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Behavioral Health, the LGBTQ Community, and Managed Care

By Heidi Arthur, LMSW, and Josh Rubin, MPP, Principals, Health Management Associates; and Christian Huygen, PhD, Executive Director, Rainbow Heights Club

A wise man once said that at times of sweeping transformation, "all that is solid melts into air." As the delivery system responds to changes driven by the transition to Medicaid managed care and, ultimately, value based payment, many are concerned about meeting the needs of historically marginalized populations, including LGBTQ individuals who are living with serious mental illness. During this time of upheaval and flux, will their needs be taken into account – or lost by the wayside?

Although our delivery systems are calibrated to broadly serve those whose needs lie within the middle of the bell curve, it's the populations at the edges of the curve that are a critical focus for reform initiatives—those whose utilization is either very high or those whose lack of access to care demands focused attention. Indeed, it is within these "edges of the edges" that some of the highest need subpopulations lie. As we all work together to bend the cost curve and meet the triple aim, concentrating on the widest part of the bell curve – the needs of the "average" recipient of services – may seem like an adequate way to proceed. But the system is already designed for this imaginary average client – and it isn't working. Many people who aren't "average" in one way or another are falling through the cracks, and contributing to the kind of poor outcomes and high costs that we are all trying to avoid, while being unable to access the kind of affirming, client centered care that we are all trying to provide.

What do we know about people who fall through the cracks? Their needs don't get met, so they experience negative outcomes, relapses, decompensations—all with no support. Then they fall back on high-cost emergency services, such as hospitalization.

LGBTQ Populations with Behavioral Health Needs Are Especially Vulnerable and Underserved

The urgency of ensuring appropriate access to "LGBTQ welcoming" behavioral health care is only exacerbated following the nation's most deadly shooting, which targeted people who are LGBTQ. Among American adults, 3.8% identify as gay or lesbian[i], 0.7% as bisexual[i], and 0.3% as transgender[ii]. That's a total of 4.8% of the general population. The US Surgeon General estimates that 2.6% of all adults in the United States are experiencing serious mental illness at any given time. By combining these rates and looking at the population of New York City and State[iii], we can estimate that well over eight thousand LGBTQ adults are living with serious mental illness in New York City alone. However, just under that number are being served in New York State as a whole. Here we have solid data because the 2013 New York State Office of Mental Health (OMH) Patient Characteristics Survey included, for the first time, questions about recipients' sexual orientation and gender identity. Of the 144,464 adults surveyed, all of whom were clients of the NYS OMH system, a total of 7,226 (5%) identified as lesbian, gay, or bisexual, and 0.3% identified themselves as transgender. These groundbreaking, first-in-the-nation results clearly demonstrate that LGBTQ people receive services in the public mental health system at rates equal to or higher than national prevalence estimates for the overall population, but still well below the range of the actual level of need, according to likely prevalence.

The following LGBTQ health disparities were identified by the NYC Community Health Survey (CHS)[iv].

• Higher depression rates; 28% of gay and lesbian people had been depressed, nearly twice as many as the 14.25% rate reported by heterosexual people

• Lower rates of health insurance coverage; uninsured rates are 20.6% for lesbian and gay individuals, 23.5% for bisexual and 32.9% transgender people versus a 14.9% for those who are heterosexual

• Lack of access to primary care; 28.3% of lesbian and gay people did not have a primary care physician compared to 17.4% of heterosexuals

• Higher rates of homelessness; 42% of homeless youth are estimated to be LGBTQ[v]

• Domestic violence; 4.5% of lesbian and gay men report fearing violence from an intimate partner contrasted to 2.3% of heterosexuals

• Significantly higher rates of alcohol and drug use among LGBTQ youth populations than heterosexual youth populations by as much as 190%[vi]

According to the Federal Bureau of Investigation, LGBTQ people are more likely to be targeted for hate crime than any other group in the United States. Disparities related to experiences of stigma, discrimination, bullying, and violence are further exacerbated for LGBTQ people who have serious mental illness and/or substance use disorders. These compounded effects are especially acute among LGBTQ youth, those who are transgender, and Black and Hispanic LGBTQ people. Indeed, untreated behavioral health conditions are especially dangerous among those who are transgender—one study in the U.S. found that 41% of transgender people reported attempting suicide, a rate that is 25 times higher than the general population. As well, in 2010, the NYS Department of Health commissioned The Empire State Pride Agenda Foundation to conduct the Statewide LGBTQ Health and Human Services Needs Assessment in New York State.[xi] While 13% of LGBTQ people reported being the victim of homophobic or transphobic physical or sexual assault, these rates are far higher for those who are LGBTQ and Black (19.3%) or Latino (20%)—rates that are twice as high as the 10.9% rate of transphobic physical and sexual assault reported among white transgender people. The Needs Assessment also found that 14% of over 3,000 respondents are currently or formerly homeless, and rates are higher among the transgender and gender nonconforming populations.

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The Board and staff of Mental Health News Education Inc. stand in solidarity with the LGBTQ community in the aftermath of the Orlando shooting. We are committed to our shared vision of dignity, pride and resilience in the face of bigotry and hate of any kind. Love and acceptance is stronger than hate, and stigma will not define nor shape who we are.

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Substance Use Disorder and the LGBTQ Youth Community

By Aaron Fallon, Assistant Director of Communications, New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS)

According to the Centers for Disease Control and Prevention, compared with the general population, gay and bisexual men, lesbian and transgender individuals have higher rates of substance abuse, are more likely to use alcohol and drugs and to continue heavy drinking into later life (http://www.cdc.gov/msmhealth/substance-abuse.htm). Many in the LGBTQ community have experienced violence, discrimination, harassment, and other issues that have impacted their physical and mental health, factors which may have steered them down the path of substance abuse.

The New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) recognizes that people in the LGBTQ community, especially younger individuals, with substance use disorder have specific needs during treatment and recovery and should even receive specialized prevention efforts. NYS OASAS, under the leadership of Commissioner Arlene González-Sánchez, assists all New Yorkers struggling with substance use disorder, regardless of sexual orientation, in getting the help and support they need so they can join the ranks of the millions of other Americans, living full, healthy lives in recovery.

The Lesbian, Gay, Bisexual & Transgender Community Center in New York City, an OASAS-certified and funded substance use disorder (SUD) treatment provider, has been a pioneer in treating and supporting LGBTQ community members with SUD. The Center's programs and services provide more than 9,000 LGBT people annually with community-based services to foster healthy growth and development through the delivery of a range of supportive interventions, advocacy, outreach, education and capacity-building. The Center's Chief Programs and Policy Officer, Carrie Davis, MSW, has decades of experience in developing guidelines, policies, regulations and best practices to better address the needs of LGBT individuals. Below are Ms. Davis's responses to some key questions about the LGBT community and substance use disorder.

The Lesbian, Gay, Bisexual & Transgender Community Center

What substances are commonly misused in the LGBT youth community?

Davis: New York City does the annual Youth Risk Behavioral Survey, an annual survey where they engage with thousands of young people – including LGBT young people. 30 percent of gay young people are likely to use marijuana, only 14 percent of heterosexual youth are likely to use marijuana. 17 percent of gay young people are likely to use methamphetamines while only 1.9 percent of straight young people are likely to use methamphetamines. So when you look at marijuana, it is almost twice as much, but when you look at something like methamphetamines we are looking at an almost eight times higher amount. And when we look at heroin use, 13 percent of gay young people are likely to use heroin and only 1.7 percent of heterosexual youth in the city's survey are likely to use. The more we learn about LGBT youth, the more we learn that they are placed in extremely high risk for substance use.

What can we do to address substance misuse with youth?

Davis: When we talk about treating LGBT youth, we think about them as whole people. We think about them first as young people who are going through a very powerful, developmental stage, and we want to make sure we address their needs as young people—not just as people who are using substances. We want to help them become leaders in their own lives. We want them to envision what their future could be. We work with them to stay in school or get back into school. We work with them to get into college and to get good jobs. All these things are part of a modality of working with young people that is developmentally appropriate beyond just talking about substance use. A big part of our development is a strong connection to peers and role models.

In your years of experience, what have you found has worked best when working with the LGBT community?

Davis: Addressing LGBT substance use is most successful when using a holistic, asset-based model. Such a model combines aspects of evidence-driven best practices such as contingency management, trauma informed care, motivational interviewing and cognitive behavioral interventions. We also incorporate community-driven elements including LGBT cultural competency, peer role models and opportunities for peer leadership, LGBT community celebration and history, and a deep knowledge of LGBT identities. The Center perceives LGBT identities as normative and works with participants to develop a healthy and un-conflicted LGBT self-concept. Our approach also emphasizes positive LGBT role models and peer participation where participants adopt the behaviors of those who are similar, utilizing a harm reduction approach that emphasizes a "stages of change" methodology that the Center applies to abstinence recovery as well.

You offer psychiatric services on-site, which is unique. What types of services? Why is this important?

Davis: We offer psychiatric services on-site as part of our OASAS-licensed outpatient substance use treatment programs. Our psychiatrist is able to provide a complete psychiatric evaluation including diagnosis and ongoing medication management sessions to these clients, including Suboxone treatment for opiates. These services are important in the context of a substance use program for a number of reasons. First, because the psychiatric evaluation adds an additional layer of assessment to the treatment process from a psychiatrist/medical provider. Secondly, medications are often a useful tool in managing symptoms of Post-Acute Withdrawal Syndrome (PAWS) as clients cease using substances. Also, underlying mental health diagnoses can be assessed and treated. Those diagnoses may have contributed to the client's use of substances in the first place. The ability to prescribe Suboxone on-site for opiate-addicted clients enables the program to retain these clients and further strengthen the likelihood that they will not return to opiate use. And lastly, like all of our services, having an LGBT competent psychiatric provider adds to the overall experience of our clients in the program.

How do you involve families in the process?

Davis: During the intake process we assess for supportive family members and/or attachment figures, such as supportive mentors, caseworkers or members of their

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The Presidential Election: Time for Behavioral Health Advocates to Speak Out

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

The next President of the United States can act to improve or to harm the American mental health system. Behavioral health advocates should speak out now to provide the political pressure that will be needed to improve rather than to harm the system.

Preserve The Affordable Care Act

Perhaps the biggest threat to the behavioral health system is the political attack on the Affordable Care Act. So far about 20 million previously uncovered people have gotten health—and behavioral health—coverage through the ACA. At long last, millions of people with diagnosable mental or substance use disorders who could benefit from treatment have insurance to pay for it.

All behavioral health advocates should insist that the provisions of the ACA—including parity—that increase insurance coverage for behavioral health services survive the change in leadership in Washington.

As we do this, let's stop referring to the ACA as "Obamacare." We don't call Medicare and Medicaid "Johnsoncare." We don't call Social Security "Roosevelt security." Why "Obamacare"? All that does is infuriate the people who hate Obama. Bad politics, in my view.

Mental Illness
Does Not Cause Homicide

We also need to persistently inform the Presidential candidates that mental illness is not responsible for homicide in America. People with serious mental illness are far more often victims than perpetrators.

Continued reduction of homicide (it has declined 13% since 2000) depends on measures other than forcing people with mental illness into treatment. Gun control, better policing, reduction of poverty and "adverse childhood" experiences, could make a big difference. But more and better mental health and substance use services, much as they are needed, will do virtually nothing to reduce homicide.

Michael B. Friedman, LMSW

It is true that illegal drugs contribute to the homicide rate. But it is their illegality not their use that causes most related homicides.

The real problem of violence related to behavioral health are the 40,000+ suicides every year. 90% of these are completed by people with mental illness. A better mental health system could and should target the terrible problem of suicide.

The Behavioral Health System
Must Grow A Lot

Presidential candidates also need to understand that America's mental health system does not have the capacity to meet the needs of even half the people with behavioral health problems who might benefit from behavioral health care. 60% of people with a diagnosable mental or substance use disorder do not get treatment. That suggests that the capacity of the mental health system should double. But since not everyone with a diagnosable disorder would benefit from treatment, it may be adequate to increase the system by 50%.

That's a very large and very costly increase. Currently behavioral health services in the United States cost over $200 billion per year. Another $100 billion? Not likely to happen. But it is very important to be clear with the Presidential candidates that proposals currently on the table for a few million dollars here and there are not nearly on the necessary scale for major change, notwithstanding the rhetoric of reform that often accompanies them.

Growth, of necessity, will be incremental, as it has been for the past 50 years. We should not let elected officials get away with the rhetoric of major reform when they are making minor improvements. But let's also press for the incremental improvements that are possible.

Quality of Care Must Improve

The presidential candidates also need to be clear that most behavioral health treatment in America is not even "minimally adequate." When it is provided by primary care physicians, as it increasingly is, it is minimally adequate or better less than 15% of the time. When it is provided by behavioral health professionals it is minimally adequate or better less than half the time.

Efforts to build a clinically, culturally, and generationally competent behavioral health workforce including more research, better translation of research into practice, and a far better trained workforce must be at the heart of the push for a mental health system of adequate quality.

Social Dimensions
of Behavioral Health

In part because of the increased reliance on health insurance to pay for behavioral health services, behavioral health policy is generally viewed as just a subset of health policy. This is a serious mistake. An effective system of response to behavioral health problems must address (1) the social welfare needs of people with psychiatric disabilities, (2) the response of the criminal justice system to people with behavioral health disorders, (3) the social determinants of behavioral health disorders, and—perhaps most importantly—the need for adequate housing.

The March of Demography

The vast changes in the demography of the United States are almost totally neglected in discussions of behavioral health reform. These changes in the American population are unfolding now and will continue throughout this century.

The "minority" population is growing so rapidly that in a few decades the United States will be a majority minority. We need a far more "culturally competent" behavioral health system in response.

In addition, the aging population is growing so rapidly that in 15 years or less there will be more adults over 65 than children and adolescents under 18. We need a "generationally competent" behavioral health system in response, including a response to the growth of the number of people with dementia far different from the current effort to prevent or cure Alzheimer's and related disorders by the year 2025. This moon shot approach rests more on hope than realistic expectations, and in the meantime does virtually nothing for the 5.5 million people with dementia now, a number that will probably double while we are waiting for a biomedical breakthrough.

Shift the Drug Abuse Paradigm

Changing attitudes towards marijuana use and the rising concern about deaths due to heroin and prescription painkillers will give the new President the opportunity to make a major shift away from America's current policy of criminalizing "illicit" drugs and to a medical model focused on prevention, treatment, and regulated access.

And More

Obviously a comprehensive agenda for behavioral health reform would be far more extensive than the few items I have noted above. And, of course, some behavioral health advocates may want to emphasize other matters.

Whatever your views, the time to speak out is now. Let's do it.

Michael Friedman is retired but continues to teach at Columbia University and to write about behavioral health and about aging. He is the founder and former director of the Center for Policy, Advocacy, and Education of the Mental Health Association of New York City. He can be reached at mf395@columbia.edu.

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chosen family. Given that LGBT youth are often faced with family rejection, we find that LGBT youth and young adults identify supportive figures within the LGBT community as part of their "chosen family." We want to leverage these important people in the young person's life to serve as a sustainable support to help the client maintain progress throughout treatment once it commences. This is facilitated through involving family member/attachment figures in some treatment sessions with the youth and giving them specific and concrete roles, such as helping with the implementation of contingency management, reinforcing progress and achieving clean drug screens (with incentives and positive feedback). They can also help to enforce consequences (for instance losing access to cell phone or certain privileges) when a youth has a positive drug screen or misses scheduled groups/appointments in treatment. We can also teach attachment figures how to provide and read drug screens to help monitor progress, even when the client is not coming to the treatment program.

NYS OASAS recently awarded you funding to start one of the first Youth Clubhouses in New York State, can you tell us about the program?

Davis: The Bridge-Q Youth Clubhouse program will be running within the next few weeks. It will be for LGBT young adults between ages 18 – 21 in need of recovery support services for substance use disorder as well as those at risk of SUD who are seeking a safe, drug-free environment. The goal is to create a Center member-led environment that utilizes the experiences of our clients and community to empower young LGBT adults both individually and as supports for each other.

In January 2016, Governor Andrew M. Cuomo announced more than $1.6 million in annual funding to create first-of-their-kind adolescent substance use disorder clubhouses in seven regions across New York State. For more on this community-based, innovative model visit www.oasas.ny.gov.

Carrie Davis, MSW, has worked collaboratively with New York City and New York State agencies and courts, as well as private enterprise to develop guidelines, policies, regulations and best practices to better address the needs of LGBT people. She is nationally recognized as an expert and advocate for the health and welfare needs of transgender people. The 2nd edition of Gary Mallon's "Social Work Practice with Lesbian, Gay, Bisexual and Transgender People" included her chapter on "Social work practice with transgender and gender nonconforming people."

Carrie currently serves on the HIV Health & Human Services Planning Council of New York, the New York City Police Department LGBT Advisory Committee and the New York City Department

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Don't miss the June edition of *OMH News* in celebration of Pride Month !

This month's features:

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- **Youth in Transition:** Understanding Gender Identity and Sexual Orientation
- **Providers:** Perspectives on Concerns of LGBTQ Clients
- **Data:** OMH Patient Survey Making LGBTQ Clients 'Visible'
- **Research:** Insights into LGBTQ Mental Health

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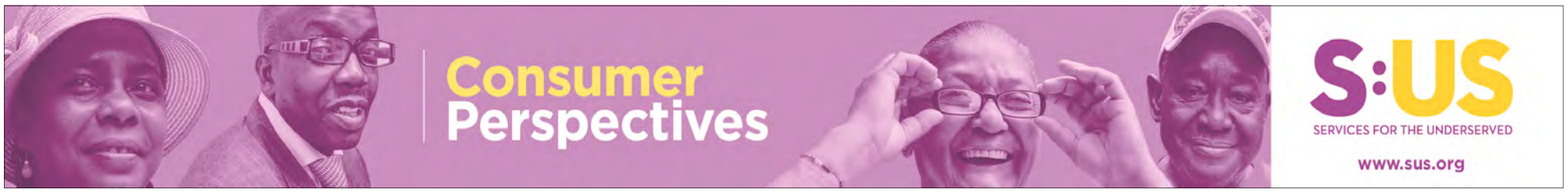

Uniquely LGBTQ

By Andre, Bernadette, Cheryl S, Cheryl G, Gladys, and Sasha

This article is the second in a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The authors of this column facilitated a focus group of their peers to inform this writing. The authors are served by Services for the UnderServed (SUS), a NYC nonprofit that is committed to giving every New Yorker the tools they can use to lead a life of purpose.

We came together to discuss the LGBTQ experience and perspective in the nexus of health, behavioral health and support services. We are gay, lesbian, bisexual, transgender, young, old, middle aged, Muslim, Catholic, African-American, Latino, the granddaughter of slaves, the grandmother of gay grandchildren. We shared our life challenges, our struggles with mental illness, addiction and homelessness and the fact that we all experience discrimination because of our sexual orientation. What we commonly hold true is that we are the whole of those life experiences and not just our sexual orientation. Identification with the LGBTQ community is complex. The diversity umbrella within the community makes definition challenging but what binds us is our coming together to fight for our civil rights, equality, and acceptance.

We came together to talk about our common ground but ended up talking more about our differences or put another way—our uniqueness. Our experiences as part of the LGBTQ community were all different. We grew up in different times, different cultures and different places. We debated whose experience was the hardest, who experienced greater discrimination and marginalization — transgender vs. gay vs. lesbian vs. bisexual. We talked about our recovery, our work, and our lives. We talked about our family and cultural backgrounds and how differently we experienced acceptance of our sexual identity, and how some of our cultures were not accepting of us at all. We talked about how even in New York City, one of the most progressive cities in the world, discrimination against the LGBTQ community still exists.

We also talked about how access to culturally sensitive services is not where it needs to be. How access to health care and housing for transgender individuals is a huge challenge and that even within the LGBTQ service community all are not welcome. Do you know how hard it is to find a primary care doc who is sensitive to the needs of someone who is transgender? Caitlin Jenner and Laverne Cox do not represent us. Their experience and access to health care, economic security, and services have not been our story. We realize we have to be our own spokespersons, speaking up about who we are, what we face, and what we need and deserve.

And finally, we talked about how people in the LGBTQ community are hardest on themselves. We have internalized a lot of the abuse we have all experienced over the years, and sometimes we just take that out on each other without even realizing it.

So here is where we landed on the topic of access to quality culturally-sensitive health, behavioral health, support services and housing. Our simple yet complex advice to practitioners/ organizations and our own members of the LGBTQ community…

- Acceptance of differences and embracing diversity starts with the organization's leadership. It should permeate the organization's culture. Services and the environment in which they are offered need to be welcoming and sensitive to our diversity.

- Cultural sensitivity training is important, but it is more important for practitioners to understand their own biases and judgments and work at setting them aside. If we don't suspend judgment about people we can't support their life goals.

- We are people first with unique experiences and abilities. Accept me for who I am, not who you want me to be. See Me and Hear Me.

- We must fight for access to culturally-sensitive health care. As long as we are alive we are never finished. We have to keep fighting and working to help ourselves and others.

- The LGBTQ community must embrace its own diversity. We must accept each other.

We wish we had the power to wave a magic wand so that we could all see that we share a common humanity. All we need is love.

LGBTQ from page 1

3.7% of transgendered people are currently homeless and 29.6% are formerly homeless – rates three times the level of non-transgendered people. As noted above, barriers to behavioral health care faced by LGBTQ populations are exacerbated in communities of color where general stigma around mental health is compounded by LGBTQ stigma. For instance, one Brooklyn focus group with older African Caribbean immigrants was noted to have agreed that they would rather have a relative die than come out as gay.

Accessible and Culturally Competent Behavioral Health Care is Hard For LGBTQ People to Find

While it is true that LGBTQ people, in general, seek care more often than their non-LGBTQ counterparts [viii], they are more likely to leave care prematurely, due to a lack of support and affirmation. When LGBTQ individuals are not engaged in needed care, they are then at risk for negative outcomes, decompensation, and the need for costly emergency services such as emergency room visits and psychiatric hospitalization. Forty two percent of nearly 3,000 LGBTQ people surveyed for the Needs Assessment indicated that community fear and dislike of LGBTQ people was a problem for them in accessing healthcare; 39.8% reported that there are "not enough professionals who are adequately trained and competent to deliver healthcare to LGBTQ people." [ix] Since homosexuality was considered a mental health disorder until 1973 by the American Psychiatric Association, it is no surprise that LGBTQ individuals do not always feel comfort within the general behavioral health system.

Lack of access to mental health care was cited by 35.3% of LGBTQ respondents to the Needs Assessment and 39.2% identified a lack of support groups. [xi] For those who do seek care, fear of culturally incompetent care leads many LGBTQ individuals to avoid disclosing their sexual orientation. Quoted in the Assessment report, one staff member at an LGBTQ-specific mental health treatment center noted that its clinic was established because services were not available elsewhere, "our people are released into an outpatient care system that is completely unprepared to deal with their needs. They're harassed. They go off their meds, spiral down, and 8-10 weeks they're back into the hospital. To break that cycle is what we do. The question I always get is, why does it have to be two systems? Why can't LGBTQ people with mental illness just go and get treated in these programs?" [x]

Cultural Competence Is Cost Containment

Rainbow Heights Club (a project of the Heights-Hill Mental Health Service South Beach Psychiatric Center Community Advisory Board, Inc.) is the only state funded mental health program for LGBTQ individuals living with serious mental illness in NYS. Rainbow Heights has a fifteen-year track record of preventing hospitalization for 90% of its 650 LGBTQ clients who have serious mental illness every year by providing LGBTQ-affirming peer support. Performance outcomes like these demonstrate that, especially with marginalized and hard to reach populations, low-cost peer delivered services are a good investment, and an excellent means of containing costs for providers able to appropriately address the needs faced by a specific population. But effective care is not a luxury; it's not a form of being nice to a handful of misfit clients. It means moving our agencies forward to meet the needs of all the clients that we serve. When we fail clients-- when we don't provide the support, affirmation, safety, and inclusion that they were hoping to find-- they fall out of care and lose more than can be quantified. In addition, we lose their potential contributions within the community and the revenue

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Clinical Work with Transgender Individuals

By Jennifer Powell-Lunder, PsyD
Senior Clinical Program Liaison
Four Winds Hospital, Westchester

The first step toward clinical work with any client involves understanding the individual, their reasons for seeking treatment, and the goals they hope to accomplish through therapy. It is important to remember that every client is unique regardless of the aspects that may be used to describe them, including physical appearance, ethnic background, and system of beliefs. Generalizations and assumptions can cause chaos in clinical work. An awareness of the concerns or issues related to how individuals describe themselves is always helpful.

To work with a transgender client it is imperative to possess a basic understanding of what the term means. Someone identifies as transgender when their assigned or biological gender does not describe their gender identity. Gender identity is the subjective internal sense or experience of one's own gender. Terms such as "Trans man" and "Trans woman" are terms that may be used by individuals who identify and live as an affirmed gender that is different from their birth assigned sex. Gender Queer, Agender, Bigender or Non-binary are terms that may be used by those whose gender identify is more fluid and/or who blur the binary assignment as male or female. It is always best to ask which term an individual prefers to use.

Our understanding of clinical work with transgender individuals has been recently redefined. One major change included in the Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM-5) published in 2013, was the revision of the diagnosis Gender Identity Disorder to Gender Dysphoria. This revision has important implications. The dropping of the word 'Disorder' highlights that the clinician is treating the client's issues with experiences associated with identifying as transgender, not labeling the identification as a disorder or condition that should be treated or changed.

For a person to be diagnosed with Gender Dysphoria, there must be a marked difference between the individual's expressed or experienced gender and the gender others would assign to him or her, and it must continue for at least six months. The DSM-5 diagnosis adds a post-transition specifier for people living full-time as the desired gender, with or without legal sanction of the gender change. This was done to ensure treatment access

Jennifer Powell-Lunder, PsyD

for individuals who continue to undergo hormone therapy, related surgery, or psychotherapy to support their gender transition. (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition, 2013). It is important to highlight however, that we should avoid assumptions when working with any client. A transgender individual may come to treatment with a concern unrelated to gender identity. Overemphasis on gender identity could then be detrimental to treatment.

The acceptance and validation that a clinician offers to a client in treatment can be invaluable. This is especially true for transgender clients, many of whom come to treatment because they lack self-acceptance and/or support from family, friends and their surrounding communities. One way to encourage validation is to respectfully address certain preliminary concerns. Clients should be called by the name they have assigned to themselves, not their legal name if a name change has not yet occurred. It is important to be mindful of the pronouns used when referring to a transgender client. If you don't know what pronouns to use, ask politely and follow the client's preference. Never use "he/she" or "it." You may want to consider incorporating a brief question about gender and language preferences into the intake process for all clients, not just those who you may think or look transgender.

When working with children and adolescents we are faced with discerning whether such identification should be considered temporary, part of the developmental journey to determine an identity, or a stable facet of an individual's identity. The APA reasons that these considerations can be clarified by focusing on whether the child or adolescent presents with a "pervasive, consistent, persistent, and consistent sense of being the other gender." (C. Meier, and MA. J. Harris, American Psychological Association Fact Sheet: Gender Diversity and Transgender Identity in Children, undated). Although research in this area is limited, the few studies available report that a vast majority of pre-pubescent children who experience gender dysphoria (between about 78-96%) no longer report gender dysphoria in adulthood. This is especially true for boys. A majority of gender dysphoric pre-pubescent boys however, identify as gay in adulthood. More recent studies have indicated that 73-88% of girls no longer report gender dysphoria in adulthood. These statistics are in great contrast with research regarding gender dysphoric adolescents. Adolescents identifying as gender dysphoric are more likely to persistently report dysphoria into adulthood. This suggests that in contrast to pre-puberty gender dysphoria, post-puberty adolescents are more likely to identify as transgender.

An aspect of treatment unique to work with children and adolescents is to clarify that at this stage in life gender identity is not necessarily permanent. Parents should be encouraged to validate their children by supporting their gender identifications. At the same time it is important to ensure children and teens who may be confused or questioning their identity know that exploration is acceptable and supported For older adolescents and for children and adolescents who have a firm and pervasive identification as transgender, clinicians will need to coordinate with healthcare providers involved in repressing puberty, and/or other medical treatments related to reassignment. In some cases clinicians may need to provide families with appropriate referrals.

Clinicians working with gender dysphoric children and teens should be aware that it is quite common for such young people to present with comorbid anxiety, depression, and/or oppositional defiant disorder. A disproportionate number of teens reporting gender dysphoria also meet the criteria for autism spectrum disorder. Transgender youth may experience gender based verbal and physical harassment and abuse and bullying. Adolescents identifying as transgender are at higher risk than their peers for attempting suicide. Some studies have found that risk to be at least two times greater. When surveyed, up to 25% of transgender teens have reported making at least one suicide attempt. For youth who are highly rejected by their family, peers and community, the risk is eight times greater. Such highly rejected youth are three times more likely than other adolescents to use illegal drugs, three times more likely to at high risk for HIV and sexually transmitted disease, and nearly six times as likely to report high levels of depression.

Thus, engendering family support is a pivotal part of treatment for adolescents. By offering education and understanding to clients and their families, clinicians can encourage empowerment and dispel common concerns and myths. A major part of treatment often entails helping transgender teens to develop skills to manage their family, school, and of course social environments. It is imperative to connect the client with resources that provide safe forums for self-expression. Clinicians offer transgender (and all) clients the most efficacious and supportive treatment when they become informed and educated regarding their clients' related concerns and challenges.

Four Winds Hospital has transgender affirming policies to ensure respectful and knowledgeable mental health treatment for transgender patients. William Riccadelli, MD, staff psychiatrist and member of the World Professional Association of Transgender Healthcare Providers (WPATH) is available to consult with hospital treatment teams, patients, parents and families about transgender health. WPATH, www.wpath.org, publishes Standards of Care and Ethical Guidelines, which articulate a professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders, and help professionals understand the parameters within which they may offer assistance to those with these conditions. Other resources for families and youth include: Trans Youth Family Allies, www.imatyfa.org; Advocates for Youth, www.advocatesforyouth.org; Parents and Friends of LGBT People, www.pflag.org (Westchester County phone numbers: 914-245-8236, Phone 2: 914-948-8435),Westchester Spanish-speaking 914-967-9429, and Rockland County: 845-268-2373); WJCS Center Lane LGBTQ youth program, www.centerlange.ny.org.

Dr. Jennifer Powell-Lunder is a Senior Clinical Program Liaison at Four Winds Hospital. Her past roles at Four Winds have included Director of an inpatient adolescent unit and Director of the Adolescent and Child Partial Programs. She is an adjunct professor of psychology at Pace University.

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and performance outcomes that they might have provided if they had remained in care. Everybody loses when clients don't receive the support and acceptance they need and deserve.

Creating a Welcoming Clinic

Identifying LGBTQ Clients: The Institute of Medicine (IOM, 2011), the Healthy People 2020 strategy[xi] and the Joint Commission on Accreditation of healthcare organizations (JCAHO) (2011) all advise that sexual orientation and gender identity (SOGI) questions be asked in clinical settings, and documented in electronic health records, to combat the dangers of *LGBTQ invisibility*. Such data can be a vital tool to detect differences and disparities in diagnoses and treatment outcomes, access to services, utilization rates, etc. Governor Cuomo has launched a statewide initiative[xii] regarding LGBTQ data collection that includes OMH and many other government bureaus. The NYS Office of Mental Health, Bureau of Cultural Competency provides an on-line training on "Collecting Sexual Orientation & Gender Identity Information on OMH Patient Admissions" and "Asking Patients about Sexual and Gender Identity,"[xiii] and The Fenway Institute offers recommended language for survey questions or interviews about sexual orientation and gender identity. At a minimum, recommended intake questions, include: "Do you think of yourself as: Lesbian, Gay or homosexual, straight or heterosexual, bisexual, something else, or don't know" and "What was your gender assignment at birth? Male, female, transgender or other. [xiv] If a client asks, "But why are you asking ME this?" you can respond by saying, "The Office of Mental Health wants us to ask all clients

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The NYSPA Report: DSRIP Made Easy

By Scott Wetzler, PhD and Bruce J. Schwartz, MD

New York State's Delivery System Reform Incentive Payment (DSRIP) program is a five-year plan to disburse a total of $8 billion in federal funding in order to comprehensively transform the way that Medicaid services are provided and paid for, with the aim of reducing avoidable hospitalizations by 25%, and converting reimbursements from volume-based to value-based payments. In order to reach these goals, the State approved 25 Performing Provider Systems (PPS), covering defined geographic regions, with each PPS including hundreds of clinics and community based providers organized into a single contracting entity.

While the scope of DSRIP is enormous and covers all domains of healthcare, behavioral health represents a core component of system transformation because so many mental health patients have potentially avoidable psychiatric as well as medical hospitalizations. Consequently, many DSRIP projects specifically target behavioral health issues, including coordination of care between behavioral and non-behavioral providers; registries for high-need patients; integrated care, which includes three different models (behavioral care integrated into primary care, primary care integrated into behavioral care, IMPACT); behavioral crisis stabilization; and the promotion of mental health of communities. While most current DSRIP funding is tied to implementation of these projects, as DSRIP evolves, more and more funding will be tied to achievement of dozens of specific outcomes, including at least 18 different outcomes metrics which target patients with mental health or substance use disorders: 7 and 30-day follow up after mental health hospitalization; initiation of substance abuse treatment; adherence to antipsychotic medication; maintenance of antidepressant medication; diabetes screening for patients on antipsychotic medication; etc. The State has identified national benchmarks for these HEDIS measures, and PPS's are beginning to receive payments if they make progress on the gap between their present performance and the national benchmark.

Even though DSRIP is completing its second year, significant funds are only now beginning to flow – a delay which was in part due to the complex relationships between federal and state regulators and the health plan intermediaries. Due to the delay in funds flow, project implementation has also been delayed. Regardless, since DSRIP is viewed as a bridge to value-based payments, the $8 billion in funding represents only a fraction of revenue which PPS's will generate once they form Independent Provider Associations (IPAs) or Accountable Care Organizations (ACOs) and develop value-based or performance-based contracts with health plans.

Scott Wetzler, PhD

Bruce J. Schwartz, MD

Since DSRIP's success depends on population health interventions, and since each PPS has hundreds of thousands of attributed Medicaid recipients, data management represents the lynchpin for achieving the program's laudable goals. Due to confidentiality concerns and lag times for accurate claims data, the State is only now beginning to provide data to each PPS. This means that PPS's have been flying blind until now. They have not known much about their attributed membership – who their high-utilizing patients are, how to find them – and therefore are hamstrung in trying to develop effective interventions. For example, a PPS might know that two years ago they had 50 schizophrenic patients with cardiovascular disease who required an annual cholesterol screen (one of the relevant metrics that is linked to funds), but they do not know how many such patients are currently attributed to them, and they are restricted in communicating with the providers who care for these patients. The development of patient registries will be the key to DSRIP's success, but useful registries depend on up-to-date claims data, and it may not be until the last years of DSRIP that they are truly operational.

What does DSRIP mean for providers working in Medicaid settings? Since most mental health and substance abuse services are reimbursed by Medicaid, psychiatrists, psychologists and social workers at clinics will be significantly impacted by these reforms. Although behavioral patients represent a large fraction of the DSRIP targeted population, mental health clinics are unlikely to receive a significant portion of DSRIP funds. This is due to the fact that patients are mostly "attributed" to primary care providers. One of the early criticisms of DSRIP is that the funding is flowing through large hospital systems, and will not end up with community based providers, including mental health or substance abuse clinics. The biggest impact on behavioral will be through investment in integrated care models, which will, and already have, increased the demand for providers with behavioral expertise.

What does DSRIP mean for behavioral health patients? We hope and expect that quality of care will improve, with better access and better care coordination. Since behavioral patients are the focus of so many DSRIP projects, insofar as DSRIP achieves its goals, there will be fewer unnecessary hospitalizations and improved follow-up, especially with medical care. All in all, considering the many behaviorally-related DSRIP projects, if DSRIP truly does achieve its goals, the Medicaid delivery system, and the mental health delivery system specifically, will be truly transformed.

Scott Wetzler, PhD is Vice Chairman and Bruce J. Schwartz, MD is Deputy Chairman in the Department of Psychiatry at Montefiore Medical Center and Albert Einstein College of Medicine.

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What This Parent of a Transgender Child Wants You to Know

By Terri Cook, BA, MS
Author, Speaker, and Advocate

I am the proud mother of two young men, but I didn't always know I had two sons. For 15 years, I believed I was raising a daughter. My younger child, who I now know is my son, is transgender. My husband and I supported his transition, at 15, from female to male.

I've been criticized and asked countless questions, such as, "How could a child possibly know who they are or what they want at that age?" and "What kind of parent would allow their child to make irreversible changes to their body with hormones and surgery?" and "What if it's a phase? Why not wait until your child is 18 or 21 or older to make these changes and decisions?"

I get that. I had those questions, too. And many, many more.

If you asked me several years ago what it means to be transgender, I couldn't have given a good answer. I had no concept of the struggles and pain he and our family would face. I've learned a lot over the years, and what I've learned has completely changed me.

My husband and I described our journey in a book, *Allies & Angels: A Memoir of Our Family's Transition.* Healthcare providers and educators can obtain a free copy of the eBook at www.alliesandangels.com/free-books.

I'd like to share a little of what I've

Terri Cook, BA, MS

learned and what I wish our healthcare providers knew. But first, let me tell you about my son.

When he was growing up (and when we still thought he was our daughter) he was happy, healthy, and full of life. He was never a fan of dresses or dolls or stereotypical "girl things," but that didn't matter to us, and so it never presented a problem for him.

In 4th grade, the parents of some of his friends asked what we were doing as parents to raise a daughter with such high self-esteem that she wasn't caught up in "girl drama" and didn't care about wearing makeup, buying clothes, or fitting in with the popular girls. We often wondered the same thing but figured he was a "tomboy" and never dreamed he wasn't caught up in "girl drama" because he wasn't actually a girl!

Our son was a straight-A student, a social butterfly, and involved in Scouts, sports, student council, and countless clubs and activities. We were proud and grateful to have a happy, loving, and successful child.

But in adolescence, everything changed. My once-happy child began to slip away.

He was 11 or 12, at the onset of puberty, when depression, anxiety, and social isolation began. Each day became more of a struggle.

He was so uncomfortable with his changing body and tried to hide his new curves under baggy T-shirts and hoodies. By middle school, he no longer fit in. He didn't look, dress, or carry himself like his peers expected of a girl, and he was relentlessly teased and bullied. Kids knocked him down in the hallways, laughed at him, called him "a freak" and "a loser" and told him he'd be better off dead.

I'll never forget the night I found him covered in blood. My beautiful child attempted suicide when he was 13 years old. His struggle to understand, accept, and simply be who he is, nearly cost him his life.

Forty-one percent of transgender people attempt suicide (as compared to 1.6% of the general population). That number rises to 51% if the person is subjected to bullying or harassment, and to 61% if the person is a victim of physical assault.*

For my son and many other transgender youth, it's not just about being bullied at school; it's about not being able to conceive of a future where they can be accepted, safe, equal members of society.

Our son continued to withdraw, yet we still didn't understand he was transgender. It would be two long years before any of us understood that. Two long years of therapy, countless prescription drugs to manage his depression and anxiety, and homebound instruction because going to school became too much. Two long years of not being able to articulate why he was so depressed. His best explanation was that no matter how hard he tried, he just didn't fit in; he didn't think like the girls or like the same things they liked. But we never thought that was because he actually wasn't a girl. We didn't know that was possible.

Unfortunately, neither did the doctors, therapists, and health professionals we consulted. Many didn't know about gender identity and transgender youth, or they

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Substance Use and Treatment Services for the LGBTQ Community

By Jill Mastrandrea, LMHC, CASAC, NCC, CRPA, Program Director Outreach

Research reveals that individuals who identify as being part of the LGBTQ community represent a higher percentage of substance users as compared to those who do not identify. In fact, there are estimates to maintain that about 20 to 30 percent of the LGBTQ population is using substances as compared to about nine percent of the universal population (Hunt, J., March 9, 2012. American Progress, Why the Gay and Transgender Population Experiences Higher Rates of Substance Use). These percentages and statistics are also thought to be underreported due to factors such as fear of self-identification and lack of research (National Association of Lesbian and Gay Addiction Professionals, nalgap.org, July 2002). Despite these statistics, there are few facilities for LGBTQ substance users to engage in.

When considering substance use treatment services for the LGBTQ community it is imperative to understand the data that represents it at a much deeper level. In 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) stated in the *Top Health Issues for LGBT Populations Information Resource Kit* that those who identify as lesbians are 1.5 to 2 times more likely to smoke and that they are "significantly more likely to drink heavily than heterosexual women." This publication also shed light on higher rates of suicide and major depression. In the same publication, it was noted that Gay Men "use substances, including alcohol and illicit drugs, at higher rates than the general population." Bisexuals "exhibit significantly higher rates of binge drinking than their heterosexual counterparts" and transgender people are shown to have a higher rate of methamphetamine and injection drug use. It is also important to note that as a part of substance use treatment services for the LGBTQ community, the inclusion of mental health services is imperative. In a Hazelden Research Update, Klein, Audrey & Ross (2013) posit that 92% of the LGBTQ adult residential patient populations have a co-occurring disorder as compared to 78% of the heteronormative population.

With all of this quantitative information available it gives the impression that developing and implementing LGBTQ affirmative services into substance abuse treatment is warranted. To come to fruition, much planning is required. The initial stages of planning include the evaluation of resources. Resources to assess include those that are internal and external. Internally, consider the support that you have from management, administration and staff. Also contemplate the space that you have available as well as financial backing available for any training, staffing or LGBTQ inclusive materials. Externally, assess community resources, funding opportunities and existing services.

Training is a critical component when implementing LGBTQ substance abuse treatment services. In "A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals." SAMHSA states that "understanding the appropriate terminology is essential to understanding LGBT clients." These terms include, but are not limited to, sexual orientation, gender identity, coming out, homophobia and heterosexism. In addition to understanding terminology from a clinical perspective, administrative issues must also be addressed. Documentation and paperwork should be updated to reflect space for those who identify outside of the binary heteronormative population (Human Rights Campaign, Guidelines for Care of LGBT Patients, 2006). The Human Rights Campaign suggests providing several options for answering questions related to sexual or relationship partners, gender or sexual orientation, or, leaving the space blank for a participant to fill in themselves.

In regards to providing clinical services, it is recommended to incorporate differing therapeutic interventions and theories. Affirmative Therapy can be defined as "an approach to therapy that embraces a positive view of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) identities and relationships and addresses the negative influences that homophobia, transphobia, and heterosexism have on the lives of LGBTQ clients" (Rock, Carlson & McGeorge, 2010). Gay Affirmative Practice (GAP) models provide guidelines for behaviors and belief in social work practice with gay and lesbian individuals (Crisp, 2006). Utilization of either or both of these therapies is paramount when working closely with the LGBTQ population and community. Clinical services themselves may also merit alterations to be more inclusive. An example of a way to explore sexuality, gender and sexual relationship from an inclusive lens and perspective would be to use the "Genderbread Person" or The Sexualitree" from the website: www.itspronouncedmetrosexual.com.

Also of importance is the creation of a Safe Space. A safe space is both visual and sensed. Visually, a safe space will include literature, brochures and other materials that pertain to and are reflective of the LGBTQ community. It is also understood via clinical interactions and application of the aforementioned therapies. A Safe Space will also include gender-inclusive bathrooms. According to The Gay Alliance, a safe space is a "place where all people feel safe, welcome and included…aims to increase the awareness, knowledge, and skills for individuals and address the challenges that exist when one

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The Right Support

By Carmen Collado, LCSW-R, Chief Networking and Relationship Officer; David Kamnitzer, LCSW-R, Senior Vice President, Residential, Rehabilitation, and Support Services; and Jose Cotto, LMSW, Vice President, Residential, Rehabilitation, and Support Services, ICL

Creating an atmosphere of inclusion and acceptance for all people coming to an organization for help begins with the core values of that agency. Here, at ICL, we believe in and offer person-centered, recovery-oriented, trauma-informed, and integrated physical and behavioral healthcare. No matter a person's history or circumstances, their story and their goals are important and listened to. When someone first comes to an ICL program, she or he is interviewed by a clinician during the intake process. The setting and the person conducting the interview are crucial components in this process. Is the physical environment fluid and diverse, or are reinforcements of heterosexism and gender-conforming norms the only things on display? Is the person asking me if I have a girlfriend or am I being asked about a partner? These are simple things we often take for granted but are factors that can create a safe space, if done right.

When "Danny" arrived to our downtown residence, he stated it felt like home. Not an easy task considering the place is eight stories high and accommodates well over 100 people. During his initial interview, he was made to feel comfortable. He was soon talking about the years of trauma he had suffered and he felt safe enough to disclose his sexual orientation as a gay man. Based on his story, the director assigned him to a Recovery Guide (formerly known as a case manager) she felt he could connect with the most. The Recovery Guide was around Danny's age and was familiar with strength-based language. This helped Danny to feel that he was being put first, that his concerns and feelings would not be minimized. Positive, person-first language enabled Danny to not feel further stigmatized by his mental health diagnosis or his sexual orientation, even though both tended to set him apart from the "norm" of society.

His Recovery Guide continued to build a relationship with Danny. When exploring potential new treatment/social service providers, Danny requested an LGBTQ affirmative program. Fortunately, there was a nearby clubhouse, which offered support and advocacy for LGBTQ persons. Danny began to attend, which further improved his self-esteem and comfort level. The importance of being around others who understand your background and the experiences that help form you has been proven time and again to be of utmost importance in the recovery and acceptance process.

Eventually, Danny opened up even more and informed his residential Recovery Guide that he had a secret, which she encouraged him to share with her. Danny disclosed that he had been taking women's clothing to the LGBTQ club and changing into them when he arrived. "Pam," his Recovery Guide, responded in a neutral, nonjudgmental way, encouraging him to open up even more and explore what he was feeling. Taking an interdisciplinary approach, she asked Danny to share his secret with the rest of his residential team (program director, nurse, counselors, cook, etc.) so that everyone involved in Danny's recovery would be on the same page and understand his thought processes. She also did her best to normalize what he was disclosing and so Danny was able to share more details and goals. Ultimately, Danny revealed that his true desire was that he wanted to transition

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Building an Integrated Health Center in East New York

By Staff Writer
Behavioral Health News

The Primary Care Development Corporation (PCDC), Corporation for Supportive Housing (CSH), Corporation (USBCDC), and Deutsche Bank's Community Development Finance Group have partnered to provide financing to the Institute for Community Living (ICL), towards the construction and substantial renovation of a $29.8 million, 44,600 square foot, comprehensive service delivery Hub in Brooklyn, New York.

ICL, an experienced behavioral health services agency, is collaborating with Community Healthcare Network, a federally qualified health center, to deliver integrated primary care and behavioral health services under one roof to meet the comprehensive needs of people dealing with serious challenges and the community and neighborhoods they live in. When completed, the Hub will consolidate several health and community-based services including family support, outpatient programs, day treatment, and care coordination to address behavioral and physical health concerns.

"The Institute for Community Living is very proud to be bringing this new center to the communities of East New York," said David Woodlock, Chief Executive Officer of ICL. "Our mission focuses on using integrated comprehensive care to promote physical and emotional wellbeing and help people struggling with life's obstacles. Thanks to the support of the Primary Care Development Corporation, U.S. Bank Community Development Corporation, the Corporation for Supportive Housing, and Deutsche Bank, our new facility will provide that care to individuals, families, and the community at large across all ages."

The financing for the project was made possible through $26.5 million in New Markets Tax Credits allocations from PCDC ($12.5 million), USBCDC ($3 million), and CSH ($11 million), and an $18.4 million loan from Deutsche Bank's Community Development Finance Group. U.S. Bancorp Community Development Corporation is also providing $8.9 million in NMTC equity. Shah Capital Advisors, Inc. was the New Markets Tax Credit financing consultant for ICL. In 2015, Brooklyn Borough President Eric L. Adams and Councilmember Rafael Espinal originally supported ICL's East New York Hub project with $750,000 in Capital Funding.

"This important project will allow ICL to serve more patients and clients and provide them with care that will be more efficient and effective. We are proud to invest in these organizations' mission to provide excellent health care to area residents," said Tom Oldenburg, vice president of USBCDC.

"The Primary Care Development Corporation recognizes that integrated care is critical to supporting 'whole patient health,'" said Anne Dyjak, Managing Director at PCDC. "That has increasingly become a guiding influence for us, and we are proud to support care providers, like the Institute for Community Living, who deliver a continuum of integrated services to address the broad needs of underserved communities."

"This investment in community-based care will build vital health assets and has the potential to drive long-term health outcomes for the people and families in East New York," said Gary Hattem, Head of the Community Development Finance Group at Deutsche Bank. "We are proud to support ICL in developing this comprehensive service-delivery hub."

The project will create at least 149 full-time, permanent jobs, two part-time jobs and at least 50 construction jobs. When completed in 2018, the new facility will serve over 9,700 patients -- more than 250% that of the existing site.

ICL is a not-for-profit human services agency leading the field in trauma-informed, recovery-oriented, integrated, and person-centered care via supportive and transitional housing, counseling with individualized therapies, rehabilitation, and other support services for adults, veterans, children, and families. We serve nearly 10,000 people each year throughout the five boroughs of NYC and have 2,300 individuals sleeping under an ICL roof every night. Our goal is to help people re-engage in a fuller life. For more information, visit www.iclinc.org.

People Get Better With Us



ICL operates three behavioral health clinics in Brooklyn — **Guidance Center of Brooklyn, Highland Park Center,** and **Rockaway Parkway Center**. Each clinic offers:

- Therapy
- Psychiatric evaluations
- Pharmacotherapy and medication education
- Connections to community-based resources
- Integrated supports for people struggling with mental health and substance abuse needs

Open Access with same- or next-day appointments and walk-in hours available at all three clinics

The **Guidance Center of Brooklyn** works specifically with individuals who have experienced their first psychotic break between the ages of 14 and 30. GCB also operates On-Site School Programs that provide mental health treatment by trained clinicians for children in designated public schools. Clinicians work closely with children, parents, and teachers to address behavioral and emotional issues that impact a student's ability to perform well in school and social situations.

Highland Park Center and **Rockaway Parkway Center** both offer integrated physical and behavioral health care on-site. HPC and RPC both strive to help consumers gain control of their lives and live to their fullest potential. Both clinics serve everyone from school-age children to seniors with individual, family, and group counseling.

All of ICL's clinics are staffed by experienced, culturally humble licensed professionals and offer a variety of individualized and recovery-oriented services.

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HOURS
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Sat.: 9am–5pm

www.ICLinc.org

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these questions, so that we can understand and meet the needs of everybody that we serve. If there's anything about you or your situation or background that you think I should be aware of, please let me know. I don't want to sit here making assumptions about you."[xvi]

Cultural Competence Training: Providers must train staff—all staff, including reception area and intake staff—to promote a welcoming environment for LGBTQ populations. Cultural Competence training should include common definitions, candid discussion of common barriers, and exploration regarding strategies that promote comfort and safety for LGBTQ populations. Six years ago, a statewide survey of NYS organizations offering an array of behavioral health, human services, and primary care found that 86% of organizations reported serving LGBTQ populations, while only 3% mandated LGBTQ-specific training and 61% reported that no training is offered regarding LGBTQ-related concerns, 82% did not offer training to educate employees or managers on how better to include LGBTQ employees, and 53% reported that their organization did not need to have training on sensitizing the workplace for LGBTQ employees in the future[xv] Now, however, cultural competency training that focuses on LGBTQ populations is readily available. OMH trainings available on line via the Bureau of Cultural Competence[xvi] include:

• Building a Culturally Competent LGBTQ Program

• Asking Questions that Welcome LGBTQ Consumers into Care

• Introduction to Therapeutic Work with Transgender Clients

• Lesbian, Gay, Bisexual, Transgender (LGBTQ) People Living with Serious Mental Illness

• Promoting Healthy LGBTQ POC Communities

• From Toddlers to Teens: Clinical and Therapeutic Work with Transgender Children and Adolescents

• Working with LGBTQ Children, Adolescents and Families

• An Overview of Best Practices in Transgender Affirmative Mental Health Care

Other resources are also available. For instance, The Joint Commission developed a 100 page LGBTQ field guide[xvii] which includes checklists and suggestions that providers can use to assess their LGBTQ cultural competency. To further support and guide provider efforts, *the* NYS *Delivery System Reform Incentive Payment (DSRIP)* initiatives being implemented by 25 Performing Provider Systems throughout NYS were each required to submit a Cultural Competency and Health Literacy Strategy Plan that describes a workforce training and community engagement plan that will ensure that cultural and linguistic needs will be addressed throughout the communities they serve. These plans are intended to address cultural competence and health literacy needs that have been assessed for each region, and LGBTQ populations were identified for special attention due to the compounded impact of stigma and access barriers related to additional cultural factors. Training materials and resources related to the healthcare needs of LGBTQ and other niche populations of focus should soon be available for providers, as DSRIP's regional training plans are implemented. If not, you can ask for it!

Although future cultural competency standards and a "proven curriculum by a qualified provider" have been recommended, no present standard has been developed to address LGBTQ needs specifically. However, ongoing efforts to improve care are underway, including the work of The New York State Office of Mental Health Statewide Multicultural Advisory Committee, which has paid close attention to the issue of LGBTQ affirming services and oversaw the pioneering SO/GI data collection that resulted in the ground breaking data from the 2013 and 2015 Patient Characteristics Surveys. The NYS Office of Mental Health can also be credited for dedicating its most recent Newsletter to "*Meeting the Mental Health of LGBTQ New Yorkers*"[xviii] In addition, in New York City, The LGBT Citywide Committee on Mental Health, Substance Abuse, and Developmental Disability Services provides a monthly open forum for stakeholders to discuss challenges and opportunities in the provision of affirming care.

Strategies for Effective LGBTQ Care: Staff of the Rainbow Heights Club do some very simple things that help clients feel safe and ordinary. This approach contributes to the kind of strong performance outcomes that they see year after year. Consider implementing the following, and instituting them as agency wide policies and practices:

• Clearly state that your agency's policy is to serve all clients regardless of their sexual orientation or gender identity or expression. Make sure staff and clients are aware of this. Posting this policy in a visible location supports staff in addressing discriminatory behaviors: They can point at the policy and say "That's why we don't talk to one another that way here."

• Ask clients what they would like to be called – and then call them that. A name and pronoun go-round happens at the beginning of every group and community meeting at Rainbow Heights Club. This helps members and staff to remind each other of what they'd like to be called, and it's especially helpful if the person has a gender identity that for many reasons they may not be choosing to show in a way that other people can see. Many people, especially people living with mental illness, are not safe in their neighborhoods if they express their gender identities. But they still get a lot of benefit and support from being called what they like to be called – just as everybody else does.

• When asking about someone's relationship status, don't say, if someone appears to be female, "Are you married or do you have a boyfriend?" That question might sound innocuous, but it's loaded with assumptions that might make it harder for a client to let us know what's really going on. Instead, ask "Are you in a relationship right now? Would you like to be in a relationship? With what kind of person?"

• In response to any disclosure about sexual orientation or gender identity, it's very helpful and reassuring to say, "I'm glad you told me that." If someone mentions a same-sex partner, follow up with the same kind of questions you'd ask any other client about their partner or spouse: "Where did you meet her? What's she like?" Again, these seemingly simple questions are loaded with important messages: they show that you think the relationship is real and is an appropriate topic for your work together, and you want to know more about it.

Delivery System Reform Presents Challenges and Opportunities

The transition to managed care and ultimately to value based payment incents achievement of quality indicators and is also driving improvements in data collection and sharing, quality improvement, and care management that will support targeted interventions customized for niche populations. As providers identify client sexual orientation and cultural and linguistic needs within their service area and begin to more effectively engage those who are LGBTQ, the flexibility for new recovery oriented interventions will create new access points for LGBTQ populations able to refer their peers, as well as new opportunities for peer support specialists who are LGBTQ to bring their own lived experience to reach and retain new clients who are LGBTQ.

At the same time, planning grants for Certified Community Behavioral Health Centers (CCBHCs) are presently underway in 24 states, including New York, New Jersey and Connecticut. Behavioral health providers selected to become CCBHCs are preparing to pilot a federal Medicaid service model financed by a prospective payment system that is based on the cost of care delivery. This financing structure will support care coordination and a full array of behavioral health treatment services for adults and children, including mental health and substance use disorder treatment, peer support services, and recovery oriented assistance to address social determinants such as housing, education, and vocational goals. The model is intended to be highly responsive to population health needs within a targeted service area. Care coordination is the linchpin, and CCBHCs emphasize data collection and customized evidence based interventions, available from the CCBHC and its partnerships with Designated Collaborating Organizations (DCO), to appropriately address the needs of specific populations based on the socio-economic, geographic, cultural, linguistic, and environmental factors that uniquely impact the community. This "future state" vision of a comprehensive behavioral health continuum able to target customized services based on individual needs is poised for implementation in 2017, if New York is one of eight states

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Promoting Cultural Competence To Address Health Disparities and Improve Health Outcomes

By U. Michael Currie
Director of Health Equity Services
UnitedHealth Group
Parent Company of Optum

Health disparities are preventable differences in health outcomes that are experienced by disadvantaged populations. They are a leading factor in the incidence, prevalence, mortality, and burden of health conditions across specific populations in the US. These factors can influence the available health services and outcomes of care, and should be monitored across age, gender, race and ethnicity, language and disability, and the communities where people live. Optum has demonstrated a commitment to monitoring and addressing these components of health and well-being across provider networks and services.

An essential goal for Optum is to reduce health disparities and improve the quality of health outcomes and overall well-being of consumers and their communities. This can be achieved in part through cultural competency, including a commitment to embracing diversity, monitoring health services for disparities, and creating culturally sensitive programs, initiatives, and health resources that foster health and recovery.

The Substance Abuse and Mental Health Services Administration (SAMHSA) cites the importance of cultural competence as: "the ability to interact effectively with people of different cultures, [which] helps to ensure the needs of all community members are addressed. Cultural Competence means to be respectful and responsive to the health beliefs and practices—and cultural and linguistic needs—of diverse population groups. Developing cultural competence is also an evolving, dynamic process that takes time and occurs along a continuum ("SAMHSA's Strategic Prevention Framework: Cultural Competence," www.samhsa.gov)." Additionally SAMHSA cites cultural competent organizations as continually assessing their organizational diversity; investing in the development of inclusion and cultural competency; utilizing strategic planning that incorporates community culture and diversity; implementing prevention strategies that use culture and diversity as a resource; and, continually evaluating the incorporation of cultural competence. Culturally proficient organizations partner with others to promote and advocate for services that meet the needs of all populations.

Optum is committed to the principles of health equity and cultural competency, and involves staff at all levels to monitor, educate, and address diversity issues across clinical and network operations, customer services, and quality management. In behavioral health, the challenges of health disparities are uniquely important and can lead to increased stigma and isolation associated with these conditions. Additionally, these issues can also complicate the integration of care for physical and behavioral health conditions.

In the development of clinical networks of care, Optum recommends assuring cultural competence across all service levels. The pathways to address diversity, health equity, and cultural competence vary depending on the state of development or transformation of existing networks of care. In all cases cultural competence should be guided by a set of principles that include the ability of service systems to provide care to covered members who may have diverse values, beliefs, and behaviors. Services must be tailored to meet an individual's social, cultural, and linguistic needs. These goals are achieved through an ongoing process that includes:

Analytics – the ongoing review of the covered population for demographics and likely disparities that may influence health outcomes including: age; gender; address; race and ethnicity; language; and other factors.

Stakeholder Awareness– Providing all clinical and non-clinical staff education and training on cultural competency. This fosters a recognition and awareness of the unique needs of covered members from various diversities including culture, race, ethnicity, sexual identity and gender preference, and other factors. This supports the delivery of more personalized and responsive services.

Member Outreach and Engagement – It is important to develop and provide health information and plan resources that recognize the unique cultural and diversity needs of the covered population. These should help support member engagement in health care services, and reduce gaps that may be based on cultural diversity issues that can impact health outcomes.

Provider Education and Technical Assistance – In the development of provider networks and systems of care, it is important to recognize issues of both the diversity of providers and the populations they serve. Providing ongoing educational and training resources for providers helps them to better understand issues of health disparities and to deliver culturally competent care. This also assures that all providers have access to understanding the unique attributes of the populations they serve.

Some examples of how Optum applies these recommendations for culturally diverse and competent care can be seen in

see Promoting on page 30

Transgender and HIV: Stigma and Discrimination Can No Longer Have a Place in Healthcare

By M. David Soliven, LCSW, CASAC
Mental Health Counselor
GMHC

In the past five or six years, I was privileged to be invited by several non-profit organizations and universities to deliver cultural humility trainings and presentations about transgender identities and experiences, and how to improve services to meet the needs of the transgender community. As a Filipino, transgender man and a clinical social worker, providing these trainings are personally and professionally meaningful and important to me. I empathize with the struggles that the transgender community face, with having their healthcare needs met, and I am committed to supporting providers and agencies that truly meet the needs of this community.

While in these presentations, I tried to observe as many audience members' facial reactions, gestures and body language, as they are non-verbal forms of communication about an individual's openness, interest or defensiveness about an issue. Being observant of non-verbal language also helps me identify how effectively I may or may not be communicating with them. People's level of knowledge, familiarity and skills, as well as beliefs and attitudes about the transgender community, vary or overlap. Sadly, I have encountered many current (as well as future) providers in the healthcare field who hold prejudice and stereotypical beliefs and attitudes about transgender individuals. However, because transgender women and men are highly stigmatized and marginalized members of society and need an array of healthcare services, I believe that it is incumbent upon providers to learn information and to practice skills that treat transgender clients with respect, sensitivity and dignity.

"Transgender" is an umbrella term to describe persons whose gender identity do not match the sex that they were assigned at birth. A transgender woman is an individual who was assigned male at birth and lives and/or identifies as a woman or female. A transgender man is an individual who was assigned female at birth and lives and/or identifies as a man or male. It is important to note that not every person uses the word "transgender" to describe their gender identity. Persons may also identify as "male" or "female." Transgender people have a range of choices when it comes to transitioning. Some may decide to transition medically and/or socially, or not at all. Medical transition includes hormone therapy, gender affirming surgery, chest or breast surgery, and electrolysis, just to name a few. Social transition involves a legal name change, gender marker change, disclosure of their transgender identity to others, change in presentation (i.e., dress, hairstyle, etc.) and so on. Transitioning is a personal choice and not every transgender person decides to do so. For many, transitioning changes their lives in positive ways. For example, their anxiety, depression, and isolation related to gender dysphoria might be alleviated. For others, the costs and risks of transitioning are too high. They might jeopardize their employment, housing, social relationships and status within their social networks.

There have been significant gains for transgender healthcare in the past few years. For example, Medicare and several states' Medicaid now cover medically necessary hormone therapy and gender affirming surgery. Many provider agencies and organizations now provide all-gender restrooms and have updated their program forms to include different identities. Despite these achievements, transgender women and men continue to face stigma, harassment and discrimination in healthcare settings and social service agencies that include lack of well-trained and informed providers, harassment in waiting rooms and bathrooms and denial of services. Negative experiences contribute to avoidance of healthcare services, poor medical and mental health conditions and distrust of providers.

One glaring example of a healthcare services gap is that transgender people are among the groups at highest risk for HIV and AIDS. According to the Center for Disease Control and Prevention (CDC), "Among the 3.3 million HIV testing events reported to the CDC in 2013, the highest percentages of newly identified HIV-positive persons were among transgender persons, and that Black/African-American transgender women were most likely to test HIV positive, compared to those of other races/ethnicities: 56% of Black/African-American transgender women had positive HIV test results compared to 17% of white or 16% of Hispanic/Latina transgender women" (www.cdc.gov/hiv/group/gender/transgender/). The prevalence of HIV and AIDS among transgender men have been reportedly low, but this might be due to lack of research and understanding about their sexual behaviors and healthcare needs.

Better anti-retroviral treatments and pre-exposure prophylaxis, or PrEP, are available, and adherence to treatment is vital to achieve and maintain an undetectable viral load and good physical health. The effects of stigma and discrimination, however, can make it difficult for transgender persons to be adherent to their medical care. According to a study on the

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LGBTQ Parenting Issues

By Santo Barbagiovanni, LMSW
Director, Center Lane Program
WJCS

Adolescence is a time for growth and exploration. In the best of circumstances, children are encountering new experiences, making new friends, pushing limits and testing boundaries, and withdrawing from family to be with friends during this time of rapid development. They are learning social skills and cues, and are beginning to feel a sense of belonging to a group of friends/peers. While this period of growth and development can be exciting, it can also be painful and confusing.

LGBTQ youth deal with all of the issues that their "straight" peers experience but too often have the added stress of exploring their sexuality and gender identity within environments that view their identity as "atypical" or "unacceptable." This lack of affirmation has negative ramifications on the self-esteem and healthy development of LGBTQ youth. If anyone remembers high school as I do, it is a breeding ground for poking fun, rumors and gossip, and last, but certainly not least, harassing one another because of differences. It is estimated that over 20 percent of the US population identifies as LGBTQ, yet data show that there is still overwhelming bias in our schools, jobs, places of worship and in our communities,

Santo Barbagiovanni, LMSW

with the greatest intolerance and bias against the Trans* community.

Adolescence can be a tumultuous time for both the LGBTQ youth and their parents. In my experience, most parents want to be supportive, but they're not sure what to do. Many parents we work with at WJCS Center Lane, Westchester's only LGBTQ youth and community education center, feel helpless and lost when they find out their child identifies as LGBTQ. They aren't equipped to deal with the intricacies of their child being gay, queer or Trans*. They aren't sure how to support their child and how to guide the child along their journey. Many parents believe, or want to believe, that their child is going through a "phase." Really, most teenagers have felt different from their peers for some time, and possibly have been struggling with it for a while. By the time they tell their parents they are LGBTQ, they have often told some friends, a guidance counselor and possibly a trustworthy family member.

So, why do parents get upset when their child tells them they are LGBTQ? The reasons are different for every parent and family. I have heard from many parents that the reason they were upset when their child came out is they don't want their child to be impacted negatively by family, friends and schoolmates. Parents are also very concerned about how other people, such as family and friends will view them. Will they question their parenting? Will they lose friends? Will they have family members that will treat them differently? What will the community that they're a part of think of them? These are all valid concerns, and most of the time one cannot predict whether their relationships outside of their family will be impacted. At Center Lane, we work with parents to help them understand many important realities: being LGBTQ is not a choice, and it's not something a parent did to cause it; children are not doing this to upset or challenge their parents; it isn't a defect or abnormality; the child is the same as they were before they told their parents that they're LGBTQ. When they come out, they are telling their truth, and it is a sign of love, trust and admiration when a child feels comfortable enough to disclose this to them.

At our center we provide a support group for Trans* youth and their parents, known as TransParentcy. These services have become an essential part of our LGBTQ program, and in the past three years we've seen an increase in the number of youth identifying as Trans*. Approximately, 17-23 percent of our youth identify as transgender or gender nonconforming. TransParentcy is divided into two separate groups, one for parents and the other for youth. This allows parents to share their stories and experiences in a private, confidential way. They are able to talk about their feelings of uncertainty, anger, disappointment and anxiety without affecting their child. Based on our outcomes and observations, it takes parents about six months of consistent group participation to fully accept their child's gender identity, and typically stay with the group for about 18 months.

Parents of Trans* youth have very unique issues and concerns, and because of this their needs are greater.

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LGBTQ: A Community in Need of Effective Care

By Amy Resnik, MHC-LP, CASAC-T; Christopher Murphy, MHC-LP; and Carlton Tanis, CASAC-T; Addictions Counselors at Realization Center

As the current heroin epidemic holds the nation in its grips, due in part to the over-prescription of opioid pain medications, there is another drug that continues to take its toll on the LGBTQ community: crystal methamphetamine. Crystal methamphetamine is not new to this community. According to Craig Sloane, LCSW, CASAC, in the late 1990's and early 2000's it became the most widely used drug among urban gay and bisexual men (The Perfect Storm: Gay Men, Crystal Meth and Sex, 2013). In 2004, the San Francisco Department of Health found 17-22% of gay men had used crystal methamphetamine within the last 12 months (SAMHSA, 2011). Data from the 2012 National Survey on Drug Use and Health (NSDUH) stated that over 12 million people (4.7 percent of the population) have tried methamphetamine at least once in their lives, while The Antidote, an LGBT support service, reported that its use amongst the LGBTQ community has quadrupled between 2011 and 2013. This research demonstrates a need for increased social awareness of this pervasive and prevalent issue and the need for urgency at LGBTQ-affirming substance abuse treatment centers.

The prevalence of crystal methamphetamine use and the severity of its consequences pose significant risks to LGBTQ individuals that must not be overlooked. Chronic use can cause heart problems, rapid weight loss, tooth decay, and can induce psychosis. Crystal meth users are more likely to engage in unsafe sex practices while under the influence; according to the National Institute on Drug Abuse (NIDA), crystal methamphetamine use raises the risk of contracting infectious diseases such as HIV and Hepatitis B and C through the unprotected sex that often accompanies it, as well as through intravenous use of the drug itself. NIDA also reported that use of crystal meth can worsen the effects of HIV/AIDS for those already living with the disease. The reality is that crystal methamphetamine addiction is a severe problem within the LGBTQ community that has grown worse in recent years and demands our attention toward the development of effective treatment options.

The crystal methamphetamine epidemic requires that treatment centers offer culturally competent and specialized care in order to cultivate a sense of community, hope, and recovery. Since its founding in 1984, Realization Center, an outpatient substance abuse treatment center in New York City, has been providing addiction treatment to individuals that identify along the LGBTQ spectrum. Within the LGBTQ program, there are more self-identified gay men with crystal methamphetamine dependence than self-identified lesbian women or those of transgender experience. Viewing this issue quantitatively, there are 105 clients within the LGBTQ program at Realization Center, 95 of whom are gay men; 79% of those gay men have entered treatment with crystal methamphetamine as their primary drug of choice. This translates to more than 70% of the population within the LGBTQ program dealing with crystal meth addiction and its consequences.

Developing specialized treatment and providing effective care for gay men addicted to crystal methamphetamine presents unique challenges, many of which are shared across the multitude of other addictions found within the queer community. The primary challenges include the lack of cultural competence regarding the both the shared experiences of and great diversity within the LGBTQ community. This can range from respecting someone's preferred gender pronoun to being able to accept that the community has far exceeded society's comfort with a binary perspective. Healthcare providers have sometimes found it difficult to adapt and respect the ongoing variety of self-identification, gender expression, or sexual orientation within the LGBTQ community. Furthermore, the vast majority of queer clients at Realization Center have self-reported experiences of prejudice, discrimination, and/or trauma. In order to provide effective care for LGBTQ-identified individuals, it is vital to create an environment that affirms their identity as well as validates the oppression and hurt they have experienced at the hands of society at large.

At Realization Center, addiction counseling for LGBTQ individuals aims to navigate treatment around such barriers, promoting an atmosphere of safety and support. Individuals are encouraged to identify their gender identity and sexual orientation with terminology that makes them comfortable. To begin LGBTQ counseling groups, clients introduce themselves with their preferred gender pronouns so they are not mislabeled. The combination of group and individual counseling helps clients develop a sense of identity and self-worth. They are advised to participate in 12-step meetings outside of treatment as a way to help them develop a sober support network and feel less isolated. For those who suffer from comorbid crystal meth and sexual addiction, Realization Center offers a gay men's sexual health and recovery group aimed at breaking the association between sex and drugs. Additionally, clients who have reported a history of trauma and/or abuse are invited to enroll in a trauma and recovery group which follows the Seeking Safety curriculum. Finally, and perhaps most importantly, counseling staff members are encouraged to attend lectures, workshops, and seminars on LGBTQ issues to remain educated and competent to address topics particular to this community.

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Understanding Eating Disorders in Gay Males

By Rachel W. Bush, PhD
Assistant Professor of Psychiatry and Behavioral Sciences,
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The National Association of Anorexia Nervosa and Associated Disorders estimate that men account for 1 million of the roughly 8 million Americans that suffer from eating disorders (McMurray, 2013). Within the gay community there is a hidden epidemic of eating disorders. Gay men are up to three times more likely than heterosexuals to have clinical or subclinical eating disorders (Feldman, 2007). How can we understand exactly why homosexuality is a risk factor for eating disorders in males (Hospers, et. al., 2005). We now know empirically that there is an atypical overrepresentation of homosexual males in clinical eating disorder samples. Men suffer in shame and silence. The risk of mortality for males with eating disorders is higher than it is for females (Raevuoni, 2014).

Rachel W. Bush, PhD

Challenging Assumptions

It is essential that we challenge some of our fundamental assumptions about eating disorders; negative body image doesn't discriminate, it plagues both sexes (Fidelman, 2013). For almost two decades we have known that eating disturbances remain undiagnosed and therefore untreated. Further clinical identification and intervention is essential (Williamson, 1999). We have a cultural obligation to improve easier access to outstanding psychological care. The focus must primarily be on de-stigmatizing eating disorders. At this point in time it is abundantly clear that there are multiple stigmas about gay males that suffer from eating difficulties. Anderson (1999) has argued that the bias against diagnosis and appropriate treatment is multi-determined. There is a bias that comes from self, from society, from health care professionals and from insurance companies. Now is the time for further development of multicultural competencies in relation to gay men.

Vulnerability

The Gay and Lesbian Medical Association is the worlds largest and oldest association of lesbian, gay, bisexual and transgender (LGBT) healthcare professionals and recommends that further research on internalized homo-negativity, internalized homophobia, internalized heterosexualism, minority stress, gender socialization and identity development needs to occur (Isacco, et. al., 2012). From a broader mental health perspective this association argues that there is a deficit model that is utilized in addressing psychological care for gay men. We know that this population is at increased risk for self harm, suicidal ideation, eating disorders, legal and illegal substance abuse, tobacco use, panic attacks, depressive symptoms and underutilization of health care services.

Cultural Pressures

Our culture is driven by the desire to maintain beauty and youthfulness. We believe that Obesity and premature aging must be avoided above all else. There are very narrow parameters in terms of being muscular and lean. When we reflect upon body image in gay and straight men, it is important to recognize the power of media and social influences (Morgan, et. al., 2009). There is a significantly higher value within the gay community placed on physical attractiveness. Superficial beauty fuels self-esteem, identity, success, desirability and the unconscious wish to be envied. The hype and selling of male beauty in media and culture comes with a tremendous psychological and emotional cost (Dotson, 1999). Men arguably continue to experience similar social injustices to women in advertisements and magazine covers based on sex appeal.

Body Dissatisfaction

Historically the emphasis on eating disorders always characterized and described "female maladaptations." For example, our cultural stereotype of Anorexia Nervosa has been narrowly defined; the poster child for this illness has been a Caucasian, wealthy, perfectionistic girl. As social scientists we recognize that Anorexia Nervosa must have a significant impact on all races, genders, ages and socioeconomic classes (Mondi, 2014). It is always important to recognize the essential nuances and subtle differences in

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BEHAVIORAL HEALTH NEWS DESK

OMH Patient Survey Making LGBTQ Clients "Visible"

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

The NYS Office of Mental Health is the first state agency in the nation to compile data in its Patient Characteristics Survey (PCS) specifically addressing sexual orientation and gender identity in mental health care.

"This is significant because this helps to make the LGBTQ community visible in the mental health care system," said Dr. Barbara E. Warren, a member of the OMH Multicultural Advisory Council and Director of LGBTQ Programs and Policies in the Office for Diversity and Inclusion at the Mount Sinai Health System in New York City.

"In order to create effective treatment programs for LGBTQ clients, providers have to know they are there in first place," she said "OMH was the first agency to understand this and the first to take the step of gathering the data. Then other agencies started to follow suit."

"We're very proud and grateful that OMH was the first mental health agency in the country to gather demographic data about the sexual orientation and gender identity of the people that it serves," added Dr. Christian Huygen, Executive Director of the Rainbow Heights Club in Brooklyn.

This data will help OMH to document LGBTQ patient outcomes, understand disparities in the delivery of mental health care, and determine the next steps for developing programs to address these disparities.

5.4% or nearly 7,700 patients who were served throughout the system self-identified at lesbian, gay or bisexual. Another 1,021 identified as transgender, a population that had not been represented in mental health statistics, until the 2013 PCS. These numbers were evenly distributed throughout all regions of the state for those identifying as transgender.

Of the 143,231 clients 18 years of age or older receiving mental health services during the two-week survey period in 2015, 4,626 were reported as lesbian or gay; 3,127 were reported as bisexual; 754 were reported as other, and 1,021 individuals reported as transgender. Increases from 2013 to 2015 are most likely due to better reporting.

LGBTQ patients also identified in equal numbers from diverse ethnic backgrounds. Reporting rates of lesbian, gay, bisexual or other; and transgender appear to be higher in the 2015 PCS than in some national studies.

According to a Kaiser Family Foundation study, 2.3% of adults 18 and older identified as lesbian, gay, or bisexual. Gallup data found between 3.4% and 3.6% of adults 18 and older identified as LGBT, compared to 5.9% of mental health clients in New York State reported as lesbian, gay, bisexual, or other (LGBO).

This Gallup data allowed OMH to compare PCS and national rates of LGBTQ across age groups. Younger adults aged 18 to 29 years old were more likely to identify as LGBTQ (6.4%) than older people aged 65 and older (1.9%).

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Health Care Center To Open in East New York

By Staff Writer Behavioral Health News

In July 2016, HealthCare Choices (HCC), Inc. will open its third community health center, the second in Brooklyn, New York. HCC was one of 17 "New Access Point" (NAP) grant recipients in New York State, to receive funding from the U. S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA). The awards totaling $9,741,841 will serve a proposed 65,309 new patients across the state. This $650,000 annual grant will enable HCC, Inc. to operate a new health center location in the East New York section of Brooklyn, which has been identified as an underserved area with limited access to primary care services.

"We are grateful to HRSA for this grant which brings with it the opportunity to expand access to medical care for adults and children in the community, regardless of their ability to pay," said Maria Siebel, LCSW-R Chief Executive Officer of HealthCare Choices, Inc. "Thanks to this generous grant, we can further strengthen the health care safety net throughout Brooklyn."

HCC's third fixed site access point will be located at 179 Jamaica Avenue, Brooklyn, NY. HCC-ENY will provide integrated, co-located, medical and mental health services to adults, teens, and young children in East New York. When operating at full capacity, HCC-ENY will serve 2,150 patients. As with the 2 existing sites, this new access point will offer same-day appointment by phone or walk-in and advanced appointments. It will be open weekend and evening hours as an alternative to emergency rooms. The goal is to provide the community with a medical home that provides medical and specialty care to meet the needs of the population and become a regular place of care.

HCC-ENY will offer services to people of all ages, with a special focus on the homeless, elderly, immigrant, special needs, low-income and the uninsured. This year the Community Health Center also began providing pediatric care at both its Brooklyn and Queens sites. In addition, these Health Centers offer on-site services in many of the area shelters. Services at HCC-ENY will be appropriate for all ages, so all family members will be able to receive their care at one health center.

"Health centers now provide primary care to one in fourteen people living in the United States," said HRSA Acting Administrator Jim Macrae. "These awards mean that more communities than ever can count on a health center to help meet the increasing demand for primary care."

For more information about HCC or to make am appointment, visit their website at www.healthcarechoicesny.org or call (718) 234-0073.

Governor Announces Programs to Help Youth with Schizophrenia

By the Office of the Governor of New York State

Governor Andrew M. Cuomo recently announced the expansion of a state program that helps young adults with newly emerging psychotic symptoms. Run by the state Office of Mental Health, the On-TrackNY program provides young adults with innovative, team-based psychiatric treatment, employment and educational services, as well as family education and support at locations throughout New York State. Three new locations are now open in Manhattan, Rochester and Albany, and eight additional sites are slated to open across the state by the end of 2016.

"Early intervention is one of the best ways to help ensure people with mental illness get access to the resources and treatment they need," said Governor Cuomo. "This program provides a crucial service to young adults when they first experience symptoms of schizophrenia – ensuring they have the support they require from day one."

With the opening of the three new On-TrackNY programs in Manhattan, Rochester and Manhattan, 12 OnTrackNY sites are now operational. By the end of 2016, eight additional program sites will open across New York State. These new sites will be located in Binghamton, the Bronx (two locations), Brooklyn, Garden City, Middletown, Queens, and Staten Island. At full implementation, it is estimated that the 20-site OnTrackNY program will serve 760 New York State youth at any given time.

"The Office of Mental Health continues to identify opportunities to expand this comprehensive program to more New York youth in need," said New York State Office of Mental Health Commissioner Dr. Ann Marie T. Sullivan. "We want to make sure these individuals have the opportunity to achieve their personal goals, especially in work and school, and easy access to community-based mental health services is a key part of this equation."

It is estimated that nearly 3,000 New York residents develop schizophrenia each year, which if left untreated may lead to a number of significant issues, including problems at school and work, strained family relations, and estrangement from friends. Untreated schizophrenia can lead to problems such as homelessness, incarceration, and substance abuse, the probability of which increases the longer the psychosis goes untreated. Oftentimes, untreated schizophrenia leads to disability, which exacts painful human costs upon the individuals and their families, as well as substantial financial costs to individuals, families, and the healthcare and social service systems.

Started in 2013, the OnTrackNY program provides an innovative, evidence-based, team approach to providing recovery-oriented treatment to young people who have recently begun experiencing

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BEHAVIORAL HEALTH NEWS DESK

New Central Nassau Facility Will Help More People

By Staff Writer
Behavioral Health News

Central Nassau (CN) Guidance and Counseling Services has opened a new 21,000-square foot facility in Plainview New York in Nassau County, expanding the nonprofit's and region's capacity to serve individuals facing substance use and mental health disorders, during an era of escalating demand and high need.

At a time when local addiction and national suicide rates are near all-time highs, the newly acquired space, nearly mirroring the size of CN Guidance's existing main facility in Hicksville, will house more than 70 staff serving local residents via several expanding CN Guidance programs. For instance, the space will house CN Guidance's Project FORWARD, a federally funded set of services focused on helping clients repair and maintain personal relationships as part of their recovery. It will also house the agency's Personalized Recovery-Oriented Services (PROS) program, serving people with mental illness through structured outpatient services; and the nonprofit's Health Home Care Management program, which proactively coordinates multiple types of needed care and services for hundreds of clients and families annually.

"This new facility represents our continuing commitment to people recovering in the community and living a productive, independent life, with community-based supports," said CEO Jeffrey Friedman of CN Guidance. "With our new facility opening, we will proudly celebrate the work that CN Guidance does in the community for the residents among us who are the most vulnerable and who don't have a voice. This ceremonial ribbon cutting will recognize the marked progress Long Island has made in the years since an earlier era of large-scale institutionalization of people facing behavioral health challenges."

CN Guidance is one of the few community organizations on Long Island licensed by both the New York State Office of Mental Health (OMH) and the New York State Office of Alcoholism and Substance Abuse Treatment Services (OASAS). The nonprofit is known for its decades of expertise in serving people with co-occurring mental health and substance use disorders. CN Guidance and Counseling Services is a nonprofit organization launched in 1972 that provides clinical treatment, rehabilitation, housing opportunities, social and support services, counseling, and guidance to individuals, families and the community affected by mental illness, developmental disabilities, psychological difficulties, addiction, and/or dependency problems. CN Guidance delivers its services to Long Island residents via 300+ staff, joined by student interns and volunteers. In addition to providing substance use treatment, mental health treatment, and case management services, CN Guidance offers clients a "Drop In" center for services and operates social enterprises including the Starry Night Café, which serve and support the organization's mission and the growth and thriving of CN Guidance's clients.

Long Island Community Residence Damaged by Sandy Reopens

By Staff Writer
Behavioral Health News

The New York State Office of Mental Health recently announced the reopening of a community residence on Long Island for individuals with behavioral health concerns that was badly damaged by Superstorm Sandy in 2012.

The South Shore Association for Independent Living Inc.'s Island Park Residence was rebuilt through funding from the New York State Office of Mental Health (OMH) and a federal Social Services Block Grant distributed through the New York Governor's Office of Storm Recovery.

"Superstorm Sandy devastated so many communities throughout the state, and today we are building back better and stronger than before," said New York State Office of Mental Health Commissioner Dr. Ann Sullivan. "New Yorkers are resilient, and this re-opening is a testament to the dedication of this provider to both the Long Island community and the individuals whom they are entrusted to serve. We are so excited to welcome South Shore's clients back into their homes after such a tragic natural disaster."

The federal block grant of $1,051,606 was used to replace, renovate and repair the debilitated structure. An additional $335,000 in OMH funding was also used to finance the reconstruction of the facility. With this funding, Island Park Residence was elevated above the new flood level set by the Federal Emergency Management Administration and the house was reconfigured to be handicapped accessible. This enables the residence to serve individuals who have behavioral health concerns as well as physical limitations. Construction started in May 2015 and was completed in early 2016.

"The Island Park Residence provides essential support and services to fellow New Yorkers," said Governor's Office of Storm Recovery Executive Director Lisa Bova-Hiatt. "The new paradigm in the aftermath of Superstorm Sandy is to minimize impacts from inevitable, severe weather events, by building in stronger, sustainable and more resilient ways – which is what the South Shore Association for Independent Living has achieved."

"We are extremely happy to return to Island Park and our new and improved residence nearly two and a half years after Superstorm Sandy. The Island Park community has always been welcoming and provides the Agency and our residents with the support and acceptance needed to integrate into the community and reduce the stigma associated with mental illness, which is, in essence, the goal of the community residence model," said South Shore Association for Independent Living Executive Director Marge Vezer, LCSW. "Although Sandy

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NYS OMH 2016-17 Budget Reinvests in Community-Based Care

By the New York State
Office of Mental Health (OMH

This year's OMH budget continues the Transformation Plan's reinvestment in community-based care – funding an array of services to help individuals make the transition from state psychiatric centers to the least restrictive settings.

"This will be the third year of full reinvestment, bringing the full annual commitment to $81 million," said Emil Slane, OMH Deputy Commissioner and Chief Fiscal Officer. "These are funds that would have been otherwise spent on avoidable state inpatient hospitalizations." As a result of this ongoing community investment, OMH estimates that 200 vacant inpatient beds can be closed in the upcoming fiscal year, making an additional $22 million available to invest in community services.

Reinvestment Brings Results: The 2016-17 State Budget fully annualizes the previous two years of pre-investment, and provides an additional $11 million – annualizing to $22 million – to further strengthen the overall community mental health safety net. Results so far have been promising.

During the last two state fiscal years, OMH has used reinvestment funding to develop new mobile crisis teams, expand clinic services, provide additional peer support services, and fund additional supported housing units – helping more than 10,000 new individuals receive services since these programs began.

"Because of these efforts, the average daily inpatient census in OMH civil adult and children's psychiatric centers declined by nearly 6% in 2015," Slane said. "During the same period, OMH's new Transformation Plan services reached thousands of new individuals in communities. This puts OMH firmly on the path toward balancing its resources to provide people with more appropriate and effective community treatment and support."

OMH is dedicating a significant share of its 2016-17 funding to help long-stay inpatients with complex medical and behavioral health needs make the transition to more appropriate settings in the community by developing partnerships with skilled nursing facilities. By helping these individuals move to more-integrated and less-restrictive community settings, OMH is freeing-up inpatient capacity and increasing its ability to provide intermediate care.

Expanding Services in Communities: Housing Options Made Easy, Inc., of Gowanda is one example of a local agency that has expanded its services through reinvestment, helping clients in six Western New York counties receive help in their own communities. For example, since its Eagle's Nest Respite House in the Southern Tier opened in November 2015, nearly 86% of its guests have been diverted from hospital stays. Eagle's Nest Respite is a program of Housing Options Made Easy.

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Some were diverted from high-end interventions due to a dual diagnosis of a developmental disability and a mental health issue. One client, who was discharged from Buffalo Psychiatric Center, was able to use the respite to prevent a return. Others would have gone to the Buffalo Psychiatric Center if hospitalization was needed.

"Nearly all guests reported that the respite helped them stay positive," said Joseph Woodward, Housing Options Executive Director. "Most people reported that the respite had helped them avoid a hospitalization. The repeat guests we had, used the respite again to avoid hospitalization."

Eagle's Nest has helped participants find peer support and the continued interaction has helped the participants avoid a hospital stay. This has led to the start of a peer-support group that meets once a month at an outside location. The respite also follows up with clients at 30, 60, 90 and 180 day intervals. All follow-ups track how the guest is feeling since leaving the respite, and whether the respite stay helped the guest avoid going to the hospital.

Not only has the program helped patients, it's saved money. Based on an average length of stay at Eagle's Nest of five days, the average cost of savings per guest that diverted from the Mental Health Department at WCA Hospital in Jamestown was $7,000, for a total savings of about $245,000.

However, because the average length of stay at WCA is closer to 11 days, the total would be much higher at $436,100. Housing Option's Warmline program in Chautauqua and Cattaraugus counties also continues to help divert people from a hospital stay. The program has opened a texting line for people who are more comfortable texting than actually talking to people.

"Callers who repeatedly call the Warmline say that having the service helps them stay well and avoid the hospital," Woodward said. Funding from the reinvestment grant is allowing them to look forward and expand services.

"We're developing a 'tool kit' for all guests who come to the respite," Woodward said. "This will be given to them at checkout, and will include community resource lists, support groups in the area, and other phone numbers and programs that offer support." The respite is planning to offer the Whole Health Action Management program which offers training and peer group support to encourage resiliency, wellness, and self-management of physical health and behavioral health.

A Place Where They Can be Listened to: Reinvestment funding has given East House and the Mental Health Association of Rochester the means to collaborate on developing a peer respite program to help individuals both during and after their stay. Open for a full year as of May 7, Affinity Place is a peer-run respite house in Rochester that's set up much like a neighborhood bed-and-breakfast. "There had been a great deal of discussion about priorities for the region," said Gregory Soehner, President and Chief Executive Officer of East House, which runs the program. "We determined that a hospital diversion program run by peers would be a priority."

After East House and MHA were awarded Reinvestment funding at the end of 2014, a great deal of legwork needed to be done before they could open, such as hiring staff, adapting one of its properties for a new purpose, and making the community aware of the program.

"Affinity Place is designed to be comforting and relaxing," Soehner said. "We refer to people who stay with us as our 'guests.' They check-in and check-out like one would at a 'B-and-B.' They stay in single rooms. They get their own room key. And we've included little touches to help them feel like they're not in a residential program – such as guest books with a list of community resources and things to do." Guests can stay up to five days.

"We don't operate on a medical model, because that's not the design of the program," said Cheri Reed-Watt, Director of Residential Services. She noted that the facility is entirely run by peers, there are no physicians, psychiatrists, or nurses on staff. "A lot of times, people don't need to be hospitalized. They just need a place to stay where they can be listened to and put things in perspective."

The admission process is set up so that people can get in quickly, often with just one phone call. Guests can come and go as they need to. Many of the guests work full time, then they can return to the house at the end of the day and get the support that they are looking for. "Our guests are offered an opportunity to take a survey at check-out," Reed-Watt added. "The results have been overwhelmingly positive. They'd often like to stay longer."

Wouldn't Exist if it Hadn't Been for Reinvestment: Guests can receive additional support after they check out from the Mental Health Association of Rochester. Each guest is offered the ability to work with a peer support specialist for up to 60 days after leaving Affinity Place.

"The peer support specialist helps them to address the issues that led to their needing a residential stay," said Patricia Woods, the Mental Health Association's Chief Executive Officer. "We assist them during this transition period. We'll work on establishing healthy behaviors, developing strategies for handling difficult situations, finding community and social supports, and referring them to employment services. We'll offer variety of services based on what the client wants to see happen in their life." Woods said that 75% of the program's clients have accepted the community services offered by MHA.

"This was one of the projects our agencies wanted to start, but we didn't yet have the resources," Woods said. "This program wouldn't exist if it hadn't been for the Reinvestment funding." In addition, Affinity Place offers a warm line, which is available to individuals who reside within the six counties it serves. This service is available 24 hours a day, seven days a week and has received more than 3,000 calls in the past year.

http://omh.ny.gov/omhweb/resources/newsltr/2016/may-2016.pdf

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selected for the federal pilot.

Regardless of the drivers, the system is pulling in the same direction, toward data informed care delivery that is culturally competent and calibrated to meet the needs of all persons. Demographic data related to sexual orientation and other factors will enable providers to effectively calibrate outreach, as well as specialized interventions. This effort will support improved cross-system awareness of, and expertise in, maximizing the efficiency of long term management for chronic psychiatric conditions, including the benefits of peer based, strengths focused recovery support – not just for the recipients of care and their quality of life, but for the bottom line.

No matter how small the niche population, over utilization of high cost care and barriers to access demand that local needs be identified and supported by customized interventions at the provider level. Although the design of more highly customized approaches to evidence based care that is responsive to person-centered needs may be taking a back seat to the establishment of the infrastructure and systems necessary for the State's transition from volume to value at the present time, the systemic components offer rich resources and opportunities for statewide improvements.

What's the point of all this effort? Shirelle, a tall, transgender woman, put it eloquently: "I'm a transgender member of Rainbow Heights Club – one of the many – and I don't stand out here. I just blend in." Blending in, belonging, being a part of the community just like anybody else – if we can give LGBTQ clients that experience, then the real work can begin. We must demonstrate, for all of the clients we serve, that we are willing and able to help them meet their own goals, in their own way, and we must ensure that they feel safe, and welcome – that they belong--in our agencies and our communities. The LGBTQ affirming services that Rainbow Heights Club provides help clients to stay out of the hospital, increase treatment adherence, increase hope and self-esteem and social support, and improve relationships with families and care providers. Establishment of new Medicaid service delivery options, such as Health Homes and Home and Community Based Services (HCBS) will promote opportunities for more customized recovery supports by providers of all types. In the value based payment environment of the near-term, all providers will want to take steps to do the same.

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and become "Wendy." Pam showed genuine excitement and interest in assisting any way she could.

The road to Danny's transition was smooth but didn't happen overnight. Staff competencies were continually assessed during staff meetings, individual and group supervisions, as well as clinical trainings. Staff were also taught about the differences between one's sexual orientation, their sex, and their gender. This was new to a lot of people. Staff showed great flexibility and person-centered care by using the proper pronouns and names that were preferred by Wendy. During the initial phase of the transition, when Danny was living at our downtown residence, Danny would fluctuate between wanting to be seen as Danny and wanting to be seen as Wendy. Staff took the time to recognize whether he was presenting as Danny or as Wendy and would address him accordingly in order to convey the utmost respect. And of course, when mistakes were made, Danny was understanding because of the relationship staff had built with him.

As Wendy became more present, staff had to constantly assess the residence as a whole to ensure that Wendy could self-actualize while remaining safe. This involved psychoeducation and celebrations around diversity as well as speaking to key informants within the residential community. Collaboration was ongoing with Wendy's treatment providers and everyone worked together to help Wendy appear as she saw herself. How well a person can *pass* for the gender they identify with most can help overcome some of the barriers and discrimination felt in the broader community. It also increases safety.

Wendy is now ready for Supported Housing and is currently exploring different roommate options. In an effort to continue to be inclusive, staff are not limiting Wendy's options. Wendy has recently identified a male friend she would like to room with and staff are working with her treatment providers to make it happen.

In residential settings, it is crucial for staff to be understanding of all the emotions residents go through as well as the traumas they've experienced, which can be overwhelming, both physically and emotionally. Residences must serve as safe spaces for all persons regardless of diagnoses or histories.

How is that accomplished? As we've seen in Wendy's story, it happens through a mixture of engagement, inclusion, and relationship building. These aspects can be particularly sensitive when it comes to the LGBTQ community. There needs to be a level of acceptance and tolerance within both staff and fellow residents. Staff must face their own internal biases and learn how to work around them and grow from them. They must also be open to reaching out for help from others who might be more familiar with a particular area of concern.

Staff also works in partnership with each individual when and if s/he might be ready to reconnect with family. Many times, an individual might have been rejected or abandoned by their family because of his or her sexual orientation, making that person distrustful of sharing their true selves with other people.

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connection between treatment adherence and viral load levels of transgender women of color, "Transgender women on ART were less likely to report 90% adherence rates or higher and reported less confidence in their abilities to integrate treatment regimens into their daily lives. Transgender women reported significantly fewer positive interactions with their health care providers. Training for providers and integration of hormone therapy into HIV care is recommended" (Sevelius JM, etal., Antiretroviral Therapy Adherence Among Transgender Women Living with HIV. The Journal of the Association of Nurses in AIDS Care, 2010). Other factors also influence treatment adherence. Many transgender women may prioritize: 1) hormone treatment because it affirms their gender identity, 2) income-generating work (e.g., sex work, part-time jobs, etc.) to support their living expenses, and 3) concerns about the possible drug interactions between their hormone treatment and ARV medications. More research needs to be funded and conducted about this issue in order to gain a better understanding of factors that affect treatment adherence.

Healthcare providers have a vital role in improving the health outcomes of transgender people living with HIV and AIDS. Stigma and discrimination serve as barriers and cause harm to transgender clients who need HIV-related healthcare urgently. To serve this community, providers need to prioritize the development of effective medical and social service interventions that "not only address and improve health, but also promote health equity…" (Reisner, S. etal. Global Health Burden and Needs of Transgender Populations: A Review," The Lancet, 2016).

Since 2012, I have worked proudly at Gay Men's Health Crisis (GMHC) as a mental health counselor. GMHC is the nation's foremost advocate and leader in HIV and AIDS prevention, advocacy and comprehensive care services. The agency exemplifies an organization that has taken seriously the healthcare concerns of transgender clients and the professional development needs of its staff. In 2014, GMHC established a committee whose primary purpose is to meet programmatic needs and to improve the quality of life for transgender and gender non-conforming individuals by developing and supporting a safe and non-judgmental culture. To this end, orientations for new hires and regular staff trainings include cultural humility trainings, two "All-Gender" restrooms are available, agency forms are inclusive of different identities, and participation and collaboration with community-based organizations at transgender-specific events have increased. Additionally, there are several full-time staff who identify as transgender and a support group for transgender people is led by a transgender woman of color. The total number of transgender clients in 2015 was 68, and although this number is low currently, this was an amazing increase compared to previous years. GMHC is hopeful that the number of transgender individuals served by the agency will multiply and obtain life-saving services and care.

The Collaborative Mental Health program in which I work provides individual, couple and family counseling services as well as support groups for long-term survivors, people in substance use recovery and those newly diagnosed with HIV. In the coming months, GMHC will open an Article 31 mental health clinic licensed by the New York State Office of Mental Health (OMH) and an Article 32 substance use treatment program licensed by the Office of Alcoholism and Substance Abuse Services (OASAS). Because the transgender community face a high risk of mental health conditions and substance use, often as a consequence of stigma and discrimination, the expansion of services designed specifically to address these issues attest to GMHC's commitment to the healthcare needs of transgender people.

Finally, cultural humility skills and practices do effect positive changes. Skills and practices that can help providers include, but are not limited to, the following list:

• Understand basic terms, definitions and health risks;

• Use appropriate gender pronouns and names;

• Discuss hormone, PrEP and ARV treatments with clients;

• Provide safe bathrooms;

• Arrange regular staff trainings about transgender health issues;

• Collect accurate demographic data;

• Employ transgender staff in all levels of the agency;

• Team up with community partners to advocate for housing, jobs, and healthcare; and,

• Understand the interconnections among stigma, discrimination, misinformation, and poor health outcomes

(New York State Department of Health, Care of the HIV-infected transgender patient, 2012; Center of Excellence for Transgender Health, 8 best practices for HIV prevention among trans people, http://transhealth.ucsf.edu; National LGBT Health Education Center, Affirmative care for transgender and gender non-conforming people: Best practices for front-line health care staff, February 2013; San Francisco Dept. of Public Health, Transgender HIV/AIDS health services best practices guidelines, July 2007).

When transgender clients feel welcomed and are treated with respect, sensitivity and dignity, their engagement in treatment and their investment in their health can improve. Establishing cultural humility skills and practices may involve hurdles and challenges, but the outcome can increase access and retention to care. Stigma and discrimination can no longer have a place in healthcare.

If you are interested in learning more about GMHC's programs and services described above, please visit www.gmhc.org or call (212) 367-1000

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wants to advocate."

A common discussion that exists is about the way in which these services are delivered. The question that is often posed is, "Do we facilitate these services separately from the general population or within already existing services?" This is a question that remains unanswered and exists with differing opinions. The ripple effect of this question is two-fold; if services are provided independently, the argument is that segregation is being perpetuated and if the services are provided within the general population one can question if there is there truly a safe space. Ultimately this dilemma leaves providers with a lot to think about.

Substance use treatment services are sparse for the LGBTQ community. In order to decrease the disparate percentages of substance users of the LGBTQ community compared to the general population, there is a need for additional services of quality and affirming interventions. It is evident that training is required and implementation of these services require much thought, planning and delicate execution.

If you have any questions or would like further information, please contact Jill Mastrandrea via email at jillmastrandrea@opiny.org or by phone at 718-383-7200 extension 6104

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There needs to be a continued social dialogue regarding the substance abuse issue in the LGBTQ community in order to cultivate effective treatment and broad scale change. As important as it is to recognize and address the current heroin epidemic sweeping the country, it is just as important to remember the methamphetamine epidemic that preceded it and continues to affect millions of people worldwide, including a disproportionately high percentage within the LGBTQ community. Acknowledging the relationship between substance abuse in the gay community and the trauma and abuse its members have suffered as a result of their long-marginalized place in society is an important first step in creating a dialogue that can help these individuals begin to heal. Treatment options that focus on the affects that society has had on this community and begin to treat the specific cognitive needs that are contributing to their addictions must be created, utilized and discussed. It is with this dialogue, social awareness, and continued specialized treatments for those suffering with crystal methamphetamine addiction in the LGBT community that the stigma can disappear and true recovery can begin.

There are Many Caring Behavioral Health Organizations In Your Community

That You Can Turn To When Life Becomes Too Hard to Bare

Please Remember - Never Give Up Hope You Can Work Things Out

A Message From the Board and Staff of Behavioral Health News

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had some awareness but not enough experience to recognize the signs.

In fact, when my son's therapist asked why he thought he didn't fit in, my son said, "Sometimes I really think I'm a boy, not a girl." His therapist, who didn't know better, responded by saying, "Well, look at you. We know, of course, you are a girl, but it's OK if you like boy things."

It took two more years before my son learned what it means to be transgender and came to understand that he actually was a boy. Two long, heart-breaking years, desperately seeking answers. And when we finally had some answers – the formal diagnosis, an understanding of what it means, and new healthcare providers with the knowledge and experience to help us – it didn't get better overnight.

For many years, I was dedicated to supporting my son's transition so he'd be seen and accepted as the young man he knew himself to be. It was a long and difficult process. There was bullying and rejection and discrimination along the way. We moved to another city, changed schools multiple times, and had to educate countless people – including doctors, educators, and court officials. Access to transition-related care is a medical necessity according to every major professional health organization, yet we had to challenge and fight our insurance company to pay for my son's care.

But many would say we succeeded. My son is now 20 years old and happy and healthy. He's a successful college student researching a cure for cancer, he's in a great relationship and engaged to be married, and he is living his life fully as the young man I now know he has always been.

In this article, you won't find any photographs of my son. The feedback I receive at speaking engagements is that audiences want to see more photos of my son before, during, and after his transition. And that actually led to my decision not to include any photos with this article. Because although I understand the curiosity of most audiences, it isn't clinically relevant.

Instead of looking at photos of my son, I'd like you to imagine that it's your child, or your best friend, or your brother or sister, or someone you care deeply about.

How my son looks, whether he can "pass" or you "can tell" he was assigned female at birth isn't clinically relevant. A person's presentation should never impact the quality of care they receive or the experience they have in a healthcare setting.

Unfortunately, a national survey found that 19% of transgender people report being refused medical care due to their gender identity or expression.* And 28% postponed medical care due to the discrimination they faced.* Twenty-eight percent report being subjected to harassment in medical settings.* Nearly 40% of medical students surveyed said they were uncomfortable caring for transgender patients. (Safer JD & Pearce EN, Endocrine Practice, 2013)

Those statistics upset me, but I understand not knowing. I understand taking gender for granted and making assumptions based on one's own experiences and identity. My husband and I didn't know. Despite our advanced degrees and access to resources, we were ignorant. My son struggled and suffered for years because we didn't recognize the signs, advocate for him sooner, and seek out providers experienced with transgender youth. But as Maya Angelou said, "When you know better, you do better." I hope I can inspire readers to know better and do better.

These days we see, hear, and read more than ever about transgender people, yet much tends to be ill-informed, negative, and misleading. Society has a long way to go. Most of us still don't talk about or learn about gender. Many conflate gender with sex or sexual orientation.

Medical students have the option of learning about transgender healthcare, but it's not a required component in most medical school curricula. This would explain why a national survey found that 50% of transgender Americans have to teach their medical providers about transgender identities and transgender healthcare.*

Let me help change that by defining some basic terms I've been using and then address some misconceptions that I (and many other parents and providers) have had.

Gender identity refers to a person's internal sense of being male, female, or something else. Gender expression refers to the way a person presents themselves and communicates their gender identity, through clothing, behavior, hairstyles, mannerisms, voice, etc. Transgender (or trans) is an umbrella term for people whose gender identity, gender expression, or behavior doesn't conform to that typically associated with the sex they were assigned at birth.

The first misconception I'd like to address is that my son was "born a girl" and he "wanted to become a boy." He was always a boy. We just thought he was a girl because he was born with a vagina. I've learned that gender is hardwired in the brain, and not assured by simply observing a newborn's genitals.

Gender identity is innate; it is not a choice or decision. There are over 150 studies, papers, dissertations, and other peer-reviewed sources that have found biological origins of gender identity and gendered behavior. Most of them found that endocrine disruptions during pregnancy affected both. This concept isn't new; studies from 1973 on have found this.

Furthermore, according to a Boston University School of Medicine study, gender identity is hardwired in the brain and not simply a matter of psychology, (Aruna Saraswat, Jamie Weinand, & Joshua Safer, Evidence Supporting the Biologic Nature of Gender Identity. Endocrine Practice, 2015)

And so, my son was always a boy, and transition for him meant aligning his body with who he always was inside.

Another misconception: Transgender children are mentally ill or being transgender goes hand in hand with having mental health issues. The American Psychiatric Association (APA) does not consider transgender people to be disordered and clearly states that being transgender is not an illness. In fact, the APA says the exact opposite: "Gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition." (Gender Dysphoria, APA, 2013) According to the National Alliance on Mental Illness (NAMI), it is the fear of coming out and being discriminated against that can lead to depression, post-traumatic stress disorder, thoughts of suicide, and substance abuse.

The overwhelming majority of studies show that discrimination, rejection, and isolation are the cause of high suicide rates in the trans community.

Another misconception is that children can't possibly know who they are and parents should not allow children to transition. All children (not just transgender youth) start understanding gender identity around age 2 years. (Carol Lynn Martin & Diane N. Ruble, Patterns of Gender Development, Annual Review of Psychology, 2013)

My son didn't say, "I am a boy," until adolescence, but he always felt something was different that he couldn't articulate. Some children, however, are insistent, persistent, and consistent in voicing who they are as young as 2 and 3 years, saying, "No, Mommy, I'm not a girl. I'm a boy," or vice versa.

In a population where nearly one half experience suicidal ideation, the risk of nonintervention is quite high. (Ilana Sherer, Social Transition: Supporting Our Youngest Transgender Children, Pediatrics, 2016)

Accepting a child's identity is the healthiest thing parents and their healthcare providers can do for them. A new study published in the journal Pediatrics found that out trans kids with supportive families have no more anxiety or depression than kids who don't identify as transgender. (Olson et al., Mental Health of Transgender Children Who Are Supported in Their Identities, Pediatrics, 2016) One recent study found that children whose parents reject their identities are 13 times more likely to attempt suicide. (Travers et al., Impacts of Strong Parental Support for Trans Youth, 2012) Another showed that having a family that accepts a child's gender identity reduces the suicide attempt rate by 82%. (Bauer et al., BMC Public Health, 2015) Negative outcomes for trans youth are strongly linked with rejection of their gender identity.

I urge all healthcare providers and behavioral health professionals not only to learn about transgender identities but also how to offer more inclusive and culturally competent care to their transgender and gender nonconforming patients.

This is not just about providing transition-related care, such as prescribing hormones or performing gender affirming surgeries. No matter what type of practice you have, you will have transgender patients. Transgender people are people, just like everyone reading this. They will need to see general practitioners, oncologists, cardiologists, urologists, dermatologists, gynecologists, orthopedic surgeons, and the list goes on.

You may think we're talking about a small number of people, so why direct your limited time to learning about transgender identities and care? In the journal Endocrine Practice, researchers said that as many as one in 100 people could be living with some form of gender dysphoria. The lead researcher said, "This paper represents the first comprehensive review of the scientific evidence that gender identity is a biological phenomenon. As such, it provides one of the most convincing arguments to date for all medical providers to gain the transgender medicine skills necessary to provide good care for these individuals." (Aruna Saraswat, Jamie Weinand, & Joshua Safer, Evidence Supporting the Biologic Nature of Gender Identity. Endocrine Practice, 2015)

Consider this: You may not treat many transgender patients, but I assure you, you can make a life-changing and even life-saving difference for all those patients—and for their families, as well. Healthcare providers are looked up to and seen as an authority. The best chances and lowest-risk factors for transgender youth are when they have supportive parents. One of the most powerful influences of parents are experienced healthcare professionals. You can help someone like me save their child's life.

My hope is that something I've written will move, inspire, and motivate you to do just that.

Terri Cook is co-author of Allies & Angels: A Memoir of Our Family's Transition and can be reached by email at terri@alliesandangels.com, and on the web at: www.alliesandangels.com/about.

* (Grant et al., Injustice at Every Turn: A Report of the National Transgender Discrimination Survey, 2011).

Support from page 27

Individuals may have long histories of trauma that include familial abuse and/or rejection. In working with individuals, staff creates a safe space where people can feel free to express their true selves. In essence, staff becomes like a family, creating an inclusive space for individuals to re-create the family experience and perhaps learn safe ways to approach and mend their pasts, if desired. Staff becomes the containers of each individual's emotional distress, empowering them as they decide what emotions they want to face.

A collaborative approach to care ensures that everyone involved in a person's recovery plan is supportive of that individual's goals and path to achievement.

Youth from page 6

of Health and Mental Hygiene Advisory Board on Gender Marker Change. She joined the Hunter College School of Social Work in 2007 as an Adjunct Lecturer and served in this role through 2014. In 2015 Carrie was named a Woman of Distinction by the New York State Senate in recognition of her contributions to enrich the quality of life in her community.

The Center fosters a welcoming environment where everyone is celebrated for who they are. It offers the LGBT communities of NYC health and wellness programs; arts, entertainment and cultural events; recovery, wellness, parenthood and family support services. For more information about The Center, visit gaycenter.org.

Promoting from page 19

several different markets. In New York, Optum has partnered with the New York Association of Psychiatric Rehabilitation Services (NYAPRS) to offer peer support services that help covered members who transition from psychiatric hospitalization to their home communities. In this program peer support specialists trained by NYAPRS work to promote community integration and support community tenure by helping members re-engage within their communities following an admission. A key to this program is the peer specialist's ability to recognize the unique attributes of an individual's culture and community and help support their engagement in care, and foster their recovery in the community.

In another example, Optum has worked with San Diego County to develop a 24/7 crisis line that gives all covered members access to urgent and emergent resources that meet the needs of the entire community. The staff in this resource are trained in cultural diversity to meet the unique social and cultural needs of those it serves. In addition, Optum has provided educational services to the community on the Seeking Safety model of suicide prevention. This approach fosters a safe environment for those of diverse backgrounds to address past traumas. Working collaboratively with the Healthy San Diego Behavioral Health Workgroup, Optum has recognized the diverse populations served to prepare for the implementation of Medicaid expansion and the development of the Medi-Cal Mental Health Severity Screening Tool.

It is vital to provide person-centered care to all of the people we serve. This approach recognizes that each individual has a unique set of personal characteristics and attributes. Care provided must be responsive and respectful of these needs. These include social, cultural, and health specific factors that influence how our members become engaged in health care, and how they activate healthy behavior change and management to achieve positive health outcomes. Cultural diversity and health equity influence how systems of care must respond to these individual factors. Optum recognizes that this is a system-wide challenge that must be addressed by all involved staff, network providers and facilities, and resources that impact health outcomes.

NOTE: Optum does not recommend or endorse any treatment or medications, specific or otherwise. The information provided is for educational purposes only and is not meant to provide medical advice or otherwise replace professional advice. Consult with your clinician, physician or mental health care provider for specific health care needs, treatment or medications. Certain treatments may not be included in your insurance benefits. Check your health plan regarding your coverage of services.

Eating Disorders from page 23

our full understanding of body dissatisfaction. There are clinical differences in females body dissatisfaction in comparison to body dissatisfaction in males. The female beauty ideal focuses on weight and being slim. The male homosexual ideal is not only about being lean but also muscular (Yelland, et. al., 2003). There is empirical evidence revealing that body dissatisfaction is related to having a higher Body Mass Index (BMI) more peer pressure and lower masculinity scores (Hospers, et. al, 2005). Siconolfi (2009) argues that there is a harsh competition within the gay community with very rigid standards of male beauty. Researchers have coined the term "buff agenda" among gay men being the fantasy that muscularity will grant social and sexual desirability and power (Halkititis, 2001). This framework further describes the cultural zeitgeist of muscle as compensatory for experiences of disempowerment and minority stress.

Assessment and Treatment

Current research on gay males with eating disorders reveals that assessment tools utilize language geared to females which has fostered misconceptions about the nature of male eating disorders. We now know that males with Anorexia Nervosa usually exhibit low levels of testosterone and Vitamin D and therefore have a high risk of osteopenia and osteoporosis. Testosterone supplementation is often recommended (Sabel, 2014). In addition, having an all male therapeutic environment is strongly recommended. Males in treatment can feel out of place when primarily surrounded by females within the therapeutic milieu. Treatment planning ideally should focus on decreasing compensatory behaviors such as vomiting and excessive exercise to control their body weight. We also know that men are more likely than women to binge eat rather than restrict food intake (Jackson, et. al.,2002).

Conclusion

In conclusion we are embarking on a critical journey that will sharpen our understanding of treating significant illnesses more effectively. The quality of our patient care will be greatly enhanced by completing a thorough diagnostic assessment process and complete evaluation. We have the potential to facilitate the treatment process by simple clinical identification of eating disorder symptomatology and the opportunity for early intervention. A comprehensive approach to providing excellent care to the gay community (Isacco, et. al.,2012) should be multi-faceted and include medical stabilization, addressing health challenges, strength building, skills training, follow up care and maintenance. Clinical rigor and further longitudinal research will provide mental health professionals with better assessment tools and individually tailored treatment strategies that foster physical health and psychological resiliency.

For further information you may reach Dr. Rachel Bush by email at drrachelwbush@gmail.com.

Parenting from page 21

Services have been adjusted to these needs, and having a support group that specializes in providing support to the parents of Trans* youth is the best way to provide the support they need. Parents of Trans* youth experience a mourning period and similar to enduring the loss of a close family member, parents will go through stages of grieving. When working with parents, they've shared their feelings and explained that their child's transition is comparable to a "living death." It is difficult to wrap their heads around their child's disclosure, and they tend to go through a period of denial. Most of the parents I work with are in this stage of grief. Having a support group with parents that have experienced their child's transition is helpful to new parents joining the support group, and parents are able to share their lived experiences with parents that are just beginning the transition.

Along with the TransParentcy group, I recommend that families of Trans* youth go for family counseling. It is important for the entire family to express any concerns that they have with the child's transition and process these issues. A child's transition can have a significant impact on the entire family, including both younger and older siblings. Family counseling and the TransParentcy group combined offer an opportunity for all the family members to reconcile their differences, and move forward to support their Trans* child's healthy transition.

At Center Lane, it has been our mission for 20 years to promote a community culture that is supportive of the healthy development of LGBTQ youth. We have made tremendous progress as a community in fulfilling this mission. Yet, both local and national data and our everyday experiences demonstrate there is more work ahead for WJCS' Center Lane.

Santo Barbagiovanni is a New York state licensed social worker and the director of WJCS Center Lane program, the only youth-serving LGBTQ program in Westchester County, New York.

Survey from page 24

This was compared to 11.7% for clients in the PCS aged 18 to 29 and 2.8% for clients aged 65 and older.

According to the Gallup Data, 4.0% identified as Hispanic LGBT and 3.2% identified as non-Hispanic LGBTQ. This was compared to approximately 6.5% of LGBO (and 0.8% transgender) PCS clients reported as Hispanics. The PCS found 6.5% of LGBO (and 0.7% transgender) PCS clients reported as non-Hispanic.

Distribution by region in the Gallup survey displayed positive percentages for LGBTO estimates across regions. 9.5% of clients who identified as multi-racial identified as LGBTQ (and 1.3% as transgender) in the PCS. Excluded were 4,456 clients who identified transgender identity as "unknown," and 13,033 who identified as "unknown" in sexual orientation.

7.1% of outpatient programs reported clients as LGBTO; the highest of all the other program categories in the PCS.

Results produced by the OMH Office of Performance Measurement and Evaluation. (http://www.omh.ny.gov/omhweb/resources/newsltr/2016/june-2016.pdf)

Governor from page 24

psychotic symptoms. OnTrackNY helps young adults with newly emerged psychotic disorders achieve their goals for school, work, and social relationships. This program follows principles of care which include shared decision making, youth friendly and welcoming environments, and connection with flexible and accessible mental health services.

OnTrackNY is funded by the New York State Office of Mental Health and the United States Substance Abuse and Mental Health Services Administration.

For more information about the OnTrackNY program, visit http://ontrackny.org/. To find a program near you, visit http://ontrackny.org/Contact.

Sandy from page 25

was a disastrous event, the whole experience has shown just how resilient people can be. We appreciate the support of everyone involved, but especially the Island Park community. In particular, we would like to thank Mayor McGinty, Father Tutone and our many neighbors, who have been cooperative and understanding throughout. In the end, we were given an opportunity to rebuild a house that is larger, safer and provides a congenial, home-like setting, with private bedrooms and landscaped outdoor spaces, in a thriving community."

At the Island Park Residence, which is a New York State Office of Mental Health licensed community residence, individuals receive behavioral health services in addition to life skills training to help them thrive in the community. These services, provided on-site, encourage independence and recovery. The building features 11 bedrooms and related living facilities, including common rooms and kitchen-dining areas.

Established in June 2013, the Governor's Office of Storm Recovery coordinates statewide recovery efforts for Superstorm Sandy, Hurricane Irene, and Tropical Storm Lee. Through its NY Rising Housing Recovery, Small Business, Community Reconstruction and Infrastructure programs, GOSR invests more than $4 billion made available through HUD's Community Development Block Grant – Disaster Recovery (CDBG-DR) Program to better prepare New York for future extreme weather events. More information about GOSR and its programs is available online at http://stormrecovery.ny.gov/.

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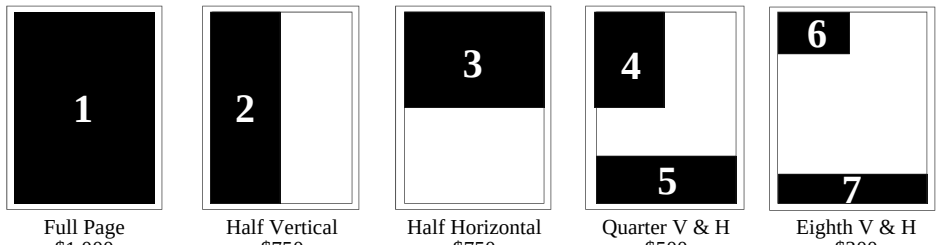

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