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SPRING 2018 ON MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT AND SERVICES VOL. 5 NO. 4

Harm Reduction: Theory and Practice

By Lloyd I. Sederer, MD
Psychiatrist and Public Health Doctor
Written on Behalf of the New York State Psychiatric Association (NYSPA)

If we want to reduce the harm that derives from psychoactive substances we need to begin by ending two ineffective, enduring and hugely expensive policies and practices in this country. Then we can get to true harm reduction.

The first are strategies that seek to control access to and distribution of psychoactive substances. The most notorious example is Prohibition. Remember that? Didn't last long but did put organized crime on the map. More contemporary control strategies include border interdiction and crop destruction; 'buy and bust' (where undercover police or FBI agents purchase drugs then arrest the dealer, who is often a youth or person addicted and selling to support their habit); "build a wall" (when the deadliest drugs, like fentanyl, are coming in from China and Russia); and the latest, out of Attorney General Sessions' ideologically driven office, namely, arrest cannabis (non-violent) users by prosecuting federal laws in states where recreational pot is legal.

We all have seen the photo-ops of a card table laden with plastic bags full of drugs, piles of cash, and usually illegal weapons, which have become deadlier to defend against competitors and "the war on drugs." These various control strategies have resulted in the USA having the greatest number of incarcerated people in the world - disproportionately people of color and impoverished - costing vast sums of money yet with no increase in the safety of our neighborhoods. Control strategies are ignorant of reality, puritanical and punitive. Money that could be spent on prevention and treatment goes into the pockets of propriety prison and jail companies.

The second strategy continuing to cause harm is scare tactics. Ads or packaging that declare "this drug will kill you" or police in uniform going into school classrooms to "DARE" and scare students are examples that truly waste precious resources. These approaches also can paradoxically promote use because adolescents are neurologically drawn to risk.

What does work? What can reduce the harms of substance misuse? Prevention, diversion from correctional settings, early detection and comprehensive, continuous treatment. As I detail in The Addiction Solution: Treating Our Dependence on Opioids and Other Drugs (Sederer, 2018), the greatest 'problems' with psychoactive drugs are that they are powerfully and immediately effective (of course, that effect is eclipsed over time but that is usually when the disease of addiction has set in). People use substances to mitigate physical and psychic pain, to tolerate a hard life with few prospects, and to escape the grind and weariness of our everyday existence.

A first preventative step would focus on the flood of fatal overdoses now occurring. We can reduce deadly overdoses of

see Harm Reduction on page 20

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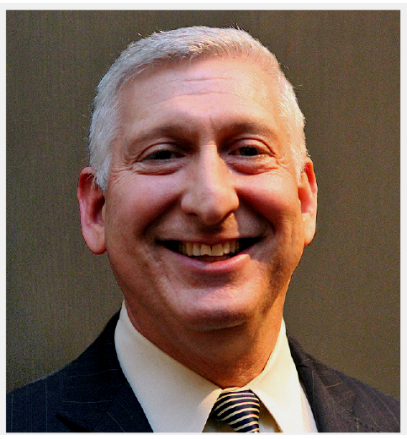

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Finding the Right Recovery Path: Welcoming Everyone into Treatment

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

This nation is in an epidemic. There are no two ways about it. By now you have undoubtedly heard that more people died of overdose in New York State in 2016 than died of motor vehicle accidents, homicide and suicide, combined. In responding to this crisis we do not have the luxury of closing our minds to any viable option.

Some people in recovery will tell you that they are alive because someone in their life insisted they "get sober," which is often a path taken reluctantly at first. They will tell you that without that someone, they may never have decided to abstain from substance use and may have never experienced the joys of recovery. Their decision to choose abstinence – saved their lives.

Others will tell you that they struggled in abstinence-based programs, were never able to achieve total abstinence, and frequently felt like they failed; a feeling that fueled the addiction. Some found a therapist or a program that took the time to understand their personal goals and helped them to achieve them. They will tell you that their lives, whether they ultimately abstained or not, were enriched by the experience and that they too have found joy in recovery of their own design.

Arlene González-Sánchez, MS, LMSW

There are very few terms that evoke more passionate responses than the term "harm reduction." I understand why. For some people, harm reduction is regarded as approval of destructive behavior. They believe the strategies taken to reduce harm of use allow the destructive behavior to continue, reduce the natural consequences of a person's choice to continue using, and may cause premature death. For others, harm reduction is a life-preserving strategy. They consider harm reduction strategies to be life affirming and support individuals who choose to continue using to do so with the least risk to themselves and others. They also believe harm reduction strategies may prevent premature death. It is the weight of this life and death debate that evokes such passion. In this article I would like to explore this issue from several different positions and move the conversation from a dichotomous one to looking at the options as more of a continuum.

In abstinence based programs a person generally stops using all substances, but relapses occur. Continued use can result in the patient being referred to a higher level of care. This practice is based on evidence that addiction impacts the brain in such a way as to interfere with cognition, judgment, goal setting and attainment. It is believed that the person must abstain to learn new skills and even to evaluate his or her own circumstance. There are many programs that work with the person to better adhere to an abstinence goal over longer periods of time.

Harm reduction can mean many things. A harm reduction approach encourages a person to set his or her own goals around substance use, and with information provided by a counselor, identify ways to reduce the negative impact of use. One example of a harm reduction approach is a syringe exchange program. The person chooses to continue using substances intravenously and also chooses to exchange used needles for new ones to reduce the risk of blood born illness. Another example might be abstaining from the substance that is causing the most harm to the person, but choosing not to abstain from another. In harm reduction, the person may or may not choose abstinence from substances as his or her ultimate goal.

There is some empirical evidence to consider. Several treatment approaches are considered effective based on the evidence. They include Twelve Step Facilitation (which promotes abstinence and attendance at self – help programs); Motivational Interviewing (emphasizes individual autonomy and choice); and Cognitive Behavioral Therapy (teaches skills to manage urges and prevent relapse). Each of these have been shown to be effective treatment approaches. Mindfulness, Dialectical and Behavioral Therapy, Seeking Safety and other approaches have also been shown to be effective.[1] Some approaches emphasize abstinence while others do not.

There is also evidence to consider from National Institute on Drug Abuse on brain changes due to substance use that indicates that higher cognitive functions are impaired through regular substance use while the reward system is enhanced – leading to increased drive toward using and decrease capacity to use reason and judgment to combat the drive.[2] And there is evidence to support the impact of poverty and social situation on use patterns with empirical support for remissions

see Welcoming Everyone on page 26

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NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

NYS OMH ACT Teams Utilize Harm Reduction Techniques

By Dr. Ann Sullivan
Commissioner
NYS Office of Mental Health

Harm Reduction can be a useful tool to help address potentially risky, dangerous, or self-destructive behaviors, including drug addiction, unsafe sexual activities, self-harm, and binge eating. The goal of harm reduction is to make dangerous behaviors safer, and to reduce the level of harmful consequences caused by the risky behavior. There is persuasive evidence that harm reduction approaches can reduce morbidity and mortality associated with these behaviors.

An important service supported by the NYS Office of Mental Health (OMH) which utilizes harm reduction techniques is our Assertive Community Treatment (ACT) program. ACT utilizes a broad array of services, including harm reduction, to help vulnerable individuals build the skills needed for integration into their communities. ACT teams deliver comprehensive and effective services to individuals who are diagnosed with severe mental illness and whose needs have not been well-met by more traditional service delivery approaches.

Typically, recipients served by ACT have a serious and persistent psychiatric disorder and a treatment history that has been characterized by alcohol/substance abuse, frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, and lack of engagement in traditional outpatient services. The population served by ACT comprises a small subset of persons with serious mental illness. Most people will not need the intense service an ACT program offers.

Dr. Ann Sullivan

The ACT team-based treatment model provides multidisciplinary, flexible treatment and support to people with mental illness 24 hours a day, 7 days a week. ACT is built around the idea that people receive better care when their mental health care providers work together. It supports recipient recovery through a highly-individualized approach that provides recipients with the tools needed to live independently. ACT team members help the person address every aspect of life, from managing symptoms, to getting a job, securing and keeping housing, reducing substance use, and maintaining relationships with family and friends. They can assist with the development of a wide range of skills including grocery shopping, cooking, cleaning, budgeting, banking and other everyday living skills.

ACT also integrates the principles of cultural competence, addressing the impact of discrimination/stigma, and inter-system collaboration into its service philosophy. ACT will provide services with consideration of linguistic preference. An essential aspect of ACT is recognizing the importance of family, community-based, and faith-based supports.

Persons are usually referred to ACT through a Single Point of Access (SPOA) process within a county, and are designated by that process as a high-priority candidate for an intensive level of service. These referrals could also include persons under a court order for Assisted Outpatient Treatment (AOT).

The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted over time. Treatment plans are established collaboratively by the ACT team and client, based on the individual's strengths, needs, desires, goals and culture. Treatment plans are modified, as needed, through ongoing assessment and goal setting. ACT teams meet daily to discuss each client's progress, allowing the team to plan or quickly adjust the services to meet clients' needs.

ACT teams utilize harm reduction techniques to assist clients with co-occurring issues. All ACT teams include a substance- use specialist, and providers collaborate and coordinate with NYS Office of Alcoholism and Substance Abuse Services (OASAS) licensed and/or designated programs to ensure warm hand offs. These programs include Chemical Dependence, Inpatient Rehabilitation, Medically Managed Detoxification, Chemical Dependence Medically Supervised Inpatient and Outpatient Withdrawal. ACT providers serve the Substance Use Disorder population and are expected to utilize resources available in the community to enhance their SUD treatment including Medication Assisted Treatment (MAT) training for prescribers and Harm Reduction.

Overall, studies show ACT improves health outcomes and reduces several aspects of harmful behavior. ACT recipients experience greater reductions in psychiatric hospitalization rates and emergency room visits and increased levels of housing stability after receiving ACT services. The multidisciplinary, flexible treatment approach is an important factor in ACT's success, and harm reduction is an important facet of the array of services provided by our ACT teams.

New York State Office of Mental Health's Assertive Community Treatment Program

NEW YORK STATE | Office of Mental Health

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OMH's Assertive Community Treatment (ACT) program provides coordinated **treatment, rehabilitation,** and **support** services in the community to people with severe mental illness whose needs aren't being met by traditional mental health services.

act

Coordinated services

Services are coordinated by a team of professionals from different mental health specialties — **psychiatrists; psychologists; nurses; peer specialists;** and **vocational, family, wellness,** or **substance abuse treatment specialists.**

Team members **collaborate** with the client to provide services that are based on the person's s**trengths, needs, and goals**:

- Educating and supporting families.
- Teaching self-management skills.
- Providing rehabilitation and support services.
- Finding employment or vocational training.
- Finding housing.
- Teaching everyday living skills.

The ratio of staff to clients is kept **small** – usually one clinician for every 10 clients. Services are available 24-hours a day, seven days a week, for **as long** as clients need them.

Follow-up studies have shown that people with very severe cases of mental illness have had **better outcomes** from ACT than from standard case management, such as **fewer** hospitalizations and **less** need for emergency housing and medical services.

For information, visit: http://bi.omh.ny.gov/act/index/

ACT Institute for Recovery-Based Practice

The ACT Institute, a program of the Center for Practice Innovations at Columbia Psychiatry - New York State Psychiatric Institute, provides training, support, and consultation to ACT providers across New York State.

Its training curriculum is based on national evidence-based practice consortium standards and modifications to these standards as developed by OMH. Training is delivered via in-person and distance-learning modalities. Trainers include both staff of the Center for Practice Innovations and other expert consultants.

For information, visit:
http://www.practiceinnovations.org/Initiatives/ACT-Institute

Why Not Harm Reduction for Problem Gambling?

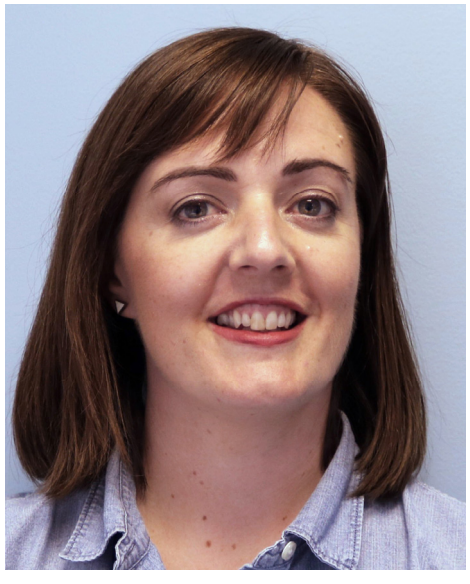
By Nada Touma, Director, Specialized Services, and Kelly Clarke, Director, NYC Well, MHA-NYC

Harmful gambling is a public health issue. As types of gambling products and accessibility to gambling have increased, so too have concerns as to the harm associated with this behavior. While there is evidence of the harm cause by some forms of land-based gambling such as electronic gambling machines (poker machines), much less is known about the impact of newer forms of gambling, such as online sports betting. With the development of a range of new gambling products, including the use of both traditional and social media platforms to promote and incentivize product use, children and adolescents are potentially exposed to gambling more than ever before (Pitt et.al., 2017).

In 2016, 5.45 million individuals in the US were diagnosed as having a gambling disorder, with an estimated 1.2% of New York adults (186,475) believed to manifest a gambling problem in New York. Overall the gambling industry's growth in 2016 exceeded the rate of inflation and established a new all-time high for consumer spending on gambling, at $154 billion (APGSA and Problem Gambling Solutions, Inc, 2016 Survey of Problem Gambling Service in the United States, 2016). In fact, in the

Nada Touma

United States, all states have some form of legalized gambling with the exception of Utah and Hawaii however, very little attention is given to problem gambling and its treatment. In the United States, treatment for problem gambling mostly focuses on the disease/abstinence model. While harm reduction approaches for drugs, alcohol and tobacco are gaining traction, the United States severely lags behind in harm reduction approaches for problem gambling compared to countries such as Canada and Europe (Blaszcynski, 2001).



Kelly Clarke

Gambling related harms can be view in the following areas (Langham et. al., 2016):

• Financial harm (to the person who gambles, the affected others, and/or the community)

• Relationship disruption conflict or breakdown (with friends, family and community)

• Emotional or psychological distress

• Detriments to health

• Cultural harm

• Reduced performance at work or study Criminal activity.

Co-occurrence with Mental Health and Substance Use Concerns

Gambling disorders have been shown to have high comorbidity with substance use and mental health issues. In a national study, almost three quarter of pathological gamblers had an alcohol use disorder, 38% had a drug use disorder, and 60% were nicotine dependent. In terms of mental health comorbidity, personality disorder (60%), mood disorder (49.6%) and anxiety disorder (41.3%) were most prevalent (Petry, Stinson, & Grant, 2005).

Similar to what is seen in the mental health and substance use fields, shame and stigma are barriers to individuals seeking assistance for gambling related issues. Indeed, despite negative consequences for gambling, only 10% of individuals experiencing problems ever seek treatment and even when the treatment is sought, the presenting concern is often not identified as problem-gambling (Tanner et. al., 2017).

Treatment and Interventions

Treatment for problem-gambling usually involves either an abstinence based model or a harm reduction approach with this latter being the least popular and

see Problem Gambling on page 28

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Consumer Perspectives

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Our Realizations and Truths About Harm Reduction

By Nelly, Ms. Arnell, Michael, Kareem, Blake, Marabelle, Simone, Douglas, and Ronald. S:US Consumers

Looking around the room in our focus group, we all realized two really interesting things about who we are and where we've been. Number one, that none of us were kids anymore, which is a nice way of saying that most of us already crossed the threshold of mid-life and were heading somewhere on the north side of 50 years old. And number two, that we all shared the experience of trying, sometimes for decades, to overcome our substance use challenges.

And, at the end of the day, our discussion revealed that harm reduction, and recovery in general, is an individual process that looks different for every one of us.

We started out with defining the word "harm," or at least trying to. Here are some of the things we came up with: Harm is putting bad things in your body, and it's especially scary now because drugs are not what they used to be and you don't know what's in things any more. Harm is going down the wrong path, over and over again. Harm is all about negative thinking, thinking about things that are very bad but that you know give you a high or a rush in your head. Harm is drinking, and what it does to you emotionally and physically. Even though all our definitions of harm came out of our personal pasts, we saw a lot of commonality when each person talked about what harm meant for them, and there were a lot of us nodding our heads in agreement even when the experience didn't exactly belong to us. With all these definitions put out there, we spent some time talking about what it has meant to get really serious about harm reduction.

All of us took different routes that got us into harm's way. For some, the drug of choice was crack cocaine, and that's what became the most comfortable thing in the world. It usually started early, and just ramped up over the years to the point where it was the main reason for living. Nothing else really mattered. For others, it was heroin, and for that fix there was nothing that couldn't be accomplished, even if it meant harming others. For others, harm's way was strewn with bottles. It didn't matter what flavor or what brand. It may have started as a cultural thing. In some of our families, little kids would be given a sip on holidays and over time that sip became a gulp, and then there was no turning back. Culture, many of us agreed, plays a big role in the habits we form, good ones and bad ones alike, and our perceptions of "normal" behavior. And let's not forget about opioids, which usually started out sanctioned by a well-meaning doctor with a heavy hand on the prescription pad.

For some of us, coming to terms with our use meant recognizing that we were accustomed to instant gratification, and that our paths to better health may require us to have to wait to enjoy the benefit of our efforts.

We've lost family members who just finally said "enough is enough." We've lost kids who just know they don't want to follow in our footsteps. We've lost friends who got taken advantage of one too many times. And we've lost ourselves, almost. Our struggles have made all of us dig deep and try to find our way out of the use and its negative impacts on our lives and the lives of others. We focused a lot of our meeting time talking about what some of these ways are, and the challenges they pose.

One of the hardest things in the world is to sit still. Mindfulness means being in the moment and not letting your mind be places you don't want it to be. Meditation can bring you to a really good place, but you have to work hard to keep your mind and your body still. Sometimes, you've got to face down your demons so you can get your heart and your head into a good space and in sync with each other. A few of us have adopted different ways of being more mindful such as, believe it or not, using adult coloring books.

see Realizations and Truths on page 28

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Enhance Harm Reduction Programs Through Health Care System Integration

By Lisa Strouss, PharmD, Director, Field Medical, and Jameelah Melton, MD, Associate Director, Medical Strategy ODH, Inc.

In many communities, harm reduction programs have helped prevent overdoses, lower HIV risk and hepatitis transmission and open the door to treatment for substance users. Originally started in the late 1980s, harm reduction approaches introduced syringe exchange initiatives with the goal of reducing the transmission of blood-borne infections.

Yet, treatment gaps resulting from uncoordinated care remain a serious challenge for many substance users. A simple example: an individual receives a prescription from provider X for suboxone to treat his opioid addiction disorder, while continuing to take the opioid prescribed by provider Y.

The problem of uncoordinated care, of course, is endemic across our health care system. Fragmented care leads to doctor shopping in some cases, medication non-adherence, poor outcomes and high costs for any given population, particularly among those with co-morbidities.

It is not uncommon for substance users to also suffer from other conditions such as HIV, Hepatitis C, and sexually transmitted infections. They may also have hypertension, asthma, diabetes, liver disease, and depression. For example, approximately 8 million U.S. adults have a co-occurring mental illness and substance use disorder. These conditions are often poorly understood by patients and inadequately managed by providers.

There are several reasons why these conditions are poorly managed. Much like the broader Medicaid population, substance users are typically under financial constraints, often with minimal or no health insurance coverage. Additionally, given the acute shortage of addiction specialists, primary care doctors with little training in identifying and diagnosing substance abuse find themselves on the front lines. The nationwide shortage of psychiatrists also exacerbates the problem. All this - while the nation's opioid crisis is at epidemic proportions - often leads these patients to seek crisis oriented, episodic, high cost care in emergency rooms.

The health care industry is increasingly recognizing that social determinants of health have a major impact on outcomes, particularly for vulnerable populations. According to research complied by the County Health Rankings, "40 percent of the variation in health status can be traced to social and economic factors – twice as much as can be attributed to clinical care".

The five percent of the population that accounts for roughly half of total health care spending are typically very sick, but just as important, they are often very hard to help due to poverty, mental illness, inability to travel and other factors. For many of these people, fulfilling basic needs such as food and housing is just as powerful as any medication to treat their condition.

Lisa Strouss, PharmD

Jameelah Melton, MD

Managing social determinants of health is fundamental to harm reduction. Many with substance abuse disorders suffer from inadequate housing, food insecurity, job instability, and lack of mobility, all of which adversely impact their health and ability to access care.

According to recent ODH research, however, the industry has a lot of catching up to do. Many health plans struggle to collect social determinants of health data and convert it to actionable insights. While nearly all payers say that integrating social determinant data is important to realizing better outcomes for their members, only six out of ten actually collect such data.

To some degree, harm reduction programs have evolved in recent years to become de facto community based care managers that address the physical, behavioral, and social care gaps of substance users – a highly chronic, disadvantaged and underserved population.

Harm reduction programs approach substance use addiction like any other chronic illness and manage it in a comprehensive, non-judgmental fashion. They typically provide referrals to primary and mental health care services and medication-assisted or other drug treatment services; support and education; case management and care coordination; Medicaid enrollment; food and nutrition services; and personal grooming services.

Harm reduction programs, in fact, could serve as a model for delivering value-based care to this population – and help contain costs - if they were more tightly integrated with other aspects of the health care ecosystem.

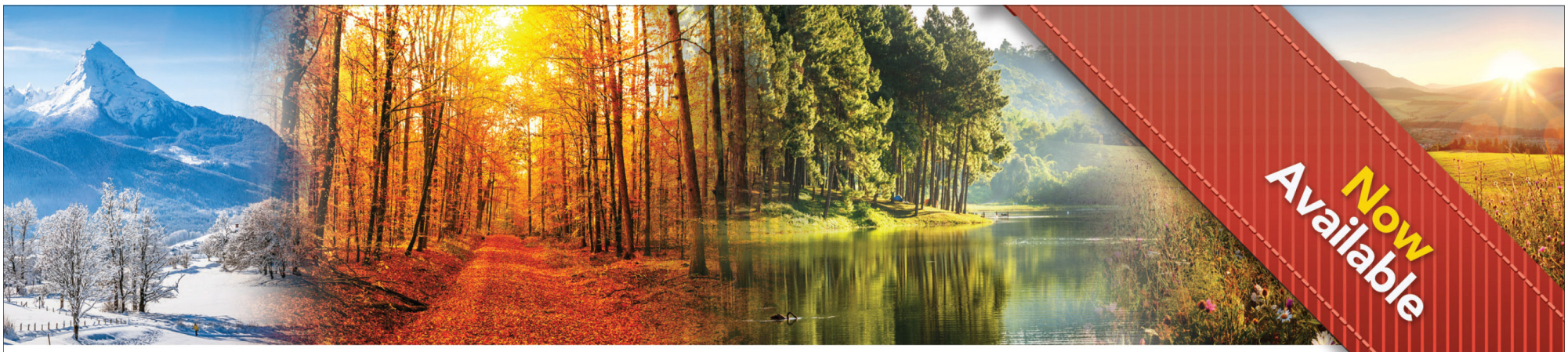
To make that a reality, however, requires four key steps:

1. Closely tie harm reduction services to primary and specialty care services. A study by the New York Academy of Medicine found that health care and harm reduction providers are forming partnerships to co-locate clinical and pharmacy services at a harm reduction center, and teaching hospitals are providing part-time clinic hours at nearby harm reduction centers. Harm reduction staff are often able to build trust and engage substance users in their care in a way that other healthcare providers cannot. When coupled with consistent primary, behavioral, and specialty care, harm reduction programs can provide holistic care that improves chronic health condition management.

2. Leverage technology to help assess and treat substance users, especially those with multiple co-morbid conditions and facing social barriers that impact their health. Solutions include: telehealth for prescribing and delivering information to substance users, particularly those in rural areas or with an inability to physically travel to a clinic or physician's office; shared information systems that facilitate coordination and communication across providers; sophisticated analytics, risk stratification and predictive modelling to identify patients most at risk; and integration of multiple patient data sets – including medical, behavioral, pharmacy and social determinants – onto a single platform to enable care managers to assess clinical complexity, identify care gaps and recommend appropriate treatment.

3. Improve access to primary care services. Substance users suffer the same shortage of primary care services as does the general Medicaid population. Further, very few primary care physicians are well versed in addiction and treatment options. Thus, more training about the signs, symptoms and treatment of addiction is needed, both in medical school and via continuing medical education.

4. Create payment delivery models that incentivize providers to cooperate with harm reduction programs. As the industry migrates to a value-based care environment, these programs can play a vital role in educating substance users about addiction, supporting recovery efforts and encouraging healthier behaviors and ultimately, helping to promote the "triple aim."



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Helping, Engaging, and Linking to Health Interventions (HEALTHi)

By Staff Writer
Behavioral Health News

The Staten Island Performing Provider System (SI PPS) is partnering with Coordinated Behavioral Care (CBC) on an exciting new project – HEALTHi (Helping, Engaging, and Linking to Health interventions). The program will focus on providing a safety net of resources to individuals with complex chronic conditions who are also affected by the social determinants of health.

"The SI PPS partners are passionate about serving our community members. This new vehicle, HEALTHi, will allow them to bring more resources to those with the most need - early intervention is key," said Dr. Joseph Conte, PPS Executive Director.

SI PPS has supported numerous innovative and successful projects such as the telemedicine program serving individuals with disabilities, 24/7 Resource and Recovery Center, ED Warm Handoff, HOPE Program, and training and deployment of peer recovery specialists. The HEALTHi project will align with the other initiatives funded by SI PPS under the Delivery System Reform Incentive Payment (DSRIP) Program, and overall goals of the Medicaid Redesign Project.

The HEALTHi project will locate and actively engage individuals who have serious behavioral and medical conditions and use wrap-around enhancement funds to address immediate, easily solved social needs, such as food and clothing, in order to secure trust and engagement in care. The HEALTHi interdisciplinary teams' outreach efforts will be in person at the individual's address, known hangouts, and through known social networks. If an individual is hospitalized at the time of referral, the HEALTHi team will engage with them, as well as the inpatient staff, at the hospital and take on an active role in the discharge and aftercare planning process as both their advocate and a community services expert.

The HEALTHi team will provide 24/7 on call coverage, ensuring support network have access to community services and care at all times. The team will utilize CBC's network of services to expedite access to crisis services such as respite beds and weekend clinic services.

Jorge R. Petit, MD

Dr. Sal Volpe, Chief Medical Officer at SI PPS added, "Our network has surpassed its goal of reducing preventable emergency room and hospital visits by 25 percent two years ahead of schedule and is nearing a 50 percent reduction in avoidable behavioral health-related ER visits. This means better, more integrated care before the onset of an acute phase which could require hospitalization.

"CBC is proud to be partnering with a strong community advocate like the Staten Island PPS," said Jorge R. Petit, MD, CBC's CEO. "Our working relationship with the PPS has been strong and deep in the Staten Island community. We are currently partners on a Health Home at Risk Project (SI CARES) and have found a willing, thoughtful and supportive partner to engage with us on these community-based care initiatives. Joseph Conte and his team are tremendous advocates for the needs of their community and are willing to think outside the box and work with the community-based provider community. I am very excited to get this project implemented and start to improve the lives of the individuals we will be working with." SI PPS has been referred to as the most successful PPS in New York State and CBC is proud to be their partner.

"We are very excited to collaborate with CBC on this new program. HEALTHi will be able to support a group of individuals who are high utilizers of ED, inpatient, and EMS services with complex chronic conditions who are affected by social determinants of health, such as housing instability, food insecurity, language and health literacy barriers, etc." said Victoria Njoku-Anokam, MPH, Director, Behavioral Health Initiatives at SI PPS

In an era of policy uncertainty, partnerships like this will continue to be the future of healthcare reform. By understanding communities, addressing gaps, and working together, SI PPS and CBC will continue to bend the healthcare cost curve and realize better population health outcomes for Staten Island.

About CBC

Coordinated Behavioral Care (CBC) was launched in 2011 by NYC not-for-profit behavioral health organizations in order to meaningfully participate in NYS's Medicaid redesign and Value Based Purchasing initiatives. CBC is dedicated to improving the quality of care for New Yorkers with serious mental illness, chronic health conditions and/or substance use disorders.

CBC operates two related service entities: A Health Home that provides care coordination services to tens of thousands of New Yorkers of all ages, with 50+ community-based care management agencies located in all five boroughs, and an Independent Practice Association (IPA) that includes a citywide network of primary care, mental health and substance use treatment services, thousands of units of supportive housing, recovery and support services, and assistance with concrete needs such as food, employment and housing.

As a recipient of a New York State Behavioral Health Value Based Payment Readiness Program (BHCC) award, CBC is poised to build the infrastructure that will enable the IPA to better understand, manage and predict the service patterns, utilization and costs of the individuals receiving care in our network agencies as well as ascertain and monitor quality and outcomes across the continuum.

About Staten Island PPS

Staten Island Performing Provider System (SI PPS) is an alliance of clinical and social service providers focused on improving the quality of care and overall health for Staten Island's Medicaid and uninsured populations, which include more than 180,000 Staten Island residents.

SI PPS is one of 25 groups across the state working on the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) program.

They are co-led by Staten Island University Hospital and Richmond University Medical Center. Their network of over 70 partners includes skilled nursing facilities, behavioral health providers, home health care agencies and a wide range of community-based clinical facilities, treatment centers, social service and community organizations, primary care physicians and medical practices across Staten Island.

Ongoing efforts of SI PPS impacts 4 out of 10 Staten Island residents by:

- Improving access to high quality, culturally sensitive care
- Improving population health and health literacy
- Reducing preventable hospital admissions and readmission

These goals are being reached through the implementation of 11 DSRIP Projects, identified by a Community Needs Assessment, and address primary care, mental health, substance abuse, chronic disease, long term care, social determinants of health, and population health.

SI PPS is constantly creating new programs to enhance care and expand services. Their provider relationships are being continually developed through the Population Health Improvement Program (PHIP). They continue to lead several state-wide initiatives on health information technology, workforce and health literacy.

For project related inquiries, contact Joseph Conte at Jconte@statenislandpps.org (917) 830-1141, or Victoria Njoku-Anokam at Vnjoku-anokam@statenislandpps.org, (917) 830-1153. For press related inquiries, contact Val Lajqi at Vlajqi@statenislandpps.org, (917) 830-1141.

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Supervised Injection Facilities: A Logical Progression in Harm Reduction or a Bridge Too Far?

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

The scourge of opiate abuse continues to rage unabated. It claimed 42,000 lives in 2016, more than in any previous year (U.S. Department of Health and Human Services, 2018). That's 115 human lives per day. Five of our brothers and sisters are lost each hour. One of our parents, spouses, sons or daughters passes every 12 minutes. An additional life will surely have vanished in the time it has taken me to compose this paragraph. This is universally recognized as the most pressing public health crisis of our time, and clarion calls for action emanate from the afflicted, the advocates and the corridors of power. Such seemingly concerted efforts have failed to staunch its progression, however. Centers for Disease Control and Prevention data reveal a 29% increase in drug-related deaths in New York State between 2015 and 2016, the largest annual increase in the 2010-2016 period (Rockefeller Institute of Government, 2018). Cities, states and municipalities struggle to contain this epidemic and the existential threat it poses, and some have turned to a potential solution that would be politically infeasible (if not altogether unthinkable) in the absence of such a crisis: Supervised Injection Facilities (SIFs).

SIFs, also known as Drug Consumption Rooms (DCRs) or Supervised Consumption Services (SCS), provide safe spaces where individuals may ingest illicit substances under the supervision of specially-trained personnel. These facilities emerged from a Harm Reduction paradigm that aims to mitigate risks associated with substance use among individuals who are not able or willing to abstain altogether. SIFs differ from other Harm Reduction approaches, however, inasmuch as they permit recipients to utilize illegally-procured substances on facility premises and under the direct supervision of their personnel. As such, they may easily run afoul of laws and regulations governing the possession and use of illicit substances. They also challenge prevailing philosophies on recovery and engender resistance from a variety of stakeholders. Some view supervised consumption as tantamount to sanctioned substance use and fear it will condone or encourage it. Others are wary of its potentially adverse impact on the communities in which they operate. We do not need to speculate, however, about the ramifications of SIFs for individuals and communities. A robust network of these facilities has been in operation throughout Europe, Canada and Australia since the late 1980s and we have a wealth of data from which to draw some informed conclusions.

Switzerland, Germany and The Netherlands have operated SIFs for the past 30 years. Canada and Australia established sites in the early 2000s and Spain, Luxembourg and Norway followed suit shortly thereafter (International Drug Policy Consortium, 2012). These facilities were established to serve a similar mission and purpose but they operate according to disparate guidelines, recipient eligibility criteria and legislative authorities. Moreover, public sentiment toward SIFs naturally varies in accordance with political, cultural and other contextual factors, so it is difficult to generalize research findings from each facility to the international network of which it is a part. Nevertheless, the findings have converged on certain conclusions that may be reasonably applied to most SIFs irrespective of differences in operational standards or the communities in which they are situated:

Ashley Brody, MPA, CPRP

• SIFs reduce drug overdoses and drug-related fatalities. An evaluation of a Vancouver-based facility revealed a 35% decrease in drug-related overdose deaths within the vicinity of this facility compared to a 9.3% citywide reduction (Otter, 2012). A SIF in Sydney, Australia had a similarly favorable impact on overdose deaths according to a comprehensive evaluation by KPMG. Between 2007 and 2010 this facility managed (i.e., supervised) 3,426 overdose events and successfully intervened to avert fatalities in each of them (KPMG, 2011). The study authors reasonably concluded at least some of these events would have resulted in death had they occurred in other public or private spaces or in the absence of supervision by specially-trained personnel. They also found a marked decrease in the incidence of drug overdoses in proximity to the facility (KPMG, 2011). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reached similar conclusions in its analysis of several European facilities (EMCDDA, 2018.) Most astonishingly, the research literature reports only one drug-related fatality on the premises of a SIF since their inception 30 years ago, and this was attributed to anaphylactic shock (Otter, 2012).

• SIFs reduce blood borne disease transmission rates. Intravenous drug users (IDUs) frequently experience significant life challenges (e.g., poverty, poor physical and mental health, etc.) and are at elevated risk of other hazardous behaviors including the sharing of used syringes with fellow IDUs. Consequently, rates of Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV) infection are disproportionately high among this population. Needle exchange programs pioneered in the U.S. in the late 1980s and early 1990s have been proven to reduce the transmission of blood borne pathogens among IDUs (Government Accountability Office, 1993), so it is not surprising that SIFs have had a similarly beneficial impact inasmuch as they customarily furnish clean needles to their recipients. Analyses of SIFs in Australia, Canada, The Netherlands, Spain and Switzerland found reductions in the rates of blood borne disease transmission among their users (Otter, 2012). Another study confirmed these findings and also revealed an increase in condom use among SIF users (Milloy & Wood, 2009). The authors of this study concluded SIFs may play a more comprehensive role in preventing disease transmission through a variety of preventive, educational and ancillary support services.

• SIFs do not produce an increase in crime or other deleterious effects in the communities in which they operate. Public sentiment toward the siting and operation of SIFs is naturally mixed, and many stakeholders have expressed concern such facilities would encourage drug-related crime and other undesirable activities in their communities. Research findings do not validate such concerns. Examinations of the Canadian and Australian facilities revealed no increase in drug trafficking, violence or other crimes in their vicinities following their establishment (Otter, 2012). Other studies also described a marked decrease in publicly observable indicators of drug consumption in proximity to SIFs. A study of an Australian facility reported a consistent decline in both public drug use and the improper disposal of drug paraphernalia (i.e., used syringes) within its vicinity during the survey period (KPMG, 2011). An analysis of a Spanish SIF yielded a similar conclusion. It revealed a fourfold decrease in the volume of disposed syringes in proximity to the facility during an eight-year survey period (Vecino et al., 2013).

• SIFs promote recipients' engagement in drug treatment and other health and social services. Examinations of SIFs confirm they generally adhere to a Harm Reduction model of intervention that aims to

see Injection Facilities on page 29

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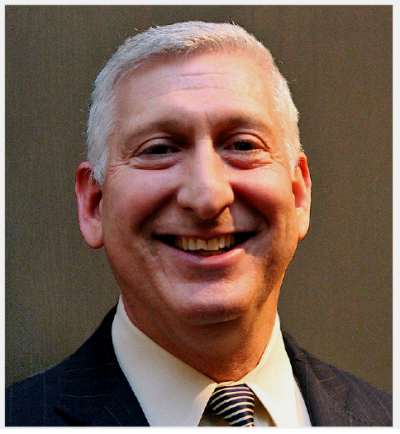

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The Culturally and Racially Safe Practice

By Mary Pender Greene, LCSW-R, CGP
President and CEO
MPG Consulting

Delivering mental health services is first and foremost about people – those of all races, cultures, and socioeconomic statuses. To provide high quality culturally and racially safe, affective services means being attuned to three key areas: 1) being knowledgeable of the clients' lived experience; 2) having a diverse, well-trained and supervised staff, and 3) having collaborative teams that bring their best selves to the work and display emotional intelligence.

As mental health leaders, we must acknowledge and understand the lived experience of clients and how these experiences shape beliefs and attitudes toward treatment. We also must acknowledge and understand cultural and racial differences. According to Speight et al (1991), "a system that does not consider race, culture, gender or social values does not adequately serve the people it purports to." This means having the ability to work with everyone and making services that are accessible to all. This entails developing practical ways of supporting those whose cultures and beliefs differ from ours, and most importantly, avoiding projecting our own cultural expectations of what is therapeutic onto clients (Elder, Evans & Nizette, 2009).

In Retooling Mental Health Models for Racial Relevance (2005), Gail K. Golden, MSW, EdD notes that "people are dehumanized when we fail to develop asset-based models which incorporate curiosity and respect about the survival skills which whole communities have had to mobilize to confront genocidal affronts to their being." She notes that credentialing, for instance – though valuable in many ways – does harm in others. Noting that it is a "gate keeping" device which can exclude people with important cultural expertise from career advancement, leadership roles as well as from participating in program and policy decisions, which can result in "impoverished and ignorant forms of treatment." In other words, in most organizations, gatekeepers without a racial/cultural lens can blindly control access to resources and opportunities which ultimately leads to services that do not adequately meet the needs of our clients.

Dr. Golden implores us to examine our thinking. Are we able to identify the resilience and assets of clients? Do we frequently examine our rules and procedures for their impact on the population that we actually serve? Do we involve or even consider our clients when developing or altering our services? How do we value and reward cultural expertise and lived experience within our staff? Does our profession's commitment to credentials hurt our ability to expand our range of services? She also notes that graduate schools in the helping professions are not graduating enough mental health professionals from diverse communities to mirror our changing demographics. The result is that many agencies serving populations of color often have staff that are predominantly white, especially in leadership roles.

Mary Pender Greene, LCSW-R

Strategies for Providing Safe Racially and Culturally Informed Care

• Recognizing that it is counterproductive to treat all people alike. There are characteristics that all people share, ones that some people share, and some that are unique to a group. This includes racial or ethnic historical conditions, such as slavery (Henderson & Primeaux, 1981).

• Allowing clients to define themselves rather than attempting to erase the clients' lived experiences with categories, notions of dysfunction, or simplistic theories (MacKinnon, 1993).

• Avoiding all stereotypes and generalizations.

• Becoming knowledgeable, sensitive and aware of clients in their cultural setting (Wright, 1991).

• Recognizing that there is diversity within groups as well as between groups (Charonko, 1992).

• Becoming aware of your own ethnocentrism, which is the belief that your own group is superior to others (Henderson & Primeaux, 1981).

• Developing policies and practices that acknowledge and reward cultural expertise and lived experience

• Recruiting, developing and retaining multi-racial/multi-cultural staff and teams.

• Being mindful that most of us have not been trained to talk about racism across racial/cultural lines and are fearful, and thus often silent about these issues.

• Being aware that privilege is invisible to people who have it and painfully obvious to those who don't.

• Being clear that many agencies unconsciously use white organizational characteristics as their norms and standards which make it very difficult to open the door to other cultural norms and standards.

• Being able to identify and name the cultural norms and standards you want is a first step to making room for a truly multicultural/antiracist organization.

• Understanding the constructs and intersections of racism, hetero-normativity, sexism, homophobia, transphobia and other systemic forms of oppression based on social identity.

• Understand that the constructs of power, privilege, hierarchical rank and culture are always fundamentally a part of the individual and institutional context.

• Learn to recognize the intersections of race and racism with gender bias, LGBTQIA+ bias, non-binary bias, class bias and religious bias (including anti-Semitism and Islamophobia) and how they impact the work environment and service delivery.

Clinical Supervision and Support

To ensure high-quality safe care, staff must be properly trained to do the work. This means having the appropriate experience, training and clinical supervision.

The most helpful trainings are those that combine didactic and experiential methods to focus on the meaning of cultural and racial identification for the clinicians and client; the experience of clinicians and clients with social service institutions related to their cultural, racial, gender identity, their sexual orientation, and immigrant status; and provide guidelines and support for addressing these issues in the workplace.

Anti-Racist/Oppressive Supervision

Bernard and Goodyear (1998) defined supervision as an evaluative relationship between a senior and junior member of the mental health profession whose purpose is to "enhance the professional functioning" of the supervisee. Their definition defines the supervisor as directing and nurturing the development of the supervisee's skills and professional identity. Therefore, an essential feature of supervision would include the supervisor's ability to raise and guide analyses of Race, Culture, Rank and Privilege with the supervisee as part of the process of honing the supervisee's ability to address these issues in treatment and with colleagues. This includes any issues, or even perceived issues, involving race and racism in the treatment or regarding the supervisee.

It enables supervisees to review and debrief approaches to practice, ensuring that service delivery is safe for clients and following anti-oppressive best practice standards.

Cross-Racial/Cultural Teams

Research indicates that staff working together in cross-racial teams help to overcome racial and cultural bias; diversifying alone is not sufficient.

At Stanford University, psychology professor Claude Steele has studied how stereotypes shape intellectual identity and performance. Since, research indicates that race indeed does matter, it is our work to prevent bias from damaging career opportunities for People of Color in the workplace and ultimately racially/culturally safe services to clients. Decades of research has shown that cross-racial teams can increase acceptance among people of different racial and cultural groups.

According to Dr. Ann W. Battencourt, of the University of Missouri, research shows that people generally experience positive feelings toward each other when working cooperatively toward a shared goal; as people work cooperatively, they can come to value their different perspectives. In other words, working intimately across racial lines can greatly reduce stereotyping, which is the root cause of implicit bias.

Cross racial/cultural teamwork can also: enhance the quality of service; increase productivity; enhance staff satisfaction; improve retention; and improve organizational accountability.

"Emotionally Savvy" Teams

More work is being done in teams. According to Cross, Rebele and Grant (2016) teamwork has increased by 50% or more over the past 20 years. The most successful teams are diverse and collaborative, with a heightened sense of awareness of the other members. Research by Druskat and Wolff (2001) indicates that teams are more creative and productive when they can achieve high levels of participation, cooperation, and collaboration among members.

They also noted that the success of a team is more likely when members engage wholeheartedly, with three essential conditions: trust among members; a sense of group identity and pride in the group; and a sense of group efficacy – the belief that they are more effective working together than apart.

They concluded that "group emotional intelligence is about small acts that make a big difference. It is not about in-depth authentic discussion of ideas; it is about asking a quiet member for his thoughts. It is not about harmony, lack of tension, and all members liking each other; it is about acknowledging when harmony is false, tension is unexpressed, and treating others with respect."

According to Relly Nadler Psy.D., M.C.C. (Leading with Emotional Intelligence, 2017), "teamwork is a necessity in organizations, but it is an unnatural act that takes a strategy, discipline and practice." Emotional Intelligence is the ability to understand and manage yourself and understanding and managing others. Nadler offered the following insights:

• Motivating average performers to be great contributors takes knowing their strength, weaknesses, and motivations.

• Emotions are stirred up in social interactions. Anger, frustration, impatience, disappointment, rejection, betrayal, injustice and isolation all happen in groups. How they are experienced and regulated are critical for top performance.

see Safe Practice on page 28

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Legalization of Drugs: The Ultimate Harm Reduction Measure

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

Illegal drugs are dangerous, but many of their dangers are caused by their illegality rather than the drugs themselves. Yes, the use of illegal (and some legal) drugs results in addiction. But if we really want to reduce the dangers of drug abuse, we must address its illegality as well as the problem of addiction.

What are the dangers due to the illegality of some drugs?

• Overdose deaths are largely caused by using substances that are contaminated or unexpectedly pure.

• Getting illegal drugs often exposes users to the dangers of doing business with criminals.

• The illegal drug business involves high levels of violence, including homicide.

• Using illegal drugs in secret can lead to hanging out in very dangerous places

• Sharing needles exposes users to the contagion of HIV, hepatitis, etc.

• Some users commit crimes to get the money to purchase drugs illegally.

• Users of illegal substances risk arrest and incarceration in jail and/or prison.

• The very large prison population in the United States reflects inordinate incarceration for use of illegal substances.

Michael B. Friedman, LMSW

• Largely unsuccessful drug enforcement activities and imprisonment result in high and unnecessary spending that could be better used for prevention and treatment of addiction.

• Long prison sentences result in wasting lives of considerable potential.

• The disproportionate impact of criminal penalties on minority populations adds to the shameful racial divide in America.

• The amount of money involved in the illegal drug business results in the corruption of some American businesses, such as banks that participate in money laundering. It also results in the corruption of some law enforcement officials.

The solution is self-evident. End the policy of treating the import, manufacture, distribution, and use of currently illegal drugs as crimes. Treat these drugs like alcohol—a drug that also risks addiction—with regulated and controlled import, manufacture, distribution, and use. **In other words, legalize these drugs.**

Among those of us who believe that America's policy of criminalizing certain drugs should be ended, there is some dispute whether to "legalize" or "decriminalize." The debate unfortunately is subject to considerable confusion because of the language used.

"Decriminalize" does not actually mean ending the policy of criminalization. It means eliminating punishment for use combined with preventive interventions, a variety of "harm reduction" measures, and increased access to treatment. But it does not mean eliminating import, manufacture, distribution, or use as crimes.

"Legalization" does mean ending the policy of criminalization but with regulated systems of import, manufacture and distribution. Use would not be a crime; but import, manufacture, and distribution outside the regulated system would be.

Decriminalize or legalize? For marijuana—a relatively non-dangerous substance that has significant medical benefits—the shift to legalization is underway. For cocaine, heroin, methamphetamine, etc. legalization appears to be completely unrealistic. Decriminalization appears to be a necessary first step.

This would have certain important benefits such as eliminating unnecessary incarceration and its consequences. If it is all that we can achieve, it's a real shame. What is called "decriminalization" does not end the criminalization of illegal substances. As a result, it does not eliminate several of the most significant dangers of illegality. Without regulation of import, production, and distribution, substances can be dangerously contaminated or unexpectedly pure. Continued criminalization of distribution will leave the dangers of violence and homicide unaddressed. And continued criminalization will support continued corruption of some American businesses and law enforcement officials.

Sad consequences for a nation that prides itself on being the "land of the free."

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The opinions expressed in this essay are his own and not necessarily shared by the organizations with which he works.

Harm Reduction from page 1

opioids by scaling up the provision of naloxone. It needs to be ubiquitous. We have learned, as well, that higher doses of naloxone are needed for longer periods of time when opioids laced with fentanyl and carfentanil are taken, often inadvertently. Some cities are piloting safe injection sites. We can also reduce many downstream consequences of IV drug use, such as Hep C and HIV/AIDS, through needle exchange programs.

As Maya Angelou remarked, "…let us try to offer help before we have to offer therapy. That is to say, let's see if we can't prevent being ill by trying to offer a love of prevention before illness."

With prevention, the earlier the better. When provided to youth, as early as in elementary school. And to their families. Skill building is at the core of some of the most successful prevention programs. Youth can learn decision-making, how to better manage feelings and impulses, and ways to improve their self-regard (e.g., Life Skills Training (http://lifeskillstraining.com/). These are skills proven to prevent use and abuse of substances. Another effective approach is Big Brothers/Big Sisters, which demonstrates the protective power of a caring adult (http://www.bbbs.org/).

Whenever possible, families too can learn the skills that make for better parenting and home life. The Strengthening Parents Program is a good example. Positive and supportive communications, time spent together (like at dinner with no TV or texting), and how to help youth engage in activities and after-school programs are important parts of their curriculum (http://www.strengtheningfamiliesprogram.org/).

Lloyd I. Sederer, MD

SBIRT (Screening, brief intervention and referral for treatment) for youth (http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf) and adults illustrates the principle of early detection and intervention.

SBIRT needs to be introduced in all pediatric and primary care practices, schools and selected community programs, and in emergency rooms. SBIRT with teenagers can focus on those youth showing evidence of problem alcohol and drug use (e.g., accidents, missing school or failing in class, risky behaviors, trouble with the law, and medical problems without a clear physical condition). The youth is asked as few as 2 questions: The first asks about friends' drinking, an early warning sign highly associated with current or future substance use, and often easier to ask. The second question is about the youth him or herself, and asks about frequency of substance youth. With older youth, the questions are reversed. The American Academy of Pediatrics, in 2011, recommended substance screening as a "routine" part of adolescent health care (https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Recommends-Substance-Abuse-Screening-as-Part-of-Routine-Adolescent-Care.aspx). SBIRT for adults follows a similar and feasible game plan (https://www.samhsa.gov/sbirt).

Treatment begins with assessing for a co-occurring mental or physical disorder and delivering simultaneous treatment. The odds of recovery are not good if a person has an active, additional condition that impairs their ability to effectively engage in and sustain substance disorder treatment.

Consumers and families should ask if a program they are considering provides comprehensive treatment. A good treatment plan would offer 12-Step Recovery but ensure that it is complemented by evidence-based practices for SUD. These include: 1) CBT (Cognitive Behavioral Therapy) focused especially on techniques to control responding to triggers. Remember that addiction is in part driven by conditioned responses, as illustrated by Pavlov's dogs who salivated to the bell, not just the food; so it is, as well, when people with substance problems pass a bar, see a needle, watch a program or listen to music infused with substance triggers. 2) Family education and support. Families represent an early warning system for recognizing problems and when relapse is imminent. They are usually the most important and enduring sources of support for a person in recovery. 3) Relapse Prevention Groups can teach about triggers, soften the shame of falling off the wagon, and provide critical peer support.

A highly effective treatment strategy is medication assisted treatment (MAT). We have abundant evidence that MAT works for opioid and alcohol use disorders. Methadone has been a MAT for opioid dependence for decades, but its demands of attending a program and directly observed medication administration deter many from using it. Since 2002, we have had buprenorphine (e.g., Suboxone and others) to reduce relapse for people dependent on opioids. Far too few doctors and nurse prescribers take the training necessary, and among those many do not prescribe or carry very small caseloads. Patient and family demand is needed to improve access to buprenorphine. Another MAT is naltrexone, especially the monthly injectable form called Vivitrol. This medication has a strong evidence base with alcohol dependence, and some promising studies on its use with opioid dependence. Dated prejudices such as "treating an addiction with an addicting drug" further impede the use of these agents.

Of course, we need alternatives to opioids for pain, with their dependency risks. Non-opioid, non-addicting

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Compassionate Care for Substance Users in Traditional Settings

By Joe Ruggiero, PhD
Assistant Clinical Director and
Director, Crystal Clear Project
Addiction Institute at Mount Sinai

Like many other mental health treatments, substance use treatment has struggled with high dropout rates and problems with engaging clients. Only 0.9 percent of people who have some substance use issues engage in treatment. While some of this may be the client's internal reluctance to get care, this may be systemic due to the lack of treatment options available.

Most treatment programs require the goal of complete abstinence from all substances. Some will not accept clients who are not committed to this goal. While this may seem routine, no other mental health field demands one specific goal defined by the agency as well as a front end commitment to one goal. For example, people who are depressed do not meet intake clinicians who insist the person be committed to not being depressed ever again.

By a clinic setting the goal of abstinence, we may lose many people to ongoing drug and alcohol use. The message that people may hear is that I should not enter treatment until I am completely convinced that I should be abstinent from all substances. A common statement in substance use treatment is that a person "is not ready" when the question should be" what are they ready for?" The stages of change model has been helpful in looking at where people might be in terms of behavioral change. Our traditional treatment model insists that people be ready for action and does not leave room for people who are contemplating change. Programs might be able to help people in a preventive way by engaging people who are contemplating making a change but not ready for action with regard to their use.

The traditional treatment model also assumes the belief that people's motivation for abstinence does not waiver and if it does, there is a problem. The theory is that once you are ready to commit to a goal you will always have that same commitment. As a director of a clinic, we have gotten referrals from programs where a client was just expressing ambivalence about their abstinence goal. For example, one referral was for a client who had been sober for 6 months from methamphetamine, their drug of choice, but was considering the option of drinking. This case seems like a success with the person building sober time but the fact that the person was thinking about drinking triggered a referral out.

When we create this context for treatment, we may be reinforcing the idea that motivation should never waiver. Clients may feel that they should not voice their ambivalence or they will be rejected. All therapists love to work with a very engaged, motivated client but part of the work is also helping these same clients build skills when they feel less motivated. Normalizing this experience may prepare people in the future. Motivation is a fluid process in our lives. If a person feels less motivated to maintain their goal of abstinence, they may judge these feelings as opposed to being prepared and having skills to deal with them.

When I first entered the field, programs often terminated clients if they relapsed a certain amount of times. Again this message seems harmful in that we are dismissing people who are exhibiting the presenting problem. While people may need higher levels of care such as inpatient, there are often ways that people are making improvements in their lives which may not be reflected in their use. Some people are reducing their drug use or not using their drug of choice. Some are making behavioral changes that will lead to healthier lives. In addition there are many clients who struggle to accept that they need more services such as medication management or inpatient and need time. There is an assumption that by dismissing

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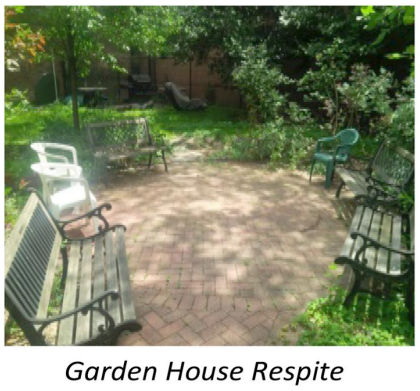

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Impulsivity as a Predictor of Suicidality

By Pablo Idez, LCSW, CMC
President, Long Island Psychotherapy and Counseling

Pablo Idez, LCSW, CMC

Few topics trigger more dread to the human experience than death. Discussing death brings up fears of the unknown and loss of personal control- two of the primary components of anxiety. We know that when anxiety arises, avoidance is one of the more predictable coping mechanisms and as such, death as a human condition is largely dealt with by simply avoiding talking about it. In working with patients that are having suicidal ideation, the therapist is best advised to understand that despite a patient's best judgement to explore their feelings, doing so can trigger debilitating anxiety which challenges the process. Further, frequently discussing suicide without progress in the treatment can begin to cause numbing around the topic, which will be discussed later as a potentiator for transitioning from suicidal ideation to actual attempt. We know that humans attempt to understand concepts through personal experience (Experiential Learning, J. Piaget) however; death is not an experience that anyone living knows very much about. Having established the physical and psychological response that death brings up in humans, we can begin to appreciate the confusion, helplessness, and, avoidance that is brought about with suicide for clients and families alike. Patients self-managing suicidal ideation without formal treatment can begin to act impulsively (cutting, risk-taking, drug abuse) and desensitize to pain, leading to greater risk of completed suicide. Therapists, friends and family members are well advised to expect resistance and be ready to confront it by linking clients with appropriate services at the first sign to begin harm-reduction efforts.

The will to live or, self-preservation is innate in all humans. Many physiological processes including the release of adrenaline (to facilitate faster response to a threat) or dopamine (to reward pleasurable and health-promoting behavior) are directly linked to our survival as a species. We may not all be keenly aware of the physiology that supports survival but we are certainly aware of the feelings that drive it. Despite these powerful forces at play, suicide remains a health epidemic considered by the World Health Organization (WHO) as the "second leading cause of death among 15–29-year-olds".

Suicide as a concept is universally recognized, in fact, 45 million Americans die by suicide each year, and for every 1 suicide, 25 others have attempted (Centers for Disease Control and Prevention (CDC) Data & Statistics Fatal Injury Report for 2016). This brings the total of first-hand experiences to over one billion per year not accounting for the friends and family members affected. The numbers are staggering and despite the large scale of impact, avoidance of the topic continues. This is true for those experiencing the impulses to end their lives and those coping with a friend or family member who succumbed to their plans or continues to struggle with them.

A suicide plan, age, gender and access to weapons have long been considered high risk factors. Impulsivity needs to be considered just as fundamentally a predictor of suicidal behavior but not necessarily for the direct impact of impulsivity itself. Impulsivity has been studied and in fact "may actually be a more significant indicator of suicide attempt than the presence of a specific suicide plan" (Bryan CJ, Rudd MD. Advances in the assessment of suicide risk). While anecdotal experience might lead us to believe that impulsive personality traits are generally strong predictors for suicide attempt, the literature indicates an interesting rationale that is less obvious. To understand the role of impulsivity in suicide, we must take into account the process of transition from suicidal thoughts to suicide attempt. Two predominant barriers to suicide attempt are its inherent provocative nature and fear of pain. In other words, a person forming a suicide plan assumes that they will have to endure some level of pain, which prevents the transition from plan to attempt.

Humans have strong reactions to learning of a loved one's suicide attempt that range from anger to alienation. The person transitioning from planning to attempting suicide is oftentimes feeling isolated and may fear that a failed attempt would bring about further isolation. In my work as a psychotherapist, fear of abandonment and being deemed as a misfit in society are oftentimes the rationale provided for not attempting. The transition from planning to attempting is more likely

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Boulevard Outpatient Stabilization Program

By Elliot Zimpfer, LMHC, CASAC
Program Director
Horizon Health Services

According to the National Survey of Substance Abuse Treatment Services (2016), facilities were asked how many patients in treatment on 03/21/16 received MAT for detoxification and maintenance purposes. Within this survey, MAT includes the use of methadone and buprenorphine for the treatment of opioid addiction or dependence, and the use of extended-release injectable naltrexone (Vivitrol) for relapse prevention in opioid addiction. Of the total 1,150,423 patients in treatment, 365,064 (32 percent) received MAT in OTP facilities.

The goal of using medications as part of comprehensive treatment plan is to assist an individual with leading a healthy, productive life in recovery. In recognizing the integral role that medication plays within the recovery process along with the connection between rapid linkage and engagement; Horizon Health Services initiated the Boulevard Outpatient Stabilization program where patients seeking treatment are triaged and given either same day or next day admission appointment to the Boulevard Outpatient Stabilization program, which consists of an abbreviated assessment process with the intention of rapid admission and linkage to a medication consult and treatment services. Within this

Elliot Zimpfer, LMHC, CASAC

assessment, core areas of lethality, substance use, and medical concerns are explored. This ensures understanding of risk management and appropriate triaging to trained high risk clinicians with various sub-specialties. These subspecialties include strong understanding of treatment modalities to assist clients with complex histories, strong understanding of family interventions, and strong understanding of MAT. The goals of this program are to assist patients with stabilization of current substance use symptoms, address foundational skill work to decrease cravings (monitored through weekly Urges and Cravings Measurement, Figure 1), and provide continued medication.

The goals of stabilizing current symptoms and exploring foundational skill work have been implemented via group and individual sessions. Within the Stabilization program, patients are recommended to engage in family group and "Mindful Recovery" group. Through DBT and relapse prevention modalities; "Mindful Recovery" has an overarching goal of decreasing high risk substance use. This is accomplished by means of working to increase mindfulness skills to directly manage cravings. While also providing information on and challenging application of wise mind/value based decisions. With the understanding that substance use in a family dictates social adaptation that impairs the system's thinking, feeling, and behavior; recovery is enhanced when therapy occurs in a family group setting. Within this systems theory, the goal of family group is to provide education and support to family members. Family members engaged in this group have reported a greater understanding of methods to support their loved ones within the recovery process and healthy management of relapse.

The role of the stabilization team, through the lens of individual sessions, is to reinforce foundational skill work to allow patients to better participate in rehabilitative therapies. Foundational skill work includes the evidenced based practices of DBT, CBT, and Motivational Interviewing. In conjunction with Family Group, high risk clinicians further encourage collateral involvement during individual sessions. Within this framework, expectations for treatment are established along with more person centered family interventions. These interventions can include: substance use education, healthy communication skills, appropriate boundary setting, increasing awareness of signs/symptoms of relapse, and healthy management of family conflict. At times, the severity of family dynamics warrant referrals to codependency counseling with our family support specialist. The high risk clinicians are further expected to monitor medication adherence, which is accomplished via patient self-report, toxicology reports, film/pill counts, and the Urges and Cravings Measurement Survey.

Upon initial admission into the stabilization program, patients meet with providers on a weekly basis. Routine coordination occurs between high risk clinician and provider to ensure medication effectiveness and adherence. As patients indicate reduction in cravings and appropriate implementation of behavioral skills,

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Self-Reflections on Self-Determination in Harm Reduction

By Eugene Aronowitz, PhD, LMSW
Management Consultant

When I was a social work student in the early 1960s, I assumed that it was imperative, even obligatory, that I respect the right of client self-determination but I certainly didn't know how to put self-determination into practice. I was placed at Henry Street Settlement and worked with two groups of unruly children who had been referred to the agency by a school in the neighborhood almost as a condition of continued enrollment. Their behavior in school and in the community was unacceptable to everyone but themselves.

My second year placement and my first job were at Jewish community centers where I continued to work with children. The only aspect of self-determination I encountered in those agencies was the ability of the children (or their parents, presumably in their behalf) to choose whether or not to participate in the programs that were offered.

My next job was as a social worker and, subsequently, as Director of Social Work at Hull House Association in Chicago. There, I worked with several treatment groups for children. My clients were like those at Henry Street Settlement, pressured to engage in treatment by their parents and teachers. However, by then, I

Eugene Aronowitz, PhD, LMSW

knew I would get nowhere with them under such circumstances. Consequently, I developed six session preparatory groups that had three goals: help the clients (1) develop sufficient self-observation capacity to be able to look at themselves somewhat objectively; (2) identify and conceptualize an aspect of their behavior that they viewed as undesirable; and (3) develop motivation to deal with that problem. To accomplish this, we assigned social work students - one student for each child – to watch their assigned child during my group sessions from behind a one way mirror. After each session, the students met individually with their child and verbally compared what they saw with the self-observations of the children. Through these interviews, the children were helped to identify problematic interactions during the sessions, generalize those behaviors to similar actions at home and school, and determine whether or not they wished to change. By the end of six weeks, most of the children were able to articulate problems they said they would be willing to deal with in the next phase of treatment. This clinical approach was strictly utilitarian. I knew that the kids would get nowhere in treatment unless they wanted to be in treatment. This had nothing to do with self-determination – at least not in my mind. But utilitarian or not, that experience was the closest I ever came to supporting client self-determination until 48 years later.

In the intervening years, I was a manager, a public official, and a management consultant. As part of my consulting practice, I had 7 interim management positions, the last of which, in 2015, was Interim Executive Director at the Lower Eastside Harm Reduction Center in Manhattan. For the first and only time in my career, I saw the ethical principle of self-determination put into practice.

At first, I was dismayed but subsequently enthralled by the live-and-let-live philosophy that is at the core of the provision of harm reduction services. Substance users who wanted to continue taking drugs were helped to do so safely by our offering sterile needles, a safe place to come down if they were too high, and access to and training to use an antidote in the event of an overdose. The choices of participants were respected although practitioners did not ignore or minimize the possible consequences of their lifestyles and certainly didn't encourage drug use. If participants wanted to engage in risky sex, they were provided condoms, helped to have frank discussions with sexual partners in order to avoid pregnancy and sexually transmitted diseases, and those at high risk for HIV were given access to medications to lower their chances of getting infected. The agency facilitated various forms of mutual support and participants were able to utilize the services provided at their own pace or not accept them at all without recrimination. This was self-determination and the benefits were enormous, not only to the self-esteem of the participants, as might be expected, but also to their abilities to manage their precarious lifestyles.

It seemed odd that it took me this long to experience and understand the benefits of self-determination since it appears to be

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Drug and Alcohol Prevention Education For Specialized Populations

By Jason B. Conover, LCAT, CASAC
PEIR Prevention Manager
AHRC New York City

Evidence based practice curricula for drug and alcohol prevention education in the United States are designed for high-school and college age individuals. However, it is the philosophy of our program that prevention can be provided, and have an impact, throughout the life span of an individual. It is never too late to improve overall health through prevention education. Drug and alcohol prevention education services can be delivered in a way that makes it accessible to people with intellectual and other developmental disabilities by modifying the materials in a way that maintains the fidelity of the program but better meets the needs of this specialized population.

As they navigate school, work and community engagement, individuals with I/DD may be considered at risk for substance use because of environment, family history, and intellectual disability. The AHRC NYC PEIR (Prevention, Education, Information, Referral) Program is a New York City grant funded program that offers evidence based practice prevention education groups to educate individuals with intellectual and other developmental disabilities, mental health issues and substance use disorders about the nature and breadth of substance use disorders as well as to develop and reinforce coping skills, effective communication, emotion regulation, problem-solving and learning, so that participants can set meaningful goals.

The PEIR program is part of the Family and Clinical Services department at AHRC NYC. Some of the evidence based practice programs utilized by PEIR include: Too Good for Drugs, Positive Actions, Project towards No Drug Abuse, DARE, Refuse, Remove, Reasons, Class Action, and SPORT. In addition to the programs mentioned above, the PEIR program includes discussion/motivation groups offering psycho-education and support around substance use through adapted AA groups and creative arts therapy modalities such as drama, art and music therapy.

Prevention education seeks to treat the individual within a holistic framework. The concept of human beings as "role takers" and "role players" is taken from role theory in drama therapy as developed by Robert Landy who posits that there is no core self but rather, what is thought of as the self consists of a system of roles that a person is born with, is given, or takes on throughout his or her life span. Health is achieved through attaining a balance within a person's role system (Landy, 2008). People who receive prevention services learn how to take on different healthy roles and how to better communicate while inhabiting these roles whether as a parent, spouse, student, supervisor or employee. Helping individuals to learn how to manage all of the roles he or she inhabits while making healthy choices is a goal of prevention.

The curricula sometimes needs to be adapted to meet the needs of individuals with intellectual and other developmental disabilities, mental health issues, and substance use disorders. Some minor modifications might include repeating concepts taught in a lesson or breaking a lesson meant for one session into two sessions so that the information is easier to process these individuals. These adaptations are taken from a book called "More Than Accommodation: Overcoming Barriers to Effective Treatment of Persons with Both Cognitive Disabilities and Chemical Dependency" (Annand, 2002).

In addition the PEIR program also offers community and professional education seminars. Community education seminars raise awareness within the community of persons with intellectual or other developmental disabilities and mental health issues and their caregivers or significant others about the intoxicating, toxic, and addictive properties of alcohol and other drugs. Professional education seminars raise awareness in the substance use disorders treatment community and the I/DD community about the incidence and prevalence of addictions in these populations and offer treatment providers effective strategies and modifications for working with the substance user who is intellectually or developmentally disabled and has a mental health issue.

The PEIR program is one example of a drug and alcohol prevention program that is tailored to meet the needs of a specialized population consisting of individuals with intellectual and other developmental disabilities, mental health issues and substance use disorders living in New York City. Other programs might wish to expand their scope of services to provide prevention education to populations that may otherwise be underserved.

Additional information about this program or ideas for adapting curricula to meet the needs of this population can be accessed by emailing Jason Conover at Jason.conover@ahrcnyc.org.

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CoveCare and MHA Putnam Team up to Provide Continuity and Services

By Staff Writer
Behavioral Health News

CoveCare Center and the Mental Health Association in Putnam (MHA) have formed an affiliation that will leverage the strengths of both organizations in order to continue and grow the robust mental health services available to residents of Putnam and neighboring counties. Through this partnership, MHA will continue to provide the valuable services and supports that they have offered since their inception in 1993 in an independent, sustainable fashion, while complementing the broad base of mental health and substance use treatment and prevention services available at CoveCare Center.

MHA will maintain its own 501(c)3 non-profit, tax-exempt status, its current employees and Brewster location at 1620 Route 22 in Brewster and, most importantly, their commitment to serving the local Putnam community. CoveCare Center, located at 1808 Route Six in Carmel, will provide MHA with enhanced business support systems and training opportunities that will allow the agency to continue to operate and grow effectively amidst the demanding changes occurring in behavioral health management.

Megan Castellano, Executive Director of MHA noted, "We are so excited about this opportunity which will allow us to expand the scope of our services while at the same time providing us with the administrative infrastructure that we need to be a service provider long into the future. Through this strategic restructuring initiative, we can continue to focus on providing support to those in need where we live and work, right here in Putnam County."

Dawn Weitz, Recovery Center Staff Supervisor – MHA; Liza Szpylka, VP Behavioral Health Services - CoveCare Center, Catherine Ptak, Director of Youth and Rehabilitation Services – MHA; Alice Herde, Deputy Director – MHA; Alison Carroll, VP Strategic Initiatives – CoveCare Center; John Bourges, Program Coordinator, PFC. Joseph Dwyer Vet2Vet Program-Putnam; Megan Castellano, Executive Director - MHA; Krista Zanfardino, Associate Vice President – CoveCare Center; Diane E. Russo, Chief Executive Officer – CoveCare Center; Cindy Ott, Chief Financial Officer – CoveCare Center; Amanda Boccardi, Director of Family Support and Outreach Services – MHA; Jonathan Bauman, MD, Chief Medical Officer – CoveCare Center

CoveCare Center and MHA in Putnam are both leaders in providing mental health services in the area. Formalizing their long-standing partnership through affiliation will allow MHA to continue as a vital resource in Putnam County, particularly in the areas of peer support, community education and outreach, with an emphasis on suicide prevention and veterans. CoveCare Center will continue to work closely with MHA in those areas while continuing to provide the caring, compassionate and confidential treatment required by those who need assistance with mental health, substance use, and emotional and social issues.

"By partnering with MHA, we enhance the services that are essential to our community. At CoveCare Center, we know that recovery is possible, and our new affiliation will allow us to continue to provide extended support to promote mental health and wellness in our community," stated Diane E. Russo, Chief Executive Officer of CoveCare Center.

Under this new affiliation, CoveCare Center and MHA in Putnam will have cross-representation on their Boards of Directors to ensure consistent governance across both agencies, and a shared vision for meeting the behavioral health needs in the area.

The Mental Health Association in Putnam (MHA): The Mental Health Association in Putnam (MHA) mission is to promote wellness and recovery for individuals and families coping with mental health issues in our community. Visit www.mhaputnam.org for more information.

CoveCare Center: CoveCare Center, formerly known as Putnam Family and Community Services, Inc., is the only private agency providing recovery-based mental health and substance use treatment and prevention services in Putnam County. More information is available at: www.CoveCareCenter.org.

Welcoming Everyone from page 4

from substance use as conditions change.[3]

We know that many approaches to treatment are effective and that both client and counselor factors influence the realization of a positive outcome. Success is often tied to a working alliance between counselor and client.[4] We know that people who address their substance use and identify that they are in recovery are passionate about their recovery and that their willingness to share their experience and hope is effective in helping others.[5] They serve as models to those who continue to experience negative effects from their addiction and represent many pathways to recovery.

How should this inform policy for Substance Use Disorder (SUD) treatment? SUD professionals should provide treatment consistent with the standard of care. People seeking treatment should be informed of the different approaches available to treat substance use. Treatment programs need to be aware that if someone is not responding to an abstinence approach, they may respond better to a harm reduction approach and vice versa. For some, a treatment system that seemed impossible to access may become accessible if abstinence is not a requirement of treatment.

Substance Use Disorder is a chronic medical condition and we need to treat it as such. We need to encourage people to remain engaged in care, even if they relapse or are not strictly abstinent. Supporting people's treatment and recovery efforts, not discharging because patients show exacerbation of signs and symptoms of their illness, and providing patient-centered and family focused care are the underlying principles of New York State's prevention, treatment and recovery services.

There are many roads to recovery. We cannot stigmatize the pathway that one chooses to take to recovery simply because it is a road less taken. We are all in this together. We must be open to and embrace less traditional models if there is clear evidence they save lives.

The evidence and our experience points to a comprehensive system of care that welcomes all, supports autonomy and promotes whole person health. The most important thing we can do is to welcome people to treatment, provide them with the care they need and help them achieve recovery.

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see Welcoming Everyone on page 29

Harm Reduction from page 20

medications will be welcome, as will effective magnetic and electrical devices that mitigate pain.

Individuals with any chronic condition, including diabetes, hypertension, asthma, cancer and substance use disorders, can learn to better care for their bodies and minds. They can benefit substantively from exercise, a healthy diet, and a variety of mind-body interventions such as yoga, mindfulness, meditation and slow breathing.

Before long, we will have vaccines that prevent an individual from responding to a specific drug, like heroin or cocaine. We already widely use vaccines for infectious diseases like polio, measles, and mumps, examples of harm reduction that need to propagate into the addictions. Some people dependent may want to have this protection as may others at risk.

Harm can also be substantially reduced by diverting people with substance (and often co-occurring mental) disorders from correctional settings. Drug and Mental Health Courts are good examples. Living under the conditions of incarceration is not conducive to recovery.

I like to think of Winston Churchill's famous words when considering the opioid (and other drugs) epidemic that has seized this country. He remarked during the darkest of days in WWII, just after the Americans entered the war: "We are not at the beginning of the end. We are at the end of the beginning."

There is so much we can and must do to reduce the harms of substance use and dependence. We have landed on the beach, have a lot of firepower (in terms of prevention and treatment), but are not effectively using the resources we have. When we do, we will change the course of this epidemic.

Dr. Lloyd Sederer is a psychiatrist and public health doctor. The opinions offered here are entirely his own. His next book, The Addiction Solution: Treating Our Dependence on Opioids and Other Drugs, will be published by Scribner (Simon & Schuster) on May 8, 2018 (http://www.simonandschuster.com/books/The-Addiction-Solution/Lloyd-Sederer/9781501179440). You may reach him on Twitter: @askdrlloyd, and on his Website: www.askdrlloyd.com.

If You're Alone and in Despair
Never Give Up Hope

There is a Caring Community of Organizations
That You Can Turn To For Help

Alan Trager, WJCS CEO Retiring After More Than 40 Year Career

By Staff Writer
Behavioral Health News

The Board of Directors of Westchester Jewish Community Services has announced that, effective June 2018, Alan Trager, LCSW will retire as Chief Executive Officer. Trager has served as CEO for 20 years, with a 42 year career at WJCS.

WJCS is one of the largest human service agencies in Westchester, providing care to people of all ages and diverse backgrounds who are confronting significant challenges. Agency experts provide mental health, trauma, disabilities, youth and geriatric services.

"We are proud of WJCS' stellar reputation. Alan has guided the agency in becoming a premier social service agency, forging a culture of caring and respect, and positioning WJCS as an industry leader in the future. And he has done this all with intelligence, integrity, uncommon dedication and a healthy dash of Trager humor," said Neil Sandler, President of the Board of WJCS.

Alan Trager, LCSW

Delivering effective social services with a dedication to quality and innovation, Alan's decades at the helm have seen the agency grow from $17 million to a $42 million agency with over 80 programs, serving 20,000 people annually with a staff of over 750.

Trager has had scores of key accomplishments over the years, most notably conceiving and creating the agency's first trauma center for victims of child sexual abuse 35 years ago. That program, recently re-named the Trager Lemp Center to honor its founder, is the pre-eminent county resource for mental health trauma treatment.

"As Westchester's largest provider of community-based mental health services, Alan's steady and expert hand and visionary strategic leadership has ensured the viability and stability of its mental health clinical services," according to Michael Orth, Commissioner of Westchester County Department of Community Mental Health.

Also notable under Trager's leadership is the agency's strong focus on research-proven services and staff training, the creation of Center Lane, Westchester's only LGBTQ Youth Community and Education Center, the expansion of person-centered services for people with disabilities and older adults, and a continued commitment to meeting the needs of the local Jewish community.

"This has been a truly humbling experience and a privilege to have been part of the WJCS story. It has been my great honor to work with an incredible staff of highly skilled leaders in our field who are committed, dedicated and compassionate, and provide services with integrity and devotion day in and day out. I've been blessed with an unequaled Board of Directors as my partner throughout my tenure at WJCS. I'm closing this chapter with great comfort in knowing that WJCS will continue long into the future to provide opportunity, hope and the highest quality care to Westchester neighbors in need," said Trager.

In addition to his service at WJCS, Alan Trager has served on the Board at Mental Health News Education, Inc., publisher of *Behavioral Health News* and *Autism Spectrum News*. "Alan has been a dedicated leader and tireless supporter of our organization - and a mentor to my son David and I since we began in 2000. We wish him all the best in his retirement and say that he will be truly missed by everyone on our Board," stated Ira Minot, LMSW, Executive Director.

PEOPLe, Inc. Receives Grant to Combat NYS Opioid Epidemic

By Staff Writer
Behavioral Health News

PEOPLe, Inc., a peer-run, not-for-profit agency that advocates and provides recovery-oriented services for people living with mental health issues or trauma, is one of five nonprofits that will share in a $10 million grant from Governor Andrew M. Cuomo for expansion of services. The grant will be administered by the New York State Office of Alcoholism and Substance Abuse Services.

PEOPLe will use $2.38 million from the grant to support the development of 20 new community-based, Medically Supervised Withdrawal and Stabilization Services beds throughout Putnam, Orange, Dutchess, Ulster, Columbia, and Greene Counties.

Cuomo said the funding will widen services for people battling addiction, especially in communities hard-hit by the opioid epidemic. "Communities across the country have felt the impact of the opioid epidemic and New York will continue to combat this scourge until this crisis has been eradicated once and for all," Governor Cuomo said in a statement. "This funding will bring desperately needed resources to communities across state, allowing us to reach more people and get them the help they need."

Steve Miccio, Chief Executive Officer for PEOPLe Inc, said the grant will provide even greater opportunities to help individuals gain knowledge on whole health and wellness approaches when facing substance use issues. PEOPLe Inc.'s person-centered trauma informed practice will assist families experiencing the overwhelming nature of addiction.

"Governor Cuomo fully understands the pressure agencies like PEOPLe face each day as we work to provide these critical services," Miccio said. "The state grant will support the expansion of 20 beds in a part of the state that is often overwhelmed with the need for addiction services."

According to Miccio, PEOPLe, Inc. is a peer-run not-for-profit agency that advocates with and provides recovery-oriented services for people living with mental health issues or trauma. Being 'peer-run' means we're an agency made up of people with their own personal lived experiences with mental illness, psychiatric diagnoses, trauma, crisis, and most importantly recovery. We use our mutuality – the shared elements of our stories – to inspire and guide people towards their own lives of wellness; and our collective imaginations & voices drive communities towards better public health through innovation and alternatives.

From Patient to President and CEO

By Staff Writer
Behavioral Health News

Chacku Mathai, a person with a history of mental illness and addiction is the next President and CEO of the Mental Health Association (MHA) of Rochester and Monroe County, effective March 2, 2018. Informed by personal experiences in Rochester, Mathai, an Indian-American, born in Kuwait, brings over 30 years of experience addressing mental health, addiction and minority health issues back to Rochester and Monroe County.

Patricia Woods, MHA's current President and CEO is retiring after dedicating 34 years to the agency. Ms. Woods said, "I have known Chacku for 20 + years; originally meeting him when he worked as a direct service provider in a local mental health agency. I was immediately impressed with his passion for and his ability to advocate for a mental health system where recipients of services are fully participating partners in the care they receive. I have watched him take on roles at the state and federal levels and am honored that he has chosen to bring his talents back to Rochester as my successor at the Mental Health Association."

Chacku Mathai credits Pat Woods and the MHA with his family's, and Rochester's, first steps towards empowerment, wellness and recovery in mental health. "There is an intersectionality to the human experience that Pat understood." Mathai said. "She started this organization on the principle of wellness, rather than illness. She saw us as people, rather than as patients. We will honor her legacy and build on the foundation of those principles."

Current MHA Board Chair, Julie DiPalma, says that, "MHA's choice to bring home Chacku Mathai's national voice of the mental health movement represents our continued commitment to the mission of breaking down stigma and building partnerships that sharpen our focus on lasting mental wellness and public health."

Chacku Mathai will be leaving his position as the Director of the NAMI STAR Center based at the headquarters of the National Alliance on Mental Illness in Arlington, Virginia.

Chacku's new role with MHA is being warmly received by many on the regional and national stage. NAMI's CEO, Mary Giliberti, introduces Chacku best when she says, "Chacku brings his personal and professional experience to his transformative work empowering change in organizations and people. He is always collaborating to strengthen the overall movement and I look forward to continuing to work with him in his new role." NYAPRS Executive Director, Harvey Rosenthal says, "Over the years, Chacku has built on his personal and professional experience to become an extraordinary leader whose dedication, expertise and accomplishments have long provided an inspiration and an example to thousands here in New York and nationally."

Rochester is fortunate to have someone of Chacku's ability to engage and lead the mental health world towards large systems transformation.

Chacku Mathai welcomes our community to get involved with him and the MHA of Rochester right away with two refrains of our cross-disability and public health movements, "Nothing About Us Without Us!" and "Everyone's In, No One's Out."

Problem Gambling from page 6

researched of the two options. However, given that gambling is legal and available and has expanded with the availability and ubiquity of internet gambling sites and variety of betting games available, a harm reduction approach can prove very beneficial in having an impact on protecting vulnerable populations from the risk of developing a gambling disorder. Additionally, harm reduction approaches can be encouraging to individuals who do not see abstinence as an attractive or feasible option. This can include older adults who derive social benefits from gambling (Tanner et. al., 2017) along with young adults and college students in particular who are more at risk of pathological gambling than the general adult population (Lostutter et. al., 2014). Harm reduction initiatives are typically divided into three tiers of prevention (Blaszcynski, 2001). Primary prevention strategies are devised to protect gambling participants from developing problems. Such interventions include public education campaigns, promotion or responsible behavior and teaching the public about the risks associated with gambling. Such initiatives could also include clearly describing the odds and probabilities of winning and clarifying erroneous cognitions and misperceptions that might be associated with gambling and associated machines (Derevensky, Gupta, Dickson, & Deguire, 2004).

Secondary prevention techniques aim to minimize the harm of gambling once it has started. Given the rates comorbidity present with problem gambling, a key strategy is for addiction, mental health, and healthcare providers to screen for problem gambling among their patients. This provides an opportunity to identify opportunities for psychoeducation, intervention and referrals.

Initiatives within the gambling industry involve training casino staff to detect and employ sensitive approaches in dealing with potential problem gamblers, reducing the amount of alcohol or cigarettes available near gaming areas, removing ATM machines from gambling areas, self -exclusion programs, expenditure limits connected to time-intervals and restricting the amount of wins and/or restricting wins to checks rather than cash.

Lastly, the goal of tertiary interventions is to reduce the gravity of gambling problems once they have commenced and helping prevent relapses of gamblers in treatment. Such measures include therapy for problem gambling and particularly therapies that focus on creating individualized controlled gambling plans rather than full abstinence (Ladouceur, 2005).

New York State has made significant strides in utilizing harm reduction initiatives around problem gambling. In 2013, the New York State Gaming Commission, the Office of Alcoholism and Substance Abuse Services (OASAS) and the New York Council on Problem Gambling announced the formation of the Responsible Play Partnership (OASAS website, 2018). This Partnership is aimed at regulating gambling venues and exploring ways to prevent and treat problem gambling. The Responsible Play Partnership has taken components such as the implementation of a statewide self-exclusions law, improving the way gambling facilities identify gamblers at risk, improving responsible gambling, enforcing age restriction laws and enhancing outreach and awareness. Through OASAS, New York State is also expanding the presence of Problem Gambling Resource Centers across the state to increase awareness of, and access to, various types of gambling treatment services.

Often viewed as cornerstones of problem gambling systems, helplines were among the first services established by many US states. Telephone and chat helplines are confidential and easily accessible, and may be an ideal vehicle for individuals, including youth, to ask questions, obtain information and acquire referrals to services. Helplines such as the HOPEline (1-877-8-HOPENY), the statewide 24/7 helpline that offers support, education as well as treatment referrals to New Yorkers struggling with substance use and problem gambling, and NYC Well (1-888-NYC WELL) which offers connection to mental health supports to New York City residents, can cut across the three tiers of harm reduction. This can include providing education around responsible gaming to its callers and break some misconceptions around winning and losing at gaming facilities, education around concepts such as self-exclusion or cash limits on gambling. Should an individual develop a problem gambling disorder, helplines are there to destigmatize the shame around problem gambling, provide emotional support to the person at risk and/or their family members and guide the individual to appropriate referrals for the treatment of problem gambling.

Nada Touma is Director of Specialized Services at the Mental Health Association of New York City. Kelly Clarke is Director of NYC Well at the Mental Health Association of New York City. Contact them at ntouma@mhaofnyc.org or kclarke@mhaofnyc.org.

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Realizations and Truths from page 8

We also discussed how, to us, reducing harm has a lot to do with attitude. Whether you see the glass as half full instead of half empty makes a really big difference in life, and you have to work hard to start seeing that there's a lot out there for you if you really want it. Changing thinking patterns and learning to focus your energy someplace other than the negative is a key factor.

People and places also have a lot to do with reducing harm. Some people call these triggers, and say you shouldn't tempt fate by being around familiar environments. Others say you bring yourself with you wherever you go, so even going to a new place could bring the same temptations. Still, we observed that it is hard to look at a place that reminds you of a past you are trying to move away from and not have memories come floating back at you. So why go there? And in relationships, it's especially hard to be around people with whom you always did things that you know are harmful, so it's more helpful to just stay away from those people. Stay away and build a new path.

Two final things: first, when all is said and done, what we all agreed we really need in order to improve our chances of making it are employment and housing. These are the two hardest things to come by, and yet we've all experienced the fact that without a place to live and job to help build a sense of self-worth, the temptations to go back where we started out are going to be too great to tackle. More help in the real world to make employment and housing a reality is critical.

And lastly, we all recognized one universal truth about our situations. As one of us observed, "When you're up against drugs and alcohol, you're up against the only truly undefeated champion in the world. So, don't get in the ring!"

Safe Practice from page 18

• Google studied teams and teamwork and found psychological safety was key factor for top performing teams. Is it safe in your team to push the envelope and bring up conflicting and opposing ideas?

• Power mutes empathy. Research shows that the higher up in an organization and more power a leader has, the less they feel they need to listen to others. The lack of empathy can decrease the psychological safety and limit the production of creative ideas.

• To raise the Emotional Intelligence of the team, honor the process of the conversation. Are all ideas and people heard, are ideas left on the table, are decisions really understood, digested and moved to actions?

• The key is to learn to have difficult dialogues in a non-shaming, non-blameful, non-judgmental collaborative manner that tackles the challenging questions, engages the difficult discussions in a transparent style, and brings everyone's authentic voice to the table.

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Injection Facilities from page 14

support recipients through various stages of change. Of the various "types" of SIFs described in the research literature the "integrated" type is the most common. An integrated SIF generally provides an array of services that may include showers and laundry facilities, counseling and testing for blood borne viral infections, needle and syringe exchange, psychosocial care, employment programs, medical services, wound care, and medication-assisted treatment, among others (Otter, 2012). Perhaps not surprisingly, recipients of such facilities often receive education, preventive care and referrals to a variety of support services designed to reduce the harm associated with drug use and to promote lasting recovery (KPMG, 2001; Milloy & Wood, 2009; Otter, 2012). The Vancouver facility is the only officially sanctioned SIF in North America and it has been subject to extensive research and evaluation since its inception in 2003. A meta-analysis of this research concluded its users were significantly more likely than non-users to enter detoxification or addiction treatment services following their engagement with the facility (Radcliffe, 2018).

SIFs remain exceedingly controversial within the United States and no officially sanctioned sites have yet emerged here. Nevertheless, a comprehensive review of an unsanctioned (i.e., "underground") site currently in operation in an urban area within the U.S. concluded it produced the same benefits as its counterparts abroad (Davidson, Lopez & Kral, 2018). Several American cities have explored the development of sanctioned sites, and San Francisco and New York have commissioned comprehensive feasibility studies to guide their deliberations. Other cities have followed suit, but many policymakers and other stakeholders fear repercussions of violating federal drug laws, especially in view of Attorney General Sessions' pledge to prosecute violations of the Controlled Substances Act. Divergent opinions and philosophies and deeply entrenched political sensibilities will surely influence the national discussion as well. In these respects, SIFs are not unlike other interventions that once challenged conventional wisdom but ultimately proved useful to the recovery movement.

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see Compassionate Care from page 21

them from treatment we are providing good care even though there is no empirical validation for this perspective.

This traditional model sets up a non-collaborative relationship between the therapist and the client where the therapist is the clear authority. When we set these goals for our clients, we make a statement that they are expected to progress on the therapist's timeline.

As a provider who oversees many levels of care, I have assessed people as needing a certain level of care such as intensive outpatient treatment which a client may refuse. There are times where a client starts a lower level of care and does well. Treatment centers should engage people with what they are willing to do rather than reject them. Many treatment centers have a very specific array of services that they "fit" the person into. For example, some programs insist on initial intensive services regardless of the person's presentation.

Our field tends to set up many ways of shaming and rejecting clients that often adds to the problem. There is so much internalized shame around drug users that it does not need to be reinforced by providers.

Substance abuse programs treat people with comorbid psychiatric issues and trauma histories but fail to acknowledge how this can make a person's struggle to reduce harm more complex. A client's history of abuse and neglect often shapes their attachment to the therapist. Building this therapeutic alliance is crucial in treatment as opposed to setting goals. In addition, many clients are self-medicating their psychiatric symptoms and it can be a process of building skills for this person so that they don't rely on substances as much.

For many years now, there has been an ongoing ideological debate that actually has faulty logic and highlights the difficulties with the types of treatment we provide in the area of substance misuse. That debate is often titled, "harm reduction vs. abstinence." However, a problem with this debate is that harm reduction includes abstinence as an option. Setting the goal of abstinence is a great way to reduce harm. Part of the problem is that people have such personal and ideological reactions to the use of words like harm reduction. They struggle to really listen to what it means. A greater investment in engaging clients by providing an array of options would increase our success in working with people who misuse substances. It actually helps the therapist see progress in a more complex way.

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Self-Determination from page 24

such a prominent value among social workers and some other helping professionals. But I don't believe I am unique. It is well known that much of social work practice, such as in public assistance, child welfare, and protective services, operates within authoritarian structures. But even group and individual treatment are often coercive, not only with children, but, for example, when offered as an alternative to incarceration or other punitive measures.

Unique or not, I was excited to find that self-determination is respected in harm reduction. I loved both the idea and the application of it. If I were able to begin my career again, I would pay more attention to self-determination, not only as a value, but also as a means toward really helping people.

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Suicide from page 22

in those who are desensitized to pain which can serve as a barrier to taking action on a suicide plan (Anestis MD, Soberay KA, Gutierrez PM, et al. Reconsidering the link between impulsivity and suicidal behavior). In assessing data from 70 different studies, Anestis and colleagues found that impulsivity as a personality trait was more likely to increase a person's exposure to "painful and provocative events". Those who have had more exposure to pain or have participated in reckless behavior are also relatively less sensitive to the experience of pain and therefore, less likely to have pain be a deterrent to attempt suicide.

In fact, the CDC reports "a prior history of suicide attempt is considered one of the most robust predictors of eventually completed suicide" www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2013-a.pdf.)

The American Foundation for Suicide Prevention (AFSP) hosts various walking and cycling events in multiple cities each year entitled "Out of The Darkness". As a participant, I have found the experience to be both deeply rewarding and educational. Considering the tendency to push suicide into "the darkness" out of fear and avoidance, the message of these events and others like it can literally save lives. If you know someone battling with depression, exhibiting impulsive behavior, stockpiling weapons or medications or have talked about ending their lives, your willingness to talk about it can be the difference between life and death. You can offer to source a mental health professional who can assess for risk and determine next steps. Another option for those unwilling to try therapy and do not have an active suicide plan is the National Suicide Prevention Lifeline- (800) 273-8255. Teens might prefer to use the Crisis Textline by texting 741741 from anywhere in The United States. Finally, if you believe someone is in imminent danger, call 911 or urge the patient to accompany you to the nearest emergency room.

Pablo Idez has served the Long Island, New York community over nearly 20 years with expertise in the treatment of Anxiety, Panic Disorder and Marital Counseling. He can be reached at (347) 772-8373. For more information, visit www.lipsychotherapy.com

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Stabilization Program from page 23

provider appointments are extended to a bi-weekly then monthly basis.

Once stabilization goals are achieved, the patient will be referred to a rehabilitative clinician who will focus on developing chronic care management. The rehabilitative clinician will conduct follow up assessment, exploring further psychosocial factors and mental health related concerns. Based on this assessment, patients will be encouraged to elaborate on their goal setting, participate in targeted group therapies, address medication management, and continue family work.

Since initiating the program in August 2017, we have seen a remarkable decrease in days wait time between initial assessment and admission and also days wait to medications consult. The data includes: Admissions (55); Average days between admission and medication consult (3.75); Average days between admission and follow up appointment with high risk clinician (4.48).

Additionally in restructuring to accommodate rapid linkage, we have found a direct correlation to increased engagement rates. This data includes: Total untoward discharges (13); Discharge reasons: Lost to contact (7); Non-compliance (3); Services refused (1); Incarceration (1).

From an anecdotal perspective, participating patients have endorsed a positive therapeutic experience and ability to effectively work towards personal goals. More specifically, a patient shared; "I was a wreck and I didn't really know if I wanted to stop. Going through this process, there couldn't be a better thing for me. Vivitrol was a great added insurance. Family Group and Mindfulness were helpful not only in my relationships with my mother, but a change in my attitude and how I react with other people on a day to day basis."

In conclusion, the Boulevard Outpatient Stabilization program, has shown to be effective in offering patients rapid medication and treatment services. Furthermore, this model of treatment presents a promising opportunity to bridge the gap between inpatient and hospital based settings with outpatient providers.

All questions or concerns regarding this article can be directed to: Elliot Zimpfer, LMHC, CASAC, Horizon Health Services, (716) 833-3708, and at EZimpfer@horizon-health.org.

Welcoming Everyone from page 26

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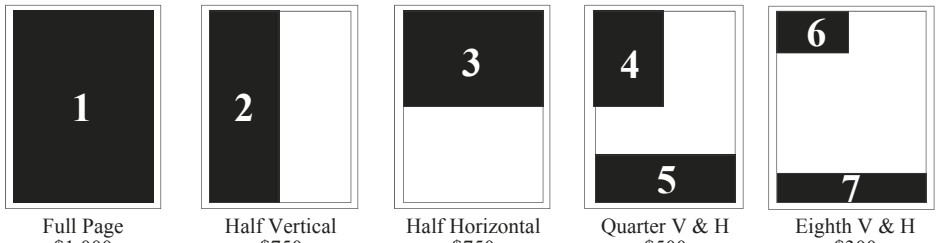

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