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SUMMER 2017 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 4 NO. 4

Meeting the Needs of Our Vulnerable Populations

Join Us in Honoring Our 2017 Leadership Awards Recipients

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Donna Colonna
Chief Executive Officer
Services for the UnderServed
"Lifetime Achievement Award"

Gary Lind
Executive Director
AHRC New York City
"Advocacy Award"

Arlene González-Sánchez
Commissioner
NYS OASAS
"Public Service Award"

Dr. Fred Volkmar
Professor, Yale University
Child Study Center
"Leadership Award"

Debra Pantin and Robert Ring Named Event Co-Chairs of MHNE's June 29th Leadership Awards Reception

Debra Pantin, MSW

Robert H. Ring, PhD

Staff Writer
Behavioral Health News

Mental Health News Education, Inc. (MHNE), the NY-based nonprofit organization that publishes *Behavioral Health News* and *Autism Spectrum News*, announced today that Board Members Debra Pantin, MSW, Chief Executive Officer, VIP Community Services and Vice Chair of the MHNE Board of Directors and Robert H. Ring, PhD, Adjunct Professor, Drexel University College of Medicine and member of the HHS Interagency Autism Coordinating Committee (IACC), have been named Event Co-Chairs of MHNE's 2017 *Leadership Awards Reception*. The event, celebrating leaders making a difference in people's lives, will take place on Thursday, June 29, 2017 at 5:00 PM at the NYU Kimmel Center in New York City.

Honorees at MHNE's June 29th Leadership Awards Reception include: Donna Colonna, Chief Executive Officer, Services for the UnderServed; Gary Lind, Executive Director, AHRC New York City; Arlene González-Sánchez, Commissioner, NYS OASAS; and Dr. Fred Volkmar, Professor, Yale University Child Study Center.

Constance Y. Brown-Bellamy, MPA, Board Chair of MHNE, made the announcement saying, "We are deeply grateful to Debra and Robert for accepting the position of Event Co-Chairs for our upcoming *Leadership Awards Reception*. This year's event will be the first time MHNE will be honoring leaders from both the autism and behavioral health communities together. Ms. Pantin and Dr. Ring will serve as MHNE's ambassadors as we look to cultivate relationships and reach out for support in honor of our fantastic honorees."

Debra Pantin joined VIP Community Services in 2013 as the Associate Executive Director. She has over 25 years of experience in the human services industry, specializing in the fields of mental health, substance use disorder treatment, homelessness, supportive housing, vocational and employment services, primary care, and HIV prevention and services. Leading agency-wide changes and managing organizational transitions are the hallmarks of Ms. Pantin's experience and reputation. Her professional experience

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Have Some CLAS:
What Leading Organizations Are Doing to Address Population Health

By Heidi Arthur, LMSW, Principal, Kristan McIntosh, LMSW, Senior Consultant, and Hannah Risheq, MPH, Social Work Intern
Health Management Associates

Adherence with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) is a common expectation for healthcare organizations of all types. Many providers assume that their efforts are sufficient as long as they hire staff who reflect the racial, ethnic, cultural, and linguistic background of their client population. Yet, full CLAS adherence, and responsive population health planning, require more thorough consideration, system-wide analysis and on-going review than most providers realize. Recent attention to the needs of immigrant and refugee communities offers a lens through which the CLAS standards might be more closely considered.

CLAS for Refugees

Considering refugees as an example of just one underserved population's needs opens the door to many questions worth considering for other populations. Many providers are not aware that NYS ranks among the top three state for refugee resettlement in the United States, behind Texas and California (Office of the New York State Comptroller, a Portrait of Immigrants in New York, 2016). Refugees are highly likely to have experienced stress and trauma, and, after they resettle, they frequently face additional, compounding issues related to poverty and limited education, discrimination, low paying jobs, and social isolation (American Psychological Association, Working with Immigrant-Origin Clients, 2013). Yet, refugees are also some of the least likely to utilize behavioral health services due to cultural and systematic barriers (CDC, Guidelines for Mental Health Screening during the Domestic Medical Examination for Newly Arrived Refugees, 2014). Although they are eligible for Medicaid under the Affordable Care Act, refugees still face obstacles to receiving proper care, including lack of access to appropriate and culturally sensitive mental health services in necessary languages, shortage of mental health workers trained to work with their presenting needs, and a lack of knowledge regarding available resources to facilitate access to services (i.e. transportation and child care). Within many refugee communities, there is an inherent mistrust associated with seeking services outside of the community. Most of the community outreach is done through word of mouth, via cultural organizations and groups, or through religious and/or spiritual forums, and many groups who are fundamentally connected to faith will take their cues from pastors and faith leaders. Addressing language barriers, the impact of new systems, and the burden of poverty, as well as secondary adversities such as the loss of and separation from loved ones, displacement, and trauma and loss reminders, is essential to providing effective interdisciplinary care (Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., & Narasiah, L., et.al., Evidence-based Clinical Guidelines for Immigrants and Refugees, 2011).

CLAS 101

The U.S. Department of Health and Human Services Office of Minority Health developed 15 national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care. While the Principal CLAS Standard is the "provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs," the additional standards, detailed in the sidebar to the right, go deeper into three broad focus areas: 1) Governance, Leadership and Workforce; 2) Communication and Language Assistance; and (3) Engagement, Continuous Improvement, and Accountability (HHS, CLAS and the CLAS Standards, 2015).

CLAS standards are endorsed by the NYS Office of Mental Health and the Department of Health. Indeed, the state required Performing Provider Systems (PPS) working within the Delivery System Reform Incentive Payment (DSRIP) Program to develop and submit cultural competency and health literacy strategies for serving their communities. These strategies directly relate to specific needs and regional demographics identified in each PPS' initial Community Health Needs Assessment, and they outline specific approaches that will be taken by the PPS to ensure success in addressing health disparities. As well, NYS Certified Community Behavioral Health Center (CCBHC) sites are required to adhere to a number of requirements related to cultural competency, including the requirement that the CCBHC staff must be culturally and linguistically trained to serve the needs of the clinic's patient population. Staff training must address the diversity within the organization's service population and must include information related to military culture if veterans are served (SAMHSA, Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics, 2015). Finally, notable for behavioral health providers integrating primary care, the standards for a Patient Centered Medical Home (PCMH) also incorporate CLAS into requirements. For instance, certification demands that providers assess population diversity and language needs and provide interpretation services and printed materials in relevant languages, collect thorough demographic information, and obtain feedback from patients and families on their experiences with the practice and their care at least on an annual basis.

CLAS Action

Despite the wealth of standards and requirements related to cultural competency, CLAS adherence in practice is only possible when care is truly person-centered and relationship-based to meet the individual patient/consumer and family's needs, preferences, and priorities. Robust stakeholder and community input is vital. Person-centered care, the key to achieving cultural competency, is defined by the Agency for Healthcare Research and Quality (AHRQ) as "relationship-based…care that meets the individual patient and family's needs, preferences, and priorities." The provision of culturally responsive health care has evolved from specific training about groups to a more universal focus on rapport-building, clear empathic communication, and respect and negotiated treatment planning that embrace patient world views and health decisions. Indeed, reviews of traditional provider educational interventions focused on the specific needs of racial/ethnic minority populations found evidence that this type of cultural competence training can have mixed effects, with two studies reporting increased negative attitudes and/or stigma among staff resulting from intervention (AHRQ, Improving Cultural Competence To Reduce Health Disparities, 2016).

Person-centered care demands that providers find ways to engage with individuals based on their specific needs, informed by an understanding of—or an openness to learning about—each clients' unique values, attitudes, and beliefs, which are intricately influenced by a variety of variables such as culture, race, ethnicity, disability, religion, sexual orientation, neighborhood, when a person immigrated to the country and immigration status, as well as incarceration history, etc. The use of professional interpreters or trained culture brokers (not children or other family members) can help providers identify patients' concerns, explain illness beliefs, monitor progress, ensure adherence, and address the social causes and the consequences of behavioral health issues (Kirmayer, L.J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A.G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K., Common Mental Health Problems in Immigrants and Refugees, 2011). The list is numerous and every "group" that can be named is comprised of individuals whose affiliations and influences cross and overlap with other groups. So, while learning population norms and trends for those of specific immigrant communities, religious groups, or racial/ethnic populations can provide a useful starting place for understanding an individual, it is by no means sufficient, and the risk of unintended stereotyping and bias is inherent.

Organizations reaching and serving culturally-based groups are often small not-for-profits with minimal resources. Although they see improvements in consumers' connection to care as a result of their services, their present size does not enable them to meet the need that exists within the community. Increasingly, these agencies are partnering with other stakeholders within the delivery system to engage in integrated care coordination, which brings together caregivers, psychiatrists, primary care providers, case managers, teachers, refugee resettlement agencies, and refugee community and religious leaders, are finding success addressing the characteristics, culture, and preferences of refugees (Isakson, B.L., Legerski, J.P., & Layne, C.M., Adapting and Implementing Evidence-Based Interventions for Trauma-Exposed Refugee Youth and Families, 2015). These approaches can be financed under emerging models for value based, accountable care.

CLAS Focus Areas

Governance, Leadership and Workforce

1. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

2. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

3. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

1. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals (i.e., family members) and/or minors as interpreters should be avoided.

4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

1. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

2. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into

see CLAS on page 32

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Treating Vulnerable, Mentally Ill Patients Who Are Navigating the U.S. Criminal Justice System

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

Erin M. Falconer, PhD

It is an alarming statistic that more people with serious mental illness are housed in America's jails than in the nation's hospitals (Torrey, E. F., Kennard, A. D., Eslinger, D., et al. 2010. More mentally ill persons are in jails and prisons than hospitals: a survey of the states. Arlington/Alexandria, VA: National Sheriffs Association and Treatment Advocacy Center). Millions of people with serious mental illness cycle repeatedly through local jails, emergency rooms, shelters, and other public health systems. These individuals are often arrested for non-violent misdemeanors (White House Fact Sheet, Data Driven Justice Initiative, June 30. 2016: https://www.whitehouse.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle). It has been estimated that 64% of people in local jails suffer from mental illness, 68% with substance abuse disorder, and 44% with chronic health problems (White House Fact Sheet, Data Driven Justice Initiative, June 30. 2016: https://www.whitehouse.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle). Research that has used county and statewide criminal justice data as well as health and social services data has found that the odds of being arrested increase in those who are homeless, those who have had an involuntary psychiatric evaluation (indicating serious mental illness), and those who do not receive outpatient mental health treatment (Constantine, R, Andel, R., Petrila, J., et al. 2010. Characteristics and Experiences of Adults with a Serious Mental Illness Who Were Involved in the Criminal Justice System. Psychiatric Services, 61(5), 451-457). The implications of this state of affairs is quite serious. Even a short stay in a jail may impact someone's psychological status, employment, family stability, and health (Haney, C., U.S. Department of Health & Human Services. https://aspe.hhs.gov/basic-report/psychological-impact-incarceration-implications-post-prison-adjustment).

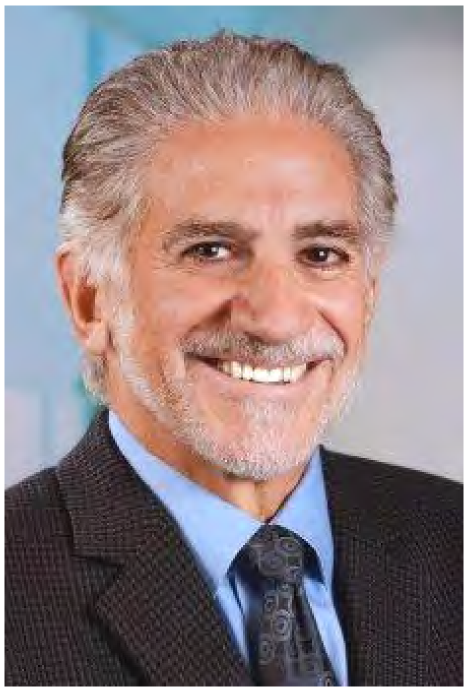
Many of these vulnerable individuals are released from prison and re-enter the community in critical need of appropriate treatment to prevent their relapse and recidivism. However, these individuals often do not receive the required care, given that they are faced with an overwhelmed, underfunded, and uncoordinated health system. Lack of timely access to appropriate treatment is essential for this vulnerable population and its absence underpins persistent recidivism. Based on our recent research evidence, we know that receipt of healthcare services within the first 3 months after release from jail significantly reduces the risk of future re-arrest (Falconer E, El-Hay T, Alevras D, et al. Health & Justice, in press). In particular, those who receive case management – including assessment, coordination of services, referral and follow-up services – after they are arrested, have a 50% reduction in the likelihood of being arrested again (Falconer E, El-Hay T, Alevras D, et al. Health & Justice, in press). Also, receiving medical services – including psychiatric assessment, therapy and medication management – can significantly reduce recidivism in this vulnerable population (Falconer E, El-Hay T, Alevras D, et al. Health & Justice, in press).

Not only is it important to ensure that these vulnerable individuals with mental illness and related comorbidities (including substance abuse) receive timely intervention after they are arrested, it is also critical to find ways to identify those who are most at risk and to proactively divert them into appropriate care. Initiatives to identify those individuals with mental illness and divert these people out of the criminal justice system have been successful at reducing incarceration and the burden on the criminal justice system. Miami-Dade County has implemented a jail diversion program that includes a pre-booking brief mental health assessment by a crisis intervention policing team, and diversion to appropriate crisis stabilization services and community-based treatment, as well as

see Navigating on page 14

Commentary on Treating Vulnerable, Mentally Ill Patients

By Richard A. Sheola
Principal
Health and Justice Strategies, LLC



Richard A. Sheola

Dr. Falconer effectively drives home the travesty of the disproportionate representation of those with serious behavioral health issues behind bars. Alarming, but not new, the "trans-institutionalization" of the 80's and 90's continues unabated to its tragic conclusion. She cogently captures the history, challenges and emerging strategies related to inordinately high rates of recidivism that characterize the experience of these individuals, an unconscionable experience that begs for reform. Re-enter Dorothea Dix, stage left, 1854, inspiring calls for a return to Asylum. (See, "Improving Long-term Psychiatric Care, Bring Back the Asylum," Journal of the American Medical Association (January 21, 2015).

Not so fast…Indeed, the lack of progress in the face of these unconscionable realities, fifty years beyond the public mental health priorities and unfulfilled promises of the last century, is hard to accept. However successful, compassionate and replicable alternatives exist, such as Judge Leifman's Miami Dade and the Leon Evans-led reforms in Bexar County. Those successes turn on redoubled collaboration among public safety, health and human services leadership and (wouldn't you know it!) much welcomed federal financial participation in the cost of these desperately needed treatment strategies. Ironically, the now sun setting ACA-driven potential for offsetting state and county costs of correction with

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Supporting Vulnerable Populations: A Model That Can Make a Difference

By Marco Damiani
Chief Executive Officer
Metro Community Health Centers

In an increasingly complex and competitive healthcare environment, ensuring access to integrated care for our most vulnerable populations is becoming evermore challenging. Metro Community Health Centers (MCHC) has embraced this challenge and is providing patient-centered services designed specfically for patients with complex needs. MCHC is a Network of five Federally Qualified Health Centers (FQHCs) providing comprehensive healthcare services to a culturally diverse, underserved, and often medically and behaviorally complex patient population throughout NYC. MCHC's team-based model of care includes primary and specialty care, behavioral health, dentistry, and rehabilitation services that are grounded in practices that empower and support each patient's physical, mental and social well-being. A significant number of our patients have intellectual/developmental disabilities (I/DD), and while some challenges to obtaining optimal health are unique to this group, many are concerns that are also seen in other vulnerable populations:

- Research shows that vulnerable populations, including the economically disadvantaged, racial and ethnic minorities, uninsured, and those with I/DD, experience inadequate access to care, poor receipt of health care services, and ultimately poorer health outcomes (Hayden, M.F, Kim, S.H., DePaepe, P., 2005, Krahn, G.L., Hammond, L. & Turner, A., 2006, Shui, L, & Stevens, G.D, 2005).

- Compared with other groups, vulnerable populations are also more likely to experience earlier onset of illness, greater severity of disease and more preventable mortality (Havercamp, S.M., Scandlin, D. & Roth, M., 2004, Wilson, P.M., Goodman, C., 2011), and preventable mortality (Havercamp, S.M., Scandlin, D. & Roth, M.,2004, Horowitz SM, Kerker BD, Owens PL, Zigler E., 2000, Williams, D.R, Mohammed, S.A, Leavell, J., & Collins, C., 2012).

- Low socioeconomic status groups and individuals with I/DD often struggle with risk factors associated with chronic conditions including poor nutrition, obesity, and sedentary lifestyles (Rimmer, J., & Hsieh, K., 2011, Pampel, F.C., Krueger, P.M. & Denney, J.T., 2010).

- Although at greater risk for chronic diseases, they often have less access to appropriate health care services, and prevention services are rarely implemented with this population. (Anderson, L.L., Humphries, K., McDermott, S., Marks, B., Sisirak, J. & Larson, S., 2013., U.S. Public Health Service, 2002).

Compounding these issues is a limited number of healthcare professionals qualified and trained to meet the specialized needs of this population, and a lack of continuity in care. In addition, many health centers lack the specialized equipment and supplies needed to accommodate a wide range of patient function and ability. This creates significant access problems for vulnerable/complex needs populations.

Marco Damiani

Maintaining continuity in care is also a critical component of quality healthcare for vulnerable populations. However, obtaining continuity across multiple service systems is challenging. Many primary care providers do not provide or have ready access to adequate case management services. They often focus on the medical issues at hand and overlook the preventative and social needs of the patient. Limited knowledge of resources available can also leads to poor continuity in care.

Some key indicators of effective and sustainable care for under-served patients with complex needs, include: (1) Integrated Care, especially Primary Care and Behavioral Health; (2) Accountable Care; (3) Holistic Care; (4) Strategic Partnerships; (4) Community Engagement; and (5) Robust Health Information Systems.

There are many other components that provide value to a patient's care, but these components, coupled with reliable and fair revenue streams (big surprise!), can truly make a difference. MCHC's approach to care, grounded in access for patients of all abilities, starts with a key foundation – the Patient Centered Medical Home (PCMH). The National Committee for Quality Assurance (NCQA) has recognized MCHC as a Level 3 PCMH. A growing body of evidence demonstrates that Medical Homes improve quality of care, health outcomes and patient satisfaction, while reducing health disparities, hospital and emergency room visits and overall costs. An array of on-site services provided under the direction of a diverse team of primary and specialty care providers enables holistic delivery of quality care.

In addition to developing a holistic model of health care for underserved and vulnerable patient groups, MCHC also recognized the value in working with a larger group of providers to meet quality of care objectives and reduce costs. MCHC is a founding member of the Alliance for Integrated Care of New York (AICNY). AICNY is a unique, state-wide Medicare Shared Savings Program Accountable Care Organization comprised of clinical partner organizations that support 6,000 vulnerable patients across NYS. Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors (Centers for Medicaid & Medicare Services, 2015). Clinical and community partnerships are essential in meeting these goals, especially when coordinating care for vulnerable populations who often require a range of services from multiple providers. Unlike many ACOs in New York over the past year or two, AICNY has been successful in reducing the cost of care while achieving high quality scores on standardized clinical care measures. Because we have strong healthcare data analytics available to our team, we are able to specifically track patient service utilization, cost, diagnoses and procedures and risk-stratify patients to help inform our care planning.

MCHC is a growing FQHC network in large part because we have committed to serving a complex patient population that the general medical community is often not prepared to treat. Cerebral Palsy Associations of New York State recognized this when they planned and successfully spun-off MCHC as an independently governed and managed organization in August of 2015. HeartShare Human Services of New York also recognized the potential of a network of this kind, and consolidated their Downtown Brooklyn Health Center into MCHC's network in August of 2016. Strengthening the network even further, NYU Lutheran Family Health Centers provided robust support for MCHC's designation as Federally Qualified Health Centers. The strengthened partnerships and collective strategic and visionary planning of these organizations resulted in an expanded scope of community healthcare and a reinforced commitment to a sustainable healthcare system for patients with complex needs.

MCHC's healthcare network, specializing in the care of individuals with I/DD, among others, is now among the largest FQHC systems in the nation with a focus on this population. Other vulnerable populations can benefit from a strategic

see A Model on page 10

Care Coordination Enhances the Medical Model for Individuals with Substance Abuse Disorder

By Florence Maroney, LMHC,
Kacie Mitterando, BA,
and Patrick Lovaglio, LMSW
WellLife Network

WellLife Network recently launched the Substance Abuse Care Coordination Team, a specialized program within their Long Island Care Management Division, designed to address the needs of the Medicaid Substance Use Disorder (SUD) population. Care Management is a comprehensive person centered intervention designed to bridge the gap in services and ensure continuity of care with the objective of promoting overall health and wellness. However, despite overwhelming evidence supporting the great need, the SUD population often lacks access to this service.

With the growing national awareness of the opioid epidemic, it has become apparent that the law and order approach initiated in 1930 with the Treasury Department's Federal Bureau of Narcotics to the current state of the War on Drugs cannot successfully subside and eliminate the vast concern that we face. According to the CDC, from the years 2000 to 2015, more than half a million people died from drug overdoses in America (Rudd, Seth, David, & Scholl, 2016). On September 21, 2016, FBI Director James Comey acknowledged this position in front of a Georgetown University audience by stating "you can't arrest your way out of any kind of problem (Documentary Screening, 2016)."

The Dislocation Theory of Addiction

The disease model of addiction remains the predominant perspective in understanding substance use disorders. Overall, as illustrated in this model, substance use is a medical ailment, changing the functioning of the brain with the repercussions of behavioral destruction. While it identifies that substance use disorders are progressive and chronic illnesses that affects the brain functioning the same way that diabetes affects the function of the pancreas, the disease model does not account for the environmental impact that Bruce Alexander claims is at the core of addiction. Bruce Alexander, an American journalist and psychologist, describes the dislocation theory as addiction being a direct result of the social stressors and acceptance that each individual is required to experience in the society in which they are currently living. Eventually, the prolonged dislocation that is often experienced can ultimately result in emotional distress, hopelessness, indignity, and eventually, addiction. This theory touches upon the important influence that society and the environment has on all individuals living in all communities in United States (Alexander, 2014).

Our society perceives individual's with substance use disorders through the impact of the War on Drugs. Since its' inception, the War on Drugs has served to perpetuate a stigma that marginalizes these individuals with a moral turpitude labeling them "addicts" pushing them to the fringes of society, isolating those labeled "addict" without holding the community accountable for the social stressors within its' environment (Alexander, 2014). This is where the Dislocation Theory of Addiction is so vital and the view seen through the narrow lens of the Disease Model fails. Often society understands the Disease Model of Addiction as a disruption of willpower or loss of control, therefore creating a perception of a being without autonomy (Buchman, Illes, Reiner, 2010). Once that perception is established it is easy to neglect their humanity and assign a label.

Filling the Gaps
Through Care Coordination

Care coordination attempts to fill the gaps that are unresolved due to different vulnerabilities that many individuals, especially those on Medicaid, experience. Standard examples of a care coordinator's practice include assistance navigating, advocating and collaborating with health care providers, social service agencies and when necessary the criminal justice system, as well as providing linkages to community resources. Care coordinators will often undertake and explore these deeper issues that disenfranchise impoverished individuals such as lack of affordable housing and access to public transportation. In crisis situations, care coordinators are able to assist individuals to the Department of Social Services and wait with them while they receive an emergency housing placement. Additionally, through networking, care management is able to develop relationships with sober housing and other transitional housing entities. This vital relationship assists individuals by providing a more stable environment for those with substance use diagnoses to ensure focus on their recovery while their basic need of safety is being met. While these concrete areas of care management are vital in providing a stable environment, it is in the development of a safe relationship which carries the most gains.

When dissecting the dislocation theory, trauma can be correlated with the causation of addiction in an individual, as well as the effect. With this knowledge, it is important that as care managers we are aware of the effects of trauma and how we can best service our clients through this lens. Trauma-informed practices and interventions are critical to providing service due to the inter-relation of substance use, mental health, and trauma. Research regarding the high level of trauma that is experienced for those seeking substance abuse treatment illustrates the importance of multifaceted care. Additionally, the research emphasizes the importance of compassion, trust building, and high quality relationships in service coordination for trauma informed care (Kirst, Aert, Matheson & Stergiopoulos, 2016).

Trauma-informed practice requires the care coordinator to be knowledgeable of the impacts and influences that previous and prior experiences can have on a person. Since those who have a history of distressing experiences, such as trauma, are linked with a significantly higher level of anxiety, it is vital for a care coordinator to encompass empathy, compassion, and trust. When discussing the medical need for a dentist for someone with a substance abuse diagnoses (Humphris & King, 2011), one of the more meaningful interactions with a client would be to attend their dentist appointment with them as a safe support through what could potentially be a re-traumatizing experience. Not only does this give the client an added security to complete a necessary medical appointment, but it also allows for a sense of peace in a stressful situation, which may not be something that they have ever experienced. This same sense of peace and connection can be illustrated through care coordination work navigating the legal system.

As a result of the War on Drugs many of our clients have been faced with criminal charges. These incidents may be indicative of where the criminal justice system is counterintuitive to the goal of health and wellness promotion or eradicating the epidemic. By attending scheduled court appearances or probation appointments to be an added support system in a stressful situation, care coordination not only serves the role of attempting to fill in the gaps in the system, but poses as the workings of the dislocation theory in real time. The technique that is at play in providing care coordination with substance use disorders is to largely understand the bio-psychosocial stressors outside of the scope of their awareness. It is not the scheduling of the doctors' appointment, or calling the probation officer to give an update that makes care coordination with substance use work, but actually going to the appointment with them.

In the field of substance abuse treatment as well as mental health, many understand the conventional perspective of therapeutic intervention. For instance, the scenario of an individual entering a clinician's office participating in session and actively engaging in treatment works for many individuals who have reached a higher level of functioning to obtain their goals.

A Bridge to Wellness

Care coordination is often the bridge that leads individuals to stable therapeutic intervention. One expectation of a care coordinator is that they are versed in evidenced based practices such as motivational interviewing, behavioral therapies, and crisis intervention. These practices allow for the care coordinator to actively assess a situation in the field to ensure the safety and well-being of the individual.

Primarily, the mobility, flexibility and consistency of the care coordinators allows for a significant and valid therapeutic relationship to be established in motion. By taking a nonjudgmental, unbiased, and supportive approach to interacting with individuals, care coordinators are able to effectively engage and provide psycho-education in the hope that their client might trust the process in conventional treatment in the future. A study published by the American Journal of Public Health discovered that of individuals enrolled in outpatient treatment, those linked to care coordination, in addition to treatment, had longer sobriety time and were less likely to relapse (Shwartz, Baker, Mulvey, & Plough,1997). Alexander referred to the opposite of addiction being connection, in a recent study, thus confirming the validity of community support and correction positively affecting individual's long-term sobriety and psychological function.

One instance of Client B is a testament to this approach. A care coordinator received a call from Client B who stated that he was in distress in a public location and was without medication. The care coordinator was able to meet client in the field and assess safely all mental health symptoms. Once danger was ruled out, the client was sent to an emergency room for psychiatric assessment and client continues to engage with the care coordinator in addition to fulfilling his treatment and legal requirements as a result of the consistency of the relationship. Through this expression of the care coordinator's engagement skills, a relationship was established. It could be argued that in a field where the environment is unstable and there can be no power differential between a care coordinator and a client, the relationship will always be the cornerstone of clients' chances for success in their goals. Client B had no prior consistency with providers in the past due to the nature of his mental illness and substance use.

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The NYSPA Report:
Repeal and Replace Should Not Harm Our Most Vulnerable

By Jeffrey Borenstein, MD
Vice President, New York State
Psychiatric Association (NYSPA)

I am honored to serve as editor of the NYSPA Report and I want to begin by thanking my friend and colleague, Dr. Barry Pearlman. Barry has served as editor of this column since its inception and has provided useful and interesting information since day one.I'm proud to have the opportunity to continue this tradition.

Let me now tell you a bit about me. I am privileged to serve as the Vice President of the New York State Psychiatric Association. I also serve as President and CEO of The Brain & Behavior Research Foundation, the largest private funder of mental health research grants in the world. In addition I am the Editor-in-Chief of the American Psychiatric Association's Psychiatric News, Associate Clinical Professor of Psychiatry at Columbia University College of Physicians and Surgeons and host of the Public Television series "Healthy Minds," a program designed to educate the public and about mental illness, to reduce stigma and prejudice, and to encourage people to seek help and not suffer in silence.

When thinking about vulnerable populations, priority number one is making sure that these people have access to the health care that they need and deserve. This is critical.

As we go to press, Congress is looking at repealing and replacing the Affordable Care Act (otherwise known as the Obamacare). In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) to ensure equal coverage of treatment for mental illness and addiction. This Act required health insurers and group health plans to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care. The Affordable Care Act further expands the MHPAEA's requirements by ensuring that qualified plans offered on the Health Insurance Marketplace cover a list of Essential Health Benefits which include mental health and substance use disorders. The potential repeal and replacement of this Act directly affects much of our nation's vulnerable populations who live on Medicaid - the largest payor for mental health and substance use services in the country.

Jeffrey Borenstein, MD

The American Psychiatric Association put out a press release on March 7th noting our deep concern that the replacement for the Affordable Care Act will "negatively impact care for people with mental illness and substance use disorders and urges continued support and expanded access to quality, evidence-based mental health and substance use services."

Discussions on applying significant reforms to the current Affordable Care Act and Medicaid raise the possibility that a large number of people with mental illness will lose some or all of their coverage. It has been estimated by the Congressional Budget Office that 24 million people will lose coverage under the new proposal.

As efforts are made to reform health care, services for people living with mental illness – and their families – must be maintained. The American Psychiatric Association press release offered the following recommendations, which are imperative:

- Maintain the current level of coverage for mental health and substance use disorders in health insurance plans.

- Maintain safeguards in private insurance by specifically prohibiting the following:

    ◦ Denying coverage based upon a pre-existing condition;

    ◦ Establishing lifetime and annual dollar limits on essential health benefits; and

    ◦ Discrimination based upon health status, including history of mental illness or substance abuse.

- Any efforts to restructure Medicaid must ensure sufficient funding for mental health and substance use issues and not shift the cost to states in a way that forces them to tighten eligibility requirements, provider reimbursement, or benefits.

- Ensure full implementation and enforcement of the bipartisan Mental Health Parity and Addiction Equity Act, which calls on insurers to offer coverage for mental health care on par with coverage for any other ailment.

The American Psychiatric Association notes that the replacement bill, the American Healthcare Act, does keep some positive provisions of the Affordable Care Act intact, such as the provision that allows for preexisting conditions and allowing young adults to stay on their parents plan until age 26. However, it is also important to note that this bill would strip away affordable access and Medicaid expansion, two key provisions that are directly related to mental health.

We must strongly advocate on behalf of our most vulnerable people to make sure than any changes to the health care law do not leave people behind. The New York State Psychiatric Association and the American Psychiatric Association will continue to work with other advocacy groups to support policies that will help make sure that our nation's most vulnerable populations have access to quality mental health care.

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Knowledge and assessment skills are essential to effective practice in this capacity. Assessing an individual's safety is a necessity and the care coordinators use of clinical assessment as an orientation allows for the relationship to be fostered. In addition, this allows care managers to have a gauge of an individual's behavioral pattern which can be beneficial with a high risk population. Care coordinators have been able to advocate for clients in emergency situations due to the care coordinator knowing the client's baseline of functioning. This knowledge can only be obtained through the extensive work of establishing a safe space with the client upon initial contact in the field.

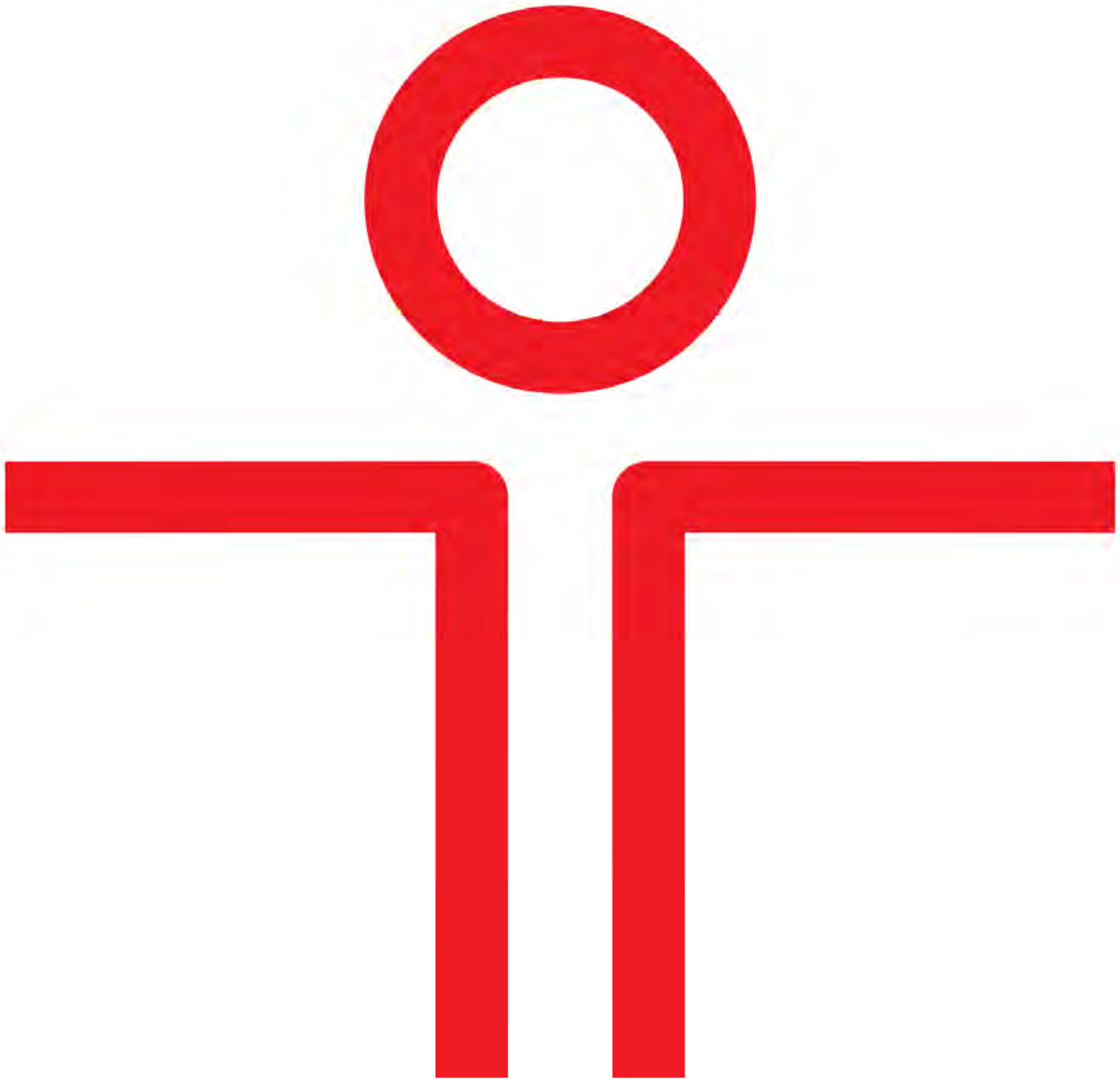
The pairing of the medical model and the dislocation theory of addiction, highlights, for care coordinators, the importance of addressing the biological as well as the societal and environmental factors effecting individuals with addiction disorders.

Florence Maroney, LMHC, and Kacie Mitterando, BA, are Care Coordinators, and Patrick Lovaglio, LMSW, is Program Coordinator of the Substance Abuse Team, at WellLife Network.

A Model from page 7

model of care such as the one we have pursued. Providing access to primary, specialty, behavioral and dental services in our health centers ensures improved access, efficiency and coordination of care for underserved and vulnerable patients. MCHC staff is experienced in working with patients with complex needs and is committed to treating patients and their families and support networks with dignity, professionalism and sensitivity. Our team is always seeking out new partners with whom we can strengthen community-based systems of care for those most in need. Now, more than ever, successful partnerships make and keep healthcare organizations strong and vibrant as we all seek new opportunities and navigate rough waters together.

Marco Damiani is Chief Executive Officer of Metro Community Health Centers, Inc., Chairman of the Alliance for Integrated Care of New York, LLC. and Chair of the Manhattan Developmental Disabilities Council.



Shift in How We Think About Suicide Prevention Needed

Beacon Health Options 2017 White Paper Promotes Zero Suicide Model as Best-In-Class Approach for Suicide Prevention

Staff Writer
Behavioral Health News

Beacon Health Options' (Beacon) latest white paper, "We Need to Talk About Suicide," (http://beaconlens.com/wp-content/uploads/2017/02/Beacon-Zero-Suicide-White-Paper.pdf) promotes the Zero Suicide model as the best approach to shift how we think about and treat suicide. Risk of suicide, or suicidal behavior disorder, is a condition that can be prevented and treated, just like other mental or physical health conditions.

This fundamental shift in thinking affects how we deliver care for people at risk of suicide. Proactive identification of individuals with suicidal behavior disorder and then treating those individuals with evidence-based practices will deliver the most impact. The Zero Suicide framework, developed by the Suicide Prevention Resource Center and the National Action Alliance for Suicide Prevention, offers the best approach for doing so.

Based on Zero Suicide's seven-pronged model, the paper sets out action-oriented recommendations on how healthcare organizations and the workplace can start thinking about suicide differently and how to apply strategies to support this different point of view. With suicide deaths increasing by 24 percent over the past 15 years, the paper is timely in its probe of this pressing topic.

Times Square Billboard

"I think most people, in one way or another, have been affected by suicide," said Beacon Health Options Chief Executive Officer Timothy Murphy. "I know that I have. As the CEO of a managed behavioral health company, I plan to lead our company in rethinking how care is delivered for people at risk of suicide. The evidence is there, and it's our responsibility to base our work in it."

"Through this publication, we are aiming to raise awareness of the prevention and treatability of suicide," said Beacon Health Options Chief Associate Medical Director and author of the white paper, Emma Stanton, M.D. "Some may question the feasibility of a target of 'zero suicides'. We are aiming to make suicide a 'never event' as much as we possibly can."

"Talking about suicide is difficult for everybody, even for clinicians," said David Covington, CEO and President, RI International Inc. and Executive Committee member of the National Action Alliance for Suicide Prevention. "It's a positive step to see Beacon Health Options igniting an important conversation about suicide prevention as a starting point for the role that payers can play in redesigning care."

To learn more about this complex condition and the Zero Suicide framework, Beacon invites you to view its blog post at http://beaconlens.com/the-power-of-zero/. There you can also download the white paper and offer your comments and questions.

"We Need to Talk About Suicide" is the third in a series of thought leadership papers on important mental health and substance use disorder topics. In 2015, Beacon released "Confronting the Crisis of Opioid Addiction," (http://beaconlens.com/the-power-of-zero/) which calls for addressing addiction as a chronic brain disease. Beacon's 2016 paper, "Integration," explored the collaborative care model as the best approach to the integration of physical and behavioral health care.

About Beacon Health Options

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

The National Action Alliance
for Suicide Prevention

The National Action Alliance for Suicide Prevention is the public-private partnership working to advance the National Strategy for Suicide Prevention and make suicide prevention a national priority. The Substance Abuse and Mental Health Services Administration provides funding to EDC (http://www.edc.org/) to operate and manage the Secretariat for the Action Alliance, which was launched in 2010 by former U.S. Health and Human Services Secretary Kathleen Sebelius and former U.S. Defense Secretary Robert Gates. Join the conversation on suicide prevention by following the Action Alliance on Facebook, Twitter, and YouTube. For more information, contact Kimberly Torguson, ktorguson@edc.org.

Suicide Prevention in the Aging

By Thomas R. Grinley, Director,
Office of Consumer & Family Affairs,
New Hampshire Department of Health
and Human Services

By 2040, it is estimated that 82 million Americans will be over the age of 65. Approximately 16 million of them will have mental health issues and/or substance use disorders (SAMHSA, 2017). It is also known that the highest rate of suicide is among those 65 years and older. 90% of those who die by suicide have a mental health issue (American Foundation for Suicide Prevention, 2017). In short, we have a growing problem with suicide among the aging.

In general, the ratio of suicide attempts to completed suicides is 16:1. Among those 65 and older, the ratio is 4:1. The reasons for this are many. The aging population has a greater tendency to use more lethal means such as firearms, hanging, and drowning. Those who are isolated and living on their own are less likely to be discovered in time to thwart the attempt. The physical frailty of the aging also makes it less likely they may survive an attempt.

Likewise, the reasons for attempts and completed suicides are many. Among the factors contributing to this epidemic are the loss of spouses and peers, physical impairments, illness, chronic pain, and isolation. These conditions all tend to be comorbid with depression which is a known risk factor for suicide. As always, stigma plays a role in that it prevents conversation and help seeking.

Depression is frequently undiagnosed but this is particularly true in older adults who may have a host of other issues. Primary Care Physicians (PCP) frequently either miss the signs of depression or chalk it up to a "normal" part of aging. Depression is not a normal part of the aging process and can be treated. It is vital that PCPs and nursing home attendants make screening for depression as routine as taking a blood pressure reading. The Patient Health Questionnaire-9 (PHQ-9) is an easily administered questionnaire of only nine questions that can quickly assess a patient for signs of depression. The National Committee for Quality Assurance (NCQA) recently added use of the PHQ-9 to its Healthcare Effectiveness Data and Information Set (HEDIS). What's more, the PHQ-9 has a specific question that screens for the presence of suicidal ideation. This should also become a matter of routine for visiting nurses who may be an important contact for socially isolated older adults.

There is also the Cornell Scale for Depression in Dementia (CSDD) which relies on an interview with a caregiver as well as the patient. This may be an important consideration where cognitive functioning is an issue in accurate screening. As we see a continued integration of physical and behavioral health, the use of these screening tools will hopefully become more widespread.

Another issue with older adults is subsyndromal depression, that is, depression that does not meet the DSM-5 criteria for major depressive disorder or recurrent depression. Lebowitz (Diagnosis and Treatment of Depression in Late Life: Consensus Statement Update, 1997) tells us that the prevalence of subsyndromal depression may be as high as 50% among medically involved older adults and nursing home patients. These symptoms can last for some time and it is urgent that physicians be able to detect and treat this risk factor.

Lebowitz further asserts that "treatment for depression is safe and effective in patients with complex patterns of comorbidity". Late life depression is readily treatable and can significantly improve both cognitive and physical functioning. In his words, "brief psychotherapy is feasible, acceptable, and effective in short-term depressive symptom reduction in medically ill older persons". Studies support the effectiveness of Cognitive Behavioral Therapy (CBT) and interpersonal therapy. Problem solving, a form of CBT, has shown to be particularly effective. Psychotherapy combined with medication typically shows the best results but psychotherapy as a standalone treatment would work where there are issues with a patient accepting or tolerating medications.

Selective Serotonin Reuptake Inhibitors (SSRIs) and Selective Norepinephrine Reuptake Inhibitors (SNRIs) may have more adverse effects in older adults but they are generally better tolerated than older tricyclic antidepressants. Additionally, with a growing selection of each type to choose from, physicians are able to select the drug and dosage with the lowest adverse effect profile and drug-to-drug interactions. Some are specifically not recommended for use in older adults. To be fair, there are studies suggesting the use of antidepressants in older adults may not be as safe as assumed. As always,

see Suicide Prevention on page 36

Seeking Health Care Services While Undocumented

By J.P., D.J., A.P., and M.R
Clients Served by Services for the UnderServed (S:US)

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

Navigating the health care system can be complex and complicated even for insured individuals with little to no barriers. For families who have parents or children who are undocumented, steering through the health care system can be even more difficult. We are all individuals living in two different shelters for homeless people; one, a family shelter in Brooklyn is home to thirty-six families, and the second, a shelter in the Bronx for twenty families who are victims of domestic violence.

According to the New York City Department of Homeless Services' daily census report, there are over 12,800 families seeking shelter services throughout the five boroughs. In addition to confronting homelessness, we are all facing additional hurdles that impact our ability to access healthcare. These hurdles include economic status, lack of familial supports, language barriers; and vulnerabilities associated with race, ethnicity, or gender. These challenges were a consistent theme that came up while speaking to the difficulties of navigating a health care system that is not made to be available to us.

We discussed three main barriers to healthcare. The first was personal barriers, those that are put in place solely by our status as an immigrant. The second was system-based barriers, which are the obstacles we face that are established by a particular healthcare provider. The last was policy-based barriers, which is the main force against us in receiving regular high quality medical care.

First, we found that there are many personal limitations when we seek medical care for ourselves. For some of us who prefer to communicate in Spanish and French, the positive news is that non-English usage did not present an issue when communicating with providers. Forms were presented in both English and our preferred language, and there was always a staff member who could communicate with us. Overall, even if a staff member could not speak with us, there was access to a translation service. However, this communication issue has caused some of us to hesitate when asking questions or when seeking additional clarity, specifically if a translation service was provided.

There is clearly a fear of discrimination for some of us when seeking medical services. While these fears largely never came to fruition, the dread of the possibility was enough for some of us to not seek care. At every level of service, from the front desk staff member who takes our information to the doctor or medical professional that provides us care, there were questions of status, and in our current political climate, the fear is greater than it used to be.

The financial limitation of seeking medical care for ourselves and for our children, specifically when uninsured, is very real. With the cost of co-pays and prescriptions high, many of us had to admit to foregoing doctor appointments and/or seeking emergency medical care more than once. One member of our group, Mary*, 32, stated that she used to frequent a health clinic that had a sliding scale payment plan. It was there that she found out she had a significant health issue that required weekly physical therapy. The clinic could provide those services to her, but the $30 a week became too burdensome to continue. Mary was told she needed to see a specialist for this health issue and was able to be provided with an affordable appointment. She was told by the specialist at the clinic that she needed surgery, but the specialist stated that due to the cost, the clinic could not provide her with the necessary procedure. If she wanted to follow through on her medical needs, she would have to do so out of her own pocket at full cost.

Then, there are system-based limitations - barriers put in place by the healthcare providers that burden our access to care. Some of these burdens are financial. Many of us have received large bills after being told that we would not be charged. Others have felt discriminated against based on the nature of our requests. Some felt judged for seeking mental health care or substance abuse services.

Another member of our group, Sylvia*, 38, talked about having gone to a hospital for an undisclosed illness and being told there that she would qualify for Medicaid as long as she filled out the paperwork before seeing the doctor. She agreed to multiple tests and procedures and was given sufficient care, all the while believing that Medicaid would cover the cost. It turns out, she was ineligible for Medicaid, and received a bill for $2,900. Of course, this is a bill she is unable to pay. No one was surprised, as these medical bills have been the main barrier to our seeking additional care. There is a basic distrust in a system that uses our undocumented status against us in this way, and it causes us to hesitate in seeking care, and to make sure to put our children's needs over our own.

Most of these barriers put in place by individual providers are due to the well-defined framework of national and state policy that prohibits us, as undocumented immigrants, from affordable and adequate care. This is the third barrier, and the one that informs the other two.

Undocumented immigrants are at high risk of being turned away from hospitals and clinics, and often go to multiple providers before receiving treatment. The issue is that things have to get to the point of being an actual emergency in order to meet the standards. John*, 29, a member of our group, is a good example. He went to the hospital for extreme pain in his abdomen and was first asked if he had insurance, then asked if he had a job. When he answered "no" to both questions, he was turned away. A week later John's appendix ruptured. He returned to the hospital and was now seen because his care could be billed to Emergency Medicaid. Another member of our group, Christine*, 31, had an uninsured child with a high fever who, after being rushed by ambulance to a hospital, was turned away based solely on being uninsured, despite a high fever. Christine took a cab to another hospital that immediately treated her son.

When asked what could be put in place to assist in clearing up these barriers, everyone agreed that consistency across providers is essential. Those without insurance should not have to "shop around" for care. Additionally, many found providers to be uninformed or misinformed about the rights of uninsured clients. Overall, uninsured clients wish the focus was more on the medical care that we need and not the fact that we are undocumented. Things would be very different if it were not for our undocumented status, and that is not a good state of affairs.

*pseudonym

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post-booking mental health assessment, whereby within 24-48 hours after arrest, misdemeanor defendants with mental illness are diverted to community mental health treatment and timely case management. Between 2010 and 2015 "Miami-Dade police have responded to nearly 50,000 calls for service for people in mental-health crises, but have made only 109 arrests, diverting more than 10,000 people to services or safely stabilizing situations without arrest," (White House Fact Sheet, Data Driven Justice Initiative, June 30. 2016: https://www.whitehouse.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle).

Initiatives such as jail diversion and appropriate coordination of services have the potential to improve the lives of vulnerable, chronically-ill individuals with behavioral health issues, and they also will help to save system costs. Between 2010 and 2015 "the jail population (in Miami-Dade County) fell from over 7,000 to just over 4,700, and the county was able to close an entire jail facility, saving of nearly $12 million a year" (White House Fact Sheet, Data Driven Justice Initiative, June 30. 2016: https://www.whitehouse.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle). Research has also shown that overall system costs are lower for adults with serious mental illness who are not arrested; for those on Medicaid in Florida and involved with Florida Department of Children and Families and Florida Department of Law Enforcement, for example, it costs less to administer appropriate mental health treatment than to deal with the cost burden if these individuals were arrested (Van Dorn RA, Desmarais SL, Petrila J, et al. 2013, Psychiatric Services, 64(9), 856-862). In other words, total system costs are less if adults with mental illness are given appropriate mental health treatment services than if they are arrested and required to navigate the criminal justice system.

The need to address the health of vulnerable patient populations who are cycling through the criminal justice system is critical. These high-risk individuals are often homeless, have a chronic mental illness, and are more likely to end up and stay longer in jail than would be the case if they were provided required mental health and social services. At a systems level, this challenge needs to be addressed through a coordinated effort between governmental agencies and criminal justice, and social and behavioral services. At the level of care services delivery, there needs to be an increased awareness of the urgent need to identify these high-risk individuals in a more timely and proactive manner, and to then divert these individuals into appropriate, immediate medical and behavioral health care management.

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

Meeting the Needs of Vulnerable Populations

By Judith Jackson
Chief of Staff, Services for
the UnderServed (S:US)

An Interview with Donna Colonna, S:US CEO and Richard Taylor, Peer Specialist, Blake Men's Shelter

J.J. SUS is an organization that takes its name seriously, and literally: Services for the UnderServed. Put more casually, SUS is dedicated to providing services for people who often get the short end of the stick when it comes to the kinds of assistance and partnership they need to build better lives. Where does "vulnerable" fit in to this equation, does "underserved" equate with "vulnerable?"

D.C. They fit together. Underserved means people and communities are not receiving what they need for health and well-being. S:US, with the purposeful colon is our way of emphasizing the US-our shared common humanity and our philosophical foundation; the organizational lens that promotes and nourishes the notion of community and partnership with those we support.

R.T. SUS is about serving people no matter who they are, and the people we are serving are definitely vulnerable. When we help people who just came out of jail, or people who are 20 years old and living in a shelter because their parents don't want them and don't love them, they are vulnerable. No question about it.

J.J. So how can you help people understand vulnerability? Or what we mean when we talk about vulnerable populations?

D.C. Vulnerable is a big tent word. People are vulnerable for multiple and different reasons. Communities are vulnerable due to complex and interrelated factors. It is useful to categorize vulnerabilities and understand the root issues that contribute to community and personal vulnerabilities so we can develop the right set of supports and interventions. We should not use the term to ascribe personal blame or to disempower people and communities. If you don't have housing, or you don't have access to food, or you experienced trauma - you're vulnerable. If you are elderly and ill and not able to take care of yourself, you are vulnerable. People with disabilities are vulnerable.

J.J. Sticking with our name for a moment, SUS purposely put a colon in its name - to emphasize "us." I suppose that's another way of saying we're all vulnerable at some point in our lives. Do you think that's accurate, and if so, what does that say about the kinds of services and supports we're working to provide?

R.T. All of us are 'us' together. When we're all together, we all have different functions that make up the whole. We is the collective thing. We are men and women that serve men and women. Some people are fortunate, some people are not. We have to help "us" get better because there really is no single individual. I can't – but we can.

J.J. Is it true that SUS has always seen itself as a community of people?

D.C. Yes. We work hard at creating community within S:US. Mutual respect is the foundation. We are all interdependent, and like Richard just said, nobody stands alone. The spirit of community is the basis for nurturing relationships. Promising and evidence based practice are important but respect is an essential ingredient.

J.J. How do you put all this into practice?

R.T. I've been through drug trafficking and addiction and am blessed today to sit on this side and share my experiences.

J.J. So it helps to be a peer?

R.T. No question about it. When I was at my worst, I first had a counselor I knew had no experience living the life. That didn't work for me. I got a new counselor and at first, just because she was a woman, I didn't trust her. I learned I was wrong. Every time I told her stuff I had done, she told me she'd been there, done that. I knew she got it. She's the one who encouraged me to go to school, get CASAC training, get a job as a security guard and learn to be a counselor. She kept encouraging me. Sometimes things happen in your life without your permission. I just wanted to stop using but I didn't know these riches were coming my way.

D.C. You are actually telling us how to harness the power of shared experience and the importance of respect and not judging.

R.T. Yes. Experience is the best teacher. My counselor told me: "You can be whatever you want to be." And at some point, I started believing her. There's something about inspiration from other people who have survived. It shows you it's not impossible.

J.J. How do we know what really works for people?

R.T. Humility has served me well. I tell clients: I'm not better than you – but right now, I'm better off than you. Sometimes that's important to hear. I know my #1 job is to build trust with clients. We can see the surface stuff but it's what's inside that

see Vulnerable Populations on page 34

Helping the Most Vulnerable Among Vulnerable Populations

By Deidre Summers
Program Director
ICL's HCBS Services

Our client, LM felt guilty when she wasn't able to make it to her weekly counseling session. She felt like the therapist she was working with became disappointed with her and that added guilt made her not motivated to go to the next counseling session as well. The therapist wasn't necessarily imposing this disappointment and guilt on LM, but LM's perception colored her view of her relationship with her therapist, thus putting her path to recovery in jeopardy.

HCBS (Home and Community Based Services) helps diffuse such situations. The HCBS counselor went to LM, rather than requiring her to come to them. With a person speaking to her where she was most comfortable, LM was able to express her reluctance about leaving her home and together, the HCBS counselor and LM were able to come up with a plan of action that enabled LM to slowly become more comfortable and empowered to go outside her apartment and eventually be able to walk to her therapist's office.

Because of ICL's HCBS services and the manner in which we've educated Managed Care Organizations and Health Homes on what HCBS can provide, our outreach to the individuals who utilize more insurance dollars than anyone else has helped interrupt the revolving door of people repeatedly entering and leaving hospitals for the same reason. Agencies such as ICL serve the most vulnerable populations, people living in extreme poverty who exhibit both mental health and physical issues—sometimes more than one of each. HCBS focuses its attentions on a population within that group—those who on average, incur more Medicaid spending (it can near $36,000 per person per year) in hospitalizations and emergency room visits.

Deidre Summers

HCBS staff works on the triggers that can set that revolving door into motion. They connect with the people they serve and work with them to identify what causes them to experience an increase in symptoms. With extra support that is provided wherever the individual feels most comfortable, attendance in outpatient programs has improved and rapport with treatment providers has been re-established.

Another client is JD, who needed to reconnect with her therapist and find a way to speak about the barriers to open communication. She was frightened and afraid that she was going to fall back into her substance use habits. When she reached out, the therapist wasn't able to connect with her on the level she needed. JD felt that she was being placated and wasn't making the connection she needed. She was ready to step away from her treatment, but instead she reached out to HCBS. Staff worked with both JD and her therapist and provided an intermediary who was able to convey the concerns to JD's therapists. Their relationship improved, so much so that JD was able to start sharing positive experiences as well as talk about her challenges. HCBS services aim to be holistic, looking at each individual from all aspects of the person's life. ICL makes sure individuals utilizing HCBS services have all the appropriate care lined up in their corner—from case manager and peer counselor to social worker and psychiatrist. Everyone is focused on supporting them on their road to recovery and living a successful life.

HCBS does more than offer counseling. Staff looks beyond behavioral health issues and focuses on what steps are needed for someone to become an active member within their chosen community, how to reconnect with family and friends, and ways to move ahead in life. Staff talks about employment service, education opportunities, wellness and healthy living, medication management, socialization skills, self-care, and much more.

HCBS services are flexible, changing according to an individual's needs. Services address each person's anxieties, mental health issues, physical complaints, and more. The care given is person-centered and goal-oriented, and each goal achieved is celebrated. Since ICL started its HCBS services, enrolled consumers have been receptive, motivated to improve their quality of life as well as self-determined and self-directed. Staff has helped mend strained family relations—so much so that family members have been able to step up to help someone avoid a hospital admission. Clients report better medication management and adherence and treaters report more attendance at regularly scheduled sessions.

By focusing on the most vulnerable within an already overwhelmed population, HCBS has started to slow the revolving door of readmissions into ERs and hospitals and turn the tide of *overspending Medicaid dollars.*

Co-Chairs from page 1

includes staff training and development, and conference presentations and planning. She participates in various national, state, and local boards. Ms. Pantin has extensive knowledge of program development and services, as well as budget management. Most recently, Ms. Pantin served as the COO of Palladia Inc., a not-for-profit agency in New York City. At Palladia, she directed program and operational services, which collectively serviced approximately 17,500 clients per year; a staff of 470 employees, and an annual budget of $45 million. As a key member of the leadership team, Ms. Pantin was tasked with influencing systematic changes. She campaigned key agency initiatives; Outpatient Substance Abuse Services and Mental Health Services, Quality Improvement processes - namely the NIATx (Network for the Improvement of Addiction Services) process, and the use of Data Driven Management. Ms. Pantin has been a driving force in educating her team, and staff in Health Care Reform. She brings to VIP her exceptional human services management experience and command of the critical policy issues of our times.

Robert H. Ring, PhD, recipient of the Beacon of Hope Award for Advancing Autism Science at the 2015 *Autism Spectrum News Leadership Awards Reception*, is a seasoned R&D leader with 16 years of experience spanning executive and technical leadership roles in the pharmaceutical industry, non-profit science foundations and venture philanthropy funds.

Ring most recently served as the Chief Science Officer of Autism Speaks (AS), a global science and advocacy non-profit celebrating over $300M in awarded R&D funding targeting improving treatment, diagnosis and technological innovations for individuals with autism. Among Ring's accomplishments at AS include the launch of an unprecedented genetics data-basing collaboration with Google called MSSNG (www.mss.ng), the establishment of the annual Autism Investment Conference, and the founding of DELSIA LLC, an innovative venture philanthropy arm of AS supporting newcos and entrepreneurial innovation across the autism space.

Prior to his tenure at AS, Ring served on the executive leadership team of Pfizer's Neuroscience Unit, and was the director of big pharma's first dedicated research program focused solely on developing first-in-disease medicines for autism and closely related neurodevelopmental disorders, including rare genetic syndromes such as Fragile X, Rett, Tuberous Sclerosis and Phelan McDermid. Ring also served on the steering committee for Pfizer's Asia Strategic Alliance for external R&D.

Appointed by HHS Secretary Burwell in 2015, Ring serves as a public member on the Interagency Autism Coordinating Committee (IACC), a federal advisory committee that coordinates all efforts within the Department of Health and Human Services (HHS) concerning autism spectrum disorder.

Ira H. Minot, LMSW, Founder and Executive Director of MHNE stated, "Our *Leadership Awards Reception* this June will celebrate our 18th year providing vital behavioral health and autism education to the community. We are very honored to have this opportunity to pay tribute to four outstanding leaders of community and hope everyone will come out in support of their lifetimes of achievement."

Mental Health News Education, Inc. (MHNE), founded in 1999, is the publisher of two award-winning print publications: *Behavioral Health News* and *Autism Spectrum News*. Both quarterly publications provide essential information, education, advocacy, and a roadmap to community resources for individuals and families coping with mental illness, autism spectrum disorders, and substance use disorder issues. To learn more visit www.mhnews.org or www.mhnews-autism.org.

Tickets are still available for MHNE's June 29th event. Tickets, Sponsorships, and Journal Ads may be reserved online at: www.mhnews.org/AwardsReception.htm.

Please Mark Your Calendar for the Fall Issue of Behavioral Health News
"The Vital Role of Housing in the Recovery Process"
Deadline: July 1, 2017 - Submit Early for Preferred Placement

People Get Better With Us

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

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

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

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

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

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

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Brooklyn, NY 11212
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Policy and Practice: A Discouraging Disconnect

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

Ashley Brody, MPA, CPRP

As soon as I learned the summer edition of Behavioral Health News would address our efforts to meet the needs of vulnerable populations I experienced a rather sudden and dispiriting thought. In so many ways we have failed to satisfactorily address the needs of our most vulnerable citizens despite ostensibly progressive public policies, dedicated advocacy efforts and a genuine commitment to infuse our service systems with recovery-oriented principles and evidenced-based practices. We are considerably better off than we were a couple of decades ago to be sure. Regressive institutional modes of care have been largely replaced with community-based alternatives that offer individuals with serious behavioral health conditions opportunities to reside and receive services in settings of their choosing. When viewed from afar our efforts appear to have delivered on many of their promises. But this perspective obscures many failures at a granular level that are bound to worsen in the absence of concerted corrective measures.

A prominent example of this trend concerns a court action advocates brought in support of adult home residents several years ago. This action followed a New York Times investigation that exposed squalid living conditions and widespread neglect within privately operated adult care facilities, many of which served as little more than warehouses for individuals with serious mental illness and other disabling conditions (Levy, 2002). The existence of such facilities and their abysmal failure to provide even a modicum of dignity for their residents was a poorly kept secret within our service system. They were ushered in during the deinstitutionalization movement of decades past and offered "community-based" alternatives for former patients of state-operated psychiatric centers and other institutional care settings. In short, they enabled the state to fulfill its aims so it is unsurprising they operated unencumbered by rigorous regulatory oversight for many years.

The Times exposé elicited predictable proclamations of outrage from policymakers and the enactment of certain practices designed to protect adult home residents. These included the introduction of independent care management services into select facilities and a prohibition on referrals of adults with serious behavioral health conditions to others. Advocates also secured a court settlement on behalf of a class of aggrieved adult home residents that required the state to allocate funding for the provision of integrated residential accommodations for individuals who fulfilled certain criteria. This settlement was largely consistent with the requirements of the Americans with Disabilities Act (ADA) and findings of the U.S. Supreme Court in Olmstead v. L.C., landmark achievements in the recovery movement that enshrined the rights of individuals with disabilities to reside in the least restrictive settings practicable. Progress was clearly at hand.

Fast forward to 2017. Of the estimated 5,000 members of the aforementioned settlement class approximately 475 have received alternative housing in integrated settings (New York Association of Psychiatric Rehabilitation Services, 2017). In other words, this settlement has achieved a 9% success rate. Sadly, this is no more surprising to many than were the findings of the Times investigation. Supportive housing providers, care managers, behavioral health service professionals and other allied stakeholders can easily enumerate the obstacles to implementation of this settlement. Many individuals who reside in adult homes experience chronic and comorbid primary (medical) and behavioral health conditions for which intensive support services are needed to forestall inpatient hospitalization or transfer to similarly restrictive facilities. Services of such scope and intensity cannot be easily provided within fully integrated settings due to a scarcity of available resources. Current state guidelines for operators of scattered site supportive housing programs (i.e., independent housing with rental subsidies and basic support services) require nothing more than monthly meetings with program residents and quarterly visits to their apartments. Individuals emerging from institutional care settings are often accustomed to continuous support, and although the quality of this support varies considerably among facilities its abrupt removal can jeopardize the stability of the most resilient recipients.

Moreover, state funding for nonprofit supportive housing operators fails to compensate them for the full cost to provide housing and rehabilitative services for their residents. A recent analysis by the Association for Community Living (ACL), a membership organization that represents a broad coalition of supportive housing and behavioral health service providers throughout New York State, determined housing providers experience significant budgetary shortfalls that impede the fulfillment of their missions. State allocations do not properly account for rapidly rising rental and personnel costs nor do they reflect other expenses housing providers regularly incur. Consequently, operators of Office of Mental Health (OMH) -funded scattered site supportive housing programs experience a collective statewide budgetary shortfall of $65 million per year (Association for Community Living, 2017). Tragically, this comes at a time when these providers serve individuals with extensive histories of institutionalization in adult homes, state-operated psychiatric facilities and other restrictive settings, many of whom require considerably more assistance than housing operators were equipped to provide even before an era of budget austerity.

Some observers might object to this characterization on the grounds other community support services are available to formerly institutionalized individuals that may supplement and enhance the impact of supportive housing providers. New York surely boasts a relative wealth of community-based services for individuals with disabilities and they deserve considerable credit for facilitating their beneficiaries' recovery. Upon closer inspection, however, we find many of these services are plagued with similarly onerous resource constraints that limit their impact on the most vulnerable beneficiaries. For example, Health Homes were established in New York State in 2012 in order to promote service integration and care coordination among individuals with complex medical conditions. This innovation has surely achieved some success insofar as it has delivered care management services to select recipients who were previously ineligible for it. For adults with serious behavioral health concerns, however, the elimination of Targeted Case Management (TCM), a modality that offered a robust level of service coordination by care managers who maintained relatively modest caseloads, and its replacement with a Health Home model of care management has not been an altogether welcome development. Recipients of TCM services who had been accustomed to weekly or biweekly meetings with their care managers are now limited to monthly visits or periodic telephone calls under the Health Home model. For many residents of adult homes and other institutional care settings who require considerable support during their transition to independence such a "light touch" to engagement is grossly insufficient.

As sympathetic policymakers strive to advance the cause of recovery and to promote our recipients' integration into less restrictive settings they would do well to acknowledge longstanding discrepancies between their legislative intent and its actual implementation. The examples

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Proceeds from this event will go towards expanding and developing the nonprofit educational mission of Mental Health News Education, Inc., publisher of Autism Spectrum News and Behavioral Health News, via print and online media to reduce stigma, promote awareness and disseminate evidence-based information that will serve to improve the lives of individuals with mental illness, substance use disorders and autism spectrum disorders, their families, and the provider community that serves them.

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Elder Abuse: A Challenge to the Mental Health System

By Michael B. Friedman, MSW
and Kerri Tavzel, LCSW

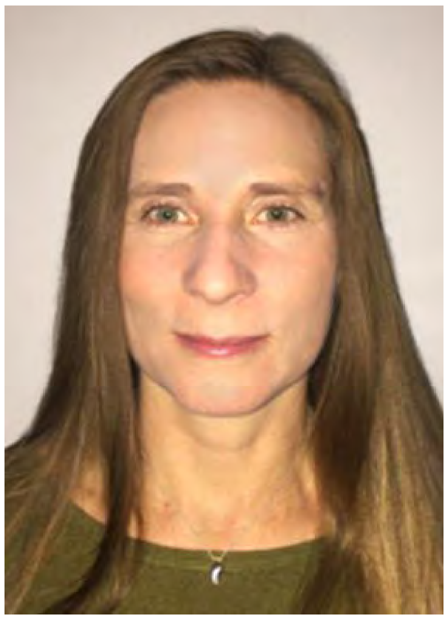
As the elder boom gathers momentum over the next 25 years, there will be more and more victims of elder abuse.

America's mental health system is not prepared to respond appropriately. It is not prepared to effectively engage victims, who are often suspicious of offers of help; it is not prepared to meet people away from mental health facilities, in their homes or an ordinary community setting; it is not prepared to respond rapidly or to give people the amount of time they need when they are in crisis even though delayed help is often dangerous; and health, mental health, and social service professionals are usually not trained to provide accurate diagnoses and effective treatment of victims of elder abuse.

Let us rush to say that being a victim and putting up with abuse are not caused by mental illness. People often remain in abusive relationships because they are very frightened of doing something to protect themselves. Where will they live? How will they manage? Will they be alone? Will they be safe? What will happen to their abuser? Older adults especially are often ambivalent about their abuser, who may be a spouse/partner of many years, a loved son or daughter, a niece or nephew, a grandson or granddaughter for whom the victim feels responsible.

Michael B. Friedman, LMSW

Why then does the mental health system have an important role in our society's response to elder abuse? Simply stated, people with mental illness or developmental disabilities are at high risk of being victims. In addition, they are likely to suffer emotional consequences that are so serious that they contribute to premature disability and death .[1]



Kerri Tavzel, LCSW

Background

Over the next quarter century, the population of adults 65 or older will double. More importantly, it will increase from about 14% of the population to 20% of the population, roughly equal to the population of children under the age of 18.[2] The fastest growing portion of the older population are those over 85, who are more likely to be disabled and in need of help to manage day-to-day. [3]

The National Elder Mistreatment Study estimates that about 10% of older adults in The United States experience mistreatment—roughly 5% neglect, 4.5% emotional abuse, 1.5% emotional abuse, and .5% sexual abuse with some overlap. In addition, about 5% experience financial exploitation.[4] A meta-analysis of international studies of elder abuse estimates that nearly 16% of older adults experience mistreatment—over 11.5% psychological, nearly 7% financial, over 4% neglect, over 2.5% physical, and nearly 1% sexual also with some overlap. [5]

According to the *Elder Justice Roadmap*, about 2/3 of victims are women. Only 1 in every 24 cases is reported to authorities. Elder abuse triples risk of premature death and disability. And financial abuse results in significant societal economic losses because victims fall into poverty and need public assistance to survive. [6]

Treatment of Victims of Elder Abuse

Although some elder abuse cases can be handled routinely by medical personnel, Adult Protective Services (APS), and the criminal justice system, a great many cases are very difficult to handle. Medical personnel often can do no more than

see Elder Abuse on page 32

Suicide Prevention as a Core Responsibility

By Sarah A. Bernes, MPH, LMSW
Director of Suicide Prevention,
The Institute for Family Health

Every year more than 40,000 Americans die from suicide and suicide is the tenth leading cause of death in the United States (CDC, 2016). Over eighty percent of people who die from suicide have contact with health and behavioral health care providers in the year prior to their death and almost half saw a health care provider in the month before death (B. Ahmedani et al, Health Care Contacts in the Year before Suicide Death, 2014). The proximity of death by suicide to health care visits makes health and behavioral health care settings ideal for intervention.

Historically suicide prevention has been seen as the responsibility of inpatient psychiatric services or community-based prevention programs. In recent years this has begun to change. Suicide prevention has been redefined and re-conceptualized as an essential obligation of health care. The 2012 National Strategy for Suicide Prevention specifically calls for suicide prevention as a core component of health care services, with objectives pertaining to delivering care in the most collaborative, least restrictive settings; providing continuity of care for suicidal patients seen in emergency departments and inpatient settings; and training clinical providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk. Last year, The Joint Commission Released Sentinel Event Alert 56: Detecting and Treating Suicide in ALL Settings (emphasis added). This alert aims to "assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation." New York State's Suicide Prevention Plan calls for statewide implementation of an approach called Zero Suicide, including all seven elements of the Zero Suicide model:

1. Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people receiving care.

2. Develop a competent, confident, and caring workforce with suicide-specific expertise.

Sarah A. Bernes, MPH, LMSW

3. Systematically identify and assess suicide risk among people receiving care.

4. Ensure every person has an individualized pathway of care, including safety planning with lethal means reduction.

5. Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.

6. Provide continuous contact and support, especially after acute care.

7. Apply a data-driven quality improvement approach to inform system changes.

Zero Suicide is a comprehensive approach to suicide prevention in health care where the entire system shares the challenge and responsibility of caring for suicidal patients instead of relying on the heroic efforts of crisis staff and individual mental health clinicians. Zero Suicide is an aspiration, a rallying cry, and the only acceptable goal.

The Institute for Family Health, a Federally Qualified Health Center network in New York State, was an early adopter of the Zero Suicide framework and we have committed to continuously improving care for our suicidal patients. Integral to our Zero Suicide efforts is leveraging strategic elements of electronic health record (EHR) design to promote population management principles with regards to managing suicide risk across our system. This has included adding suicide risk to the problem list where it is visible alongside other health conditions and implementing a prominent visual indicator in the patient's chart to alert all of the patient's providers of the risk. This provides unrestricted access to suicide risk information in the EHR so that meaningful assessment and care for suicidal patients can occur with any health care provider, including non-behavioral health specialists (e.g. primary care, nutritionists, care navigators).

Zero Suicide will, by necessity, look different in every organization that takes up the charge. The Zero Suicide framework is flexible and applicable to various health and behavioral health care settings. For example, the framework does not dictate how staff should be trained or how suicide risk should be identified among patients, but instead allows each organization to address elements of the model according to the unique needs and constraints of their service delivery settings. What must remain constant across all organizations is the unwavering commitment to progress towards Zero Suicide among patients receiving care.

During my graduate training I was fortunate enough to attend a lecture by D.A. Henderson, who led the global eradication of smallpox for the World Health Organization. After the lecture, a classmate asked Dr. Henderson what factor contributed most to the eradication. He could have cited the absence of a non-human vector, assuring that if the virus could be stopped in humans it would not continue in another insect or animal, or the heat-stable vaccine, which allowed it to be easily transported and administered across the globe. But he did not. Dr. Henderson credited the eradication of smallpox to a small group of dedicated staff who didn't know that it couldn't be done. What can this teach us about suicide prevention? How would we design our health care systems differently if we didn't know that suicide couldn't be eradicated?

To improve suicide care, community mental health centers first must take an honest appraisal of how they currently care for suicidal patients. Does your organization's staff truly believe that suicide is preventable? Has leadership made a commitment to keeping patients alive and helping them create lives worth living? Do you keep track of patients at risk for suicide so they do not fall through the many cracks within and between health care organizations?

Visit www.zerosuicide.com for more information about the Zero Suicide framework, a self-study to assess your organization's current provision of care to patient at risk for suicide, and implementation examples from other organizations.

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federally subsidized community based services and supports, may soon elude us. (Under the provisions of the ACA "more than half of the 730,000 federal and state prisoners reentering the community each year are estimated to have been eligible for either Medicaid funded services or federal subsidization of their purchase of vitally important health coverage"1).

Dr. Falconer also gets it right in her identification of those individuals who are most likely to be incarcerated and the behavioral, medical, and social determinants of care that drive their inevitable relapse, recidivism and a tenfold increase in the likelihood of their death by overdose following an unplanned, and uncoordinated release This lack of post-release treatment, case management and social supports, including housing, are the major contributors to our unconscionable levels of recidivism, just as they are the main factors that drive unacceptably high rates of preventable hospital readmissions to general care beds, invariably by patients with one or more behavioral health diagnoses.

So, I suggest: (1) The best re-entry is no -entry. To that end, it is critically important to identify and divert those at greatest risk to responsive care management and treatment alternatives to incarceration. (2) Law enforcement and the courts need assured access to alternative dispositions that will obviate their current reliance on lock ups and overcrowded ER's. (3) Even in the best resourced service environments, it takes exceptional community providers, well linked to essential cross system supports and well supported by aggressive and effective case management, to produce the results we seek. (4) Many offenders living with mental illnesses have committed an offense that is often a manifestation of their illness rather than the result of criminal intent. (5) Our ability to translate that understanding into a clinical direction of trauma-informed, person-centered care is essential. (6) Leading edge analytic tools are required to optimally inform our targeted strategies and sharpen the focus of our clinical models. (7) Value based purchasing must support and ensure the viability of our specially capacitated community partners as they drive the systems reforms leading to the desired outcomes of community stabilization and recovery. (8) Not generally embedded in the comfort zone of most health care payers or providers, these required cross systems challenges are indeed daunting. But know that they reflect the emerging expectations of Federal, State and local leadership that call for: Diversion, Jail In-Reach Service Planning, Data Sharing, Care Coordination and Re-Entry strategies replete with systems oversight and accountability.

In closing, let us continue to honor Dorothea Dix, but avoid the temptation of

see Commentary on page 31

We Must Advocate for Older Adults with Behavioral Health Conditions

By Kimberly Williams, MSSW,
Lisa Furst, LMSW, MPH,
and Michael Friedman, LMSW

As of this writing, the healthcare and behavioral health systems are facing unprecedented threats from proposed legislation to significantly roll back the gains achieved through the Affordable Care Act (ACA). Medicaid is also under threat, as the current legislative proposal attempts to alter its funding structure to block grants or "per capita" funding to the states without the proportional federal funding match. The proposed changes not only threaten to severely restrict, if not eliminate, some people's ability to access behavioral health care, and are particularly likely to affect older adults. For example, while the ACA requires behavioral health care to be an "essential" covered service by all insurance carriers, such a requirement is not guaranteed under the current legislative proposal. In addition, "younger" older adults (for example, those aged 55-64 who are not yet eligible for Medicare) who may have gained behavioral health care either by becoming eligible for Medicaid under the ACA, or who purchased insurance through a state or the federal exchange, may not be able to access care if they are unable to afford to buy insurance with the proposed tax credits, which are significantly less generous than ACA subsidies. Inability to access care may also result if older adults live in states that have to curtail eligibility for Medicaid or reduce covered benefits as they struggle under decreased overall funding for services.

Kimberly Williams, MSSW

While these proposed system changes have been widely acknowledged as generally disastrous for many, including older adults, there has been relatively little acknowledgement of the particular risks to older adults with behavioral health needs. This is problematic, as the population of older adults continues to expand rapidly, with the number of older adults who have a diagnosable psychiatric disorder expected to reach 14 million by 2030. Despite this, however, older adults with behavioral health challenges continue to be an afterthought for policy makers and for mainstream providers. Going forward, it will be especially important for behavioral health advocates to understand the unique challenges of older adults who need behavioral health services and supports to ensure that they are not left behind.

This article provides a brief overview of the needs of this population in order to illustrate the necessity of coordinated, integrated services that address the dynamic interplay between physical and behavioral health in older age. This group of individuals is heterogeneous, ranging from people living with long-standing psychiatric disabilities to those who have acquired symptoms of behavioral health challenges in later life. Regardless of the age of acquisition or degree of functional disability, most older adults with behavioral health issues also need to manage co-morbid physical health problems and require services and supports that reflect their physical, psychological, developmental and social needs.

Physical Needs

Older adults with chronic physical and mental disorders have different needs and challenges than younger populations with complex conditions. Normal physical age-related changes, such as sleep problems, declines in vision and/or hearing and/or mobility may require older adults to modify their activities and/or environment to adapt to these changes. Modest environmental modifications may be needed to help older adults remain at home independently. Vision, cognitive, and physical changes increase the risk of falls among older adults, which are often due to hazards that are easy to overlook. The risk of medical illnesses, particularly chronic conditions, increases with age, therefore requiring effective and integrated medical management. Good nutrition and exercise become particularly important for older adults to reduce their risk of chronic disease, lower their body weight, and improve their overall quality of life.

Psychological Needs

Dementia, which doubles every five years after the age of 60, , leads to memory loss as well as loss of executive and other functioning that interferes with the ability to manage activities of daily living. In addition, it is important to note that

see Older Adults on page 34

Animal Assisted Therapy for Vulnerable Youth

By Andrew Malekoff, LCSW, CASAC
Executive Director and CEO, North Shore Child & Family Guidance Center

For almost two decades, North Shore Child & Family Guidance Center has been utilizing Animal Assisted Therapy (AAT) in outpatient mental health work with youths and their families, working in partnership with local canine and equine organizations. An adjunct to traditional therapy, AAT relies on the human-animal bond in goal-directed interventions as an essential part of the therapeutic work. According to leading AAT expert Cynthia Chandler some of the reasons to include animals in therapy are: (1) Consumers may be more motivated to attend and participate in therapy because of a desire to spend time with the therapy pet; (2) Consumers may receive healing nurturance and affection through physical contact with the therapy pet; (3) Consumers may experience genuine acceptance by the therapy pet; and (4) In many instances . . . consumers may be able to perform activities and achieve goals that would not otherwise be possible without the assistance of a therapy pet.

Following is an illustration of animal assisted group work using a therapy dog to build social competencies and self confidence in group members.

Andrew Malekoff, LCSW, CASAC

In a group that was composed of early adolescents who were identified as painfully shy or socially awkward, the group members were all drawn to the therapy dog Elvis, who was introduced as a new "group member."

Everyone wanted to pet Elvis, a Basset Hound, and feed him treats. The norm in groups like this is to earn time with Elvis by taking steps forward in skill development. For example, speaking up and talking about one's experiences in the previous week could earn time with Elvis. In addition, the work is metaphorical in the sense that the group members are directed to notice things about Elvis. For example, one group member says, "Elvis looks a little shy." To which the worker asks, "How can you tell?" This ignites a process in which members begin to build their powers of observation and reading non-verbal cues, for example.

In animal assisted groups the group worker must work closely with a co-facilitator, the animal handler. The handler is like an interpreter who can teach about his or her dog. For example, "This is how Elvis will show you if he is a little shy and here is how you can approach him." The group members transfer learning by observing and learning about and interacting with the animal. They can then practice without being hit over the head with it by being lectured to. Success comes by noticing the animal or by failing to do so. For example, if an animal shies away, group members learn that maybe he needs some quiet time. In other words, the members discover that there are lessons learned from not having their wishes fulfilled all the time.

Having an animal handler as a co-leader is not very complicated since their role is circumscribed. The handler is an interpreter who loves to talk about the personality of his or her dog and its uniqueness. They can humanize how the dogs speak and keep appropriate boundaries (e.g. not rushing at someone socially). Using dogs are a little easier to arrange for logistically, but there are a growing number of settings that offer equine facilitated therapy, which add another dimension to group work for shy and awkward youths.

According to my North Shore Child & Family Guidance Center colleague social worker Lee Holtzman, Animal Assisted Therapy is a viable alternative to work with children and youths who have a history of trauma. Expanding research in the area of how trauma affects the brain has highlighted the role of adjunct therapies such as yoga and animal assisted therapy, for example, to help people safely regain the ability to feel their bodies and to uncover and release painful memories stored in the body.

Finally, two guidelines to keep in mind when planning to use animals are: (1) Seek parental permission. This is particularly relevant to culturally sensitive practice. There are certain cultures that may have strong attitudes towards human-animal interaction that might preclude practice with animals. In any case, engaging parents in the process is a must; and (2) Screen for proper credentialing and training. Carefully screen animals and handlers to be sure that they are properly trained and credentialed.

Andrew Malekoff may be reached at: amalekoff@northshorechildguidance.org. This article is adapted from his textbook Group Work with Adolescents: Principles and Practice, 3rd Edition, New York: The Guilford Press.

Why Trauma Informed Care with Vulnerable Populations?

By Darin Samaha, LMSW
Director of Community Services
Schenectady County

A vulnerable population can be described as a group of persons whose range of options is severely limited, who are frequently subjected to coercion in decision making, or who may be compromised in their ability to give informed consent (U.S. National Library of Medicine). There are many populations that fit this definition of a vulnerable population including: those with disabilities (both physical and mental), children, the elderly, individuals with substance abuse problems, those living in poverty and many other groups.

One experience common to all these populations, in fact to human beings in general is trauma. Trauma refers to experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual wellbeing (Substance Abuse and Mental Health Services Administration-SAMHSA Working definition of trauma and principles and guidance for a trauma-informed approach, 2012). As you'll see, going through trauma is not rare.

Let's look at some statistics on trauma. The following are taken from the U.S. Department of Veteran's Affairs National Center for PTSD, 2017 Online: Approximately 6 of every 10 men (or 60%) and 5 of every 10 women (or 50%) experience at least one trauma in their lives. Women are more likely to experience sexual assault and child sexual abuse. Men are more likely to experience accidents, physical assault, combat, disaster, or to witness death or injury.

Here are other facts about trauma and PTSD based on the U.S. population –VA National Center for PTSD, 2017:

- About 7 or 8 out of every 100 people (or 7-8% of the United States population) will have PTSD at some point in their lives. So, the same number of people who have PTSD in a given year is approximately the same as the number of people who reside in the state of New Jersey. A staggering number when you think about it.

- Although about 8 million adults have PTSD during a given year this is only a small portion of those who have gone through a trauma.

- About 10 of every 100 women (or 10%) develop PTSD sometime in their lives compared with about 4 of every 100 men (or 4%).

Here are additional facts about trauma to demonstrate its impact on vulnerable populations. Many people who have substance use disorders have experienced trauma as children or adults (Koenen, Stellman, Sommer, &Stellman, 2008; Ompad et al., 2005) and more than half of women seeking substance abuse treatment report one or more lifetime traumas (Farley, Golding, Young ,Mulligan, & Minkoff, 2004; Najavits et al.,1997).

In the Adverse Childhood Experience Study, Anda and Felitti (2003) found that 21% of a 17,000-person sample drawn from mostly middle class educated adults reported being sexually abused; 26% were physically abused; and 13% lived in a home with domestic violence as a child. 50% to 70% of women in psychiatric hospitals, 40% to 60% of women receiving outpatient mental health services, and 55% to 90% of women with substance abuse disorders report being physically or sexually abused, or both, in their lives (SAMHSA, 2007). In 2011, there were approximately 3.4 million reports of abuse or neglect that covered 6.2 million children (U.S. Department of Health and Human Services, 2011).

When we look at individuals with behavioral health disorders many clients with severe mental disorders meet the criteria for PTSD. Traumatic stress increases the risk for mental illness, and findings suggest that traumatic stress increases the symptom severity of mental illness (Spitzer, Vogel, Barnow, Freyberger& Grabe, 2007).

Without effective intervention, there is evidence of long-term adverse consequences of untreated trauma lasting into adulthood including substance abuse, suicidality, serious mental illness, and long-term physical health factors associated with early death (Felitti, Anda, Nordenberg, Williamson, et al., 1998; Anda, Dong, Brown, et al, 2009).

This evidence clearly demonstrates the need to create trauma informed systems of care and use trauma informed intervention strategies with vulnerable populations that we serve.

To address this problem, in May 2012, SAMHSA convened a group of national experts who identified three key elements of a trauma-informed approach: (1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice (SAMHSA, 2012).

In a working paper SAMHSA (2012) suggests that a trauma-informed approach is guided by 10 principles:

1. Safety: throughout the organization, staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.

2. Trustworthiness and transparency:

see Trauma on page 32

Innovation and Efficacy Modeled at ANDRUS: Meeting a Vulnerable Population Using a Sensory and Body Regulation Approach

By Andrea DeSantis, PT, MSOT, SEP©, PhD, Clinical Psychologist and Physical Therapist, Somatic Experiencing Practitioner©

Dr. Andrea DeSantis

Meeting a Vulnerable Population Where They are At

Some children experience mental and behavioral difficulties that make their daily life a challenge. They struggle to regulate their emotions and cope with a world that isn't always receptive to their reactive behavioral outbursts. At risk children are more vulnerable to anxiety and explosive anger. Their emotions can quickly escalate into a highly distressed state. These heightened reactions alienate them from society and reduce their participation in joyful relationship experiences with their family, school, and community. Use of sensory and body regulation activities facilitate a more optimal state of calm energy and focus, which improves the child's emotional coping tolerance. Imagine an approach that could help these children learn new coping behaviors while they simultaneously experience joy and a sense of confidence. This is what the addition of sensory rooms and sensory/body-based interventions at ANDRUS have aimed to accomplish over the past 4 years. Use of sensory and body regulation interventions directly support the child's body and nervous system. As a result, behaviors improve because the interventions help them regain a calm, alert state. Identifying effective means to manage their stress can be transformative for the child and provide valuable skills and tools that will serve them well and far beyond their ANDRUS experience. We are seeing higher numbers of children in this vulnerable population everyday, and some of the success we've experienced with Sensory and Body Regulation at ANDRUS can be learned from and used as a tool for a more general population.

Benefits of Sensory Rooms and Body Regulation Tools

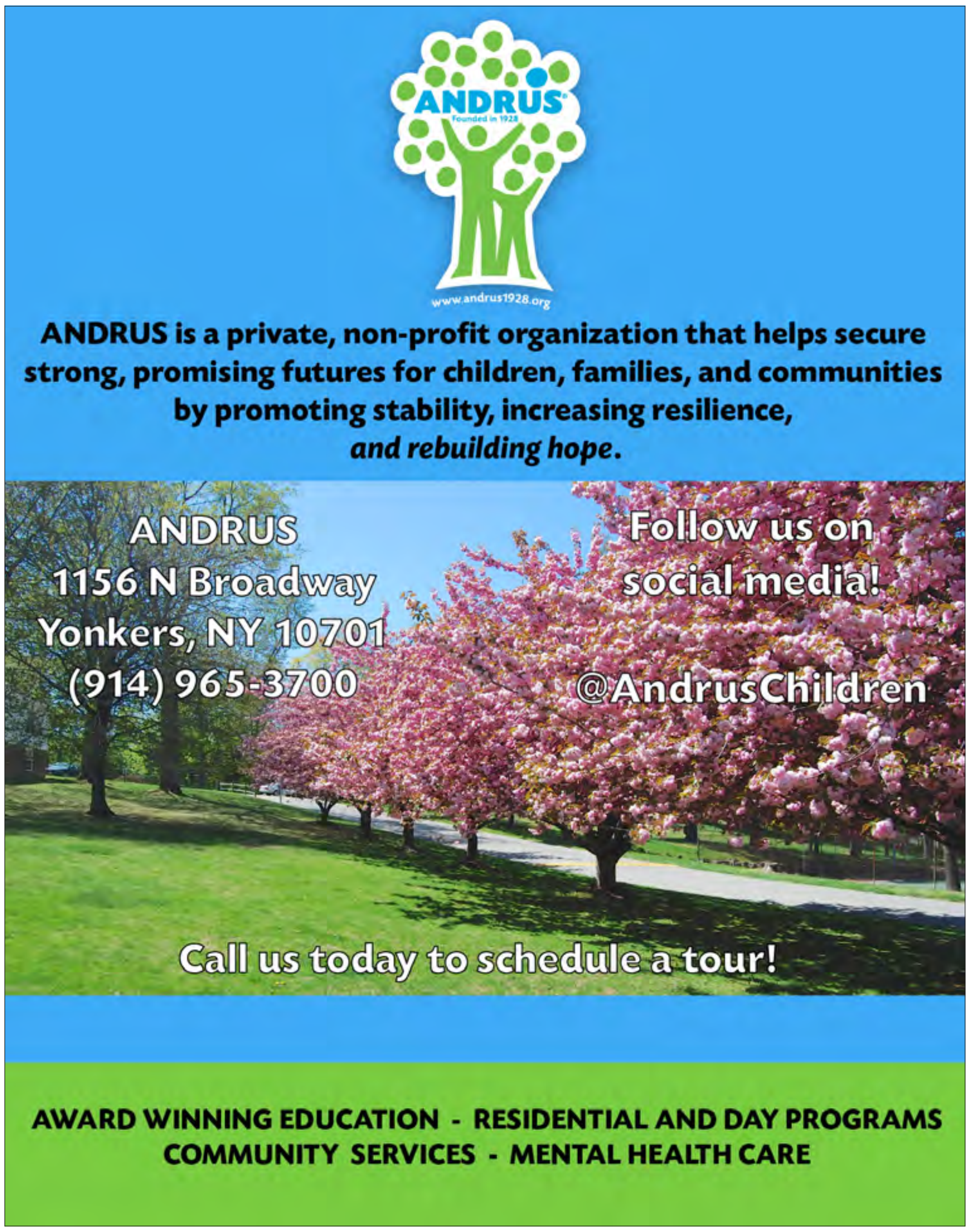
ANDRUS' Orchard School, Residential Sensory Rooms, and body regulation tools are powerful methods to improve emotional and behavioral regulation. Studies by several leaders in the field of therapeutic interventions (e.g., Dan Siegel, Tina Champagne, Jane Koomar, Bessel van der Kolk, Peter Levine, Bruce Perry) document the impact of supporting sensory and body regulation "bottom up" approaches to minimize aggression and stress in individuals who demonstrate autism, attention deficit disorder, trauma, and mood disorders. At ANDRUS our preliminary research shows that children who used our body regulation tools and the sensory room several times per day, showed more than a 50% decrease in incident reports and property damage and drastically improved classroom behavior. One of the most striking aspects about ANDRUS' Sensory Program is that it permeates every level of the child's experience and is truly integrated into the different settings in the school and residential programs. These include dedicated sensory rooms, classroom sensory toolkits, "body breaks" for students and teachers, weekly body regulation groups, family and attachment support, and integration into psychotherapy sessions and our Positive Behavior Intervention program.

Sensory rooms provide a well-padded, safe space where a child can engage in activities to help their brain-body connections. These organizing and calming activities might include use of specialized swings, breathing exercises while swinging in a spandex-material hammock swing, and relaxation in a ball pool. If the child exhibits excess energy build-up from stress and academics, a short break in the sensory room allows the child to safely engage in activities geared toward discharging this energy. For example, children release stress and feel powerful as they run and jump into a pile of large soft pillows. This is often followed by comforting pressure touch while they breathe to bring them to a calm, alert state and ready for school work. Other Sensory Activities might include: activities on large inflated therapy balls, balance challenges, weighted blankets and pillows, and cocoon-type body socks. These sensory and movement activities send powerful signals to enhance the brain-body connections. In response, the "ramped up" emotional brain centers can more rapidly settle down and help a child be more receptive to positive behavior interventions. Engaging in these activities help the child's brain/body connections from the "bottom up" so they can verbally process their feelings more effectively which is critical in developing self-control. The playful rhythmic movements they experience allow them to positively interact with peers and adults.

In addition to the use of sensory rooms, ANDRUS' classrooms and cottages have an array of tools that help children maintain their level of alertness and attention regulation during learning (e.g., scented lotions, balance discs, stretch fidgets, weighted stuffed animals). Teachers and students engage in 3 minute "Body Breaks" several times per day to proactively facilitate a calm, focused state with mindful awareness. The activities are a compilation of methods developed through Dr. DeSantis' background in Sensory Integration and Somatic Experiencing©. These sensory and motor activities promote self-awareness to help children learn how to shift their body and emotional states. Even use of these tools and the sensory room before or during a psychotherapy session can better produce a calm, alert state whereby the child can more easily process emotions in their body.

ANDRUS staff members are encouraged to use yoga stretches, breathing, rhythmic arm/leg movements, or a soft squeeze ball throughout their day. In our over stimulating world, filled with fast paced technology and social media, we can all benefit from engaging in frequent activities throughout the day that support our body, mind and physical health. One of the goals at ANDRUS is to weave this model into the daily lives of our children and staff in order to reap the benefits of Sensory and Body Regulation. For children and families who experience mental and behavioral difficulties or have trouble regulating emotion, experimenting with these tools can provide great support. In fact, we all experience times when we need to refocus or return to a calm state, and practicing some Sensory and Body Regulation techniques can be a great start.

About the author: Dr. Andrea DeSantis has worked with families and children for over 25 years. She brings her unique multidisciplinary background in psychology, physical and occupational therapy to support complex developmental difficulties. She also has a private practice in Pleasantville seeing children, families, and adults with a variety of learning, emotional, and behavioral challenges.



When the Therapist Comes to You: A Model Home Visiting Program for Seniors

By Nancy Harvey, LMSW
Chief Executive Officer
Service Program for Older People
SPOP

Sarah is 95 years old and is determined to live out her days in the small New York City apartment she has called home for over 60 years. Her walls are covered with four generations of family photographs, and her shelves are filled with books and mementos of her work as a teacher and travels with her husband and family.

Sarah is able to remain in her home thanks to a network of formal and informal services available in New York City, including caregivers, neighborhood shops that deliver groceries, a friendly visiting program through her synagogue, assistance from her building staff, and daily calls and visits from her adult children who live nearby. She had considered a move to a nursing home, but that she has found a way to age in place successfully with the support of her family and other resources.

In nice weather Sarah goes out in her wheelchair, but there is one place she never goes: the doctor's office. Six years ago her physician encouraged her to enroll in Mount Sinai Visiting Doctors, a home-based program that makes over 6,000 medical visits to homebound New Yorkers each year. Sarah receives all of her medical care at home -- and she hopes that she never sees the inside of a medical office or hospital again. She appreciates and enjoys the visits from the nurse, doctor or social worker, which often brighten up a long day.

Nancy Harvey, LMSW

Last winter, when Sarah became anxious and increasingly impatient with her caregivers, her Mount Sinai social worker referred her to Service Program for Older People (SPOP), a behavioral health agency for adults age 55 and older, which works in partnership with the Mount Sinai team. Sarah enrolled for behavioral health treatment and now receives weekly visits from her therapist that focus on mindfulness, relaxation techniques and strategies to manage her relationships.

SPOP is the region's only agency that is exclusively dedicated to meeting the behavioral health needs of older adults. The agency operates a clinic, which serves over 600 adults each year, as well as free Bereavement Support, Training & Education, Information and Referral services, and New York State's only all-geriatric PROS/Personalized Recovery Oriented Services program for those with severe mental illness. SPOP has provided home visits for 45 years and has demonstrated that the home visit is effective in improving the emotional well-being and overall health of the client – while alleviating social isolation and providing some respite for caregivers. About one-third of all SPOP clinic appointments are conducted in the home, and we are the region's leading provider of in-home geriatric behavioral health care.

The partnership between SPOP and Mount Sinai Visiting Doctors addresses the comprehensive health needs of some of New York City's most frail and vulnerable seniors. In virtually any other setting, this patient population would require nursing home care. The partnership enables seniors to age in place, reduces demand on the health care system, and has also shown that even the most fragile patients are able to benefit from behavioral health services and obtain a better quality of life.

We are proud to partner with the Mount Sinai team to support older New Yorkers like Sarah in their wish to age in place, and are especially grateful to our project funders, the Altman Foundation and New York Community Trust. Our partnership has provided therapy to over 80 homebound seniors since its launch 18 months ago, and Mount Sinai Hospital has become a leading source of referrals for the SPOP clinic.

The SPOP therapist and the Mount Sinai Hospital medical team are working together to make certain that Sarah receives coordinated medical and behavioral health care at home. She reports that she is now more comfortable and has gained the tools to manage her anxiety and relationships. With the support of SPOP and Mount Sinai, Sarah is on track to achieve her goal of never entering a medical office or hospital again.

Nancy Harvey, LMWS, has served as the chief executive of Service Program for Older People for 26 years. To learn more about home visiting and SPOP's other community-based behavioral health programs for older adults visit www.spop.org or contact Nancy at nharvey@spop.org.

Stopping the Hospital Revolving Door: A Pathway Home to Stable Community Life

By Danika Mills, LCSW, LCAT,
and Barry Granek, LMHC
Coordinated Behavioral Care

Danika Mills, LCSW, LCAT

Barry Granek, LMHC

A not-for-profit organization formed by behavioral health (BH) community agencies, Coordinated Behavioral Care (CBC) operates one of NYS's largest Health Homes (HH) and has formed an IPA to deliver integrated outcomes-oriented care. The many care managers who work with our HH members often face insurmountable challenges to support individuals after they are discharged from a long episode of inpatient care. There simply are not dedicated, flexible, time-limited services available in NYC to provide inpatient to community care transitions services.

In 2014, CBC created Pathway Home (PH), a care transitions program funded by the New York State Office of Mental Health, to fill this service gap. Operating in Brooklyn, the Bronx, Manhattan and Queens, three multidisciplinary teams comprised of licensed mental health clinicians, case managers, nurses and peers offer community-based time-limited services (average six months) for adults with serious mental illness who have experienced long-stays in psychiatric inpatient care. PH staff address a host of issues—housing, food, economic security, medication adherence, linkage with outpatient providers, family conflict, and social isolation--faced by individuals transitioning to the community.

PH uses the evidenced-based Critical Time Intervention (CTI) model, providing intense services beginning shortly before hospital discharge to build trust and continues with the individual into the community after hospital discharge. The intensity, type and duration of services vary depending on the individual's needs. By the time a PH participant is ready for "discharge," they have engaged with appropriate outpatient providers and are following prescribed treatment. They are stably housed with benefits and adequate food, and have reconnected with family/friends and/or started to develop new social networks. Many have formed a trusting relationship with a HH care manager.

Literally, CBC's Pathway Home bridges the divide between the 3 to 9-month post-discharge period when individuals are both vulnerable and face gargantuan challenges until they engage with community services. The program's target population are adults with serious mental illness, many of whom are being discharged from State Psychiatric Centers. This group is at an extraordinary disadvantage navigating the complex and fragmented community care system. Fundamental independent living skills required to take care of basic needs may be lost or eroded during a long hospital stay. Yet how can a person survive, much less thrive, without the skills to use public transportation, buy food on a budget, prepare nutritious meals and maintain new housing? Additionally, the social determinants of health, if not adequately addressed, result in poor outcomes, avoidable readmissions and emergency department visits. Consistent and meaningful mental health treatment, along with adequate case management, is important to stabilization post-hospitalization.

The CBC Pathway Home model achieves positive outcomes by addressing four key areas:

1. Pre-Discharge Engagement/Planning:

see Pathway on page 35

Yvette Brissett-André Wins Best of the Bronx Award

Staff Writer
Behavioral Health News

Unique People Services (UPS) Executive Director Yvette Brissett-André is the recipient of the Bronx Chamber of Commerce's Best of the Bronx Award of the Year. Brissett-André was selected for her extraordinary leadership at UPS and her deep dedication to improving the lives of individuals in need in the Bronx and across the city. The award will be presented at the Best of the Bronx 2017 Golf Outing on Monday, May 22, 2017 at Trump Links at Ferry Point Park.

As a nonprofit 501(c)3, UPS has been providing vital programs for individuals with HIV/AIDS, developmental disabilities and mental health challenges since 1991. Large-scale fundraising efforts executed by Brissett-André have enabled the agency to expand its reach and contribute to the reduction in homelessness in New York City. This year, she will lead UPS in its first affordable housing initiative, Lynn Place, when the Bronx housing complex opens in September. Other essential services include UPS' Annual Health Fair, an important community resource supporting the #Not62 campaign, a call-to-action to improve the health of Bronx residents.

Yvette Brissett-André

In addition to leading Unique People Services, Brissett-André, a 2016 SmartCEO Brava Award winner, also serves on the boards of the Interagency Council of New York and Mental Health News Education, Inc. (MHNE).

Commenting on her Best of the Bronx Award, Brissett-André said, "At UPS,

see Award on page 36

Stoltz Elected Co-Chair of Regional Mental Health Consortium

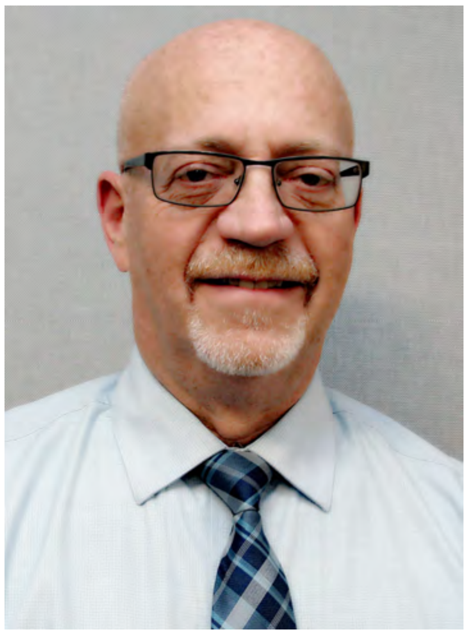
Staff Writer
Behavioral Health News

Michael Stoltz, LCSW, of Smithtown, C.E.O. of the Association for Mental Health and Wellness, based in Ronkonkoma, has been elected Co-Chair of the Long Island Regional Planning Consortium (RPC), a part of the New York State Conference of Local Mental Hygiene Directors.

In this role, Mr. Stoltz will help facilitate collaboration that promotes problem solving and system improvement for the integration of mental health, addiction treatment services, and physical healthcare on Long Island.

"I am proud to have this opportunity to help identify and prioritize the healthcare needs of Nassau and Suffolk counties," commented Mr. Stoltz. "Services that are data informed, person and family centered, cost efficient, and results in improved overall health for adults and children are vital to all members of our communities."

"Michael Stoltz will be a superb addition to our leadership team," said Michael Hoffman, the Long Island RPC Coordinator. "He is an innovative thinker with a broad scope of knowledge and experience within the behavioral health community and I am confident that he will make great contributions to the region and the state in this new role."



Michael Stoltz, LCSW

Stoltz will serve as co-chair alongside James R. Dolan, Jr., DSW, LCSW, Acting Commissioner of the Nassau County Department of Human Services. "I am pleased to partner with Michael Stoltz as co-chair of the Long Island Regional

see Consortium on page 36

Behavioral Health News Theme and Deadline Calendar

Fall 2017 Issue:

"The Vital Role of Housing in the Recovery Process"

Deadline: July 1, 2017

Winter 2018 Issue:

"Addressing the Opioid and Suicide Epidemics"

Deadline: October 1, 2017

Spring 2018 Issue:

"Understanding & Treating Co-occurring Disorders"

Deadline: January 1, 2018

Summer 2018 Issue:

"Harm Reduction: Theory and Practice"

Deadline: April 1, 2018

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Trish Marsik New COO at Services for the UnderServed

Staff Writer
Behavioral Health News

Trish Marsik has recently joined Services for the UnderServed's executive team as it Chief Operating Officer. For the last two years, Marsik has worked as the Executive Director for the Mayor's Task Force on Behavioral Health and the Criminal Justice System, working out of the Mayor's Office of Criminal Justice. There she oversaw the implementation of the task force action plan, seeking to better serve people with behavioral health issues who come into contact with the criminal justice system. For 14 years prior to that, Marsik worked in multiple capacities at the New York City Department of Health and Mental Hygiene (DOHMH), eventually serving as Assistant Commissioner for Mental Health, where she managed the development, implementation, and oversight of contracted mental health programs as well as policy and programmatic initiatives. Marsik also served as the Chief Administrative Officer for the Early Intervention Program, a multi-million dollar federal entitlement program for children ages birth-3 with delays and disabilities; and was the Director of Project Liberty, New York City's mental health response to 9/11.


Trish Marsik

Before joining DOHMH, Marsik directed service programs for New York City residents who were homeless, justice-involved and/or had a mental illness for organizations that included Legal Aid and the Urban Justice Center. Marsik earned a Bachelor of Arts from the University of Michigan and a Master of Social Work from Columbia University.

Stacey Weston New Chief Development Officer at S:US

Staff Writer
Behavioral Health News

Having served as the head of fundraising for the United States' largest nonprofit home health care organization, Visiting Nurse Service of New York (VNSNY), Stacey Weston will now join the executive management team at Services for the UnderServed to usher in a new era of enhanced and targeted fundraising to help sustain and grow the work of creating opportunity for vulnerable New Yorkers.

Weston brings two decades of successful nonprofit experience to the task, with a significant background in building boards with major gift capacity, creating and launching operating and capital campaigns, developing and managing donor relationships, and identifying, cultivating, soliciting and stewarding individual donors and institutional funders.

Prior to her tenure at VNSNY, Weston served as Vice President for Development at the League of American Orchestras, NY, and as Associate Vice President for Corporate Relations at the New York Botanical Garden. She received her formal education at the University of Oregon (Master of Music) and at Humbolt State University (Bachelor of Arts).


Stacey Weston

Founded in 1978, Services for the UnderServed provides $200 million in services and supports, including providing 3500 units of housing, through the dedicated work of 2,200 staff, serving 25,000 of the most vulnerable individuals in New York City. SUS works in partnership with

see S:US on page 32

Disconnect from page 18

described above are merely two of many in which progressive public policies fail to secure the resources necessary to fulfill their promise. Our most vulnerable citizens deserve more than policy statements borne of noble intent and purpose. Their success demands adequate reinvestment of resources saved through a continuing decline in state-administered services and related initiatives.

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a return to the failed policies of the last few decades. Let us redouble our collaborative efforts to advance inextricably linked health care and criminal justice reform by attacking the challenge of mass incarceration associated with the preventable arrest and recidivism of those with significant behavioral health challenges. In doing so, we will strengthen our communities as we strengthen our families, minimize victimization, and empower individuals to live meaningful and fulfilling lives.

White House Fact Sheet: Launching the Data Driven Justice Initiative: Disrupting the Cycle of Incarceration (June 30, 2016).

Richard Sheola can be contacted at richard.sheola@healthandjusticestrategies.com.

CLAS from page 4

measurement and continuous quality improvement activities.

3. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

4. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

5. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

6. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

7. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

What You Can Do

Many tools and resources exist to help organizations comply with CLAS guidance, including organizational self-assessments and toolkits, a few of which are listed below under Resources. Providers preparing for value based payment are analyzing their continuous quality improvement data to assess which populations and groups they are serving AND what populations are being lost to care, based on local health needs data and population demographics. Proactive providers are not waiting for new funding opportunities to support specialized programs. Rather, capitated rates and new quality incentives, plus attention to CLAS standards that has included increased planning input from community groups, are leading accountable entities to identify new partners, such as community based organizations addressing the social determinants of health or faith based organizations serving unique cultural and/or religious communities.

CLAS Resources

1. Race Matters: Organizational Self-Assessment: http://www.aecf.org/resources/race-matters-organizational-self-assessment/

2. Self-Assessment for Cultural Competence: http://www.asha.org/practice/multicultural/self.htm

3. The Cultural Competence Self-Assessment Protocol for Health Care Organizations and Systems: http://erc.msh.org/mainpage.cfm?file=9.1g.htm&module=provider&language=English

4. Health Research and Educational Trust Disparities Toolkit: http://www.hretdisparities.org

5. "Improving communication—improving care": the AMA Ethical Force program toolkit: http://www.ethicalforce.org/

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organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of people being served by the organization.

3. Collaboration and mutuality: there is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.

4. Empowerment: throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary.

5. Voice and choice: the organization aims to strengthen the staff's, clients', and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach.

6. Peer support and mutual self-help: are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

7. Resilience and strengths based: a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma; builds on what clients, staff and communities have to offer rather than responding to their perceived deficits.

8. Inclusiveness and shared purpose: the organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.

9. Cultural, historical, and gender issues: the organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

10. Change process: is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments

Based on the evidence, trauma informed care should be the universal approach in the human services arena; shifting the conversation from, "What's wrong with you?" to "What happened to you?"

This paradigm shift in understanding the impact of trauma is especially important in our work with vulnerable populations. These are the individuals and groups least likely to have a voice and at the same time most likely to have been or be at risk of being impacted by trauma. It is important that we adopt trauma informed principles throughout all aspects of our systems and organizations.

Trauma-informed care engages customers and clients as partners, empowering them and helping to reclaim the voice that they may have lost. It provides safety and fosters resilience to increase the capacity to face and overcome adversities now and in the future.

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those who come to its doors for services by providing the tools and supports they need to empower themselves as they create pathways to rich and productive lives. SUS envisions a city where everyone has a roof over their head, is healthy, productive and can enjoy the social connections that create a life of purpose.

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to treat physical wounds of abuse. When their patients refuse additional help from social workers (if they are available), all that they can do is to discharge and hope, make a referral to APS, or call the police.

Criminal justice interventions, which are often critical, are, unfortunately, blunt instruments in situations that call for subtlety.

The APS has limited capacity to intervene because caseloads are very large and workers are under great pressure to assess, refer, and close the case. Referral resources are very limited—few crisis centers, residential alternatives, or counseling services. Referrals to family service organizations that have clinical social workers seem to make sense. But because they usually are licensed and funded as mental health clinics, their capacity to intervene effectively is also limited. Too often referrals have to be made to nursing homes despite the fact that most victims of abuse want to remain in their own homes.

Westchester County is one of very few places in New York State and the nation that has a program to intervene in elder abuse cases that the APS cannot handle. The Elder Abuse Prevention Program of Family Service of Westchester is funded by New York State to provide essential counseling services in ways that are difficult for licensed mental health clinics. A clinical social worker (who is the co-author of this article) is able to go to the home of a person who is being abused and to spend as much time as necessary to listen and build trust with people who are very suspicious of those who offer help. Only then can they be engaged in developing a plan to protect themselves.

For example, Mr. and Mrs. L are in their late 60s. Both have developmental disabilities, but they have been married for nearly 50 years and until recently both worked and supported themselves. He had an accident eight years ago and suffered some brain damage. Since then he has been distrustful and short-tempered. Recently, Mrs. L. broke a hip and became unable to take care of the house as she always had. She needed help with all the basics and had home health aides assigned 4 hours a day. Her husband distrusted them, often would not let them into their house, frequently yelled at his wife, and sometimes hit her. APS was called in but Mrs. L. denied abuse. APS closed the case without action except to make a referral to Ms. Tavzel, who visited her at home within a few days. She found Mrs. L. was very frightened and very confused. Little that she said made sense. It took several hours of patient listening before Mrs. L was able to acknowledge how dangerous it was for her to remain at home with her husband and to agree to go to an emergency shelter that designed for victims of elder abuse.

The key in this case was being able to make a home visit rapidly and to spend hours with the victim. It was also very important that Ms. Tavzel resisted diagnosing her as psychotic, instead giving her time to calm down and regain coherence.

Another example, Mrs. S. is 68 and lives in a 2-story house with her husband, two sons, (one of whom is addicted to heroin), and a grandson. The addicted son dominated and terrorized the household. He stole money from his father, mother, and brother. To keep them all under control he had boarded up all the doors and windows on the first floor except for the front door, which he watched nearly all the time. One day Mrs. S jumped out of a window on the second floor to escape her son's rage. She was injured and taken to a nearby hospital, where she was well-known from frequent visits to the emergency room with injuries they suspected to be from abuse. Fearful of what would happen to her family, she always had denied abuse and returned home. This time, however, her injuries were severe. She remained in the hospital and then went to rehab where Ms. Tavzel visited her repeatedly over the next month. Slowly she started to talk about the daily abuse and acknowledged that she was terrified. She felt that she was responsible for her son's addiction and abusive behavior and believed that she had to protect everyone in the household including her abusive son. Eventually, she decided to report her son to the police. He was arrested and the rest of the family, with support and reassurance of local professionals, corroborated the report. The son is now in jail, and the family is safe.

The key to this case was having the time for frequent, lengthy visits to help the client understand that she was not at fault, that she could not save her abusive son, and that she needed to report him to the police to protect the victims in her family.

Lessons for the Mental Health System

Even though they do not illustrate the full range of elder abuse, these two cases give some sense of how difficult cases of elder abuse can be and that some need intervention of the kind that a skilled clinical social worker can provide—if they have time.

Particularly important are responding rapidly during times of crisis, spending considerable time with the victim in their homes or community settings to build trust and an alliance to overcome danger, resisting quick diagnoses that can result in confusing severe anxiety due to abuse with psychosis, and giving priority to safety rather than to treatment.

Unfortunately, licensed mental health clinics—which are often the only source of counseling—are usually very limited in

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As Thousands on Long Island Struggle with Mental Health and Addiction NY State Awards Half-Million Dollar Grant to Update Outpatient Facility

Staff Writer
Behavioral Health News

Demonstrating commitment to the treatment and recovery of Long Island residents facing mental health and substance use disorders, the New York State Dormitory Authority announced last week a $561,000 grant to nonprofit CN Guidance & Counseling Services to enable needed upgrades to the organization's main client-serving facility in Hicksville. The funding will allow improvements to client and staff accessibility, comfort, security, and efficiency at 950 South Oyster Bay Road.

CN Guidance is a local leader in delivering behavioral health services to individuals and families, helping over 4,600 people annually—especially those facing financial hardship. The agency holds an uncommon Integrated Outpatient Services license, meaning clients can receive substance use disorder treatment and/or mental health treatment together, at the same site. Many L.I. residents suffer from co-occurring disorders, like depression and alcoholism.

The grant announcement, applauded by community leaders, comes during an unprecedented epidemic of heroin and prescription drug dependency, with record fatalities on Long Island, and in the aftermath of the U.S. Surgeon General's historic November "Facing Addiction in America" report denoting that 90 percent of people with a substance use disorder are not getting treatment.

"This grant from New York State means fewer barriers to service for individuals and families struggling with addiction or facing mental health issues," said CN Guidance CEO Jeffrey Friedman. "When someone takes the courageous step of seeking help, we need them to feel comfortable, safe, and confident immediately. This grant will improve physical infrastructure—and, at its heart, that translates into preserving and enhancing people's confidence and persistence in recovery."

Improvements to the 25,000 square-foot facility will comprise updating and enhancing accessibility of four restrooms; overhauling an aging 46,000-square foot parking lot before it limits access for some clients with disabilities; and adding numerous indoor and outdoor security features to increase clients' and staff's safety, ranging from a sturdy perimeter fence to video surveillance, a new alarm system, and other features to allow instant response in the event of a crisis. The improvements—to occur in a phased rollout between January and September 2017—are aimed at promoting strong engagement and retention of both clients and staff so that families affected by mental health disorders and substance use can experience maximum recovery.

About Central Nassau Guidance and Counseling Services

CN Guidance & Counseling Services is one of the region's leading mental health, behavioral, and addiction-related service providers. Established in 1972, the mission of this nonprofit organization is to improve the quality of life for individuals and families on Long Island affected by mental health and/or substance use disorders. It succeeds by providing integration of clinical treatment, housing opportunities, social and support services, counseling, and guidance to individuals, families and the community. CN Guidance has been a leader in providing outreach, supports, and counseling to community members during peaceful and traumatic times alike.

Collaboration for People with MI/IDD: System Failures and Promising Practices

By Robert J. Fletcher, Founder & CEO
and Kayla Behn, Intern
NADD

Individuals who have both mental illness (MI) and intellectual/developmental disabilities (IDD) present unique challenges to both mental health and developmental disability service structures. The group comprises a complex population whose needs are often poorly identified and who are often referred from agency to agency in a fruitless effort to obtain services. Because of the fragmentation of service delivery, this vulnerable population often does not receive appropriate services to meet their mental health and developmental needs. This paper is intended to address systemic barriers concerning people who have MI/IDD and offer a strategic plan to address their unmet needs. Collaboration between the mental health and the developmental disability service structures will be highlighted.

It has been reported that individuals with IDD who also have MI may constitute one of the largest underserved populations in the United States. Persons of normal intelligence who experience psychiatric problems can avail themselves of clinical services within the mental health system. But persons with IDD who experience similar problems do not have easy access to psychiatric services. These persons, referred to as having a dual diagnosis, characteristically "fall through the cracks" in the delivery service system because neither the mental health system nor the developmental disability system wants to take responsibility for people with a dual diagnosis. Recent large scale research reflects that 40-50%of people with IDD have a psychiatric disorder.

Lack of Planning

This failure to take responsibility can be attributed to the lack of a clearly articulated policy among providers for addressing the needs of individuals with MI/IDD co-occurring disorders. Service systems are often fragmented, characterized by each system operating within a silo framework. People with IDD who have co-occurring mental health disorders frequently are not understood and do not have their needs met. This barrier to service delivery is clearly the result of lack of planning. It is worth noting that individuals with co-occurring MI and IDD are among the most challenging persons served by both the MH and IDD service delivery systems.

The lack of intersystem planning has resulted in a splintered system of care and has created a quagmire for both the MH and the IDD service delivery systems.

The lack of strategic planning has led to challenges faced by the federal government and state regulatory authorities and local communities. There are significant systemic issues highlighted by eligibility and access barriers as well as financial challenges. As a result of the failure to strategically plan for appropriate cross-system services, people with a dual diagnosis have not received the services they need. In spite of many innovative developments in service delivery for people with disabilities, success for people with a dual diagnosis has lagged behind that for other disability groups.

To some extent, policy barriers can be rooted in a lack of understanding of how one system can collaborate with another. Individuals with IDD co-occurring with MI are typically supported through different state agencies. Structural differences between the IDD system, on the one hand, and the mental health system, on the other, have resulted in misconceptions and the general lack of understanding of how the two systems can work in a collaborative way.

There is a lack of adequate training for professionals to recognize the possibility of a co-occurring mental health disorder in a person who has IDD. There is a near absence of intersystem professional training, and this has led to clinical myths and mistrust.

The mental health and the IDD service delivery systems are separate and parallel systems. Each has its own eligibility criteria, philosophy of care, and treatment/support approaches. Even language used in each system can be different than language used in the other system. Professional staff find it difficult to understand and grasp each other's perspective.

Intersystem Service Planning

Principles in Intersystem Service Planning: It is important for all parties to agree upon a set of planning principles. The planning principles are the foundation stones for building cross systems collaboration. Some of these major principles should include the following: (1) Co-occurring disorders should be treated as multiple primary disorders, in which each disorder receives specific and appropriate services. (2) Collaboration of appropriate services and supports must occur as needs are identified. (3) Services provided to the individual are consistent with what the person wants and what supports are needed. (4) Services are determined on the basis of comprehensive assessment of the needs of each individual. (5) Emphasize early identification and intervention. (6) Involve the person and family as full

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people with histories of clinically significant behavioral health challenges may also acquire a dementia-causing illness in later life. Therefore, they experience additional cognitive impairment, which can make it increasingly difficult to manage activities of daily living. Both conditions will need to be managed carefully by health care and behavioral health care providers.

Depression and Anxiety: While depressive and anxiety disorders are somewhat less common among older adults than in the general population, depression frequently co-occurs in older adults with dementia, with long-term psychiatric disabilities, with chronic physical conditions, with reduced social networks, or with reduced quality of life. Both depressive and anxiety disorders are associated with increased health care utilization, poorer health outcomes, and increased functional disability; however, a majority of older adults who experience depressive and anxiety disorders do not receive mental health services in traditional settings, so it is imperative that older adults are able to access services where they need to receive them, such as in primary care, aging services programs, and in long-term care; the current proposed changes to the health care delivery system do not take into account the need for providing services in non-traditional settings.

Suicide is a major concern among older adults. They are 50% more likely to take their own lives than the general population, particularly white men of over the age of 85. Suicide is also part – though by no means all - of the reason for the lower life expectancy of people with long-term psychiatric illness, as some adults living with psychiatric disabilities complete suicide before achieving older age. A number of factors increase the risk of suicide for older adults, including depression and other mental disorders, comorbid physical illness, social isolation, and feeling a lack of meaning or purpose in life, among other risk factors.

Recovery, a core value in the mental health care delivery system, is as relevant and possible for older adults as it is for younger populations. Unfortunately, ageism leads to the false perception that older adults cannot recover and/or learn new skills. The concept of recovery for older adults can and should focus on achieving integrity, which is centered around increased acceptance of one's life and history, a sense of meaning and purpose in one's current life, which can be influenced by engagement in valued relationships and activities and interest in guiding future generations, in addition to what might be achieved in the current moment. Recovery for older adults should also include the goal of living in a setting, often in the community, that promotes optimal functioning and independence.

Developmental Challenges

Older adults experience a number of normal developmental transitions as they age. How these transitions are experienced and managed are critical to successful aging, which we define as older adults' ability to feel good about their lives, even as they live with physical, emotional and social challenges. Typical developmental transitions may include voluntary and non-voluntary retirement from employment; loss of family and/or friends; shifting social and familial roles; diminished cognitive and/or physical abilities; spiritual concerns; and confronting end-of-life. Dealing with these transitions as part of programming will help support older adults' physical and mental wellness. Death and dying, a reality for older adults, unfortunately is rarely dealt with openly but requires careful end of life planning to prepare for properly. Preparation includes helping older adults manage their needs and wishes for end of life care, but also for helping them meet the developmental task of addressing mortality in the first place. Grief is a common problem for older adults because they are more likely to experience the deaths of family and friends as they get older. Grief, while not a mental disorder, often leads to additional mental and emotional challenges.

As people age, staying connected with family and friends and avoiding isolation is also important for well-being. Some older adults with long-term psychiatric disabilities may have close family relationships, while others have been estranged from their family and may want to reconnect. Many adults with long-term psychiatric illnesses often rely on their family members, especially parents and siblings, for support throughout their lives. Therefore, they risk losing this primary support as they get older and their family members have less ability to provide care or die. Helping older adults with long-term psychiatric disabilities connect to community supports and develop additional relationships – or strengthen existing relationships, where possible - can be particularly critical as they enter older age.

Recreational activities, which are often associated with retirement, may be particularly important for those older adults who are no longer employed. They include various activities such as the arts, cooking, gardening, exercise, religious practices, education, and more. Some older adults want to participate in volunteer work as opposed to paid employment. Volunteer work can be formal, such as within an organization, or informal, such as time spent helping a neighbor or friend. Some older adults want to engage in programming offered for their age cohort. Additionally, older adults are more likely than younger adults to be concerned with religion and spiritual issues. Being a part of a religious community is a way for older adults to stay connected and explore the meaning, value, and purpose of their life.

Social and Economic Needs

Older adults often face financial problems because the traditional sources of income, such as pensions or public assistance are generally not enough to live on. Also, there are housing issues related to the possibility of aging in the community rather than in institutions. While there is specialized housing for adults living with psychiatric disabilities, such as supported housing and community residences, these are not typically designed to meet the needs of an aging population. Conversely, housing designed for older adults, such as senior housing, supportive housing and assisted living, are not typically designed to address behavioral health. As older adults with behavioral health needs increasingly live in the community, issues of cost, safety and accessibility, among other concerns, will need to be considered.

The population of older adults with behavioral health challenges will to continue to grow at a time when access to the services and supports that help them to achieve and sustain recovery are increasingly at risk. It is imperative that we in the behavioral health community work hard to ensure that essential services are not limited or stripped away. The specific issues facing older adults with mental health and substance abuse problems deserve careful attention and planning, and we must not allow them to be neglected as we advocate to preserve the ACA, Medicaid and any other entitlements upon which this vulnerable population depends. If we do not address the needs of older adults with behavioral health conditions, we not only risk diminishing their quality of life, but we also continue to promote an ageist society that fails to care and support the most vulnerable among us.

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we want to get at. You have to be respectful because if you can't show that, they won't want to even talk to you.

D.C. Humility has worked for S:US. Humility makes us continually look inward to asses if we are making a difference and how we can improve. First we ask people how we are doing. And how are you doing? Do you feel respected and supported? This may sound simplistic and it is not the only data point but if you skip this step you really won't be able to answer the question you asked. This approach is person-centered and it should be and by using validated surveys we can also use the results to benchmark and improve our services.

J.J. Do we feel we are making a difference?

D.C. The short answer is yes. But how do we know we are making a difference is a more important question.

We create housing and access to housing for consumers and we know that the majority of individuals that access housing with supports stay stably housed. We collect data on homeless prevention. We collect data on the impact of our employment services. We study the impact of our services on unnecessary hospitalization, ER use and overall health. We played a significant role in ending veterans' homelessness. I could go on but quantitative data and qualitative data are both important.

R.T. What SUS is doing is definitely working. Now, what we want to do is just make sure it's working better. We can't stagnate. We have to keep growing. For people coming out of jail who never had a home, we have to teach them how to "have a home" – how to manage money, pay bills, all the basics.

This is where supported housing, as opposed to just housing, comes in. Sometimes we over-professionalize supports-basic supports are important.

D.C. We know the work is hard, and no easy solutions. We employ evidence-based practices and interventions but I agree with Richard we have to marry those practices with putting food on the table, getting a roof over a person's head, social supports, employment. We know that access to healthcare and recovery services and treatment is important but without addressing what we now call the social determinants of health -- housing, food, education, employment, meaningful social roles, social connections, etc.-- our chances of supporting people toward well-being and quality of life are diminished. We have to do a better job of connecting the dots.

Our urban farms initiative is a good example of how we married meaningful work, training, healthful food, cooking, community and peer support .Our ICCD Clubhouse is a powerful peer-directed community. Our Parachute respite residence offers a low cost supportive alternative to hospitalization.

J.J. People are afraid that managed care will result in fewer and fewer dollars to really provide the kind of person-centered care people need, especially vulnerable people. Are you concerned about that and if so, what are some of the specifics that you think will make the system even more fragile than it already is?

D.C. When managed care works it should be about better coordinated, integrated and person-centered services--especially important for people with complex needs. I believe that partnerships with enlightened plans and provider partnership have the potential to improve personal and health outcomes for people we serve. Paying for value or value based payments offer a framework to do impactful work. Resource limitation is and will most likely continue to be challenging but finding a way within the value-based framework to pay for the social determinants of health and wellbeing is key to changing the narrative.

J.J. So to both of you - any parting words of wisdom?

D.C. We need to spend more time engaging with our customers about how the health transformation effort is working for them and how we can do better. Partnerships with consumers should occur at a systems development level and at a personal level. Focus groups with consumers

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Early engagement is important to increase participation and build a therapeutic rapport. Many of the barriers and challenges that impact success at discharge can be identified, mitigated and resolved during the inpatient stay. As well, potential pitfalls and problematic issues can be preemptively addressed before they can undermine the individual after discharge. The CBC team begins developing a relationship before discharge that is critical to the success of the intervention. Simultaneously, the team collaborates with the care team (e.g. hospital, housing and support staff) to develop a discharge plan that connects multiple systems of care and establishes accountability. With input, the Care Plan better reflects the unique personality and immediate needs of each individual. If family is involved, CBC will engage them as a support during the transition.

Early engagement helps forestall some typical causes of community instability during the care transition. During the transition, unexpected and unanticipated challenges or barriers to community stability can occur. For example, appointments with clinics or doctors may not be scheduled by the inpatient discharge staff, or they may be made so far in the future that medication will be depleted. Pathway Home staff can problem-solve during the discharge process or advocate directly with the outpatient provider to address any issues.

The CBC team is available to accompany the individual home upon hospital discharge, allowing an in vivo assessment and resolution of any immediate needs that may pose potential barriers to care. In the first week, the individual has an appointment at a BH clinic, which Pathway Home will facilitate by either accompanying or meeting the individual there. The team visits several times a week and at times daily immediately post-discharge, depending on the needs of the individual. Medication management and reconciliation support is provided by nurses. If transportation is needed but not arranged, Pathway Home will arrange it to ensure attendance.

2. Community Providers/Natural Supports Linkages: To prepare for long-term stability in the community, individuals are connected with various resources. Appointments are made with community providers of outpatient clinics and programs, as well as clubhouses, vocational, educational and other services that can lead to successful transitions. Pathway Home is an intense support that is meant to be temporary. A key priority is to facilitate enrollment and engagement with the CBC Health Home, so that care management services are in place after our care transition services end.

3. Community Reintegration: Successful transition is not just about making appointments and taking medication. People need to feel productive and engage in meaningful activities, such as relationships and social networks that provide friendship, love and hope. The CBC Pathway Home team accesses both community resources and State-sponsored wraparound funds to help address issues that may negatively impact success in the community (e.g. smart pill dispensers, clothing, or transportation). Family meetings are offered to provide psychoeducation and support to both the person served as well as their family members. These types of activities not only support treatment goals, but imbue purpose and meaning into an individual's life.

4. Fostering Self-Efficacy: CBC Pathway Home ensures that the time-limited nature of the intervention is made known at beginning of the relationship. Self-efficacy and self-sufficiency are fostered by encouraging participants to be accountable for their own treatment. Individuals are expected to assume responsibility by making appointments, managing medications, and becoming productive in the community. Using Motivational Interviewing, the team shares tools that support skill-development and self-reliance. Participants are better prepared to function independently after the intervention ends.

Stopping the Revolving Door: Through Medicaid system redesign, NYS is seeking to reduce avoidable inpatient admissions and emergency room presentations. CBC Pathway Home is contributing to achievement of this goal with a person-centered, skills-building care model. In two years, we have helped participants achieve better health outcomes: 93% attended a BH appointment within 30 days and 82% attended a medical appointment within 90 days of inpatient discharge; and 79% enrolled in a Health Home prior to Pathway Home discharge.

CBC Pathway Home is a Hospital to Home intervention that is stopping the revolving door by improving health outcomes and reducing avoidable costs. It successfully addressing treatment-related issues and social determinants of health that are drivers of preventable readmissions and/or emergency room visits. As important, many participants are now thriving in their communities, connected to care, and living healthier, happier lives. In 2017, CBC seeks to build on this model of care for similar vulnerable populations, including individuals who are justice involved, have medically co-morbidities and/or are long-term chronic State hospital patients.

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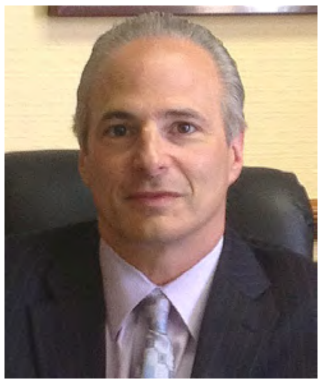

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what they can do to help victims of elder abuse.

- Clinics work almost exclusively with clients who can keep appointments at the clinic site. Home visits are rare.

- Clinics provide time-limited visits, usually 30-45 minutes once a week.

- Clinics have lengthy processes to go through before treatment begins—typically with a significant wait before up to 3 visits of assessment, diagnosis, and treatment planning.

Delayed start of treatment in clinics is in part due to insufficient staffing to respond to community need, but it is also embedded in an antiquated model of treatment that grew out of the early history of psychotherapy. Regulatory requirements are derived from the same model, a model built on the idea that the primary purpose of clinic treatment is to address a diagnosable mental illness and only incidentally to help someone change their lives so that they can be safe and productive.

- Perhaps the most significant limitation on clinics is that they depend on fee-for-service funding and volume of visits to survive. Lengthy visits away from the office are a fiscal nightmare.

Effective intervention with victims of elder abuse, therefore, calls for very substantial changes of the mental health system including: support for home visits, for rapid response, for lengthy and frequent visits in times of crisis, and for “treatment” goals that focus on safety and life satisfaction as well as the amelioration of diagnosable disorders that may be a consequence of abuse.

Achieving this requires changes in regulation, in funding methodology, and in the training of health, mental health, and social services professionals who come into contact with victims of elder abuse.

Even in the best of times, this would be difficult. In America’s current circumstances—with attacks on federal mental health funding such as repeal of the Affordable Care Act, conversion of Medicaid from an entitlement to a block grant, and privatizing Medicare—making essential changes is virtually impossible.

We need to fight to retain what we have. But as we do so, let’s not forget that the system also needs substantial improvement.

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have informed us that we need to do better at communicating all the systems changes and available service options and what all these changes mean for them.

R.T. No matter how many big words you use, always use small words. I'm proud to be giving back so I can do for somebody what somebody did for me. We try to save everyone, but if I can just help one or two people, that’s a plus. All we can do is put our best foot forward and hope and pray that someone will accept it. We can’t help you unless you tell us who you are.

D.C Partnering with “vulnerable” people and communities to develop the right set of supports transforms vulnerable into empowerment. This work requires leveraging bold partnerships with individuals we serve, communities, the health care sector, the community based providers and businesses. It is not the responsibility of any one sector to make things better for everyone. We need to figure it out together. We need to advance that goal. We can’t do perfect. We just have to keep trying.

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partners. (7) Coordinate at the system and service delivery level. (8) The systems need to recognize and value the long term cost effectiveness of providing best practice services and supports for persons with co-occurring disorders.

The issue of what is the primary versus secondary diagnosis has served as an obstacle to planning and practice. The identification of a primary versus secondary diagnosis is an administrative artifact related to the funding source but has no clinical value. If a person is receiving treatment services for a mental health disorder, the psychiatric diagnosis is considered primary. If that same person is receiving residential services from an IDD provider, then a developmental disability diagnosis is considered primary for that provider.

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Planning Consortium,” said Mr. Dolan. “He is sure to make invaluable contributions to the effort of assuring that those with behavioral health needs have access to the highest quality of care possible.”

The Long Island RPC is one of a network of 11 regional boards comprised of stakeholders who work closely with state agencies to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend priorities for reinvestment of Medicaid savings. Additional information on the RPC can be found at http://clmhd.org.

The Association for Mental Health and Wellness (MHAW), a not-for-profit 501 (c)(3) corporation based in Ronkonkoma, NY, provides programs, services, and advocacy for people facing mental health challenges with an enhanced focus on serving military Veterans.

MHAW dates back to 1955 with the incorporation of the Mental Health Association in Suffolk County (MHA Suffolk). In 1990, Clubhouse of Suffolk was launched, providing a wide array of vocational rehabilitation services and recovery programs. With the growing need to provide services for Veterans with PTSD and other battle-related brain injuries, Clubhouse merged with MHA Suffolk and Suffolk County United Veterans in 2014 to form the Association for Mental Health and Wellness.

MHAW is committed to the core practice values of empowerment, hope, opportunity, and cultural competence. All of the agency’s direct service workers are trained in the importance of addressing health from trauma-informed and whole person perspectives with enriched understanding of the social and economic conditions that contribute to physical and mental health and substance abuse.

Award from page 30

we’ve always stayed true to our Bronx roots. To be recognized for our work is truly an honor and a fitting tribute to our late founder, Lynn Wonsang, who strived for compassionate care for all. With the 2017 opening of Lynn’s Place, the next chapter in our Continuum of Care, we look forward to touching more lives in the borough for years to come.”

Founded in 1991, Unique People Services, Inc. (UPS) is a New York-based nonprofit 501(c)3 that provides supportive housing and medical case management services to individuals and families living with mental health challenges, developmental disabilities and HIV/AIDS. Now celebrating its 26th Anniversary, the agency operates 27 supportive housing programs in the Bronx, Manhattan, Brooklyn, Queens and Westchester County.

More than 500 New Yorkers call UPS home, living in well-appointed residences where they receive meals and support services to help them achieve the highest possible levels of independent living and community inclusion. The transitional, long-term and permanent housing UPS provides has also become a safe haven for many formerly homeless individuals.

With the opening of Lynn’s Place in 2017, the agency’s first affordable housing initiative, UPS will help transform more lives, deepening its mission of Understanding People, Providing Homes, and Serving Communities. For more information about Unique People Services, visit www.uniquepeopleservices.org.

Suicide Prevention from page 12

physicians must weigh risks and benefits.

Research in Sweden (Lebowitz, ibid.) has shown that treating depression can have a significant impact on suicide deaths. We must call on both medical and behavioral health providers to be more aware of these issues. Up to three quarters of those who took their life by suicide saw their PCP in the past 30 days (US DHHS, National Statistics of Older Adult Suicide from the National Suicide Prevention Plan). Assessing suicidality can be difficult because passive suicidality (“Soon I want be here anymore” and similar expressions) may be mistaken as the preoccupation with death that is typical at older ages.

In addition to treating depression, physicians must also treat the comorbid conditions, especially chronic pain, which are also risk factors in suicide for older adults. Based on these comorbid conditions as risk factors, suicide prevention includes promoting healthy behavior (Conwell, Suicide Later in Life, 2014).

It should be the role of anyone in contact with older adults to watch for signs and symptoms of depression and suicidality. Likewise, everyone should be prepared to do their bit to increase protective factors and decrease risk factors. Counseling on Access to Lethal Means (CALM) is a crucial part of intervention given that older adults tend to complete suicide more frequently due to their use of lethal means.

In addition to treatment and efforts to reduce risk factors, we must also work to increase protective factors. Improving social connectedness is a key factor in reducing the likelihood of suicidality. Promoting cultural and religious beliefs that discourage suicide and promote self-preservation (US DHHS, National Statistics of Older Adult Suicide from the National Suicide Prevention Plan) is a protective factor. As we have already said, promoting healthy behaviors is a protective factor as is reducing the stigma of suicide and mental health issues. There is much we can do and much we must do to slow this epidemic.

Collaboration from page 36

All services need to be based on a comprehensive biopsychosocial assessment for each individual. The assessment needs to consider historical, as well as current and interrelated variables including medical, psychological, as well as environmental factors.

Practices in Intersystem Collaboration: Developing a local, regional, or statewide task force can be a very important method in the attempt to improve service delivery for this underserved population. The task force can gather information and data to analyze relative strengths and weaknesses in the service delivery system for people with a dual diagnosis. This can allow planning to address the weaknesses while taking advantage of the identified strengths.

The dual diagnosis task force needs to include decision making representatives from the MH and IDD systems. The composition of the committee should also include representatives from state regulatory authorities, service providers, family representation, and advocacy organizations. The working group could include other constituents either on an ongoing or as needed basis. The stakeholders would include, for example, representation from the criminal justice system, special education, and substance abuse. There is a need for comprehensive service components to be available, accessible, and appropriate for each individual. This involves an array of service components that need to be coordinated.

Effective Planning and Practice Elements: There are four aspects that are needed for effective planning and practice with regard to intersystem collaboration for people with co-occurring disorders. These four elements are: (1) leadership, (2) effective staff, (3) effective treatment, and (4) staff training. Each of these four practice elements is relevant to advance intersystem collaboration. The elements taken together are designed to have a synergistic effect on promoting intersystem collaboration.

Effective Leadership: Leadership's embrace of intersystem collaboration is essential. Without leadership to support advancing intersystem collaboration, little can be accomplished from a systemic perspective. Identifying a "champion of the mission," from a leadership position, would facilitate the process leading to a more likely positive outcome.

Effective Staff: It is important that the "right" staff be at the intersystem collaboration table. Systems planning requires decision makers who can effectively represent their constituency or system in a manner that seeks to promote intersystem collaboration.

Effective Treatment: Treatment follows diagnosis. Therefore identifying the appropriate diagnosis is crucial. The Diagnostic Manual – Intellectual Disability (DM-ID-2) can assist in the diagnostic process. Once a diagnosis has been established, there may be a need for medication and/or psychotherapy. Medication treatment should be aligned with a psychiatric diagnosis. A holistic approach to care and treatment essentially requires both a mental health and a developmental disability approach. Positive behavioral supports should be used along with mental health treatment. Psychotherapy such as DBT and CBT have been growing substantially as they are adopted and applied to people with a dual diagnosis.

Staff Training: Staff training at all levels is a prerequisite to effective planning and practice. At all levels, staff need knowledge, practice skill, and competency. For example, Direct Support Professionals need to learn how to observe behaviors that might be indicative of a mental health disorder. Clinicians need to appropriately identify specific psychiatric disorders in persons with limited language skills. Additionally, service coordinators, supervisors, as well as administrators need to know how to negotiate the complexities of various systems.

Summary

While care for this vulnerable population poses obvious obstacles, it is not impossible to come up with an effective management plan that will get individuals the supports and treatment that they need. There should be coordination and collaboration at both the systems and the service deliveries levels while still involving the mental health and developmental needs of the individual with assistance of their family. The most important thing to remember is that all systems must work together to ensure the smoothest management from all entities including local, regional, and state organizations. Even though this process is challenging, it is an important step in getting members of this population the support and treatment they need and deserve.

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Vulnerable Populations: People of Color in Leadership Roles

By Mary Pender Greene, LCSW, President MPG Consulting

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

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

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

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

Prior to my training and exposure to aspects of organizational life (ie; the role of organizational dynamics, roles, posturing for power and authority) at the William Alanson White Institute, I had no awareness of organizational life despite my extensive clinical training and practical experience. Because of this lack of awareness, and lack of knowledge about organizational theory, I spent years taking organizational issues personally. I learned, and truly internalized at The White Institute, that an individual in a group or organization is no longer just an individual. In other words, it's not about me – which makes dealing with criticism much easier. We, as people of color who regularly experience criticism due to racial stereotyping, need to develop a more measured response. Also, alternative explanations for criticism for our actions should be thoroughly examined from an organizational lens, while keeping our integrity and self-esteem intact. At the same time, we must be mindful that learning to distinguish between racially motivated and substantive criticisms requires time, sophistication and intense awareness of one's strengths and challenges.

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

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

***Leadership Today*:** In the U.S., white supremacy is "a pervasive social, political and economic phenomenon." Not only is it an ideology based on racial prejudice, but it is also a system that includes cultural messages, policies, practices, beliefs and actions (Disrupting White Supremacy from Within, 2004). As a result, white men have historically carried out leadership in organizations. Cultural overlays are at the core; these institutional structures have created and sustained the dominant way of being. According to SPAN Anti-Racist Education (2005), there may be tokenized hiring, repetitive injury and denial of racism. They may ignore, blame and retaliate. These internal practices harm people of color. But pushing for accountability means pushing against "the system."

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

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

Despite the obvious need and research confirming the value that difference and inclusion can make to our organizations, why is it so difficult for People of Color to lead? One factor is our mental models for leadership. A charismatic, heroic white male model is indelibly etched in our collective mindset. There is still little acceptance for a model of leadership using all the talents in an organization and valuing all perspectives. While we all understand that change – whether individual, family or organizational – involves letting go of the familiar. And we all resist change.

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

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

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

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

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

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

Equipping ourselves with two vital pieces of knowledge will enable us to have truly authentic relationships. The first is a genuine understanding of the role oppression plays in people's lives. The second is a sincere appreciation of privilege, what privilege is, who it impacts and how it permeates our culture – often in ways that are difficult to recognize and even harder to understand. We must accept that we don't know what we don't know. To get that understanding, we must first be willing to learn about issues that may not be a part of our personal experience. If you see something, say something. It will heard more objectively if the issue is not your own. When I, a straight woman of color, discuss LGBTQ issues, Islamophobia or bicultural/bilingual representation, it has greater impact.

Workplace diversity is important, but so is organizational culture. Organizational culture is often inhospitable to people of color in leadership roles. This is why so many people of color are overlooked, opt out of leadership paths, or simply leave an organization after just a few years. Many who leave publicly claim it was for a better opportunity, but privately they admit to not feeling valued for who they were and what they contributed. When people feel valued, welcomed and appreciated, they do a better job and are more productive. It is no secret, people want to connect and make a difference.

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

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

***Suggestions for Improving Our Profession*:** In order to truly assess an organization for the impact of structural racism and to have authentic cross-racial and cross-cultural dialogue, training is key. A more diverse executive suite means more role models and opportunities to achieve professional goals. But most importantly, it means an opportunity to bring new aspects of leadership into our profession. While change supported from the top is easier, I believe change can start with you, regardless of your positional authority: (1) Take the Undoing Racism workshop that is offered by the People's Institute for Survival and Beyond. It changed my life and my practice. (2) Regularly visit the AntiRacist Alliance website www.antiracistalliance.com for hundreds of meetings, articles, books, workshop etc. (3) Recruit at least one other person to accompany you on your professional and personal antiracist journey. (4) Develop a close and authentic cross-cultural relationship. It will help you to expand your life and your practice. (5) Support and work towards building a leadership team that reflects your organizations client population.

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

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Mary Pender Greene, LCSW-R, CGP is a psychotherapist, career & executive coach, trainer and consultant with 20+ years of experience and a private practice in NYC. Her background includes executive management roles at America’s largest non-profit organization, The Jewish Board of Family Services in NYC. She is the President & CEO of MPG Consulting and author of Creative Mentorship and Career-Building Strategies: How to Build Your Virtual Personal Board of Directors. She is the Co-Editor of Strategies for Deconstructing Racism in the Health and Human Services.

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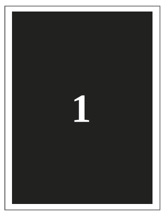

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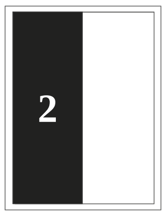

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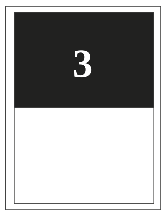

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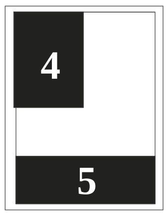

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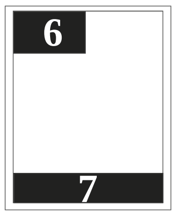

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