BEHAVIORAL HEALTH NORMATION, EDUCATION, ADVOCACY AND RESOURCES

FALL 2017 ISSUEFROM THE LOCAL, STATE, AND NATIONAL NEWS SCENEVOL. 5 NO. 1

The Vital Role of Housing in the Recovery Process

A Healthy Place to Rest Your Head

By Andrew Bloch, LCSW, Marcie Katz, LCSW, and Fabricio Loza NewYork-Presbyterian Westchester Division, Second Chance Program

he Second Chance Program at NewYork-Presbyterian Westchester Division is an in-patient psychiatric rehabilitation program for men and women with difficult to treat psychotic disorder illnesses. Most of the individuals referred to the Second Chance Program (SCP) have struggled with being able to remain in the community. In addition, they have often had numerous hospital admissions to acute units that have failed to break the cycle of repeated hospitalizations or to provide the necessary structure, safety and support needed to help these individuals increase community tenure and begin to thrive outside of the hospital setting. The goal of the SCP is to teach the adaptive skills needed to live safely in a community setting, reducing the need for hospitalization and improving the ability to thrive.



Andrew Bloch, LCSW, Marcie Katz, LCSW, and Fabricio Loza

In a general inpatient behavioral health hospital setting the focus is on crisis stabilization, and the treatment teams on the acute units are more limited in their scope of interventions. They will usually discharge patients back to where they were residing prior to admission. For those with difficult to treat psychotic disorder illnesses, these may have been inadequate to provide the needed additional structure and support. A housing application is completed by the social worker and handed off to Assertive Community Treatment teams or care coordinators to follow-up on once the individual is back in the community. While a reasonable plan, our experience tells us that such a plan is fraught with numerous pitfalls for this population that make the successful transition to more supportive and stable housing unlikely. These include skills deficits such as how to manage residual symptoms, impaired problem solving skills that can lead to impulsive decision-making and a return to maladaptive coping strategies that have failed to work in the past.

More than half of the patients referred to Second Chance Program (SCP) are either street homeless, residing in shelters or transitional living residences, or patients who would benefit from a higher level of supportive housing than they currently have. The focus of the program's treatment is rehabilitative, with up to 90-120 days for

see A Healthy Place on page 6

Leaders Honored at MHNE Annual Awards Reception

By Ira Minot Executive Director Mental Health News Education

n June 29th, Mental Health News Education, Inc., (MHNE) publishers of Autism Spectrum News and Behavioral Health News held its first combined Leadership Awards Reception at the NYU Kimmel Center overlooking Washington Square Park.

Receiving honors at the sold-out event were four outstanding leaders from the autism and behavioral health communities, including: Donna Colonna, Chief Executive Officer of Services for the Under-Served (S:US), Gary Lind, Executive Director of AHRC New York City, Arlene González-Sánchez, Commissioner of the New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS), and Dr. Fred Volkmar, Professor of the Yale University Child Study Center.



David Minot, Debra Pantin, Arlene González-Sánchez, Dr. Fred Volkmar, Gary Lind, Donna Colonna, Constance Brown-Bellamy and Ira Minot

The event was attended by many executives, program directors, consumers, corporate partners, and state and local state agencies from both communities, who enjoyed a lively networking opportunity before the summer vacation season. MHNE Board Chair Constance Brown-Bellamy moderated the program which included a Media Award presented to MHNE Associate Director, David Minot, on the 10th anniversary of his publishing Autism Spectrum News. Co-chairing the event were MHNE Board Co-Chair, Debra Pantin and board member Dr. Robert Ring.

Dr. Alan Siskind, Founding Chairman of MHNE stated, "This combined behavioral health and autism leadership awards annual event marks a new future for MHNE, one of unity, education and friendship."

Our event Sponsors are listed on page 20. To view our event photos, please go to: www.bit.ly/2spQYiH.

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Table of Contents

- $1\,\mathrm{A}$ Healthy Place to Rest Your Head
- 1 Leaders Honored at MHNE Annual Awards Reception
- 4 ICL Housing: Like a Nice Piece of CAKE
- 6 Why Are We Still Criminalizing Mental Illness?
- **8** A Good Place To Live Is Critical for Older Adults
- 10 WellLife Network: Offering Vital Residential Services
- 12 NYSPA: Recovery and the Federal Fair Housing Act
- 10 NYSPA Report: Repeal and Replace Should Not Harm
- **14** Supportive Housing: Challenges and Opportunities
- 16 People of Color in Leadership Roles
- 18 Crisis Respite: An Effective Intervention of Recovery
- 19 Mental Illness and Homeless Baby-Boomers
- 20 Consumer Perspectives: Supported Housing is Key
- 21 More Than a Roof
- 22 MHNE Leadership Award Reception: Thank You Sponsors
- 23 Homeless Older Adults: Tools for Aging in Place
- 23 Mobile Teams: A Catalyst for Success
- 24 The Housing Prescription
- 24 Let's Strengthen Sober Housing Resources
- 25 The Step-Up Intervention Program
- **25** For Those on the Threshold of Adulthood
- **26** Housing as Healthcare
- 27 Housing and Support Services Create Greater Stability
- 28 Charlotte Ostman New MHA Westchester CEO
- 28 Recovery Begins with Housing
- **29** The Current State of OMH Housing
- **31** Improving Health: Better Targeting of Supportive Housing

Editorial Calendar

Behavioral Health News Theme and Deadline Calendar

Fall (2) 2017 Issue: "*Addressing the Opioid Epidemic*" Deadline: October 1, 2017

Winter 2018 Issue: "Understanding and Treating Co-occurring Disorders" Deadline: January 8, 2018

> Spring 2018 Issue: "Harm Reduction: Theory and Practice" Deadline: April 1, 2018

Summer 2018 Issue: "A Special Issue: Now in Development" Deadline: July 1, 2018

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ICL Housing: Like a Nice Piece of CAKE

By: Jose Cotto, LMSW: Camille Davis, LMSW: David Kamnitzer, LCSW: and Eleanor Lalor, LMSW ICL

s the story goes, at ICL we've been saying for quite a while, that Housing is much more than just a bed, some clean sheets and case management services. At ICL we believe that Housing is far more complex and that at the very core of all of our Housing is hope and relationship building. Today, these elements of recovery are not only a keen principle that we stand by, but an essential philosophical approach to care that ultimately leads to healing. We sort of view our Housing programs like a nice piece of CAKE with many layers and the essential ingredients being: (1) Collaboration; (2) Accountability; (3) Kindness; and (4) Excellence.

Collaboration

Housing is about forming partnerships and communicating regularly with friends and natural supports, treatment providers, community resources and family. It's about working closely with care coordinators and recovery coaches. Housing is about creating a safe space for the individuals we serve. While these individuals are the drivers of their treatment it is the Housing staff that often plays the role of the gatekeeper. We collaborate with the court system and advocate for social justice and prison diversion. We work with CIRT teams and mobile crisis to avoid unnecessary hospitalizations. We work with psychiatrists and primary care doctors to help individuals mange symptoms and control A1C levels. Collaboration requires a firm commitment that there are no silos in housing and that there are multiple individuals committed to recovery. To collaborate means that there must be a philosophical approach that views individuals from a holistic standpoint. As a provider, you must be willing to see beyond the front door of the residence in an effort to help your resident step out. Parallel to this process is another key component of collaboration that involves all staff communicating with each other. Whether it's thru, shift meeting or clinical rounds, supervision or case conferences, to be successful as a housing provider you must make room for all participants at the table. Housing staff do not work in vacuums. They are visiting PROS programs, calling clinicians and escorting individuals as they begin their job searches. They are the glue that keeps all staff together and true collaboration is invaluable.

Accountability

A competent team of employees is paramount to having a successful program and accountability in housing starts with clear expectations.. Each employee



Seated: David Kamnitzer Standing from left: Eleanor Lalor, Camille Lowe-Davis, Jose Cotto

must understand that what they do each day is important towards recovery. Our housing leadership works to foster an environment where staff are empowered to make decisions on their own, and not be afraid to make mistakes. Leaders appreciate when employees makes decisions, and don't wait for them to give them the solutions. Holding staff accountable leads to quality care as staff take pride in their work and the relationships they form with our tenants. True accountability in housing means that our leaders must establish clear objectives that can be measured and sustained. Our staff must truly believe that there are many paths to recovery and that the individuals we serve are complex. Staff must own their struggles and take responsibility for their personal and professional growth by using supervision. Our staff must buy into the responsibility they have as mentors and change agents and must work collaboratively and in a person centered, trauma informed manner.

Kindness

Perhaps one would say that kindness plays the most important role in the healing process. What people often remember most about what helped in their recovery is how they were treated by others. Each day we strive to fulfill our mission in providing high quality comprehensive services to our tenants. This is exhibited through caring, compassion and kindness which starts at the front door. We place our clients first by providing them with a holding environment and we always view our folks through a Trauma Informed lens. We take pride in creating rich environments that promote diversity and acceptance and where each individual is able to be themselves. Our residences are seen as homes where people can display their authentic selves and where there is a culture of compassion and nurturance. An act of kindness makes one happy, can lift one's spirit and promote safety and facilitate trust.

Excellence

Providing excellence in Housing consists of implementing the best care that's available. It entails investing in the training of your staff in areas that are known to be effective in our field. We are usually referring to evidence based practice, and models that cater to the individual needs of people in our programs. Of course, as is the case with most effective therapists in clinics and private practice, the art is for our housing staff to incorporate different components from multiple perspectives; to utilize what's practical and most importantly, what the person receiving services desires.

At ICL, we rely heavily on Person Centered Planning and we practice from a Strengths Based Approach. We partner with people who need a hand creating their road to recovery. We treat the person with utmost respect and steer clear of pathologizing and labeling them. Our interactions and medical documentation begin with the identification of their strengths. If a person desires to become the next U.S. President, we respect their goal and explore the next steps to achieve it.

We also create a blend of Motivational Interviewing, Cognitive Behavioral Therapy, Harm Reduction, Narrative Therapy and the list goes on. For instance, we may use motivational interviewing to help a person identify a life goal and help create ambivalence about their substance use by showing how their current actions may be delaying their goal attainment. If they agree, we can begin working on reducing harm in realistic ways and come up with action steps they can commit to. When they begin to recognize any progress made, they can begin to create a new narrative, altering their lens for a future that may not have seemed possible before.

Excellence is not just accredited by degrees, licensures, trainings and certifications. Excellence in services must also include lived experiences and finding creative ways to pull that into practice. One of the popular means of achieving this has been through the hiring of peer specialists who often have a direct connection to our line of work. As youth, we're sometimes taught to forget the trauma or difficult times we've conquered once we become adults. However, it's those experiences that helps us maintain humility and authentically engage with those in need, expediting the beginning stage and helping the person towards their recovery.

At ICL, we commit to excellence in our housing by providing an array of trainings including clinical rounds for staff as well as different events for people in our programs. This includes an annual trip to Albany where, together, we advocate for excellence across the board. Our agency holds different reviews to explore how our care can be further enhanced; committees such as our Internal Review Committee where we review incidents, Sentinel Reviews and Clinical Risk Consultation Team meetings help to accomplish this.

So now the disclaimer, like your Mother's homemade chicken Soup, Aunt Bertha's collard greens, or Uncle Joes meatloaf, there are many different wonderful recipes. Likewise, while we sincerely believe in collaboration, accountability kindness and excellence as core ingredients to ICL housing there are indeed other models. Try out what works for you but always be sure to keep your tenants front and center and empower your staff to contribute their own special touch....

Jose Cotto, LMSW, is Vice President, Residential Rehabilitation and Support Services; Camille Davis, LMSW, is Vice President, Residential Rehabilitation and Support Services; David Kamnitzer, LCSW, is Senior Vice President, Residential Rehabilitation and Support Services; and Eleanor Lalor, LMSW, Vice President, Residential Rehabilitation and Support Services, at ICL.

If you need more information about ICL Housing contact Sarah Abramson, LMSW, AVP of Central Access at 718-855 -4035x16002 or visit our Website at ICLINC.org

PAGE 5

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

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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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Housing People with Serious Mental Illness in Jails and Prisons: Why Are We Still Criminalizing Mental Illness?

By Erin M Falconer, PhD Associate Director, Medical Affairs ODH

ack of appropriate access to mental health care for the seriously mentally ill in the U.S. is a critical issue. Such lack of access can lead to significant, adverse living outcomes for individuals living with mental illness, including homelessness and incarceration. It is a disturbing fact that the criminal justice system is increasingly "housing" people with serious mental illness in the U.S. (Torrey, E. F., Kennard, A. D., Eslinger, D., et al. 2010. More mentally ill persons are in jails and prisons than hospitals: a survey of the states. Arlington/Alexandria, VA: National Sheriffs Association and Treatment Advocacy Center). As an example, in 2015 it was estimated that as many as 4,000 mentally ill inmates were housed in the Los Angeles county jails on any given day (https://www.nytimes.com/2015/08/06/ us/los-angeles-agrees-to-overhaul-its-jailsystem.html). In the 1800s, the US criminal justice system did not distinguish between mental illness and criminal intent, and therefore the most severely mentally ill were housed in prisons. It is startling and discouraging that, in 2017, we are still criminalizing mental illness.

In the late 1800s, Dorothea Dix raised public awareness about the plight of the mentally ill in jails and prisons, and, as a result of this work, the US Congress created mental asylums. For a century, these hospitals were responsible for housing the population with serious mental illness; the understanding was that mentally ill individuals did not belong in prisons and jails, and instead should be appropriately treated and cared for. However, financial pressures, the presence of abuses of the mentally ill in these institutions, and therapeutic optimism led to deinstitutionalization and the increasing closure of residential mental hospitals. In 1963 John F. Kennedy signed the Mental Health Act, which shifted funding from state residential hospitals towards community-based treatment. This enabled more people with mental illness to return to live within the community. Around this time, there was also research released that critiqued the state hospital system and the validity of psychiatric diagnoses (Rosenhan, David L. "On Being Sane in Insane Places", 1973. Science). Further, the introduction of Medicaid and Medicare shifted funding from institutions such as state hospitals. While overall these changes produced an improvement in the housing situation for many patients and their families by pro-



Erin M Falconer, PhD

viding community-based alternatives to state hospitals, an inadvertent consequence of the belief that "desintitutionalization" itself would be curative was that those people with more severe mental illness have been left without an appropriate housing or treatment option. The proportion of people with the most severely impaired mental illness are increasingly lost from the community - many become housed in prisons (Frank, Richard G. and Glied, Sherry A. 2006, "Better But Not Well: Mental Health Policy in the United States since 1950"). Increasing homelessness and incarceration of the mentally ill has largely reversed the gains won by Dorothea Dix; the result is that we are incarcerating and treating as criminals those individuals in most need of mental health treatment. Mental illness recovery requires access to stable supported housing conditions, adequate mental and physical healthcare, and a decent quality of life.

Unfortunately, structural characteristics of the current system are making it progressively more likely that those with mental illness will stay in prison longer, and be placed within an environment which can worsen their mental health symptoms. For example, if an individual with serious mental illness fights with a prison guard, they are likely to be moved to solitary confinement, and punished with an extended sentence in prison (Treatment Advocacy Center, "The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey", April 8, 2014). Living in the community, disturbing behavior may lead to eviction from stable housing environments, and the combination of poverty and limited access to housing means that those with mental illness are more vulnerable to criminal and abusive environments.

Simulation modeling work has provided a way of visualizing and modeling the housing situation for individuals with serious mental illness in the U.S. (Johnson K, Alevras D, Falconer E, Docherty JP. "An Agent-Based Explanation for 20th Century Living Situation Changes in America's Severely and Persistently Mentally Ill Population," AnyLogic 2014). We demonstrated, using an agent-based simulation model, why the population with the worst symptoms are more likely to pool within jails and prisons. The model accounts for the fact that in certain housing situations such as jails, prisons, and longterm hospitals, patients are kept longer when they have mental health relapses,

while other living situations, such as shelters, assisted living, community hospitals, or private or subsidized residences, will tend to evict those who demonstrate disturbing behaviors associated with mental health relapses. This means that the healthier proportion of the population will be able to live in relative stability within the community, while those with more severe illness will end up pooling within jails and hospitals. With the closure of hospitals, this means more and more people will remain in the prison system. As such, the current U.S. system is set up in such a way as to increasingly "burden" the criminal justice system with those with severe mental health issues. Governments, however, can lower such prison rates and the resultant cost burden by taking actions to improve mental health

see Criminalizing on page 32

Is criminalizing mental illness the real crime?

The answer is complicated. ODH can help.



A Healthy Place from page 1

our patients to learn and practice skills that will improve overall functioning. This sense of accomplishment and growth instills pride and a hope that they are finallyon the road to recovery with a chance to stay out of the hospital and achieve their personal goals for the future. A big part of the recovery process includes working to match a housing option that meets the needs of the individual to support the gains made while in the hospital.

While at SCP, patients and staff work together to practice community living skills including basic safe cooking skills, budgeting, shopping, medication management, and social skills. The recovery process can be a fragile one, but we find that with each passing day, week and month, our patients develop a more solid foundation in order to succeed with the life goals they are hoping to accomplish. These include developing meaningful relationships, returning to school, or thinking about working in a desired field. The support and structure provided by stable housing is a cornerstone to making this all possible. We would like to illustrate this by sharing the story of one of our former Second Chance patients, SG, and the role housing played to help him thrive in the community.

SG arrived to the Second Chance Program a reclusive yet willing participant. He was a 38 year old male referred due to his history of non-compliance with treatment and continued hospitalizations. His

PAGE 7

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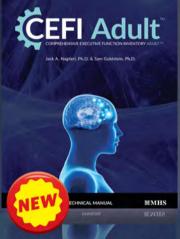
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A Good Place To Live Is Critical for Older Adults With Psychiatric Disabilities: Needed Public Policy Changes

By Michael B. Friedman, MSW: Lisa Furst, MSW, MPH: Kimberly A. Williams, MSW: Paul S. Nestadt, MD: and Lina M. Rodriguez, MSW

ot so many years ago a diagnosis of schizophrenia was a life sentence, shortened only by the low life expectancy of people with serious and persistent mental illness. Thanks to the recovery movement, we now understand that a diagnosis of schizophrenia or other serious psychotic disorder does not doom people to terrible lives. The quality of individuals' lives can be better or worse, and which it is depends to a considerable extent not only on the treatment and care that they get, but largely on the conditions in which they live. Safe, stable, and appropriate housing is critical to their quality of life.

Providing decent housing is, however, an extremely complex matter because older adults with severe, long-term psychiatric disabilities live in many different settings. Some live independently. Some live with caregiving family or friends. Some get formal residential care in senior housing, supportive housing, community residences, assisted living, adult homes, nursing homes, or homeless shelters. Some are literally homeless and live "on



the streets." And some are incarcerated in jails or prisons. A few remain in state hospitals for many years.

Independent Living

People with serious, long-term mental disorders encounter several difficulties living independently. First, it is a struggle to pay the rent when cost of living adjustments to public assistance do not keep pace with rising housing costs. Those with housing subsidies, such as Section 8, that cover rents that are over 30-40% of income are protected from this, but relatively few people have such subsidies. Second, people can lose their housing if they have extended hospitalizations or incarceration in jail or prison. Third, in-home services such as home healthcare and psychiatric services that may be necessary to be able to remain at home are often not available. Fourth, and very importantly, living independently can result in social isolation that contributes to—or is a consequence of—increasing levels of depression.

Living With Family

People with serious, long-term mental disorders who live with caregiving family and friends also may encounter difficulties remaining at home. Caregivers typically experience great stress resulting in high rates of physical and mental disorders and increased placement of disabled family members in residential care. In addition, as caregivers age, they are more likely to become disabled themselves or to die, leaving the person who needs help to remain in the community without needed care. Unfortunately, Adult Protective Services, which are supposed to step in when adults cannot live safely in the community, are of notoriously uneven quality and are hampered by a lack of appropriate alternatives.

Living in Supportive Settings

Older adults with serious, long-term mental disorders who live in settings that

see Older Adults on page 30



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WellLife Network:Offering a Continuum of Residential Services Vital to the Recovery Process

By Crystal John, Director Behavioral Health Residential Services WellLife Network

ore than 800 people live with dignity and as independently as possible in WellLife Network's behavioral health housing settings throughout New York City and Long Island.

Each day, our homes integrate care into the community and celebrate residents' cultures and traditions. Using a personcentered approach, WellLife Network's housing and residential programs cover a broad array of alternatives – from 24-hour staff supervised residences for those with the greatest needs, to apartment living with ongoing supports for those able to live more independently in the community.

For more than 30 years, WellLife Network's model of care has effectively focused on assisting residents to develop key life skills, become integrated within the neighborhoods where they live, receive necessary medical and mental health care, and connect with education and employment programs to become more self-reliant.

WellLife Network is a New York-based health and human services agency whose mission is to empower individuals and families with diverse needs to realize their full potential, guided by principles of independence, health, wellness, safety and recovery.



Crystal John

As one of the largest regional providers of supportive housing, WellLife Network currently operates over 800 residential housing beds, including 3 supervised residences (70 beds), a 44-bed CR-SRO in Far Rockaway, 168 Apartment Treatment Program beds at scattered sites in Queens and Brooklyn, and over 560 Supportive Housing beds throughout metropolitan New York.

WellLife Network has geared much of its residential program towards a variety of priority populations, including those with co-occurring disorders, forensic histories, reunified families, young adults and homeless, as well as those transitioning from State and private psychiatric centers.

Offering a Cadre of Support Services

Since its inception, supportive housing has provided tenants assistance with job placement, family reunification, appointment management, (safe and affordable) housing accommodations and any other related housing assistance supportive of general health. Residential case managers facilitate service planning across a broad spectrum of identified needs, with special attention to ensuring that each component of the service plan enhances tenant independence and quality of life. Case managers are supported by peer specialists who provide key assistance in helping clients address basic activities of daily living.

WellLife Network currently operates two supported SROs, which include supportive units targeted for individuals who were formerly homeless and are now recovering from mental illnesses, and a percentage of affordable and low-income individuals and families. Our SRO apartments are safe, high-quality, attractive, and are designed to enhance tenant selfesteem and the surrounding neighborhood. Units range from studio, one and two bedroom apartments. They include full kitchenettes, private bathrooms, spacious living rooms, communal computer, exercise, and laundry room, and landscaped outdoor gardens. Our tenants are valued for their positive contribution and impact on the local business economy.

A Story of Hope Overcoming Adversity

Rafael R. is a truly amazing individual, whose life story reflects a lifelong struggle with mental illness, substance abuse, and incarceration.

Rafael's parents were addicted to drug. His father, passed away when he was 20 years old from HIV. His mother was an alcoholic and diagnosed with bi-polar disorder. He began experimenting with drugs at an early age and was besieged by the ravages of drug addiction. He lost his job and housing simultaneously and lived in his car until it was repossessed on a cold winter night. He eventually was forced to enter the shelter system, an alternative frought with danger and conflict.

One day Rafael received news of an apartment vacancy that would be his own. Rafael rejoiced, "God heard my cries and my prayers – WellLife Network was giving me an apartment which I now call home". Despite the difficulties of his earlier life, he exhibits a determination and a commitment to overcome the past and create a new future. "I thank God for my blessings and to WellLife Network for giving me a new start," said Rafael.

For more information, call WellLIfe Network's Residential Intake: (917)563-3348.

A Healthy Place from page 6

pattern over the past several years was walking away from his transitional living residence (TLR), resulting in missed treatment appointments and rapid decompensations. Negative symptoms, paranoid thoughts, and a quiet disposition made him a difficult person to deeply know at first. The treatment team focused energy on building a rapport, eventually leading to a more trusting relationship. He was eventually referred back to his TLR after completing the social learning program and demonstrating an improvement in his negative symptoms, attending groups, and taking medications. The treatment team felt that by addressing some core functional skills and providing community reintegration activities as part of the program, he would have an increased chance of success upon discharge. Given that he had a housing provider already in place, had demonstrated improvement in his functional skills, and was seemingly willing to return to the residence, new housing was not sought out. Immediately after his first discharge from the unit, however, he fell into old patterns and did not even spend the first night at his residence, resulting in a rapid re-hospitalization. It became clear that housing placement would be the linchpin clinical intervention to make a real difference in SG's life.

Upon his second admission to Second Chance, SG began going on trips with staff into the community, both individually and as part of a group to help immerse him into life outside of the hospital and to assess where he struggled. He accompanied staff on housing interviews scheduled for other patients to further strengthen the working relationship and to see how he would respond to various environments. SG was most functional in small, quiet settings where he would not easily slip into the shadows. In focusing efforts primarily on finding the most suitable housing placement, the team was addressing the core clinical issue behind his poor community tenure.

Because securing the most appropriate housing placement was the goal, additional factors related to placement were also addressed. A trip to the Social Security Administration resulted in him being awarded a large sum of money in back disability checks as he had not received his Social Security benefits in quite some time due to his elopement history. Finally, the treatment team helped him obtain a Social Security card, copy of his birth certificate, a state identification card and a bank account where his benefits could be directly deposited so he would not be out of funds in the future.

At this point in his treatment, his symptoms had remitted and functioning had improved enough to secure an appropriate housing placement through a specific Community Residence/Single Room Occupancy (CR/SRO) program, Concern for Independent Living. This agency could meet his needs in that it provided a feeling of safety - his own studio apartment that was much quieter than the TLR he had previously stayed in. A final personalization of care came on the day of his discharge when staff helped SG select a new wardrobe, electronics and furnishings for his new home. SG settled in well and has been living at the CR/SRO since. He has been adherent to his medication regimen and has consistently attended treatment. He has not had one hospitalization since his discharge from the Second Chance Program over two years ago.

As evidenced by SG's case, the benefits of suitable housing to the patient's assessed needs and strengths are vast. Implementing a housing plan such as his, however, presents challenges on several levels, including the heterogeneity of the patients at the residence, the expectations of providers, and the larger systems involved.

Due to the complexity of mental illnesses, each person being placed in the supportive housing network has an individual set of symptoms and clinical needs. Often a patient's disorganization, lack of insight into their illness, struggle to accept their need for medications or delusional content can impact his or her ability to interview for housing. Patients may walk into an interview convinced they do not have a psychiatric diagnosis and have no need for psychotropic medication. Learning how to assist patients in accepting help without fully challenging their world view is a method that allows patients to partner with their clinical team. Focusing on functioning - instead of symptoms and stigmatizing labels - brings a level of compassion to this task that is ultimately in the patient's best interest. In SG's case, his poor ability to appropriately communicate his reasons for leaving residences

was a large factor in his repeated hospitalizations. Encouraging patients such as SG to engage in the process helps clinicians understand how to meet their patients' needs by finding appropriate placement. Working with an individual's clinical picture is one of several factors imperative to the process.

Housing providers themselves add a level of difficulty in this endeavor. They expect patients to be able to speak to their illness, diagnosis, and sometimes checkered histories. In addition, they will also ask for patient to have various forms of identification, which patients might not have readily available. They understandably want to know who they are taking responsibility for and where they came from. SG would barely speak when he first arrived to the Second Chance Program, let alone have a full discussion about his illness, symptoms and history of elopements from residences. For this reason, preparing housing providers for the interviews is as important as preparing the patients. When sending housing applications, calling ahead of scheduled interviews to discuss an individual's clinical picture, bolstering the paperwork by contextualizing a patient's history and highlighting the reasons specific placements have been selected can prepare providers for an otherwise unproductive interview. Finding appropriate matches for housing and allowing for transitional visits can also prove effective in increasing the comfort level of both providers and

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The NYSPA Report: Recovery and the Federal Fair Housing Act

By Jeffrey Borenstein, MD, Vice President, The New York State Psychiatric Association (NYSPA): Seth Stein, Esq., Executive Director of (NYSPA) and Partner at Morritt Hock & Hamroff, LLP: and Robert Schonfeld, Esq, Counsel, Morritt Hock & Hamroff, LLP

his issue of Behavioral Health News focuses on "the vital role of housing in the recovery process." We know that stable housing is important to individuals seeking treatment and that recovery is possible when a person's basic need for safety and housing are met. Having somewhere safe and warm to live (both literally and figuratively) is fundamental to our mental health and wellbeing. The following article was written by Seth Stein, Esq., the Executive Director of the New York State Psychiatric Association, and his colleague Robert Schonfeld, Esq.

The Federal Fair Housing Act ("FHA") can be used to obtain housing for persons with a mental disability or recovering from alcoholism and/or substance abuse. It can be applied against landlords and condominium and coop boards who refuse to allow such persons to reside in housing or impose special or unnecessary rules or restrictions on such persons. Likewise, it can be applied against zoning rules or building codes that exclude such persons. A person is covered under the FHA if that person has "a physical or mental impairment which substantially limits one or more of such person's major life activities, a record of having such an impairment, or being regarded as having such an impair-ment." (42 USC 3602 (h).) The statute does not cover persons who are currently using an illegal controlled substance or are addicted to an illegal controlled substance or anyone who was convicted of the illegal manufacture or distribution of a controlled substance. (42 USC 3602 (h), 3607(b)(4).) The statute also does not apply to persons "whose tenancy would constitute a direct threat to the health or safety of other individuals or whose tenancy would result in substantial physical damage to the property of others." (42 USC 3604(f)(9).)

With regard to landlords and condominium and cooperative boards, the FHA prohibits those entities from refusing to lease or approve applications on the grounds of a mental disability or recovery from alcoholism and/or substance abuse. (42 USC 3604(f)(1), (2).) The FHA also prohibits those entities from imposing special requirements on persons covered by the FHA, such as any requirement that persons covered by the FHA must disclose their medical records when other prospective renters or purchasers are not required to make the same disclosure. (42 USC 3604(f)(2), Cason v. Rochester Housing Authority, 748 F.Supp. 1002 (W.D.N.Y. 1990.) The FHA also requires landlords and condominium and cooperative boards to make reasonable accommodations in their rules to allow a person with a mental disability or recovering from alcoholism and/or substance abuse to use the housing. (42 USC 3604(f)(3)



Jeffrey Borenstein, MD

(B.) For example, if a person with a mental disability needs a pet because of a mental disability and the building at issue has a "no pet" rule, the landlord or board must allow that person to have a pet where it would be reasonable to do in spite of the "no pet" rule. (Bronk v. Ineichen, 54 F.3d 425 (7th Cir. 1995); Crossroad Apartments v. Leboo, 578 NYS2d 1004 (City Ct. 1991).

With regard to zoning authorities and building inspectors, those persons may not exclude persons with mental disabilities or recovering from alcoholism and/or substance abuse from residential neighborhoods or place unnecessary and burdensome requirements on such hous-ing. (42 USC 3604(f)(1),(2). Laws excluding such persons from residential neighborhoods, laws limiting the number of unrelated persons with disabilities who could live together, laws placing spacing limitations between residences for persons with disabilities, "neighborhood notification" laws and laws requiring special registrations and inspections of housing for such persons have been invalidated by the courts under the FHA. (Human Resource Research v. County of Suffolk, 687 F.Supp.2d 237 (E.D.N.Y. 2010). Indeed, we won a case annulling a local Suffolk County law that would have limited the number of people recovering from alcoholism and substance abuse from living together, placing spacing requirements on such residences from each other as well as a neighborhood notification requirement, and imposing unnecessary registration and inspection requirements on those residences. (Id.)

Laws that are, on their face, discriminatory against persons covered by the FHA as well as actions taken with discriminatory motives violate the FHA. (MHANY Management v. County of Nassau, 819 F.3d 581(2d Cir. 2016); Human Resource Research, supra.) While entities who discriminate often do not express discriminatory views against persons with disabilities, those entities can be found to have acted in an intentionally discriminatory manner if, by their actions, they treat persons with disabilities differently from non-disabled persons. (MHANY Manage-



Seth Stein, Esq.

ment, supra.) Even if such entities have no discriminatory animus against persons with disabilities, if they react in response to people who do have such animus, they could also be held to be in violation of the FHA. (Id.)

As stated above, housing entities and municipalities must make a reasonable accommodation in their rules and laws to allow housing for people with disabilities. (42 USC 3604(f)(3)(B).) Also, if a housing entity or a municipality has a rule or policy that negatively impacts on people with disabilities more than non-disabled persons, that rule or policy may also be violative of the FHA. (Oxford House, Inc.



Robert Schonfeld, Esq.

v. Town of Babylon, 819 F. Supp. 1179 (E.D.N.Y. 1993).) For example, we won a lawsuit that barred a town from prohibiting a home on the ground that the residents (people recovering from alcoholism and/or substance abuse) were transients in a zoning district that prohibited transient residency. (Id.) We were able to show that a law prohibiting transient residency had a greater impact on people with disabilities because of their disabilities, and that keeping these people out of the neighborhood served no legitimate governmental purpose. (Id.)

see Fair Housing Act on page 30



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Supportive Housing Development: Achievements, Challenges and Opportunities

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

overnment-funded supportive housing in New York State has a richly textured history that entails an amalgam of competing philosophies, political trends and economic imperatives. A complete survey of this history is beyond the scope of this article, and a comprehensive assessment of the "current state" of supportive housing cannot be rendered with concision. So how might one *briefly* characterize its current state? In the words of a good economist, "It depends."

There are surely reasons to be hopeful about the current trajectory of supportive housing inasmuch as the New York State Office of Mental Health (OMH), the state agency charged with the financing, development and regulatory oversight of most housing units for adults with behavioral health conditions, has committed considerable resources to housing development in recent decades. Between 1983 and 2011 the supply of OMH-funded housing stock increased from 4,953 units to 33,615 units (New York State Office of Mental Health, 2013). This sixfold increase reveals a statewide commitment to provide community-based residential opportunities for vulnerable individuals, many of whom had histories of institutionalization in state-operated psychiatric centers and would remain at risk of continued institutionalization or similarly adverse outcomes in the absence of supportive housing. In addition, a vast array of other municipal agencies has promoted the development and operation of supportive housing. These include the Office of Alcoholism and Substance Abuse Services (OASAS), Office for People with Developmental Disabilities (OPWDD), Office of Temporary and Disability Assistance (OTDA) and Department of Housing and Urban Development (HUD), to name a few.

This movement toward communitybased alternatives for vulnerable individuals was surely borne of noble intent and a progressive orientation, at least in part. It is also a byproduct of a longstanding economic imperative to reduce the capacity of costly state-operated psychiatric facilities. In fact, during the past three decades we have witnessed an inverse correlation between the overall stock of supportive housing and the census of state-operated psychiatric centers. The census of stateoperated facilities decreased from 20,650 in 1983 to 3,069 in 2011 (New York State Office of Mental Health, 2013). Other factors have lent impetus to the movement toward community-based residential accommodations, not least of which was a landmark ruling of the U.S. Supreme Court in Olmstead v. L.C. that codified the rights of individuals with disabilities to reside in the least restrictive settings practicable (Olmstead v. L.C., 1999). New York State has applied an expansive interpretation of this ruling via an Olmstead Development and Implementation Cabinet that



Ashley Brody, MPA, CPRP

aims to reduce institutionalization in all its forms (Report and Recommendations of the Olmstead Cabinet, 2013). This has led to targeted supportive housing investments for specific subpopulations, including residents of adult homes and skilled nursing facilities and inmates of state and local correctional facilities. These investments assume the provision of supportive housing to vulnerable and previously institutionalized individuals will enable them to achieve greater autonomy and lasting community tenure, and there is considerable data to support this proposition (Culhane, et al., 2002; Gulcur, et al., 2003; NYC Department of Health and Mental Hygiene, 2013; Perlman & Parvensky, 2006.) In addition, the recovery movement has gained political currency in recent years, and key stakeholders now recognize the significance of this movement and its central tenets. Antiquated, provider-centric modes of service delivery have been largely (albeit not entirely) replaced by person-centered practices that accommodate recipients' expressed needs and preferences. Within the realm of supportive housing these principles manifest as integrated, individualized residential accommodations with flexible support services. The foregoing trends, when viewed in the aggregate, suggest our state has adopted an exceedingly progressive orientation to community-based alternatives for vulnerable individuals that maximizes their opportunities to receive appropriate, individualized housing accommodations. But this is merely part of a larger and considerably more complex story.

Emerging data on social determinants of health suggest the conditions in which we live, work, learn and grow are more determinative of our health status than the quality or quantity of healthcare services available to us (Chaiyachati, et al., 2016). Quite simply, our zip code might be more important to our overall health and wellbeing than our genetic code. Decent, safe and appropriately supportive housing is arguably the most significant social determinant of health inasmuch as our success

in other realms is contingent on residential stability. Prima facie evidence of this proposition will emerge through any encounter with a homeless individual who receives treatment for a serious health condition. Chronic conditions such as diabetes, cardiovascular disease or schizophrenia cannot be effectively managed without protection from the elements, adequate storage for food and medicine or the myriad other benefits that accrue to the domiciled. Nevertheless, the United States spends considerably less than other developed nations on essential social services (including housing supports), although it spends considerably more than its peers on healthcare (Butler, et al., 2017). This imbalance has worsened in recent years as state investments in social services have stagnated relative to inflation while expenditures on Medicaid (the primary public payer for healthcare services for disabled and economically disadvantaged individuals) have substantially increased (Gais, et al., 2009). This trend belies our nation's collective misunderstanding of the role of healthcare (as it is traditionally defined) in the health equation. Sadly, New York is not insulated from national trends as evidenced by its overreliance on Medicaid to address the needs of its vulnerable citizens. Until recently, our state had the highest Medicaid expenditures of any in the nation and this largesse

produced mediocre health outcomes at best. Moreover, federal regulations prohibit the use of Medicaid funds for housing, so our seemingly robust investment in healthcare did little to advance the most significant social determinant of health. It is therefore not surprising that our state's sizeable investment in Medicaid yielded a paltry return on investment.

Policy makers and other key stakeholders have awakened to these realities and enacted certain reforms that are now coming to fruition. In 2011 a Medicaid Redesign Team (MRT) was appointed to overhaul a dysfunctional program and it produced numerous recommendations in its report to the Governor's Office (New York State Department of Health, 2011). Significantly, the MRT included a Supportive Housing Workgroup that recommended targeted investments in supportive housing for exceptionally vulnerable individuals (i.e., those with chronic and comorbid health conditions who rely heavily on inpatient hospital and emergency department services). This workgroup presumed the provision of supportive housing to these individuals would effectively achieve the "Triple Aim" of healthcare reform, if only for a select subpopulation. In other words, it would reduce the cost of care, improve the

see Development on page 35



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Vulnerable Populations: People of Color in Leadership Roles

By Mary Pender Greene, LCSW President MPG Consulting

hile we all know that much stress comes with leadership, authority and responsibility, People of Color (POC) in leadership roles must also deal with the unique stressor of structural racism. Viewing Barack Obama's experience as President clearly indicates that even highly educated, successful POC at the top of their profession do not, and cannot, escape the ravages of structural racism and microagressions.

Psychologist Derald Wing Sue defines microaggressions as "brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership." We know that it is difficult to gauge the intent of the person who does a microaggression. They may either deny it was a microaggression or say that it was simply misunderstood. People tend to deny biases that are more implicit, so the recipient then has to justify his or her position.

Senior leadership roles held by POC are still a novelty in many of our institutions, which leads to their heightened visibility and vulnerability. Though all leaders are vulnerable to criticisms and subsequent attacks, it is exacerbated for POC. Since POC are underrepresented in leadership, they become much more visible and receive more scrutiny. This intense inspection can add pressure to assimilate into the majority culture. Internalizing criticism not only enhances this vulnerability, but also discourages them from bringing their individuality and uniqueness to the role.

Constant scrutiny can lead to self-doubt which can compel people of color in leadership roles to be more accommodating accepting the status quo rather than following their instincts and offering a more authentic and diverse point of view. This results in our organizations being denied all the benefits of fresh perspectives and change that is so desperately needed to meet the needs of a primarily diverse client population. The challenges proposed by increased visibility and vulnerability drains energy, and often causes executives of Color to lose touch with other colleagues who can empathize and act as a sounding board. The first step is to become aware of the impact of this increased vulnerability that stems from increased visibility on leaders of color.

Prior to my training and exposure to aspects of organizational life (ie; the role of organizational dynamics, roles, posturing for power and authority) at the William Alanson White Institute, I had no awareness of organizational life despite my extensive clinical training and practical experience. Because of this lack of awareness, and lack of knowledge about organizational theory, I spent years taking organizational issues personally. I learned, and truly internalized at The White Institute, that an individual in a group or organization is no longer just an individual. In other words, it's not about me - which makes dealing with criticism much easier. We, as people of color who



regularly experience criticism due to racial stereotyping, need to develop a more measured response. Also, alternative explanations for criticism for our actions should be thoroughly examined from an organizational lens, while keeping our integrity and self-esteem intact. At the same time, we must be mindful that learning to distinguish between racially motivated and substantive criticisms requires time, sophistication and intense awareness of one's strengths and challenges.

Additionally, leaders, managers and supervisors must be taught to recognize that contemporary forms of racism exist and become familiar with the various forms that it takes within the institution. A part of adequately assessing talent in an organization and improving effectiveness requires thinking about power, splitting, boundaries, authority, roles and tasks through a race lens in order to avoid the impact of stereotyping and scapegoating within the organization. It is also necessary for all leaders both White and POC to understand organizational life in order to build strong partnerships which will ultimately lead to a greater numbers and success of leaders of color.

As White leaders, managers, supervisors or colleague, there are a few things that you can do to make a difference: (a) Identify and name racism directly – when you see something say something, even when a POC is not present. Be mindful remaining silent, "neutral" or "objective" can be a form of race privilege and it leaves the POC feeling alone and abandoned by you. (b) Take responsibility for self-education and don't expect POC to teach you. (c) Cultivate genuine relationships with POC that are mutually beneficial. (d) Struggle every day to understand and undo aspects of your own privilege. (e) Accept that POC's experience of racism is not debatable. (f) Don't require POC to display proof of racist injury. (g) See racism as a problem because it is personally offensive. (h) Consistently interrupt racist statements or behaviors whether or not a POC is present or objects. (Adapted from Antiracist Alliance: Checklist of Characteristics of Active Anti-racist Ally Behavior)

Leadership Today: In the U.S., white supremacy is "a pervasive social, political and economic phenomenon." Not only is

it an ideology based on racial prejudice, but it is also a system that includes cultural messages, policies, practices, beliefs and actions (Disrupting White Supremacy from Within, 2004). As a result, white men have historically carried out leadership in organizations. Cultural overlays are at the core; these institutional structures have created and sustained the dominant way of being. According to SPAN Anti-Racist Education (2005), there may be tokenized hiring, repetitive injury and denial of racism. They may ignore, blame and retaliate. These internal practices harm people of color. But pushing for accountability means pushing against "the system."

We know from organizational literature that many human services organizations are struggling to survive. There is a desperate need for leadership that is transformative, collaborative, relationship oriented, empathetic and visionary. Our organizations also need to become more adaptive and responsive to the changing environment by becoming more, inclusive, pliable and reliant on teams, all of which requires building authentic relationships.

People of color comprise more than half of the clients being serviced by our organizations. Who better to articulate the depth, intensity and perspective of diverse groups than a leader from that group who has lived the experience? This is not to say other leaders cannot provide credible leadership. However, knowledge based on lived experience in a given culture creates the potential for bringing a unique perspective to leadership. Their presence adds another level of credibility to the organization and has great value to the community, the staff and the clients.

Despite the obvious need and research confirming the value that difference and inclusion can make to our organizations, why is it so difficult for People of Color to lead? One factor is our mental models for leadership.

A charismatic, heroic white male model is indelibly etched in our collective mindset. There is still little acceptance for a model of leadership using all the talents in an organization and valuing all perspectives. While we all understand that change – whether individual, family or organizational – involves letting go of the familiar. And we all resist change.

Social service organizations have claimed the reason leadership talent is sought outside of the profession is because it cannot be found within. Translation: qualified and desirable candidates can only be found by increasing the pool to candidates from outside of the profession, or more specifically, white men with traditional skill sets from the business and legal worlds. Leaders are thought to be competitive, dominant, confident, aggressive, take-charge individuals – qualities more likely to be attributed to white men.

Although both female and male leaders of color face great challenges in leadership roles, men tend to fare better. While men may suffer from racial stereotyping (where people might report being afraid of them), they still receive the benefit of male privilege. Catalyst, the leading research and advisory organization, found that while white women frequently reference the glass ceiling as obstructing their advancement, women of color characterize their barriers as the "concrete ceiling." The study found that the darker the woman's skin, the more dense the concrete ceiling. Authority and credibility were also constantly questioned. This double outsider status results in exclusion from informal networks.

Catalyst likens the professional journey of people of color to a labyrinth, with very persistent and intractable negative racebased stereotypes. Webster dictionary defines a labyrinth as, "an intricate, confusing combination of paths in which it is difficult to find one's way; a complicated or tortuous arrangement". Additionally, with credibility and authority constantly in dispute, people of color in leadership positions have to continually prove themselves.

Since women often require more external validation than men, this problem is further exacerbated by the combination of gender and race. In order for women to be accepted in some leadership roles, they often need external endorsements - especially in highly competitive environments. Simply having adequate leadership training or task-related expertise does not guarantee success unless accompanied by a legitimation by an established leadership source. Sadly even today, because gender stereotypes often hinder the ability to see female executives' competence, it is often necessary for a highly regarded male to vouch for their credibility

We, as women and POC leaders in a White male dominated environment, may be hesitant in advocating for gender or racial equality out of the fear it may compromise our own personal success. This heightens the competition between us because we are all vying for the same few spots. It causes a negative impact on our connection to other women and POC in the lower levels of our organization and lessens our potential for developing a strong support base. When there are fewer leaders of color at the top, the message sent to younger POC is that only a minor percentage of opportunity in the organization is available to them. This ultimately leads to fewer people of color in the pipeline for leadership. Another opportunity is then missed to add diversity to our leadership - not instead of, but in addition to, white leaders.



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Mary Pender Greene, LCSW-R, CGP is a psychotherapist, career & executive coach, trainer and consultant with 20+ years of experience in Health and Human Services and a private practice in NYC. Her background includes executive management roles at America's largest non-profit organization, The Jewish Board of Family Services in NYC.

She is President & CEO of MPG Consulting and the author of *Creative Mentorship and Career-Building Strategies: How to Build Your Virtual Personal Board of Directors.* She is also the Co-Editor of *Strategies for Deconstructing Racism in the Health and Human Services.*





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Crisis Respite: <u>An Effective Intervention in the Contin</u>uum of Recovery

By Kearyann Austin, MS, LMHC, Program Coordinator, Garden House Respite, and Amy Winarsky, LCSW-R, Senior Director for Residential Programs ACMH

hink about your work with a client with a psychiatric diagnosis in emotional crisis. Did your client get what they needed at an emergency room? Or, after hours of waiting, were they told they were well enough to deal with it at home, perhaps by themselves? A peer-run Crisis Respite stay is an alternative to emergency room visits and hospitalization or a step-down from hospitalization back into the community. Shortterm Crisis Respite is getting increased attention from providers and insurers as a proven and cost-effective intervention.

ACMH's Garden House Crisis Respite, an Enriched Crisis and Transitional Housing pilot funded by NYSOMH as a Medicaid Redesign Team (MRT) initiative, serves three guests, typically for a seven-day stay. Co-located with OMH licensed units for singles in an apartment building located in Manhattan's East Village, Crisis Respite is staffed 24/7 by Peer Counselors with lived experience as consumers of mental health services who are certified by the Academy of Peer Service (APS) and supervised by a licensed mental health counselor. Certified Peer Counselors must meet continuing education requirements on a yearly basis in order to maintain their certification. AW, a Respite guest, noted, "What was most helpful during my stay was speaking to other peers about my depression and finding support groups with the community."

Staff members work closely with guests and their treatment team to establish goals for their stay and for their return to their community setting. Peer Counselors follow up with guests after they leave to reinforce the skills they learned during their stay. AW, a Respite guest, further comments, "I did the Wellness Recovery Action Plan which was extremely helpful. I also did worksheets on assertiveness and learned how to put myself first." The work of learning and practicing coping skills is at the core of the Respite model.

In operation since April 1, 2015, ACMH's Garden House Respite has demonstrated that peer services in conjunction with mental health treatment, prevents escalation of a problem into a full-blown crisis. So far, 83 guests out of a total of 191 served through June 20, 2017 (43%) reported that they would have gone to the emergency



Kearyann Austin, MS, LMHC and Amy Winarsky, LCSW-R

room if Respite was not available. Sixteen guests came to Respite directly following psychiatric hospitalization, as an interim step before returning home, using their Respite stay as a time to sharpen coping strategies and learn new ones. Respite guest SA went on to note, "If Respite wasn't available, I would have turned to drugs and alcohol. This place is better than a hospital, jail, or any institution."

During their stay at Garden House Respite guests develop a Wellness and Recovery Action Plan (WRAP) that tailors services and supports to their individual needs. The WRAP is designed to support protocols that guests have established, or establish during their stay, with their treatment team. According to SB, one of the six Crisis Respite Peer Counselors, "The beautiful part is seeing someone that may have come in crying without a vision of wellness leaving Respite uplifted, and not only visualizing their wellness, but planning for their next steps."

Over the course of their stay, guests identify impediments to recovery and develop specific plans to address them. Some types of services delivered since April 1, 2015 through June 20, 2017 for 191 guests: Daily Living Skills 1,091 contacts; Symptom Management 1,002, Socialization 810, Supportive Counseling 735, Community Integration and Resource Development 253, Self-Advocacy Training 199, Stress Reduction 196, Skills Development 112, Health 104, Conflict Resolution 90, Mental Illness Education 87, Job Assistance 78, Medication Management 54, Substance Abuse Treatment Referral 25.

At the beginning and at the end of their stay guests complete several assessments including, most recently, the Patient Health Questionnaire (PHQ-9) to monitor depression and level of safety risk. Since mid-April 2017 to June 20, 2017, of the thirty guests during that period, 56% had a decrease in risk level from admission to discharge. The average guest decreased the risk by 4 points, and 100% moved from Severe Risk to a lower level when assessed at check-out. A Comprehensive Assessment and a Goals sheet are also completed at check-in to establish the work for the stay. SA, the Respite guest, said "I was able to talk with all staff on my issues at hand. I was able to learn coping skills from Respite staff. Thank God!!!

Out of 191 guests served from April 1, 2015 through June 20, 2017, only three

guests required emergency medical attention, and one needed emergency psychiatric services. All three guests requiring emergency medical care returned to Respite by the following day.

During their Respite stay, guests are encouraged to avail themselves of community supports which they may previously considered but not used. Guests are given information on club houses, LGBTQ networks, smoking cessation and harm reduction services, housing resources, self-esteem and self-care enhancements like free haircuts and low cost gym memberships, among other options. Guests who acknowledged during their stay that substance use is a problem they would like to address have been linked to treatment programs.

see Crisis Respite on page 30



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A Healthy Place from page 10

patients. SG's move-in day is a prime example of such work. Helping him furnish his room turned his housing placement into a home. All of this takes a significant amount of care, coordination, and understanding of both the patients and providers. It also requires clinicians to bear in mind that the housing providers do not work in a vacuum. There are larger systems at play, which also must be navigated carefully. Anyone working to house patients in the New York metropolitan area is governed by larger agencies at the city, county and state levels. These bodies are designed to ensure fair treatment of patients but also add a layer of effort required to appropriate place patients. Before a patient can move in to one of the scarce available beds, SSI benefits must be in place and Medicaid needs to be active (or at least pending). Agencies such as the New York City Human Resources Administration or Westchester County's Department of Community and Mental Health will prioritize some patients over others based on histories of documented homelessness or clinical need. The shortage of available beds at various levels of care further speaks to the insufficient resources for this most vital of services. In working with SG it became clear he was one of the many who had fallen through the cracks in the system. Hospitals were forced to discharge him before understanding the motivating forces behind his repeated hospitalizations. The Social Security office had not known of his whereabouts for years. Without being able to look at the full picture, SG would have been doomed to continue his cycle of institutionalization. As SG's case highlights, a clinician's thorough understanding of the systems within which they interact

see A Healthy Place on page 30

Mental Illness and Homeless Baby-Boomers: What Can Be Done?

By Carroll Timothy Longshore, MD, FABNP, Senior Psychiatrist, Metro Community Health Centers, and Medical Director of NYSTART, Brooklyn & Staten Island

reater longevity combined with the aging of the baby-boom generation is rapidly increasing the 50-and-over age group in the United States. The greatest surge will be seen among the population aged 65 and over, which is expected to increase by 65% by 2030 ("Demographics of an aging America" Harvard University). This aging trend is also changing demographics within the homeless population. For example, in 2003, one third of homeless adults were aged 50 and over. However, by 2015, this percentage increased to 50% and is continuing to grow (Brown, Thomas, Cutler & Hinderlie, 2014). Furthermore, according to a study that looked at aging patterns within the homeless population of New York City baby-boomers born between 1954 and 1964 were at higher risk of homelessness than any other age cohort (Culhane, Metraux, Byrne, Stino & Bainbridge, 2004). Research shows that veteran status, substance use, and mental illness increase the risk of homelessness (National Alliance to End Homelessness). Baby boomers comprise the largest segment of the veteran population, and research indicates that by 2030, the number of people aged 65 and older with a mental illness, including substance abuse disorders, will equal or exceed the number with mental illness in younger age groups (Choi, Di-Nitto, & Marti, 2015 & Aging Veterans in the United States).

As the number of older adults experiencing homelessness continues to increase, addressing the unique care and housing needs of this population becomes increasingly important. In addition to problems typically associated with homelessness such as mental health and substance abuse, older adults also experience higher rates of chronic illness and geriatric comorbidities such as dementia, Parkinson's disease and functional disability ("Ending homelessness among older adults and elders through permanent housing"). The age of onset of physical health conditions is also lower within the homeless population requiring chronic care management services at an earlier age than typically seen in the general population (Brown, et. al., 2014). Managing chronic disease entities and geriatric predispositions within shelter environments is challenging. Adapting the physical environment to accommodate limitations is not easily accomplished, and following medication regimes and adhering to medical advice is difficult due to the transient nature of the population ("Ending homelessness among older adults and elders through permanent housing"). Typical recovery and therapy counseling also may not address age-appropriate issues for the older and elderly population including grief counseling, medication management,



Carroll Timothy Longshore, MD

health promotion, and other specific geriatric issues that can create unique challenges to managing recovery (Torres, 2014).

The Corporation of Supportive Housing (CSH), a group dedicated to finding housing solutions for the most vulnerable members of the community, and Hearth, Inc., a Boston-based non-profit dedicated to ending homelessness among older and elder adults through housing, outreach and advocacy jointly compiled a policy paper with recommendations on developing successful permanent housing for homeless older adults. Given the multiple, and clinically complex medical and psychiatric conditions often experienced by older homeless individuals, the policy paper recommends permanent supportive affordable and accessible housing linked to a comprehensive support system (Ending homelessness among older adults and elders through permanent housing"). This is a biopsychosocial approach to addressing homelessness through an integrated system of accessible housing with easy access to coordinated medical, mental health, substance abuse treatment, and social services. The goal is to create an environment where this population can age in place with easy access to ageappropriate supports and services.

In addition to developing housing and service solutions for the actively homeless population of older adults, given the size of the current and future aging population, developing prevention and early intervention strategies to prevent homelessness among at risk older adults is important (Choi et al., 2015). According to the "Homeless Older Adults Strategic Plan" developed by the Shelter Partnership, many formally homeless individuals who participated in the research stated that "discharge from hospital or illness/ medical problems led to their homelessness" ("Ending homelessness among older adults and elders through permanent housing" p.6). A typically less robust support system combined with potential cognitive decline can make compliance with

discharge instructions challenging for older adults (Torres, 2014). Also, given the complex needs of older adults a discharge plan following a hospitalization may require follow-up visits with multiple specialists. Mental health issues can further complicate compliance with follow-up care. According to the CDC, 20% of people age 55 and older are estimated to have some type of mental health condition ("The state of mental health in aging America"). Research suggests that coordinated discharge planning can be a building block for developing a comprehensive community homelessness prevention strategy ("Ending homelessness among older adults and elders through permanent housing"). Creating partnerships with local federally qualified health centers implementing the patientcentered medical home model can be key to a successful transition from hospital to home for this population.

Federally qualified health centers (FQHCs) have long served as a foundation for comprehensive, high quality, cost -effective care for low-income and underserved patient populations. In fact, it is estimated that 93% of FQHC patients are at or below the 200% and 76% are either covered by Medicaid/CHIP or uninsured ("Chronic care management for adults at FQHCs, Washington State University).

Patient-centered medical homes (PCMH) provide holistic and comprehensive care, which includes coordinating the full range of medical, specialty, mental health and social services (Agency for HealthCare Research and Quality). Therefore, FQHC's implementing the PCMH model of care are an ideal option managing the health care of individuals at-risk of homelessness. One-stop access to medical, behavioral and specialty care offered by these health care centers can significantly help increase compliance with discharge instructions for patients with complex conditions. Social service support provided through the PCMH model can also help atrisk older adults navigate the system for housing, and well as other services and eligible benefits. Hopefully this will lead to enhanced mental health care as well as stabilizing and optimizing the treatment of chronic physical illnesses. Older adults with substance abuse issues can be referred for treatment that would be followed by their primary care and behavioral health providers. Given the expected growth in the older population developing prevention and early intervention strategies for older adults at-risk for homelessness is critical. FQHC's implementing the PCMH model can be a vital support in developing this prevention model.



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PAGE 20

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Consumer Perspectives: Supported Housing is Key to Our Recovery

By Cheryl, Sharon, Monique, Christopher, Joseph, Andrea, Selena, and Flora

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

Eight of us, all tenants of various supported housing residences run by Services for the UnderServed, sat together one afternoon to share our thoughts about how supported housing has impacted our recovery, for better or for worse. All of the quotes in this piece represent sentiments expressed directly by one of us.

Each of us has experienced mental health, substance use, trauma, or other challenges, including unstable housing. It was clear from our conversation that, given our different life journeys, recovery means different things to each of us. Still, we came together in defining recovery as the process of sustaining good physical and mental health, attaining our goals, and reaching the milestones we have set for ourselves.

Our individual stories are diverse, but through our discussion we drew some conclusions about the value, as well as the challenges, of supported housing in our recovery.

How Supported Housing Contributes to Our Recovery

• The guidance of supportive, nonjudgmental staff is critical.

"One person who has played a big part in my life is my former case worker. From that day that I began living in supported housing, she was my backbone, my rock [...] I utilized everyone in that office. Everyone, even the receptionist, heard from me [...] I just love the staff. They have helped me, and are still helping me to this day, with so much."

One of the most helpful aspects of supported housing is the staff who work with us. Our case workers often become our biggest support systems, listening and linking us to tools we can use to guide our own lives. When they listen without judgment, we know we can say whatever needs to be said and be honest with our-



selves, and with them. Case workers are crucial to our recovery. Staff help us see opportunities and they help us identify resources, such as job training and educational programs. All of this helps create healthy foundations that lead to increased independence.

• Having our own physical space gives us comfort and strength.

"During my homelessness, I was working full-time and desperately needed therapy. I had to hold a lot together on the outside, and supported housing gave me a private place to cry."

We are often juggling many different stressful aspects of life at one time, so there is something extremely comforting about coming to a place that really is home. As individuals who have struggled to maintain stable housing in the past, the safe physical space provided by supported housing is extremely powerful. Living spaces are very personal, and a home is one of the few places where we can express our vulnerability. This helps relieve stress and gives us much-needed space for rest, reflection, and healing.

• A positive, pleasing atmosphere has a big impact.

"I feel very lucky where I live. I can open my window at night and hear people laughing. The fact that I live somewhere where people actually talk to each other and laugh makes me feel good."

Many of us expressed appreciation for the physical beauty and uplifting atmosphere of our buildings. Some of us live in residences that include urban farming spaces run by SUS. These spaces not only beautify the grounds of the buildings, but provide a therapeutic outlet for us through gardening and farming. Supportive, positive features like this add to our sense of comfort and safety.

The Challenges of Supported Housing

• Staff changes are difficult.

"I don't want to meet another case worker [...] I don't want to start sharing my life again with another person [...] I might not take well to them."

The support of staff in our residences is vital, and building genuine trust with staff helps us make real progress in our recovery and health. When the staff we have grown to trust leave their jobs, it is difficult to adjust. Once an honest, comfortable relationship with a specific staff member has been established, it feels like something vital to our recovery is being taken away when they leave. This can be a real roadblock to healing and recovery and it's frustrating to feel like we have to start all over again with a new case worker.

Staff also have different approaches to interacting with us. For instance, when a staff member tells us, "You have to be at this meeting," in an authoritative way, that can be very off-putting and uncomfortable. But when a staff member treats us with respect and says, "You might want to come to this meeting because there will be some good information for you here," we know our choices and independence are being respected. While we have to learn to adapt, we find that we feel most comfortable and open with those who have lived experiences—our peers who can relate to many of our challenges.

• Shared living spaces and new neighborhoods can be challenging.

"Right now, my apartment is just a bed to me. I want it to be a home."

Having a roommate can be very challenging, especially when it's not a match made in heaven. As tenants, we are unable to control many of the circumstances around us, such as the behavior of our roommates, those in surrounding apartments, and what takes place in the hallways or outside. Unfortunately, these things can impact our sense of safety and comfort in the spaces where we live. The good thing about housing with supports is that we have access to resources that can address challenges like these.

• Things that are out of our control cause anxiety.

Many of us are very aware of the fact that our supported apartments are managed by a nonprofit organization that is dependent on funding to support its services. In the current political climate, we know that social supports are vulnerable and could be hit by funding cuts. This sense that our lives are fundamentally influenced by things outside of our control creates a feeling of unease and instability. Sometimes it feels like the rug could be pulled out from under us at any moment.

While we differ in the specifics of our experiences with supported housing, our discussion revealed that, for the majority of us, supported housing has impacted our lives, and our recovery, in overwhelmingly positive ways. One of us talked about how important it has been to have staff to talk to when family is unavailable or absent in our lives. Another of us, challenged by dissociative identity disorder, expressed the immense peace that comes with the stability of housing with supports and knowing that "no matter who I am, I have some place to be." Another one of us, having experienced severe trauma, stated that the healing space provided by supported housing prevented him from taking his own life.

A safe, secure home is the place we go to reflect, to unwind, and to feel grounded. Home is a foundation for growth and health, and a basic human need. Supported housing provides us with not only a key to a living space, but a key to stability. And stability is a fundamental part of our recovery.

More Than a Roof

By Trish Marsik Chief Operating Officer Services for the UnderServed (S:US)

oday's focus on revenue streams, value based payments and the needs of people who use multiple services creates one of two false paradigms. Either we try to fit the square peg of supported housing into the round hole of clinical interventions, or we reduce housing to merely a roof over one's head. Neither appropriately captures what supported housing is, what it accomplishes or the way we implement it in New York City.

New York City's tens of thousands of units of supported housing are exceptionally diverse: single site and scatter site, living alone or with roommates, single use or mixed used buildings, tens of units or hundreds of units, and the nature and frequency of services spanning the gamut. In all of these instances, the people we serve succeed both because they have a roof, AND because having a roof opens opportunities for receiving individualized services, for engaging in collective activities and for becoming part of a wider community.

True supported housing builds a home, frequently through a messy, complicated process with multiple fits and starts. In order to do it well, continually improve how it's done, and secure funding for it, we desperately need to get clear on how



Trish Marsik

we describe just what it is. Supported housing is, at its most basic—stability and shelter. But those two components do not come close to describing the full picture. The additional services that help people to stay in housing and make it a home are highly individualized and difficult to measure, which is why assigning a value to this "product" is so difficult.

The most attractive (to funders) and easily reimbursed interventions are those

to which we can attach a Medicaid billing code and a clinical outcome. At SUS, we've had difficulty locating the billing code that corresponds to the weekend barbecue – even though after that, one of the building's residents finally started meeting with a case manager to go grocery shopping. The clinical outcome associated with helping set up a study space in an individual's room was very difficult to describe – but there was a big party when this person got her GED.

We are still far from a consensus on what "value" means in housing and are still counting and reporting on those things we try to prevent, like hospitalizations and incarceration, rather than those things we try to promote like employment, independence and recovery. Indeed, A1C levels and fewer emergency room visits do tell us a part of the story, but we need new colors and new paint brushes to truly paint the full picture that depicts the energy, time and resources that go into creating homes and community.

Activities that promote social connection, that give a person a purpose, and aid in recovery are at the base of delivering supported housing. We know the detrimental health effects of social isolation and we implement the kinds of recovery-oriented, peer-supported collective activities that promote health and wellbeing. Yet, we still have few ways to measure them. Adopting one of the fledgling measures for happiness, or community integration is a good start. The isolated measure of medication adherence, for example, disregards the community of the building: staff, the people who live there, the people who visit, the people who do business there and nearby, the activities and shared meals and support; and it also discounts the way our buildings and the people who live and work there impact the greater neighborhood. We know supported housing raises surrounding property values. It's time to measure how our well planned, well integrated buildings increase the health of the surrounding communities.

Engaging the people we serve in collecting these measures will ensure we get it right. They tell us how to define success. They know what to value. And, they know it is about much more than how many "units" are filled. We need to listen more closely, and then hear, understand and incorporate the fact that success has to do with how people feel when they wake up in the morning and go to sleep at night in their own beds in their own homes and what they do in between.

The future of housing services depends on a number of factors: the commitment of government to support capital costs while a roof is not the sole necessity for success, it is a critical component; the ability to provide intense support services, e.g., case management, on-site psychiatry, etc. to manage transitions and complex

see More Than a Roof on page 30

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The Critical Solution for Homeless Older Adults: Tools for Aging in Place

By Susan Dan, LMSW, Deputy Director, Project Renewal; and Kristan McIntosh, LMSW, Senior Consultant Health Management Associates

lder adults over the age of 50 who are homeless are oftentimes an overlooked subpopulation. Nicknamed the "invisible population" by many including the Corporation for Supportive Housing (Healthy Aging in Supportive Housing, 2016), their needs differ from the general population of homeless adults, but the existing delivery system and benefits structure are frequently not set up to meet these needs, resulting in an increased likelihood that these individuals are relegated to institutional settings. However, with the right support, existing supportive housing providers are uniquely positioned to adapt their programs to meet the needs of older homeless individuals, allowing them to age in place within the community and thereby supporting the achievement of the Triple Aim of better care for a lower cost resulting in better overall health.

Unique Needs of Older Homeless Adults

Older adults are more likely to have undiagnosed behavioral health conditions than their younger counterparts. The impact of mental health conditions on older adults can be severe, but some conditions



like depression are often disregarded as frailty or as an inevitable result of life changes, chronic illness, and disability (NIMH, Older Adults and Mental Health, 2016). Older adults also respond differently to treatment regimens than their younger counterparts. For example, risks of maladaptive antipsychotic side effects such as strokes, fractures, kidney injury, and mortality are greatly increased for older adults when compared to their younger counterparts (Olfson, M., King, M., & Schoenbaum, M., Antipsychotic Treatment of Adults in the United States, 2015).

This is compounded by the fact that

homelessness itself can cause premature aging that leads to significantly lower life expectancies than the general population. Homeless adults aged 50+ have rates of chronic illnesses and geriatric conditions similar to or higher than those of housed adults who are 15 to 20 years older, including conditions often thought to be limited to the elderly, such as falls and memory loss (Goldberg, J., Lang, K., & Barrington, V. How to Prevent and End Homelessness Among Older Adults, 2016). Homeless older adults are also more likely to experience difficulty in activities of daily living, like bathing and dressing, at a younger age than the general population. These types of functional impairments occur in 30% of homeless adults in their 50s and early 60s—a prevalence far exceeding that of housed adults who are 20 years older (Goldberg, J., Lang, K., & Barrington, V. How to Prevent and End Homelessness Among Older Adults, 2016).

Delivery System Gaps

Despite this rapid aging process that results in increased functional, physical, and behavioral health impairments, many programs target "seniors" using eligibility criteria that identifies individuals by chronological age rather than by their needs. While 65 - the dominant age of retirement — is the most widely accepted marker of "old age," it is deficient for later life homelessness given the fact that trajectories across the life course, not just chronological age, define the experience of aging (Grenier, A., Barken, R., Sussman, T., Rothwell, D., & Lavoie, J., Literature Review, Aging and Homelessness, 2013). For example, while homeless individuals ages 50-64 years are not technically old enough to qualify for Medicare, their physical and behavioral health, assaulted by poor nutrition and severe living conditions, may resemble that of a 70-year-old (National Coalition for the Homeless, Homelessness Among Elderly Persons, 2009).

see Aging in Place on page 34

Mobile Teams: A Catalyst for Success

By Elizabeth Galati, MA Karen Gorman, LCSWR, CASAC Karen Leggio, LMHC Kimberly Tucker, MA Federation of Organizations

s we closely examine the topic of housing, it is important to stress one of the main catalysts for success in a supportive housing environment: the mobile transition team. Mobile transition teams have



Elizabeth Galati, MA

revolutionized the way in which we deliver care to individuals and are the future of treatment for people who are typically difficult to serve via traditional treatment approaches. In addition, logistically, these teams make care accessible to some of the most vulnerable populations. It is safe to say that without mobile support teams, many individuals transitioning out of institutionalized care would not be able to successfully live independently.

Federation of Organizations has seen first-hand the positive effects of deliver-

ing care to individuals through mobile means and providing customized care and services to address specific needs. The agency operates the only two Residential Transitional Support (RTS) teams in Suffolk County, New York both of which originated with the Office of Mental Health closure of the Residential Care Center in Kings Park, NY (RCCA). They also operate one of the four Mobile Residential Support (MRS) teams in Nassau County. These teams step in and play a critical role when individuals, who may have been living in institutional settings for a number of years, transition into a more independent supported housing environment and are now charged with taking care of themselves, managing their medications, making decisions about their nutrition, cooking meals, buying groceries, navigating public transportation, and deciphering what benefits they are entitled to in addition to many other responsibilities.

One of the most unique and important

see Mobile Teams on page 33







Karen Gorman, LCSWR, CASAC



Karen Leggio, LMHC

The Housing Prescription

By Peter Semczuk DDS, MPH, Senior Vice President and Executive Director, Montefiore Health System's Moses Campus; and Deirdre Sekulic, LCSW, Assistant Director of Social Work, Montefiore Health System

he Housing @ Risk Program, under the leadership of Peter Semczuk, DDS, MPH, Senior Vice President & Executive Director, Moses Campus, Montefiore Health System, began in 2009 and is designed to provide coordinated health and housing support to a vulnerable population in the Bronx. This is a hospital-based, multi-discipline program that identifies people who are unstably housed and uses a range of interventions to support them. This effort is based on the fact that housing is a demonstrable social determinant of health and therefore Montefiore cannot effectively support people's healthcare while they are experiencing housing insecurity. This is particularly challenging for the population with behavioral health needs.

The H@R team is composed of a Social Work Assistant Director, a Program Manager, a Social Worker and a part-time consultant whose goal is to help these patients find stable housing and address their health care needs. Although the team is small, its impact is wide. It provides direct services to patients, and educates



Peter Semczuk DDS, MPH

nurses, physicians, navigators, social workers and others, about housing assessment and interventions. Outside Montefiore, the team works with a variety of community based organizations, including the Bronx Health & Housing Consortium and BronxWorks, to effectively support unstably housed patients. These contacts have been invaluable in adding to the quantity and quality of available interventions, improving overall patient care and outcomes. The H@R program has several key components:



Deirdre Sekulic, LCSW

1. In 2009, an automated alert system was created to identify patients in the Emergency Department (ED) who may be unstably housed. It notifies ED social workers to create an onsite intervention and inform the clinicians if necessary, about how a patient's housing status may affect their care. A similar alert was triggered when these patients are admitted or discharged in order to support interventions at every stage of hospitalization. Priority was given to patients with high health service utilization to address avoidable ED and inpatient services, often due to their housing situation.

2. The Team also accepts direct referrals from social workers and others throughout the hospital and some ambulatory settings. Having a team to refer patients with serious housing and health issues has been helpful to staff who may have time limitations and do not have the skillset to understand and support patients with a variety of housing issues. The H@R team accepts cases that require immediate action (e.g. someone is being evicted soon), involve high utilizers, and/or involve patients with high clinical needs (e.g. without an address one cannot get a transplant). They have created an Intensive Case Management system to support these patients, including representation during eviction proceedings in Housing Court.

3. H@R staff educates social work staff, nurses and others about how to identify and support people who are unstably housed. They contribute to various other hospital committees and bring that expertise to every table.

4. The Team participates in internal and external case conferences.

5. A system called 'Closing the Loop' has been developed with external providers to facilitate follow up community care for

see Housing Prescription on page 38

Let's Strengthen Sober Housing Resources

By Jim Malone, Director THRIVE Recovery Community Outreach Center

magine someone drowning at night in the middle of the ocean. Suddenly a ship appears! Spotlights pinpoint the poor swimmer. A floatation device is tossed into the sea, and words of encouragement float down from the deck of the boat. The swimmer is quickly brought on board and provided with warm food, camaraderie, and helpful information about the dangers of swimming alone. He agrees that tackling the ocean is a foolish notion, and resolves to rebuild a sane life on solid ground.

After several weeks on board the ship, he is returned to his homeland – but the only port available is a rickety old dock jutting out from a coastline jungle filled with dangerous predators. "Good luck!" the crew yells. "We wish we could drop you in a safer space, but this is all that's available. If you can make it through the jungle, there's a wonderful life waiting for you inland!"

And the ship sails away as darkness comes, the ominous sounds of the jungle growing louder.

Terrifying? Yes. And this is precisely how the landscape can look to people leaving treatment and trying to find safe harbor in their home communities. Grateful for the rescue and provision of the wonderful ship that pulled them from the water and set their feet on a journey back to physical and emotional health, they are baffled to discover that the support ends at the most critical moment: just as they are reentering the places where they first fell victim to the illness of addiction.

For many, returning to their previous residence is not an option, so they turn to what are often called "sober homes." Many of these houses, lacking county or state oversight, take advantage of people in their most vulnerable moments, collecting payment from the county for rent and board while providing little or no support. "Several years ago there seemed little means of stopping this predatory behavior," say Dr. Jeffrey Reynolds, President and CEO of Family and Children's Association. "This kind of housing isn't currently regulated. Even when reliable and safe housing is available, the Department of Social Services can't 'steer' people regarding where to live."

It is a frustrating situation not just for those striving to recovery and treatment professionals, but also for parents concerned about their sons and daughters. "Parents know they have to 'cut the cord," says Pam DiLorenzo, the mother of a young man in recovery. "Recovery has to build toward independence and empowerment. But this has to occur in an environment that is safe and supportive." To encourage the growth of such environments, Dr. Reynolds and others like Nora

Milligan, co-founder of Addiction to Recovery Magazine, came together to form Sober Home Oversight Board. the Milligan's involvement was an outgrowth of both her own journey in recovery, and her son's struggles with addiction. "When he came out of his third rehab, the professionals were all telling me, 'Don't let him come home - a sober home is the best next step.' They were giving me the best advice they had, and I wanted to follow it. The problem was there were no good options. The best we could find was a shady house where he was exposed to more unhealthy behavior."

The driving premise of the Sober Home Oversight Board was simple: if there was no way to limit or prevent "unscrupulous" operators from preying on people who needed help, perhaps there was a way to encourage the homes that were actually providing the support needed. This encouragement came in the form of offering more money to those who keep clean, well-managed homes, and were willing to voluntarily submit to having the county closely monitor them.

The cynically-minded might be critical of such an approach, believing that it taps into the same motive – monetary compensation – that drives so many of the poorly run houses. But such thinking overlooks a simple truth: long before such rewards became available there were already sober homes striving to truly support and assist people in recovery, like those operated by Mainstream House and Seafield Resources. And there's even better news. Since 2014, new sober homes have been opening that, while they are not yet able to enjoy these new incentives, are nevertheless striving to meet stringent, selfimposed benchmarks.

One such agency is New Hope Rising, Inc., which operates three sober homes for men and women in Shirley and Mastic Beach, and is currently pursuing a fourth home in the Patchogue or Medford community. Featured recently in an NBC news story about the need for sober living supports, the agency takes its responsibility to its residents very seriously. One of the founders, Danielle Bruschi, says the agency began when she and co-founder Lauren McNamara were working with the homeless population and were troubled by the lack of safe and supportive housing resources for people with substance abuse disorder.

The two women got to work, building a 4-phase program that brings residents through a continuum of increasingly independent levels of accountability. "The same question always comes up when people are seeking sober housing," says Bruschi, "whether they're seeking it for themselves or for a loved one. That question is: How soon can the recovering person venture out alone? Of course, the hoped-for answer is different depending on who is asking." New Hope Rising's

The Step-Up Intervention Program: A Positive Youth Development Approach to Support Youth Experiencing Housing Instability and Homelessness

By Zoila A. Del-Villar, LMHC-Limited Permit, CASAC, Research Scientist McSilver Institute of Poverty Policy and Research

ousing instability and homelessness can be defined by frequent moves, couch-surfing, eviction, living in severely overcrowded housing, and living in housing that is not stable (Cutts, Meyers, Black, Casey, Chilton, Cook, & Rose-Jacobs, 2011). Housing instability and homelessness create significant barriers to academic, social and emotional functioning (Gregory, Wilcox, & Lawson, 2017). Young people experiencing housing instability and homelessness also experience disconnection from school, in the form of interruptions in instruction, excessive absenteeism, chaotic environments, stress, and disruptions in receipt of support from network members including peers, mentors, and teachers (Brennan, Reed, and Sturtevant, 2014).

Schools can function as a healthy, consistent and structured environment for young people experiencing housing instability and homelessness. In conjunction with programs like Housing First, afterschool programs and community-based sponsored services, without preconditions, can further support the lives of young people experiencing the various types of



housing instability. Additionally, schools and their associated services can provide safe spaces that are non-violent, structured and consistent, which is often not the case for these vulnerable youth.

With this in mind, Step-Up, a schoolbased program of the McSilver Institute for Poverty Policy and Research at the New York University Silver School of Social Work, utilizes a positive youth development (PYD) framework to support adolescents by strengthening their sense of competence, self-efficacy, belonging, and empowerment related to participation in positive behaviors, and to reduce the likelihood of engaging in risky behaviors such as drug use, unprotected sex, and truancy (Bowers, Li, Kiely, Brittian, Lerner,& Lerner, 2010. Step-Up offers "one-on-one" mentorship, life skills groups, mental health support, structured opportunities for community service, and leadership development by working with povertyimpacted African American, Latino and LGBTQ school-aged youth in New York City's public school system. Although Step -Up does not specifically target youth experiencing housing instability and homelessness, some families of youth in schools targeted by Step-Up actually experience housing instability and homelessness. The Step-Up program also incorporates youth engagement and mentorship components with high school youth, which is unique because services are offered in a school vs. a shelter setting.

The PYD framework has been an essential feature of prevention programs targeting youth experiencing housing instability and homelessness. This framework is an integral feature of the Step-Up curriculum and moves beyond a deficit model to more of a strengths-based approach, particularly involving youth in the develop of the actual curriculum. In Step-Up, PYD principles are also incorporated to build on youth strengths and resiliency and to provide opportunities for youth to acknowledge and process interpersonal issues through exposure to new experiences. Program activities such Photo-Voice with the Josephine Herrick Project, overnight trips to Camp Ramapo, and community service opportunities with organization such as the Youth Services Opportunity Project allow youth to critically think, question, and analyze the world around them, while honing in on their leadership skills. PYD ultimately meets the needs of youth experiencing

see Step-Up Program on page 32

For Those on the Threshold of Adulthood: No Thresholds Beckon

By Robin Sklarin, MA, MS Director, SafeTY.net Program Staten Island Mental Health Society

upported housing for young adults living with mental/ emotional challenges, including chemical dependency, is a rare commodity in New York and is almost non-existent on Staten Island. Once they leave home or the foster care system, no government funding, no agency contracts, no appropriate supportive housing plans or programs exist for youth over 18 years old to provide a roof over their head as they transition into adulthood. If they are under 21, they are not eligible for city shelters. They face a waiting list of several years for subsidized low-income Section 8 housing.

This a very special population – they fall through the gaps in our system. Although at 18 these youth are considered adults and are eligible for the adult system of services, they are really not adults. They are high risk and usually fragile youth who need support, nurturance and guidance as they enter the world of adults with all its demands and challenges. These young adults are illequipped to manage or live on their own. Many wind up homeless, "couchsurfing," sleeping on the ferry or living in a car. One local agency provides longterm shelter beds for homeless youth many of whom have mental health challenges. Their 16 beds are for young people ages 14 - 21 who have found themselves homeless and are without support from their families. This shelter is excellent, but there are limited beds, youth usually stay no more than 18 months and they age out at 21. If more permanent housing has not been found, they are forced to go to Manhattan where there are shelters that will accept them.

This vulnerable youth population has been abandoned by the system. They are on the fringes of society, forced to seek a temporary "home." When they run out of options, they may live on the street, turn to prostitution, or become victims or perpetrators of crimes.

The Staten Island Mental Health Society's (SIMHS) SafeTY.net (Safe Transition for Youth) program was created to address this and other needs of challenged youth. The program provides a quartet of transitional services in education, employment, housing, and community living to individuals between 16 and 23 who live with behavioral or mental health challenges, such as PTSD, substance abuse, or emotional disorders.

The SafeTY.net program works in collaboration with many agencies and services including District 75 (special education) of the New York City Department of Education, the Coalition for Be-

havioral Health, Workforce ONE, and other business and educational agencies. SIMHS's SafeTY.net is funded by the New York City Department of Health and Mental Hygiene.

The transitional years between 18 and 23 for youth challenged with mental/ emotional disorders are crucial – not only because this is a very vulnerable age, particularly for fragile youth, but also because their government support ends when they "age out" of the system. They are most frequently left on their own without housing options, and even the few who can afford apartments are not treated or regarded as well as their typically-functioning peers who don't have to deal with health care, psychiatrists, and medication issues.

The most difficult transitional life challenge faced by SafeTY.net clients is finding housing. We have a network of contacts in the business sector to provide employment experience; our partnerships with various organizations furnish a diversity of services; our doors into the educational system offer GED preparation, remedial and vocational classes, and help entering and staying in colleges and

see Adulthood on page 38



Housing as Healthcare

By Andrea Kocsis, LCSW, CEO and Kathy Pandekakes, COO Human Development Services of Westchester (HDSW)

he design and operations of supportive housing programs in New York State has been positively impacted in numerous ways by the state's Medicaid Redesign process over the last six years. The state's Medicaid Redesign Team (MRT) recognized early on that housing is a major social determinant of health that can significantly impact the health of vulnerable populations, as well as health care costs and utilization. According to NY State Department of Health data, MRT-funded supportive housing provided to over 11,000 high acuity Medicaid members since 2012, has reduced: inpatient days by 40%; emergency department visits by 26%, and overall Medicaid health expenditures by 15%.

This funding has supported a variety of extremely high-need persons, including those with serious mental illness, substance use disorder, HIV + diagnosis, and other chronic medical conditions; and has taken many forms. It has provided construction capital grants, rental subsidies, case management services, home modifications (ramps, handrails, etc.), crisis/respite and step-down residence capital conversion, and other kinds of supports.

An additional MRT initiative, the Delivery System Reform Incentive Payment (DSRIP) program, promoted community wide collaborations of hospitals, health care providers and other community based organizations, also to further the state's goal of a 25% reduction of avoidable emergency room and hospital admissions over a 5 year period. There are 25 such collaborations across NY State, supporting a variety of healthcare projects, but ALL are required to address and promote the integration of primary care and behavioral health services. There has historically been a woeful lack of communication between the clinicians providing physical health care and those providing behavioral health care, but also between medical clinicians and community based providers of such services as housing and other social determinants of health, including employment, access to food, transportation, etc.

While agencies in NY State that provide housing services have been able to increase housing opportunities through the MRT process, they have also been active participants in the DSRIP projects, and have engaged in actions to integrate the primary care and behavioral health services of their housing tenants. Our agency, Human Development Services of Westchester (HDSW), a housing and Health Home care management provider, has engaged significantly with our two Westchester County DSRIP partners, Montefiore Medical Center and Westchester Medical Center in this integration endeavor.

In recent years, NY State has seen an increase in clients utilizing emergency departments often as a means to quick access to care or to have multiple unmet needs addressed: HDSW tenants also par-



Andrea Kocsis, LCSW

ticipated in increased emergency room visits, which often exacerbated rather than reduced their mental health crises. In 2016, as one step in addressing this rise, and in the interest of improving medical and behavioral health integration by providing in-house medical expertise, HDSW hired a full time Registered Nurse who has over 25 years of community-based and hospital experience serving those impacted by behavioral health issues. She understands both the complex medical needs of our population and the interconnection with behavioral health issues. The RN is responsible for the coordination of the medical and behavioral health needs of clients in all HDSW programs. She has been working closely with each department Director and providing critical consultation services to individual staff members as needed, and insuring that clients are linked to proper medical care. She is a key component in current agency Recovery Services, and in direct client care, and as a resource/partner to peer counselors and social work staff. To date, the RN has had over 2,800 medical and behavioral health education interventions, either through direct individual or group contact services with clients, or education and consultation with staff.

On at least 4 occasions, the RN's direct intervention saved an HDSW client from a life threatening situation by providing encouragement and education, which offered the client the knowledge and support required to attend to health crises or undergo diagnostic procedures.

• During an HDSW family event, the RN was concerned after seeing a young child in our housing program in apparent serious medical distress. After she talked with the parent to share her concerns, the child was brought to the hospital and was found to have a critical medical condition.

• During four initial Health Home care management visits, new clients were found living in dire conditions in their own housing. The RN and care managers worked in tandem to convince the clients to allow their homes to be cleaned of accumulated dirt, feces, bed bugs, roaches and fleas. These individuals were steadfast in their unwillingness to allow anyone into their homes, afraid that their belong-



Kathy Pandekakes

ing would be destroyed or removed. The RN spent critical hours with each person explaining the health-related complications each person might be facing if work did not begin to remediate the situation. After making a commitment to each client that she would assist in the clean-up herself and oversee each task, to insure that their belongings were safe, all of the four clients agreed to the cleaning of their apartments. New furniture, new clothing, and new household supports were required for some clients. All were thankful and said if not for the RN, they would still be living the way they had been for so many months, and in some cases, years.

• The nurse has assisted one supportive housing tenant to follow through in the lengthy preparation needed for a specific medical procedure, including fasting. She stayed with the tenant for 24 hours, to make sure the she adhered to the guidance of her physician. The procedure was completed, important recommendations made, reviewed with the tenant, and implemented, resulting in greatly improved tenant health. The tenant had had four previous failed attempts to complete the procedure.

• The nurse was a significant support to a tenant who required a medical procedure which included an overnight stay in the hospital. In addition to the psycho-education of the importance of completing the procedure, she was able to assist the hospital nurses in supporting the tenant, who was extremely anxious and uncooperative with hospital staff and procedures.

These are just a few examples of how the RN supportive housing team member provides critical support to the health and well-being of our tenants, education and support to our housing care managers, and cost savings to our communities by preventing further deterioration in tenants' health that would require high-cost medical care. PROBLEM: none of the nursing services described above are funded by

see Housing as Healthcare on page 32



Human Development Services of Westchester

Human Development Services of Westchester is a social service organization providing quality psychiatric, rehabilitative, residential and neighborhood stabilization services in Westchester County.

HDSW is dedicated to empowering the individuals and families we serve to achieve well-being. The mission is accomplished through the provision of housing, vocational services, case management, community support, and mental health rehabilitation services.

HDSW - Main Office 930 Mamaroneck Avenue Mamaroneck, NY 10543 (914) 835-8906 HOPE House - Clubhouse 100 Abendroth Avenue Port Chester, NY 10573 (914) 939-2878

Housing and Support Services Create Greater Stability for Adults With Behavioral Health Issues

By Yvette Brissett-Andre, MPA, Executive Director, and Cynthia Isaac-Gueye, LCSW, Director of Mental Health and Health Home Services, Unique People Services (UPS)

s supportive housing continues to be a necessity for individuals across New York City, Unique People Services' (UPS) social workers, clinicians and case managers are working together to create safe havens and essential resources for hundreds in need. Our Bronx-based agency operates nearly 30 supportive housing programs across New York City, serving more than 500 residents, many of whom are formerly homeless and living with serious mental health challenges and HIV/AIDS.

Individuals come to the agency extremely fragile, after living in shelters or on the streets. Many have been cut off from their families and are unable to cope with psychiatric disorders or chemical dependency that have severely impacted their lives. Our transitional and long-term housing is instrumental to the recovery process, giving individuals increased stability and more independence to reach their optimal health as they try to overcome addiction, trauma and other struggles they faced while living on the street.

To align with the city's shift toward community-based settings for mentally challenged individuals, we are helping to decrease the need for institutional care through our Community Residence Single Room Occupancy (CR/SRO) residences, Haven and Hunter Apartments, both located in the Bronx.

Approximately 100 formerly homeless men and women reside at Haven and Hunter, receiving case management, medication monitoring, and nutritional and recreational services, with the goal of decreasing hospitalizations, enhancing community integration and ensuring residents maintain their housing. Referrals are made for medical and psychological care and substance abuse counseling.

The meticulously kept residences are well lit with welcoming environments, designed to eliminate the institutional feel many residents previously experienced. Twenty-four hour manned reception desks provide added safety and security; meals are offered at a nominal cost for individuals who do not cook.

To keep residents on the right path, case managers help them set goals while staying vigilant to observe any behavioral changes that may occur. Repeatedly missing meetings with a case manager or poor



Yvette Brissett-Andre, MPA

spending habits (such as excessive purchases of lottery scratch-off games) is often a sign of a deeper issue.

The anxiety many individuals felt while living in shelters is channeled into positive energy by staff. We have ensured that residents are linked to vocational training and eventually employment. Many have reconnected with loved ones, demonstrating renewed self-confidence, thanks to the greater independence they have achieved.

One such individual, K.A., sought long -term housing so he could be reunited with his son and raise him in a stable environment. With the help of UPS staff, K.A. received job coaching and essential parenting tips, while navigating the New York City school system. He was able to move from his transitional residence into an affordable and permanent twobedroom apartment (at 30% of his benefits). He also obtained part-time employment, which has enabled him to pay his bills on time. In court, UPS case managers advocated for K.A., helping him gain full custody of his son. He remains determined to give his child everything he needs to succeed in life.

For others, the journey toward hope and recovery is not always as smooth. One of our individuals, diagnosed with mental illness and HIV, began abusing drugs, even rummaging through trash to try to score his next hit. UPS case managers consulted with a community health partner whose assessment struck a chord about the vital role supportive housing plays: our individual has food to eat, a



Cynthia Isaac-Gueye, LCSW

place to lay his head, and case managers to talk to. Supportive housing *literally* saves lives. Without it, ramifications can be tragic if individuals do not have a stable place to improve their behavioral health and gain sound peace of mind.

UPS' commitment to population health extends to our support of the #Not62 campaign, a borough-wide call-to-action to improve health outcomes in the Bronx, ranked last among all 62 New York Counties in Robert Wood Johnson's 2016 County Health Ranking Report. We also stand united with Governor Andrew Cuomo's plan to end the AIDS epidemic in New York State by decreasing new HIV infections to 750 per year.

Our supportive housing programs have served more than 1,000 individuals with HIV/AIDS within the past five years. Funded by the New York City Human Resources HIV/AIDS Services Administration (HRA/HASA), the program assists individuals with securing entitlements while referring them to necessary services to foster increased independence and stability. Many residents are linked to medical and psychological care, substance abuse counseling, health home services and job placement services to help them get back on their feet. On-site nurses provide medication monitoring to ensure individuals adhere to their treatment plans, while a Program Advisory Board oversees service delivery. Monthly home visits and ten office visits are conducted by case managers to track residents' progress, and make sure they successfully maintain their housing.

The Scatter Site Program has a growth rate of 100%, with 40 units added every two years. Anyone earning an income is required to cover the cost of rent and utilities; additional support is provided by the program or through public assistance. For individuals ineligible to receive HASA services, UPS provides temporary Scatter Site housing through its HOPWA Program, delivering support services to undocumented New Yorkers living with HIV/AIDS. The program is funded by the Department of Health and Mental Hygiene.

This fall, we will embark upon the next phase of our Continuum of Care – the opening of Lynn's Place, the agency's first affordable housing complex for low income New Yorkers and mentally challenged individuals. The 69-unit, energy efficient residence, located in the Bronx, will play an integral role in Mayor Bill de Blasio's 15-year plan to create 15,000 units of supportive housing, helping to curb homelessness and ease the strain of housing costs. Sixty percent of Bronx residents currently earn below the median household income.

First Lady of New York City Chirlane McCray was among several city officials who attended the December 2015 groundbreaking of Lynn's Place, calling the complex a "launch pad to a better life" for mentally challenged residents who will soon call Lynn's Place home.

As we continue to grow our supportive and affordable housing programs, we have also expanded staffing to facilitate this crucial process. In January, Diane Louard-Michel was hired to oversee acquisition, development and management of UPS' supportive housing projects, after a 20-year career at Corporation for Supportive Housing (CSH), where she executed complex service modeling and large-scale housing finance projects. As UPS' Senior Director of Real Estate and Development, Diane leads community engagement strategies to identify potential impacts and innovative funding scenarios.

Through strong relationship building and community partnerships, our agency looks forward to collaborating with agencies citywide to create pathways of opportunities for New York's lower income working class and many other unique individuals in need. To give someone a key to a physical space where they can be safe and cared for in a home they can afford is truly the epitome of hope for a successful future.

For more information on UPS' programs and services, visit our website at www.uniquepeopleservices.org.

☆☆ Behavioral Health News Upcoming Issues Announcement ☆☆ Our Next "Addressing the Opiod Epidemic" Issue Will Be Our Fall (2) 2017 Issue To Keep It and All Future Issues in Better Sync with the Seasons

Charlotte Ostman New CEO at MHA of Westchester

Staff Writer Behavioral Health News

he Mental Health Association of Westchester (MHA) is pleased to announce the appointment of Charlotte Ostman, MHA's Chief Strategy Officer, to the position of Chief Executive Office effective June 5, 2017. Ostman will take over the role from Dr. Amy Kohn, who will retire in June after leading the mental health agency through a decade of innovation, expansion and collaboration.

"The Board of Directors is delighted that Charlotte will become the next Chief Executive Officer of the organization. We are completely confident that she is the right person to lead MHA," said Board of Directors President Michael Lombardi, who established a Board Search Committee following Dr. Kohn's announcement last summer.

"Over the past two years, I have had the pleasure of working closely with Charlotte as we developed, executed and sustained large-scale business initiatives and change efforts. She has done an outstanding job, and I am confident her keen understanding of the complex behavioral healthcare world and her sharp acumen will continue to set MHA apart as an innovative leader in the community," said Dr. Amy Kohn.



Charlotte Ostman, BA, MSW

Ostman joined MHA in May 2015 in the newly created position of Chief Strategy Officer, a role designed to assist the organization to develop its capacity for responding to evolving environmental pressures and a rapidly changing world of healthcare. In her time at MHA, Ostman has played a key role in developing

see New CEO on page 35



Recovery-oriented services for over 2,300 individuals with serious behavioral health conditions in New York City.

Housing

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Recovery Begins with Housing

By Ralph Fasano, MA, MEd Executive Director Concern for Independent Living

oncern for Independent Living, a leading non-profit provider of supportive housing, held a Ribbon Cutting/Grand Opening Ceremony on June 30, 2017 to celebrate the opening of Concern Bergen, a 90-unit supportive housing development for persons with disabilities and families in need of affordable housing in Brooklyn.

Concern Bergen follows NYS Office of Mental Health's very successful Supportive SRO Model. This model allows for the integration of disabled individuals (often with a history of homelessness) with members of the community. In addition to private apartments, residents are offered person-centered, flexible supportive services that reflect evidence-based practices that promote wellness and recovery. Persons who were formerly homeless or institutionalized are able to live in a community that encourages recovery, dignity and respect.

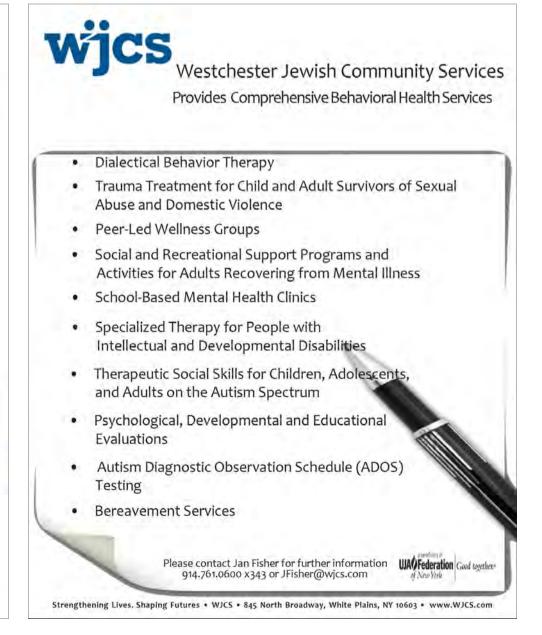
The former warehouse that once occupied the site was demolished in early 2014 to make way for a newly constructed 7-story building. Concern Bergen offers an array of apartment sizes (studio, one-bedroom and two-bedroom apart-



Ralph Fasano, MA, MEd

ments) and amenities, including a computer room, exercise room, laundry facilities, community room, and rooftop garden with panoramic views of the City. Staff work proactively with residents to develop customized service plans aimed at maximizing their independent living skills. Supportive services include selfadvocacy training, community integration, daily living skills training, medication management and training, financial/

see Recovery on page 35



The Current State of OMH Housing

By Toni Lasicki, JD Executive Director Association for Community Living (ACL)

ew York is one of the most expensive states in the country to live in, while the consumers that our nonprofit OMH housing providers serve are among the poorest. This combination requires New York State to step in to help make available enough safe and affordable housing for the most vulnerable among us. Although the OMH funded, contracted and/or regulated housing system today is arguably the most varied and robust in the nation, if not the world, it is facing unprecedented financial challenges. This article will focus on the financial issues faced by housing providers.

The New York State Office of Mental Health (OMH) developed transitional residential programs for people with severe and persistent psychiatric illnesses at a brisk pace in the 80's, and shifted its focus to permanent scattered site supported housing in the 90's. Other models were developed after 2000 to address the emerging needs of all those being served. For the most part, the different housing and support levels matched the needs of the people being admitted. Statewide, New York now has: (1) 4,794 units of Transitional Licensed Treatment Apartments; (2) 5,113 units of Transitional Community Residences; (3) 3,139 units of



Toni Lasicki, JD

Long term transitional Community Residence - Single Unit Occupancy (CR-SRO); (4) 4,882 units of Permanent Support Single Unit Occupancy (SP-SRO); and (5) 18,933 units of Permanent Scattered Site Supported Housing ¹

However, while the state focused on creating new housing, a laudable and necessary endeavor, it neglected the fiscal and programmatic health of the housing and programs that it spent so much manpower, energy, expertise and money developing. The nonprofits that operate

OMH housing are facing more than 25 years of funding erosion with a mandate to admit people with the most compelling need, meaning those with the most serious co-morbid medical, psychiatric and substance use issues. The funding and programming no longer match the needs of the clients being served although the agencies do their best to use as much of their funds for direct care as possible, to reduce costs where they can and to operate with very lean administrations. Some engage in fundraising (although it is this writer's opinion that they should not have to use fundraised dollars to subsidize government contracts) while others double and triple clients in apartments in the community to make the funding work, a practice that is clinically contra-indicated for some people with serious psychiatric illnesses requiring much more diligence and attention on the part of the staff during the admission process and beyond. This practice often results in reduced occupancy rates due to roommate compatibility issues. To highlight the problem in one program, scattered site supported housing, the following shows the per bed per year reimbursement rate by region for each unit as follows: (1) New York City and Long Island: \$16,656; (2) Hudson River: \$9,349-\$16,156 depending on county; (3) Central: \$7,746 - \$8,748 depending on county; and (4) Western:

This rate must cover the rental subsidy, staffing, administration, i.e., ALL costs related to the program. In NYC, the rate does not even cover the rent, let alone all the other costs associated with operating a program. In all areas of the state, the rate is just ludicrously low.

While programming and housing dollars continue to erode, moving administration dollars to programming as a coping strategy is no longer a viable option. These non-profit housing providers must operate and develop housing in a much more complex world with scant administrative resources. Many are functioning with a 9 - 10 percent administrative share because they shift money to staffing to alleviate staff vacancy rates of up to 35% and staff turnover rates of up to 65-75%. They operate in a highly-regulated environment where OMH, their Local Governmental Unit(s), the Office of the Comptroller, the Office of the Medicaid Inspector General and the Justice Center all have oversight authority. These last two are recent additions to the state's array of oversight entities. Some organizations are under audit for months in a given year. Moreover, the newest and only new model of housing being developed - congregate mixed use - is developed with a dizzying combination of funding sources including, but not limited to, HUD, HCR, OMH, HPD, OTDA, NYSERDA, Low



Older Adults from page 8

provide support or care often do not get services that they need.

Community residences and other specialized mental health housing programs are generally designed for younger adults who are physically healthy. Those who have co-occurring disorders often cannot get admitted to these facilities or, if they do, cannot get appropriate medical care. This is particularly true for those who develop dementia.

Those who live in other residential care facilities such as assisted living, sen-



Michael B. Friedman, MSW

ior housing, supportive housing, homeless shelters, and nursing homes generally cannot get appropriate treatment for mental or substance use disorders even when they can get decent physical health care or care for dementia.

Living In Jails Or Prisons:

The number and proportion of older adults in jails and prisons in the United States is rising rapidly and will continue to grow as the elder boom gathers force. Although estimates regarding mental illness among incarcerated older adults vary, the rate is clearly much higher than in the general population. Needless to say, they generally fare very badly.

Whether older adults with severe mental disorders and/or dementia who are not dangerous to others should serve their full

A Healthy Place from page 18

is paramount to best advocate for the patient's needs.

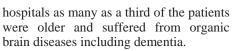
Social workers placing patients in the supportive housing system find themselves at the junction of several impediments to housing placement. It is no easy task, however, when the right fit is found, the results can be life changing.

Fair Housing Act from page 12

A person who is injured by a discriminatory action can either file an action in court (42 USC 3613.) or file a complaint with the United States Department of Housing and Urban Development ("HUD") (42 USC 3610.) HUD will interms in prisons is controversial. Those who believe that the purpose of imprisonment is punishment generally oppose early release. Those who believe that the purpose is rehabilitation and public safety generally support early release.

Older Adults In State Hospitals

As the number of people in state hospitals has dwindled so has the population of older adults. In fact, transferring older adults from state hospitals elsewhere has been a high priority, especially because during the peak years of the use of state



This has been a matter of debate for over 50 years. But recently, it has gathered new force with vociferous and vituperative ideological disputes about whether deinstitutionalization was a major cause of homelessness and the rise of jail and prison populations and whether a vast increase in long-term hospitalization would reduce these problems.

> Public Policy Implications: Residential Problems and Issues



Kimberly A. Williams, MSW

Given the importance of stable housing to quality of life, it seems clear that public policy changes are needed. These include:

• Protection from eviction due to unaffordable rent increases or extended stays out of the home when hospitalized or imprisoned.

• Funding for renovations that are needed to live safely at home.

• Modification of Medicaid and Medicare to fund in-home health and mental health services.

• Protected access to activities that counter social isolation including those in senior centers, social adult day care, medical day care, psychiatric rehabilitation, day treatment, and partial hospitalization.

More Than a Roof from page 21

cases; and the support for stabilizing activities which promote health through community, purpose and leisure time well spent. Perhaps most importantly in these times, our future mostly depends on our ability to define, measure and describe

Crisis Respite from page 18

With round the clock Peer Counselor support serving only three guests at a time in a normalized community residential setting, both staff and guests report that remarkable progress is made on crafting and fine-tuning wellness and recovery plans. And Garden House Crisis Respite has enjoyed remarkably low staff turnover. The staff says they are dedicated to teach• Support for family caregivers including respite, counseling, support groups, and tax relief.

• Development of more residential care alternatives that provide as much freedom and access to the community as possible while still providing appropriate care and treatment for people with co-occurring physical and behavioral disorders.*

• Reduced incarceration in jails and prisons for older adults with severe, long-term behavioral disorders who are not currently



Paul Nestadt, MD

a danger to society.

• Redoubled efforts to end homelessness.

• Resolution of the ideological disputes about deinstitutionalization that have vastly impeded unified advocacy to improve our nation's mental health system.

* The current public policy assumption that it is preferable for people with disabilities to live independently if at all possible needs to be examined in light of the risks of social isolation.

This article is drawn from a work in progress on public policy issues related to schizophrenia and other psychotic conditions in later life.

see Older Adults on page 35

our success in ways that include what it is to live a rich, full, purposeful life AND with all the requisite data our funders need and deserve.

Services for the UnderServed has been serving vulnerable New Yorkers for 40 years. Contact us at www.sus.org or info@sus.org.

ing others what they have learned: how to thrive in recovery. According to Respite guest WM, "I feel like I can think straight because of this program. Thank You!"

To obtain more information about ACMH's Garden House Crisis Respite, or to make a referral or schedule a tour, contact Kearyann Austin, LMHC at kaustin@acmhnyc.org. Or, please visit www.acmhnyc.org and download a referral form.

Andrew Bloch, LCSW, is Program Coordinator; Marcie Katz, LCSW, is Social Work Advanced Clinician; and Fabricio Loza, is Social Work Resource Liaison, in the Second Chance Program at NewYork-Presbyterian Westchester Division in White Plains, New York. For more information on NewYork-Presbyterian's Second Chance Program, please contact Andrew Bloch, MSW, LCSW-R, at (914) 997-5738.

vestigate the complaint, and will pursue a remedy if it finds that there is probable cause for the complaint. (42 USC 3610(g) (2).) It is also noted that New York State also has an anti-discrimination law and a complaint can be filed with the New York State Division of Human Rights as well. (N.Y. Executive Law 296.)

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Lina M. Rodriguez, MSW

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Improving Health: Better Targeting of Supportive Housing

By Kristin Miller, MSW and Pascale Leone, MPP Corporation for Supportive Housing (CSH)

ew York has demonstrated a strong commitment to addressing social determinants of health. At the center of this effort is supportive housing, which combines stable, affordable housing with services to meet the needs of homeless individuals facing multiple complex challenges like serious mental illness, substance use disorders and chronic medical conditions. Significant investments by both the State and City of New York over the past five years have greatly expanded the use of supportive housing to improve health outcomes and reduce public spending.

Medicaid Redesign Team

Recognizing both the cyclical nature and causal relationship between poor health outcomes, multiple crisis systems use and homelessness, New York State policy leaders sought to break this pattern in 2011 through the Medicaid Redesign Team (MRT), which fundamentally changes how services are delivered and paid for under the State's Medicaid program.

While MRT is a multi-faceted, multiyear action plan to transform the State's Medicaid program with well over 200 initiatives, a key and pioneering endeavor has



Kristin Miller, MSW

been its investment in supportive housing. New York MRT has led the nation in identifying supportive housing as a health care intervention and invested the state-share of Medicaid savings into various innovative pilots and programs linked to it. MRT created numerous supportive housing programs to provide vulnerable high-cost Medicaid members with rental subsidies, new capital construction financing, and grants for pilot projects testing new models



Pascale Leone, MPP

of care. Since 2012, over 11,000 high acuity Medicaid members have been served.

The recent first installment of a threeyear evaluation performed by the State University of New York (SUNY) Re-search Foundation's MRT Supportive Housing initiative observed early findings demonstrating investments in social determinants like housing can have a profound impact on health care costs and utilization, including: 40% reduction in inpatient

days; 26% reduction in emergency department visits; and 15% reduction in overall Medicaid health expenditures.

While further analysis of MRT supportive housing investments is needed to assess the impact on health outcomes and quality of life, there already exists a large body of research demonstrating supportive housing's efficacy in helping individuals with disabilities maintain stable housing and improve outcomes.

Approved in 2014, the Delivery System Reform Incentive Payment (DSRIP) program is the main mechanism by which New York State fundamentally restructures how it pays for and delivers health care services under Medicaid, with the primary goal of reducing avoidable hospital use by 25% by the year 2020.

Doubling Down on What Works

Facing daunting and unprecedented homelessness, and recognizing the efficacy and cost-effectiveness of supportive housing in improving outcomes for highneed homeless individuals and families, New York State and City have responded with robust initiatives. New York Governor Andrew Cuomo, in his 2016 State of the State address, unveiled his plan to create 20,000 units of supportive housing statewide over 15 years. This announcement was preceded by New York City

see Better Targeting on page 34





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Looking Ahead: It will take all of us, and our combined efforts, to make our organizations and our profession a place where all people can contribute to their full potential. It's about fully utilizing the talents of all people - women and men, People of Color and White people, LGBTQ and straight, old and young, physically challenged and able bodied. We need to draw and benefit from all of the talent available to us. Splitting in the form of racism, sexism, classism, anti-Semitism, Islamophobia and all of the isms, invalidates the unique richness available in a truly diverse executive suite. Our organizations are often left with a less than ideal vision for providing leadership and services because of the impact of white organizational culture, stereotyping and splitting.

Equipping ourselves with two vital pieces of knowledge will enable us to have truly authentic relationships. The first is a genuine understanding of the role oppression plays in people's lives. The second is a sincere appreciation of privilege, what privilege is, who it impacts and how it per-

place culture to be hostile or at the very least, uncomfortable. In subtle ways, they can feel devalued. As leaders, we should not be surprised when they seek out more supportive environments. There are subtle but effective methods that can exclude – exclusion from work that matters, treating someone as though they are invisible when they're present, and marginalizing their contribution.

The topic of microaggressions at work has been hotly debated. On one side of the argument are those who believe microaggressions (everyday slights and snubs, whether intentional or unintentional, that make people feel like they don't belong) must be actively challenged and stopped. On the other side are those who suggest people of color who are demanding that everyone should become sensitive to the impacts of historical and structural racism are furthering a culture of victimhood and threaten free speech.

Suggestions for Improving Our Profession: In order to truly assess an organization for the impact of structural racism and to have authentic cross-racial and cross-cultural dialogue, training is

Step-Up Program from page 25

housing instability and homelessness by providing skills of self-efficacy.

Another key aspect of the Step-Up program's success is its mentorship role models.

the Step-Up model is youth engagement. Youth engagement can be defined as "helping youth gain a sense of control over their own lives and take an active role in shaping the programs and activities around them through their words and actions" (Yonezawa, Jones, & Joselowsky, 2009, p. 260). Youth engagement is salient because it helps youth increase self-esteem, build personal and professional networks, bolster their life skills, all of which are critical for successful transition to adulthood. key. A more diverse executive suite means more role models and opportunities to achieve professional goals. But most importantly, it means an opportunity to bring new aspects of leadership into our profession. While change supported from the top is easier, I believe change can start with you, regardless of your positional authority: (1) Take the Undoing Racism workshop that is offered by the People's Institute for Survival and Beyond. It changed my life and my practice. (2) Regularly visit the AntiRacist Alliance website www.antiracistalliance.com for hundreds of meetings, articles, books, workshop etc. (3) Recruit at least one other person to accompany you on your professional and personal antiracist journey. (4) Develop a close and authentic cross-cultural relationship. It will help you to expand your life and your practice. (5) Support and work towards building a leadership team that reflects your organizations client population.

Based on what I witness daily, a larger number of people of color, attainting and succeeding in leadership roles within our profession is not only possible - but is indeed the future!

Sober Housing from page 24

solution? A program that begins with the kind of supervision a family member wants in place, and moves toward the kind of freedom a recovering person wants to enjoy.

Bruschi and McNamara encourage such inquiries, and have even created a list of helpful questions that they share with people exploring housing options. The list includes everything from questions about curfew and having a car, to policies regarding length of stay and how relapses are handled. According to Bruschi, "A supportive environment doesn't just focus on 'not using.' We also provide vocational support like transportation to interviews, exposure to wellness activities like meditation and Reiki, and sober recreational events like attending plays and comedy shows."

meates our culture - often in ways that are

difficult to recognize and even harder to

understand. We must accept that we don't

know what we don't know. To get that

understanding, we must first be willing to

learn about issues that may not be a part

of our personal experience. If you see

something, say something. It will heard

more objectively if the issue is not your

own. When I, a straight woman of color,

discuss LGBTQ issues, Islamophobia or

bicultural/bilingual representation, it has

so is organizational culture. Organiza-

tional culture is often inhospitable to peo-

ple of color in leadership roles. This is

why so many people of color are over-

looked, opt out of leadership paths, or sim-

ply leave an organization after just a few

years. Many who leave publicly claim it

was for a better opportunity, but privately

they admit to not feeling valued for who

they were and what they contributed.

When people feel valued, welcomed and

appreciated, they do a better job and are

more productive. It is no secret, people

People of color may find their work-

want to connect and make a difference.

Workplace diversity is important, but

greater impact.

Sober housing like that provided by New Hope Rising is certainly a step in the right direction. Incentives for such programs need to be increased to ensure their availability and facility their growth.

The jungle on the coast where newly sober people are landing is still full of predators. Real regulation and oversight whether through the county or state - will ultimately be necessary to ensure the resources needed by many for safe passage to sober, purposeful lives.

Criminalizing from page 6

treatment and housing alternatives within the community.

To address the overwhelming and urgent needs of the mentally ill, actions need to be taken to address the insufficiencies in both the mental health and criminal justice systems, as well as to improve access to stable housing alternatives for the mentally ill. There is some suggestion that we return to long-term hospital care ("Improving Long-term Psychiatric Care, Bring Back the Asylum," Journal of the American Medical Association, January 21, 2015). We also need to proactively identify individuals who are at high risk for incarceration, and re-incarceration, and divert them earlier from the criminal justice system to appropriate mental health services within the community. Effective mental health case management by community-based providers is essential for these high-risk individuals. Finally, as our simulation model demonstrated, access to stable longterm housing is critical to help support mental health recovery and to reduce the population of the seriously mentally ill that end up incarcerated.

For more information, contact Dr. Erin Falconer, erin.falconer@odhsolutions.com; and visit https://www.odhsolutions.com.

Housing as Healthcare from page 26

public dollars. Housing providers are woefully under-resourced in our system they have lost 40% of their budgets due to inflation over the last 15 years (Association for Community Living data). Nursing services ARE funded by state and federal dollars in other housing programs (OPWDD), and should also be funded in Office of Mental Health residential services. In recognition of New York State's determination that, indeed, HOUSING IS HEALTHCARE, we all need to advocate for the dollars to support this critical nursing services healthcare resource.

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component. Mentorship increases intrapsychic measures of well-being in youth, as well as social confidence and healthy behaviors (Curran & Wexler, 2017). Implementing successful mentorship requires flexibility, authentic decision making and reciprocal learning that allow both youth and adults to showcase their skills and talents (Heffernan, Herzog, Schiralli, Hawke, Chaim, & Henderson, 2017). One-onone mentors assist youth with enhancing their informed decision making skills, and self-advocacy. In this regard, Step-Up can help youth experiencing housing instability and homelessness create healthy and stable adult relationships. Program mentors are professionals or in-training mental health providers such as psychologists, social workers, and mental health counselors who model positive adult relationships and foster caring, stable, and creative environments where youth discuss topics relevant to their lives. Mentorship connects youth experiencing housing instability and homelessness to positive adult

A final indispensable component of

Moreover, youth become active participants in shaping the Step-Up program. In addition to collecting feedback through formal annual evaluations, Step -Up utilizes a youth collaborative board to inform and revise aspects of its Life-Skills curriculum. The youth collaborative board come together during the summer months to review and edit the curriculum in order to improve the experience for the next cohort of Step-Up members and to ensure topics are current and up to date. Curriculum topics in the LS curriculum include: effective communication, coping and stress management, relationships (friends, family, partners), race and racism, health and wellness, drugs and alcohol, sex and sexuality, the cycle of violence, to name a few (Parchment et al., 2016). The collaboration promotes ownership of the overall experience and acknowledges youth as experts of their own experience in Step-Up. Youth voice in curriculum, work to build therapeutic relationships with oneon-ones. Youth engagement gives youth experiencing housing instability and homelessness a voice and a choice when they often feel invisible and ignored.

To summarize, the goal of Step-Up is to build life skills, promote positive youth development, identify and address individual student needs, and sustain engagement via opportunities for interaction with peers and staff throughout the program. Step-Up is an exemplary example of how a program with a PYD framework can be deployed to address the issues facing youth experiencing homelessness and housing insecurity. Although Step-Up primarily functions in school settings, it can be easily adapted for youth living in shelters.

For more inquiries regarding this article and the Step-Up Program, please contact Zoila Del-Villar at: zdv1@nyu.edu or visit our website: www.mcsilver.nyu.edu/ programs.

Never Give Up Hope - Healing and Recovery Take Time

OMH Housing from page 29

Income Tax Credits, and historic tax credits. Non-profits sometimes take on financial risk to build these. Development today is not for the faint of heart. Meanwhile, the state is moving the behavioral health system to managed care and value based contracting, creating new structures for service delivery and payment. To add to the acronym list above, non-profits must understand, engage with, and/or become part of MCOs, PPSs, and Health Homes while being asked to join with their competitors to also become part of BHCCs, e.g., Behavioral Health ASOs, MSOs, and IPAs. Add legal fees related to staff and client care issues, evictions, etc., as well as the federal government, e.g. HIPAA, to all the above, and a 10% administration and overhead share is just not realistic

Obviously, these organizations' executive staff know the reimbursement rates are too low to sustain administration and daily operations. Yet their dedication to their mission, long wait lists that demonstrate a compelling need and faith that the state will eventually correct the problem, propel them to accept underfunded contracts. This is changing. Fewer and fewer organizations are responding to new state issued Requests for Proposals, particularly for the most integrated and independent model of all, scattered site supported housing. Some have failed and given beds back. Although so far there have been organizations willing to take on the contracts that others are giving up, or are forced to give up, that is also changing. Many who have done it in the past say that they will not again.

When Governor Cuomo first took office, he convened a team of people to redesign Medicaid - the Medicaid Redesign Team (MRT) - to significantly reduce the growth of Medicaid. Savings accrued, some of which was invested in new housing units and new housing models. The people placed in these new units were all high users of high cost Medicaid services: the Department of Health tracked their progress. A recent DOH report shows what all housing providers have known for years - housing and services support people in fundamental ways so that they can stay out of other high cost settings. The MRT Housing programs have realized significant cost savings to the state, successfully steering participants away from costlier venues. Yet none of that funding is invested in rate increases so that the programs can continue to do the work. They are not rewarded - just overburdened.

The state closes some number of state psychiatric institutional beds every year which results in savings that are reinvested into additional community based programs. State staff work with housing providers to ensure that people coming out of state institutions are admitted to existing housing programs, usually transitional programs with 24/7 staffing. In some cases, admissions from state institutions are mandatory, however, the savings accrued from these bed closures are used for new programs and new beds in the affected catchment areas of the state institutions. These savings have never, as far as this writer knows, been used to increase the rates in the programs that accept state institution discharges making the closing of beds and, in some cases, entire wards of hospitals possible. The CR-SRO and CR models that accept most of the people coming out of state institutional care are significantly underfunded and understaffed. Moreover, there are no clinical staff integrated into these models that admit people with some of the most challenging service needs in the behavioral health system.

All of this translates into a mental health housing system that is spectacular on paper but is extremely difficult to manage and sustain.

The people served and the staff caring for them deserve better. Consumers need consistency and an essential array of services delivered by competent and caring staff that will help them become more integrated into the community. Their short and long term recovery depends on it. The staff who do this work deserve a living wage so that they can focus on the work and not on getting to their second job on time. The executives that bear the responsibility of operating these programs should be able to sleep at night knowing that they have done everything they can to ensure the safety, care, and futures of the staff and consumers in their agencies. They are all our family members, friends and neighbors. Let's not let them down.

We recommend that significant dollars be invested into these housing programs to ensure their continued viability. ACL has determined that the programs have lost more than \$100 million over the last 25 years, which should be restored immediately. Then a serious analysis of the consumers served, staffing needed and administrative capacity needs to occur. Future adjustments would need to follow.

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2 For additional discussion of this issue see documentary trailer regarding inadequate non-profit administration funding levels at https://youtu.be/PTMnylz6jmU as well as Human Services Council. "New York Nonprofits in the Aftermath of FEGS: A Call to Action"

3 DOH. Medicaid Redesign Team Supportive Housing Evaluation: Cost Report. https://www.health.ny.gov/health_care/ medicaid/redesign/2017/docs/2017-05_cost_rpt.pdf

"Our greatest glory is not in never falling, but in rising up every time we fall" - Confucius -

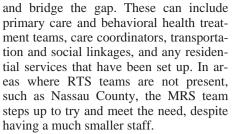
Mobile Teams from page 23

services the RTS team offers is medication management services. They educate individuals on their medications, showing them how to order their prescriptions and pick them up, and encouraging them to take their medication independently sometimes providing daily support. Teams also work with clients to help them get to AA meetings, teach harm reduction models and coping skills, and link them to PROS and outpatient services. Nurses interpret medical information and advocate for their client. They also show individuals how they can have a life outside of the programs they attend.

Each RTS team is comprised of 11 staff members including master's level behavioral health professionals, RNs, LPNs, direct care staff and peers. The team provides skill building as needed where residents are accompanied to local stores with staff to assist them with integrating into the community. Staff assists with making healthy food choices, medication management, budgeting, nutritional meal planning, benefit assistance, socialization, appropriate daily living skills, and community safety. RTS staff provides recreation trips to the library, concerts, parks, movies, and any other trips residents would like to attend that assist with community integration. RTS provides linkages and education on any additional services that assist residents with their recovery goals. These teams work very closely with residents, meeting with them several times a week and are available 24 hours a day, seven days a week. In the first quarter alone of 2017, RTS teams conducted over 2,300 face to face visits with 146 clients with visits lasting on average 33 minutes. The work is intense, but the results are nothing short of astounding.

Since the RTS teams' inception in 2015, they have served 270 individuals, 52 of whom have graduated into even less supportive settings. Last quarter alone, 13 individuals graduated to less supportive care with 21 individuals increasing their ability to manage their own medication from the previous quarter. For individuals who have spent a lifetime institutionalized, this is nothing short of remarkable and a testament to the power of support, determination, and hope.

The MRS team is comprised of three staff members and serves as a step-down for clients who no longer require more intensive RTS services. When individuals are able to stepdown to an MRS team, the other services they are linked to phase in



Despite exceptionally strong results, challenges remain in implementing more mobile transitional support teams. Because the programs are still relatively new and there are a limited number of teams in operation in NYC and Long Island, hospitals typically neglect to think of these units as the first referral and opt for sending individuals back to traditional congregate care settings. This is unfortunate because these teams will meet individuals in the hospital and begin the transition process immediately and seamlessly, an aspect that is of utmost importance when treating an individual in crisis. To counter this problem, Federation's staff routinely meets with community members, health professionals, mental health providers, and hospital discharge units in an effort to establish strong relationships and provide education that will foster more referrals.

So why are these mobile teams important? Because they work. Obviously, one program cannot work for everyone, but enhanced mobile team services do bridge the gap for individuals with severe mental illness to be able to enjoy successful independent housing with opportunities to grow and focus on their recovery.

As the healthcare landscape evolves, we as providers need to start thinking outside of the box when it comes to holistic care of the individual. When a client relapses, instead of automatically referring them back to a congregate care setting, we need to critically evaluate what support and tools we can provide them with so that they have a chance at achieving the dreams they hold in their hearts. For many, we may find that a different approach may be the one that leads to success.

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Aging in Place from page 23

Supportive housing programs are also experiencing a "graying" tenant population that further calls for changes to the way that quality supportive housing is delivered. Indeed, about 40% of supportive housing tenants nationwide are now over age 50 (CSH, Healthy Aging in Supportive Housing, 2016). Although many of these individuals are aging in place, they often experience the same expedited aging and development of functional deficits as homeless individuals given their former homelessness, resulting in increased placement in nursing homes and the like if supportive housing programs do not have the specialized capacity to meet these needs. Unfortunately, this situation occurs too often, as much of New York's housing programs are designed primarily for working age adults, lacking necessary accessibility features like grab bars and elevators, as well as a comprehensive array of interdisciplinary staff trained to meet the unique needs of older adults (Liu, J. C., Morales, R., Hoffnung, A., Gold, J. S., Morris, D. R., Bardin, R., & Pak, C. M. Senior Housing in New York City: The Coming Crisis, 2013).

Project Renewal's Solution

There are a few model programs that have effectively transitioned to serving older homeless adults. Project Renewal, Inc. (PRI) operates one such program. Established in 1967, PRI is a nonprofit whose mission is to end the cycle of homelessness by empowering individuals to renew their lives with health, homes and jobs. With over 800 employees, PRI serves more than 16,000 homeless and unstably housed clients each year across its 39 programs, which include shelters, as well as transitional and permanent supportive housing. PRI is particularly adept at coordinating care for clients with multiple physical and/or behavioral health issues, and, for a subset of their aging permanent housing residents, they developed a pilot program nicknamed "Tools for Aging in Place" (TAP) that is currently being implemented at their largest permanent supportive housing program where 57% of the residents are 55 or older.

The TAP pilot is a replicable model for senior supportive housing that supports homeless older adults at risk of nursing home placement to acquire and sustain stable housing and improve their quality of life as they age. TAP includes senioraccessible apartment modifications and support services provided by an interdisciplinary team consisting of not only traditional health and behavioral health providers, but also occupational therapists, occupational therapy interns, and case aides able to specially address health and social challenges related to aging.

The program, initially funded by the NYS Department of Health, has resulted in clear benefits and improved outcomes for participating older adults, including: Significantly increased engagement in healthcare and psychiatric services; enhanced skill sets related to activities of daily living; and improved program satisfaction, social connectivity, and enjoyment.

Moving Forward

Adequate Financing for and attention to the needs of older homeless adults is critical. Despite the program's significant positive outcomes, sustainable financing has been a challenge. Today, TAP's enhanced services are mostly funded through grant funding and other private donations, as many of TAP's clients fall into the eligibility "donut hole" of not being chronologically old enough to qualify for services designed for older adults 65+ but having equivalent functional deficits that require those services. However, given the pro-

gram's success in increasing engagement in community services and keeping older homeless adults in the community out of institutional care, the value of such programs is becoming clear. In order to ensure all homeless and unstably housed individuals have the opportunity to age within community based settings rather than having to move to an institutional setting because the system is not designed to meet their needs, the TAP program and others like it should be viewed as models for replication by supportive housing providers across the state. And critically, to allow the expansion of such programs, supportive housing funders and stakeholders must recognize that when it comes to homeless adults, chronological age is not the equivalent to functional age; therefore, supportive housing policies and rates must support enhanced services for "older adults" who are younger than the traditional 65 years but are living with significant functional deficits.

To learn more about Project Renewal and its TAP program, visit our website www.projectrenewal.org or contact Susan Dan at susan.dan@projectrenewal.org. To learn more about Health Management Associates and its public sector consulting services, visit www.healthmanagement.com/ what-we-do or contact Kristan McIntosh at kmcintosh@healthmanagement.com.

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Better Targeting from page 31

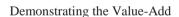
Mayor Bill De Blasio's pledge to create 15,000 units of supportive housing over 15 years. The initiatives combined will create 35,000 units of supportive housing statewide – marking the largest commitment in the nation. These actions follow in the footsteps of the NY/NY agreements, a series of long-term pacts between New York City Mayors and New York State Governors to increase the pipeline of supportive housing for high-need homeless individuals.

NY/NY III, the last iteration before the recent announcements, is fully leased up and provided supportive housing for nine distinct populations in New York City through a diagnosis-driven and siloed structure. The new initiatives by the Governor and Mayor are somewhat more flexible, recognizing that eligibility categories must be comprehensive and accommodating enough to encompass the needs of individuals with multiple, cooccurring challenges, a variety of housing requisites and a range of homelessness histories. Requests for proposals for operating and service contracts for this new supportive housing are released and target resources to address vulnerable populations experiencing homelessness and/or significant life challenges. The Governor's plan includes a five-year goal of developing more than 6,000 congregate, newly constructed supportive housing units for vulnerable populations through the Empire State Supportive Housing Initiative (ESSHI). The Mayor's plan, known as NYC 15/15, will develop 7,500 new congregate units and 7,500 scattered site units.

Deeper Targeting to Screen In the Most Vulnerable: Reduce Costs

Anchored by a HUD directive and a desire to ensure new and existing resources are effectively used to end homelessness, CSH is helping lead systems transformation efforts in New York City by supporting the development and implementation of a Coordinated Assessment and Placement System (CAPS). CAPS will streamline access to housing for homeless clients by establishing a single assessment process for housing types and a prioritization process taking vulnerability factors into account when determining priority for supportive housing. When fully implemented, New York City will have a more efficient process to identify and prioritize the most vulnerable individuals in greatest need of supportive housing. Also, supportive housing providers will likely be serving a more medically complex cohort with significant behavioral health, social and long-term care needs. It is therefore imperative providers have appropriate staffing models, comprehensive and flexible service arrays and accessible physical environments to support what will likely be a more medically frail population.

Communities are spending millions on services for vulnerable individuals and families trapped in a revolving door of costly public systems use, often reflected in numerous emergency room visits and hospitalizations. Individuals frequenting these crisis systems suffer from multiple and debilitating co-occurring chronic medical, social, behavioral health and long-term conditions and fall victim to a fragmented health care system, all of which greatly exacerbate their unmet health and other needs. CSH's Frequent Users of Systems Engagement (FUSE) model works to solve this problem. FUSE helps to break the cycle of homelessness and multiple systems use among individuals with complex health challenges who are the highest users of costly crisis services by targeting limited housing resources to the most vulnerable and increasing housing stability. FUSE reduces multiple and avoidable crisis service utilization, which means a more effective use of public funds. In the Bronx, CSH and its partners, the Bronx Health and Housing Consortium, the Bronx RHIO, managed care entities and about a dozen supportive housing providers are working on a FUSE initiative focused on homeless frequent users of hospital systems.



While the future of Medicaid coverage remains uncertain, it is clear that states will have to operate more efficiently. As such, it is of paramount importance that states look to innovative and costeffective solutions like MRT and supportive housing, which enjoys wide bipartisan support because of its positive return on investment, to address the needs of their most vulnerable and costliest Medicaid members. As we embark upon value-based arrangements under Medicaid that seek to drive innovation through transformative delivery and payment reform, and effectively bend the healthcare cost curve, new and more meaningful integrated partnerships between the health and housing sectors will be required. Supportive housing providers have already entered into many of these partnerships. Their efforts foster stability, reduce avoidable healthcare usage and improve outcomes through stable housing, intensive case management and wrap-around community supports. And at a fraction of the cost of what managed care entities currently pay for avoidable re-admissions that yield no positive health returns.

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Recovery from page 28

entitlement training and assistance, substance abuse services, symptom management and crisis management.

Supportive housing in New York arose in response to a number of social and economic factors, including the loss of low-income housing and the financial crisis of the 1970s, the deinstitutionalization of the State's in-patient psychiatric hospital population, the reduction in single room occupancy units and rooming houses, and the dramatic rise in homelessness across New York City. The early 1980s formed the basis for what would become today's Supportive Housing model. Pioneering non-profits such as St. Francis Friends of the Poor, Catholic Charities of Brooklyn and Queens, and the West Side Federation for Senior Housing created hundreds of units by piecing together up to a dozen funding sources. Today, New York leads the nation in Supportive Housing development, with more than 50,000 units in operation.

In addition to the supportive units at Concern Bergen, the project also includes 32 apartments for community members in need of affordable housing. Our experience has shown that an integrated environment results in better outcomes for our residents, including housing stability, increased employment and decreased hospitalizations. By offering persons with psychiatric disabilities the opportunity to reside in their own apartment in a highquality building, they can shift their focus from maintaining the bare necessities of life to their wellness and achieving higher goals such as educational, vocational, and social ambitions.

Supportive Housing has been proven again and again to play a vital role in the recovery process for persons with disabilities, with staggering outcomes that include and 85.6% decline in the mean number of shelter days; up to a 60% reduction in state hospital use; and 68.6% reduction in public hospital use (D. Culhane, Et Al., *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 2002). In the last year, Concern has opened a number of similar projects including Norwood Terrace in the Bronx and Liberty Landing in Lake Ronkonkoma. Funded in part by Governor Cuomo's MRT Initiative, Norwood Terrace will contribute to decreasing Medicaid spending in New York State, while increasing the much needed stock of affordable apartments. Norwood Terrace consists of 115 apartments, 58 of which are for homeless adults with psychiatric disabilities and a history of high Medicaid usage.

Similar to Concern Bergen, both Norwood Terrace and Liberty Landing integrate affordable units with supportive units. The inability to obtain housing that is affordable is one of the largest contributors to homelessness among families in both New York City and on Long Island. In addition to the thousands of families residing in shelters, there are tens of thousands more that are just one personal crisis away from homelessness because they are living paycheck to paycheck and spending too much of their income on housing. Affordable housing offers these families the chance to enjoy quality living environments, as well as the opportunity to better their future by saving money and investing in educational and employment opportunities for themselves and their children.

Liberty Landing in Lake Ronkonkoma is Concern's second Veterans project on Long Island. It includes 59 units, of which 30 are reserved for homeless Veterans with psychiatric disabilities. Designed in a townhome-type configuration, Liberty Landing is a community which blends seamlessly into the surrounding suburban neighborhood. An on-site community center includes staff offices, community space, exercise room, computer room and laundry facilities.

Recognizing the importance of this housing model, in May, 2017 Governor Andrew Cuomo made a historic commitment of \$2.5 billion for the creation and preservation of 6,000 units of supportive housing across New York State. Concern for Independent Living, Inc. is pleased to be a part of this historic effort to end homelessness and promote recovery though housing.

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Older Adults from page 30

Michael B. Friedman, MSW is an Adjunct Associate Professor at Columbia University School of Social Work and co-founder of the Geriatric Mental Health Alliance; Lisa Furst, MSW, MPH, is Assistant Vice-President of the Mental Health Association of NYC and Director of the Geriatric Mental Health Alliance; Kimberly A. Williams, MSW is President of the Mental Health Association of NYC. She is co-founder of the

New CEO from page 28

relationships and business partnerships that will continue to be instrumental during ongoing healthcare transformations. Ostman, who earned a BS from Cornell University and a MSW from New York University, has extensive management and practice experience developing and delivering behavioral healthcare in various community-based medical settings. Special areas of interest include crisis intervention, integration of medical and behavioral health, value based reimbursement and telehealth.

"I joined MHA because of its forward -thinking leadership and excellent reputation for high quality behavioral health

units in coming years, and our state legisla-

Geriatric Mental Health Alliance and chairs the National Coalition on Mental Health and Aging; Paul Nestadt, MD, is a postdoctoral fellow in the Psychiatric Epidemiology program in the Johns Hopkins Bloomberg School of Public Health and serves as supervising psychiatrist for the Anxiety Clinic in the Johns Hopkins School of Medicine; Lina M. Rodriguez graduated from the Columbia University School of Social Work in 2017 and is Prof. Friedman's research assistant.

programs and services. It is a tremendous honor to have been chosen to lead the organization," said Ostman. "The current healthcare environment is dynamic, but full of opportunity. I am excited to guide the next chapter of growth and innovation by maximizing the use of data and technology to deliver value based care."

For more than 70 years, The Mental Health Association of Westchester has promoted mental health in Westchester through advocacy, community education and direct services. MHA offers a range of services that are recovery-oriented, trauma-informed and individualized to promote recovery and wellness. To learn more, visit www.mhawestchester.org.

Development from page 14

experience of care (from the recipient's perspective) and produce better outcomes. A preliminary evaluation of MRT investments in supportive housing was recently published by the Department of Health and it confirmed the assumptions of the workgroup. This evaluation examined 11,000 "high need" individuals who received supportive housing as a result of targeted MRT investments. Following the provision of supportive housing and related services this population enjoyed a 40% reduction in inpatient hospital days, a 26% reduction in emergency department encounters and a 15% reduction in overall Medicaid-funded

health expenditures (New York State Department of Health, 2017). In an economy that measures progress by single percentage points and incremental changes these results are nothing short of epic, and they have significant implications for future investment in housing and other social support services.

The results of this evaluation coupled with our increasing awareness of the relevance of social determinants of health to the healthcare equation suggest significant investments in supportive housing are forthcoming. This is certainly true in some respects. Mayor de Blasio and Governor Cuomo have pledged their support for the development of thousands of new housing

ture has begun to authorize some expenditures necessary for this development. The fulfillment of these commitments, however, is contingent on continuing budgetary appropriations (and the caprice of the legislative process) and other fiscal mechanisms of great complexity and questionable reliability. For instance, a movement to commit all state Medicaid dollars to the stewardship of privately-operated Managed Care Organizations is bound to upend existing service systems through which these resources flow. In other words, a seismic disruption within a Medicaid program on which numerous social service providers depend might limit their capacity to provide a broad variety of services, including supportive housing. Other initiatives presently underway, including DSRIP and the emergence of Value-Based Payment models of service delivery and reimbursement, will also substantially alter the allocation of public dollars in coming years. Supportive housing faces a dubious future in the absence of well-defined, actuarially sound and politically viable funding mechanisms. Our policymakers and key stakeholders should take heed lest our pursuit of the Triple Aim falter for lack of investment in one of the most essential social determinants of health.

The author may be reached at (914) 428-5600 (x9228) and at abrody@searchforchange.org.



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Housing Prescription from page 24

people who are unstably housed.

6. The H@R Team focuses on people with immediate housing needs and high health service utilization. They addressed 122 cases that were active in 2016. Half of the patients were women and the age range was 21-76, with a median age of 51.

The majority of the people served have behavioral health diagnoses, as well as medical diagnoses. The Team's work with unstably housed people with behavioral health diagnoses can be illustrated using these cases.

Patient 1 is a homeless patient who was successfully housed, but continues to require support to remain housed and prevent avoidable ED visits and admissions. She is a 28 year old transgender female with a history of schizophrenia, hypertension, bipolar disease, asthma and polysubstance abuse.

Housing Situation: Prior to working with the Housing @ Risk Team, she was in the Moses ED almost daily. Her last admission was in 2013. The team worked to house her in SUS (Service for the Underserved), Medicaid Redesign Team supportive housing and was successful in 2013. She has been living in supportive housing since then.

Her situation remains precarious when the rent is not paid, often due to missing appointments with Public Assistance, located in Brooklyn. She then faces eviction proceedings.

Income: Prior to working with the H@R team her income was derived from being a sex worker. She now receives Public Assistance and has an upcoming hearing for SSI in 2017.

Interventions: This patient requires ongoing support to remain housed and relatively healthy. She was an active, open case for the Team from 6/14-7/16, or 753 days. She receives support from the H@R Team in a variety of ways. For example, in 2016 when her Public Assistance case was closed, someone from the Team needed to accompany her to the Brooklyn Public Assistance office. This is often an all-day process which is why many patients lose benefits. When she was not well, the Team managed to reschedule the appointment which required many phone calls. She also required an escort to apply for and receive Food Stamps and rental assistance from HRA. Additionally she was assisted to receive SSI, after an initial rejection. SSI appeals are complex and require documentation, explanations, etc. Without support, the appeal would not have been successful.

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She was taken to Housing Court by her landlord in April 2016 because there were arrears of more than \$3,000. After numerous re-scheduling appointments, HRA paid the owed back rent. The next step was getting a letter from HRA stipulating this and a rental breakdown from the landlord. After several appointments and chasing of documents, a further rental lease was signed and renewed in July 2016. Her housing court case was closed.

This patient was also behind in utility payments. Once again, the H@R staff worked to connect her to Catholic Charities for assistance and after several meetings and arrangements, this need was also addressed.

When there are issues with her current landlord, case conferences including the H@R rep and housing case manager are used to address them periodically to ensure she remains housed. We recognize that cases like this require intensive staff time; we also recognize that the alternative may be more time in hospital with no safe discharge plan.

The team is also working to get her needed psychiatric and counseling support. She currently is considering job applications and preparing for job interviews.

Analysis/Outcome: The change in hospital utilization for this patient is very dramatic. From almost daily ED visits, In the year prior to placing her in housing she had 50 ED visits and 3 inpatient stays. In the year post housing (January 28th 2014) she had 2 ED visits both for legitimate reasons (pneumonia and lacerated finger). In 2016 she had 4 ED visits, 3 in 2017 and one overnight inpatient stay. The reasons included food poisoning and serious dizziness. We also note that in 2013 this patient also used Jacobi Hospital for additional ED visits and has not been back there at all. Thus the Montefiore Housing@Risk Team's work reduced overall Medicaid spending.

While there are multiple 'case manag-

ers' working with this patient, it is clear that she trusts only the H@R staff. Although there have been attempts to move that responsibility to others, the patient continues to use H@R resources in order to remain housed. When she is feeling uncomfortable about daily life issues, she comes to the H@R office to discuss them. Although moving her onto other providers is a goal, it is also important to acknowledge the need of patients to feel comfortable and for systems to acknowledge and accommodate people whose needs are such that long-term support is necessary to support stability and prevent unnecessary hospitalizations.

The Team's work with her highlighted the need for improved access to psychiatric and counseling services. Meanwhile, her condition may deteriorate and need for more Team services to increase.

Patient 2 is 62-year-old patient who was homeless and needed a home in order to address her health conditions. She has ongoing depression/anxiety as well as severe COPD, diabetes, asthma and a history of substance use. She uses a walker and receives some home care services.

Housing Situation: This patient had a long history of housing instability, fragmented care and high hospital utilization. She was residing at a friend's home in Westchester when she came to the attention of the H@R Team. The home was deemed a hostile environment that put her at risk for further hospitalizations. Although she uses a walker and oxygen, she was using a Metrocard to ride more than two hours by public transportation from Westchester to her long-time methadone program in Manhattan. That Metrocard program disqualified her from Medicaid ambulette services. For her income, she has SSI.

Intervention: The Team quickly assessed this patient and referred her to the BronxWorks MRT housing program. Because BronxWorks and the H@R Team have been working so well together, this process is efficient and effective. Transfer to the BronxWorks Health Home was also organized. BronxWorks located an appropriate unit in April. Meanwhile, in February, the patient was informed that she required a toe amputation. After the procedure she was placed in St. Barnabas Hospital for rehab. The Team worked with St. Barnabas Hospital and others to ensure she could stay there and then move directly to housing. In June, she moved into her new apartment, where she still lives. H@R arranged for the Montefiore Community Intervention Nurse Practitioner to work with her in her new community and coordinate local care for her. Also, the Team arranged for her belongings in Westchester to be moved into her new home and for food delivery. To support her going to various appointments, the Team successfully replaced the Metrocard service to a more appropriate Medicaid ambulette service.

Analysis/Outcome: True care coordination among agencies resulted in a homeless patient obtaining housing. These relationships were internal to Montefiore and external with St. Barnabas Hospital and BronxWorks.

Transfer to a Health Home associated with her housing aided coordination and shifted the work from the H@R Team.

Housing with wrap-around services to address behavioral health issues is necessary to prevent future incidents of homelessness and avoidable hospital services. In the year prior to placing her in housing she had 8 ED visits and 9 lengthy inpatient stays. In the year post housing she had 2 ED visits and 5 inpatient stays.

Conclusion: This population with a mixture of medical, behavioral and housing needs must be supported by integrated teams that address all these needs at the same time or in an appropriate sequence. These teams are often composed of staff working for several organizations-in these cases, housing and health is the key partnership. The patients who the Montefiore Housing @ Risk Team work with point to stable housing as a means to then address various medical and behavioral health needs. Although one major goal is increased independence, we have also learned that both the housing and health support require an investment of time and staff. As a result, the patient experience is more positive, the health situation improves and the cost decreases-meeting Triple Aim goals. These achievements are key motivators of these teams and help them support people well.

For further information, please contact Deirdre Sekulic at dsekulic@montefiore.org.

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Adulthood from page 25

universities; and our 24/7 "life coaches" assist with the vital living skills and routines that a young person must develop. But our efforts to provide housing usually fall into the category of "lucky accidents."

Several case histories will shed more light on the critical housing dilemma faced by so many SafeTY.net clients and other special young adults with emotional needs over the age of 18. Every day we work to find safe and clean housing for these youths. These case studies reveal the issues encountered by our clients when they do not have housing with their biological families.

Silvana is a young 22-year old wife and mother of a two- year old who is currently living in a shelter in Manhattan. She receives mental health services for her anxiety, panic attacks and chronic depression. Living in one room without

even a small refrigerator to keep food fresh and no ability to provide healthy meals for her family adds to her stress. She desperately needs to find housing on Staten Island and has spent 14 months in shelters trying to return.

Thomas lived in a DCYD- funded shelter for young men and women ages 12-21 for four months. When he aged out of that program, he was sent to a men's shelter in Manhattan where he feels unsafe and depressed. He is reluctant to accept mental health services where he is and continues to struggle to get back to Staten Island where he has roots. There are no housing programs available so he cannot return.

Peter is 21 years old and graduated from high school in June 2017. He is diagnosed with PTSD and lives with his siblings, his mom and his step-father who has been charged with domestic violence on three separate occasions. Peter wants to leave the apartment and live independently, but needs financial and supportive services to function successfully. There are no programs that he can access here in Staten Island. Peter will be forced to leave his family and go to a shelter in Manhattan, where he does not have to witness the violence in his home.

One of the problems with the housing situation in Manhattan, where many of our clients land, is the lack of safety. They report being robbed and sexually assaulted. In addition, they do not receive a consistent level of care or support through care management services or clinical services.

These formidable circumstances are too common among the young adults served by SafeTY.net on Staten Island. Once they reach their 18th birthdays or age out and their state support ends, their parents, caregivers, or guardians all too often want nothing more to do with them.

They are abandoned and left to fend for themselves, abandoned not only by their relatives, but by the system. This segment of our youth comes from a broad array of socioeconomic, racial, and ethnic groups, but they experience the poorest outcomes compared to their peers living with all other forms of disabilities.

I do believe there is a solution to these tragic situations. Modeled after supported housing programs that exist for adults with long-term mental health histories and long-term housing needs, similar housing opportunities can be created targeting the transitioning young population and helping them to learn skills necessary to live independently in the community. With a roof over their heads and the nurturing support they need, these young men and women will be more likely to progress to better outcomes in the future and live independent and fruitful lives.

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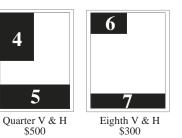
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