty years, international researchers and clinicians have slowly gained a better understanding of YwSA and the best ways to help them. In doing so, they have learned that many older ideas about these issues were incorrect. Unfortunately, many of these errors linger in the popular consciousness and even the thinking of mental health professionals. These misconceptions need to be corrected and the JSO program at WJCS in concert with the Subcommittee on Youth with Problematic Sexual Behavior of the Westchester County Coordinated Children's Services Committee, is helping to lead the way.

In the early 1990s, many adult sex offenders told mental health professionals that their inappropriate sexual interests and behaviors, such as attraction to and molesting of young children, began in adolescence. Consensus rapidly spread that the best way to prevent the development of adult sex offenders is to aggressively treat young people with sexual behavior problems. This view cast YwSA as "sexual predators in the making" and a group warranting fear by society and professionals. It is illogical to conclude that because some adult sex offenders had problems as youth that all youth with sexual behavior problems are destined to become adult sex predators. Nonetheless, this view dominated thinking in the field for some time.

During this period, treatment of YwSA looked very similar to the treatment of adult sex offenders. Due to fear the problems would worsen, treatment was applied aggressively and often in highly restrictive residential settings. The programs made much use of confrontation to reduce the manipulation and dishonesty common among adult sexual predators. Treatment often assumed that youth had deviant sexual interests and sexual thinking that reflected an incurable addiction. Even if the youth had one past offense, treatment focused on interrupting the "cycle" of sexual misbehavior and the prevention of "relapse" back into that cycle.

In recent years, research has made clear that YwSA rarely show the features of adult sexual predators, they look a lot more like youth with nonsexual behavior problems, and they are unlikely to continue offending in adolescence, let alone adulthood. For example:

- Unlike adult sexual predators, YwSA rarely have multiple offense victims and rarely demonstrate engrained patterns of deviant sexual interests.

- When compared to youth who have nonsexual conduct problems, YwSA tend to have similar vulnerabilities (e.g., family disconnection) and problems (e.g., school difficulties), and they show similar social skills, attitudes toward sex, and history of sexual experiences. The two groups overlap in that many YwSA also have nonsexual behavior problems, and some youth with nonsexual behavior problems will later engage in sexual aggression. Some experts, in fact, have argued that YwSA are not a specialized group at all and should be understood in the same ways we understand youth with general conduct problems.

- Relatively few YwSA continue to engage in sexual aggression after their misbehavior is detected. For example, 85-95% of juvenile sexual offenders will not commit another sexual offense across five to ten years.

Treatment for YwSA has evolved greatly based on these findings. Still, there is no single Evidence-Based Program for treating YwSA. This is because, when looked at more closely, YwSA are a diverse group and are not all alike. They vary in the types of offenses they commit; the social circumstances they come from; their sexual knowledge and experiences; their cognitive and mental health problems, etc. Some of these youth are engaging in a broad array of misbehavior. Others show focused weaknesses in judgment, social skills, interpersonal boundaries, and sexual knowledge such that they naively stumbled into sexual misbehavior. And a few do have focused deviant sexual interests and may be on a path to chronic sexual misbehavior.

Effective treatment of YwSA must be individualized and matched to what is needed in each case. This is consistent with what is known about treating youth with general behavior problems. There is no single treatment manual or protocol that is effective with every youth. But there is a model for conceptualizing and guiding treatment interventions that is very effective: the Risk-Needs-Responsivity model (See Vincent, G., Guy, L., & Grisso, T. (2012). Risk assessment in juvenile justice. A guidebook for implementation. MacArthur Foundation).

Risk: The number, type, and severity of Risk factors are issues proven to be associated with continued sexual misbehavior. The number, type, and severity of these factors helps identify a youth's risk level and informs the intensity of services needed to successfully manage the youth. This way, lower-risk youth do not suffer the potential negative effects of over-involvement in services and precious resources are most efficiently assigned. Notice that treatment intensity is not based on the severity of past sexual misbehavior or on the breadth of mental health concerns alone.

Needs: Criminogenic needs are dynamic and changeable factors that are directly linked to the individual's sexual misbehavior and provide the primary targets of successful treatment. The goal here is effective treatment focus. Hours spent addressing deviant sexual interests is wasted time, for example, with a teen who has none. And a child whose sexual aggression was mainly due to poor social skills may require only social skills training to prevent reoffending.

Responsivity: Responsivity factors are not, in and of themselves, linked to the sexual misbehavior but they may interfere with successful treatment and need to be addressed. For example, a youth whose resistance to treatment receives no attention will not be successful no matter how well-focused the treatment is. Likewise, a youth who is struggling with posttraumatic anxiety may not benefit from treatment if that underlying issues is not addressed. Responsivity also means delivering treatment in ways that match the developmental, cognitive, and emotional abilities of the youth.

The Juvenile Starting Over (JSO) program at WJCS is a community-based program dedicated to serving the needs of Youth with Sexual Aggression in Westchester County using a Risk-Needs-Responsivity model. Referrals to the program come from the local juvenile probation department, social services, other agencies serving the social and clinical needs of troubled youth, and families of these children. Treatment begins with a detailed Psychosexual Risk Assessment geared to identifying the youth's risk level, needs factors, and issues related to treatment responsivity. Clearer information about risk has allowed for many more Westchester youth to be treated in the community and for residential placement to be used with only the few highest risk youth.

For Westchester youth provided treatment in the community through the JSO program, a critical first-step is developing a Safety Plan that specifies the youth's supervision needs in the community. A critical goal is limiting the youth's access to their victim(s), to other potential victims, and to sexually activating experiences, such as viewing pornography. When youth in treatment are on probation, probation officers work in concert with the JSO therapists to develop and monitor these plans.

Once safety is established, the Psychosexual Risk Assessment is used to develop an individualized treatment plan addressing each youth's needs and responsivity factors. More commonly targeted needs include the following: Poor Sexual Knowledge, Poor Social Skills, Poor Impulse Control, Poor Affect Regulation, Family Dysfunction, Antisocial Associations, Lack of a Plan for Managing Risk, Low Appreciation of Victim Experiences, Cognitions and Attitudes that Support General and Sexual Misbehavior.

see Youth on page 52

Outdated Perspective, Says Who? Therapeutic Work Programs with Land and Animals

By Richard Beauvais, PhD, Director
The Wellspring Institute

In 1870 the Quakers' Friends Hospital used greenhouses and acres of its natural landscape as integral parts of treatment for the mentally ill. At the turn of the century, Frederick Peterson, a neurologist and head of the New York State Board of Lunacy, did the same with a state asylum. Both the Quakers and Peterson believed involvement with nature through manual work would be healing. That proved to be true, but many such programs were abandoned later due to costs and legal issues about the exploitation of patient labor. Eventually, all were replaced by psycho-tropics and the sedentary joys of TV.

Although therapeutic work programs have mostly vanished from behavioral health care, manual work in nature is, nonetheless, inherently "therapeutic" as many of us know from personal experience. Based on 37 years of experience with work programs in Wellspring's multi-modal, process-oriented residential treatment programs for children, adolescents and young adults, I am convinced that work, as a therapy in its own right, currently has more importance for behavioral health than ever, particularly for young people.

Richard Beauvais, PhD

As a therapeutic medium, there are three aspects of manual work to consider: How direct involvement with nature, or the lack of it, affects mental health; how manual work can be instrumental for character building and personal growth; and how a work program can be developed into a therapy in its own right.

The basis of this "outdated perspective" is that the healing power of manual work is intrinsically connected to direct involvement with nature – with the physical matter of creation – wood, grass, rocks, dirt, plants and animals. In his book, *The Last Child in the Woods*, Richard Louv coined the phrase "nature deficit disorder," a non-medical term used to describe the unhealthy effects on children of increasing disengagement from nature. Research shows that children – tweens and teens – now spend an average of 7.5 hours before screens and 90% of their time indoors. Attention, concentration, and cognition are being negatively affected in both direct and subtle ways, accompanied by measurable increases in stress, anxiety and depression.

These effects are clinically evident in the escalating numbers of children diagnosed with ADHD. Child obesity, a national concern, is indirectly related to nature deficit disorder through inactivity. As children stay indoors, fixated on the TV or computer, they tend to become couch potatoes. On the other hand, research indicates that direct involvement with nature in whatever form reduces stress, alleviates depression, and provides an effective alternative to medications used to counteract ADHD. While research about these positive and negative effects is mostly correlational in support of Louv's argument, for the sake of our children, we need to take it seriously and find corrective ways to respond. From a therapeutic perspective, I propose that manual work on the land is especially suited to this task.

Children learn about the world first hand through their senses – touching, tasting, smelling, seeing and hearing. In this respect, a child's withdrawal from the natural to the virtual world causes the sensory world to shrink. The plethora of electronic devices – the TV, computer, iPhone, iPad, etc. – may expand access to information, but sensory experience becomes restricted to the flat screen and the keyboard. Social networking presents itself as a tool for expanding relational contact, and it does that, but the actual experience of participants is more of isolation and containment than face-to-face contact and exchange. In the documentary film, *Play Again*, one boy says, "I'm in my own little world where I can control what's happening."

At Wellspring, work programs on the land are combined with adventure programming and animal care in an effort to restore healthy balance between virtual and natural reality. In this effort, a therapeutic work program confronts three major obstacles, which present both a challenge and a therapeutic opportunity:

see Work on page 52

Services for the UnderServed Addresses Mental Illness Among Young Adults Under New Citywide Initiative

Staff Writer
Behavioral Health News

Many youth are hit suddenly with mental illness during their teens and early adulthood. For some, it may be as many as seven years between their "first break" and the first time they formally receive treatment. This results in many of them lagging behind their peers as they transition to adulthood. Working in partnership with the New York City Department of Health and Mental Hygiene (DOHMH), Services for the UnderServed (SUS) aims to change that trajectory.

With funding from the Centers for Medicare and Medicaid Services, DOHMH has launched Parachute NYC, a new citywide pilot, which provides options for people experiencing emotional and mental health problems. When youth grow older and fall into an adult age bracket for treatment—often leading to institutionalization—they are stigmatized and marginalized by society. This strips them of hope for the future and disconnects them from their communities.

Instead of going to a hospital, Parachute NYC offers a "soft landing" into mental health care and support for people in crisis. The project offers an alternative to traditional emergency room and inpatient care, through which young adults are diverted from institutional settings, and are able to avoid a revolving door of repeat hospitalization.

As part of Parachute NYC, SUS and several other New York City-based organizations were selected to create an integrated series of interventions for these individuals. SUS is the only agency chosen to serve young adults 18-30 years old with mental illness—those with little or no experience with the institutional mental health system, and those needing respite from their current living environments. SUS' Parachute Project, a Crisis Respite Center (CRC) in Brooklyn, is as much a respite for these young adults as it is a prevention program. It offers them temporary residential care for up to two weeks, in a safe and supportive home-like environment, helping to prevent chronicity of mental illness.

During their voluntary stay, Parachute "guests" are taught recovery and relapse prevention skills with the 24-hour support of peers in conjunction with the clinical support of the Woodhull Hospital Mobile Crisis Team. Project staff work with the young adults and their families, where indicated, to develop a recovery plan that focuses on their immediate wellness goals in preparation for their return home, to school and to work. The Project is intended to help these young adults get their lives back on track as quickly as possible and restore their wellness by providing immediate and continuous care. This model is designed to ensure better continuity of care and recovery outcomes for these young adults and will reduce their use of emergency and inpatient care during psychiatric emergencies.

SUS' effort in this space carves a new niche for the agency in the health care landscape by pioneering a new approach to treatment for this population, which is often overlooked in the mental health field. SUS is proud to be a partner in this new initiative, which empowers young adults in managing their own recovery from mental illness.

Promoting Integrative Behavioral Healthcare: Gradualism and the Mechanisms of Change

By Scott Kellogg, PhD
Clinical Assistant Professor
NYU Department of Psychology

The behavioral healthcare field is currently going through a period of transition – a time of increasing emphasis on the use of integrative approaches in the treatment of substance use and mental health problems. This change is not only being driven by economic necessity, but also by innovations in clinical practice. For this effort to be successful, however, we will want to have therapeutic models and philosophies that not only help us to better conceptualize the relationship between drug use and inner suffering, but also effectively guide us in our clinical work. Gradualism, I believe, is a paradigm that can serve this purpose.

As the name would imply, Gradualism is a clinical paradigm that conceptualizes addictions as complex behaviors and understands that, for many, the process of healing and change will take place over an extended period of time. First formalized in 2001 (Kellogg, 2003; Kellogg & Kreek, 2005), Gradualism was an attempt to "utilize and integrate the best of the harm reduction, traditional, and scientific treatment approaches to create an effective and compassionate model" of addiction treatment.

Scott Kellogg, PhD

Working to creating a treatment structure appropriate to this clinical philosophy, I began to explore what I have come to think of as the Mechanisms of Change Project (Kellogg & Tatarsky, 2010, 2012). Drawing on what I have learned from these two efforts, I believe that there are four clinical concepts that can usefully guide clinicians who wish to work within an integrated model of care.

1. Drug use and inner pain are the experiences of individuals and treatment should reflect this.

While the psychotherapeutic traditions have certainly emphasized the centrality of individual treatment, this has not been the standard in addiction care. As both research and clinical practice have shown, a strong and viable therapeutic alliance is at the heart of successful treatment. This means that the promotion and maintenance of this kind of connection should be an essential concern of both individual clinicians and the treatment systems in which they work. Along these lines, each patient comes to treatment with a unique psychological make-up, genetic profile, medical background, motivational state, and drug history – which means that treatment planning that is uniquely conceived for the patient should be the norm.

2. Drug use is both complex and meaningful.

The understanding that drug use is a multiply-determined behavior connects us to the Self Medication Hypothesis of Dr. Edward Khantzian (1985) and the Integrative Harm Reduction Psychotherapy model of Dr. Andrew Tatarsky (Tatarsky, 2002; Tatarsky & Kellogg, 2012). In essence, it means that people use substances in problematic ways for reasons – reasons that need to be understood, respected, and, at times, treated directly. Importantly, some patients will not be willing to alter their substance use patterns until this work is done.

For example, a woman in a drop-in center said, "I've always felt like I wanted to die since I was a little kid. I don't know why… I want to see a therapist or psychiatrist about it but I don't go 'cause I'm afraid to tell them I still do dope. I still just really love to get high." (Welch, 2011). The dilemma facing this woman is that she is both troubled by some kind inner pain and still very invested in the use of opiates. What she wants is a clinician or a clinical setting that can "hold" both of these realities while helping her sort through them. She believes, however, that if she goes to see a professional, she will immediately be told to stop using substances before getting a chance to successfully do this. The result is that she stays away from treatment. Unfortunately, her assessment of the situation is probably correct.

Looking at this more broadly, the reasons that people use drugs and alcohol in

see Integrative on page 51

Cognitive Behavioral Therapy for Anxiety

By: Lisette Dorfman, PhD, FNP
Assistant Professor of Nursing
College of Mount Saint Vincent

Are you living with anxiety? Do you know someone who always views the glass half empty? Given recent events such as natural disasters, shootings, bombings and the recession, it's not surprising that many of our friends, family members and our patients have experienced various levels of anxiety. An individual doesn't have to be directly affected by an adverse event to feel anxious. An Anxiety disorder crosses all races and socioeconomic classes and can even affect our support systems such as healthcare professionals, police officers, fire fighters and first responders. In a given year, approximately 18.1 percent of Americans are diagnosed with an anxiety disorder (Kessler, Chiu, Demler, & Walters, 2005). The symptoms denoting an anxiety disorder may be divided into cognitive, affective, behavioral, and physiological.

Cognitive symptoms can include hypervigilence, inability to recall important things, confusion, distractibility, loss of objectivity, cognitive distortion, or repetitive fearful ideation. Individuals with affective symptoms can exhibit impatience, tension, feeling frightened or alarmed. Behavioral symptoms can be illustrated by inhibition, tonic immobility, speech

Lisette Dorfman, PhD, FNP

dysfluency, impaired coordination, restlessness, or hyperventilation. Physiological symptoms can present as palpitations, heart racing, increased blood pressure, pressure on the chest, rapid breathing, startle reaction, insomnia, tremors, loss of appetite, abdominal discomfort, nausea, flushed face, or sweating (Beck, Emery, & Greenberg, 1985).

Metaphorically, an anxiety disorder can be conceptualized as a hypersensitive alarm system. The anxious individual is highly sensitive to stimuli and is vigilant about potential or perceived dangers. This individual experiences innumerable false alarms which keep him or her in a constant state of emotional stress and turmoil. This preoccupation with danger is manifested by the involuntary intrusion of automatic thoughts whose content involves possible physical or mental harm.

Automatic thoughts consist of interpretations of events or experiences that are spontaneous, appear valid, and associated with problematic behavior or disturbing emotions. These thoughts occur in shorthand and are often composed of one word or a short phrase which can function as a label for a group of painful memories or fears. Automatic thoughts are spontaneous thus the individual believes the automatic thought because of its reflexive nature. These thoughts are often unconscious, persistent and self-perpetuating as automatic thoughts are hard to turn off or change because they are ingrained into an individual's thinking. Automatic thoughts are relatively idiosyncratic, unique to the individual's view of the stimulus event, and generally involve a distortion of reality that is repetitive. Subsequently, the result is an intense emotional response to the underlying distorted thought (Beck, 1976).

Automatic thoughts are almost always believed no matter how illogical the thought appears. These thoughts occur despite the fact that they are contrary to objective and reasonable evidence. Automatic thoughts have the same believable quality as direct sense impressions thus the anxious individual attaches the same truth to automatic thoughts as to sights and sounds of the real world without question. Unfortunately, this individual continues to have automatic thoughts no matter how many times these thoughts are invalidated by external experience or solid evidence. These thoughts tend to occur repetitively and rapidly and seem completely plausible at the time of their occurrence. Many times a thought is so fleeting that the individual is aware only of the anxiety it has generated. While the individual may agree that these fearful thoughts are illogical, his or her ability to view them objectively without help is limited. The individual behaves as though he or she believes in the validity of one's misinterpretations (Beck, Emery, & Greenberg, 1985).

A common misinterpretation or faulty thinking which is characteristic of many anxious patients is catastrophizing. Individuals who catastrophize tend to dwell on the worst possible outcome of any situation in which there is a possibility for an unpleasant outcome. The individual overemphasizes the probability of a catastrophic outcome or exaggerates the possible consequences of its occurrence. The anxious individual has no patience for uncertainty or ambiguity and views possible dangers in absolute, extreme terms

see Therapy on page 51

AHRC New York City Launches New Initiative to Better Serve the Community

Training Programs Will Enable Staff to Better Serve Individuals and Families

Staff Writer
Behavioral Health News

Individuals on the autism spectrum have always received services from AHRC New York City (www.ahrcnyc.org) although many did not formally receive this diagnosis years ago. This group of individuals is without question exponentially increasing with referrals from families in great need of assistance growing enormously every year. AHRC currently serves several hundred school-age children in specialized programs for individuals on the spectrum that have been in operation for over a decade and are well respected in the educational community. AHRC New York City has made the commitment to increase our clinical competencies in the provision of services to individuals with autism and others with challenging behaviors and their families, particularly adolescents and adults for whom specialized services are sorely lacking.

Beginning in March of 2012, sixty AHRC staff members from the many AHRC New York City program departments spent three days in a TEACCH (Treatment and Education of Autistic and Communication Handicapped Children) training session. The TEACCH approach is an evidence-based program for individuals of all ages and skill levels with autism spectrum disorders (and other challenging behaviors) developed and researched by the University of North Carolina at Chapel Hill.

The three-day training was followed up with the creation of user groups so AHRC New York City staff were able to support one another – and other AHRC staff – in the implementation of these strategies. A cadre of twenty AHRC staff member were then sent to North Carolina for further training in the summer of 2012 and AHRC has utilized these trained staff to train additional staff in this very effective approach. The TEACCH folks from North Caroline will be coming to New York once again early in the fall of 2013 to further train AHRC staff members.

In addition to TEACCH which is a broad framework for building a successful setting in which individuals with autism can succeed, AHRC New York City has embarked on a partnership with a the University of Texas to offer Board Certified Behavior Analyst certification to ten staff members. These ten staff have already completed two of the five courses required for obtaining certification. Not only is AHRC assisting in paying for these intensive online courses, but additionally, they are paying for the requisite hours of supervision by Board Certified Analysts. This has been possible through generous support from the AHRC New York City Foundation (www.ahrcnycfoundation.org).

The four PhD psychologists hired by AHRC to provide supervision are some of the best ABA practitioners in the tri-state area. They come from Rutgers University Douglas Center, the New York State Institute for Basic Research and Long Island University. AHRC is proud to be supporting this group of staff as a cohort so that they have the benefit of working with one another as part of a learning community. We plan that once certified, this group will be able to supervise greater numbers of staff in becoming BCBA's.

The TEACCH and BCBA training efforts will expand each year with the hope of providing large number of staff with the skills and techniques necessary to support individuals on the spectrum in the most effective way and provide assistance to families struggling to help their loved ones.

The Future from page 14

systems in the world. We certify 6,724 Intensive Residential Treatment beds that admit about 13,000 people a year, for a total cost of $171 million. Let me be clear – I support residential treatment but I also believe that even the label "Intensive Residential Treatment" does not do justice to our providers – it is a single label for a shifting menu of services and varying client needs.

I believe that our shared vision of a residential treatment model should be that there is an intensive part of the treatment that is focused on stabilization, the phase that occurs when people first enter treatment followed by a rehabilitation phase that focuses more on drug-free life skills development—and finally a reintegration phase that focuses on education and jobs.

As we move forward we cannot forget that one of our greatest challenges is misunderstanding. Addiction is still seen by many as a failure of will. The public still doesn't understand that addiction is a medical condition, that it is an extremely common brain disorder that affects nearly 2 million New Yorkers. The clinical and policy implication of this misunderstanding is enormous. We need to confront this misunderstanding together!!!

I know personally from prior experiences the clinical and fiscal challenges that a full transition to managed care will bring. Clinically, plans will need to develop an understanding of our clients and our system. As Commissioner, you continue to share with me, your concerns that commercial managed care insurers have not always understood addiction services and used a medical model that often created a barrier to access to care. To protect the expertise of your clinicians, we are developing a new level-of-care tool, the OASAS LOCATDR 3. We will require Medicaid managed care plans to use LOCATDR 3, so that decisions about medical necessity are driven by clinical judgment. Fiscally, we will have to assess our business models; develop networks and create attractive and innovative services that you can market to plans. OASAS with our partners at OMH and DOH will carefully qualify, monitor and hold accountable the plans that manage the SUD benefit. OASAS will also change the way in which we regulate services to allow the flexibility to thrive in this new day. We understand providers are concerned about this transition and I am telling you that OASAS will continue to do all we can to allow providers to survive and thrive in the new health care world.

Let's continue our work together to face the future with optimism and a clear vision. We will cultivate the new opportunities and partnerships, develop new and innovative models to achieve better outcomes and we will face the challenges together that will make addiction treatment stronger. It's a new day. And together, as partners, we can make our work even more effective, meaningful, and rewarding.

Texting to Save Lives

By Donald M. Fitch, MS
Executive Director
Center for Career Freedom

At a family dinner, my granddaughter Sarah, a high school sophomore in Fairfield, CT, and I were talking about the tragedy in Sandy Hook. She asked me, "Why?"

I talked about the need for school programs for early detection and prevention, but I had no real answers or solutions.

Later, I searched several terms online in hopes of finding some answers. I was surprised to learn that "1 in every 20 teens either made plans to kill themselves or actually attempted suicide, and that fear, anger, distress, disruptive behavior, and substance abuse were predictors of suicidal behavior" (M. Nock, JAMA Psychiatry, January 2013).

I also learned that according to the U.S. Centers for Disease Control and Prevention, suicide is the third leading cause of death among adolescents, taking more than 4,100 lives each year (Healthfinder.gov).

Some of the answers I found appeared on 24/7 hotlines that encouraged callers to speak to their parents, teacher, counselor or doctor American Association of Suicidology).

A disturbing article in the NY Times (D. Murphy, Child Trends 2013, NY Times 6/19/2013) cited a national survey that found among the high school class of 2013:

- 71% experienced physical assault
- 39% had been bullied
- 29% felt "sad and hopeless"
- 28% were sexually assaulted

The more I learned the more helpless and frustrated I felt. What would make a difference in the lives of thousands of teens?

We had a thought; what if we created a sticker of a hotline that you could stick on the back of a cell phone? Old cells have 1"x2" space; smart phones a 2"x4" space.

I contacted Lifeline, the leading National Suicide Prevention Lifeline, administered by the Mental Health Association in New York City.

Sunitha Menon, MSW, Program Manager of the Crisis Text Line at Link2Health Solutions, MHA said they would be moving into texting following their launch of their chat programs and we were welcome to produce a Lifeline sticker for research purposes.

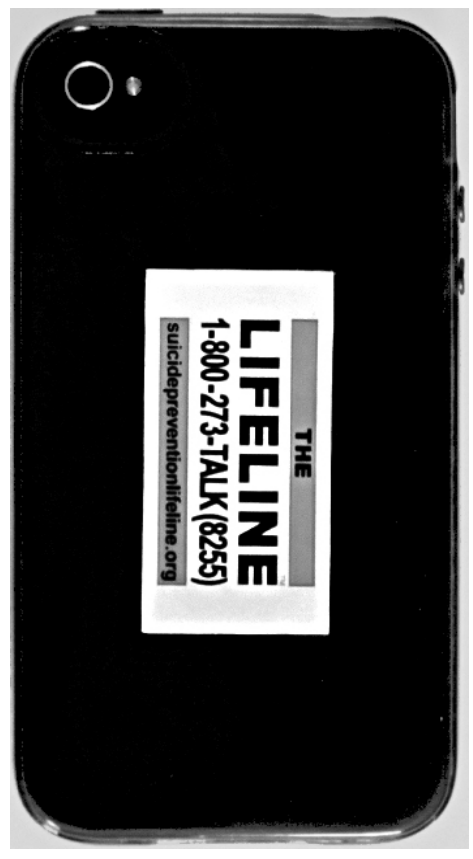
We produced a hundred 1"x2" stickers at about 10 cents each (see photo).

Sarah conducted several interviews with her classmates to explore their reactions to a cell phone sticker that would have a text number on it, and I conducted several focus groups of young people at the Center for Career Freedom:

- "I would definitely call if I saw someone who needed help, like a friend who drank too much alcohol or an abusive guy"
- "I text about 3,000 times a month; I rarely email or phone my friends; texting is quicker, cheaper, and anonymous"
- "I think most teens know if a classmate is having problems before their parents do. The Lifeline sticker could make us like, first responders"
- "I'm embarrassed to snitch on my classmates, but if they were in deep trouble and I could alert someone anonymously, I would do it"
- "I know a few teens that need help with drinking & drugging. I think one is a cyber-bully; another steals stuff"
- "Teens are more comfortable texting their thoughts—no one around you knows what your texting"
- "I know several girls in my school who struggle with depression, and one boy who's always getting into fights and acting out Mortal Combat fantasies"

I also interviewed several teachers, a school psychologist and several mental health professionals. They thought the cell phone sticker would prove to be an effective tool to help more teens get the professional help they need sooner, before their situation becomes critical.

Jeremy Willinger, Director of Communications and Marketing at MHA of NYC said it best, "The Lifeline sticker accomplishes a necessary goal of making people more aware of this life-saving service, available anytime, anywhere, anyplace. For over a million Americans this year alone, the National Suicide Prevention Lifeline will be their beacon of hope during their darkest hour. Having a reminder on your phone is a great way to keep the service top of mind when you or a friend is in crisis."



The Lifeline Sticker on the back of a cell phone

Optum Newest *Behavioral Health News* Sponsor

Staff Writer
Behavioral Health News

Optum is committed to helping people reach recovery through behavioral health programs and services that improve resiliency, outcomes, and well-being. Therefore it was not surprising that when the seeds to develop the new *Behavioral Health News* took root, Optum was at the forefront to lend much needed financial support to the project. *Behavioral Health News*' mission of providing vital mental health and substance use education to the community provided an ideal fit for Optum, our newest Gold Sponsor.

According to Sue Bergeson, Optum's Vice President of Consumer and Family Affairs, "Optum is committed to supporting the overall health and well-being of the members we serve through behavioral health programs that promote recovery and resilience. We believe in a recovery-centered approach to behavioral health treatment that engages individuals in their own care and fosters collaboration among the consumer, their providers and family members. In order for this collaboration to be successful, it's important that everyone involved have access to trusted, up-to-date behavioral health information so they feel empowered to take an active role in the journey to recovery. That's why Optum is happy to support Behavioral Health News in its efforts to keep our community informed about the latest behavioral health news and trends."

Peg Moran, a member of the *Behavioral Health News* Executive Committee stated, "On behalf of the Board of Directors of Mental Health News Education, Inc., we are enormously grateful for Optum's support as we launch our new publication. As a well-respected national leader in managed behavioral health, Optum has a robust record of promoting wellness and reducing stigma for people needing behavioral health services."

Optum operates the New York City Behavioral Health Organization (BHO), offering outreach and training to all of the New York City providers in support of New York State's efforts to transition the public behavioral health system into managed care. Optum has worked diligently with the behavioral health community to improve clinical outcomes and strengthen individual capabilities to pursue wellness and recovery — enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. Stella V. Pappas, LCSW-R, ACSW, has recently joined Optum's BHO team as Executive Director. Stella has a strong track record as a provider for over 20 years in New York City.

Optum is also the largest managed behavioral health organization in the nation, and currently serves over 60 million people in both commercial and publicly funded programs through a vast provider network of over 100,000 clinicians nationwide. They are recognized as a proven and trusted leader in this industry, and has improved the quality of behavioral health care for our existing customers by helping to remove some of the stigma associated with seeking behavioral health services.

In addition to behavioral health, Optum offers population health management, care delivery, pharmaceuticals management, and technology-enabled health services. They also provide these specialty services through a partnership with UnitedHealthcare Community and State. Because Optum serves people throughout the entire health system—from those who promote wellness and prevention, to those who provide care or research, manage and deliver medications—they bring a unique perspective. Optum has the ability and scale to help its clients both envision and implement new approaches that drive meaningful and enduring positive change.

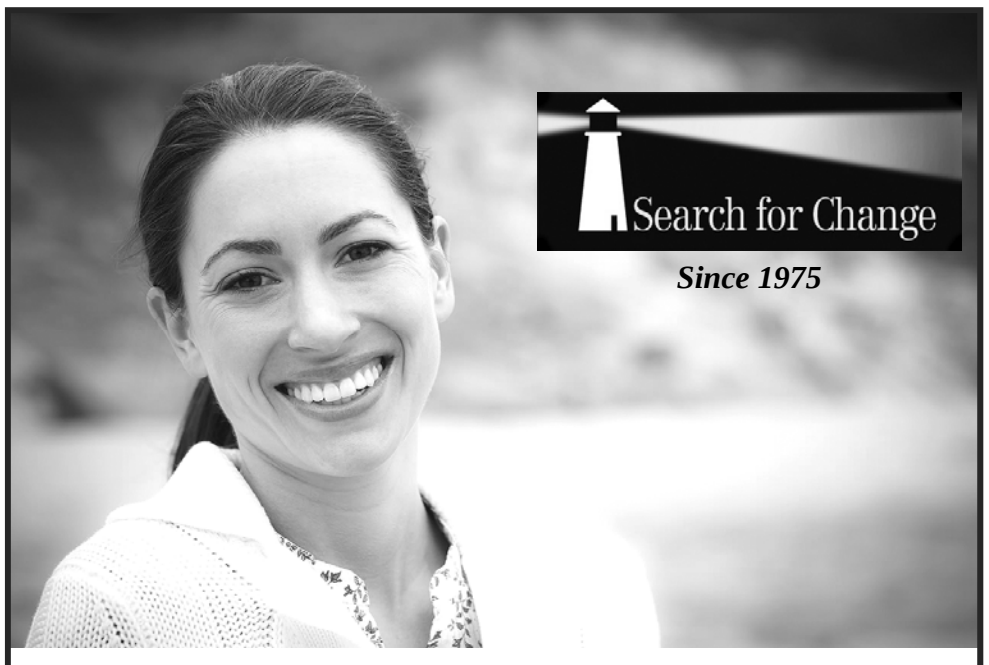
Tracking from page 22

like Superstorm Sandy have taught us that there is no such thing as being too prepared. OPWDD is pleased to be part of this initiative and we are grateful that Governor Cuomo is taking this important step to further ensure the health and safety of the individuals we serve."

Gladys Carrión, Commissioner of the New York State Office of Children and Family Services (OCFS), said: "During a major weather event and or unforeseeable crisis, the patient and resident tracking system will significantly bolster the state's ability to respond and address the needs of individuals in our care or custody. Access to such critical medical information is not a luxury, it's a necessity and OCFS stands ready to implement the system for future events."

Arlene González-Sánchez, Commissioner of the New York State Office of Alcoholism and Substance Abuse Services (OASAS), said: "In the aftermath of Hurricane Sandy, OASAS and our healthcare partners recognized that we needed a system to better account for displaced patients. This new electronic patient and resident tracking system will enable OASAS to better account for the whereabouts, care and well-being of our clients during the immediate aftermath of a disaster.

More information about NYS e-FINDS is available at: http://nysandyhelp.ny.gov/e-FINDS.



Rivel New CEO at JBFCS

Staff Writer
Behavioral Health News

David Rivel has become CEO at the Jewish Board of Family and Children's Services (JBFCS), the largest provider of social services in New York City and one of the largest such agencies in the country. He will lead the agency in new directions as government funding changes the way human services agencies are paid. With an eye toward data-driven and outcome-focused care, Rivel says JBFCS must determine what kind of outcomes we want for our clients and how we plan to achieve them.

JBFCS has a new strategic plan that begins with one overarching statement of purpose: Hope, recovery, and resilience guide our work, as we help individuals realize their potential and live as independently as possible. "We need to focus on our desire to do better for our clients," Rivel says, "and it is important for us, as practitioners, to learn to determine what the best outcomes are and which path we should use to achieve them."

Prior to joining JBFCS, David was the Executive Director of the City Parks Foundation, which he built into one of New York's premier not-for-profit organizations, responsible for enhancing the quality of life for New Yorkers in more

David Rivel

than 750 parks neighborhoods around New York City. Before City Parks Foundation, there were stints as President of the Brooklyn Conservatory of Music and senior management positions at Lincoln Center. David brings 20 years of experience in strategic planning, finance,

see Rivel on page 54

Woodlock New CEO at ICL

Staff Writer
Behavioral Health News

David Woodlock has been selected as the new President and CEO at the Institute for Community Living (ICL), an award-winning not-for-profit, human service agency that offers a wide array of residential, treatment, rehabilitation and support services to children, families and adults in New York City and Montgomery County, PA.

An experienced leader with a number of hard-won accomplishments, David Woodlock brings to ICL his exceptional government and private sector management experience. Most recently, he served as CEO of Four Winds Hospital's Saratoga Springs campus, a private psychiatric facility in upstate New York.

Mr. Woodlock brings to ICL his decades-long experience working in New York State government, including his four years as a Deputy Commissioner of the NYS Office of Mental Health where he was responsible for the children and families system of care. During his tenure, he was successful in securing the largest annual appropriation for children's mental health services in the state's history. Mr. Woodlock also served as the Executive Director of the Rockland Children's Psychiatric Center from 1995 to 2004, where

David Woodlock

he was responsible for operating 55 acute inpatient beds, serving 1,500 outpatients per year in 13 county sites throughout the lower Hudson Valley area.

Mr. Woodlock received a Bachelor's of Arts in Humanities and a Master's of Science in Special Education from

see Woodlock on page 54

Edwards Joins Parachute NYC

Staff Writer
Behavioral Health News

Jonathan P. Edwards, LMSW recently joined the Parachute NYC project team at DOHMH as the new Training Specialist. For the past 15 years, Jonathan has worked in several different capacities in healthcare serving individuals living with mental health, substance use, and HIV related issues; most recently, he worked as Director of Peer Services for Kings County Hospital Center. Prior to that, Jonathan worked as Consumer Affairs Coordinator for NYC Health & Hospitals Corporation. Mr. Edwards holds a Bachelor of Arts degree in psychology from CCNY of the City University of New York (CUNY), a Master's degree in social work from Hunter College, and is working on his doctorate in social welfare at the Silberman School of Social Work at Hunter College.

In this pivotal role, Jonathan manages internal and external trainings of providers, peer consumer groups, and other health professionals, as well coordinates trainings focused on state of the art established treatment models for participating providers in this project, which include crisis intervention and health navigation curricula. In addition, he will interact with families and advocacy groups representing consumer needs and interests. As an experienced group worker and facilita-

Jonathan P. Edwards, LMSW

tor, Jonathan will work with other project leadership to build relationships between practitioners of traditional and innovative care models. This endeavor is central to the project and seeks to create an unprecedented partnership between a renowned recovery model, Intentional Peer Support (IPS) with a highly innovative model, derived from the Need Adapted Treatment

see Edwards on page 54

Torres New CEO at HCC

Staff Writer
Behavioral Health News

The Hispanic Counseling Center's Board of Directors is very proud to announce the appointment of Dr. Anderson Torres as the newly elected Chief Executive Officer. Dr. Torres comes with a solid background in the integration of business development, behavioral health services, home care, community organization, and academia.

Appointed by Governor Andrew Cuomo and confirmed by the Senate, Dr. Torres serves on the New York State Public Health and Health Planning Council. Additionally he serves on the Region II Health Equity Council focusing on the Affordable Care Act. Dr. Torres's passion is addressing health disparities in marginalized communities. He will be focusing on the transformation of health services across the continuum of care delivery from children to older adults and caregivers.

The Hispanic Counseling Center is a fully bilingual, bicultural not-for-profit social services agency serving Long Island since 1977. It is the only completely bilingual agency in Nassau County licensed by the State of New York to provide treatment services in the areas of mental health, substance abuse, alcoholism, and youth and family services. The agency fosters an environment of hope, encouragement, and sup-

Anderson Torres, PhD, LCSW

port for individuals and families working toward a constructive, self-sustaining way of life.

The mission of the Hispanic Counseling Center is to enhance the strengths of Long Island's Hispanic families and children through bilingual, bicultural counseling, prevention, vocational, and educational services to enrich their lives, foster economic independence, and nurture dreams for the generation to come.

Peer Support from page 33

Center for Integrated Health Services has also deployed the Whole Health Action Management program, a peer-coaching model that supports both health and behavioral health created by Larry Fricks, in integrated behavioral health and primary care settings.

The Centers for Medicare and Medicaid Services (CMS) has issued several advisories to states highlighting the value of peer coaching in all its forms. Its most recent letter from May 2013 clarified the viability of peer coaching for family-to-family peer partners and for addiction recovery coaching. Thirty-nine states have set guidelines for the training, certification and use of peers within their mental health workforce systems

Optum recognizes that peers in recovery are uniquely positioned to promote engagement, foster activation, and support recovery. They can help overcome the stigma, fear, shame, and lack of hope that often gets in the way of activation simply by being a listening, caring exemplar of the reality that people do recover. As one person recently said to an Optum peer coach, "If you did it, I know I can, too." The peer can share tools, resources and services to fit the unique needs of the individual and connect them with local or online support groups, smartphone apps and other e-tools. They can also help the individual prepare for conversations with their provider by thinking through their questions and encouraging them to share their concerns and potential barriers to treatment.

The use of laypeople (Community Health Workers, Promotores) in promoting health and managing illness within non-behavioral health has been recognized by the Centers for Disease Control and Prevention (CDC), and they note that their roles "have been extensively documented and recognized for a variety of health care concerns, including asthma, hypertension, diabetes, cancer, immunizations, maternal and child health, nutrition, tuberculosis, and HIV and AIDS. Evidence supporting the involvement of community health care workers in the prevention and control of chronic disease continues to grow."[2]

With growing evidence of the positive impact of Peer Support Services, more individuals with behavioral health conditions are benefiting from their work with peer specialists. By promoting engagement, reducing isolation, and supporting hope, Peer Specialists are able to help individuals foster activation and take an active role in their own health and wellness. Or, as the Optum peer helping "Mr. West" recently stated, "The Whole Health Peer Specialty program has assisted Mr. West to look beyond depression and pain, to remember his strengths, to aid in future planning and to have hope." From despair to hope, from uninvolved to activated — all it took was a peer!

If you are interested in hiring a Peer Specialist, contact your local consumer-operated program or your state behavioral health authority to connect with peers who have gone through the state-approved training and certification process.

If you're interested in becoming trained as a Peer Specialist, connect with your state's behavioral health authority to learn which training program is preferred in your state. Depression and Bipolar Support Alliance, Recovery Innovations, and Mental Health America (MHA) of Southeastern Pennsylvania have well-regarded training programs for adult mental health peer coaching that is offered across the country. The Federation of Families for Children's Mental Health has a certification and training program for Family Partners. The Connecticut Community for Addiction Recovery (CCAR) has a well-regarded training program for Addition Recovery Coaches.

1. Greene J, Hibbard JH, "Why Does Patient Activation Matter? An Examination of the Relationships Between Patient Activation and Health-Related Outcomes," Journal of General Internal Medicine, published online Nov. 30, 2011. http://www.ncbi.nlm.nih.gov/pubmed/22127797

2. National Center for Chronic Disease Prevention and Health Promotion. Addressing chronic disease through community health workers: A policy and systems-level approach. Policy brief on community health workers. Washington, DC: Centers for Disease Control and Prevention; 2010. http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

Behavioral Health from page 18

At that time, I was Director of Operations at The Jewish Board of Family and Children's Services and helped the agency create a managed care division. To us and to other companies, "behavioral" health was a term that served two purposes. First, it referred to both mental and addictive conditions, indicating to potential customers that we would take care of both kinds of problems. Second, it emphasized the importance of behavioral change at a time when mental health professionals were perceived (fairly or not) as Freudians who would let people lie on the couch for years without any change in behavior. Neither employers paying for health coverage nor health insurance companies trying to keep costs predictable wanted employees or their families in endless treatment that produced no improvement in the behavior that resulted in lost productivity. They wanted treatment to be short-term, focused on documentable behavior change, and in the community rather than in hospitals whenever possible. This is what managed care promised; and despite widespread criticism from traditional providers, it appeared to be effective.

By the early 1990s the public sector had been drawn to the idea of behavioral managed care, and it became a core element of the push for Medicaid managed care. Grand visions to the contrary and with exceptions in a few states, early Medicaid managed care used behavioral managed care organizations primarily for people on Medicaid who were not seriously and persistently mentally ill (SPMI).

During this same period, there was increased awareness that a great many people with serious mental illness also had substance use disorders and vice versa. It was clear to almost everyone that these people needed treatment for both disorders and that at the very least providers from the two silos should coordinate treatment or, better yet, that providers with expertise in both types of disorder should provide integrated treatment for people with co-occurring disorders.

As a result, some mental health organizations that had not provided substance abuse services began to provide them, and governmental mental health and substance abuse authorities that had stayed largely out of each other's business talked more and more about cooperative arrangements or even mergers.

According to the National Council of Community Behavioral Healthcare, these developments led to its name change. "As services offered to the mentally ill became more diverse and comprehensive, it also became clear that helping people function at optimal levels would require the addition of treatment services for addiction disorders. This coordinated brand of service was labeled as "behavioral healthcare" — and providing comprehensive behavioral healthcare services is the goal of community-based organizations today." (http://www.thenationalcouncil.org/cs/history)

Substance abuse organizations also had changed. Some were prepared to provide mental health services; and many had largely professionalized. The personnel of the fields of mental health and substance abuse were increasingly similar in professional background.

It also became clear that providers who were struggling to survive efforts to contain Medicaid and other costs would have greater political clout if they worked together. This was another important reason why some trade associations shifted to calling themselves "behavioral" health organizations.

In short, the use of the term "behavioral health" emerged from a combination of the growth of behavioral managed care, the effort to integrate care for people with co-occurring mental and substance use disorders, changes in personnel, and the political advantages of cooperation rather than competition.

General health care reform and especially the passage of the federal Affordable Care Act have provided additional reasons to think in terms of "behavioral" rather than "mental" health. Health care reform calls for the development of comprehensive service organizations with high levels of coordination. Health care models such as "medical homes," "health homes," and "accountable care organizations" presumably will become the primary vehicles for health, and perhaps behavioral health, service delivery. By coordinating care and particularly by integrating physical health and behavioral health services, they are expected to improve the quality of services, improve health status of Americans, and hold down costs.

In addition, the effort to control Medicaid costs has focused particularly on people who have co-occurring serious mental, substance use, and physical disorders because they are generally the highest cost cases and are the most likely to have long-term disabilities and to suffer premature mortality. Medicaid, in New York State and elsewhere, has turned to behavioral health managed care organizations to make sure that people on Medicaid get the services they need in the community and use inpatient treatment as little as possible. That is just an interim measure, however. Over time, Medicaid managed care is supposed to become comprehensive, covering people with both behavioral and physical health disorders, including those with SPMI.

In essence, general health care reform and the effort to contain Medicaid spending create powerful economic incentives for mental health and substance abuse providers to join forces as a business and political strategy and as a way to improve the quality of care.

Given these trends, it is pretty clear that the concept of "behavioral health" is here to stay for a while. And, by including substance abuse providers among its sponsors and authors *Behavioral Health News*, née *Mental Health News*, will be in a far better position to foster the integration of mental health, substance use, and physical health care services that is a fundamental goal of health care reform.

I look forward to having *Behavioral Health News* as the observer of the vast changes already underway, a source for constructive critics to voice their concerns publicly, and as a vehicle of cooperation among providers who have historically been divided against each other.

Michael B. Friedman teaches health and mental health policy at Columbia University. He can be reached at mf395@columbia.edu. His writings are at www.michaelbfriedman.com.

OnTrackNY from page 20

Program, which is focused on helping people with recent-onset psychosis get their lives back on track. RAISE is an initiative of the National Institute of Mental Health (NIMH) and the RAISE Connection Program is jointly funded by NIMH and OMH.

"*OnTrackNY* builds on the successful RAISE initiatives in New York State which showed that early intervention services helps people young people who have just started to experience psychosis stay in school and work. We are excited to be able to enable more New Yorkers in need to access this innovative program." said Dr. Lisa Dixon, Director of the Center for Practice Innovation at the New York State Psychiatric Institute.

Measuring success of *OnTrackNY* will include measures of recovery, including staying in or returning to school or employment, improved control of mental illness, and, at a system level, reducing the duration of untreated psychosis.

OnTrackNY treatment teams will consist of a team leader, a recovery coach, a supported employment/education specialist, an outreach and enrollment specialist, a psychiatrist and nurse. Each *OnTrackNY* treatment team will serve up to 30 individuals and provide a range of treatment including: relapse prevention, illness management, medication management, integrated substance use treatment, case management, family intervention and support, as well as supported employment and education.

Services will be provided in individual and group formats according to consumer preferences and employs outreach strategies with a high value on engaging and retaining consumers and families over time.

For more information about OnTrackNY services in Westchester County, New York, visit www.mhawestchester.org.

Preventing from page 1

of dependence and overdose. Rates of misuse (using a medication in a way other than prescribed or without a prescription) are rising in parallel with the rate of prescribing of these powerful drugs. Prescription opioid misuse is more common in New York City than use of cocaine or heroin. In essence, this is an epidemic that originates in the medical system: physicians trying to address their patients' pain have been prescribing these drugs without sufficient regard for the potential for serious adverse consequences. These consequences are the result both of risk to the individual for whom the drugs are prescribed (overdose risk rises sharply with the dose taken) and also, via the potential for unused pills to be obtained by others. In New York City, overdose fatalities associated with prescription opioids increased by 65% between 2005 and 2011; on Staten Island, which is the epicenter of the crisis in the City, rates increased by 260%. DOHMH is working intensively on preventing these tragic outcomes, with a focus on the medical community, where we are encouraging more judicious, safer prescribing of these medications. We have developed prescribing guidelines for office-based and emergency department physicians, are visiting nearly every prescriber's office on Staten Island to provide education and tools, and have supported the State's initiative to improve its prescription monitoring program. Critically, as these and other initiatives serve to decrease the availability of these drugs in New York City communities, the treatment system must have capacity and be accessible to those who need it, and we are working to make sure that effective modalities of care, especially medications such as buprenorphine, in a variety of settings, are available. In another prevention effort, DOHMH and the State Health Department's AIDS Institute both administer programs to distribute an antidote to opioid overdose – naloxone (Narcan) – to lay community members who may be in a position to reverse an overdose (the medication is administered as an injection, like an Epi-Pen, or sprayed into the nose). Thousands of people have been trained and given naloxone to carry, and hundreds of overdose reversals have been reported.

Syringe Exchange: Preventing illness among people who are using drugs is a key priority. In collaboration with the AIDS Institute, DOHMH oversees the system of syringe exchange in New York City. In addition to providing clean syringes, these programs assist individuals in gaining access to other important medical, behavioral health, and social services.

Adverse Childhood Experiences: The association between adverse childhood experiences (ACEs) -- such as maltreatment, parental loss, or significant family disruption -- and subsequent mental illness and substance use, is increasingly recognized, via studies such as the Centers for Disease Control's ACE study in California, and in survey data from the National Comorbidity Survey Replication (NCS-R). One analysis of NCS-R, by Greene and colleagues, provocatively estimated that over 20% of child and adult mental illness and substance use is associated with ACEs. Other research has shown that serious trauma in childhood is also associated with psychotic illness later in life. These findings suggest that reducing trauma and promoting healthy early child development may be powerful prevention strategies to promote behavioral health. A comprehensive and multicomponent approach is essential, and should include parenting supports, such as the intensive Nurse-Family Partnership; Head Start, Early Head Start and other educational models; routine monitoring of development and screening for problems in primary pediatrics practices, identification and treatment of maternal depression, clinical/educational services such as Early Intervention, and other programs. One

see Preventing on page 54

Integrative from page 44

addictive or problematic ways can be organized, for the most part, into two categories. The first is pleasure. The hedonic qualities of drug use may come from their ability to connect people to experiences of pleasure, creativity, joy, and a sense of being alive. For some, these may be states that they find to be quite difficult to access without the use of substances. Drugs may also allow individuals to connect to others more readily and/or to become members of desired groups or subcultures. The second reason, as we have seen, is that they reduce inner pain and suffering. The self-medication properties of drugs may, at least temporarily, alleviate psychiatric symptoms, quell drug-induced, neurobiological changes, and/or reduce pain connected to medical illnesses.

In turn, the motivation to change is often driven by fear and desire. The fear may be based on the growing realization that continued drug use will (a) have detrimental effects on family, children, and other significant relationships; (b) lead to job loss, prevent career advancement, or jeopardize a professional license; (c) threaten an individual's freedom; and/or (d) damage their health in serious ways or lead to their death. The desire for something better may include spiritual or existential experiences or profound moments when the individual comes to the realization that there is something more important that he or she could be doing with his or her life. All four of these motivations will play a role in depth-oriented work.

As a way of operationalizing these ideas, it is very useful to conceptualize the internal world of patients using models of Multiplicity of Self. This means that patients are not seen in a unitary fashion; instead, they are seen as containing a number of different selves, modes, or parts – each of which may be active in different situations and for varying lengths of time (Rafaeli, Bernstein, & Young, 2011). This, of course, is not a new idea in the culture of addiction as many people make reference to Dr. Jekyll and Mr. Hyde (Stevenson, 1967) when they speak about their struggles with drugs. From a clinical perspective, the Jekyll and Hyde reference is not particularly accurate as it fails to capture the reality of inner suffering. Nonetheless, it does provide a therapeutic entrée for working with ideas of personal complexity (Kellogg & Tatarsky, 2012).

In practice, these forces can often be identified using the Decisional Balance technique (Marlatt & Gordon, 1985) – a therapeutic process in which the patient is asked to identify the positive and negative aspects of the drug use and the perceived positive and negative aspects of making a change. The work then involves first giving voice to the different parts and then working to understand what they want and need. Attempts are then made to address the needs of those parts that are in pain so that they do not have to turn to substances; efforts are also made to empower the healthy parts and help them find expression in the world.

3. Integrated treatment involves addressing both the underlying pain and the drug use itself.

While problematic substance use may have its origin in one or more of these factors and while these forces may continue to play a role throughout the using career, addictions have their own dynamic and momentum. Working with the underlying causes is sometimes not enough; the drug use must also be addressed directly. Given these complexities, it is important for clinicians to have the skills and mastery to work on two dimensions – the Horizontal and the Vertical. The horizontal interventions are those that are concerned with helping patients alter, reduce, or cease their use of substances. These include Substance Use Management, Relapse Prevention, and Contingency Management or the use of positive reinforcement systems. The vertical, in turn, are focused on addressing and treating the underlying pain, suffering, and psychopathology; these include the full range of relational, cognitive, behavioral, experiential, existential, and mindfulness-based interventions.

In a related vein, many patients who wrestle with addictions, psychological difficulties, or both report being plagued by experiences of self-hatred or self-attack. Often referred to as an inner critic, these experiences drive both the emotional suffering (i.e., depression and anxiety) and the problematic behaviors that patients use to cope with it (i.e., self-harm, rituals, and addictions) (Rafaeli et al., 2011; Tatarsky & Kellogg, 2011; Wurmser, 1978). The internal world of these patients is typically out of balance, and the internal leader, healthy self, or ego is often not strong enough to combat the critic, soothe the suffering parts, or lead the system. This, then, becomes a central focus of the therapy. In my clinical work, I have found the Gestalt Chairwork technique to be a strikingly effectively method for doing this kind of work (Kellogg, 2004; Perls, 1969).

The therapy, then, involves working on both dimensions – sometimes focusing on the drug use, sometimes working with the pain, and sometimes working with both simultaneously. Again, this approach acknowledges that while some patients may make dramatic life changes, slow and gradual progress may be the norm for many others.

4. Long-term, successful recovery involves the creation of meaningful and rewarding identities that can compete with and replace those based on the use of drugs.

One way of understanding addiction is to see it as an experience in which the Addict Identity has become a central and defining identity in the person's role hierarchy. Successful long-term healing and recovery takes place when identities based on work, family, recovery, athletics, spirituality, or some other form of group connectedness or activity compete with and replace those based on the drug and alcohol use.

This was brought home to me early in my career in my work with a woman I will call Natalie. A patient in a methadone clinic who had a history of heroin use, Natalie revealed to me one day that she had never used heroin intravenously – only subcutaneously or intramuscularly. This was certainly very unusual behavior for patients in that kind of setting. As we explored it further, she revealed that being a mother to her two daughters was so important to her that it had, in face, impacted on her heroin use. She felt that "shooting" heroin would be so dangerous to her role and identity to as a mother that she refused to take that "final" step that so many others had taken. In fact, it was her love for her children had led her to join the methadone program in the first place. Natalie did quite well in treatment, started to attend college, went through a dose-reduction process, and completed treatment – all for the sake of her two little girls. While a very unusual story, it does show the power of identity in the processes of change, healing, and recovery. Most stories of long-term abstinence and moderation embody these kinds of identity transformations (Biernacki, 1986; Kellogg, 1993).

With the move toward integrative care, I believe that the insights and strategies of Gradualism can be both empowering to therapists and curative for patients. Those who are suffering from addictions need treatments that are driven by compassion, creativity, and science. It is with this spirit that I hope we will embrace the future.

Scott Kellogg, PhD, is the former President of the Division on Addictions of the New York State Psychological Association, a Certified Schema Therapist, and a Clinical Assistant Professor in the New York University Department of Psychology. He has a private practice at The Chairwork/Schema Therapy Treatment Project. His websites are www.gradualismandaddiction.org and www.transformationalchairwork.com. Dr. Kellogg can be reached at: scott.kellogg@nyu.edu. All references contained in this article are available on request.

Therapy from page 44

which only increases anxiety as one approaches the danger situation. This anxiety can be manifested in numerous ways such as sweating, difficulty breathing, hands trembling, heart racing and wobbliness in legs.

To alleviate the anxiety the individual can be trained to rewind and recover the automatic thought preceding the affect. Subsequently, according to Beck's cognitive behavioral theory, anxiety should improve as these thoughts are unlearned and changed (Beck, Emery, & Greenberg, 1985).

Cognitive Behavioral Theory

Cognitive Therapy has been supported in the research to be effective in treating anxiety and negative automatic thoughts (Kehle, 2008; Stanley et al., 2009). Cognitive therapy is an active, directive, time limited structured approach used to treat depression and anxiety. Cognitive Therapy is based on an underlying theoretical rationale that an individual's affect and behavior are largely determined by the way in which he or she structures the world (Beck, 1967). The individual's cognitions are based on attitudes or assumptions (schemas), developed from previous experiences (Beck, Rush, Shaw, & Emery, 1979).

The therapeutic techniques are designed to identify, reality test, and correct distorted conceptualizations as well as the dysfunctional beliefs (schemas) underlying these cognitions. The individual learns to master problems and situations which he or she previously considered impossible by re-evaluating and correcting his or her thinking. The cognitive therapist assists the individual to both think and act more realistically and adaptively about his or her psychological problems and thus reduce symptoms (Beck, Rush, Shaw, & Emery, 1979).

A variety of cognitive and behavioral strategies are utilized in cognitive therapy. Cognitive techniques are aimed at delineating and testing the individual's specific misconceptions and maladaptive assumptions. This approach consists of highly specific learning experiences designed to teach the individual the following operations: (1) to monitor negative, automatic thoughts (cognitions); (2) to recognize the connections between cognition, affect, and behavior; (3) to examine the evidence for and against distorted thoughts; (4) to substitute more reality-orientated interpretations for these biased cognitions; and (5) to learn to identify and alter the dysfunctional beliefs which predispose him or her to distort experiences (Beck, Rush, Shaw, & Emery, 1979).

Various verbal techniques are used to explore the logic behind and basis for specific cognitions and assumptions. The individual is initially given an explanation of the rationale of cognitive therapy. Next, he or she learns to recognize, monitor, and record one's negative thoughts on the Daily Record of Dysfunctional Thoughts. The cognitions and underlying assumptions are discussed and examined for logic, validity, adaptiveness, and enhancement of positive behavior versus maintenance of pathology (Beck, Rush, Shaw, & Emery, 1979). Behavioral techniques are used with more severely anxious individuals not only to change behavior, but also to elicit cognitions associated with specific behaviors. A sampling of these behavioral strategies include a Weekly Activity Schedule in which the individual logs his or her hourly activities; a Mastery and Pleasure Schedule, in which the individual rates the activities listed in his or her log; and Graded Task Assignments in which the individual undertakes a sequence of tasks to reach a goal which he or she considers difficult or impossible. Furthermore, behavioral assignments are designed to help the individual test certain maladaptive cognitions and assumptions (Beck, Rush, Shaw, & Emery, 1979).

Therapy generally consists of 15-25 sessions at weekly intervals. The moderately to severely anxious individual usually requires therapy on a twice-weekly basis for at least 4 to 5 weeks and then weekly for 10-15 weeks. The frequency of therapy is tapered to once every 2 weeks for the last few visits and booster therapy is recommended after the completion of the regular course of treatment. These follow up visits may be scheduled on a regular basis or may be left to the discretion of the individual (Beck, Rush, Shaw, & Emery, 1979).

Work from page 41

Body, Effort and Authority.

Manual work is a body-relational medium. You have to be in your body to do it. Manual work compels body presence because of its direct involvement with matter – with the soil, plant, animal and human levels of creation. Being present to a task in body also requires being in the here-and-now – a piece of work in itself. As Fritz Perls, the originator of Gestalt Therapy used to say, "Get out of your head and come to your senses." Manual work challenges head trips and ways of escape through distraction, ways of disconnection typical of many disorders – nature deficit disorder perhaps most of all. Manual work also presses the body to be lived as an instrument – not viewed as an object – and body image concerns must give way to experience of the functional body – true even for anorectics who misuse it for over-exercise.

A second obstacle to work is effort. Manual work takes physical exertion and, consequently, draws upon all the qualities of personality and character that effort can engender – patience, persistence, endurance, focused aggression, care and attention, will and will power – the list is endless. These are all ego strengths, and as such they are the very stuff of personal growth and character building at the core of treatment. Surely, the development of a strength comes from its exercise. And as work requires the ability to do hard things, to expend oneself energetically and go beyond one's sense of limitation, this builds self-confidence while accomplishment builds self-esteem.

A third obstacle to manual work is authority: Who or what am I working for or under, as the case may be? Authority comes from the Latin *auctor*, which means to author, to originate, to bring forth and create. At Wellspring, the authority of a work therapist is based on her ability to author the client into personal growth and healing through the medium of work. The authority of the client, on the other hand, comes from learning to exercise authority over herself, by directing energy into the work, and by learning how to take charge of a task from a sense of personal empowerment. Nowhere was this more evident than when Heather, a milieu counselor, directed a crew of adolescent girls in a series of landscaping projects one summer. Beginning with a sense of work as slavery typical of adolescents, what a potent force they became, so proud of themselves in what they accomplished!

A therapeutic work program has many objectives: To learn how to work, to gain satisfaction from accomplishment, to increase self-esteem, to develop a positive work ethic, to acquire basic work skills, to learn how to work with others for a common good, and to learn skills of relationship with co-workers and staff. A work program directed toward these goals can accomplish much therapeutically. However, for a work program to become a therapy in its own right, the work must be related to the individual's treatment process and become an integral part of treatment planning. This involves the subjective side of work, where the work experience is focused on specific issues of individual growth – where work becomes a way of working on oneself. To the degree that a work program does this, along with general goals, the legal problem of exploitation can be resolved. It can also answer questions from clients such as, "Why should I work? What does this have to do with me? I'll never have to muck stalls or mess with animals, dig a ditch, plant flowers, whatever. Wellspring should be paying me to work." This is where a work program that is therapeutic develops into Work Therapy as an art.

The first requirement for a work therapist is to know the work task intimately from personal experience. This knowledge is both external and internal, both physical and psychological. By experiencing and reflecting on each task – weeding, raking, digging, lifting, shoveling manure – the work therapist gains an understanding of the qualities of personality, the particular ego strengths, required of the worker. These strengths (or weaknesses) are revealed by the internal demands a task makes on a worker through its physical demands. Tasks can then be chosen to address relevant issues relevant for an individual, whether to utilize and build upon an existing strength, or to address a weakness in need of development. This allows the work therapist to articulate why she assigns a particular task to an individual and invite the person to take on the task's inner work as a way of self-development. The trite generality – "this work will be good for you" – becomes redefined into a specific opportunity for personal growth.

To fit the task with the person in terms of specific treatment issues and objectives, the work therapist has to know the individual both clinically and as a worker. Work histories are intertwined with clinical and relational histories that can have a determining effect on a client's attitudes toward manual work. Information about parenting is particularly important in determining the client's expectations about work and relationship to authority. By assessing this personal dimension, the work therapist will be aware of reaction and response patterns emerging in work that may be unconscious to the client. They can also affect how the individual relates to different kinds of work and different kinds of matter, like soil, leaves, rocks, wood and manure, their various smells and textures. As these response patterns emerge in various tasks and contexts, they can be addressed, reframed, re-decided and changed in the treatment process.

Assessment of the individual as a worker – her actual functioning in work – can only be obtained through close observation with different kinds of work. As various ego strengths and weaknesses are revealed in response to the demands of different tasks, the work therapist reads the body of the worker – the non-verbal language of energy, movement, breathing, posture, alertness and alacrity. It is this language that guides assessment and intervention.

For example, Corinne was a teenager who was negative toward everything, especially work of any kind, when she first arrived at Wellspring. Although she was distinctly overweight and preferred sitting around and griping to doing anything active, something about her underlying physicality belied that. Personal history revealed that when her father, whom she looked up to, abandoned the family for another woman, Corinne became depressed and began using drugs. In revenge, Corinne quit Karate where she had excelled, and rejected the male coach she had admired much like her father. In her anger, she became destructive to the very physical nature with which she was gifted, as well spewing her anger at everyone around. Within the context of multi-modal treatment with intensive individual and family work, Work Therapy was the key experiential element of her treatment that literally gave Corinne a way to work out her problem. As she understood the nature of her predicament, she was focused on directing the energy of her anger into the work. By doing so, she was able to replace her external father with the development of an interior "masculine" capacity that found expression in her ability to work. Corinne came alive and became both a model worker and a leader in work program and the community. Work Therapy, in combination with other modalities, provided the ideal context and instrument for this to occur. It literally saved her "life."

As an "outdated perspective" for behavioral health, a therapeutic work program is able to combine involvement with nature, with character building, and experiential interventions in treating core issues. Context is important, because residential treatment at Wellspring is able to provide direct involvement with nature in a rural setting, within a framework of multi-modal, process-oriented, relational treatment. Although these elements may not be available in every circumstance or to the same degree, effective therapeutic work programs can be designed to fit different circumstances and take advantage of the natural surroundings in some way – if there's the will to do that. Community gardens in urban settings are a case in point. The greater challenge is to develop a mindset based on values that grasps how truly important this perspective is, now more than ever, for the behavioral health of young people.

Richard Beauvais, Ph.D. and his wife, Phyllis, are co-founders of Wellspring, a multi-service mental health agency in Bethlehem, Connecticut. Richard is now the Director of the Wellspring Institute, a vehicle for training and consultation, and is also Chairman of the Board.

Youth from page 40

Treatment within each area utilizes workbooks, videos, and other materials developed by the nations' experts in treating YwSA. Whenever possible, Evidence Based Treatments are used, such as using Aggression Replacement Training methods to target impulsivity or using Dialectical Behavior Therapy principles to address emotion dysregulation. JSO clinicians also use Evidence Based Treatments to address responsivity factors, such as Motivational Interviewing for treatment resistance or Trauma Focused – Cognitive Behavior Therapy for posttraumatic anxiety. Treatment can be provided in various modalities, including individual, group, and family counseling sessions. When changes to environmental circumstances are critical, training can be provided to parents/caregivers or consultation offered to staff at residential treatment facilities. Treatment progress is tracked in collaboration with each client using a standardized instrument with the goal of discharge once all treatment needs have been met. When the youth victimized individuals within their own family, treatment sessions are used as a context for apologies and reunification of the family.

Most Youth with Sexual Aggression are not the sexual predators they were once believed to be. Many can be effectively treated while residing in the community. Still, many of them have gaps in their knowledge, deficits in their skills, and limited insight into their behavior and its consequences that requires focused treatment. The JSO program at WJCS is constantly evolving in its efforts to provide the most effective and evidence-based treatment interventions to help these children and teens, along with their families, right their course.

Disaster from page 12

"our people" and the work they did was selfless and impressive.

Providing information and assisting with concrete tasks were critical activities and evacuees were extremely grateful for anything that responders were able to do for them. Responders accompanied evacuees to FEMA and the bus stop; helped evacuees to locate missing relatives, we contacted school principals, employers and landlords; and used our personal cell phones to call long distance to notify relatives of evacuee whereabouts. Responders helped evacuees get food, clothing, METRO Cards; medication and psychiatric assessments; and arranged for their case managers to come to the shelters. We mediated disputes about space within the shelter, about personal belongings and supplies; and arranged for children's activities and Halloween candy. And sometimes we simply sat and had a cup of coffee with an evacuee, and listened.

Observing evacuees was as inspiring as observing fellow responders. And their coping skills and adaptive behavior was enlightening. Moms were like bears protecting their cubs, arranging their family's cots with a perimeter, "their area" to create a sense of safety and security and perhaps an illusion of privacy. "Good Samaritans" were helpful and altruistic, keeping an eye out for fellow evacuees who were in need, perhaps getting their meals for them, helping them to the rest room, or advocating for their needs with personnel.

Hurricane season started on June 1st in Nassau County and the news media predicted an "active" season with some hurricanes expected to make landfall in the northeast. I must confess that this news caused what I would like to call "forecast anxiety." During the days following Hurricane Sandy, after power was restored in my neighborhood, if I saw a power company truck nearby my anxiety level increased. "Oh no, don't tell me my power is out again." Likewise for forecasts about hurricanes, my anxiety level increases and a sense of dread overcomes me – "Oh, no, not another one." Hopefully there will be no future hurricanes, not even a nor'easter, but our Office and treatment provider system responders deployed for Irene in 2011, Sandy in 2012, will be on the ready again, if needed.

Edwards from page 48

Model/Open Dialogue in Finland, to deliver best, recovery-focused and person-centered practices in mental health care to consumers, their families, and the community.

Parachute NYC, a new and innovative approach to providing community-based services to individuals aged 16-65 who are experiencing symptoms of psychosis, offers a timely response to several paramount concerns in healthcare. In addition to projecting a $50 million reduction in gross Medicaid expenditures over the next three years, the project meets two other objectives of the "Triple-Aim" by improving the care and health of individuals and the population. Furthermore, Parachute NYC will improve the continuity of care through a coordinated continuum of services implemented both by professionals and peers, including home based treatment of up to 1 year provided by specially trained mobile treatment teams, open doors Crisis Respite Centers (CRCs), consumer peer lead "support line" as well as integration with medical services. Parachute NYC mobile treatment and respite will provide care in the community to individual's experiencing symptoms of psychosis, and will include their families and social supports in their care plans. The support line is more broadly targeted to anyone in distress.

In essence, Parachute NYC will provide a "soft landing" as an entry point to the mental health system to individual's experiencing a crisis and help the person to develop his/her full potential in the community. For more information, please visit us at http://www.nyc.gov/html/doh/html/mental/parachute.shtml.

Time from page 4

managed care initiatives can have a tremendous impact for individuals who suffer from mental, physical or substance abuse problems; the homeless; and returning veterans and their families.

I know it's an overused phrase these days, but there really are opportunities in the crises that seem upon us; opportunities to do some of the kinds of care some of us have hoped for for decades. It certainly won't be without its challenges, but let's all keep our eyes on the prize.

There are a growing number of innovative managed care programs that are showing positive results on the local, state and national level. Their success is a fulfillment of the principle espoused in 1979 when President Jimmy Carter's Commission on Mental Health sought to maintain "the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind and spirit" for those with behavioral health issues. And it's about time!

Woodlock from page 48

Syracuse University. He was an Associate in Clinical Psychiatry at Columbia University College of Physicians and Surgeons, as well as a Member of the American College of Healthcare Executives.

Rivel from page 48

nonprofit management, fundraising, and government relations.

JBFCS is NYC's largest provider of human services, serving 30,000 clients annually in 50 locations in the five boroughs and Westchester.

New Era from page 1

by the same history which has led us to this point, namely by the outdated and costly way in which we provide long-term inpatient treatment in our twenty-four legacy psychiatric centers, three times as many as other comparable states.

Embarking on this journey required an unflinching look at the forces of change within the world of behavioral health. No longer is recovery a far-off goal for individuals with serious mental illness, but an expectation of many individuals who would have formerly received long term care in an institution. Individuals in treatment have a better chance of recovery when receiving care within their communities and an investment in early intervention methods, as we will see through this plan, will help individuals stay connected with their communities and stay in school or keep their job.

The forces of change go beyond advances in modern medicine and treatment trends. The Affordable Care Act, the transition to "managed care" for behavioral health and the United States Supreme Court's "Olmstead Decision" will converge and bring change with or without us. It is important that we direct this change in a way that maximizes our current structure, increases availability of community-based services and allows us to remain competitive in a fast-changing field. This plan is an investment in the future of behavioral health services in New York.

Building our future system within our Regional Centers of Excellence plan, we placed recovery and resiliency as the foundation. Promoting choice as both a recovery tool and a much needed addition to our system, we eliminated catchment areas, allowing individuals and families to pursue specialized treatment throughout the State. Enabling local communities to have a voice in the process, OMH created a team-based structure with stakeholders having a formal role, charged with the examination of current services, community needs and reuse of facilities to custom fit a service structure for each region.

Perhaps our most valuable asset is the OMH workforce. It was apparent that in order for this plan to be successful, we would need to empower many of our dedicated employees in new roles. The Regional Centers of Excellence plan creates regional outpatient service hubs. Our employees are among the best qualified and most experienced anywhere in the world and it is important that we use their knowledge to our advantage. Potential new roles for these employees could be much different from their previous jobs; they could be a member of mobile crisis team, they could be part of a maintenance crew working to support residential providers throughout the region or they could be providing outpatient services within a clinic setting, to name a few options.

New Yorkers are courageous and determined, as is the Regional Centers of Excellence plan.

We will bring our history along with us as both education and inspiration, enabling our agency and our State to provide the highest-quality services for the next 170 years. Bringing this transformation about was not easy, nor will be seeing it through to completion, but I am confident that through continued efforts in pursuit of recovery for all, we will begin a new chapter in the history of behavioral health.

Preventing from page 50

DOHMH initiative to integrate many of these components is Project LAUNCH, targeting the East Harlem and Hunts Point neighborhoods, in which we are working with caregivers, pediatricians, daycares, schools, and behavioral health organizations to build a network that comprehensively promotes children's positive social-emotional development population-wide.

One implication of a prevention-oriented perspective is that it prompts policymakers and planners to think "upstream" – toward strategies that do not rely primarily on individual interactions between, say, clinicians and consumers, but rather on interventions to change the social and physical environments that shape behaviors and affect mental health. Increasing evidence from epidemiologic studies documents the complex influences of, for example, the attributes of the neighborhood in which a person lives on the likelihood of their developing symptoms of depression. Social isolation and social connectedness affect mental health. The social environment affects drinking behaviors. How do we design public health strategies that address these influences? How can we in behavioral health learn from and collaborate with other public health practitioners who are concerned with environmental and social determinants of health? Care and treatment providers should be important contributors to this thinking and add their perspectives and experience to the development of creative approaches.

Adding a prevention focus amplifies the impact of our ongoing work to improve the system of care and treatment for individuals living with mental illnesses and substance use disorders. It also reminds us that the rate of these conditions in our communities is not fixed and unchangeable. The prevention perspective also challenges us to consider how connected many of the issues we face are and how upstream solutions potentially can have broad impact across a variety of outcomes.

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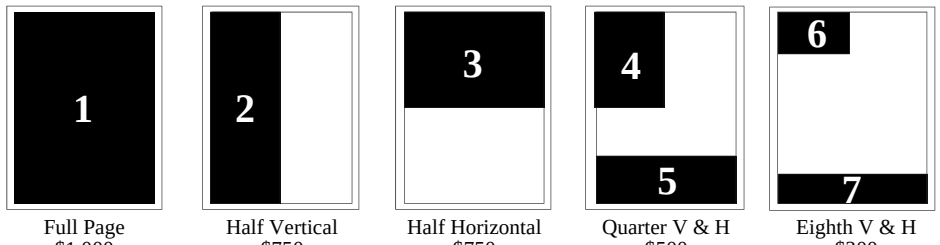

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