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SPRING 2016 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 3 NO. 3

Preparing the New Behavioral Health Workforce

By Andrew F. Cleek, PsyD and Boris Vilgorin, MPA

The Affordable Care Act marked a national healthcare reform effort, and within that context, New York State, led by Governor Cuomo's Medicaid Redesign Team, is undergoing a substantial shift in publicly funded physical and behavioral healthcare. The authors have been deeply involved in the rollout of these changes dating back to the Adult Chronic Illness Demonstration Project (a precursor to Health Homes), the Adult Health Home Rollout, NYS Mental Health Clinic Redesign, and now, the transition to Managed Care. A consistent thread within each of these initiatives is the evolving skillset needed among the workforce. Hospitals, FQHC's, Community-Based agencies, government, and payers are each struggling to identify the specific workforce skills needed for individual staff and organizations to succeed in this ever evolving environment. This article draws from the authors' experience developing the NYS behavioral health workforce to propose a number of core skills in which all staff need increased knowledge.

A key area that defines successful organizations across multiple different systems and provider types, is the ability of staff to communicate across roles. In our experience, organizations that have successfully adapted to recent changes are those where the administrative, program and clinical, finance, and HIT staff have regular and ongoing dialogue. When each of these systems operate in separate silos or do not collaborate, it does not bode well for the respective departments, or most importantly, the provider's clients. Perhaps in the behavioral health system of a decade ago it was possible to know "your job only," but in the new world, each staff member needs to know how all of the different pieces fit together and understand their role within the overall organization and healthcare delivery system.

Familiarity with the following identified topics is necessary in order for each staff member to be successful:

1. Finance: In successful organizations, all staff have a basic understanding of where they fit in the overall funding structure of the agency. This includes a staff member's role in generating revenue and supporting overall fiscal health of the organization. For example, front line clinicians need to understand how productivity and documentation affect their program's bottom line. The program director not only

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Behavioral Health News to Honor Peter Campanelli, PsyD, John Coppola, MSW, Linda Rosenberg, MSW, and Ann Sullivan, MD, at June 21st Leadership Awards Reception

☆☆ You Are Cordially Invited - See Page 22 for Registration Details ☆☆

By Staff Writer
Behavioral Health News

Behavioral Health News will hold its Annual Leadership Awards Reception on June 21st at NYU Kimmel Center's Rosenthal Pavilion. Jorge R. Petit, MD, Board Chairman of Mental Health News Education, Inc. (MHNE), publisher of *Behavioral Health News*, made the announcement saying, "We are extremely excited to be holding our second annual Leadership Awards Reception and equally excited to be honoring four outstanding leaders of the behavioral health community: Peter C. Campanelli, PsyD, John Coppola, MSW, Linda Rosenberg, MSW, and Ann Marie T. Sullivan, MD. We hope all of our colleagues and supporters will come out to pay tribute to our honorees and to help support MHNE's behavioral health education mission."

Peter C. Campanelli, PsyD, is Senior Scholar, Organizational and Community Services and a Senior Research Scientist for the McSilver Institute for Poverty Policy and Research at New York University Silver School of Social Work. Among other initiatives, Dr. Campanelli co-developed and co-directs NYU Silver's six-module Advanced Certificate in Integrated Primary and Behavioral Health (IPBH). He is the former President and Chief Executive Officer of the Institute for Community Living.

John J. Coppola, MSW, is the first Executive Director of the New York Association of Alcoholism and Substance Abuse Providers, Inc. (ASAP). He has held that position since June of 1996. Mr. Coppola is responsible for representing the interests of substance use disorder and problem gambling treatment, prevention, recovery, research, and training providers throughout New York State. John serves on a variety of national, state, and local working groups and committees that address major issues affecting the field.

Linda Rosenberg, MSW, is President and CEO of the National Council for Behavioral Health. A healthcare architect who has advanced quality care for people with mental and substance use disorders, Linda is a national expert in the financing and delivery of mental health and substance services. Under her leadership, the National Council for Behavioral Health has become our nation's most effective advocate for behavioral health prevention, early intervention, science-based treatment, and recovery.

Ann Marie T. Sullivan, MD, is Commissioner of the New York State Office of Mental Health (OMH). Dr. Sullivan was confirmed by the New York State Senate as Commissioner on June 20, 2014. New York State has a large, multi-faceted mental health system that serves more than 700,000 individuals each year. The Office of Mental Health operates psychiatric centers across the State, and also oversees more than 4,500 community programs, including inpatient and outpatient programs, emergency, community support, residential and family care programs. As Commissioner, she has guided the transformation of the state hospital system in its emphasis on recovery and expansion of community based treatment, reinvesting over 60 million dollars in community services. Previously, she was the Senior Vice President for the Queens Health Network of the New York City Health and Hospitals Corporation.

Ira Minot, LMSW, Founder and Executive Director of MHNE stated, "Our Leadership Awards Reception this June will celebrate our 16th year of providing vital behavioral health education to the community. I am very honored that we will have this opportunity to pay tribute to four outstanding leaders of our community, and hope everyone will come out in support of their lifetimes of achievement."

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Behavioral Health News
2016 Theme and Deadline Calendar

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Spring 2017 Issue:
"System Reform Progress Report"
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Looking Ahead: The Future of Behavioral Health

By Arlene González-Sánchez, MS, LMSW
Commissioner, New York State Office of Alcoholism and Substance Abuse Services (OASAS)

Integrated care that aims to treat the whole person, including addiction, mental health and primary care needs, is changing the landscape of healthcare. These changes are ushering in a new era for addictions professionals. The New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) is committed to ensuring that all of its services fully recognize and respond to the needs of those in or seeking recovery from Substance Use Disorders (SUDs). Sustaining recovery from SUD goes beyond treatment and abstinence to the lifelong process of improved health, wellness, quality-of-life and continued reintegration with family and community. NYS OASAS is adapting a new model of patient care, one that addiction professionals will have to embrace and be trained in to ensure that quality care is delivered and indeed services that address the needs of the whole person are provided.

The New Behavioral Health Workforce: Changing with the Times

The medical field is constantly evolving and the addictions field is changing right along with it. To that end, the Credentialed Alcoholism and Substance Abuse Counselor (CASAC) job task analysis is updated on a regular basis. The most recent CASAC competencies included knowledge and skills related to screening, identification, integration and referral for co-occurring mental and physical health problems. Additionally, OASAS certifies a total of 89 CASAC certificate programs statewide, 56 Colleges/ Universities and 33 Community Based Education programs, to offer a standardized 350 Hour Curriculum of SUD specific education. In addition to Addiction Counseling programs OASAS also certifies Bachelors, Masters and Doctoral programs in Psychology, Social Work, Mental Health Counseling and Marriage and Family Therapy to ensure that students receive addiction specific coursework and work experience that is not currently required for these disciplines. This prepares clinicians working toward NYS licensure to gain both mental health and addiction competencies that can be used in OASAS programs and other counseling and healthcare settings to provide integrated treatment.

There is also a fellowship opportunity for those individuals who are currently enrolled in or entering their second year of a Master's Program that is also certified by OASAS as a CASAC Certificate Program. The fellowship is offered by the National Association of Addiction Professionals (NAADAC) and awards up to $20,000 toward tuition fees for those students who are currently, or committed to, working with minority populations and/or transition age youth. More information about this opportunity can be found at: http://www.naadac.org/nmfp-ac-eligibility-application-process.

Additionally, medical professionals will need to embrace further educational and experiential opportunities to learn more about SUDs. OASAS currently requires that all Medical Directors in OASAS certified programs also be Board Certified in Addictions. There will also be a need for additional Certified Addiction Registered Nurses and Nurse Practitioners to serve on the multi-disciplinary teams that treat clients in OASAS programs. This is important because individuals with co-occurring substance, mental health and/or physical conditions will need to have care that addresses all of their illnesses simultaneously without inadvertently making one or more worse due to lack of understanding of the interactions of the treatments being provided.

OASAS Commissioner
Arlene González-Sánchez, MS, LMSW

Fortunately, this has been foreseen for some time. In 2012, a study found that the implementation of the Affordable Care Act in 2014 would result in a significant increase in the need for professionals who are able to care for individuals with SUDs in a variety of managed healthcare settings [Vital Signs: Taking the Pulse of the Addiction Treatment Profession- Addiction Technology Transfer Center Network, 2012]. The same study also acknowledges the constant changes in technology and recognizes the importance of SUD treatment practitioners making sure they stay up to speed, building their computer and web-based technology skills.

More than Medicine: Skills to 'Manage Care' Needed

While the focus remains on the care and interest of the patient, there are other aspects changing in our field right now. Managed care is altering the landscape in which healthcare is delivered. Now that health insurance plans or health care systems are coordinating the provision, quality and cost of care for its enrolled members, addictions professionals need to know more and understand the principles of these payer systems. They will want to have a more comprehensive understanding of insurance and insurance companies to better understand how to work with payers, providers, patients and their families with regard to levels of care, reintegration and reimbursement.

Shortage in the Workforce: Building Our Ranks

The new age of the addictions field is in dire need of professionals. A recent survey found that retention continues to be an ongoing challenge for SUD treatment facilities. According to respondents, the average staff turnover rate is 18.5 percent [Vital Signs: Taking the Pulse of the Addiction Treatment Profession- Addiction Technology Transfer Center Network, 2012]. Additionally, the Bureau of Labor Statistics has indicated that the Substance Abuse and Behavioral Disorder Counselor category is growing at a much faster than average rate nationally at 22% for the years 2014-24. But efforts are underway to attract more interested and compassionate individuals into the field and current addictions professionals can help. There are several paths to take for anyone interested in pursuing a career in addictions. If you or someone you know is interested in working to address addictions in individuals, families and/or communities, head to www.nysoasas.ny.gov and click on Credentialing. There, you'll find valuable information including eligibility requirements for Credentialed Alcoholism Substance Abuse Counselor (CASAC), Credentialed Problem Gambling Counselor (CPGC) or Credentialed Prevention Professional (CPP) and Credentialed Prevention Specialist (CPS). As stated above, the educational requirements for these credentials can be earned as part of an Associate's, Bachelor's, Master's or Doctoral program in Psychology, Social Work or Counseling that are listed at this link: http://www.oasas.ny.gov/training/providers.cfm?providerType=CASAC-350.

Our community based CASAC certificate programs also offer opportunities for those that may already have degrees or are not seeking a degree at this time. Many second career individuals, who are retiring from one career and looking to continue to make a difference in people's lives, are also taking advantage of these programs and the demand for new addiction counselors. Additionally, OASAS also approves two organizations to offer the Certified Recovery Peer Advocate certification for those individuals who are interested in serving those with SUDs in a peer capacity. Peer Advocates can work in OASAS programs or for agencies that are approved to offer Home and Community Based Services (HCBS) to individuals who qualify as members of Health and Recovery Programs (HARPs). More information on the OASAS approved Peer Advocate certification can be found at: www.oasas.ny.gov/recovery/PeerServices.cfm.

Education is not limited to those looking to get started in the addictions field. NYS OASAS is encouraging current professionals to expand their knowledge through 'Learning Thursdays.' This program

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Meeting the Challenges of Healthcare Reform: Preparing the Workforce for Transformational Practice Change

By Peter C. Campanelli, PsyD, Kyle H. O'Brien, DHSc, MSW, MSOT, LCSW, OTR/L, Dottie Lebron, MPA, and Joseph Cerniglia, BSW

There has been a tremendous amount of discussion associated with workforce retraining since the passage of the Affordable Care Act (ACA). Since its inception, it has been clear that the ACA establishes a new framework for health care from nearly universal insurance coverage to the re-conceptualization of health care service delivery. This framework includes the utilization of evidence based treatment practices and the restructuring of service delivery systems.

Changes to the provision of health care in the U.S. are tied to and depend upon a well-equipped and trained workforce. Several questions must be considered in order to understand how the workforce can be transformed in a way that will best meet the goals of the ACA. First, who comprises the health care workforce and where can they be found? Second, what do they need to know and do in the future that is different than what they have been doing in the past? Third, where and how should they be trained? Fourth and finally, how do we achieve and measure changes with practice implementation and subsequent health care outcomes to determine the effectiveness of new processes and strategies being taught?

The health care work force consists of a diverse group of professionals, para-professionals, and peer specialists including, physicians; nurses; social workers; occupational, physical and speech therapists; dentists; pharmacists; psychologists; case managers; peer advocates as well as other administrative titles that include medical records technicians and patient resource coordinators among others. Bodenheimer and Grumbach (2012) estimate that over 5 million staff comprised the healthcare workforce in 2008, not including para-professionals and peer advocates. Specifically, 642,000 were social workers, of which 43% worked directly in health care settings. Three-million Nurses overwhelmingly represent the workforce, many of whom worked in hospital based settings. Taken together, social workers and nurses alone comprised approximately 72% of the workforce. Contrary in concept and practice to the person centered, community based, prevention oriented, collaborative care model promulgated by the ACA, many health care providers have been trained as independent practitioners in institutional settings. Therefore, inherent challenges exist with re-training a workforce to work collaboratively and within community based contexts.

The Affordable Care Act (ACA): Setting the Transformational Agenda

The Affordable Care Act (ACA) has been characterized as a transformational shift designed to achieve its triple aim: to expand insurance coverage, reduce the cost of healthcare, and improve healthcare outcomes. The triple aim is envisioned as being accomplished through insurance market place reform resulting in considerable expansion of insurance coverage to those who are marginally insured or uninsured. This expansion is anticipated to result in insurance coverage to more than 32 million Americans from the commercial market and through the expansion of State Medicaid programs, thereby expanding the demand for health care within communities (Hofer, Abraham, & Moscovice, 2011). Reducing the cost of health care in America is easier said than done, especially when the addition of 32 million insured health care consumers is part of the goal. Presumably, many of the people being covered by Medicaid expansion will come with a history of poorly managed care and multiple comorbidities. Under these circumstances cost reduction can only be realized by improving the quality of the care provided while providing care in the most cost efficient manner.

America currently outspends all other industrialized nations on health care, yet ranks between 17th and 37th, depending on the measure, on many clinical outcome indicators, (Berwick, Nolan, & Whittington, 2008). The ACA improves service delivery systems to ensure that the best possible care is being delivered to those people in need, in easily accessible community locations and that the delivery system has its focus on payment for valued outcomes rather than volume.

It has been said that the most important legacy of the ACA is that it legitimizes prevention as an important individual and population health activity (Koh & Sebelius, 2010). The ACA places the management of population health front and center with its emphasis on prevention, which has led to the development of wellness self-management tools for primary, secondary, and tertiary interventions (Campanelli, 2015; Anderko et al., 2012). The ACA has changed the conversation governing research on most University campuses through the implementation of the Person Centered Outcomes Research Institute (PCORI) not only with its focus on prevention but also on the emphasis placed on person centered, clinical outcomes.

There is not a single dimension of the triple aim that will not require workforce "re-tooling" of the existing cadre of health care workers and researchers as well as refocusing the education of our aspiring professional workforce.

While various segments of the American population are impacted by the implementation of the ACA in different ways, perhaps the populations of greatest concern are those covered by health insurance provided by the federal government: Comprehensive Health Insurance Program (CHIP) for children; Medicare for older adults, especially the frail elderly, and Medicaid for the disabled and poor. CHIP, Medicare and Medicaid are the largest health insurance carriers in the country, insuring an estimated 3.6 million children, 4.6 million older adults, and 31 million poor and disabled people (Medicaid .gov. 2014). The total cost of health care in the United States is approximately $3 trillion, hovering at 18% of the gross national product. The ACA was intended to bend this proverbial and unsustainable health care "cost curve," while also improving the health of the nation.

Given the amount of U.S. health care expenditures and the current state of quality within the health care arena, there is no more important priority than helping the workforce re-align its skills and practice behaviors to be in sync with ACA trajectories. There are many ways to provide training and many training settings that have developed in response to this need. In response to recognizing the urgent need to re-train the workforce, both federal and state initiatives are requiring that workforce re-training be written into health care requests for funding and grants that are being made available specifically targeting this purpose.

Universities are not known for flexible curriculums that rapidly respond to changing circumstances, but continuing education programs within various graduate programs do have considerably more flexibility and have the ability to bring the considerable University resources to bear on rapidly evolving training programs to meet the needs of adult learning communities. This is precisely why several major universities across the nation have developed certificate programs in integrated primary and behavioral health care within their continuing education programs. It makes perfect sense that schools of Social Work are likely places to embrace this adult education activity given the fact that social work is the second largest profession among the health care work force (Bodenheimer & Grumbach, 2012).

The University Response to Re-Training the Workforce: Credentialing and Developing the Metrics of Practice Change

Higher education has historically been charged with preparing the workforce for health care delivery, specifically, by providing the training needed to produce competent professionals who have the capacity to provide high quality care. However, the vast majority of graduate health professional training programs are challenged to move away from training that prepares solo practitioners toward a new focus on on collaborative interventions that involve evidence based treatments and technological advances. In 2010, as the ACA was signed into law, the New York University Silver School of Social Work (SSSW), under the auspices of the Dean of the SSSW, and in collaboration with the Office of Global and Life Long Learning and McSilver Institute for Poverty, Policy and Research, undertook the development of an Advanced Certificate program in Integrated Primary and Behavioral Health Care. This development was facilitated by an interdisciplinary and inter-governmental steering committee whose mission was to identify and develop a curriculum for a continuing education program that would allow participants to develop the necessary skills to successfully practice within the new, evolving health care system. Initially, five learning domains were identified which included (1) The Affordable Care Act; (2) Social Determinants of Health; (3) Person -Centered Planning; (4) Promoting Systems and Organizational Accountability; and (5) Providing Leadership through Times of Change. Subsequently, a sixth module, Trauma Informed Care, was added as an option to students interested in learning about the enormous impact that trauma has on health care outcomes (Fellitti et al., 1998). In addition, a seventh module is in development focusing in on the role of prevention and wellness management within the context of case management and chronic illness. Table 1 on page 34 reflects each module and the topic areas covered within each.

During the committees work three important principals emerged that helped guide the structure of the advanced certificate. First, it was believed that this training should be based on the most current literature related to health care practices during this time of change and it was also important to make sure the training experience was standardized. Each module is a carefully designed and outlined for students with a syllabus that includes guided readings in the current literature. Students are also provided with an instructional power point presentation for each lesson and also have the opportunity of learning from guest presenters who are experts in their respective fields. Secondly, it was acknowledged that people who participate work during the day and therefore most modules are offered during the early evening hours and also utilize

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- 25% discount for three or more applicants from the same agency
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BEHAVIORAL HEALTH NEWS DESK

NYC Mayor and First Lady Release Mental Health Roadmap

Office of NYC Mayor
Bill de Blasio

Mayor Bill de Blasio and First Lady Chirlane McCray have released ThriveNYC: A Mental Health Roadmap for All. ThriveNYC is a plan of action to guide the city toward a more effective and holistic system that outlines 54 initiatives, 23 of them new, to support the mental well-being of New Yorkers. Additionally, ThriveNYC creates a model that can be applied nationally and a framework for advocacy.

ThriveNYC is a bold response to a challenging reality: one in five adult New Yorkers face a mental health disorder each year. Eight percent of high school students in New York City report attempting suicide, and more than one in four report feeling persistently sad or hopeless. Deaths because of unintentional drug overdose now outnumber both homicide and motor vehicle fatalities.

Many New Yorkers are suffering, even though mental health problems are treatable. In addition to the human toll, failure


Credit: Rob Bennett

Mayor Bill de Blasio

to adequately address mental illness and substance misuse costs New York City's economy an estimated $14 billion annually in productivity losses.


Credit: Demetrius Freeman

First Lady Chirlane McCray

ThriveNYC sets forth a plan to make sure that New Yorkers can get the treatment that they need – and lays out an approach that will improve the mental wellbeing of all New Yorkers. The plan sets forth six principles for achieving long-term change:

• Change the culture by making mental health everybody's business and having an open conversation about mental health.

• Act early to prevent, intervene more quickly and give New Yorkers more tools to weather challenges.

• Close treatment gaps by providing equal access to care for New Yorkers in every neighborhood.

• Partner with communities to embrace their wisdom and strength and to collaborate for culturally competent solutions.

• Use data better to address gaps and improve programs.

• Strengthen government's ability to lead by coordinating an unprecedented effort to support the mental health of all New Yorkers.

see Roadmap on page 37

Training Increases Substance Abuse and Mental Health Interventions

By National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Two to three brief training sessions can significantly increase pediatricians' use of techniques for identifying and treating young people with potential alcohol, substance use, and mental health problems, according to a new study in a large pediatric primary care clinic. Collectively known as screening, brief intervention, and referral to treatment (SBIRT), such techniques could be important tools for preventing and treating these common problems among young people. The study also found that pediatric practices can improve support for patients who need these services by adding behavioral health clinicians to their teams. A report of the study, which was funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), part of the National Institutes of Health, is now online in JAMA Pediatrics.

"This research provides valuable new information about strategies that might improve implementation of SBIRT in everyday pediatric practice settings," says NIAAA Director George F. Koob, Ph.D.

Underage drinking and drug use, which often coexist with mental health problems, are common and dangerous. Risks of heavy drinking in adolescence, for example, range from injuries and school troubles to long-lasting brain changes and dependence.

Research has shown that primary care physicians who conduct SBIRT with adult patients can reduce heavy drinking, its harmful consequences, and related health care costs. In recent years, mounting evidence has supported the use of SBIRT by primary care pediatricians to prevent substance use problems from starting or escalating in their young patients. However, physicians often face barriers to providing these services, including time constraints and a lack of training in SBIRT.

The new study, led by Stacy Sterling, Dr.P.H.(c.), M.S.W. at Kaiser Permanente Northern California in Oakland, compared practical ways to overcome both barriers in a general pediatric care clinic.

In a two-year trial that involved nearly 50 pediatricians and about 1,900 adolescents, researchers measured SBIRT use among three groups of clinicians.

"A 'pediatrician-only' group was offered three 60-minute SBIRT training sessions," explains Ms. Sterling. "In the clinic, this group was then expected to conduct full SBIRT assessments and brief interventions by themselves as needed."

A second group of pediatricians had one 60-minute training session. In the clinic, this group was expected to assess patients and refer them as needed to clinical psychologists who had been "embedded" into the practices to conduct interventions.

A "usual care" group of pediatricians served as controls. They had access to the same clinical guidelines and tools, but did not take part in SBIRT training or have embedded clinical psychologists in their practices.

The researchers found that, following SBIRT training, the pediatrician-only group was about 10 times more likely (16 percent vs. 1.5 percent) to conduct brief interventions with patients deemed at risk, compared with "usual care" pediatricians. In the group of SBIRT-trained pediatricians that worked in-tandem with "embedded" clinical psychologists the brief intervention rate was 24.5 percent, compared with 16 percent in the pediatrician-only group, and 1.5 percent in the usual care group.

"Both intervention arms administered more assessments and brief interventions than those in usual care," notes Constance Weisner, Dr.P.H., M.S.W., at Kaiser Permanente Northern California in Oakland, and the University of California, San Francisco, the principal investigator of the study. "However, overall pediatrician attention to behavioral health concerns was still low. Embedding non-physician clinicians in primary care could be a cost-effective alternative to pediatricians providing these services, and future analyses of the study data will examine patient outcomes and cost-effectiveness of the two SBIRT modalities."

BEHAVIORAL HEALTH NEWS DESK

Beacon Health Options Names Jorge Petit, MD To Lead NY Market

By Amy Sheyer,
AVP, External Relations, Beacon

Beacon Health Options (Beacon), the nation's premier behavioral health company, announced today that Jorge R. Petit, MD, has been named the Regional Senior Vice President for Beacon's New York market. In this role, which began in September, Dr. Petit will work with stakeholders in the New York health care delivery system to develop strategies for improving behavioral health care throughout the state. This collaborative work will guide him in overseeing the delivery and coordination of mental health care and substance use disorder services for the company's more than 5.5 million New York members.

"Jorge is a perfect fit to lead our New York team. He thoroughly understands the provider community and health care policies of New York as a result of his extensive consulting work and his three-year term as Associate Commissioner in the New York City Department of Health and Mental Hygiene's Division of Mental Hygiene," said Jim Spink, Beacon Health Options Executive Vice President, National Client Partnerships. "This experience combined with his work as a practicing psychiatrist gives him an in-depth understanding of the New York health care market, including the consumers, and health plan clients we serve."

Jorge R. Petit, MD

A board-certified psychiatrist, Dr. Petit joins Beacon from Quality Healthcare Solutions Group, a consulting and training firm focused on patient care and health information technologies to improve health care systems. As founder and president of the organization, he has consulted with many New York City (NYC) community-based organizations and has worked on projects with the NYC Department of Health and Mental Hygiene, the New York State Office of Mental Health, as well as stakeholder groups, such as the Coalition of Behavioral Health Agencies. As the Associate Commissioner of NYC's Division of Mental Hygiene, Dr. Petit managed a $280 million annual budget, he oversaw all of the city's funded contracts and agreements in the areas of mental health, chemical dependency, and mental retardation and developmental disabilities. Most recently he served as the Clinical Director for Integrated Care and Clinical Partnerships at the Institute for Family Health, a position funded by a Robin Hood Foundation grant to focus on how integrated care models can improve health outcomes and reduce poverty.

Dr. Petit has been appointed to numerous academic, hospital, professional and committee positions, including the North East Business Group on Health (NEBGH), Mental Health Task Force, One Voice Initiative and the Mental Health Workplace Summit. He has been tapped for his expertise on mental health issues by numerous broadcast news outlets, including, CNN, CNN Español, Fox News and NY1. He has also used his psychiatry expertise and hands-on experience in the community to write books and articles on various mental health issues, ranging from depression to emergency psychiatry to psychiatric administration and leadership. He currently serves as Chairman of the Mental Health News Education, Inc. Board of Directors, publishers of Behavioral Health News.

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10 Percent of US Adults Have Drug Use Disorder at Some Point

By National Institute on Alcohol Abuse and Alcoholism (NIAAA)

A survey of American adults revealed that drug use disorder is common, co-occurs with a range of mental health disorders and often goes untreated. The study, funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), part of the National Institutes of Health, found that about 4 percent of Americans met the criteria for drug use disorder in the past year and about 10 percent have had drug use disorder at some time in their lives.

"Based on these findings, more than 23 million adults in the United States have struggled with problematic drug use," said George F. Koob, Ph.D., NIAAA director. "Given these numbers, and other recent findings about the prevalence and undertreatment of alcohol use disorder in the U.S., it is vitally important that we continue our efforts to understand the underlying causes of drug and alcohol addiction, their relationship to other psychiatric conditions and the most effective forms of treatment."

A diagnosis of drug use disorder is based on a list of symptoms including craving, withdrawal, lack of control, and negative effects on personal and professional responsibilities. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) no longer uses the terms abuse and dependence. Instead, DSM-5 uses a single disorder which is rated by severity (mild, moderate, and severe) depending on the number of symptoms met. Individuals must meet at least two of 11 symptoms to be diagnosed with a drug use disorder.

This includes the problematic use of amphetamines, marijuana, club drugs (e.g., ecstasy, ketamine, methamphetamine), cocaine, hallucinogens, heroin, non-heroin opioids (e.g., oxycodone, morphine), sedatives/tranquilizers, and solvents/inhalants. Face-to-face interviews were conducted to diagnose drug use disorder, as well as alcohol use disorder, nicotine use disorder, and various personality disorders.

The study, based on NIAAA's National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III), found that drug use disorder was more common among men, white and Native American individuals, and those who are single or no longer married. Younger individuals and those with lower income and education levels were also at greater risk. Regional differences were found as well, with those living in the 13 Western-most states in the U.S. (including Alaska and Hawaii) more likely to have drug use disorder during their lives.

The study was led by Dr. Bridget Grant, Ph.D., Ph.D., (doctorates in psychology and epidemiology), of the NIAAA Laboratory of Epidemiology and Biometry. Dr. Grant's lab conducts NESARC, a series of national epidemiological surveys that evaluate alcohol use, drug use and related psychiatric conditions. More than 36,000 people were evaluated using DSM-5 criteria. The study currently appears online in the Journal of the American Medical Association (JAMA) Psychiatry.

Similar to past research, the present study showed that people with drug use disorder were significantly more likely to have a broad range of psychiatric disorders, including mood, anxiety, post-traumatic stress and personality disorders. Individuals with drug use disorder in the past year were 1.3 times as likely to experience clinical depression, 1.6 times as likely to have post-traumatic stress disorder (PTSD) and 1.8 times as likely to have borderline personality disorder, when compared to people without drug use disorder. Drug use disorder was also linked to both alcohol and nicotine use disorder, with a three-fold increase in risk.

"The prevalence and complexity of drug use disorders revealed in this study coupled with the lack of treatment speak to the urgent need for health care professionals to be trained in proper techniques to identify, assess, diagnose, and treat substance use disorders among patients in their practice," said Nora D. Volkow, M.D., director of the National Institute on Drug Abuse, which contributed funding to the study.

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The NYSPA Report: Momentum Building For Comprehensive Mental Health Reform in Congress

Matthew Sturm, Director
Legislative and Regulatory Policy
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More than three years after the tragic shooting at Sandy Hook Elementary School sparked a national conversation on issues related to mental illness and the prevention of violence to self and others, Congress is currently closer than any point in recent history to act on bipartisan, bicameral comprehensive mental health reform legislation that many say would rank along with the Community Mental Health Services Act of 1963 and the Mental Health Parity and Addiction Equity Act of 2008 in terms of historical significance.

After Sandy Hook, leaders of the House of Representatives tasked Representative Tim Murphy, PhD (R-PA) with investigating and providing recommendations on federal mental health policies and priorities. What followed was a bevy of oversight hearings led by Murphy, reports, and stakeholder meetings that resulted in his introduction of the Helping Families in Mental Health Crisis Act of 2013 along with his lead Democrat partner Eddie Bernice Johnson, RN (D-TX). It should be said that both Murphy and Johnson are mental health clinicians (a clinical psychologist and psychiatric nurse practitioner, respectively) with significant real world experience in these issues outside of their responsibilities as sitting members of Congress.

Though his legislation was held up in Congress in 2013 and 2014, the reintroduced version of the Helping Families in Mental Health Crisis Act (H.R. 2646) has received heightened interest and, as a critical step, passed out of the House Energy and Commerce Subcommittee on Health in November. Companion legislation has now also been introduced in the United States Senate by Bill Cassidy, M.D. (R-LA) and Christopher Murphy (D-CT). The Mental Health Reform Act of 2015 (S.1945) has a number of bipartisan cosponsors in the Senate, and its provisions substantially overlap Murphy's efforts in the House.

These bills would institute a number of critical reforms to the nation's fragmented mental health system.

Both bills would establish a new single coordinator for federal mental health resources and research. The duties and priorities of the proposed *Assistant Secretary for Mental Health and Substance Use Disorders* would emphasize the promotion of science-driven and evidence-based approaches to care. The Assistant Secretary would also evaluate mental health delivery models and disseminate evidence-based strategies to federal grantees and work to modernize and raise the profile of the Substance Abuse and Mental Health Services Administration.

Both bills would address pervasive workforce shortages among psychiatrists and other mental health clinicians. Representative Murphy has undertaken considerable effort to add workforce provisions

Matthew Sturm

to his legislation, and Senators Cassidy and Murphy have followed suit. The bills would require the development, implementation, and continuous review of a Nationwide Mental Health Workforce Strategy, among other provisions.

Both bills step up enforcement of the landmark bipartisan Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA, and subsequent expansion of parity in the Affordable Care Act, barred most health plans from discriminatory coverage or treatment limitations for individuals suffering from mental illness, including substance use disorders. While the passage of the Parity Act was monumental, much work remains to enforce the parity law so as to realize its vision. These measures would strengthen parity through better coordinating enforcement activities, requiring relevant federal agencies to make important disclosures on compliance investigations, and strengthening oversight on insurers.

Both bills propose to boost financial support for important mental health research within the National Institutes of Health (NIH) related to brain disorders, innovative treatments and technologies, and the determinants of self and other-directed violence. As we know, federal funding supports the vast majority of research conducted by our nation's medical schools and universities. Unfortunately, appropriations for the National Institute of Mental Health over the last five years have not kept pace with biomedical inflation.

Both bills would support funding for innovative models of care, like the landmark Recovery After Initial Schizophrenia Episode (RAISE) program, which helps individuals with schizophrenia lead productive, independent lives with aiming to reduce financial impacts on public systems. Overall, the bills are substantially focused towards improving care for individuals with severe and persistent mental illness.

The efforts of these mental health champions have enjoyed wide support from the advocacy community. For example, leaders of the House Energy and Commerce recently received a letter urging advancement of comprehensive mental health efforts from groups including American Psychiatric Association, American Psychological Association, the National Alliance on Mental Illness, Mental Health America, the American College of Emergency Physicians, and the National Council for Behavioral Health, among many other signatories.

Comprehensive mental health reform efforts in Congress have also received significant media coverage and editorial endorsements from outlets as diverse as the Wall Street Journal and the National Review to the Washington Post and San Francisco Chronicle. As someone who monitors Capitol Hill health policy coverage daily, I can say with confidence that the attention and coverage of this moment in mental health advocacy history is truly unique when judged by the quantity of blogs, email alerts, and inquiries from the likes of Politico, Congressional Quarterly, and other newspapers that cover the Hill.

Moreover, these bills have widespread bipartisan support among their sponsors' colleagues. H.R. 2646 has 166 bipartisan cosponsors, and S. 1945 has cosponsors that range from hardline conservatives like Senator David Vitter (R-LA) to liberal stalwart Elizabeth Warren (D-MA). Notably, Paul Ryan, the freshly minted Speaker of the House of Representatives recently remarked that "we need to look at fixing our nation's mental illness health system – an example, Tim Murphy, Congressman from Pennsylvania, has a bill that is working its way through Committee – I'm sure both parties have lots of ideas in this area, but we should make this a priority."

This is not to gloss over the fact that clear challenges remain before the President's signing ceremony for comprehensive mental health reform legislation. Further committee action and floor consideration are required for both H.R. 2646 and S. 1945 in their respective chambers. Though the bills are remarkably similar, any policy differences will need to be ironed out in a bipartisan and bicameral conference. Congress must also not let firearms politics sink the opportunity to substantially improve the nation's mental health system. Moreover, federal budget and deficit worries frequently necessitate the identification of "payfors" (corresponding cuts or raises in revenue) that would offset any proposed increases in mental health spending. Lastly, the nation and its political infrastructure are moving into the 2016 Presidential election season and all of the associated baggage that entails.

My sincere hope is that this clear momentum for enactment of comprehensive mental health reform translates into action by Congress.

A Behavioral Health Workforce for An Aging America

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

As efforts are made to improve America's inadequate behavioral health workforce, the needs of older adults should be a central concern.

By 2030, Americans over the age of 65 will become as large a portion of the population as children under the age of 18. But there is far more interest in meeting the mental health needs of children than of older adults.

One of the reasons for this is the sense that older adults are not the future of America; children are. Obviously, children have more years of life ahead of them than older adults do, but a person who has lived to be 65 will, on average, make it to about 85; half will live longer.

Older adults do have a future. Not only will they survive for many years; they also will have many years in which they can enjoy life and contribute to the American society. Making the most of old age should be a major social goal and is a key challenge for America's behavioral health systems.

The current behavioral health workforce is neither large enough nor adequately prepared to respond effectively to the specific needs of older adults.

It is important to understand that old people are not just adults who are older than younger adults. They are in a different developmental stage and experiencing significant changes both physically and psychologically.

Michael B. Friedman, LMSW

The behavioral health workforce in an aging America needs to understand these developmental changes. It needs to be "generationally" as well as clinically and culturally competent.

Key characteristics of a generationally competent behavioral health workforce include:

Geriatric Clinical Competence: Behavioral health professionals and paraprofessionals need to make adaptations to clinical practice for older adults in a variety of ways. For example, psychiatric medications have greater risks for older adults. These include increased rates of serious physical side effects and especially of falls, which are the greatest cause of disability among old people. In addition, older adults are likely to have chronic physical conditions as well as mental and/or substance use disorders. This makes integrated treatment critical for older adults. Of particular concern is physical pain, which can contribute to misuse and abuse of alcohol and painkillers.

Generational Competence In Multiple Fields Of Practice: Although mental health and substance abuse professionals are obviously central to a behavioral health workforce for older people, they are far from the sole important practitioners. For example, primary health care professionals currently provide most treatment for mental disorders, relying heavily on the use of psychiatric medications. In general they are poorly prepared to identify mental and/or substance use disorders or to provide appropriate treatment even when medication is the treatment of choice. Preparing primary care professionals is a critical challenge in developing a competent geriatric behavioral health workforce.

In addition, older adults with psychological problems seek and get help in a variety of settings that are not designed to provide psychological or substance abuse treatment, including senior centers, houses of worship, senior housing, and naturally occurring retirement communities (NORCs). People who work in these settings also need to be far better prepared to identify and respond to mental and substance use disorders.

A Developmental Perspective: In our culture many of the physical, mental, and social changes associated with old age are regarded as pathological rather than as normal human development. A developmental perspective includes an appreciation of both the challenges and opportunities of aging. Role changes—such as retirement and changes in parental responsibilities, diminished physical and mental capacities, chronic ailments often with increased pain, losses of friends and family, and ultimately facing death can make aging difficult. But it is also possible for old age to be a time of fulfillment. Eric Erickson, for example, noted that old age could result either in a sense of "despair" or in the achievement of "integrity," a complex state that includes pride, meaning, authenticity, and hope despite approaching the end of life. A generationally competent behavioral health workforce needs to have a developmental perspective along Ericksonian lines.

The Spiritual Dimension Of Life: For most people regardless of age, religious or spiritual experience is an important and valued part of life. For many older adults, the spiritual dimension of life becomes more and more important as they come closer and closer to death. Most behavioral health professionals are not trained to understand or relate to their clients' spirituality. In fact, many shy away from it because the spiritual seems unscientific. This limits their ability to help the people they serve to achieve integrity in old age. A generationally competent behavioral health workforce needs to be able to help those for whom spirituality matters to have a positive spiritual experience and especially to help people nearing death to make peace with mortality.

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More Than Just a Change in Title: New Statewide Effort Supports the Move from Case Management to Care Management

By Ruth Colón-Wagner, LMSW
Senior Projects Coordinator
New York Association of Psychiatric Rehabilitation Services (NYAPRS)

How does one move from working as a Case Manager to a successful Care Manager? The change in title is simply the exchange of one letter, the 's' for an 'r'. However, the change from one role to the other is not so simple.

It's been almost five years since New York State instituted the Health Home initiative with the overall purpose of helping people live healthier lives. As with the change of title, the change may seem simple yet the impact on population health has the potential to be life altering. In this case, the purpose of Health Homes is simple, straightforward, and even noble.

The Health Home integrated approach to care for people with disabilities moves us from our traditional siloed treatments to more holistic approaches. Finally, someone realized that treating the whole person is best. While a major goal of this initiative is to save healthcare dollars, its new focus and design will serve us all well.

The "Triple Aim" emerged in 2008 and has since served as the foundation for the federal Affordable Care Act and state reform efforts including New York's Medicaid Redesign initiatives. The idea is that the healthcare system will provide better care, people will become healthier and the system will provide more effective care at lower costs. Traditionally, the healthcare system has used a fee-for-service billing structure. Now, with the system focused on improving health, it is changing in the direction of payment for value, over payment for volume – or per each contact.

With the advent of Health Homes and the changes that followed, silos are being eliminated and a uniform workforce is being created to assist people to achieve wellness with collaboration from all appropriate systems and supports. Case Managers have been transformed to "Care Managers" and tasked with working directly with the Health Homes. The new Care Management staff are now charged not only with assisting a person with their mental health needs but also with their physical health needs. To be successful, the Care Manager must serve as the conduit for all services and supports in a person's life so that overall health and wellness can be achieved.

To help create an image to this concept of enhanced communication, let's consider a spider's web. The nexus of the web is the person accessing services and all their supports are the intersecting points of the web around them. All of these web points in turn connect to the nexus – the person – as all web points connect to each other. They can only do this through the silk web strand which creates the web. Imagine the silk strand as the Care Manager. Each support, whether individual or system, is linked to the person and to each other through the Care Manager.

The transformation required of this new workforce is significant. For a workforce that historically only navigated one system, the mental health system, the challenge becomes how to navigate the physical health system as well and how to integrate each person's needs and the services that can assist them. The systems are highly complex and the Care Manager must now become the 'expert' in understanding multiple systems – the person placed in the role of ensuring all people in this person's support are tethered together, to continue the web analogy.

The broadened responsibilities of the new role of the Care Manager add a number of new competencies. Overall, the CM must be able to demonstrate competent engagement skills and knowledge of the Stages of Change (Prochaska, JO.; DiClemente, CC.; 2005.) to even begin to work successfully.

Other competencies include the ability to integrate physical health, mental health and substance use treatments for people with multiple chronic conditions; knowledge and understanding of health, the impacts on health and social risks; intervention strategies; assessment and care planning; collaboration and referrals; ability to communicate with various disciplines within varied systems; providing care that is recovery oriented, person centered and culturally relevant; possessing the ability to provide care that is proactive and focuses on prevention and diversion instead of reactive traditional care;

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Supervision: Paying Attention to the Soul, Not the Technique

By Samuel C. Klagsbrun, MD
Executive Medical Director
Four Winds Hospital

Although I've never been a psychoanalyst I did spend a year in analysis and took classes at the Columbia Psychoanalytic Institute. I left at the end of a year because being in practice at that time I came to realize that my own style of work was much more realistic, confrontational and time conscious than my analytic experience was and so I left the program.

Yet after over fifty years of practice I am deeply appreciative of my analytic experience as short as it was! Being conscious of childhood history, being sensitive to dreams, unconscious thoughts and emotions as well as free associations has always made me sensitive to my patients in ways that today's therapy seems to pay little attention to or ignores completely.

Picking up on those kind of comments when my patients utter them has always led me to ask more profound questions and pursue issues which have frequently led to important matters which could easily have remained hidden.

By contrast, today's psychotherapy style is leading us to a much more rapid approach to treatment. DBT, CBT, mindfulness, psychopharmacology are all practical and offer realistic approaches to speeding up therapy. But I feel we have left the baby in the bath water—to use a very old fashion word, we have abandoned the soul of therapy.

Granted we may with current approaches ease the pain or depressive and anxiety symptoms effectively, but what about the person behind the symptoms.

My own emphasize in therapy stresses the nature of the relationship between the patient and the therapist. A patient who feels a profound connection to a therapist—who feels deeply understood—who feels the therapist "gets" him or her—who is feeling accepted and understood as a whole person, not as a diagnostic entity with symptoms, will invariably open up and reveal much more than a "patient" would.

Therefore as a supervisor I always stress the need to know the patient's history in detail, as opposed to focusing primarily on the symptoms. I inquire about the relationships, successes and failures, goals and frustrations, losses and traumas as well as a detailed history of upbringing. I want to be able to feel whatever the patient is feeling. Once this information is given I will then focus on symptoms and diagnostic issues.

To start with, I strongly believe that the impact of early child experiences, whether positive or negative have a profound impact on a person's life throughout their entire life. Subsequent life experiences, in my view, are always handled through the prism of the way we have all grown up. Let me offer an example. Obviously I will present a case whose identity will be disguised but the basic issues presented will be accurate and real.

Samuel C. Klagsbrun, MD

One of my longest lasting patients in weekly therapy for many years is a woman in her 60's. Married with three adult children who was referred to me by her Internist who became alarmed with her wildly fluctuating, often hysterical behavior. He feared the danger of her accidently causing herself harm due to poor judgment, impulsivity, and out of control behavior.

In our early meetings, she insisted on getting pills to calm her down and was very reluctant to engage in any exploratory talk. At one point I told her to answer my questions, other-wise I would not write any prescriptions to calm her down. She reluctantly began to respond with deep resentment.

It turned out that she was born into a family of very damaging parents. Her mother was a massively controlling person. Her father was constantly furious, short-tempered, unreachable and critical. Her parents fought and argued constantly.

My patient Ruth, remembered closing the door to her room to shut out the screaming her parents did constantly, feeling frightened and crying.

Her college years were a bit more stable being away at school; however upon graduation she moved back with her parents and sank into depression. She was introduced to a man by her aunt and ended up marrying him, though admitting she got married not out of love but as a solution to leave her home.

At times of tension in her new home she quickly seemed to lose control in a manner very much like her mother—throwing things and breaking them, screaming, running out of the house, taking the car and driving away in an erratic way.

When they began having children, her outbursts decreased somewhat, but as the kids got older they became the target of her anger along with her husband.

Finally, her exasperated husband insisted that she get into therapy otherwise he would leave her and take the kids with him. That's when she came to see me.

One approach could have been to use "anger management" techniques. In reviewing her history however, including the impact of her upbringing on her way of dealing with frustration, I felt it much wiser to go to a more classical route and focus on the impact of her early life on her present situation.

By being gentle, supportive and focusing on understandable anger, she felt that I accepted the legitimacy of her feelings. She slowly began opening up feeling safe in expressing her feelings and making the connections between the feelings stemming from her early life to the current difficulties. She slowly evolved into a much more calm, understanding and accepting person.

Over the course of some years of weekly sessions her behavior at home turned around and she became secure and comfortable with herself. Her ability to go back to childhood, understanding what she went through, gave her a good understanding of the consequences influencing her adult life. It gave her insight into her behavior and with a strong wish to change her life; it enabled her to manage her emotions in a mature and sensible way.

A second example is that of an artist in his mid-fifties who decided to seek therapy because of the conflict between his own wishes and his mother's continuing, amazing, incredible and total control over every decision he's made in his life. Ben has a studio in which he paints and has his work shown in a number of galleries around the city. He is totally dependent financially on his parents having rarely succeeded in selling his work. Ben is also spending a lot of time with a very talented, independent-minded and self-sufficient woman who is a singer. She is reasonably successful, travels far and wide, singing in concerts and clubs in America as well as Europe. Ben's mother constantly interferes in the relationship between Ben and Joan.

In the early stages of our therapy Ben spent a tremendous amount of time describing every single interference of his mother in all aspects of his life during early childhood. He rarely was allowed to play by himself. His mother chose all of his friends, criticizing any of them who demonstrated any inclination towards independence. Ben went to private schools chosen by his mother. She spent a lot of time meeting his teachers and expressing her wishes to them about Ben. There was almost no mention of his father. As Ben moved into high school, his mother became even more involved in his social life, resenting any move towards independence. Ben never rebelled, never contradicted her and was the "ideal good boy." He rarely has any close relationships with boys or girls and ended up going to college near his home, therefore never spending any time away from his mother.

As Ben matured he was able to convince his mother to give him permission to rent a studio while still living at home. He expressed himself in his art work in a very infantile fashion and was not very successful in getting his work shown.

At one point Ben was introduced to a woman who was very similar to his mother. She was intense, controlling, domineering and clearly approved of his mother's style. They got married and had a baby girl who was totally controlled by Ben's wife in the same way that he had been controlled by his mother.

Ben spoke a lot of his sadness at watching his daughter become part of his wife's life and basically totally distant from him. As their life became relatively empty of emotions his wife decided to separate and Ben offered no objection. They got divorced and now a few years later, he rarely, if ever, sees his daughter.

In his early fifties Ben became aware of the profound emptiness with his life and entered into therapy. His longing for independence has been a constant theme in his expressions. The other side of the coin however is that anytime he spoke of his wishes to become independent, self-sufficient, and to separate from his mother, the level of guilt sweeping into his language was incredible. It was as though he was saying things that were totally sacrilegious and wrong. Spending a lot of time encouraging him to express precisely those thoughts and to recognize the level of guilt he felt in expressing them as an indication of pathology—not wrong doing, became a theme of therapy for a long time.

Luckily Ben was introduced to a subsequent woman, Jane, who appreciated his artistic work and was apparently very interested in Ben becoming very independent. Her influence in Ben's life made my work with him speed up consistently. The level of guilt in speaking about his mother never quite left him but decreased a great deal. Making decisions without checking with his mother became more frequent and interestingly enough Ben's relationship with his father, who was an extremely weak man, also under the control of his wife, helped the father speak up more openly about his own wishes. Between Jane and Ben's father, the atmosphere in the family changed gradually but significantly. Ben began spending much more time away from his parent's home. He traveled more with Jane, at times not even staying in contact with his parents when away and most recently ended up moving into an apartment with Jane, and letting his parents know that he had made that decision. There are still times when he feels that he is doing something wrong in making independent decisions but he seems to be able to get over those feelings fairly quickly.

In both these examples both patients demonstrate the power and influence of a restricted upbringing on their adult life. The influence of their upbringing seeps into nearly every aspect of their adult lives and the amount of work it takes to become free of that early training is enormous and is essential to the patient's growth and independence.

Effective Supervision: An Essential Component to Enhancing Consumer Outcomes

By David Kamnitzer, LCSW-R
Senior Vice President, Rehabilitation and Support Services, ICL

The behavioral healthcare industry is facing a monumental time of change. The mental health field in particular is faced with putting more responsibility on consumers to drive their own treatment. No longer, it seems, will a person with mental health challenges be cared for in a prescriptive, or "by-the-book," kind of way. When an agency says its model of care is person-centered and individualized, that means that consumers are given the challenge of driving their own treatment, with the help and guidance of a knowledgeable workforce. Staff today are trained to understand that our work with individuals must come from the core belief that hope and healing are possible and that recovery has many pathways.

What does this new healthcare environment mean for staff? It means they must begin to think about the individuals they work with from multiple lenses, learning to understand their own feelings and reactions and how that might impact a consumer's actions. It means that supervisors must help the workforce buy into new models of care, models that sometimes require staff to look inward. It

David Kamnitzer, LCSW-R

means that supervisors must help staff look at outcomes—Are consumers getting better? Is the treatment provided effective? —and must make asking about outcomes part of the supervisory discourse. Supervisors must help staff be objective, introspective, and reflective. And it is through this active and collaborative supervision that both consumers and staff will learn to be more effective agents of change.

The new frontier of managed care requires a degree of collaboration not seen before. Care providers will be speaking with one another and working with the consumer to help him or her get the best outcomes possible. So while this interaction may enhance a consumer's future, staff must be willing to partner with collateral providers in a variety of new ways that may be quite unfamiliar at first. This interactivity may require more patience, a greater understanding of the system, and more accountability. Here is where supervision can offer its greatest reward. Staff can learn to listen more effectively to what consumers are saying as well as to what other care providers in the consumer's network are saying. This coordination requires that staff be open, flexible, and honest with themselves and one another, as well as respectful of differing viewpoints. They must learn to accept feedback in a non-defensive manner and must be willing to integrate their supervisor's consultation.

Supervision becomes even more important in this cooperative scenario because the supervisor wants to make sure that all staff members are effectively collaborating with one another. Supervision is where that care coordination can be discussed—working to make sure that everyone is looking to achieve the best possible outcomes for the consumer and understanding the pathways each member of the care team is taking to get there. Learning to update each team member's activity with other providers is pivotal in making sure that the consumer's goals are a priority.

In any field, an effective supervisor helps get the best out of his or her staff and motivates a worker to perform at an optimum level. Particularly in the behavioral health field, the best care is relationship-based—built on trust and mutual respect. This is true between staff and the consumer as well as between staff and his or her supervisor. The role of supervision must be one of respect, and it must be one of support. The supervisor is there for staff to bounce ideas off, to develop a plan for updating a consumer's records, to help understand how to best inspire, and to entrust that staff members learn to trust themselves and their ideas.

Accountability is essential. Supervisors must help staff transition to this new healthcare environment, where we know that recovery is possible. Staff must learn to embrace their roles as helpers as consumers learn to advocate for themselves and their own goals. Supervisors must assess staff competencies and provide support in areas that need work while

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The Challenges of Hiring and Retaining Top Talent

By Mary Pender Greene, LCSW-R, CGP
President and CEO
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Management consultant, educator, and author Peter Drucker stated, "Making a living is no longer enough. Work also has to make a life." In this economic climate, many organizations have designed initiatives to nurture its rising talent. It makes good economic sense, as high-performance individuals can have great impact on program results. However, retention strategies geared toward top talent often fall short of delivering anticipated results.

According to recent leadership development research by Harvard Business Review, disengagement by high-potential employees has been high since the beginning of the recession. According to one survey, nearly 40% of internal job moves made by staff identified as rising stars ended in failure. Additionally, more than 10 percent of all high potentials studied had reported actively seeking new employment. Many organizations may see their most promising employees leave as the economy rebounds.

We know that an organization's greatest asset is its staff. But even top staff may look for new opportunities unless they have compelling reasons to stay. High employee turnover hurts both the bottom line and morale. Research suggests that it can cost twice an employee's salary to source and train a replacement. So how can we, as non-profit leaders, ensure success when interviewing and hiring?

The best salary that our budgets will allow is only the beginning. Interestingly, it is not always the most effective retention tool. We must make many efforts to retain our top performers.

Interviewing

According to organizational management research, organizations that use a team approach to interview and select candidates make smarter hiring decisions. The purpose of the interview team is to evaluate the skills and talents the candidate needs to be successful. It's designed to reveal otherwise hard-to-detect strengths and challenges. Team interviewing involves multi-level staff that can determine if the candidate is a good fit with the organization's culture and the populations they are serving. Each member can offer a different perspective about the candidate's potential success in the new role. This enables collaboration and a sharing of insights and wisdom.

It's important to interview a mix of both generalists and experts with the population your organization serves. Look for individuals who have a "cradle to grave" skill set, those who can fill in workplace gaps, and those who have a passion for working in specific areas. Make certain the candidates are very knowledgeable about those they are serving. Train, coach, and supervise staff strategically to prevent inefficiencies, job dissatisfaction, and burnout. Prepare staff as experts for special populations, such as older adults, immigrants, and people who have experienced trauma. Train them to supervise a mixture of staff, and to be culturally and racially competent. Encourage staff to bring their whole selves to the role.

Experts agree that at least one interview question should require the candidate to stand and address the group to determine if he/she can quickly think on their feet. This is especially true if presenting, speaking, or facilitating skills are desired. If the candidate must be particularly effective interpersonally, suggest that he/she interact with future reports or a client group.

Staff Development

Neglecting staff development can cost you top talent. Staff development requires high-quality supervision and training. A strong supervisory team contributes to a positive work environment and enables success. This is a critical competitive advantage in attracting and retaining good staff. Skilled supervision means clearly defining roles and expectations, and then ensuring supervisors have the competencies to perform successfully.

Strong organizations have both effective management and leadership. What is the difference?

According to The Wall Street Journal's "Lessons in Leadership" Guide, managers plan, organize and coordinate. Leaders inspire and motivate. Or, as Peter Drucker put it, "Management is doing things right; leadership is doing the right things."

According to career experts, it's critical that the work consistently provides meaning, gratification, and fulfillment of potential. These intrinsic needs are equally important as compensation – and oftentimes even more so.

Tips

• Hire the right person from the start. Ensure that candidates not only have the right skills, but also fit in with the organization's culture and those they serve.

• Engage your staff. Create a positive work environment by giving respect, acknowledging accomplishments, and rewarding achievement. Give meaningful feedback, and never underestimate the power of praise.

• Be present for your staff. Pay close attention to your staff's personal needs. Offer compassion, flexibility, and resources when possible. Regularly touch base to gauge stress level and overall happiness.

• Outline clear career paths. Build many ladders and establish custom career paths. Make sure there are multiple opportunities for advancement. Tell your staff how they can improve and move up. Make check-ins around career goals a part of supervision. Encourage supervisors to perform as both coach and supervisor.

• Create challenges. Give challenging assignments. Encourage staff to attend workshops, seminars, and trainings. Offer CEUs at your location, if possible, and support other continuing education efforts.

• Keep up with technology. Invest in the best equipment your budget allows so your staff feels equipped to perform necessary research and deliver the best results possible.

• Be mindful of work-life balance. The stars of an organization are often the first to experience burnout and compassion fatigue. They are often overstretched due to managing many key projects. Promote balanced workloads and work-life balance.

New App Turns Compassion into Action to Help NYC's Homeless

By Staff Writer
Behavioral Health News

Three New York technologists recently launched WeShelter, a new app that provides a way to take meaningful, immediate action in response to homelessness. WeShelter, available now for iPhones, allows New Yorkers to unlock sponsored donations with the tap of a button – in less time than it takes to send a text – to support local non-profit homeless service partners. The entire process takes seconds, requires no monetary contribution from the user, and supports the effort to help people get and stay off the street. If a homeless individual needs assistance, the app can also connect users directly to a street outreach operator.

WeShelter was founded by Ilya Lyashevsky, Robb Chen-Ware and Ken Manning, experienced product managers, tech executives and engineers. With a record 62,000 homeless people in New York City, like many New Yorkers, they felt compelled to help their neighbors who live on the streets.

"When you see someone on the street, you feel compassion and you have the impulse to help, but you're not sure how," said Ilya Lyashevsky. "Now, all you need is your phone. The next time you pass someone on the street, you no longer have to feel like there's nothing you can do."

Robb Chen-Ware said, "As engineers, we wanted to develop a tech solution that captured the empathy people feel when they encounter someone living on the street, and let them take action simply and immediately."

Using the WeShelter app is easy: A user taps a large green button on the home screen whenever they want to raise money for the cause. WeShelter partners with local businesses that pledge sponsorship funds. Users unlock the funds with taps, then see the branding of the business sponsoring the donation, which goes to the city's most prominent homeless service organizations: Breaking Ground, Goddard Riverside Community Center, and Urban Pathways.

"Breaking Ground is excited to partner on this new effort to engage members of the public in solving homelessness," said Brenda Rosen, President and CEO of Breaking Ground, the city's largest supportive housing developer and street outreach provider for Brooklyn, Queens and nearly a third of Manhattan. "We're always looking for new ways to generate understanding of and support for our street outreach and housing programs to help the most vulnerable New Yorkers. The WeShelter app offers an innovative approach to engage and connect with everyday New Yorkers on this critical issue."

Frederick Shack, Chief Executive Officer of Urban Pathways, one of the City's leaders in providing a full range of services to homeless adults, from outreach to transitional and permanent housing, expressed similar sentiments. "Urban Pathways is proud to be a partner in this innovative program to help New York's hard-to-engage street homeless," Mr. Shack said. "New Yorkers are known for their compassion, and WeShelter will provide New Yorkers with an immediate way to provide direct support to benefit homeless individuals, many of whom have mental illnesses and have been living on the streets for years. New Yorkers who donate will also be confident that their donations are being directed to organizations with a proven record of effective service to the City's homeless."

In speaking of Goddard Riverside's involvement with the project, Stephan Russo, the organization's Executive Director, said, "Goddard Riverside has been at the forefront of New York City's homeless outreach efforts since 1979. We are keenly aware of the need for more public awareness of this important issue and are excited about the possibilities that the WeShelter app provides for raising public awareness and generating support for the vital work we do every day."

For future versions of the app, WeShelter is working on expanding to provide real-time data to street outreach workers about homeless activity around the city. By mapping information collected from thousands of people, WeShelter would enable outreach teams to operate more effectively as they attempt to locate and assist people in distress. WeShelter also seeks to provide key facts about homelessness to its users, and encourages them to share the information on social networks, with the hope of fostering a better understanding of the issue in the community.

For more information, visit their website at www.weshelter.org or contact Ilya Lyashevsky at ilya@weshelter.org.

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Building a Quality Behavioral Health Workforce: Employing Service-User Perspectives Throughout Your Organization

By Kendall Atterbury, LMSW, Certified Peer Specialist, and PhD Candidate, Peer Initiatives Consultant, Community Access

With the introduction of Managed Behavioral Health Care in October of 2015 and the soon to be implemented Home and Community Based Services (HCBS), engagement of "peers" in the workforce has become a topic of considerable interest. HCBS introduces peer support as a Medicaid billable service giving organizations a financial interest in providing the service. In order to provide billable peer support, an organization must be formally designated to do so under HCBS, peer staff must be certified, and the scope of billable practice is defined by CMS. A peer is loosely defined as someone who has the lived experience of being a recipient of mental health services and/or someone who has been given a psychiatric label. The introduction of peer support as a billable service has the potential to mark progress in the delivery of mental health services. This potential will be compromised, however, if provider agencies are not able to absorb the distinct values, ethics, and intent of peer support as an alternative to traditional approaches to care delivery.

Peer support for people with psychiatric diagnoses is an evidence-based practice that has been demonstrated to improve quality of life outcomes for people who receive mental health services. While peer support has been a part of substance use recovery for some time, it has not been as quick to gain traction among many traditional mental health service providers. Peer support in mental health should be transformative for people and for systems. Drawing from the wisdom of Intentional Peer Support (IPS) developed by Sherry Mead, genuine peer support "doesn't start with the assumption of a problem. With IPS, each of us pays attention to how we have learned to make sense of our experiences, then uses the relationship to create new ways of seeing, thinking, and doing" (www.intentionalpeersupport.org). Certified Peer Specialists thus have the potential to introduce a radically different approach to those experiences that non-peer providers see as barriers to mental health.

In part, Certified Peer Specialists help service-users develop the skills and confidence to advocate for themselves in a system that often works against their chosen interests. Certified Peer Specialists may advocate on behalf of service-users to ensure that they receive proper informed consent, participate in shared-decision-making, and receive truly person-centered care in an atmosphere that can too often dismiss these as unimportant. Certified Peer Specialists are ethically prohibited from either encouraging or discouraging people around issues of medication. It is not appropriate for providers to ask a peer support specialist to assist in this task. It is crucial as peer support becomes an integral part of mental health service delivery that organizations understand both the values of peer work, the Code of Ethical Conduct by which they are expected to abide, and ideally the history of peer work. Job descriptions should reflect the particular skills and contributions peer support specialists offer. All of this being in place, peer support is positioned to truly improve the quality of services on offer in mental health care.

As peer support finds a home under HCBS, it is critical that non-peer providers understand that peer support offers a path to recovery from trauma incurred in systems of care that are often alienating and stigmatizing as much as it offers recovery support from psychiatric distress itself.

This requires non-peer providers to consider what role systems play in constructing and sustaining illness rather than recovery. It may require non-peer organizations to rethink the way care is delivered and structured. For Community Access taking the peer perspective seriously has meant transforming an entire organizational culture.

At Community Access the value of a person's experience in systems of care is taken seriously, and for over 20 years, the organization has actively sought to develop a workforce with the goal of becoming 51% "peer." What this means at Community Access moves far beyond common understandings of peer work particularly as it is defined under HCBS.

At Community Access, service-user experiences and perspectives are represented at every level of organizational structure from executive staff and senior management through direct service providers. This creates a culture that is sensitive and responsive to the needs of our tenants and program participants in a way not accessible when the voices of service-users are absent. There are very few peer specific positions, functionally eliminating the distance between peers and non-peers. Moreover, all direct service staff receive core training that is peer-informed, reducing stigma and common misperceptions about what it means to be a service-user.

Building a behavioral health workforce that employs service requires an evaluation, and sometimes an amendment, of organizational policies and protocols that may place barriers to the employment of people who have been or continue to be service-users.

At Community Access, respect and value for service user experiences is written into the organization's mission statement which explicitly states "We are built upon the simple truth that people are experts in their own lives." Human rights, peer expertise, self-determination, harm reduction, and healing and recovery are the central organizational core values. Living into this commitment begins when a person applies for a job and continues throughout an employee's training and work tenure. Regardless of position – whether or not a particular job is designated for a peer – regard for service-user experiences is taken seriously. Several mechanisms exist to ensure this attitude permeates organizational culture.

Central to building a workforce that incorporates service-user perspectives is a robust Human Resources department that recruits, hires, and retains people with diverse experiences. This includes removing barriers to employment for people who have experienced incarceration, homelessness, poverty, trauma, etc. This may require eliminating some educational barriers. It means understanding how to assess for lived experience during an interview while respecting legal limits. It means establishing organization-wide policies and protocols that make workplace accommodations available to all employees. It means assuring that all employees receive regular and quality supervision and support. Perhaps most of all, it requires flexibility and continued conversations between Human Resources and organizational leadership. Human Resources departments, however, cannot singularly sustain an atmosphere that welcomes and highly regards service-users in the workforce. Organization-wide training is essential.

At Community Access, all direct service employees receive the organization's core training. This core training is designed and delivered by peers and non-peers. It supports new workers as they learn to implement the organization's mission and values into their day to day work (including peer expertise). Core training extends for approximately 20 sessions and covers topics such as Committing to the Work and to Ourselves, Developing Ethical and Supportive Relationships, Mental Health, Healing and Recovery, Self-Determination, Trauma-Informed Services, and Working with Individuals in Extreme States and Crisis. The training department also hosts open workshops on topics of interest to which all employees, tenants, and program participants are invited. Continuing training framed around the organization's mission and values helps to sustain a work culture that learns, grows, and succeeds because of the added-value of employee lived experiences.

Establishing a culture that fully incorporates the service-user experience and perspective places a demand on organizations to look carefully at their own culture, policies, and programs. A strong Human Resources department and training arm are necessary, but not sufficient. Organizational culture must be open to change, from the leadership through direct service providers. Community Access has made this transition over time and has become a more effective provider as a result.

The goal of mental health services ought to be supporting people in the processes of personal recovery. Supporting recovery requires that mental health providers reduce system-induced trauma, stigma, and alienation. It requires giving respect and consideration to the voices and wisdom of those who have lived experience of both the mental health system and psychiatric struggles. It means giving those who have had such experiences a seat at the table. In the end, peer support is underwritten by values that respect the humanity and personhood of peers and non-peers alike. Peer values, at their core, are human values. Too often, however, people receiving mental health services are not offered these basic values, a consequence perhaps of the inevitable impersonal logic of systems. Re-establishing these values and overriding systems logic requires a committed human effort. The introduction of peer support under HCBS provides an opportunity to engage this effort. Non-peer providers can choose to take advantage of this opportunity to transform the very ethos of mental health service delivery. The decision rests on how seriously non-peers take the personhood of people who are currently in psychiatric crisis or who have experienced such a crisis and moved through it.

While billable peer support under HCBS is a particular service with a fairly narrow scope of practice, mental health service providers can choose to engage peer perspectives more fully. Doing so does not undermine services already offered; it improves current best efforts to support people in personal recovery. Working together, peers and non-peers can better achieve New York State's Medicaid Redesign Goals that mirror the triple aim of improved quality, lower per capita costs, and better population health. The beginning step in working together, however, is not building a peer workforce; it is acknowledging the deep absence and need for such a workforce in the first place.

There is a Caring Community of Behavioral Health Organizations
That You Can Turn To When Difficulties in Your Life Become Too Hard to Bear
Please Remember - To Never Give Up - You Can Work Things Out !!
A Message From the Board and Staff of Behavioral Health News

The Foundations of a New "Wellness" Workforce

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

A revolution in the payment and delivery of behavioral health services is poised to transform the healthcare industry and all of its participants. Key stakeholders, including service recipients and their families, medical professionals, social service and community-based organizations, governmental regulators, public and commercial payers, advocates and educators, to name a few, anticipate seismic shifts that will rattle the foundations of our service systems. Lasting repercussions, expected and unexpected, desired and undesirable, are inevitable.

Many with significant behavioral health needs rely on a publicly-funded service infrastructure that becomes more fragile in the face of increasing demand and diminishing resources. There are perhaps no resources more critical to the success of service organizations than their human resources – the deeply committed professionals and paraprofessionals who endeavor to improve the lives of those entrusted to their care despite significant challenges and modest remuneration. How might these resources be cultivated and deployed to properly address the emerging needs and contingencies of a transformed healthcare system? What is the charge of the new behavioral health workforce and what forms will it take? I proceed from an admittedly radical premise that this workforce should not be a behavioral health workforce at all. It should simply be a "wellness" workforce whose composition reflects the primacy of social and physical determinants of health in the recovery process. It should also be one that acknowledges the limitations of our conventional approach to the management of chronic illness. This approach erroneously applies an acute-care model of disease management more appropriate to the eradication of pathogens than the amelioration of conditions in which various factors, including genetics, socioeconomic status, lifestyle habits, historical influences (e.g., exposure to trauma, etc.) and the availability of social and emotional support networks are implicated. We must reconcile the medical and sociocultural history of this approach and the economic context in which it thrives with the current realities of chronic illness if we hope to promote meaningful and sustainable recovery for individuals with behavioral health conditions.

Our nation allocates a disproportionate share of resources to conventional healthcare (i.e., inpatient and institutional care, medical and surgical interventions, pharmacotherapies, etc.) at the expense of the many socioeconomic support services that bolster the health and wellness of our brethren in other industrialized societies. By some estimates traditional healthcare accounts for no more than 10% of our health status, whereas other factors, including stable housing, income supports, access to nutritious food, genetics and lifestyle habits (e.g., substance use, physical activity levels, etc.), social and emo-

Ashley Brody, MPA, CPRP

tional support networks and meaningful activity are significantly more determinative of our health and wellbeing (Sederer, 2013). Despite the relatively insignificant contribution of conventional healthcare to overall public health the United States commits 17% (approximately two trillion dollars per year) of its Gross Domestic Product (GDP) to healthcare spending, and it is expected to exceed 20% of GDP within a few years (Johnson, 2012). This is staggering when considered in contrast to an average expenditure (by share of GDP) of 9.3% for other industrialized nations (Organization for Economic Co-operation and Development, 2014). I am convinced beyond any doubt that if Dwight D. Eisenhower were alive today his concerns about our emergent medical-industrial complex would eclipse his fears of the military-industrial complex that proved so prescient in 1961.

The healthcare behemoth is comprised of extraordinarily lucrative pharmaceutical corporations, hospital and healthcare associations, insurers and legions of lobbyists charged to influence public policy in a manner that ensures it commands an increasing share of resources without a commensurate contribution to the public good. It is therefore unsurprising that outcomes of traditional healthcare interventions are dismal in view of our skewed priorities and inattention to the primacy of social and physical determinants of health. By some measures there are at least 11 nations whose public health outcomes are consistently superior to ours despite our extraordinary expenditures in healthcare (Davis, Stremikis, Squires & Schoen, 2014). We realize a paltry (read "pathetic") return on our investments at both local and national levels. Until recently, New York State committed more resources to its publicly-funded healthcare (i.e., Medicaid) program than any other state, but it lagged behind many in certain outcome measures and languished near the bottom in rankings of potentially preventable hospital readmissions (Office of the New York State Comptroller, 2015).

It is now well known in many quarters that individuals with significant behavioral health and comorbid medical and substance use conditions are at great risk of poor health outcomes and premature mortality. A new behavioral health and wellness workforce must acknowledge its interventions will continue to have limited effect on the overall health status of its recipients unless it reconceptualizes its role in a manner that subverts the current paradigm and challenges the dominant role of its sacred cows, most notably its reliance on pharmaceutical interventions. The pharmaceutical approach to disease management emerged in response to widespread public health crises that resulted from infectious diseases and their associated pathogens (Bland, 2014). Pharmaceutical agents have proven uniquely effective in extinguishing select pathogens and they can be credited with the eradication of many diseases that condemned our forebears to a diminished life expectancy. It is not surprising this approach led to the development of one of the most lucrative and influential industries on the planet. The pharmaceutical industry is the metaphorical hammer that regards all infirmities as nails, and as chronic illness has supplanted infectious disease as the malady of the new millennium Big Pharma continues to strike repeated blows at ever-increasing cost and diminishing returns. An acute-care treatment modality originally tailored to the eradication of disease is now routinely applied to the management of illness. Phenomena we classify as diseases typically originate in one bodily organ or organ system and arise from a verifiable exposure to pathogens or biological imbalances. These are the maladies for which pharmaceutical and other traditional medical and surgical approaches are most appropriate and effective. Chronic illnesses, however, including those in the behavioral health realm, implicate multiple organs and organ systems, arise from myriad biological and environmental causes and require corresponding interventions. Nevertheless, the pharmacologic approach to the management of illness and disease continues to prevail.

Behavioral health and social service providers have witnessed an exponential growth in the use of pharmaceuticals in recent years. Chemical agents that have satisfied the Food and Drug Administration's (FDA) standards of safety and efficacy are lucrative commodities for their manufacturers who enjoy longstanding patent protections after their products enter the marketplace. Even the most casual and uninformed of observers are cognizant of this, as all of us have been encouraged by countless advertisements to "ask our doctor" if Medication X is right for us. These agents customarily target the symptoms but not the causes of our afflictions. It is therefore unsurprising that individuals with behavioral health and comorbid medical conditions routinely visit their

see Foundations on page 40

Coming to Grips with Substance Use Issues Among Employees' Young Adult Dependents

By Martin Rosenzweig, MD
Senior Medical Director, Behavioral Solutions, Optum

The impact of substance use and mental illness on the workplace has been well documented. But how well do employers grasp what's at stake when faced with employees whose adult dependents are grappling with a mental health or substance use issue?

These employers are confronted with two significant challenges:

1. Hidden Costs: Employees' dependent children ages 18 to 25 with mental health conditions or substance use disorder (SUD) contribute to higher benefits costs through increased claims. But what employers may not realize is that these costs may spiral out of control when young adults seek treatment at out-of-network facilities in states far from home.

2. Ripple Effect: Beyond the costs, the ripple effect of mental illness and SUDs also takes a toll on employers in the form of lost productivity and absenteeism. Employees whose children experience mental illness and/or SUDs are often preoccupied with managing their children's conditions.

These young adults may be unable to stay in school or keep a job. They may be in and out of hospital emergency rooms and rehabilitation treatment centers, or arrested for criminal activity.

Family strains caused by these difficulties frequently spill over into the workplace. The resulting stress, anxiety and distractions may hinder parents from being fully engaged at work.

By understanding these conditions and their impact, employers can begin to take steps to contain costs and help their employees improve productivity.

Treatable Condition

SUD encompasses the abuse of alcohol and other drugs, including the use of legal substances such as prescription medications in ways not prescribed or recommended.

It is important for the general public and for those impacted by substance use disorders to understand that a SUD is not an indication of moral or personal weakness. Rather, it is a chronic, complex brain illness – commonly associated with genetic and biological factors – that interferes with a person's day-to-day ability to function. Unfortunately, the stigma associated with having a SUD often deters people from seeking treatment.

It's important to recognize that SUDs are treatable. Indeed, treatment can help individuals recover their ability to live a full life. Success rates for treatment are roughly on par with recovery rates for other chronic diseases including asthma, diabetes and hypertension, according to the Office of National Drug Control Policy. Recovery is possible and is a reality for over 23 million Americans across the country.

Impact on Young Adults

Many mental health and substance use disorders begin when people are in their teens and 20's. The numbers paint a stark picture.

• SUD rates among people age 18 to 25 are twice that of adults 26 and older (18.9% versus 7.0%, respectively, in 2012; Source: Substance Abuse and Mental Health Services Administration. [2013]. Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings [HHS Publication No. SMA 13-4795, NSDUH Series H-46].)

• Among 18- to 25-year-olds, 32 percent of those with any mental illness and 40 percent with a severe mental illness also have a substance use disorder (Source: Ibid.)

• Rates of chronic nonmedical use of opioids are highest among 18- to 25-year-olds. (Source: Behavioral Health Coordinating Committee, Prescription Drug Abuse Subcommittee, U.S. Department of Health and Human Services, Addressing Prescription Drug Abuse in the United States: Current Activities and Future Opportunities, 2013.)

Why Costs are Soaring

Optum has seen a substantial spike in treatment costs among 18- to 25-year-olds in recent years. Our behavioral health claim costs for 18- to 25-year-olds soared 41 percent (per member/per month) between 2011 and 2013. SUD monthly costs jumped 80 percent. (Findings from an Optum May 2014 analysis of behavioral care costs for dependents ages 18-25 among national, ASO and fully insured, HMO/PPO/POS membership.)

A significant portion of these costs is attributable to young adults receiving medical care at out-of-network residential treatment centers with high per-diem charges.

Substandard quality at some of these facilities is another cost driver. In our experience, patients typically have higher relapse and readmission rates than those using in-network facilities closer to home. Recovery from SUDs is an ongoing process and individuals treated in their local communities are better able to connect with recovery support services to assist them in the process.

Inappropriate Treatment Settings

In our estimation, members may not receive the most appropriate or cost-effective treatment in out-of-network

see Grips on page 39

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Brief Inpatient Psychiatric Treatment: Designing Social Work Education to Enhance Clinical Practice

By Catherine D. Bookless, LCSW
Andrew Bloch, LCSW
Michael Cavallaro, LCSW
Kathleen Friedman, LCSW-R, CSC
Melodee Morrison, LCSW
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Andrew Bloch, LCSW; Melodee Morrison, LCSW; Catherine D. Bookless, LCSW; Barbara Waltman, LCSW-R; Arabelle Rowe, LCSW; Kathleen Friedman, LCSW-R, CSC; and Michael Cavallaro, LCSW

Over the past several years, the primary focus of inpatient psychiatric treatment has moved to a model of brief treatment and shortened length of stay. There have been many factors driving this, including the advent of managed care. The main goal of inpatient treatment has become rapid assessment and psychiatric stabilization. Whereas once deeper psychological issues were treated on inpatient units, the current focus is on treating acute symptoms and returning patients to the community, where they may work on longer term problems in outpatient settings. As a result, patients and families as well as inpatient and outpatient providers have had to adjust their expectations during inpatient stays. At NewYork-Presbyterian Hospital, where "We Put Patients First," these changes were the driving force in identifying the need to assist Social Work staff in developing increased competencies and new tools tailored to meet the needs of the current healthcare environment.

At NewYork-Presbyterian/Westchester Division, approximately 40 Licensed Social Workers provide treatment to individuals, families and groups on 12 inpatient units. Our Social Work Department has a long established continuing education program. As patient lengths of stay decreased, it became evident that we needed to provide Social Workers with clinical training targeting the evolving needs of our patient populations, while simultaneously enhancing Social Workers' competence, confidence and job satisfaction. In our annual staff satisfaction survey, Social Work staff told us that it was important to them to do meaningful clinical work with patients during their brief stays, and expressed an interest in trainings that would help them maintain their roles and professional identities as clinicians in a changing environment.

In order to address the needs identified by the Social Work staff, our Social Work Education Committee, comprised of senior clinical staff, considered skill sets required for care of patients during brief hospitalizations. The Committee felt strongly that providing brief treatment requires a high degree of proficiency in the use of our best practice clinical skills for assessment and intervention regardless of length of stay. We initiated a literature review on clinical Social Work in brief inpatient treatment and discovered that there were few articles. In fact, there seemed to be little written on the impact of shortened lengths of stay on outcomes, patient satisfaction, and follow-up in general. Similarly there was little literature on the impact on the practice of clinical Social Work, including the development of curriculum that focuses on clinical skills in brief treatment settings. One relevant article, "Everybody Puts A Lot into It! Single Session Contacts in Hospital Social Work" by Jill Gibbons, PhD, and Debbie Plath, PhD from the School of Social Sciences, University of Newcastle, Australia, explored Social Workers' experiences of brief treatment in a hospital setting and supported our thinking that the best way to identify training needs and clinical best practices was to elicit this information from the staff themselves.

The Social Work Education Committee conducted focus groups with the Social Work staff that identified the skills that were useful in providing brief treatment sessions with their patients and what theoretical frameworks they used in their work. Additionally, the questions helped the staff to look more closely at their own attitudes and potential biases regarding the brief treatment model. They were also asked to identify what might be valuable for the patients using such a model and to examine what attitudes, behaviors, and skills can facilitate rapid alliance building and effective outcomes. In addition, we wanted staff input regarding realistic expectations as to what constitutes effective outcomes in a brief treatment setting.

From these focus groups, we learned that some staff were concerned that brief treatment would utilize less clinical skills than in longer term care. Overwhelmingly, however, the information gathered from both staff and supervisors supported our hypothesis that brief therapy actually utilizes the same important skills in caring for both patient and family. The difference is that our patients' critical areas of need have to be prioritized and conceptualized earlier in the treatment and implemented with a well-defined focus. Additionally, Social Workers need to be able to help patients and families establish clear expectations about the treatment outcomes from a brief inpatient stay. It became evident that to be able to effectively provide brief treatment, we had to adjust our mindset and embrace what we are able to accomplish within shorter lengths of stay.

The Committee gathered and synthesized the information from the Focus Groups, which was then incorporated and expanded upon in the development of a curriculum to be used for the first academic year of this initiative entitled: "Brief Inpatient Psychiatric Treatment: Clinical Social Work Practice." The curriculum presented a clinically clear framework for brief treatment Social Work practice which focused on ten key competencies over sixteen training seminars. These included process skills that would help Social Work staff use time and organization skills to maximize efficiency in service of high quality care. Another process skill reinforced was the critical importance of always engaging in active listening toward the goal of rapport building with patients and families. Our curriculum focused on case conceptualization and treatment contracting over five seminars, allowing for teaching of theory, discussion and practice sessions. We also focused on such issues as managing expectations, goal setting and benchmarking progress - all skills that reinforce interactive processes with patients and family members. Other topics included how to engage families and build bridges into the community after discharge, as well as concepts related to empowerment and recovery. In one of our final seminars, we focused on the importance of keeping a good work/life balance so that Social Work staff would be able to sustain their level of professional commitment and engagement in patient care and to minimize the risk of burnout.

Our Social Work Education Program was enthusiastically received by the staff. Program evaluations collected after each seminar indicated that the seminars had a high degree of relevance for daily social work practice and that they were supporting the need for the continuous identification of highly proficient clinical skills. These evaluations also indicated that staff were eager for ongoing educational programs that targeted the development of ever evolving skills that would effectively address the needs of our patients and their families, while recognizing the impact of the brief treatment model of care both for inpatient stays and for outpatient after care.

Since the inception of this "Brief Inpatient Psychiatric Treatment: Clinical Social Work Practice," our Social Work Department and the Education Committee continue to work together annually to develop curricula relevant to the needs of patients and families and to identify staff training needs that will ensure our practice skills will always be commensurate with those needs. In subsequent training years, we have addressed topics related to "Group Work in Brief Inpatient Psychiatric Treatment," and "Working with Families in Brief Inpatient Psychiatric Treatment." We believe that these efforts allow our Social Work staff to function optimally and to always honor that "We Put Patients First."

Catherine Bookless, LCSW, is Program Coordinator of the Co-occurring Disorders Program; Andrew Bloch, LCSW, is Program Coordinator of the Second Chance Program; Michael Cavallaro, LCSW, is a Social Work Supervisor; Kathleen Friedman, LCSW-R, CSC, is Director of the Deaf and Hard of Hearing Program; Melodee Morrison, LCSW, is a Social Work Supervisor; Arabelle Rowe, LCSW, is a Social Work Supervisor; Michelle Sardone, LCSW, is a Social Work Supervisor; and Barbara Waltman, LCSW-R, is the Director of Social Work at NewYork-Presbyterian/Westchester Division.

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Investing in a Professional, Caring, and Mission-driven Workforce

By Staff Writer
Odyssey House

The behavioral health care workforce is one of the fastest growing in the country. Projections for 2020, based on U.S. Bureau of Labor statistics, forecast a significant rise in employment for substance abuse and mental health counselors with a 36% increase from 2010-2020 – greater than the 11% projected for all occupations.

This increase, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) Workforce Issues Report of 2013, is based on an expected increase in insurance coverage for mental health and substance abuse services brought about by passage of health reform and parity legislation; the rising rate of military veterans seeking behavioral health services; and the growing opioid epidemic.

SAMHSA's prediction both confirms the value of our talented workforce and presents challenges for under-resourced social services to meet the increased demand.

As behavioral health care providers, we are confronted with a range of expectations: ensuring our services meet the needs of diverse populations with a complex set of problems; satisfying increased demands for demonstrated outcomes; and doing more with shrinking resources.

Helping us rise to these challenges at Odyssey House is our professional and dedicated workforce. This broad staff of 350 employees include licensed counselors, social workers, doctors, nurses, and dentists, wellness and recreational coordinators, facility and housing managers, educators, administrative, communications and financial managers, maintenance, nutrition, security and transportation coordinators. All of these staff perform essential roles that keep our clients moving forward in their journey towards health and recovery.

While the roles our staff fulfill each day are quite different, the expectations are the same across the organization: that clients come first; policies and procedures are strictly adhered to; and our resources are tightly managed to be cost-effective and outcome driven. Accomplishing these tasks in a challenging human services environment where clients require intensive care for a myriad of emotional, mental, and physical health deficits, demands practice and training.

Investing in Training

Training is an integral part of ongoing performance management at Odyssey House. We encourage our clinical and administrative staff to take advantage of in-house training opportunities and offer tuition reimbursement towards the cost of professional accreditations and courses. In 2015, our employees earned 35 professional awards ranging from Credentialed Alcohol and Substance Abuse Counselor (CASAC) and Certified Addiction Recovery Coach, to Bachelor's and Master's degrees in social work and accounting.

The Odyssey House training department offers a range of professional development options that support direct service and management staff in both progressing their careers and delivering the highest quality care to our clients. Workplace trainings are adaptive to our service environment, track trends and study client profiles, monitor client management systems, and review incidents, chart audits, and quality assurance activities. Training is delivered by experienced licensed staff including medical doctors, clinical social workers, mental health counselors, and certified rehabilitation recreation counselors.

In 2015, clinical staff participated in one or more training sessions that included both group workshops and online individual courses that focused on motivational interviewing, opioid overdose prevention, level of care placement, diagnosis using DSM-5 criteria, ethics and boundaries, safety and crisis management for mental health workers, and cultural diversity and competency.

And we also offered administrative trainings including clinical recordkeeping, documenting medical necessity, fire safety, workplace safety, electronic health record keeping, incident reporting, HIPAA and other confidentiality rules, and basic writing skills.

Focused and Flexible Online Training

We recently enhanced our capabilities with the addition of flexible web-based training. This online system, offered by Relias Learning Management Systems (RMS), further allows staff to refresh their skills and stay up-to-date with regulatory changes ushered in by the 2010 Affordable Care Act and the Mental Health Parity and Addictions Equity Act of 2008. Topics covered include general administrative management requirements like corporate compliance and ethics, fire safety, HIPAA overview, sexual harassment/discrimination prevention, hazardous chemicals, infection control, quality improvement, blood-borne pathogens, and first aid refresher.

We are also utilizing RMS to deliver a range of clinical management trainings including: Screening, Brief Intervention, and Referral to Treatment (SBIRT) for individuals with substance use issues, domestic and intimate partner violence, overview of clinical supervision, best practices in substance use treatment engagement, structured group therapy approaches, co-occurring disorders, and HIV/AIDS.

Odyssey House is committed to developing and maintaining a professional behavioral health care workforce. The clinically focused in-service trainings we offer can be used towards CASAC continuing education credits and many are also approved for New York State Social Work continuing education hours.

By making training a priority, our staff can work in confidence, assured they have the resources and skills they need to succeed in a demanding and rewarding workplace.

The Emerging Role of Nursing in the Delivery of Psychiatric Care

By Andrew P. Levin, MD
Medical Director, Westchester Jewish Community Services

Although we have always known that mind and body are connected, there is now increased understanding that mental and physical health are closely intertwined. Recent studies indicate an interaction between symptoms of mood and anxiety with exercise, diet, and overall health, as well as chronic diseases such as diabetes, gastrointestinal illnesses, and cardiac disease (Kiecolt-Glaser, Derry, & Fagundes, 2015). Another body of research has shown that early life trauma results in increased risk for obesity, cardiac disease, cancer, and substance use as well as depression, suicidal behavior, and psychiatric hospitalization (See ACEs Study at CDC.gov). Beyond these relationships, many of the pharmacologic treatments utilized to address behavioral health carry the risk of producing metabolic syndrome, a combination of weight gain, increased cholesterol, and the development of diabetes. These factors reinforce the emerging consensus that behavioral providers must attend to the individual's total health. We can no longer label our clients' physical health as someone else's problem.

Across the country the medical and mental health communities have developed new approaches to the total care of the individual. These efforts have been described as "integration" or "co-location" (Raney, 2015). In practice, the models take several general forms. First, there are new expectations that primary care providers monitor behavioral health parameters such as depression and anxiety. Regulatory expectations dictate the administration of instruments such as the PHQ-9 measure for depression. Subsequent interventions in the primary care setting include pharmacologic treatments coupled with counseling and consultation. A complementary, although less popular model entails locating primary care providers in mental health settings for ease of access. In contrast to these approaches, other groups have co-located full medical and mental health services in the same delivery system. In our area, mental health and primary care providers have embarked on an intensive effort to enhance collaboration and develop integration.

In addition to integration models, in New York's statewide Health Homes program, individuals with chronic medical and psychiatric conditions receive care management to best coordinate services delivered by community medical and psychiatric providers. As part of all of these efforts, agencies around our area and across New York State are working to develop electronic record systems that can, with proper privacy protections, share information between behavioral and medical providers.

As the drive toward integration unfolds, mental health agencies themselves are enhancing their capabilities to monitor and manage physical health needs. This has taken on a number of dimensions. Mental health providers are increasing their surveillance of the metabolic impact

Andrew P. Levin, MD

of treatments with more regular laboratory studies of diabetes indicators and cholesterol, periodic weight monitoring, and regular blood pressure measurements. Coupled with increased surveillance is an expectation of more consistent outreach to primary care providers to obtain critical information regarding diagnosis, laboratory results, and prescribed medications. This data is now regularly summarized in the "Continuity of Care Document," the so -call "CCD," that is an integral part of all electronic medical records. This document facilitates the rapid transmission of information between providers. As regional and statewide networks solidify, providers will be able to exchange this document (with proper consent) to coordinate care.

With an eye to the need for increased comprehensive evaluation and monitoring of clients, mental health agencies are now adding additional professionals to their teams, with a specific emphasis on nursing. At Westchester Jewish Community Services (WJCS) we have integrated three levels of nursing care—licensed practical nurses (LPNs), registered nurses (RNs), and psychiatric nurse practitioners (PNPs) into our teams. LPNs undergo a one year training program and are licensed by the State. They are trained to gather and monitor health information, administer medication, and provide health education. At our agency LPNs meet with new clients to obtain a health history, measure vital signs, and record medications prescribed by outside providers. This information is then entered directly into the EHR. The system utilizes this information to identify possible interactions between medical conditions, allergies and all prescribed medications. As part of the initial evaluation, LPNs reach out directly to primary care providers and specialists in the community to obtain records.

Beyond the initial health screening, LPNs re-evaluate our clients on a regular basis to assess vital signs, weight, and ongoing health issues. With their medical training they can also assist in obtaining prior authorization of pharmacologic agents. In addition, LPNs co-lead health education and wellness groups. Wellness is an area that, until recently, has largely been neglected. These groups focus on promoting improved health behaviors and optimal engagement in both medical and psychiatric treatment. In addition, LPNs participate in tobacco use identification, education, and referral. There is now ample evidence that individuals with mental illness are at greater risk for tobacco use and concomitant health problems.

Registered nurses (RNs) have 2-4 years of training and are licensed by the State. In WJCS group homes they play a central role in the care of the more than 100 individuals with developmental disabilities. RNs evaluate health needs, administer medication and supervise others to provide medication administration, coordinate care between our providers and medical specialists in the community, and work with our psychiatric providers to develop, administer, and assess the impact of psychiatric treatments. Their role is particularly critical given the wide ranging health needs of people with developmental disabilities.

Health homes, another dimension in the drive toward integration, utilize care managers to work with individuals who suffer from chronic psychiatric and medical conditions. At WJCS an RN leads our Health Homes Adult Care Management program. Using her medical expertise, she assesses eligibility for services based on medical conditions, interprets medical tests and treatment plans, and directs care managers in the scheduling of tests and follow-up care, all tasks that require her nursing training. Currently she is overseeing the care management of 240 individuals.

Psychiatric nurse practitioners and family psychiatric mental health nurse practitioners (PNPs) are uniquely qualified to address both psychiatric and medical needs of individuals with mental illness. PNPs have a two year Masters' degree beyond the Bachelor of Nursing degree. They receive comprehensive education in psychiatric disorders and psychopharmacology. Based on the orientation of the training program, PNPs develop expertise in the psychiatric management of children, adolescents, and adults. With their licensure they can prescribe medication under the umbrella of a collaborative relationship with a psychiatrist.

Because most PNPs have usually spent several years as RNs working in psychiatric settings such as inpatient units, partial hospitals or day programs, and emergency settings, they have a special hands-on appreciation for psychiatric illness. But beyond this, their medical training equips them to evaluate individuals across all dimensions and coordinate with medical providers. PNPs at WJCS carry full caseloads, perform comprehensive diagnostic evaluations, provide ongoing treatment with psychotropic medications, monitor health conditions by gathering vital signs and ordering laboratory studies, and coordinate with outside primary

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Developing Workforce Knowledge Through Technical Assistance

By Daniel Ferris, MPA
and Meaghan Baier, LMSW

The transition to Medicaid Managed Care holds the promise of moving the behavioral health system toward the triple aim. It requires many organizational changes, from responding to and managing shifting resources, to shifts in job descriptions and roles to which agencies must acclimate. The result, if the changes achieve the aim, will be reflected in superior behavioral health care, better outcomes for clients, and lower costs.

The New York State Office of Mental Health and Office of Alcohol and Substance Abuse Services (OASAS) have funded the Managed Care Technical Assistance Center (MCTAC) to develop tailored training, tools, and resources to target the work force in a variety of different platforms and capacities. This article addresses the need for technical assistance in any transition and certainly in one as complex as New York State's transition to managed care. It also provides an overview of available resources for behavioral health providers as they make the transition.

In addition to physical changes such as new forms, new processes, and new technology, the transition requires a change in mindset for all levels—from board members to frontline staff. Board members and executives must conceptualize a shift in their organization's role, and staff members must be kept informed of how these changes will impact them. Additionally, a result of this shift is ambiguity in a number of areas, and staff should be acknowledged for the changes they are managing, along with the potential instability they experience. In many instances the transition can mean a heavier workload for providers especially as they estimate volume for new services, and build an infrastructure to support the requirements of a new system. To balance this, communication and transparency become critically important to ensure staff and senior leadership alike understand the goals and benefits of the new system as well as the very real impact that health care transformation has on the staff providing services.

As provider type, populations served, and staffing levels vary across the behavioral health field, training must acknowledge and accommodate for this diverse range of needs by offering technical assistance to best engage and support providers using a variety of methods, tactics, and settings. The collaborative partnership of MCTAC involves government, health plans, providers, advocacy groups, academic, and research based organizations, all of whom participate in a dynamic working partnership in the development and delivery of technical assistance with the common goal of supporting and improving the delivery of behavioral health services in New York State. Training content and priorities are informed by providers in the field, and directly linked with provider needs relating to Managed Care readiness.

MCTAC provides training and resource content through a variety of platforms, including Face-to-Face Presentations and Conferences, Web-Based Trainings, Learning Communities, Office Hours, Tools and Resources, and Self-Learning. Materials from all offerings, including slides, recordings, Q&A, and other developed resources, are available on the MCTAC.org website and circulated via e-mail to newsletter recipients on a weekly basis. This "clearinghouse" function serves to highlight and disseminate information from state partners and other colleagues working to support this system transformation. Additionally, MCTAC has implemented a constant and robust feedback loop through training evaluation forms for all offerings, and the creation of the MCTAC.info@nyu.edu email box fields questions and acts on inquires from the field. This prioritization of user and provider experience seeks to address training topics and ongoing assessment of specific provider needs.

One of the most critical functions of MCTAC is to provide information. Presentation-based training and learning communities offer one opportunity for this work. Attendees are encouraged to share information and resources with their colleagues and generate new questions and ideas facilitated through informal information sharing or through the establishment of a managed care implementation task force and a more deliberate meeting and support infrastructure.

Tools and resources are another crucial element of this work. These tools, developed in collaboration with the array of state, plan, advocacy and agency partners include a managed care language guide; definition of top acronyms; a plan matrix with information spanning all designated plans in NYC, with update planned for the rest-of-state and children's implementation; a consultant directory, and many others currently in development. Tools have been developed to save valuable time for providers and plans, and can be readily accessed on the MCTAC.org website.

Through its partnership with CASA Columbia, MCTAC is working with OASAS on systems redesign initiatives particularly focused on the residential system, promoting medication assisted treatment, and clinic redesign.

Efforts to support providers and staff extend beyond New York's largest cities

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Addressing Workforce Challenges in Serving Individuals with Co-Occurring MI/IDD

By Robert J. Fletcher, DSW, ACSW, NADD-CC, Founder and CEO NADD

Individuals with mental illness (MI) co-occurring with intellectual/ developmental disability (IDD) have complex needs and present clinical challenges to the professionals, programs, and systems. These individuals are among the most challenging, expensive, and intractable to work with. Although the situation has been improving, there are still many instances when the two relevant service delivery systems (behavioral health and developmental disabilities) deny services, believing that the appropriate provider of services should be found in the other service delivery system. Service providers and clinicians often feel poorly prepared to serve this challenging population, and as a result they may choose to not work with individuals who have these two co-occurring disorders.

NADD, whose mission over the past 30+ years has been "to advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care," has developed a series of initiatives aimed at raising the confidence and quality of the workforce providing services to individuals with MI/ IDD. Divided between training and certifying competence, these initiatives are designed to result in improved quality of life for individuals receiving services, increased knowledge and competency for staff, as well as overall cost savings.

Robert J. Fletcher, DSW, ACSW

Training Component

NADD offers training by recognized experts in the field on all aspects of mental health concerns in individuals with intellectual/developmental disability. Our new training initiative centers on offering train-the-trainer sessions based on Mental Health Approaches to Intellectual/Developmental Disability: A Resource for Trainers by Robert J. Fletcher, Daniel Baker, Juanita St Croix, and Melissa Cheplic. A flash drive is included with this book, which has PowerPoint slides to facilitate offering trainings. Ten modules are covered in these trainings:

- Module I: What Is a Dual Diagnosis?
- Module II: Building on the Basics: Understanding Assessment Practices in Dual Diagnosis
- Module III: Mental Health Evaluations: Mental Status Examinations (MSE)
- Module IV: Signs and Symptoms of Mental Illness
- Module V: From DM-ID to DM-ID-2
- Module VI: Support Strategies
- Module VII: Adaptive Therapy for People with IDD
- Module VIII: Childhood and Adolescences
- Module IX: Aging
- Module X: Inter-Systems Collaboration

Learning objectives are included for each module and pre- and post-tests are included in an appendix, as well as in an accompanying work book: Trainee Workbook for Mental Health Approaches to Intellectual/Developmental Disability.

Accreditation and Certification

With the NADD Accreditation and Certification Programs, NADD, in association with the National Association of State Directors of Developmental Disability Services (NASDDDS), has established standards and benchmarks for services provided to individuals who have intellectual and developmental disabilities co-occurring with mental illness. The NADD Accreditation and Certification Programs were developed to raise their level of care, as well as to provide recognition to those programs and professionals offering quality care.

The NADD Accreditation and Certification Programs are composed of four interrelated programs: Accreditation for programs, Competency-Based Clinical Certification, Competency-Based Dual Diagnosis Specialist Certification, and Competency-Based Direct Support Professional Certification.

The NADD Accreditation Program

NADD developed the NADD Accreditation Program to improve the quality and effectiveness of services provided to individuals with a dual diagnosis through the development of competency-based

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Dual Career Path Development: A Critical Component of Staff Retention and Development

By Virna Little, PsyD, LCSW-R, SAP, CCM, Senior Vice President, The Institute for Family Health

The creation and implementation of a dual career path program can dramatically improve an organizations staff retention rates. Most organizations offer only one track for advancement for employees, the entry into management. Employees choosing not to enter into management are often left with little or no opportunities to advance within the organization. Longer term employees who chose not to pursue management or for whom management is not a skill set they either possess or wish to acquire feel advancement is not possible and often choose to leave the organization. A dual career path program creates multiple opportunities for staff to develop outside of entering into management. Dual career path programs should be intentional and well planned, if done correctly dual career path programs can be mutually beneficial for both employers and employees.

Dual career paths can be especially beneficial for front line clinicians who, after several years in an organization, would like to advance and have some job diversity outside of direct clinical care. As an example, many organizations are implementing electronic record systems, an ideal individual to provide tech support, help choose, create or implement a system is a clinician who uses or will use the system on a daily basis. A dual career program allowing clinical staff to participate in these activities, obtain necessary certifications or training allows them to grow and advance and provides the organization with a technology workforce with "real life" experience with the system. Additionally, these staff have credibility with other clinicians in the organization a critical element in electronic records training and development.

It is critical that the creation of a dual career path program is not perceived by staff as work that is in addition to their current tasks, that the opportunities are replacing some current responsibilities and are meant to provide opportunities for professional growth and development. As part of the roll-out of a dual career program job descriptions need to be created or changed, managers need to be trained and at times a dual reporting structure needs to be created. Thought needs to be paid to how responsibilities will be "back filled" as individuals take on dual roles. The Institute for Family Health has created multiple dual role positions in behavioral health, creating a model that allows for clinicians to be in direct care a self-sustaining amount of time and have a dual role in other areas. The creation of this dual career path model has allowed for many employees to pursue other roles and helped advance the organization in areas of technology, clinical care, research, publications, evidence based practices and compliance. The Institute supports employees in these dual roles by supporting certifications and /or advanced training in the secondary role, a small cost in exchange for increased employee satisfaction.

Dual career path programs can be helpful for many organizations, creating opportunities for employees, improving an organizations ability to recruit and retain their workforce, especially employees with longevity. Dual career programs can be created in any area an organization identifies as a need or employees have expressed interest in. While often challenging to implement, the outcomes have proven beneficial for both employers and employees.

Increasing the Addiction Workforce: Fellowship Training in Addiction Medicine

By Abigail J. Herron, DO, FAPA, FASAM, Director of Psychiatry and Director of the Fellowship in Addiction Medicine, The Institute for Family Health

Substance use is one of the most significant public health issues in the United States. Annual costs related to crime, lost work productivity and health care due to use of tobacco, alcohol, and illicit drugs exceeds $700 million annually (http://www.drugabuse.gov/related-topics/trends-statistics). In 2013, an estimated 9.4% of the population (24.6 million Americans aged 12 or older) were current illicit drug users. Slightly more than half (52.2 percent) of Americans aged 12 or older (136.9 million people) were current alcohol users, with nearly one quarter (22.9 percent) reporting binge alcohol use. (Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality. September 4, 2014. The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings. Rockville, MD.)

Despite the prevalence of medical illness in this population, their high utilization of health care services, and the increasing availability of effective treatment options, large numbers of individuals with substance use disorders still do not receive treatment. In most settings, substance abuse treatment is not readily available in coordination with medical treatment, leaving individuals to receive care from specialty treatment centers. These specialized settings however, are not sufficient to meet the need for treatment. The 2013 National Survey on Drug Use & Health estimated that 22.7 million individuals aged 12 or older needed treatment for an illicit drug or alcohol use problem. Of these, only 2.5 million received treatment at a specialty facility for addiction (SAMHSA, 2014).

Abigail J. Herron, DO, FAPA

A number of factors contribute to this discrepancy between individuals in need of treatment and the services available. While addiction is increasingly recognized as a medical illness, ongoing stigma remains about substance use and other behavioral health disorders. Limited insurance coverage for addiction related services also contributes to the treatment gap.

Traditionally, the bulk of addiction services have been provided outside the medical model by non-physician staff. Greater acceptance of the notion of addiction as a disease has shifted that somewhat, with greater physician involvement in treatment, particularly over the last few decades. Most physicians, however, do not receive sufficient education about addiction during medical school and residency, leading to a physician workforce that is inadequately equipped to provide substance abuse treatment services. Addiction specialists, individuals who have received additional training and practice in substance abuse treatment, are a critical component in closing this treatment gap. Specialists can provide direct care as well as support primary care and other providers in the treatment of individuals with substance use disorders. When primary care providers can trust in the availability of expert consultation, they can be more confident in their ability to treat individuals with addiction. Addiction specialists can also serve as educators, helping to ensure evidence-based care models are followed and providing guidance about resources such as self-help and specialty addiction treatment programs with which primary care providers may not be familiar.

The first physicians to become board-certified as specialists in addiction were psychiatrists. Since 1991, the American Board of Medical Specialties has recognized addiction psychiatry as a subspecialty, requiring fellowship training and a certifying exam. While these specialists have been a welcome addition to the field, the number of addiction psychiatrists is not sufficient to meet the treatment needs of individuals with substance use disorders.

Non-psychiatric physicians specializing in the treatment of substance use disorders are called specialists in Addiction Medicine. Addiction Medicine is distinct from Addiction Psychiatry, and is one of the few multidisciplinary specialties, meaning that addiction medicine physicians come from a wide range of primary specialties such as family medicine, internal medicine, pediatrics, emergency medicine, obstetrics and gynecology, and surgery. A certifying examination has been offered since the 1980s, first by the American Society of Addiction Medicine (ASAM) and since 2007 by the American Board of Addiction Medicine (ABAM), an independent board which oversees the exam, as well as promoting the mission of physician training

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Workforce Development Needs of Addiction Professionals in New Jersey

By Diane Litterer, MPA, CPS
CEO and Executive Director
New Jersey Prevention Network

A unique structure has been created to support the training and workforce development needs of addiction professionals in New Jersey. Through the NJ Department of Human Services Division of Mental Health and Addiction Services, a statewide Addiction Training & Workforce Development (ATWD) program has been funded to provide all required educational courses for initial certification and renewal credits to support individuals interested in becoming New Jersey addiction counselors. As CEO and Executive Director of NJPN, I am proud that our agency is the steward of a comprehensive workforce development program that has remained ahead of the curve in preparing New Jersey's counseling professionals. It is a model that is worthy of attention and replication to provide opportunities for qualified individuals to receive quality education focused on addiction.

The ATWD program also attends to internship placement for students under approved supervision, and provides training for clinical supervision credentialing. As a result of this coordinated effort, students learning is reinforced in their work environment and required clinical hours and 270 educational hours are accumulated

Diane Litterer, MPA, CPS

simultaneously. The ATWD program has produced 582 credentialed professionals of which 54% became licensed certified Alcohol and Drug Counselors (LCADC) and 46% became certified alcohol and drug counselors (CADC). The ATWD students reflect NAADAC's direction that provides for a tiered system of credentialing, indicated by increasing levels of education (beginning with a minimum of an associate degree, and progressing to a bachelor's and master's degree). Each tier leads to an increase in the clinician's scope of treatment. (www.naadac.org) Of students who have already become licensed or certified since graduating from our program, 54% are Master's-level LCADC clinicians; 25% are CADC's with a Bachelor's degree; and of the ATWD Bachelor's-level graduates, 25% of them then earned a Master's degree after obtaining their CADC.

New Jersey Prevention Network (NJPN) has been trusted with the ATWD grant to provide all initial certification coursework, mandatory renewal courses, internship connections and customer service to guide professionals along the path to state certification. The emphasis in class and throughout the internship is on learning and employing empirically-tested best-practices for clinical effectiveness in the treatment of substance use disorders. This requires extensive attention to emerging trends in the field, including diagnosis and treatment for Co-occurring Disorders, identifying and treating trauma issues, the use of Medication Assisted Treatment, and providing a culturally competent, diverse, and welcoming environment for clients from all walks of life.

Tony Polizzi, LCADC, has been an ATWD instructor since 2006. "I have seen remarkable growth in new and credentialed students while teaching these courses. I have taught on both the undergraduate and graduate level at state universities, and the diversity of experiences, academic training, and backgrounds of the participants in this community-based program provide an even richer environment for learning. The ATWD structure gives me the opportunity to provide a combination of counseling, teaching, modelling, supervising, and mentoring while delivering educational material, theoretical foundations, and intervention skills. A favorite theme that runs through most classes is the process of change taking place, the adaptation of new ideas, the exposure of and elimination of biases, the 'cultural' transformation of the students over the course of their involvement in the classroom environment. It is very rewarding to see the evolution of an empathetic person willing to develop the attitudes and skills necessary to become an effective counselor."

A primary goal of the Addiction Training Workforce Development initiative is to produce well-trained, competent clinicians to be employed in stable, effective treatment agencies. To achieve this, several scheduling models were tested and the result was the creation of multiple statewide training sites within or local treatment or substance abuse prevention facilities. The program model for initial certification includes multiple training sites from which students select a primary location to attend the 45 required courses that are staffed by rotating trainers. This structure promotes student networking among local treatment professionals to support job placement and community-learning circles. Additionally, this allows trainers to work with students for up to a year of nearly

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Governor Cuomo Signs Executive Order To Protect Homeless Individuals During Inclement Winter Weather

From the Office of
Governor Andrew M. Cuomo

Governor Andrew M. Cuomo issued an Executive Order on January 3, 2016 to protect homeless individuals from inclement winter weather where temperatures decline to 32 degrees or below. The order will ensure that homeless individuals are directed to shelter during inclement winter weather which can cause hypothermia, serious injury and death. It also requires homeless shelters to extend their hours of operations so that those without shelter can remain indoors. The State will assist local social services districts if they are lacking facilities, resources or expertise.


Photo by Pat Arnow

Governor Andrew M. Cuomo

EXECUTIVE ORDER

Emergency Declaration
Regarding Homelessness
During Inclement Winter Weather

WHEREAS, New York State is currently in the winter season and is subject to inclement winter weather that poses an imminent danger to public health and safety; and

WHEREAS, such inclement winter weather means air temperatures at or below 32 degrees Fahrenheit, including National Weather Service calculations for windchill; and

WHEREAS, when such inclement winter weather occurs, it presents a threat to the life, health, and safety of the State's citizens, particularly to persons who are homeless, including the risk of hypothermia and potentially death; and

WHEREAS, pursuant to the New York State Constitution, the State of New York has an obligation to provide for the aid, care and support of persons in need and to protect and promote the health of its citizens; and

WHEREAS, it is imperative that the State act to ensure that such aid, care and support is provided to address the needs of the State's homeless population, which need is further heightened during the winter months; and

WHEREAS, homelessness is an issue that impacts citizens in all regions of the State, from large cities to small towns and rural communities; and

WHEREAS, certain parts of the State are facing a crisis of homelessness unprecedented in recent history; and

WHEREAS, the State has a comprehensive system of more than 77,000 emergency shelter beds for homeless single adults, families, and unaccompanied youth, designed to meet the housing and supportive services needs of these homeless residents; and

WHEREAS, localities customarily work in coordination with police agency resources and local social service providers to conduct outreach to the homeless and to facilitate their transfer to sheltered locations; and

WHEREAS, the State will assist local social services districts if they are lacking facilities, resources or expertise; and

WHEREAS, the State will be imminently commencing and mandating that local social service districts establish comprehensive regional housing and supportive service networks designed to meet the diverse needs of each subgroup within the homeless population; and

WHEREAS, New York State law is clear and well-established that the State can take appropriate steps, including involuntary placement, to protect individuals from harming themselves or others;

NOW, THEREFORE, I, ANDREW M. CUOMO, Governor of the State of New York, by virtue of the authority vested in me by the Constitution of the State of New York, Sections 28 and 29 of Article 2-B of the Executive Law, and consistent with the Laws of the State of New York, including the Mental Hygiene Law, and the judicial interpretations of those laws, do hereby issue this Executive Order to mitigate the effects of such inclement winter weather and the resulting impacts of such weather on individuals experiencing homelessness;

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Make a 2016 Resolution to Talk About Mental Illness: Your Story Could Change a Life

By Amy Sheyer
AVP, External Relations, Beacon

As we look to the new year and the resolutions we can make to improve our lives and the lives of others, Beacon Health Options (Beacon) urges you to resolve to break the silence and stamp out the stigma around mental illnesses. Talk about it; your story could change a life.

Today, Beacon, the nation's premier behavioral health management company, will ask New Yorkers and those visiting the "Big Apple" to make mental health awareness their 2016 New Year's resolution. A 23-story digital billboard in New York City's Times Square will remind them about the importance of talking about mental illness as a means to stamp out stigma.

According to the National Institute of Mental Health, one in five U.S. adults will be affected by a mental illness in a given year, approximately 43.8 million Americans. Factoring in family, friends and colleagues, all of us are affected by mental illness in some way. Unfortunately, the reality is that approximately 30 percent of people living with mental illness say they choose not to seek treatment due to fear of judgment. The good news is that mental illness is treatable.

"You wouldn't necessarily know the high prevalence of mental illness in the U.S. because we rarely talk about mental health in public," said Dr. Jorge Petit, a psychiatrist and Beacon Senior Vice President, National Client Partnerships – New York Region. "Like diabetes, heart disease or high blood pressure, mental illness is a medical condition that requires care; yet because of the stigma that a mental illness diagnosis carries, we have made it something that is easier to hide than to seek treatment. And that needs to change."

In 2013, ValueOptions, before it merged with Beacon Health Strategies to become Beacon Health Options, took its first step to do just that when the company launched its Stamp Out Stigma initiative. Now spearheaded by the Association for Behavioral Health and Wellness, in which Beacon is a member, the initiative continues work to reduce the stigma surrounding mental illness and substance use disorders. This campaign challenges each of us to transform the dialogue on mental health and substance use disorder from a whisper to a conversation.

More recently, New York City Mayor Bill de Blasio and First Lady Chirlane McCray launched ThriveNYC: A Mental Health Roadmap for All, an action plan to guide the city toward a more effective and holistic system to support the mental well-being of New Yorkers. One of the program's principles is to change the culture by making mental health everybody's business and promoting open conversation about it.

What can you do in 2016 to help bring mental illness out behind closed doors and into the public space?

Learn the facts about mental illness. Remind others that it is not the result of personal weakness, lack of character or poor upbringing. Mental illness is a disease just like diabetes, asthma and high blood pressure. It is treatable. See more at: nami.org/stigmafree.

Learn to listen with an open mind and without judgment. It can be one of the most powerful ways to support a friend, family member or colleague who has a mental illness. Visit naminyc.iwilllisten.org/how-to-listen/ for more information.

Sign up for a Mental Health First Aid course and learn the risk factors and warning signs of mental health and substance use problems. The course also teaches a five-step action plan to help people get the care they need in their community. Visit mentalhealthfirstaid.org.

Take the pledge to stamp out stigma and discover what you can do to recognize, educate and reduce stigma at stampoutstigma.com/pledge.

Supporting Peer Specialists

By Thomas R. Grinley, Program Planner
Office of Consumer and Family Affairs
NH Bureau of Behavioral Health

An increasingly common workforce issue is preparing "traditional" providers for working beside peer providers, that is, individuals with the lived experience of mental health issues. SAMHSA (Substance Abuse and Mental Health Services Administration) defines a peer provider as "a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience" (SAMHSA, 2013). The use of peer specialists in different roles and different settings has been growing steadily especially since 2001 when Medicaid made peer services billable under Medicaid rules (Daniels, Grant, Filson, Powell, Fricks, and Goodale, 2010).

To be sure, the existence of peer providers predates, by far, the 2007 CMS memo that laid out the Medicaid billing rules (Smith, 2007) and we saw a rapid expansion of peer specialist services. However, until this point the services provided had been primarily volunteer and outside the realm of "traditional" services. Now we were seeing the professionalization of peer providers within the traditional system of services (Chapman, Blash, and Chan, 2015). As Chapman, Blash and Chan (2015) also noted, stigma continues to be an issue impacting the hiring and acceptance of peer workers in traditional treatment programs. However, properly leveraging the lived experience of peers will help define their role in the program and assist with the integration of peers onto the treatment team (Resources for Integrated Care, 2015a).

The burden is necessarily on the mental health program to create an environment which aids the integration of peer providers into the workforce. The most common barrier to the use of peer specialists was the acceptance of the positons within traditional mental health centers (Daniels, Grant, Filson, Powell, Fricks & Goodale, 2010). In 2009 at the Pillars of Peer Support Services Summit, one of the pillars that was identified was "a Comprehensive Stakeholders Training Program that communicates the role and responsibilities of Certified Peer Specialists and the concepts of recovery and whole health wellness to traditional, non-peer staff (peer specialist supervisors, administration, management and direct care staff) with whom the Certified Peer Specialists are working" (Daniels, Grant, Filson, Powell, Fricks, and Goodale, 2010). The call for training recognizes acceptance as the most significant barrier to the peer specialist workforce.

The organization intending to hire peer specialists must also have a strong philosophy of recovery without which may not have the "attitudinal and structural supports to successfully employ peers/coaches in their workplace" (SAMHSA, 2012). These strong principles of recovery are essential for integration of peer supports into the service array. Likewise, a strong program commitment is necessary for the transformation of service delivery to include a peer support component.

At the fourth annual Pillars of Peer Support conference three years later, there was still a call for "creating recovery cultures that support peer specialists" (Daniels, Tunner, Bergeson, Ashenden, Fricks, Powell, 2013). At the sixth annual conference two years later, conference participants began prescribing supervisory roles for the integration of peer specialists into the workforce. The conference monograph found "A key element of peer specialist supervision is to create a supportive and stimulating environment where the job role and expectations of the peer specialist are open to collaborative discussion" and that "The peer specialist's supervisor should also be an advocate and should convey the importance of the peer specialist's roles with human resources and others in the organization." (Daniels, Tunner, Powell, Fricks, Ashenden, 2015).

As we have said, the burden is necessarily on the mental health program to create an environment which aids the integration of peer providers into the workforce. The Dimensions: Peer Support Program Toolkit (Morris, Banning, Mumby & Morris, 2015) organization assessment makes it clear the responsibility falls to the mental health program with questions such as:

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Preparing from page 6

distance learning technology for a hybrid format. Each module is crafted to be a stand-alone experience and therefore results in a completion certificate within the respective topic area.

Finally, recognizing the need professionals have for career advancement, students who complete any five (5) modules in any sequence within any time frame are awarded an Advanced Certificate in Integrated Primary and Behavioral Healthcare signifying the extensive training that students have undertaken. Each module is recognized by the New York State Department of Education for the award of CEU credits as noted below. Table 1 below provides topic descriptions of each module.

Measuring Training Outcome

Since its inception two years ago, the Integrated Primary and Behavioral Health Care certificate program has had 122 students participate and complete one or more of the offered modules, while 55 students have since received advanced certificates having completed a total of 5 modules. Participants were from the fields of social work, law, nursing, medicine, peer advocates and paraprofessionals. They represented upper and mid-management as well as direct service staff.

Measuring training outcomes is always a challenging undertaking. The purpose of training is not only to communicate new knowledge but to also teach new skills that can be applied within practice settings. Measuring skill acquisition is one issue but the more important aspect of training is whether new knowledge and skills are applied in work settings.

In an attempt to measure outcomes, students were asked to develop implementation plans utilizing aspects of principles and skills contained within each respective module. These were reviewed and feedback was provided as necessary. In addition, a specialized self-report evaluation has been developed to help understand students' motivation to change at the conclusion of each module. The data contained in table 2 and 3 below represents only a sample of the data collected and is representative of two modules. It reflects the level of engagement and enthusiasm of the group who thus far has taken the training.

Students were asked to complete an online evaluation at the commencement of each module. Some questions were answered using a Likert scale ranging from Strongly Disagree (1) to Strongly Agree (5), while other questions were open-ended in an effort to gather qualitative data about each student's individual experience.

Table 2 below reflects data from the first year of the program and is limited to the first several modules. This data reflects the high level of student satisfaction with the training and content. Perhaps as important, Table 3 below, also from the same cohort, reflects an equally high level of desire to change practice within the workplace, however it appeared that work place support is lagging somewhat behind employee motivation toward change.

Concluding Comments

Health care transformation brought on by the ACA is complex, multi-dimensional and spans the entire health care enterprise. Delivery systems, payment methodologies, health insurance operational protocols, evidenced based treatment, wellness self-management designs and clinical research focus are all in motion. The workforce must absorb these new movements by first learning the information necessary for implementation followed by engagement in practice change.

The purpose of this brief report was to describe one approach to re-training the workforce that several major Universities are pursuing in various forms. Alternatively, there are national conferences, web based learning opportunities, and stand-alone workshops that are all offering various renditions of training in Integrated Primary and Behavioral Health Care, all of which have a role to play in re-training the workforce. Regardless of training venue, training in this area needs to include practice exercises that will allow participants to leave with new knowledge and skills that can be reinforced back at the workplace. Those trained in Integrated Primary and Behavioral Health Care can serve as leaders within their own organizations providing practice change sustainability within this rapidly changing health care environment.

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Table 1 Advanced Certificate***
Integrated Behavioral/ Primary Health Care
Content Areas Descriptions

Modules # 1-7

	#1	#2	#3	#4	#5	#6	#7
Domains	*The Affordable Care Act*	*Social Determinants of Health*	*Person Centered Planning (PCP)*	*Promoting Systems and Organization Accountability*	*Providing Leadership through Times of Change*	*Trauma Informed Care*	*Care Management of Chronic Illness**
Learning Focused Topic Areas	Insurance Marketplace Transformation	Social Determinants of Health	Recovery Concept & Process	Metrics of Health Care	Managing During Times of Change	Literacy & Neurobiology	
	Healthcare Disparities	Health Equity Through Social Action	Evolution Of PCP	Individual Performance & Quality Measure	The Role of Leadership	Culture & Trauma	
	Clinical Practice Changes	Poverty, Trauma& Food Insecurity	PCP & Treatment Planning	Actionable Data to Improve Care	Sustaining Change: Role of Supervision	Clinical Aspects Of Trauma	
	DSRIP & Medicaid Redesign	Integrating Health, Mental Health, and Substance Abuse Services	PCP and Prevention	Accountable Care Organization	Implementing Evidenced Based Treatment	Trauma & Client Engagement: Motivational Interviewing	
	Unintended Consequences	Improving Population Health Through Prevention	Peer Support Models		Understanding Managed Care	Trauma Informed Care In Organizations	
Approved CEU's for Social Work**	10 CEU's	20 CEU's	20 CEU's	10 CEU's	20 CEU's	20 CEU's	

*In development…available Fall 2016
**Approved by NYSDE Modules 1-6
***Completion of any five modules in any sequence across any time frame results in the award of The Advanced Certificate in Integrated Care

Table 2 **Student Satisfaction**

Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Total Responses	Mean
1. *The readings, lectures, and group discussions were relevant and helpful toward understanding the course objectives.*	0	0	2	26	27	55	4.45
2. *The readings, lectures, and group discussions provide information that is valuable to my work and agency.*	0	0	3	23	29	55	4.47
3. *I believe this certificate program is necessary for ensuring the use of best practices at my work place during the implementation of the Affordable Care Act.*	0	1	3	17	34	55	4.53
4. *The readings, lectures, and group discussions were thought-provoking and kept me engaged and interested in the learning process.*	0	0	2	20	33	55	4.56
5. *I am satisfied with the training I received in this module.*	0	0	3	24	28	55	4.45

Table 3 **Student Motivation to Change**

Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Total Responses	Mean
1. *I have a desire to change workplace policy, procedure, or applied skills having now participated in this program.*	0	0	4	23	26	53	4.42
2. *I have the necessary knowledge and skills to lead and/or manage at my workplace.*	0	1	2	30	20	53	4.30
3. *I have the proper amount of support at my agency to implement the attitudes, knowledge, and skills I have acquired from participating in this program.*	2	4	6	28	13	53	3.87
4. *I intend to actively participate in changes at my workplace related to integrated health and behavioral health.*	0	0	2	22	29	53	4.51
5. *I am implementing changes in my workplace using the knowledge I learned in this program.*	0	0	4	30	19	53	4.28

Co-Occurring from page 29

professional standards and through promoting ongoing professional and program development.

A NADD Accreditation survey evaluates a program on the basis of eighteen competency modules:

- Medication Reconciliation
- Holistic Bio-Psycho-Social Approach
- Database/Outcome measures
- Protocols for Assessments
- Treatment/Habilitation Plans
- Basic Health Care
- Interdisciplinary Team
- Training / staff and family
- Crisis Prevention and Intervention
- Cultural Competency/Family Values
- Trauma
- Quality Assurance/Incident Management
- Evidence-Based Treatment Practices
- Ethics, Rights, Responsibilities
- Interagency and Cross-Systems Collaborations
- Long Term Living – Service Coordination
- Advocacy and Rights Health Informatics (Technology)

(Note: Only the standards that are applicable to the program will be evaluated.)

One way that NADD Accreditation differs from almost all other accreditation programs is the inclusion of a consultation component. Through their expertise, NADD surveyors are not only able to identify areas that are in need of improvement, but they are also able to offer concrete suggestions about how to improve the program. The consultation component takes place on site during the course of the survey.

Competency-Based Clinical Certification Program

The NADD Competency-Based Clinical Certification was developed to improve the quality and effectiveness of services provided to individuals with a dual diagnosis through the development of competency-based professional standards and through promoting ongoing professional development. Certification attests to the clinician's competency in providing services to individuals with a dual diagnosis.

NADD has identified five competency areas that applicants for Clinical Certification must demonstrate mastery of.

- Positive Behavior Supports and Effective
- Environment
- Psychotherapy
- Psychopharmacology
- Assessment of Medical Conditions
- Assessment

In order to be considered for Clinical Certification, an applicant must meet certain pre-requisites. They must be licensed to practice in a state or province or recognized as Applied Behavior Analyst, and they must have five years experience in support of persons with intellectual disabilities and mental health issues. They are required to submit three letters of reference.

Applicants are required to submit a five page work sample of a case that demonstrates clinical work with a person who has a dual diagnosis. The work sample should include formulation/conceptualization of clinical problem(s), format for therapy or intervention, landmark events or salient issues that arose during the course of treatment and how these were addressed within treatment, reflection on issues within therapy and/or ethical concerns and/or issues relevant to cultural competency, and how the clinical approach was informed by an understanding of intellectual disability or dual diagnosis.

The final aspect of the certification process is a telephone-based interview/exam. Prior to the interview, the applicant is presented with a case vignette approximately about which he or she will be asked to verbally offer his/her thoughts and reflections (i.e., provide a case formulation and treatment plan).

Clinicians who receive NADD Clinical Certification are entitled to use "NADD-CC" as a credential.

The NADD-CC is being recognized by a wider and wider variety of different entities as a unique specialty, and we anticipate broader recognition as time passes. Individual municipalities such as the City of Philadelphia recognize the NADD-CC, giving specific preference in a Request For Proposals. Some third party payers, including managed care entities, recognize NADD-CC. Individual states, such as MN and NJ, recognize NADD-CC and are in the process of adopting NADD-CC into service qualifications and job class specifications.

Competency-Based Dual Diagnosis Specialist Certification

The NADD Competency-Based Dual Diagnosis Specialist Certification Program is designed for specialists in the field of dual diagnosis who deliver, manage, train and/or supervise services for persons with intellectual/developmental disabilities and mental health needs. Staff working in units of county, state or provincial government, QIDPs, RN's, LPN's, program directors, program supervisors, case/care managers, program specialists, supports coordinators, peer specialists, trainers, and others are examples of roles that can apply for this certification.

The specialist seeking certification is required to demonstrate mastery of the following six competency areas:

1. Bio-psycho-social approach
2. Application of emerging best practices
3. Knowledge of therapeutic constructs
4. Respectful and effective communication
5. Knowledge of dual role service delivery & fiduciary responsibilities
6. Ability to apply administrative critical thinking

Competency-Based Direct Support Professional Certification

In general, DSPs spend more time with the person with IDD/MI than any other professional. The competence of the DSP can make a big difference in the quality of life for people. DSPs are often the ones charged with supporting skill building. They help the person engage in recommended therapies on a day-to-day basis. This work requires an advanced level of skill and knowledge to do well. However, there is little available to guide DSPs and others in identifying the specific competencies a DSP should have for this work. As a result, many DSPs are under-qualified. Too often, they lack the support and training to do well. This lack of standards can make finding, hiring, training, and retaining qualified DSPs difficult. As a result, many people with IDD/MI do not have adequate daily support.

NADD identified five competency areas that the DSP applicant must demonstrate competency in:

1. Assessment and Observation
2. Behavior Support
3. Crisis Prevention and Intervention

see Co-Occurring on page 40

Beacon from page 9

Dr. Petit earned his medical degree from University of Buenos Aires and completed his psychiatry internship and residency at the Mount Sinai Hospital School of Medicine. Additionally, he completed a public psychiatry fellowship at Columbia Presbyterian-New York State Psychiatric Institute.

About Beacon Health Options

Beacon Health Options is a health improvement company that serves 47 million individuals across all 50 states and the United Kingdom. On behalf of employers, health plans and government agencies, we manage innovative programs and solutions that directly address the challenges our behavioral health care system faces today. Beacon is a national leader in the fields of mental and emotional well-being, addiction, recovery and resilience, employee assistance, and wellness. We help people make the difficult life changes needed to be healthier and more productive. Partnering with a network of providers nationwide, we help individuals live their lives to the fullest potential. For more information, visit www.beaconhealthoptions.com.

Disorder from page 9

Based on the results of the study, the majority of people with drug use disorder never receive any form of treatment. About 14 percent of people who had drug use disorder in the past year and about 25 percent of people who had ever had drug use disorder received care. Even among people with moderate-to-severe drug use disorder, less than 20 percent of those with past-year drug use disorder and less than one-third of those with lifetime drug use disorder received treatment.

Treatment rates for alcohol use disorder are similarly low. Earlier this year, Dr. Grant's group found that nearly one-third of adults in the United States have alcohol use disorder at some time in their lives, but only about 20 percent receive treatment www.niaaa.nih.gov/news-events/news-releases/nih-study-finds-alcohol-use-disorder-increase.

The authors note that low treatment rates for drug use disorder may reflect skepticism about the effectiveness of treatment, as well as insufficient resources, lack of knowledge among health care providers and barriers related to stigma. They note the need to destigmatize drug use disorder and educate the public about recent advances in evidence-based treatment and how to access help.

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demonstrating the ability to use electronic medical records; and tracking and reporting outcomes.

In recognition of the need to support the healthcare staff in the face of these broad-brush changes, the New York State Department of Health has funded a project that directly targets the healthcare workforce through their Health Workforce Retraining Initiative (HWRI). As the entire healthcare system is undergoing change, HWRI is intended to support the workforce to learn the new skills required for them to retain and thrive in their positions.

In order to support the newly created Care Management workforce, through this grant, the New York Association of Psychiatric Rehabilitation Services (NYAPRS) developed the Care Management Training Initiative (CMTI) for Care Managers and their supervisors across New York State. Over the course of 4 years, NYAPRS has developed two CMTI trainings that have been provided to over 900 Care Management staff. Both training series were designed to enhance care managers' skill sets so that despite the massive changes to our system, they can remain a successful workforce and continue to assist the people they work with to achieve and maintain wellness.

The first phase of the training consisted of 10 webinars and a series of face to face trainings and was successfully completed in 2013 with over 500 staff completing the training. The second phase of the training is currently underway and will be completed in March 2016. The training target for the DOH is 253 trainees, however, the need is so great that over 700 care managers have enrolled in the current training project.

NYAPRS collaborated with four organizations to implement these trainings: the NY Care Coordination Program, the Center for Practice Innovations, the NYS Council for Community Behavioral Health, and Tech Leaders. Over the course of 15 months, the training provides web-based learning for all staff with additional components specifically for the supervisors that included a telephonic learning collaborative and in-person learning sessions. By creating these additional supports for the supervisors, the training teaches supervisory skills specific to the content covered in the webinars. The intent is to build the supervisor's skill set so that they can support their staff as they implement what they have learned.

Topics include: Outreach, Engagement and Retention; Understanding Complex Needs; Navigating Complex Systems; Effective Outcomes Measurement and Management; and Workload Management and Using Technology to Enhance Productivity and Effectiveness. Each of the five content areas covers competency areas needed to be an effective, efficient and successful care manager.

The new Care Manager role will be essential to the success of this new approach to healthcare. To succeed, the system has created this special position in the helping profession – a person who must know all, sometimes, be all, but above all, be genuine, engaging, supportive and adaptable. That brings us back again to the spider's web of silk strands. They have the unique requirement to provide tensile strength and yet be immensely flexible.

The efforts of the training collaborative are helping to support the framework for these webs of care and offer the resources for care managers to achieve the promise of the Triple Aim. For the participants of care, the training will assure that the staff they work with will understand and negotiate all the systems of care that make up the complex web of our health care system. And hopefully, with that added knowledge, recovery and wellness will prevail as the valued outcome.

Ruth Colón-Wagner of NYAPRS can be contacted via email at ruthcw@nyaprs.org.

Aging from page 11

Living With Disability: Obviously, older adults are more likely to experience disabilities than younger people. But this is far from the end of their potential to get satisfaction out of life.

In the field of psychiatric rehabilitation, a concept of recovery has emerged that does not mean that people with long-term psychiatric disabilities eventually get over their mental illnesses fully. Some do; but many continue to experience the symptoms and psychological struggles of severe, long-term mental disorders. "Recovery" for them means that they can nevertheless discover ways of living that they find satisfying and meaningful.

Geriatric behavioral health professionals need a similar concept for people who develop disabilities as they age, including those who develop dementia.

Successful Aging: "Successful aging" is one such concept. Recent literature on this concept borrows from the concept of recovery and distinguishes between objective and subjective successful aging. Emphasis on objective successful aging leads to various anti-aging initiatives and the hope that decline and death can be defeated. Emphasis on subjective successful aging emphasizes that success, like beauty, is in the eye of the beholder. In fact, many older adults experiencing the challenges of aging, even those with extensive losses of prior capabilities, can nevertheless feel that their lives are satisfying. Instead of trying to defeat old age, the concept of subjective successful aging leads to efforts to help older adults to maintain and develop relationships, to participate in activities they find pleasurable and meaningful, and to maintain a positive attitude despite the typical trials and tribulations of aging.

A generationally competent workforce needs to understand the opportunities of old age and work to promote successful aging as well as to prevent and treat mental illness.

Rejection of Ageism: In our culture, age is associated with decline, disability, and death. Aging well strikes most people as an oxymoron. In fact, however, most people over the age of 65 are not disabled and dependent, not decrepit, not finished, not over the hill, not on the edge of death. Yes, old age has its difficulties. But, surprisingly, mood and anxiety disorders are less common among older than younger adults, and suicide rates are lower than those of working age adults except for white men over 85. Yes, cognitive impairment becomes more common with age, and by 85 nearly half of older adults will have significant impairment. But that's 20 years of potentially satisfying, independent living for the majority of older adults. It is a time when older adults can—if they want—make substantial social contributions by continuing to work for pay, by volunteering, by being grandparents, etc. Failure to recognize this fact is fundamentally ageist.

In addition, it is possible for people with physical, mental, and cognitive impairments to have satisfying lives. Failure to recognize this fact is also ageist.

Hopefully, the geriatric behavioral health workforce of the future will reject ageism and will work to fulfill the opportunities of old age. This should include not only efforts to prevent and treat mental and/or substance use disorders using interventions that are specifically adapted to the needs of older adults. It should also emphasize efforts to promote "positive mental health"—i.e. well-being in old age.

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

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and agencies and will continue to evolve in order to offer support to agencies outside of the state's large metropolitan areas through tailored tools, self-guided learning modules, and resources, so that all agencies have the support they need and all New Yorkers are able to access quality care.

As MCTAC transitions into the rest of state and children's implementation the authors encourage providers to familiarize themselves with our tools and previous offerings. All of these offerings and tools will be updated for the upstate and children's roll outs. Also, please take advantage of MCTAC.info@nyu.edu to share any suggestions for needed technical assistance.

Daniel Ferris, MPA is the Assistant Director, Policy and External Affairs within the McSilver Institute for Poverty Policy and Research, NYU School of Social Work. Meagan Baier, LMSW is a Project Manager and Analyst at the Institute for Community Living. Questions can be directed to Daniel Ferris at dan.ferris@nyu.edu.

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care providers and specialists. Through collaboration with WJCS psychiatric staff they receive ongoing supervision and training to enhance their expertise and extend their services to special populations such as children and individuals with developmental disabilities. This truly comprehensive approach to individuals with mental illness has resulted in improved health for WJCS clients.

Going forward, nursing will play an expanding role in the delivery of integrated mental health and psychiatric care. With their unique blend of medical and psychiatric training and experience, they are well positioned to care for the whole person.

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is designed to provide those already working in the profession new, current evidence-based information to help ensure the delivery of the best clinical practice. The courses are free and strives to improve the lives of clients in prevention, treatment and recovery services. To register to receive Learning Thursday information visit www.oasas.ny.gov/LT/index.cfm. OASAS also offers in-person Regional Learning Opportunities which can be found at: www.oasas.ny.gov/workforce/training/oasastraining.cfm and a list of free online courses at: http://www.oasas.ny.gov/workforce/training/FreeLDO.cfm, all of which are approved for those seeking to satisfy the continuing education requirements necessary to renew an OASAS credential.

Current professionals can also do more to help fill the shortage in the addictions workforce. They can be mentors and role models, inspiring others to join the fold. We need a workforce that reflects our great nation, with professionals of all ages and from diverse backgrounds. All must be able to work together in this new, integrated setting.

Supporting from page 33

• Is your leadership team in support of implementing a peer support program?

• Is a peer support program consistent with your organization's mission and values?

• Does your organization have identified champions of peer support?

• Do the benefits of implementing of a peer support program at your organization currently outweigh the perceived barriers?

Support from leadership and identification of peer support champions will both be crucial to paving the way for successful integration of peer specialists to the workforce. Typical concerns include whether peer specialists may relapse, whether they have the requisite skills and experience, and a perceived risk that peer specialists may supplant other team clinicians (Morris, Banning, Mumby & Morris, 2015). Only leadership from the top can impart the clear message that the organization is fully committed to integrating peer specialists and receiving the expected benefits of doing so. Only then can the champions smooth the path for full integration.

Tips to Reduce Negative Attitudes Faced by Peer Support Staff (Resources for Integrated Care, 2015b) also made clear the expectations of the mental health program with its key considerations:

• Recognize that people can be both clients and providers

• Identify stigma in your organization

• Prepare your organization

• Develop a plan to train and educate peer support staff and supervisors

• Create an inclusive culture

• Ensure effective supervision

Again, these steps need to be initiated by leadership and receive implementation support from the peer support champions.

Supervision of the peer specialist is also crucial to success. The role and services offered are different from any other position on the clinical team. The peer specialist is expected to form a mutual relationship- ordinary clinical boundaries do not apply (Hendry, Hill & Rosenthal, 2014). The peer specialist role is different from any model that programs may attempt to fit it into. A peer specialist is not delivering case management or functional support services. They are delivering a level of support that can only be classified by what it is- peer support. It is essential that team members understand this key difference in roles.

It can also not be avoided that there will be some stigma attached to the idea of peer specialists. It is the role of leadership to educate and supervise the other team members to help them grow beyond this. Coaching is the preferred method of supervision (for all staff) as it best communicates the strengths of peer support and concepts of recovery. It is essential that the entire treatment team understand what is required for the implementation of recovery-based services (SAMHSA, 2005). Matthew Federici said that training of peer specialists "places a large focus on preparing the environment to employ them in ways that transform the behavioral health system to be more recovery-oriented" but the same can be said of supervision.

Indeed, peer specialists have said that lack of strong supervision tends to reduce the "peer-ness" of their role as they find themselves identifying with the clinical staff to secure some level of support (SAMHSA, 2012). When peer receive the strong supervision required of this model of services they "are able to stay faithful to and engaged in their peer roles (SAMHSA, 2012). Drifting from the peer role into the realm of the other professionals usually creates role confusion and competition which unbalances the entire team.

Another concern expressed by peers regarding supervision is uncertainty about their own success. The unclear nature of the peer role and perhaps even unclear job descriptions make it difficult for peer specialists to judge on their own how well they are doing. This is where strong and consistent supervision is crucial to providing that feedback so the peer specialist remains comfortable as they work toward defining their role. Ideally, there is supervision by another peer or other arrangements for peer-to-peer support.

The evidence base for effective peer support is growing in leaps and bounds but effective peer support requires effective supervision and organizational support. With these in place, the peer specialist and the mental health program are both positioned for greater success.

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Roadmap from page 8

Taken together, these principles outline a public health approach to mental wellness that charts a path toward a healthier and happier future for all New Yorkers. ThriveNYC focuses on promoting mental health, preventing illness, and detecting problems early, in addition to treating mental illness.

Similar approaches have dramatically improved public health issues. For example, through a combination of policy bans on smoking, broad public communications, increased federal, state and local excise taxes and increased access to treatment tools, New York City cut the adult smoking rate by 35 percent in about a decade. The youth rate fell even more – by 52 percent.

"If you look at how mental illness has been addressed over the years, you see a lot of broken promises," said Mayor Bill de Blasio. "You don't see a concerted, holistic effort to help people be well and stay well. The people of NYC needed something different, something like ThriveNYC. It will take years to address the problem the way it should be addressed. But we need to start now, we need to start aggressively. The people of NYC deserve nothing less."

"We want New York City to be a place where people can live their lives to the fullest," said First Lady Chirlane McCray. "ThriveNYC is about more services, better services and easier access to services. It's a plan of action that shows us how to treat mental illness – and also promote mental health."

"Mental illness truly impacts the lives of every New Yorker – our quality of life, our health and our economy," said Deputy Mayor for Strategic Policy Initiatives Richard Buery. "New York City can and will ensure that all New Yorkers have access to the services and treatment they need to feel better and live healthier. ThriveNYC is a plan of action to guide us towards a more holistic public health system that prevents, detects and treats mental illness."

"Like much of the United States, New York City is facing a crisis when it comes to mental health. Mental illness and substance use disorders touch every family, and rank right up there with heart disease and diabetes as leading causes of poor health, shortening the healthy life years of New Yorkers," said Mary T. Bassett, Commissioner of the Department of Health and Mental Hygiene. "But there has been insufficient attention to prevention, and the fragmented array of services has allowed too many New Yorkers to fall through the cracks. The challenges ahead are significant, and the mental health system will not be fixed overnight. But the Roadmap launched today sets our City on a new path – with new resources and an unprecedented political. commitment for all parts of city government to be part of the solution."

"ThriveNYC fills both a vacuum of vision to align and guide policy, and a vacuum of credible action for realizing that vision. When we measure the huge impact and terribly common frequency with which mental illness and misuse of drugs and alcohol affects families in our city, it is clear we need to provide both," said Gary Belkin, MD, PhD, MPH, Executive Deputy Commissioner of the Department of Health and Mental Hygiene. ThriveNYC highlights include:

• Mental health First Aid Training: The City will fund and facilitate the training of 250,000 New Yorkers, to better recognize the signs, symptoms and risk factors of mental illness and addiction and more effectively provide support.

• Public awareness campaign: A city-wide public awareness campaign will reshape the conversation around mental health, promoting mental wellness and early intervention and educating New Yorkers about how to get services.

• NYC Mental Health Corps: The city will hire 400 clinicians and recently graduated Masters and Doctoral-level clinicians to work in substance abuse programs, mental health clinics and primary care practices in high-need communities throughout the city. When fully staffed, this Corp can provide 400,000 additional hours of service.

• Mayor's Conference for Mental Health: In 2016, the City of New York will host the first Mayor's Conference for Mental Health. The conference will bring cities together to share new ideas and promising initiatives and send a strong message that mental wellness must play a central role in ongoing policy development.

• Mental Health in Schools: Building on the expansion of mental health services in Community Schools, the City will hire 100 School Mental Health Consultants who will work with every school citywide to ensure that staff and administrators have an outlet to connect students with immediate needs to care.

For an overview of or to download ThriveNYC, visit the Thrive NYC website: https://thrivenyc.cityofnewyork.us/

Awards Reception from page 1

More on our honorees…

Peter C. Campanelli, PsyD

Dr. Campanelli founded the Institute for Community Living in 1986 as part of his doctoral dissertation project, and served as President and CEO until 2012. Under his leadership ICL and partner Agencies developed a diabetes management protocol for seriously mentally ill people along with the first community based health home under the chronic illness demonstration project (CIDP). ICL's healthcare integration efforts also led it to develop its own health care clinic which it latter evolved into a specialty federally qualified health center (FQHC). He has served as Board Chair of The Association of Community Living and Managed Care Innovations, as well as President of the Coalition of Voluntary Mental Health Agencies' Board of Directors. He also served on the Board of the National Council for Community Behavioral Health, and is a past Chairman of the Mental Health News Education, Inc. Board of Directors.

Dr. Campanelli holds a Doctorate in Clinical Psychology from Rutgers University, Graduate School of Applied and Professional Psychology, and is a past recipient of the university's Peterson Prize for Community Service. He is also a past recipient of the Visionary Leadership Award from the National Council of Community Behavioral Health, and the Congressional Community Corporate Partnership Award from Hon. Edolphus Towns. His work has twice been recognized with the Gold Medal Award from the Hospital and Community Psychiatry Division of the American Psychiatric Association.

John J. Coppola, MSW

Mr. Coppola is a Past-President of the State Associations of Addiction Services, the national association of state associations that represented substance use disorders services providers and which recently merged into the National Council for Behavioral Health. John has served on numerous national advisory committees, including the SAMHSA/CSAT Partnership for Recovery, the CSAT Recovery Month Advisory Committee, and the National Council of State Legislators Addictions Committee. He has also served and is on a number of regional and statewide advisory committees, including NYS Governor Andrew Cuomo's Medicaid Redesign Team Behavioral Health Work Group, former NYS Governor David Paterson's Commission on Juvenile Justice Reform, the Northeast Addiction Technology Transfer Center Advisory Committee, Council on Accreditation, and numerous NYS Office of Alcoholism and Substance Abuse Services (OASAS) workgroups. John also served in an advisory role with the Office of National Drug Control Policy.

Prior to becoming Executive Director of ASAP, Mr. Coppola worked for Catholic Charities of the Diocese of Albany from 1981 through 1996, serving most recently as the Executive Director of Montgomery County Catholic Charities. During his tenure at Catholic Charities, Mr. Coppola served as Chairperson of the Catholic Charities USA Alcoholism and Substance Abuse Committee and as Chairperson of the NYS Catholic Conference Alcoholism and Substance Abuse Committee.

Mr. Coppola received his Master's Degree in Social Work from the State University of New York at Albany and his Bachelor of Arts in Psychology from Dominican College.

Linda Rosenberg, MSW

Harnessing the voices of the 10 million adults, children, and families served by the National Council's 2,500 member organizations, Linda Rosenberg helped secure passage of the federal parity law, expanded integrated behavioral and primary care services, introduced Mental Health First Aid in the U.S., and built an array of organizational, clinical and workforce improvement initiatives. The National Council's strong support of the Mental Health Excellence Act will result in the first comprehensive effort to establish community accountability for the health of people with serious mental illnesses and addictions, the consistent utilization of evidence-based practices, and the standardized measurement of outcomes.

Linda was Senior Deputy Commissioner of the New York State Office of Mental Health prior to joining the National Council. She has over 30 years of experience in designing and operating hospitals, community and housing programs, and implemented New York's first Mental Health Court. She serves on an array of boards of directors and is a member of the Executive Committee of the National Action Alliance for Suicide Prevention.

Ann Marie T. Sullivan, MD

As Commissioner of the NYS OMH, Dr. Sullivan has worked closely with all mental health providers and health plans, and is responsible for the movement of the health benefit for the seriously mentally ill into managed care beginning in October 2015. This new Health and Recovery Plan (HARP) benefit will embed in the Medicaid benefit critical recovery services such as crisis respite, peer, educational and employment supports. She has also been instrumental in expanding services for the mentally ill in prisons and in expanding the much needed community based continuum of care for the seriously mentally ill leaving prison and returning to their community.

As the former Senior Vice President of the Queens Health Network of the New York City Health and Hospitals Corporation, Ann was responsible for Elmhurst and Queens Hospital Centers, two public hospitals which serve a community of over 2 million New York City residents. Along with ensuring the seamless integration and coordination of services across the Network, Dr. Sullivan aligned and helped to implement key corporate programs such as the Care Management Initiative on the inpatient units and in the emergency services; the launching of best practices to improve patient safety; and the integration of behavioral health and medical sciences.

Dr. Sullivan grew up in Queens, New York City. She graduated from NYU and its School of Medicine and completed her Psychiatric Residency at New York University/Bellevue Hospital in 1978. She has served as Associate Director of Psychiatry and Medical Director of Ambulatory Care at the Gouverneur Diagnostic and Treatment Center and joined the Queens Health Network as Regional Director of Psychiatry in 1990, overseeing the administrative, budgetary, and clinical aspects of the psychiatric services of both Network hospitals. She has enjoyed an extensive career in public psychiatry and has lectured and published on best practices in community care.

Dr. Sullivan is an active advocate for her patients and her profession, is a Distinguished Fellow of the American Psychiatric Association and has served as the Speaker of the American Psychiatric Association's Assembly and on its Board of Trustees. She is a fellow of the New York Academy of Medicine, a member of the American College of Psychiatrists and the Group for the Advancement of Psychiatry.

Addiction from page 30

and certification in addiction.

Historically, physicians have been eligible to take the exam to become certified in addiction medicine if they had an unrestricted medical license, were board certified or board eligible in a primary specialty, documented 1 year of practice with patients with substance use disorders, and completed 50 hours of continuing medical education in the field of addiction. More recently, individuals can also become eligible through the completion of an ABAM accredited addiction medicine fellowship program, and it is likely that fellowship training will become a required qualification for certification in addiction medicine within the next several years.

Formalized fellowship training in addiction medicine is a groundbreaking step towards increasing the number of addiction physicians and closing the treatment gap. The ABAM Foundation defined required competencies for this training in 2010 and the first ten fellowship programs were recognized in 2011. Fellowship programs accept physicians that have trained in a wide range of medical specialties, and training consists of exposure to substance abuse treatment in the inpatient and outpatient settings, consultation-liaison services, and continuity care for individuals with substance use disorders. Today, there are 39 fellowship programs in the US and Canada, and ABAM has set a goal of 65 fellowships by 2020.

In the newly established Fellowship in Addiction Medicine at the Institute for Family Health, fellows will have the opportunity to provide substance abuse treatment in an integrated care model. Integrated treatment, in which substance abuse treatment (and often behavioral health treatment) is provided in collaboration with primary care services at the same location, allow individuals to receive care from a team of treatment providers and increases access to care. Further, integrated treatment models may reduce the stigma that can be associated with seeking substance abuse treatment by providing treatment from clinicians with whom the patient has already developed a therapeutic relationship in a setting that is already familiar to the individual.

Providing comprehensive medical and substance abuse services also enhances recovery. Research has shown that individuals with substance abuse related medical conditions who access primary care services are three times more likely to achieve remission over 5 years and are up to 30% less likely to require hospitalization (Weisner, C, Mertens, J, Parthasarathy, S, Moore, C, and Lu, Y. (2001). Integrating Primary Medical Care with Addiction Treatment. JAMA: The Journal of the American Medical Association, 286(14):1715-1723. doi:10.1001/jama.286.14.1715). Integrated treatment is ideal for meeting the comprehensive needs of individuals with substance use disorders.

The growth of addiction medicine promotes an integrated model of health care and moves towards closing the treatment gap. Addiction medicine training expands the workforce of specialist physicians to include a broad array of medical specialties and allows for treatment of a more diverse population in a greater number of clinical settings.

Consumer from page 14

being encouraging in places where care meets the mark and beyond.

Supervisors must believe that the culture of their workplace is supportive of their efforts, that the road they lay out before staff and consumers is a road that works within an agency's guidelines and ideology. Supervision is where the belief of success becomes part of an agency's operational procedure. In addition to individual supervision provided to all staff, at ICL, we use such resources as Tip of the Week, which brings thoughtful suggestions on how to approach different consumer problems with compassion. Our nursing triage and internal mobile crisis teams work together to bring integrated care to the neighborhoods where consumers live. When new consumers are coming to an ICL facility, senior clinicians weigh in on high-risk behaviors, comorbidities, histories of aggression and violence, and more through our SARC (Special Admissions Review Committee) team. When staff feels it has exhausted all other interventions, a Clinical Risk Consultation Team (CRCT) can be gathered in which senior staff meets with the consumer and the entire treatment team to formulate a safe and effective care plan.

So we are learning that the best consumer outcomes come from a team approach that starts during individual supervision. It is the agency's leadership that must support staff who, in turn, help consumers realize that their successes are within reach. People do get better and achieve meaningful lives and true community integration. Effective supervision is an essential component in helping this come to fruition.

Grips from page 21

treatment settings for three reasons:

1. Some out-of-network facilities may not abide by an insurance plan's treatment guidelines. As a result, patients may not be covered for certain services and would have to pay out of pocket.

2. Close analysis of claims from some treatment centers indicates questionable practices in treatment protocols and in billing patients, families and their insurance companies. A prime area of concern is drug screenings through laboratory tests. These tests are often administered inappropriately and far more frequently than necessary, and are billed at rates well beyond the usual and customary charges.

3. Typically, after release from an out-of-network facility, patients return home without a support system. This may trigger a return to previous self-destructive behavior and relapse, followed by readmission to another treatment center. Receiving treatment at a facility close to home, however, helps reduce the potential for a future readmission. Patients return home with an established local support network of family, friends and providers that is vital to recovery. If, in fact, relapse does happen, early intervention is available because the support system is in place to re-engage the individual in their recovery process.

Case Study: Florida

Optum's analysis of recent claims for substance use treatment in Florida found:

• The costs of treatment in out-of-network facilities were, on average, three times higher than the costs of treatment at in-network facilities.

• Nearly 75 percent of the cases of young adults treated in Florida involved individuals who were not Florida residents.

• Individuals from outside the state treated at out-of-network facilities were readmitted at higher rates — between 11 percent and 40 percent higher, depending on the level of care — than Florida residents who used in-network facilities.

(Findings from an Optum May 2014 analysis of behavioral care costs and readmission rates among 18- to 25-year-old members using at least one facility-based service for non-alcohol substance abuse treatment that discharged in 2013.)

What Employers Can Do

Educate: Young adults and/or their families typically select treatment centers in the heat of a crisis. They may not be equipped to ask probing questions about the treatment practices or outcomes before deciding. They also may not know what treatment and support systems are available to them in their home communities. During the recovery process, access to advocates and peer support is essential. Employers can provide educational resources to help employees with young adult dependents understand the many options available for SUD treatment which may include medication assisted treatment.

Promote: Use of Employee Assistance Programs should be encouraged. EAPs are a valuable resource for employees and their young adult dependents to seek counsel and assistance with confidential screenings, treatment referrals and follow-up care to support individuals in or seeking recovery.

Monitor: To help uncover potential fraud and abuse, employers — in partnership with their health plans — should implement drug screening and reimbursement codes that follow the recommended guidelines of the Centers for Medicare and Medicaid Services

Advocate: Two-thirds of young adults with mental illness and/or substance use disorder did not receive any services in the past year. When they do seek treatment, it sometimes falls well short of evidence-based practices. Employers should advocate for more evidence based practices within community-based programs and the availability of peer support networks which support long-term recovery.

Of course, it will take action from everyone with a stake in this issue — employers, patients and their family members, health plans and providers — to create better systems for supporting young adults trying to recover from mental illness and/or SUD.

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

Changing from page 1

needs to have a budget, but also understand the details of that budget and be involved in its development and, when necessary, modification. In the same vein, agency finance staff need to understand the program implications of budget decisions and the contractual and regulatory requirements that might impact meeting the goals and expectations for productivity, overall budget, quality of care, or documentation.

2. Integrated Health and Best Practices: Clients with mental health and substance use challenges have complex needs, both behavioral health and often, also co-morbid medical conditions, all of which are deeply affected by the social determinants of health. Understanding the interplay between all of these different needs is critically important to helping a consumer move towards recovery. A basic understanding of common terms, an ability to communicate effectively with each of the different service systems, and an ability to help clients navigate those systems is a critical and necessary skill.

3. Outcomes and Key Performance Indicators: As the New York State health care system moves toward value-based payments, a significant factor in an organization's success will be its capacity to demonstrate the impact of its services. The understanding of the shift from Fee-for-Service to Value-Based Payment will be important at all levels of the organization. Each individual provider will have to understand the impact of their interventions, and be able to monitor and adapt the interventions based upon data and evidence-based practice. In addition, organizations will need to understand how their delivery of service fits into the broader context of a person's care, demonstrating their impact across programs and systems and extending beyond their individual agency. For example, a staff member who is tasked with supporting a client's connection with primary care will need to understand the critical impact their role has on reducing ER utilization.

4. The Consumer Experience: Consumer experience is a key component in evaluating an organization. As we move to managed care and value-based payments, agencies will have to distinguish themselves based upon the quality of their outcomes as well as the experience of the individuals they serve. Successful staff and agencies will create an engaging and welcoming environment, requiring collaboration across what have traditionally been silos. This applies to direct care staff as well as staff who manage the front desk, maintenance, and beyond. Customer service will also need to consider and reflect the principles of a trauma-informed workplace.

5. The Role of Technology in Treatment and Reporting: Technology is a crucial component in healthcare. It organizes the work we do and how we measure it through the use of electronic health records. As we move into an APP environment, technology is also quickly becoming a treatment extender and for some, the direct link with care. Interoperability is a critical component of integration as it facilitates communication among providers. In addition, the ability to generate actionable, clear and simple reports will be one of many requirements for staff and agencies who are successful in the new world. There is often a tendency to keep technology purchases to the IT staff. In a changing system, agencies must be thoughtful as they consider the implementation of any new systems to ensure that they cut across departments and systems, and ensure that both operational and IT staff communicate about these crucial technologies to ensure that they perform the bridge role they are capable of—staff must not only be well-trained in the systems, but will also play a key role in informing the technology acquisition process.

6. Social Determinants of Health: Social determinants of health, the conditions in which people are born, grow, live, work and age, are a crucial component of recovery. More than ever, staff will need to understand the role they play and how to interact with other social service providers both inside and outside of the behavioral health field. Understanding social needs and engaging consumers in establishing pathways in meeting those needs is best accomplished through collaborative work with other social service providers, health homes, and community supports.

While there is no reasonable expectation that any one individual within an organization would be an expert in all or even most of the proposed content areas, each staff member will need to possess a working knowledge in regard to how these different aspects of the whole impact their specific job and day-to-day responsibilities. Traditionally, only senior executive staff was expected to have significant content knowledge outside of their discipline. As the behavioral health field trends toward integration and value-based, however, all staff will require this knowledge. Payers, providers, and regulatory bodies alike will need to work together in order to address this workforce development challenge.

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weekly engagement (45 classes), promoting growth in theoretical foundations and clinical skills for those just entering the field of addictions, as well as, for those who had been employed in the field for some time but lack formal education or training. There is also a marked improvement in the understanding of the nature and development of substance use disorders for credentialed social work and mental health clinicians with little experience treating this population.

This opportunity supported professionals like Elizabeth, LPC, LCADC with Masters in Mental Health Counseling, who graduated the ATWD program and is working as a supervisor at Jersey City Medical Center. "Knowing the dynamic layers of mental health care, in regards to substance abuse I came to understand that this enmeshed co-occurring population would require more education on my part to obtain employment and provide competent clinical care."

It more frequent to see ATWD graduates with multiple behavioral health credentials. It is essential that a variety of health care professionals gain a solid understanding of substance use disorders. With the prevalence of substance use, abuse and various process addictions the cross training to multiple professions requires so much more that then the few hours of attention. The ATWD program has prepared over 1,400 professionals to staff New Jersey's behavioral health field and provide the trainings, courses, and support services that that have advanced the field of addiction and behavioral health in New Jersey.

The New Jersey Prevention Network is a public health agency working to create healthier communities by reducing the burden of substance abuse, addiction and other chronic disease. For more information about the Addiction Training Workforce Development program visit www.njpn.org

Foundations from page 20

pharmacies with fistfuls of prescriptions and stock their medicine cabinets with droves of agents designed to target primary symptoms, secondary side effects and tertiary complaints that would be more effectively remedied through changes in lifestyle or environment. The conventional approach surely benefits some of its recipients, but it is ineffective on a population level. The most vehement proponents of this approach would concede our nation has never been sicker than it is now in so many respects. Furthermore, this approach is downright hazardous to many. The protocol through which our FDA deems new agents to be "safe" and "effective" is a highly circumscribed one that evaluates each agent in isolation against a placebo and amidst relatively small and homogenous groups of research participants. This protocol cannot be expected to yield meaningful information concerning the consequences of long-term use of individual agents it has deemed safe, nor can it anticipate the potential contraindications of a polypharmaceutical approach to treatment. For instance, a patient who has been prescribed multiple medications for the treatment of schizophrenia, diabetes, asthma, hypertension and hypercholesterolemia cannot consult the research literature on the potential contraindications or long-term effects of his specific regimen. He and his treatment providers can simply learn from his experience and consider the experience of others who once held a fervent belief in the safety of their medications because they carried the imprimatur of their manufacturers. Tardive dyskinesia, Metabolic syndrome, Agranulocytosis, Neuroleptic malignant syndrome and many others constitute the sordid legacy of a longstanding approach that has helped some but sickened others. And few would deny our pharmaceutical industry and the purveyors of its goods are complicit in our national epidemic of opiate addiction. Thus, our conventional approaches to the "treatment" of behavioral health conditions often violate a cardinal dictum of medical practice. They do not simply fail to help the afflicted. They cause harm.

This critique is by no means a categorical condemnation of pharmaceuticals and their role in the management of illness and disease. Many of these agents save lives. Others effect immeasurable improvements in the quality and quantity of years lived. They hold an invaluable place in our expansive arsenal of treatment modalities. But they must be considered in accordance with the aforementioned caveats and innumerable factors that influence the course of chronic illness. An emerging body of research has revealed benefits associated with low-dose pharmaceutical interventions coupled with other biopsychosocial modalities (Carey, 2015). These approaches emphasize the value of social and physical determinants of health to the recovery process and ascribe a more appropriate (i.e., limited) role to traditional medical interventions. These approaches and the orientation that informs them should serve as the foundation on which a new behavioral health workforce is built.

Herein lies the "prescription" for this workforce. It is one that regards individuals in the context of historical factors and the social and physical determinants of health and wellness. It gives secondary consideration to clinical diagnoses, as these are rapidly evolving and culturally defined constructs. They simply enable us to classify individuals' experiences without understanding or transforming them. Of those entrusted to its care this new workforce must ask, "What happened to you?" It cannot ask, "What's wrong with you?" Findings of the landmark Adverse Childhood Experiences (ACE) Study suggest an understanding of the deleterious effects of trauma and its repercussions within and across generations is integral to our treatment of behavioral health conditions (Centers for Disease Control and Prevention, 2014). We must also question popular convictions concerning the biological underpinnings of illness and their influence on individuals' health status. The science of genetics once taught us certain facets of biology were immutable and impervious to environmental influences. The emerging science of epigenetics teaches us of a fluid and nuanced interaction between genes and environment that permits one's genetic complement (i.e., genotype) differential outward manifestation (i.e., phenotype) in response to environmental influences. An individual who is exposed to early-childhood trauma, viral infections, a poor diet and income insecurity might be inclined to develop symptoms of schizophrenia and diabetes in adolescence or adulthood. This individual might thrive and exhibit no signs of illness if raised in a safe, loving and economically secure household. His genes remain unchanged but environmental contingencies alter their expression. Thus, our new workforce should be comprised of healthcare professionals but in proper proportion to their influence on recipients' health status, and the lion's share of our investment should accrue to other professionals, paraprofessionals, individuals with lived experience in recovery (i.e., peers) and emerging classes of practitioners with proven expertise in facilitating recipients' access to essential social and physical determinants of health. A workforce that can "write prescriptions" for safe and affordable housing, nutritious food, physical activity in open spaces, stable relationships with family and friends, and meaningful activity in the social, vocational and educational realms will address the 90% of the wellness equation for which traditional healthcare has no answer.

It is now incumbent on key stakeholders to garner the resources necessary to support this workforce and there is promising evidence this is beginning to occur. Many states, including New York, have pursued waivers of federal Medicaid regulations that permit them to apply funds toward the provision of services and supports that are customarily excluded from Medicaid coverage. A vast array of psychosocial and rehabilitative services is now available to many recipients, and the Centers for Medicare and Medicaid Services (CMS), the federal agency charged with oversight of the Medicaid program, recently issued guidance that suggests it is open to the application of Medicaid funds toward housing-related support services (Ollove, 2015). This is significant because Medicaid is statutorily prohibited from paying for housing, much to the consternation of many stakeholders who recognize the importance of decent and safe living accommodations to individuals' stability. Moreover, there is a widespread movement among both public and private payers toward reimbursement of service providers in accordance with the quality of services delivered as assessed by various outcome measures. Such a movement toward Value-Based Purchasing (and away from the Fee-for-Service model that incentivizes providers to deliver more, but not necessarily better, services) necessitates a renewed focus on social and physical determinants of health. If providers' reimbursement is contingent on the achievement of favorable outcomes they can no longer ignore the factors that account for 90% of their recipients' health status. New York State has compelled this movement toward Value-Based Purchasing via its implementation of Managed Care models of payment and service delivery that scrutinize outcomes and the means through which they are attained. The state is also in the midst of another grand experiment that aims to reinvest savings in Medicaid expenditures into services and supports that are significantly more community-based and outcome-oriented than the institutional structures (e.g., inpatient institutions, emergency departments, etc.) on which we have relied. This experiment bears the ungainly moniker of "Delivery System Reform Incentive Payment" program, and it aims to deliver payments to coalitions of providers who achieve favorable healthcare outcomes for their service recipients. Like Managed Care and related initiatives, DSRIP presents an opportunity for providers to realign their services and the workforce through which they are delivered in a manner that enhances recipients' access to social and physical determinants of health. But it is merely an opportunity. Payers, providers, recipients and other stakeholders must properly apply the opportunities afforded via healthcare reform in order for its new workforce and the countless lives on which it depends to flourish.

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Co-Occurring from page 35

4. Health and Wellness
5. Community Collaboration and Team work

Synergy and Motivation

Several programs, recognizing the value of having qualified, certified personnel, reward employees who achieve certification through a financial bonus or increased pay. The CLOUD Project in South Carolina rewards certified DSPs with a bonus. The Behavioral Health Center of Nueces County, Texas, gives NADD-certified DSPs a raise. Certain Departments in the State of Ohio recognize NADD Clinical Certification as one of the certifications that entitle employees to increased remuneration.

One requirement of the NADD accreditation is that after the initial period of the accreditation the program is required to have 10% of their workforce, in various categories (clinical, dual diagnosis specialist, DSP) be NADD-certified. This will help insure the quality of the services and supports provided.

Those who complete the train-the-trainer model will have a higher level of knowledge and will have the tools and skills to train others concerning mental health aspects in persons with IDD. Those who complete a NADD competency-based certification program have demonstrated a high level of competency in their respective role. Programs that receive NADD accreditation have demonstrated that the treatments and supports they offer are of a high quality as measured by NADD standards. As a result of NADD trainings, certifications, and/or accreditation, it is expected that we will see improved outcomes for clients who use the services. Additionally, the anticipated outcome will include fewer hospitalizations; fewer emergency room visits and less needed for other crisis intervention services. This should significantly reduce costs.

Additional information is available on the NADD website, www.thenadd.org. Dr. Fletcher can be contacted by Email at rfletcher@thenadd.org or by phone at (845) 331-4336.

Homeless from page 32

FURTHER, I direct all local social service districts, police agencies including the New York State Police, and state agencies to take all necessary steps to identify individuals reasonably believed to be homeless and unwilling or unable to find the shelter necessary for safety and health in inclement winter weather, and move such individuals to the appropriate sheltered facilities;

FURTHER, I direct all local social service districts to take all necessary steps to extend shelter hours, to allow individuals who are homeless to remain indoors, to instruct homeless service outreach workers to work with other relevant personnel and to work with local police in relation to the involuntarily transport of at-risk individuals who refuse to go inside and who appear to be at-risk for cold related injuries to appropriate facilities for assessment consistent with the provisions of section 9.41 of the Mental Hygiene Law, and to work in coordination with the State Police and all police agencies to ensure that homeless individuals receive assistance as needed to protect the public health and safety and at all times consistent with the State's Constitution and existing statutes;

FURTHER, I direct all local social services districts to comply with their obligation to ensure that all facilities used for temporary housing assistance placements are safe, clean, well maintained and supervised and fully compliant with existing state and local laws, regulations, administrative directives, and guidelines; and

FURTHER, this order shall take effect on January 5, 2016 and supersede all local laws, as well as any local directives, guidance, or policies to the contrary.

GIVEN under my hand and the Privy Seal of the State in the City of Albany this third day of January in the year two thousand sixteen.

By The Governor

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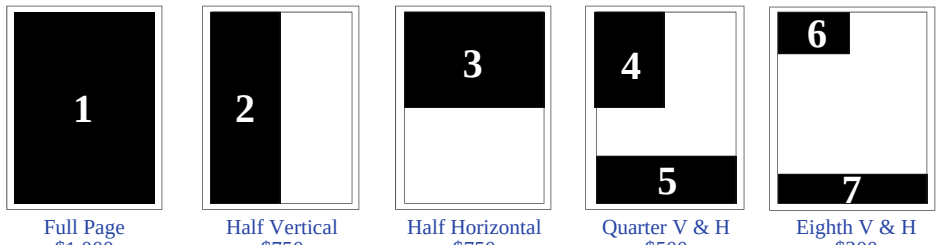

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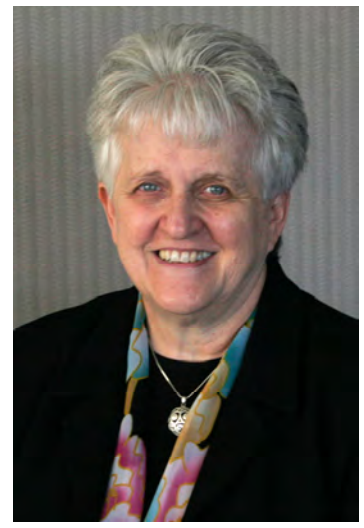

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Contact Ira Minot with any questions at: iraminot@mhnews.org or (570) 629-5960