# BEHAVIORAL HEALTH NEWS

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SUMMER 2019 ON MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT AND SERVICES VOL. 7 NO. 1


## The Behavioral Health Workforce Crisis: Past, Present, and Future

**By Michael B. Friedman, MSW**

First on the list of topics for this issue of *Behavioral Health News* was "The Workforce Crisis Today." That's interesting because the workforce "crisis" is anything but new.

For example, when I first entered this field during the height of deinstitutionalization in New York—the early 1970s—there was a vast shortage of English-speaking psychiatrists in the state hospital system. Having the proper credentials was good enough at the time. Never mind being able to communicate with one's patients; there was paperwork to be signed.

Fortunately, progress has been made. The problem now is finding psychiatrists who speak languages other than English and who have real clinical and cultural competence, especially regarding kids and older adults.

Of course, it was even worse in the years before deinstitutionalization. Staff-patient ratios in state hospitals were often 1 staff to 8 patients. And the quality of the staff—the attendants and others—was often abysmal. Some were lovely, caring people, no doubt, but some were abusive in the extreme and clinically incompetent. Now a minimum is more like two staff per patient. And abuse, especially the officially sanctioned abuse of the old days such as harsh restraint and punitive seclusion, has been significantly reduced if not eliminated. Much better.

How did they manage in the old days? The patients did much of the work. They cleaned the hospitals, cut lawns, cooked meals, chauffeured the hospital directors, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

So, to say it again, a mental health workforce crisis is not new. And since the beginning of the community mental health movement, many somewhat successful efforts have been made to address both the shortage of mental health personnel and their limited clinical, cultural, and—I would add—generational competence.

These efforts fall into three broad categories—education and training, recruitment,

*see Workforce Crisis on page 31*

## Leaders Honored at MHNE Annual Awards Reception

**By Staff Writer**
**Behavioral Health News**

It was a night to remember for everyone who attended the 2019 Leadership Awards Reception at the NYU Kimmel Center in New York City on May 22nd. Mental Health News Education, Inc. (MHNE), publisher of *Behavioral Health News* and *Autism Spectrum News*, celebrated its 20th Anniversary with leaders and supporters from the behavioral health and autism communities.

Honored at this year's reception were: Steve Coe, CEO of Community Access, who received a Lifetime Achievement Award; Daniel Etra, CEO, and Eran Rosenthal, President and COO of Rethink Autism, received a Leadership Award; Peter Provet, PhD, President and CEO of Odyssey House, received a Community Service Award; and Joyce Wale, Regional Executive Director of United Healthcare, received a Corporate Leadership Award.

Debbie Pantin, MSW, President and CEO of Outreach and MHNE Board Chair, opened the evening's program stating, "As we celebrate the 20th Anniversary of MHNE, we are so proud to be honoring such a distinguished group of leaders from the behavioral health and autism communities." Prior to the award presentations, Ira Minot, LMSW, Founder and Executive Director of MHNE and Publisher of *Behavioral Health News*, told a heartfelt story of his recovery from depression, entitled, "The Handshake of Hope." His son David Minot, BA, Associate Director of MHNE, and Publisher of *Autism Spectrum News*, spoke of the organization's vision for the future which will be greatly enhanced by MHNE's launch of a more sophisticated internet and social media presence.


**Debbie Pantin, David Minot, Dr. Peter Provet, Joyce Wale, Steve Coe, Daniel Etra, Eran Rosenthal, Ira Minot**

MHNE Vice-Chair, Rachel Fernbach, Esq., Deputy Director and Assistant General Counsel of the New York State Psychiatric Association and MHNE Board Secretary and 2019 Leadership Award Reception Event Chair, Yvette Brissett-André, MPA, Executive Director and CEO of Unique People Services, stated, "We both want to thank our many 2019 event sponsors and guests for their outstanding support of our 20th Anniversary event. Thanks to their efforts, we raised over $100,000 which will go directly to expanding MHNE's educational mission."


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**Summer 2020 Issue:**
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# New Mental Health Parity Laws in New York State

**By Ann Sullivan, MD**
**Commissioner**
**NYS Office of Mental Health (OMH)**

About one in five New Yorkers require behavioral health services, but many do not receive treatment because of a lack of access to insurance coverage. More than 10 years ago, the federal Mental Health Parity and Addiction Equity Act required large group health plans that provide mental health coverage to do so at levels comparable with medical services.

And yet national studies continue to reveal significant challenges with accessing behavioral health services for individuals and families even if they have comprehensive health insurance coverage. Individuals and families often experience higher out-of-network use, lower reimbursement and restrictions on coverage for needed behavioral health services including mental health services and treatment for addiction.

Fortunately, Governor Andrew Cuomo included critical parity and insurance reforms in his 2019 Justice Agenda, and these new laws and regulations will help guarantee access to mental health care for all New Yorkers. These laws require that insurers apply the same standards for access to mental health and addiction treatment services as they do to medical and surgical care. Some of the strongest and most effective in the nation, these laws will offer additional protections to individuals in need of mental health services and will provide them with help if they feel these laws are not being followed. We now have a clear blueprint to ensure real parity!

## Community Health Access to Addiction and Mental Healthcare Project (CHAMP)

In order to help all New Yorkers access insurance coverage for substance use disorders and mental health services, Governor Cuomo and members of the State Legislature created the Community Health Access to Addiction and Mental Healthcare Project (CHAMP).

**Dr. Ann Sullivan**

CHAMP, an ombudsman program developed in partnership with the Community Service Society, the New York State Council for Community Behavioral Healthcare, The Legal Aid Society, the Medicare Rights Center, and the Legal Action Center, will assist individuals and families in obtaining their legal rights to insurance coverage, helping them to access treatment and services, and resolving complaints regarding denial of health insurance coverage.

The program can help participants by: Listening to their concerns and complaints; Educating participants about their insurance rights; Empowering participants to advocate for themselves and work successfully with treatment providers to address insurance concerns; Helping to address barriers to treatment they need, including medication; and Getting the most from their insurance coverage for substance use disorder and mental health services.

Helpline representatives may be able to resolve concerns immediately, or will enlist the expertise of dedicated CHAMP legal, substance use disorder, or mental health specialists to address the issue. Participants can be assured of timely, respectful, and culturally sensitive assistance with concerns regarding: Access to treatment; Denial of services; Access to medication; Parity/coverage discrimination issues; System navigation; Medical benefits; Enrollment referral; and Legal assistance for insurance appeals.

Consumers and providers can get help from CHAMP by calling the new helpline number (888-614-5400) or by writing to ombuds@oasas.ny.gov.

## Additional New Parity Laws and Regulations

Under Governor Cuomo's leadership, New York has enacted additional tough new laws and regulations that will: Prohibit prior authorization for minors entering inpatient psychiatric treatment and prohibit concurrent utilization review during the initial 14 days of treatment; Prohibit insurers from requiring prior authorization to receive medication-assisted treatment (MAT) for substance use disorders (SUDs) and extending the time period for concurrent review for inpatient and outpatient addiction treatment; Require insurers' medical necessity criteria for mental health services be reviewed and approved by the Office of Mental Health; Limit patient co-payments for outpatient mental health services and SUD treatment to the equivalent cost of a primary care visit and limiting co-payments for outpatient SUD treatment to one per day; Require network adequacy that provides for timely access to providers; and Codify key parity standards in State law for both MH and SUD benefits.

Governor Cuomo also signed the Mental Health and Substance Use Disorder Parity Reporting Act (Chapter 455; Laws of 2018), which requires health plans to submit key data to the Department of Financial Services (DFS) to ensure compliance with State and Federal Parity Laws. DFS will post this information on its public website, allowing consumers and healthcare providers to determine how well insurers comply with the Parity Act.

This builds upon last year's implementation by DFS of a new regulation that required insurers to include in their policies a process for insureds, their designees or prescribers to request a review of a decision that a medication for detoxification or maintenance treatment of a substance use disorder drug is not covered by the policy.

Under that regulation, every insurer that provides hospital, surgical, or medical expense coverage and also provides coverage for medication for the detoxification or maintenance treatment of a substance use disorder must include in the policy processes that allow an insured, the insured's designee, or the insured's prescribing physician to request a formulary exception and gain access to clinically appropriate medication for the detoxification or maintenance treatment of a substance use disorder not otherwise covered by the policy.

Insurers must make determinations on standard exception requests and notify the insured, or the insured's designee, and the insured's prescriber no later than 72 hours after the request. It also required insurers to have a process for expedited formulary exception requests based on exigent circumstances and make determination and notification no later than 24 hours after such requests.

New York has been a leader in advancing parity during the past decade, with early passage of Timothy's Law, protections for the integration of behavioral health services into Medicaid managed care and reforms to address the opioid epidemic. This package of new laws will help to improve access to insurance coverage for substance use disorder and mental health services and will help eliminate barriers, increase accountability among insurers and health plans, and ensure that New Yorkers receive all the benefits they are entitled to.

# Strengthening the Addiction Workforce and Beyond

**By Arlene González-Sánchez**
**Commissioner, NYS Office of Alcoholism and Substance Abuse Services**

Over 20,000 professionals make up the Substance Use Disorder (SUD) Prevention, Treatment and Recovery Workforce in NYS. The US Bureau of Labor Statistics projects that the SUD workforce will grow at a much faster rate than other occupations in the country and in NYS. The Credentialed Alcoholism and Substance Abuse Counselor growth rate in NYS is projected at 30% between now and 2026 with 1,280 average annual openings projected. That number includes those needed to meet the new demand as well as those that will need to backfill the positions created by the average annual separations in this occupation.

To help meet this need many local Career Centers across the state received Opioid Disaster funds to fund occupations associated with the opioid crisis. Career Centers in the following areas received these funds and those interested in training for an addiction career should visit one of the following Career Centers, Columbia/ Greene, Finger Lakes (Ontario/Wayne/ Seneca/Yates), Nassau (Hempstead/Long Beach), Herkimer/Madison/Oneida, Monroe, North Country (Essex/Franklin/ Clinton), Onondaga, Orange, Suffolk, Sullivan, Westchester/Putnam to inquire about the availability of funds. Additionally, OASAS has received $350,000 for scholarship funds this year and those funds will be disseminated to those working in OASAS Prevention and Treatment programs. OASAS has funded Certified Recovery Peer Advocate (CRPA) scholarships for the past two years.

Additionally, OASAS received $2M in Recovery Tax Credits to disseminate to employers to offset their corporate sales tax. On or after January 1, 2019 OASAS will disseminate $2,000 tax credits to for-profit employers for each new employee they hire who is in recovery from a SUD. Many employers have already found the benefit of hiring recovering people into their workforce and the Recovery Tax credits will be will be used to increase those instances. Recovering individuals are not only dependable, reliable and hard -working employees but they can also have a positive impact on their colleagues who may be suffering from addiction themselves or are struggling with a family member or loved one who is addicted. The Recovery Tax Credit program makes recovering individuals even more attractive to employers and helps reduce the stigma that has plagued those recovering from addiction. It is an investment in the recovery capital that individuals have built through their recovery and it will go a long way to reaching others in workplaces that are struggling with addiction.

**Arlene González-Sánchez**

OASAS ensures that staff working in the continuum of prevention, treatment and recovery services are competent in delivering addiction service by providing credentialing for SUD and gambling prevention and treatment professionals. OASAS also provides training for other medical and behavioral health professionals working in our system. Currently, no other NYS licenses/certifications require addiction competencies as part of their required pre-service coursework or examinations. Many professionals voluntarily seek out elective coursework during their pre-service education and may obtain addiction credentials/certifications in the course or their career, but addiction competencies are not part of obtaining a medical or behavioral health license in NYS, which is why OASAS must continue to credential addiction professionals and require additional addiction training for those working in our services.

Prevention staffing guidelines require all Prevention Directors and a percentage of staff to have either an OASAS prevention credential or a related certification (i.e. - Teaching, Health Education, Social Work) along with SUD prevention specific coursework and experience. OASAS also requires that all new Prevention Specialists complete a Substance Abuse Prevention Skills Training (SAPST) course within their first year of employment in an OASAS funded Prevention Program. The SAPST is a blended learning course consisting of a 5-hour online course and a 4-day face to face course. The course was developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to give Prevention Specialists a foundational training in the SUD prevention framework.

Treatment staffing requires a multi-disciplinary team format. Most levels of care require a Medical Director with a DATA 2000 Waiver, which allows them to dispense addiction medications. Many programs also employ Nurse Practitioners and Physician Assistants with DATA 2000 waivers to extend their ability to provide addiction medications for their patients/clients. Nursing staff are also a required component of many levels of care. Additionally, programs include Credentialed Alcoholism and Substance Abuse Counselors (CASACs) and other licensed, Social Workers, Mental Health Counselors and/or Marriage and Family Therapists. Many programs also employ vocational counselors, and some have recreation therapists.

In 2018, OASAS implemented a SUD Counselor Scope of Practice which outlines a career ladder for SUD Counselors and indicates which clinical skills each level can perform and what level of supervision is required for each level. All Supervisors must at a minimum have a national credential or state licensure and a bachelor's or master's degree. Supervisors must also complete a 30 Hour Clinical Supervision course to be at the Advanced or Master Level and to supervise clinical staff. Additionally, all staff are required to complete training on Medication Assisted Treatment/Recovery, SUD Ethics, SUD Confidentiality and other addiction coursework as a minimum requirement for their orientation. All programs are required to document that staff meet and maintain their credentials and complete the orientation coursework. OASAS also offers, at least monthly, free, online training on pertinent addiction topics which includes a year long series on Ethics which can be accessed at: https://www.oasas.ny.gov/testportal/LTcourses.cfm . Additionally, free regional trainings are offered throughout the state and can be found at: https://www.oasas.ny.gov/workforce/training/oasastraining.cfm.

Along with treatment services, recovery services have expanded throughout the state. Community based recovery services are now available in all regions and in many communities across NYS. The Peer Workforce are the newest members of the SUD workforce. In 2013, OASAS approved the New York Certification Board (NYCB), a subsidiary of the New York Alcoholism and Substance Abuse Providers (ASAP), to certify Certified Recovery Peer Advocates (CRPAs). Since then more than 1,100 CRPAs have been certified and may now perform Peer Services in OASAS outpatient clinics and those services can be reimbursed by Medicaid and Managed Medicaid.

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# Mental Health Parity and Its Impact on the Behavioral Health Workforce

**By Rachel A. Fernbach, Esq.**
**Deputy Director and Assistant General Counsel, New York State Psychiatric Association**

In 2006, New York enacted a parity mandate in the form of Timothy's Law, which requires group health plans to provide 30 inpatient days and 20 outpatient days for most mental health diagnoses and requires large plans to provide full coverage for certain biologically based illnesses. Several years later, Congress enacted the federal Mental Health Parity and Addiction Equity Act, which expands Timothy's Law into a full parity benefit. Despite these hard-won legislative successes, full implementation and enforcement of parity requirements has yet to be achieved and challenges remain, particularly in the context of parity in reimbursement and parity in utilization review. These areas often have a significant impact on the behavioral health workforce and their ability to receive adequate reimbursement for the essential care and treatment they provide to patients in need.

This article will address some recent legislative and litigation-related successes in New York and in other jurisdictions as well as additional advocacy work that is still needed in the parity arena.

### Behavioral Health Insurance Parity Reforms

One recent success involves the 2019-20 New York State Budget, which included a comprehensive overhaul of the New York Insurance Law seeking to eliminate discrimination in coverage of care and treatment for mental health conditions, substance use disorders and autism spectrum disorders. These new provisions, called Behavioral Health Insurance Parity Reforms (BHIPR), apply to all health insurance and health benefit plans offered in New York State, including individual plans, group plans and HMOs.

**Rachel A. Fernbach, Esq.**

The following are some of the key provisions of the BHIPR:

• Coverage for all mental health conditions, substance use disorders and autism spectrum disorders, as defined in the most recent edition of DSM or ICD;

• Prohibits preauthorization and concurrent review of substance use disorder services during the initial 28 days of inpatient and outpatient treatment;

• Prohibits preauthorization and concurrent review of psychiatric inpatient services for persons under the age of 18 for the first 14 days;

• Prohibits prior authorization for formulary forms of prescribed medications for treatment of substance use disorders;

• Clinical review criteria applied by utilization review agents must be approved/designated by OMH or OASAS, where applicable;

• Medical necessity criteria must be made available to insureds, prospective insureds, or in-network providers upon request;

• Prohibits taking any adverse action in retaliation against a provider filing a complaint, making a report, or commenting to a government body regarding policies and practices that violate the law;

• Requires insurers and health plans to post additional information regarding their in-network providers of mental health and substance use disorder services, including whether the provider is accepting new patients as well as the provider's affiliations with participating facilities certified or authorized by OMH or OASAS; and

• Provides additional funding resources for staffing at DFS and DOH to handle oversight and enforcement of parity.

Self-insured plans are not subject to these new provisions, but remain subject to the federal parity law and regulations. The BHIPR provisions take effect January 1, 2020 and apply to all policies issued, renewed, modified or altered after that date.

### Landmark Mental Health Ruling in Class Action Suit

A second success in the fight for full implementation of the parity statutes took place earlier this year, when the U.S. District Court for the Northern District of California held that United Behavioral Health (UBH) illegally denied coverage of mental health and substance use disorder treatment by relying on flawed medical necessity criteria (Wit v. United Behavioral Health, Findings of Fact and Conclusions of Law, Case No. 14-cv-02346-JCS, (N.D. Cal. Mar. 5, 2019), ECF No. 418). The Court found that UBH was liable under ERISA for developing restrictive medical necessity criteria that deviated from generally accepted standards, resulting in systematic denials of outpatient, intensive outpatient and residential treatment. Although UBH has indicated publicly that it plans to appeal the decision, this is an important breakthrough because the Court acknowledged that UBH's utilization review activities appear designed to limit coverage and therefore reduce access to necessary behavioral health care and treatment. Although the class action suit did not address parity issues, targeting the treatment of mental illness for medical necessity reviews constitutes a pattern and practice of impermissible discrimination that may also violate the federal Mental Health Parity and Addiction Equity Act.

In the 106-page decision, the Judge noted: "…in every version of the Guidelines in the class period, and at every level of care that is at issue in this case, there is an excessive emphasis on addressing acute symptoms and stabilizing crises while ignoring the effective treatment of members' underlying conditions." He further noted that UBH guidelines appear to be aimed at reducing costs rather than fiduciary duties owed to beneficiaries and reflected "a 'utilization management' model that keeps benefit expenses down by placing a heavy emphasis on crisis stabilization and an insufficient emphasis on the effective treatment of co-occurring and chronic conditions."

### Evaluation and Management Claims

On the other hand, there remain significant issues with reimbursement for behavioral health services that directly impact providers and must be addressed. Recently, two NYSPA members received disallowances of evaluation and management (E/M) codes by a commercial carrier in connection with combination psychotherapy claims. During the course of a post-payment documentation audit, the carrier took the position that "the use of

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# Self-Care is Essential to Well-being at Work

**By Lisa Furst, LMSW, MPH**
**Assistant Vice President, Center for Policy, Advocacy and Education, Vibrant Emotional Health**

By now, "self-care" and "workplace wellness" aren't novel concepts. It would be difficult not to find myriad references to both in the popular and professional press. Many organizations, including in the private sector, healthcare and government have embraced employee wellness programs, seeking to improve staff health, morale and productivity.

But could well-being - or lack thereof - in the workplace actually be a public health issue? The World Health Organization thinks it is, reporting in May 2019 that burnout is a "syndrome" that is the direct result of "chronic workplace stress that has not been successfully managed (World Health Organization 2019, Burnout an "occupational phenomenon": international classification of diseases. https://www.who.int/mental_health/evidence/burn-out/en/ Accessed June 12, 2019)." The implications of this are significant for the behavioral health workforce, which works to address both the ongoing needs and emergent crises of some of the most vulnerable populations in New York State and is subject to significant workplace stress.

Workplace stress can be understood as harmful physical and emotional responses that occur when the requirements of the

**Lisa Furst, LMSW, MPH**

job do not match the capabilities, resources, or needs of the employee (National Institutes of Safety and Health 2007, Workplace Stress. https://blogs.cdc.gov/niosh-science-blog/2007/12/03/stress/ Accessed June 12, 2019). But what makes working in behavioral health stressful? While clinical practice, direct care and program administration all provide their share of stressors, many people in our sector would point to persistent systemic and organizational factors that induce or exacerbate workplace stress. These are numerous, but some of the most significant include: (1) Heavy workloads or caseloads with demanding documentation requirements; (2) Inadequate funding, leading to staff shortages and salaries that do not meet the cost of living; (3) More work than can be accomplished during a regular shift or work day; (4) Not having adequate supervision to support best practices and to address the effects of regular exposure to learning about the traumatic experiences of those we serve.

So, what can behavioral health organizations do to promote wellness for its workforce?

Workplace wellness, while often conceptualized as something individual employees engage in on their own, starts with an organization's commitment to creating a culture in which staff feel respected, engaged, and supported so that they can provide high quality services to consumers. There are many ways to develop an organizational culture of wellness. Some examples of steps that organizations can take to foster employee well-being include:

*Create a Listening Environment:* Have regular staff meetings; Ensure staff have consistent supervision time to discuss their work; Engage staff in conversations about their work and organizational operations and put their suggestions into practice, wherever possible.

*Foster a Culture of Acknowledgement:* Celebrate staff successes–and not just the large ones; Reward excellent performance; and Explicitly recognize how central staff are to achieving organizational goals.

*Encourage Movement:* Create and promote opportunities for exercise, such as group lunchtime walks; Engage local resources, like gyms or health clubs, to provide reduced memberships for staff; and Organize lunch-and-learn sessions to teach chair yoga, stretching, and breathing exercises that can be done at work.

*Ensure a Healthy Workspace:* Find ways to reduce environmental stressors, such as noise pollution, inadequate or harsh lighting, and outdated equipment that is difficult to operate; Develop a workplace safety plan to help staff defuse consumer crises and address emergencies that threaten to disrupt program operations – and make sure that everyone knows how to enact those plans; and Promote existing resources to which employees can turn for help when dealing with emotional distress, and encourage staff to use them where indicated.

And what can we in the behavioral health workforce do to take care of ourselves while we're at work?

First, it's important for us to acknowledge that taking care of ourselves is critically important when the primary focus of our job is to care for others. While some of the workplace stressors we experience are common across various sectors – tight deadlines, for instance – the behavioral

***see Self Care on page 35***

# Millennials in the Workplace: Investing in a Generation

**By Colleen Beagen, Vice President, Director of Human Resources Odyssey House**

Millennials are now the largest age demographic in the country and the fastest growing cohort in the workforce. Based on U.S. Bureau of Labor statistics, it is projected that by the end of next year millennials will make up 47 percent of the employees in the workplace, and five years later they will exceed 75 percent of the entire workforce. Given these statistics, it benefits organizations to tap into what motivates and appeals to this demographic in order to attract and retain the best talent.

Workplace trends and research on the millennial generation (generally categorized as born between 1981 and 1996), find that one of the most important characteristics for this age group is that they are primed to do well by doing good. Almost 70 percent say that giving back, being civically engaged, having opportunities for social impact, and making a difference are their priorities.

**Colleen Beagen**

## Purpose Over Paycheck

They don't just work for a paycheck, they work for a purpose. That millennials are driven to be socially engaged is good news for behavioral health care providers. When we asked our millennial staff members why they chose to work for Odyssey House, their responses were on target with workplace trends for their generation. When accounts payable specialist Wendolin Pantaleon graduated from college with a BA in Accounting, she hoped to work for an organization where she could make a "meaningful impact in her community." She would pass by Odyssey House facilities in the South Bronx on her way home from college and was interested in pursuing opportunities to give back in her neighborhood. For Wendolin, presented with a choice of potential employers, she chose an organization with a reputation for investing in local services and investing in its workforce.

Other trends show the millennial employee is very interested in feedback on his or her performance. Millennials have received adult feedback throughout their earlier years. They've often had close involvement from parents in their education and individual support and encouragement from teachers and mentors at school. The contrast can be jarring when they arrive at their first professional position and suddenly only get traditional semi-annual or annual reviews. For them it's too infrequent, they crave feedback, good and bad.

At Odyssey House we have supervision schedules where employees are given feedback on a consistent basis. They receive formal supervision up to twice a month, depending on their job title, and more than that if necessary. Along with tuition reimbursement allowances, employees who are pursuing further education, advanced degrees, certifications or licenses receive additional structured supervision from a certified instructor.

## Teamwork and Engagement

Another key workplace expectation for this generation is an emphasis on teamwork. Many millennials have grown up under parenting styles that supported empowerment, where the kids were included in family decision-making. Now, as they enter the early stages of their careers, millennial employees look for employment with organizations that foster an employee-driven decision-making process. Not only do they want to share responsibility and decision-making, they want to discuss their ideas and be taken seriously as problem solvers.

When Elizabeth Gary found out Odyssey House was looking for social workers to work with pregnant women and mothers with infants at its newly renovated Family Center on Ward's Island, she was excited to be a part of a family-focused service. For her, the Healthy Mothers, Healthy Families program that brings extended family members into the recovery process and provides young mothers with continuity of care after completion of residential treatment was a therapeutic approach that made sense and inspired her to apply to an organization that she says "has progressive programs where what I do has a meaningful impact and makes a difference every day."

Adding to the sense of purpose she derives from her work with families, Elizabeth said she is further motivated by having a voice in the creation of the program. "Everyone asks me my opinion, and it's really great to be encouraged to have input."

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# An Effective Work Force Embraces and Drives Integrated Care

**By David Kamnitzer, LCSW-R**
**Chief Clinical Officer and Senior Vice President for Housing and**
**Mindy Liss, Vice President for Strategic Communications**
**ICL**

**David Kamnitzer, LCSW-R**

**Mindy Liss**

The behavioral health sector has been in the throes of a generational change over the past decade, one that has challenged the very way we offer treatment, organize operations and receive funding for our services. Our agencies have worked hard to adapt to these changes while maintaining the strongest commitment to the people we serve and the quality of their care.

Among the most significant challenges has been in preparing our workforce for the shift to integrated care. Fortunately, ICL had long understood the importance of treating both the physical and mental health needs of an individual as well as the impact of their total life experience – the social determinants of health. As far back as 2011, our agency was awarded a SAMHSA grant to support a ”whole health” perspective that addressed the critical importance of person-centered care.

One of the most significant challenges of the shift to integrated care has been how to help staff incorporate this approach into their work to best serve clients.

ICL recognized that this whole health perspective required a completely new way of looking at practice. In 2013, when David Woodlock became ICL CEO, he brought with him a longstanding commitment to integrated care that was central to his plans for the agency. While integrated, person-centered care had already begun to be practiced at ICL, under his leadership, the agency moved toward more formalized training by identifying four pillars of care – otherwise known as TRIP – care that was trauma-informed, person-centered, integrated and recovery-oriented. This became the centerpiece of training and ongoing education at ICL and would come to be shared with staff at all levels – from social workers to fee clerks, from case managers to office managers.

## Understanding Social Determinants of Health

This new paradigm in care has meant reshaping ICL services through an integrated care lens and giving staff a deeper understanding of who they are serving – people in poverty, in distressed, underserved and highly diverse communities and the multiplicity of factors affecting their lives – the Social Determinant of Health. What sets apart ICL is that in our widely varying programs, all staff are now trained to address medical issues with clients. Workers helping people with serious mental illness now ask about their diet, how their blood pressure is, if they are taking insulin for diabetes. We encourage and track our clients getting flu shots and having `heir A1c tested. Among the many tools we offer staff is a Healthy Living Workbook with tools and tips for assessing and improving health status of all clients.

For the past decade, we have been writing and discussing individuals with “co-morbidities” -- who have both a psychiatric illness and a medical diagnosis such as diabetes, asthma or high blood pressure. In the process of building a more whole health approach to care, we’ve sought to break the cycle of emergency room usage and hospitalizations for both physical and mental health reasons. Driving our work is the staggering statistic that individuals with serious mental illness die 25 years earlier than the general population. Part of SAMHSA’s mission has been to urge providers to think about integrated care by incorporating Wellness Self-Management throughout all areas of programming and over the past ten years there has clearly been a positive shift in this direction.

At ICL, our outcomes are measured through twice yearly surveys – and the results have been consistently impressive. In 2018, for example, 98% of client say they feel more in control of their lives and more connected to family and community. Once again, SAMHSA recognized our work in 2017 when they selected ICL as only one of three agencies from around the country with their Wellness Award for improving health outcomes for clients with serious health challenges.

At the core of our shift to a more integrated care model is our commitment to and respect for our dedicated staff, who are always poised to learning and advancing new ideas. As a result of the intensive training we offer throughout the year, staff at all levels are developing and refining new treatment tools. Whether an inpatient setting or outpatient clinic, whether delivering services in the home, in a shelter or providing street outreach, ICL staff have become increasingly skilled at addressing both the emotional and physical needs of the people they work with.

All of this represents a major shift for staff, particularly people trained in behavioral health, where assessments were historically focused on past psychiatric hospitalizations, substance use history and other psychosocial stressors. While this remains critically important information in care planning, we understood it was simply not enough. We came to understand the need to “know all the facts” of a person’ life, including their physical health status.

## Bringing the Whole Health Model to the Next Level

ICL’s embracing of an integrated care model took on even greater significance with the opening last Fall of our East New York Health Hub. After years of planning with community partners and funders and builders, ICL opened a spectacular 43,000 square foot center designed with the health of the community top of mind. A number of critical ICL programs including Family Resource Center, PROS, ACT teams and our Highland Park Clinic, moved into the space. But the Hub is far more than about co-location. It is about giving access for the people of East New York to the finest health and behavioral health services.

Our innovative health care partner in the Hub is Community Healthcare Network (CHN), a highly regarded organization that operates 13 FQHCs (federally Qualified Health Centers) around the city and shares our vision for maximizing care that addresses all aspects of a person’s life. While our two organizations operate under very distinct and sometimes contradictory regulations and have different cultures, from the beginning we have had an open dialogue and were open to learning from each other as we fine-tune the workings of the Hub. One of the principles we’ve both adopted is the understanding that people coming to the Hub are not a client of CHN or ICL -- they are being served at the Hub; together we ensure people get the best and most integrated care possible.

Accomplishing true service integration at the Hub is not easy but the Altman Foundation and New York Community Trust are generously supporting our development of shared policies, procedures and workflows to standardize provision of care. Timely and effective service and information coordination between our organizations is critical for us to reach the best possible outcomes for the people we serve.

ICL and CHN staff meet regularly to address concerns and challenges; they also socialize and celebrate holidays, reflecting the importance of relationship-building that is at the heart of good practice.

Because in the end, good practice is still what drives us, especially in the face of major changes in the health care system. We continue to be guided by the roots of social work education and clinical practice and their emphasis on relationship-building, engagement and establishment of trust as rudimentary tenets in building rapport with individuals seeking services. In addition to adapting new tools and approaches, those working in direct care must still learn the fundamental skills of empathy, compassion, employ unconditional regard, demonstrate respect for cultural differences, and pay close attention to social justice, oppression and marginalized communities.

Ultimately the success of the paradigm shift around integrated care rests on our respect for our clients and the experiences that have affected them throughout their lives. This is the necessary first step to real recovery.

So while we’ve been at work rethinking how we provide services and want to help staff incorporate new approaches into their work, we have not lost sight of our core values and our mission that people get better with us. Our health care system is in constant evolution – we are confident that the work we are doing at ICL will continue to move the needle on health care that improves lives. Our staff are fully dedicated to be part of this incredibly important moment in history and to providing meaningful and impactful care to people in the 21st century -- care that changes lives.

# A Dedicated but Neglected Workforce: A Clarion Call for Change

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

**Ashley Brody, MPA, CPRP**

The social service agencies on which vulnerable New Yorkers depend rely heavily on the state government for financial support inasmuch as they act as extensions of it in fulfilling many responsibilities that would otherwise be borne by the public sector. Nevertheless, the period following the Great Recession (i.e., 2011 to the present) has been marked by a massive governmental divestment in the private nonprofit service sector with predictably deleterious effects on many organizations, their dedicated workforces, and the individuals entrusted to their care.

This has occurred despite steady growth in the state economy in recent years and a corresponding increase in inflation-adjusted state disbursements for other sectors and services. For instance, financial aid for public schools has risen at an annual average rate of 4.6% during this period. State Medicaid expenditures have increased by 3.8% per year. By contrast, however, state aid for human services has decreased by 26% between 2011 and 2018 (The New School Center for New York City Affairs, 2019). This bifurcation betrays the deceit inherent in a 2% spending "cap" that has been invoked selectively and led to unforced austerity within some, but clearly not all, industries. This spending cap has been in effect since 2012 but applies only to the "state operating funds" component of the annual state budget. Operating funds constitute little more than half of the budget and exclude federal aid and other resources. Furthermore, as illustrated by the foregoing trends, this cap applies to operating funds in the aggregate and not to specific expenditures itemized therein. Spending that exceeds the cap for select programs and services necessitates draconian reductions for others in order to ensure total spending does not exceed statutorily prescribed limits. The human services sector has borne the brunt of this budgetary balancing act.

It is therefore not surprising that nonprofit human services organizations have experienced unprecedented challenges in recruiting and retaining qualified personnel, as rapidly diminishing revenue has rendered them incapable of offering anything more than modest compensation for extraordinarily challenging work. A recent survey of 126 community-based behavioral health service agencies representing 14,499 employees revealed statewide personnel vacancy and turnover rates of 14% and 34%, respectively (Mental Health Association in New York State, Inc., 2019). These rates reflect statewide averages. Vacancy and turnover rates are considerably higher in Downstate regions – Long Island and New York City, in particular. These trends compromise the viability of these organizations and the quality of care afforded to increasingly vulnerable service recipients. Moreover, the decimation of our valued workforce occurs at a most inauspicious time. A deinstitutionalization movement, initiated decades ago and continuing in earnest, aims to support vulnerable individuals in integrated, community-based settings (i.e., the "least restrictive" alternatives to institutionalization). The laudable philosophical and financial underpinnings of this movement notwithstanding, its success is contingent on robust investment in the community-based health and social services infrastructure. That is, individuals emerging from hospitals, nursing homes, adult homes and similarly restrictive settings frequently manifest complex and comorbid health conditions and associated life challenges for which intensive and comprehensive support services are necessary lest they falter in the transition to community-based care. Their right to reside in less restrictive settings is surely beyond question, and it now bears the imprimatur of the United States Supreme Court. Its landmark ruling in Olmstead v. L.C. codified in law individuals' right to community integration and led to the establishment of a statewide Olmstead Implementation Plan that informs many public policy proposals. For this and many other reasons, our community-based system of care warrants an infusion of additional resources with which to meet the needs of formerly institutionalized individuals.

The opposite has occurred, however, and recent initiatives continue to give the nonprofit human services sector short shrift. For example, the Health Care Efficiency and Affordability Law for New Yorkers (HEAL-NY), legislation that authorized substantial investments in facility and information technology enhancements for health and social service organizations, allocated only 1.4% of $2.76 billion to community-based providers. The Capital Restructuring Financing and Healthcare Facility Transformation Programs were established to promote similar improvements in the health and social services infrastructure but included de minimis allocations to community-based providers (1.5% and 6.5%, respectively) (New York State Council for Community Behavioral Healthcare, 2019). Other initiatives aspire to nothing less than the utter transformation of our health and social services system and the replacement of costly institutional services with efficient and effective community-based alternatives. These are consistent with the espoused "Triple Aim" of healthcare reform, longstanding principles underpinning the redesign of the State's Medicaid program, and the aforementioned Olmstead Implementation Plan that seek to improve individuals' experience of the care process, enhance the overall health of vulnerable populations, and reduce the per capita cost of care. Nevertheless, these grand initiatives, including the Delivery System Reform Incentive Payment (DSRIP) program, Value Based Payment Quality Improvement Program (VBP QIP), and New York State Behavioral Health Value Based Payment Readiness Program, have allocated only 0.7% of $8.47 billion to community-based organizations (New York State Council for Community Behavioral Healthcare, 2019). Such a meager investment stands in stark contrast and diametric opposition to these initiatives' intended aims and requirements for success.

The most recent example of the state's continuing neglect of the nonprofit social services sector is its deferral of a statutory Cost of Living Adjustment (COLA) for its workforce. This workforce, already grossly underpaid in comparison to those in the public and private sectors, relies on modest increases to mitigate the adverse effects of inflation and other economic stressors. Yet the state has approved this COLA for only two of the past ten years, excepting modest "targeted" adjustments for select personnel at the exclusion of others. This has enabled the state to "save" approximately $700 million during this period. This is roughly equivalent to a rounding error in an annual state budget of $175 billion borne on the backs and bank accounts of its most underpaid personnel. It has surely exacerbated the crises in recruitment and retention described above. It has also led many poorly paid professionals to rely on some of the same publicly funded benefit and entitlement programs on which their clients depend. Approximately one-third (32%) of low-wage workers, many of whom are employed in community-based social services agencies, access one or more public assistance programs (Jacobs, Perry, & MacGillvary, 2016). Thus, the state's inattention to the needs of its social services employees is not merely inimical to its stated objective to replace institutional care with efficient and effective community-based alternatives. It is costly

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# Peers in the Workforce: Reversing Misconceptions and Succeeding

**By Kerry, Andrea, William, Shaneefa, Elfreda, and Joseph**

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

Employment is one of the most essential aspects of a stable, productive, well-rounded life. This is no less true for us, individuals with behavioral health needs with lives impacted by mental health challenges, substance use, and homelessness. But maintaining stable employment can be more difficult and fraught for us. Instability in our lives may have prevented us from working for periods of time, making it harder to find gainful employment now. We may experience particular obstacles stemming from our individual diagnoses and needs that make certain types of employment difficult. On top of this, we may also be up against stigma from employers and structural barriers.

But, as several of us learned when we gathered to discuss our experiences as part of the 'behavioral health workforce,' we are more than capable of thriving in our jobs and building careers. The possible challenges we may face certainly don't encapsulate our experiences. Here is some of what our conversation revealed.

## Support Tailored to Our Needs

Members of our discussion group have been employed consistently from 10 years to 6 months. One of us is currently seeking employment, but has a diverse work history with periods of long-term employment. Our experiences finding a job are varied, but what they have in common is the importance of the support and resources made available to us through organizations like S:US, and programs designed specifically for our needs. For instance, one of our discussion participants found permanent employment through a job fair run by the New York City Office of People with Disabilities and a program that adjusts typical employment testing requirements for people with disabilities. With these two resources, he was able to secure a permanent job with the City. "Prior to that," he says, "I had been sending out dozens and dozens of resumes and no one was responding."

Two of us are participating in transitional employment (TE), which we obtained through S:US' Brooklyn Clubhouse. (The Brooklyn Clubhouse is part of Clubhouse International, an organization that provides opportunities and resources for individuals with mental illness to live healthier, happier lives.) Transitional employment opportunities typically last for 6 to 9 months each, and are secured by the Clubhouse. One of us talked about an exciting TE opportunity with the NYC Mural Arts Project (part of the NYC Department of Health and Mental Hygiene), helping to design and install a mural to raise awareness about mental illness on a wall of a local Brooklyn school. While the Clubhouse encourages members to obtain outside employment on their own as well, it also offers opportunities for Supported Employment and Independent Employment. Under these two employment types, the Clubhouse provides us with varying levels of intervention to support our adjustment to our places of work.

## Paying it Forward as Peers

Two participants in our discussion group work as Peer Specialists with S:US. Having gone through their own journey through behavioral health services, whether for substance use recovery or some other need, they received training (with the support of S:US staff), and now serve other individuals with behavioral health needs. Because of their lived experience, peers can provide invaluable knowledge and support that can't be taught formally.

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# Licensed Practical Nurses: Furthering the Goal of Integrated Health

**By W. Andrew Mullane, PhD**
**Regional Director, WJCS Behavioral Health Services in Southern Westchester County**

It is a startling and sad fact that individuals with serious mental health problems on average die earlier than those without mental health issues. An article in JAMA Psychiatry reported that these premature deaths are primarily due to largely preventable conditions, such as high blood pressure, high cholesterol, diabetes, and heart disease. In 2013, the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration reported that one of every three adults with mental illness smokes cigarettes, compared with one in five adults without mental illness. Individuals with substance use disorders are also likely to have a shortened life expectancy. While the reasons for these outcomes are vast, all point to the need to expand efforts to address the inextricable link between physical and behavioral health.

In an effort to help clients live healthier and longer lives as well as support our therapists and psychiatric staff so they are better able to provide the services which they are uniquely qualified to offer, WJCS, the largest community-based provider of licensed outpatient mental health services in New York's Westchester County, launched a pilot program in 2012. Licensed Practical Nurses (LPNs) were hired to enhance the integration of mental health, substance use, and physical health treatments as well as boost staff efficiency. Seven years later, this program is a well-established, vital, and valued model that validates the benefits of expanding the traditional behavioral workforce model to include LPNs.

There are multiple factors that make integrating LPNs into the behavioral health treatment model beneficial. The United States is facing a crisis of profound impact: the shortage of medical doctors, including primary care physicians, psychiatrists, and doctors specializing in addiction. Access to much-needed care is becoming increasingly challenging for consumers as well as for health and mental health organizations who must maximize the efficiency of practitioners. By integrating LPNs into our behavioral health model, WJCS is now able to provide more comprehensive care to a higher volume of clients and is positioned to better meet the needs of our clients and communities in a managed care environment.

The presence of LPNs in our clinics has allowed us to expand our capacity to conduct medically necessary screening of consumers in areas that are known to contribute to long-term negative health outcomes. In addition to our other providers, our LPNs, trained in motivational interviewing, screen clients for tobacco and alcohol use, help clients explore their desire to reduce or end their use of tobacco,

**W. Andrew Mullane, PhD**

aid clients in obtaining nicotine replacement therapy or medication-assisted treatment, follow up with clients and communicate with their care providers to successfully reduce harmful substance use.

Our LPNs help us to identify clients who are at metabolic risk by tracking PSYCKES data and through regular screening. They ensure that clients obtain the medical lab work necessary to ensure medications prescribed are appropriate for the client's health profile and to monitor for reactions to medication. LPNs conduct real time screening of clients for substance use, via breathalyzer or on demand urinalysis, when our psychiatric providers are prescribing controlled substances in order to minimize the risk of adverse medication and substance interactions.

At WJCS, LPNs have been instrumental in helping to identify clients in need of outside care as well as facilitating that care. At intake screenings and at an annual wellness screening, LPNs review client health concerns and actively connect them to medical providers, often going as far as calling to schedule a doctor visit for consumers who are not connected with a primary care physician or who have not had a physical in the last year. Krystle Colon, Supervising LPN at the WJCS Yonkers Family Mental Health Clinic states, "Clients see me as an extension of their care team and if they have some pressing or, perhaps, embarrassing health concern, they will come to me and ask about it. It's gratifying to see them address health concerns and increase healthy behaviors."

On occasions when they have identified a grave medical concern, such as unmanaged diabetes or very high blood pressure, LPNs have walked clients over to a medical provider's office. In each case, the LPN follows up with the client to be sure he or she has received needed care. The LPN also brings these matters to the awareness of the client's therapist and psychiatric providers.

As a result of LPNs conducting wellness screenings prior to initial therapy appointments, our mental health practitioners are armed with comprehensive health information at the time of the appointment and freed up to focus on the needs of the client. By having LPNs complete prior authorizations of medications, address concerns regarding medications and medication refill requests, and respond to emergent medical concerns, our system of care is better able to respond to client concerns in a timelier fashion and is also able to offer services to more individuals. LPNs have also begun assisting our psychiatric providers with urgent care walk-in hours by prioritizing clients by need, collecting vitals, completing necessary medical tests, and identifying concerns so that the time with the psychiatric provider is optimized.

Challenges to integrating LPNs in our mental health clinics do exist. Most of the services our LPNs provide are not reimbursed through commercial insurance companies. Adding LPNs to our workforce has added a financial cost but it has enabled us to provide high quality integrated care, which can be life-saving. Additionally, integrating LPNs into our workforce in the ways described above requires much thoughtfulness in the development of workflows to ensure all staff are working at the top level of their licensure. WJCS clinicians welcomed the LPNs, after witnessing the full value of such changes to our clients, our communities, and to the providers themselves.

In summary, the addition of LPNs to the behavioral health team at our WJCS Article 31 Community Mental Health Clinics is helping to enhance our capacity to provide the highest quality health services to the consumers and communities we serve. It is our goal that through innovations like those mentioned, we enable clients to live longer, fuller, and healthier lives, reversing the trend of shortened longevity and more negative health outcomes in people who experience mental health issues.

*WJCS-Westchester Jewish Community Services provided mental health services to 3,900 individuals in 2018. For more information, please visit wjcs.com or call (914) 761-0600.*

# Behavioral Health Care: How Far We've Come in 15 Years

**By Linda Rosenberg, MSW**
**Former President and CEO**
**National Council for Behavioral Health**

Fifteen years goes by in the blink of an eye. This summer I'm stepping down after 15 years as president and CEO of the National Council for Behavioral Health, which is celebrating it's 50th anniversary. This is a good time to take stock of where we have been as a field and where we are going.

When I joined the National Council in 2004, some in the behavioral health community spoke of a system in shambles and unfairly pointed fingers at others. But my perspective was from the ground up and I saw a different reality. When I testified before the Institute of Medicine, I described our members as essential community providers, chronically underfunded, struggling to transform lives.

I told them how our members were reimbursed at rates far lower than others that share the safety-net – hospitals, health centers, the Department of Veterans Affairs – creating a workforce crisis and compromising quality. Then, together, we went to work.

We moved health care integration from concept to reality. Today, integrated physical and behavioral health care isn't the flavor of the month – we know it's the best way to meet the complex needs of individuals with chronic, co-occurring conditions.

**Linda Rosenberg, MSW**

We embraced the science and practice of recovery and of trauma-informed care. Recovery is now the expectation, not the exception, in mental health and substance use treatment. We recognize and are increasingly prepared to respond to the trauma the majority of our patients' experience. We have stopped asking, "What's wrong with you?" and started asking, "What happened to you?"

We successfully advocated for parity, for full inclusion of mental illnesses and addictions in the Affordable Care Act, and for creation of Certified Community Behavioral Health Clinics (CCHBCs). CCBHCs are remaking specialty behavioral health care in this country by providing crisis services; integrating physical and behavioral health; delivering medication-assisted therapies; implementing evidence-based practices; partnering with peers; and collaborating with law enforcement, schools, and hospitals. They are working with groups that have special needs, such as veterans, who may not otherwise receive evidence-based services. CCBHCs are hiring new staff, easing the critical shortage of psychiatrists, especially in rural areas.

We don't pay for cancer treatment with demonstration grants, and we shouldn't do so for mental illnesses and addictions. Today, lack of access to care has replaced stigma as the leading barrier to a healthier America. We need sustained funding that supports a comprehensive continuum of services, and the Excellence in Mental Health and Addiction Treatment Expansion Act is a good start. The Act extends the CCBHC program, meeting the growing demand for more mental health and addiction treatment capacity and giving more people the opportunity to recover.

The National Council brought Mental Health First Aid to the United States and we have trained 1.7 million people. This means 1.7 million people from all walks of life are now able to initiate a conversation with someone experiencing a mental health or substance use crisis and refer them to community resources and professional help, if needed. We are well on our way to making Mental Health First Aid as common as CPR.

We continue to promote the adoption of technologies that have revolutionized other industries and are now being applied to health care – technologies that support and educate staff, increase treatment capacity and measure outcomes, put patients in charge of their own health, support the office operations vital to effective care, and deliver psychiatric services into our clinics and homes from across the country. We can be both high-tech and high-touch.

Working together, the National Council and its members have done this challenging and rewarding work. But we have much left to do.

Startling figures show that average life expectancy in the United States dropped for the third straight year, driven by increases in overdose deaths and suicides. You are now more likely to die in this country from an opioid overdose than a car accident. Partisan divide over the Affordable Care Act persists and Medicaid is still under assault.

Where do we go from here? To begin with, we need leaders who have a bias toward action, who are fearless but not reckless.

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# Addressing the Human Services Workforce Crisis Through Training and Professional Development

**By Shawn P. Quigley PhD, BCBA-D**
**Jennifer Ruane MS, BCBA, and**
**Lindsey Dunn MA, SPHR, CPHRM,**
**Melmark - PA Division**

In 2017, the President's Committee for People with Intellectual Disabilities provided a report (retrieved from https://www.nadsp.org/wp-content/uploads/2018/02/PCPID-2017_-Americas-Direct-Support-Workforce-Crisis-low-res.pdf) to the President of the United States regarding the workforce crisis for direct support professionals (DSP). Specifically, the number of DSPs needed to support individuals with intellectual disabilities (ID) and autism is not sufficient, causing many individuals to be waitlisted with no supports (see Table 1 of President's Committee Letter for detailed information). The key variables of the workforce crisis were identified as high staff turnover, growing demand for services due to population growth, increased survival rate for people with ID, fewer people in the workforce, lack of living wage, insufficient fringe benefits, high stress on the job, insufficient training and preparation, and a lack of professional recognition and status for all DSPs. Some recommendations to address these key variables include wage initiatives, use of technology solutions (e.g., remote monitoring, robotics), designation of DSPs as a distinct occupation and career training and credentialing for DSPs. Other entities have also stated concern with the omnipresent workforce crisis and stated similar causal variables and potential remedies (e.g., M. Davis, Pennsylvania Advocacy and Resources for Autism and Intellectual Disability, Letter to Pennsylvania Department of Human Services, 3 April 2018; see also https://www.fixthedspcrisis.com/).

In response to the recommendation of distinct occupation status and training needs for DSPs, some entities have proposed core competencies and credentialing standards for DSPs. The New York State Office for People with Developmental Disabilities, in conjunction with the New York State Talent Development Consortium, has developed some direct support professional core competencies (www.workforcetransformation.org/wp-content/uploads/2017/03/NYS_Core_Competencies_and_NADSP-Code_of_Ethics.pdf). The competencies are presented as seven overarching service goals. The goals are broken into competency areas (e.g., supporting a person's unique capacities, personality, and potential; demonstrate support for individual choice-making), and competencies are comprised of multiple skills (e.g., communicate directly with individuals; uses person-first language). Although structured in a manner that would lend itself to job training, the competencies are explicitly described as a representation of the "day-to-day work that DSPs perform" and "are not a training program" (see http://www.workforcetransformation.org/nys-dsp-core-competencies-resources/). Adopting the competencies provides a context to define a distinct occupation status and expectations for those employed.

The Behavior Analyst Certification Board (BACB), a nonprofit credentialing corporation, was established to meet the professional credentialing needs of behavior analysts, government and consumers (https://www.bacb.com/about/). The BACB seeks to protect consumers and solve socially significant problems via increased availability of qualified behavior analytic professionals. One credential developed to meet this mission is the Registered Behavior Technician® (RBT®). Registered Behavior Technicians® must meet initial minimum competencies and receive ongoing supervision from professionals with additional training credentials ( https://www.bacb.com/rbt/ ). Requiring DSPs to become an RBT® provides training directly related to the job responsibilities, offers a framework to support DSPs' professional growth and development, recognizes the DSP role as a distinct occupation within a critical service field, and establishes minimum expectations for acting ethically while supporting individuals.

The New York State competencies and the RBT® credential both have different points to consider. The purpose of this publication is not to debate those options. Rather, the intent is to describe how organizations can be actively engaged in addressing the workforce crisis. Specifically, this publication strives to describe a training and professional development program focused on addressing DSP turnover, emphasizing job specific skill development for DSPs, and providing career paths for DSPs.

## Training Program Overview

Melmark is a multi-state human service provider with premier private special education schools, residential living, professional development, training, and research centers. Melmark is committed to enhancing the lives of individuals with autism, intellectual and developmental disabilities, and their families by providing exceptional evidence-based and applied behavior analytic services to every individual, every day. Many of Melmark's more than 1,100 staff members are DSPs. While the educational requirement for this position is typically a high school diploma, some positions require a bachelor's degree.

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# Primary Care Integration: Alternative Workforce Strategies for Community-Based Behavioral Health Service Organizations in the Era of Physician Shortages

**By Rachael A. Petitti, PhD, LCSW**
**Lecturer, Program Director,**
**Department of Health Administration and Policy, University of New Haven**

It has been many years since the surgeon general report declared that vastly poor health outcomes for persons suffering from behavioral health disorders was a public health crisis. Lives filled with long term disability and early mortality caused, in part, by service fragmentation within the U.S. healthcare system. (Parks, J., Svendsen, et al Morbidity and mortality in people with serious mental illness. Technical report of the National Association of State Mental Health Program Directors. 2006.) Among those in the behavioral health field, this report became widely referenced as it conveyed the changing core principles of care; that mental health and primary care integration is a necessary and basic tenet for this population. Despite that call to action, the provision of integrative services may likely continue to be unequal nationwide for community-based, nonprofit, behavioral health providers, in part due to shrinking public funding and the competing high costs of employing primary care physicians.

**Rachael A. Petitti, PhD, LCSW**

Alternative Models of Care: Primary Care Physicians Shortage, Funding Limitations.

Compounding these service delivery limitations is a growing shortage of primary care physicians. In a study conducted by the AAMC (American Association of Medical Colleges), it is projected that by 2030 there will be a shortfall of between 14,800 and 49,300 primary care physicians. This is largely due to three reasons: the growing U.S. population, which by 2030 is expected to grow 11%, the aging of the "baby boomers," with the over 65 population expected to grow by 50% by 2030, and the shortage of medical residents interested in pursuing a primary care practice over a lucrative career as a specialist. (Academy of Family Physicians. Family physician, scope, philosophical statement. In AAFP Reference Manual. Leawood, KS: AAFP; 2012). This year alone, the number of U.S. medical school graduates entering primary care, family medicine, internal medicine and pediatrics residencies combined totaled 2,730. (Peikes, D. The Comprehensive Primary Care Initiative: Effects on Spending, Quality, Patients, And Physicians. Health Affairs. 2014;37(6).

This is a significant shortfall that does not even come close to addressing the predicted deficiencies in the primary care provider pool, which is expected to reach 23,640 by the year 2025. On the contrary, according to the Bureau of Labor Statistics Occupational Outlook Handbook, the projected percent of change in employment for nurse practitioners from 2016 to 2026 is up to 31%. Projected growth in physician's assistants is 37%, resulting in an increased supply for both occupations with higher than average growth rates.

Coupled with this labor force reality is the unequal distribution of funding available to the nonprofit sector to support integrated service delivery models. We know that the largest portion of resources available to this sector came through the Substance Abuse and Mental Health Services Administration (SAMHSA) 2009-2016 Primary and Behavioral Care Integration (PBHCI) Program grant funding which averaged $400,000 per year per organization, renewable for up to 4 years. This program was developed to address community-based service capacity issues, but what remains unclear are the sustainable effects from the service systems' ability to continue cost-effective primary care models in the era of reduced funding.

Consequently, with the limited supply of physicians and existing economic challenges for nonprofit providers, we propose a departure from the traditional model of physician-based primary care. We advocate for the adoption of a universal industry standard that allows for Nurse practitioners or Physician Assistants to be given full regulatory approval by each state to act as the patient's primary care

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# Staff Development at the Mental Health Association of Westchester

**By Barbara Bernstein, PhD, MPH**
**Chief Planning Officer**
**MHA of Westchester**

In recent editions of Behavioral Health News, we have written of sweeping transformations in services offered at The Mental Health Association of Westchester (MHA). These transformations require critical staff development - learning new skills and new processes of working. To manage these changes, "owners" of the Change Management Process are essential. Thus, we need owners of training and incorporation of new skills, of integrating new ways of working, of communicating about and keeping large changes on time and on track, as well as evolving infrastructure to support our work.

*Change Management Champions:* MHA has invested in developing change management leaders and an ongoing Project Management initiative. Meeting regularly with our Project Management team, Program Directors are responsible for keeping identified projects on track. They identify the action steps, the associated timelines and additional support required to move forward. Progress is tracked regularly, highlighting aspects that are moving forward as planned and especially those that require assistance. Examples of significant initiatives that are "project managed" include the expansion and integration of Substance Use Disorder (SUD) services into our clinics and development of a new residential site that integrates affordable housing with supported housing for individuals with behavioral health diagnoses.

*Skill Development:* Across all of our services, staff have been required to expand and deepen their skill sets. For example, as we incorporate SUD services, clinicians have learned new assessment tools as well as clinical approaches, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), Integrated Harm Reduction, and Dialectical Behavior Therapy (DBT) for SUD. Physicians are now providing Medication Assisted Treatment (MAT). Our Peer Specialist training, which prepares participants for NYS certification through OMH, now includes Certified Recovery Peer Advocates (CRPA) training, enabling them to provide peer support through the lens of substance use as well as preparing them for NYS certification under OASAS. These certifications provide trained Peers with marketable skills and enhance capacity to obtain meaningful paid work. Throughout the agency, interested staff have participated in training to use Narcan to reverse opioid overdose. Care Managers assist individuals who experience complex and chronic medical and/or behavioral health conditions. To do their jobs effectively, Care Managers have required training in medical conditions, medications, and the interaction of multiple health conditions. Effecting change in life is difficult. Whether the change is related to use of substances or alcohol, developing wellness practices or developing new ways of managing life's stresses, change requires significant personal commitment. To that end, staff across many of our services have been trained in Motivational Interviewing (MI). Beyond our clinic, our expanded Children's Services and Home and Community Based Services staff train in the specific skills required to deliver those services.

In addition to training that we organize or that is provided by regulators, we strongly encourage staff to pursue learning in areas of particular interest to them. Staff are encouraged to apply internally for financial support and/or use of work time to hone specific skill sets that support their work. These opportunities are available not only to those who provide direct services, but those who support the work – e.g., those in Finance, Communications, and HR. To support our Licensed Social Workers and Mental Health Counselors to satisfy their NYS Continuing Education requirement, we deliver on-site courses that enable them to substantially or fully meet that need.

*Train-the-Trainer Capacity:* Expertise to deliver in-house training enables us to provide training when and as needed, flexibly meeting the needs of staff. In-house training is time and cost efficient and allows us to adapt training to our specific needs. MHA staff include credentialed trainers in, e.g., Suicide Awareness for All (safeTALK), Applied Suicide Intervention Skills Training (ASIST), Motivational Interviewing (MI), SBIRT and CRPA. We are currently developing Train-the-Trainer capacity for Peer Supported Open Dialog (POD). POD is a fully collaborative model that utilizes a family and peer "social network" model to address acute crises as well as ongoing concerns. To assure that those who have content expertise are also effective trainers, we have developed internal "Train-the-Trainer" preparation that teaches principles of adult learning and facilitation skills.

*Leadership Development:* As in many agencies, skilled providers are promoted to managerial positions. However, the knowledge and skills of managing program operations, budget, and staff are different than that required to do the work. We have invested in developing the next cohort of leaders in multiple ways. Groups of our middle managers have participated in a formal 3 ½ -day Middle Managers Academy training delivered by The National Council for Behavioral Health. The curriculum, specifically created for the behavioral health field, addresses developing leadership style, mastering key management tasks and responsibilities, managing and motivating employees, teamwork and accountability, as well as managing budgets and financial information. We consolidate these learnings through an ongoing peer-led monthly meeting for managers, which includes focused training delivered by executive staff. The goals of the initiative are to deepen managerial skills and provide peer support through challenging situations. Executive staff have participated in other leadership development programs, including those offered by Nonprofit Westchester and Manhattanville College.

*Philosophy:* MHA prides itself on maintaining its focus on delivering person-centered care based on principles of shared decision-making. All staff receive training on the philosophical framework within which our services are delivered. At orientation, and then in a more in-depth manner during their first year of employment, all staff participate in training about the principles of person-centered care, trauma informed care and aspects of cultural competence. These sessions are in addition to training required by regulation, including sexual harassment, compliance, and reporting of child abuse and neglect.

*Challenges:* Developing a well-trained staff and supervising implementation of new knowledge and skills presents numerous challenges. For example, as we expand the array of new services – such as incorporating SUD services into our more traditional mental health services – we must assure that staff are fully trained. Appropriate training programs must be built or identified and purchased. Taking staff away from daily responsibilities is costly: in many cases reducing delivery of billable services while staff participate in training sessions or requiring that services be delivered at other times. Our workflows and supervisory process must support the integration of new skills. At times, on-going scheduled consultation calls are built into the training schedule. The significant time and money dedicated to developing staff capacity is an investment in improved quality of services, greater efficiency of delivery, and ultimately improved outcomes and client satisfaction. High quality training is expensive. In recent years, government attention to workforce development has provided a significant source of financial support, e.g., through DSRIP and other initiatives. Going forward, alternative sources of funding will be required.

As staff size and training requirements grow, tracking training needs presents another challenge. The Excel spreadsheet which once met our needs is now outdated, inefficient and underpowered. Numerous Learning Management Systems are available for purchase. It is critical that we find the system that is the best 'fit' for our agency; a task that is still in process.

Historically, we have relied on face-to-face training sessions and highly value the opportunity for in-depth conversation. As we have embraced the many advantages of online training, especially appreciating the time flexibility of 'on-demand' training, we continue to explore the best hybrid model for our needs. Should staff participate in online training as it suits their schedule and then meet for discussion? Are we better served by participating as a group? Are there some topics that do not require discussion?

Finally, one of the most significant challenges is that of evaluating training. How do we assess that a training module has effectively delivered the essential content? Most importantly, how do we assess the degree to which staff have

*see Staff on page 36*

# Organizational Needs-Based Toolkit for Peer Workforce Integration Introduced at NYC Peer Workforce Consortium

**By Aviva Cohen, LMSW**
**Office of Consumer Affairs**
**NYC Department of Health and Mental Hygiene**

On Thursday, April 18th, the NYC Peer and Community Health Worker Workforce Consortium convened over sixty stakeholders at CUNY Graduate School for Public Health for an event to "kick off" its new toolkit. The toolkit offers guidance to provider organizations who are interested in advancing the involvement of peer specialist or community health worker employees.

Peer Specialists provide support by drawing upon their own experiences with mental health/substance use challenges. They convey a message of hope and empathy by sharing their wellness and recovery processes to help individuals achieve their own goals. Community Health Workers (CHWs) are trusted community members who hold a close understanding of the communities they serve in frontline public health work. The peer movement has faced a long history of stigma, and of under-recognition as valuable sector of the workforce. The recognition of peers' value has progressed, particularly when influenced by shifts in policy. Since New York State approved Peer Support for Medicaid reimbursement in 2016, Peer Support has seen substantial growth, demonstrating positive outcomes across an

**Aviva Cohen, LMSW**

expanding variety of service settings. Peer support improves access to, and engagement in, services for individuals experiencing behavioral health challenges. Enthusiasm about new approaches to support and integration was strong throughout the Toolkit Kickoff event.

The event began with a welcome from Dr. Hillary Kunins, Acting Executive Deputy Commissioner for the Division of Mental Hygiene at New York City's Department of Health and Mental Hygiene. We then heard the encouraging words of Public Health Dean, Ayman El-Mohandes who highlighted the value of lived experience in decreasing significant health disparities. The kickoff attendees enjoyed hearing from keynote speaker, Joyce Wale, who is the Regional Executive Director for Behavioral Health at United Healthcare Community. Ms. Wale shared her experience and insight about the factors that have increased support of peer services by managed care organizations.
The toolkit kickoff sparked new discussions about how the toolkit can generate growth and advance organizations' efforts to integrate peers within the behavioral health workforce. Attendees brainstormed about opportunities for collaboration, and eagerly connected to others with common goals.

Consortium Background

Plans for an organizational toolkit have been a part of the Consortium's discussion since its onset. The Consortium began in 2016, after ThriveNYC, a citywide initiative to address mental health, held a Workforce Summit. At the Summit, Subject Matter Experts gathered to discuss the needs of the behavioral health workforce in New York City. The Summit's peer workforce leaders recommended the formation of a centralized leadership body to coordinate peer workforce stakeholder groups and improve understanding of the Peer Specialist and Community Health Worker (CHW) roles. The NYC Peer and Community Health Worker Workforce Consortium was established to serve as that suggested leadership body.

In order to learn more about the workforce and about related programs and practices, the Consortium gathered comprehensive information on the state of the Peer and Community Health Worker Workforce. Using a mixed methods approach, which comprised interviews, surveys, and thematic analyses of materials, the Consortium evaluated active practices and identified the strengths and needs of Peer and CHW roles within the behavioral health workforce of New York City.

About the Needs Based Toolkit

The Needs-Based Toolkit is an online, automated guide with features that create a customized set of resources. The toolkit is designed to automatically adapt its content according to a completed self-assessment. The customized set of resources provided by the toolkit is specific to the needs of each organization, encouraging use of the toolkit as an action-oriented pathway to improved integration. Based on the information gathered, the Consortium identified areas that impact recruitment and retention of peer

***see Toolkit on page 36***

# Lippman Joins Beacon Health Options

**By Staff Writer**
**Behavioral Health News**

Jason Lippman has joined Beacon Health Options as VP, Strategy and Development in the Tri-State/Mid-Atlantic region. In his new role, Mr. Lippman will be responsible for generating new sales growth through customer acquisition, developing strong client relationships and solutions for Beacon to be a valuable business partner to its clients.

Mr. Lippman comes to Beacon from The Coalition for Behavioral Health, where he served as Executive Vice President. Upon rejoining The Coalition in 2016, Lippman played a vital role in providing stability and management of the organization's operations through two leadership changes and successfully implemented a strategic transition plan as Interim President & CEO. His major accomplishments during the Interim role included: 100% retention of the membership base, 26% improvement in revenue collections, and 17% rejoin rate of member resignations from the previous year. As EVP, Lippman was instrumental in The Coalition's resource development activities, securing media coverage from major news outlets and overseeing of public and private sector partnerships.

Prior to Mr. Lippman's latest tenure at

**Jason Lippman**

The Coalition, he served on Amida Care's Senior Management Team as the primary lead for policy and advocacy initiatives. Major accomplishments included the launching of the agency's government relations department, improved city and state legislative and regulatory policies for programs impacting people living with HIV/AIDS, mental health and

***see Lippman on page 34***

# 20th Anniversary Retrospective

**By Staff Writer**
**Behavioral Health News**

According to Ira Minot, LMSW, Founder and Executive Director of Mental Health News Education, Inc., (MHNE) and Publisher of *Behavioral Health News*, "It seems like only yesterday that my recovery from mental illness led me to create *Mental Health News*, the predecessor of this publication. Since our beginning in 1999 the past 20 years has been an amazing journey filled with many equally amazing experiences for me. Meeting and working closely with some of the field's finest community leaders, educators, scientists and advocates has made this 20th Anniversary possible and a brilliant accomplishment for all involved."

David Minot, BA, Associate Director of MHNE, who joined his father in 2006 to launch *Autism Spectrum News*, stated, "I am so proud to carry on the vision created by my father in providing vital behavioral health and autism education to the community. Working closely with our dedicated Board of Directors, we are charting a new course for the future which will enable us to utilize the internet and social media to give our readers a richer experience and enhance our vital educational mission."

**Ira and David Minot**

Over the last 20 years, Ira has published 62 print issues of *Behavioral Health News* and its predecessor *Mental Health News*, and David has published 44 issues of *Autism Spectrum News* - that's over 100 quarterly issues! With an average of around 20 articles per issue, in 20 years this father and son team have published over 2,000 articles that have been

***see Retrospective on page 34***

# Peers: An Essential Component to the Behavioral Health Workforce

**By Barbara Faron, LMSW, CPRP**
**CEO, Federation of Organizations**

What makes a well-rounded behavioral health workforce who can deliver innovative, person-centered services that can affect change for the better? For Federation, the answer is Peer Specialists. Peers have become an integral part of the behavioral health workforce and Federation has been a pioneer in using peers to deliver services.

Peer Support services began to emerge in 1970s with the introduction of self-help recovery and advocacy organizations. Peers were used and accepted in providing substance abuse services well before they achieved acceptance in mental health system. In 1981, Federation of Organizations was a pioneer in utilizing peer specialists. Our first program here that provided peer support was our Senior Companion Program. People with long-term histories of psychiatric hospitalization worked with adult home residents providing friendly visiting, advocacy, and community integration activities. The program provided opportunities for people in recovery to explore vocational goals by volunteering at community sites such as social programs, adult homes, hospitals, outreach programs, food pantries and soup kitchens. Through the principles of peer support and self-help, Companions

**Barbara Faron, LMSW, CPRP**

helped to improve the quality of life for other individuals within the mental health community. Participants received a meal allowance, travel reimbursement; paid vacation, sick and personal days. They also received on the job training and support. The demonstrated benefits to both the peer worker and the residents they served spurred the growth of the program and variations on the theme of involving peers in the delivery of services. Through the years since, Federation has been working to integrate peers into all aspects of our workforce—both in positions designated for peers and for all other positions within the agency for which an individual is qualified.

Lessons Learned

What have we learned over the last 35+ years? That peers bring a new perspective to the services we provide. This view has changed the dynamic of service delivery and added another layer of support, communication, and a unique experience for both the peer specialist and the individual they serve. Peers share the experience of living with mental illness or and/or a substance use disorder with the individuals they serve. This shared experience helps form a trusted bond and with that bond comes the attainable goal for recovery.

We've learned that peers understand what it is like to live with voices in your head. What it feels like to not have family support or be living on the street. Peers have experienced the side effects of medication and understand what it feels like to lose a job, or a home because of mental illness. Despite all this, they have overcome these challenges to move forward in their recovery. They have progressed, suffered setbacks, and again moved forward. They understand the road to recovery is not a straight line and with each stumbling block comes a chance for learning and growing.

Time and time again, peer services have been shown to be a benefit to the individual subsequently improved the quality of their life. Since the 1980s, Federation has seen amazing success for its members by incorporating peers into every facet of service delivery within the agency. Peers participate in groups, work in our residences, and are deployed with members of our mobile teams. The truth, honesty, experience, and hope that they bring to our members is immeasurable.

In addition to providing hope, support, and trust, peers also advocate on behalf of the client, making sure the services they receive are person-centered and that the individual is involved with decision making regarding their care. This is turn helps the individual learn to advocate on behalf of themselves, bringing them closer to independently managing their own care and taking more control over their own lives.

The benefits to individuals who serve as peers are equally astonishing. For many, this role fulfills a greater purpose and serves as a calling. They are able to use their life experiences, recovery and accomplishments in a way that help others do the same. On the same note, they are able to be gainfully employed leading to

***see Component on page 33***

# The Experience of Workplace Stress and Compassion Satisfaction of Licensed Social Workers

**By S. Lala A. Straussner, PhD, LCSW**
**New York University Silver**
**School of Social Work**

Employed in fast-paced, often poorly funded agencies and working with clients who have experienced significant traumas, many licensed social workers are believed to experience a high degree of stress. At the same time, many feel emotionally fulfilled by their work and experience "compassion satisfaction," i.e., deriving pleasure from being able to perform their work effectively, helping others and contributing to the greater good of society. Yet, solid evidence confirming these beliefs is lacking. This paper discusses the findings of a study that examined workplace stress and compassion satisfaction, and workplace environment factors impacting these phenomena among more than 6,000 licensed social workers.

Workplace Stress
Among Social Workers

While generalizable research studies on social workers and workplace stress in the USA are limited, a study in England comparing work-related stress among 26 occupations found that "social service workers providing care" were among six occupations with the highest levels of

**S. Lala A. Straussner, PhD, LCSW**

stress (Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor. P. & Millet, C. (2005). The experience of work-related stress across occupations. Journal of Managerial Psychology, 20(2), 178-187). An Australian study (Harris, L.M., Cumming, S.R., Campbell, A.J. (2006). Stress and psychological well-being among allied health professionals. Journal of Allied Health, 35(4), 198-207) compared various aspects of workplace stress among social workers, psychologists, and three other health profession and found that social workers reported the highest level of workplace stress related to "client" dimension; they also were over-represented in their experience of depression. Finally, Stevens and Higgins (Stevens, M., & Higgins, D.J. (2002). The influence of risk and protective factors on burnout experienced by those who work with maltreated children. Child Abuse Review, 11(5), 313 -331) found that 100% of their sample of child welfare workers working with maltreated children in Victoria, Australia scored in the high range of emotional exhaustion. There is no question that social workers experience high levels of stress in many different settings.

Compassion Satisfaction
Among Social Workers

Despite the greater attention paid to workplace stress, a few international studies noted the considerable satisfaction social workers derive from helping others. For example, in a large study in England, the occupation of social work ranked 17 out of 88 regarding job satisfaction, higher than medical practitioners and nurses (Rose, M. 2003, Good deal, bad deal? Job satisfaction in occupations. Work, Employment and Society, 17(3), 503-530). A Canadian survey of child welfare social workers (Stalker, C.A., Mandell, D., Frensch, K.M., Harvey, C., & Wright, M. (2007). Child welfare workers who are exhausted yet satisfied with their jobs: How do they do it? Child and Family Social Work, 12, (2), 182-191) found that despite high levels of emotional exhaustion, 41% of workers were highly satisfied with their employment and only 10% scored in the low range of job satisfaction. A study of hospice social workers (Pelon, S.B.,2017. Compassion fatigue and compassion satisfaction in hospice social work. Journal of Social Work in End-of-Life and Palliative Care, 13(2-3), 134-150) found that despite the vast majority indicating compassion fatigue, only 20% scored in the low range of compassion satisfaction. The above studies tended to have small sample sizes, and many did not focused exclusively on licensed social workers. Thus the need for our study.

Our Study

While a detailed description of our study (methodology and data analysis) is available elsewhere (see Acknowledgement), we had 6,112 state licensed social workers respond to a 75-item online survey which included questions focusing on their experiences and feelings regarding their work. We used an 8-item Workplace

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BEHAVIORAL HEALTH NEWS DESK

# CBC-Pathway Home Wins 2019 Heritage Provider Network Healthcare Innovations Award

**By Staff Writer**
**Behavioral Health News**

Coordinated Behavioral Care (CBC) is delighted to announce Mark Graham, CBC's Vice President of Program Services was awarded the 2019 Heritage Innovation in Healthcare Delivery Award for Pathway Home at the 2019 Heritage Healthcare Innovations Award. Mr. Graham was recognized for his work in designing and implementing CBC's innovative Pathway Home program, which has over the past four years helped countless New Yorkers with serious mental illness transition back to the community from institutional settings.

Mr. Graham thanked Dr. Richard Merkin—Heritage Provider Network CEO and the ceremony's presenter—for recognizing Pathway Home as a model of care that has upended the traditional care delivery system and in doing so positively transformed the lives of over 1,500 New Yorkers, while significantly reducing hospital readmissions and cutting costs across health care systems. Mr. Graham stated, "Pathway Home's approach is a return to quality, client-centered care, early hospital engagement, immediate community needs assessments and spending quality time with participants on discharge to address isolation and social determinants of health. The Pathway Home Teams are supported by the comprehensive community supports that the CBC Network provides, which are an essential ingredient in the success of the Pathway Home model of transitional care."


**Aja Evans, LMHC; Jorge Petit, MD; Mark Graham, LCSW; Barry Granek, LMHC; Sasha-Marie Robinson, MA, LMSW; Joan Sass, LCSW; Sylvia Andreatto, RN**

At the luncheon yesterday in support of Pathway Home were representatives from S:US and Catholic Charities who partner on these Pathway Home Teams: Joan Sass, LCSW, Sylvia Andreatto, RN, Alethea Glave, LMSW, and Sasha Robinson, MA, LMSW.

Jorge R. Petit, MD commented, "We need to give a lot of thanks to the NYS Office of Mental Health for their commitment and active partnership in what began as a one-year grant-funded pilot program and is now a multi-team operation that serves distinct and diverse populations across the City. In addition, we need to also extend our gratitude to the CBC Board and IPA Network for their dedication to working with the most vulnerable New Yorkers in making an impact in their lives."

Pathway Home was up against stiff competition from some amazing innovators in the healthcare space; highlighting cutting edge applications of technology and up-and-comers in the healthcare industry. CBC wishes to congratulate Geoffrey Chaiken, Co-founder and CEO, Blink Health; Daniel Etra, Co-founder and CEO, Rethink Autism; Iyah Rohm, Co-founder and CEO, Cityblock Health and Thomas Tsang, MD, MPH, Co-founder and CEO, Valera Health on their nominations.

Mr. Graham commented on the successful growth of Pathway Home, "It has grown from a small pilot project to 3 teams and now we are at 8 teams across the city and targeting new populations

***see Award on page 35***

# Mental Health Housing Workforce Left Short in State Budget

**By Jim Mutton, LMSW**
**Director of NYC Operations**
**Concern for Independent Living, Inc.**

Thousands of non-profit employees working in mental health supportive housing programs across the state were left shorthanded again in the 2019-20 State budget this April, despite a year-long advocacy effort with the Bring It Home Campaign (www.bringithomenys.org), a coalition of over 1,000 mental health housing organizations, faith leaders and individuals. A 2.9% Human Service COLA for state funded community programs was deferred for a tenth year and $13 million in hard fought additional funding from the Assembly and Senate to enhance supported housing and SRO programs was removed in final budget negotiations, leaving only a $10 million increase to these programs to help address a cumulative funding shortfall of $162 million. While the $10 million is appreciated, it is not sufficient to solve the crisis that exists in the mental health housing system. The Times Union also reported that millions in funding for agriculture, healthcare, veterans and youth employment programs included in previous state budgets was reduced, shifted to other priorities or eliminated in the first budget since Democrats took over the state Senate.

**Jim Mutton, LMSW**

As the Director of NYC Operations at a 45-year old non-profit which operates numerous mental health supportive housing programs in Brooklyn, the Bronx and on Long Island, I found myself reflecting on how such a momentous effort could go belly up yet again after months of campaigning, hundreds of legislative visits and six weeks of continuous protests in Albany. How could our state government have failed us again, when a mental health supportive housing stock of over 40,000 units now stood with a crumbling infrastructure 40-70% behind the cost of inflation? How could our agency continue to attract a skilled and competent workforce, when direct care positions now paralleled in salary with entry level jobs in the fast food industry or private car-for-hire ridesharing services. How could I turn to our dedicated workforce who work 2-3 jobs to stay afloat and battle cycles of burnout and vicarious trauma week in and week out and convince them to stick with this career and not jump ship to hospital and union jobs? To put it in perspective, the $10 million increase in the state supported housing and SRO budget would translate to about $500 per bed and do little but add a few dollars to the biweekly pay checks of case managers and supervisors.

Despite the budget crisis, the housing pipeline hasn't slowed down. Quite the reverse. The need has never been greater for supportive housing in our city and state and government funders have released a record number of RFP's. In the past five years, our agency has almost doubled its housing stock to help thousands of individuals and families find a pathway out of poverty, illness and hardship to successful community reintegration and recovery. We were part of the effort to end chronic homelessness for veterans recovering from mental health and substance use challenges on Long Island and now intend to do the same in NYC.

New capital and operating funding opportunities are needed to address record levels of homelessness and growing institutionalization of mentally ill individuals. In addition, more sensible funding rates to build attractive housing and hopefully re-engage and re-energize a new workforce. However, unless these rates are adjusted for the entire mental health housing workforce, it will not be enough to resolve the longstanding erosion that has taken place over the last 30 years. To quote the Bring It Home Campaign website, "Integration works so much better than institutionalization, we know that. We also know that institutionalization is very expensive..." It's time to recognize that community reinvestment also means workforce preservation and investment.

# New Management Services Organization Established to Support NY Community Behavioral Health Providers

**By Staff Writer**
**Behavioral Health News**

Coordinated Behavioral Care (CBC) and Coordinated Behavioral Health Services (CBHS) announced today their joint formation of a Management Services Organization (MSO), Innovative Management Solutions NY (IMSNY) to support New York State's Behavioral Health provider community. IMS's initial offering is a customized data warehousing and business intelligence solution that is tailored specifically to meet the needs of New York-based Independent Practice Associations (IPAs) of Behavioral Health providers. Plans are already underway to expand IMS's services to include other MSO services, including practice management, credentialing, revenue cycle management, and other administrative support services, as well as to meet the needs of other sectors in New York's rapidly evolving healthcare ecosystem.

"We are thrilled about this collaborative undertaking, as it will provide efficiencies and economies of scale not just for our IPAs, but the for the whole sector," said CBHS Co-Chair Elizabeth Kadatz, of RSS, "and we think the timing is right for our community to come together to adapt to the changing healthcare landscape."

**Jorge R. Petit, MD**

CBC Chairwoman, S:US's Donna Colonna, said, "This offering is so needed by the sector, that I'm gratified that we are able to make it available, and at a lower cost than if each IPA were to acquire these services on their own. This is the first of what we expect to be many offerings from IMSNY."

"I'm grateful for the collaboration of our colleagues at CBHS." said CBC CEO Jorge Petit, MD, "With their partnership, we will be able to help agencies throughout the state address a wide range of administrative and clinical needs that will lead to better care and outcomes for people with chronic health conditions, mental illnesses and substance use disorders. It is clear that unless the behavioral health provider community comes together, we will not have the needed resources and bandwidth to engage in meaningful contracting opportunities."

"This is a real opportunity for the sector to come together to make the most effective use of scarce funding. As the administrative burden on providers increases as a result of state-level healthcare transformation initiatives, providers will need to find efficient, effective, and integrated solutions to a wide range of problems. We will be working with our colleagues around the state to identify other needs we can address with this powerful collaboration. While today's announcement represents a major achievement, it is only the beginning; the best is yet to come," said CBHS CEO Richard Tuten, JD.

**CBHS:** The CBHS Corporation is comprised of over forty progressive, nonprofit, community behavioral health and disability service providers serving seven counties in the Hudson River Region. CBHS maximizes the intellectual capacity and resources of its members in order to meet the challenges of a rapidly changing health care system. CBHS, founded in 2012, is developing business initiatives to successfully integrate and manage care and provide the cost-effective outcome-based services required for the future. Our commitment is to promote health and wellness, to facilitate the attainment of life roles in the areas of employment, housing, and social connectedness; to ensure access for whole populations, to ensure satisfaction from the people we serve and their families; and to do so at sustainable costs.

**CBC:** CBC is a results-driven healthcare organization dedicated to improving the quality of care for Medicaid beneficiaries with serious mental illness, chronic health conditions and/or substance use disorders. CBC seeks to create a healthcare environment where New Yorkers–especially those most impacted by social determinants of health–receive coordinated, individualized and culturally competent care that is effective in preventing and managing chronic physical and behavioral health conditions. We help New Yorkers live long, healthy and fulfilling lives. CBC was launched in 2011 by innovative NYC not-for-profit behavioral health organizations in order to meaningfully participate in NYS's Medicaid redesign and Value Based Purchasing

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# Clinicians' Perceptions of Telephone-Delivered Mental Health Services

**By Micaela Mercado, MSW, PhD,**
**Virna Little, PSyD, LCSW-R, SAP, CCM**
**and Eunice Kim, LCSW**
**Concert Health**

There is a significant need for professional programs to provide training in the provision of telephone-delivered mental health services. Telephonic mental health services is an emerging practice approach that may meet the needs and the field's commitment to addressing access to mental health services. We know that access to mental health services is limited for individuals in geographically underserved areas. This access gap is in part due to shortages of mental health professionals, and other determinants like limited transportation, stigma, impairments due to the mental health diagnosis and/or physical health, or limited physical mobility (Hoerster et al., 2014; Simms, Gibson, & O'Donnell, 2011; Smalley et al., 2010). Despite gaps in care, clinicians' tend to think that telephonic mental health service is not the same as in-person therapy and, thus, less effective. This notion is further reinforced by many state licensing entities, and there is a lag among accreditation bodies to examine emerging forms of technology in practice (Christiane & Lambert, 2018).

These reasons negatively impact patients' options for services that can be accessible, and contradict existing evidence-based practices such as Collaborative Care, which has a substantial telephonic component. Telephonic mental health service also has the potential to reach segments of the population that cannot access care in a timely manner (Gifford, Niles, Rivkin, Koverola, & Polaha, 2012).There is also preliminary data that suggests that patients enrolled in telephonic mental health services "attend", on average, more sessions than patients who receive in-person treatment, which has consistently been at low levels. This may indicate that a segment of patients prefer telephonic services. Training the workforce in telephonic mental health services is even more critical now that four Medicare CPT Payment codes have been introduced - CPT99492, CPT99493, CPT99494, CPT 99484 – which allow for service reimbursement implemented through Collaborative Care, an evidence-based model that is primarily carried out through a telephonic modality. Collaborative Care is a renowned model demonstrating significant evidence for improving health outcomes for depression and anxiety (Carleton et al., 2018).

In our effort to learn about telephonic mental health services, we interviewed mental health clinicians who provide telephonic mental health treatment. We learned that clinicians' perceptions towards telephone delivered care vary. One clinician commented "I didn't know what to expect. I wondered if it would be less personable." Another clinician said "I thought it would be mainly for two specific populations, the elderly or people who are disabled. But also people who might have fear or stigma [towards] counseling or therapy." Despite these differences, clinicians' overall perceptions of patients' acceptability of these services were positive. For the most part, we heard that "generally patients are satisfied". In one interview, a clinician said "Everyone I spoke to has positive feedback. I always receive a lot of 'thank you's and patients are appreciative when I call them and when they receive help from me. It's been very positive and seeing that is it helping them and that patients are really benefiting from the service."

Unlike the sparse research in this area, clinicians we interviewed were not reluctant to provide non-in-person services. In fact, they perceived it as a convenient and beneficial modality for getting patients the care they needed, and even enrolling patients that would not have otherwise sought services. This was clear when one clinician said "I feel that when people are in need of therapy it should be an option and it can definitely help and can be as effective" as in-person treatment." In our interviews with clinicians, they often mentioned the therapeutic alliance with the patient as one aspect of their work that they had to adapt to in providing services over the telephone. Several clinicians mentioned having to pay close attention to their voice tone, their word choice, and actively listening to patients for "clues" to build rapport. In adapting to this modality and reinforcing her skills, one clinician said her experience over time changed: "I thought it would be harder to build rapport with patients but patients have been able to engage over the phone." The general consensus from clinicians was that the therapeutic alliance with their patients was not negatively affected in any significant way nor was treatment or quality of care compromised when they delivered care remotely. These comments support what we know from existing research which demonstrates that telephonic services are effective in treating mental health conditions like depression, and other behavioral health conditions (Boyden & Dobel-Ober, 2016; Datto, Thompson, Horowitz, Disbot, & Oslin, 2003; Ekeland, Bowes, & Flottorp, 2010).

Part of clinicians' acceptance and adoption of telephone delivered mental health services stemmed back to initial training they received. It was clear that clinicians, who struggled using the telephone to do their work, needed more training. This has implications for clinicians who lack training in telephonic mental health services or who face providing therapy telephonically to patients. The field has long maintained that in-person mental health services to patients are the basis for providing care. Yet emerging technological approaches once

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# Meeting the Workforce Challenge at Outreach

**By Debra Pantin**
**President/CEO**
**Outreach Development Corporation**

As behavioral health care providers confront the unrelenting opioid epidemic, in an environment of rapidly evolving reforms in health delivery and payment systems, one theme continues to resonate: the importance of a vital workforce. It comes as no surprise that compounding the reality of systems reform, our field is experiencing a number of workforce recruitment and retention challenges.

Across the country, there remains a critical shortage of sufficiently trained and credentialed health workers and clinical professionals to meet the growing population of individuals in need of behavioral health care, particularly with focus on addiction treatment. A 2016 report published by the Health Resources and Services Administration (HRSA) highlighted worker shortages as a key challenge for meeting the nationwide need for behavioral healthcare. There are over 123 million Americans living in designated Mental Health Professional Shortage Areas (HPSAs), and the report estimated it would take nearly 6,000 additional health workers to meet these needs.

A January 2019 publication provided by the Mental Health Association in New York State summarized statewide survey results of turnover and vacancy rates

**Debra Pantin**

among behavioral health providers. New York's average annual turnover rate was a staggering 34%. In its segmented data, results showed that regions with higher costs of living had higher rates (up to 42%). Rates across the country are comparable and equally concerning. Salary growth and compensation has largely stagnated, a factor that emerges as highly consequential for behavioral health nonprofits. An inevitable consequence of these challenges is the increasing occurrence of worker "burnout" from high caseloads and more demanding and complicated cases.

Outreach's Own Workforce

At Outreach, our programs directly experience these challenges, especially in our residential treatment programs. Our capacity to provide vital and accessible care to our clients expands or contracts drastically with the loss or addition of a clinician. With this in mind, we carefully examine and gauge workforce issues, with focus on employing best practices in recruiting and retaining a qualified, motivated, engaged and job-satisfied staff.

We have fortunately been able to, in some ways, go against the tide on some of these trends, specifically on retention. Of almost 200 full- and part-time employees eligible for one-year retention at Outreach, over 80% have been with us for 2 or more years. The average length of employment for full and part-time staff at Outreach is over 7 years, with almost a quarter with the agency for 10 or more years. Much of these retention trends can be attributed to Outreach's focus on employee engagement.

Employee Engagement at Outreach

Ten years ago, Outreach embarked upon a culture change initiative. We commissioned experienced executive consultants to interview stakeholders key to our agency: our referral sources, board members, and most importantly, our staff. An opportunity was identified to "de-silo" Outreach's leadership and programs through a major rebranding and internal organizational culture change. The biggest takeaway from this experience was the ability to establish systems to engage and listen to our employees across our programs.

An important initiative undertaken at Outreach was to participate in the Best Companies to Work for in New York program. Created by the NYS Society for Human Resource Management (SHRM), The Business Council and Best Companies Group, the effort recognizes outstanding places of employment by capturing data on employer benefits, HR policies, practices and demographics, and more crucially, employee engagement and satisfaction.

While designation as a 'best company' would enhance Outreach's reputation as an employer, we were especially invested in the results of the anonymous, voluntary satisfaction surveys completed by our employees, the results of which are aggregated by Best Companies' statisticians for our review, and highlight trends in key areas such as: trust and confidence in the agency's leadership, professional development and career advancement, pay and

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# Adding Recovery Professionals to the Continuum of Care

**By Ruth Riddick**
**Community Outreach**
**ASAP New York State**

What is the purpose of our work, of all the prevention, intervention and therapy, all that merciful medical model and multi-volume DSM? The treatment plans? Aftercare? All this helping apparatus – what's it for?

Now, the agreed response is that "recovery" is our mutual goal irrespective of our specialization or wherever we engage professionally with substance use disorder. Recovery is the stated goal of interventionists, counselors, addiction doctors and nurse-practitioners, community mutual-aid. Where, then, do we add recovery professionals?

Way back when I completed a reputable program for alcoholism, I remember being issued with a treatment plan, a 12 Step meeting list, and a plethora of good wishes from gifted counselors, many of whom remain personal friends. Clinical staff had done a great job with me, but I still hadn't the first idea where to find the bus back into the city or the money to pay my rent. To this day – forgive me! – I haven't read that treatment plan; it's somewhere in my archive, safely stowed by UHaul. Could I have used a recovery coach? Could I ever!

A recovery coach is defined by training pioneers CCAR (the Connecticut Community for Addiction Recovery) as "Anyone interested in promoting recovery by removing barriers and obstacles to recovery and serving as a personal guide and mentor for people seeking or already in recovery." Barriers? Obstacles? In this model, we're talking about quotidian life-challenges: couch-surfing might be considered a barrier to recovery, unemployment an obstacle to rebuilding a credit score. Recovery coaches usually have direct personal experience of meeting these challenges in their own lives.

Indeed, Professor Thomasina Borkman at George Mason University wrote about the value of deploying such "peers," locating non-clinical authority (her word) in a potent mix of "experience" and "expertise" (1976, quoted in William White). In the recovery field, this formulation has come to mean: "Experience coming from a personal history of, or exposure to: (i) substance use disorder, (ii) the process of change, and (iii) a sustainable life in recovery; Expertise requiring application of that knowledge to the skill of helping others establish, and live in, their own definition and pathway of recovery across a lifetime." (Riddick, 2017).

According to the International Coach Federation, leaders in advancing the coaching profession, coaches "partner with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential." Avowedly non-clinical, ICF sees coaching as an integral part of a thriving society.

Thus, to be effective, coaches require strong communications expertise and a mature understanding of the recovery experience on which they rely. As professionals, we'll also have completed practice-specific training, we'll attest to a profession-specific ethical code, and we'll hold a role-specific certification from our local state board.

Just what is it that recovery coaches do to support the continuum of care? The simplest definition is that we help people build a sustainable life in recovery. And we do it by using our own strengths to support self-efficacy in others. "Our strengths help us be happier, fulfilled, engaged, and energized, achieve our goals, have better relationships, and bounce back faster from setbacks," writes career coach, Sonya Tinsley.

That is, coaches focus on the recovery goals of the individual ("client" or "participant") through purposeful conversations; in effect, mini-strategic planning sessions. These conversations are propelled by the agenda-setting question, "How can I help you with your recovery today?" We leverage our own experience to present options and resources, we encourage practical initiatives in support of both micro goals and the individual's recovery mission, and, if it's helpful, we can be something of an accountability buddy. Most important, we serve as role models for recovery ("this is what recovery means to me"), encouraging individual visions for that sustainable life. What you might refer to as "talk WITHOUT therapy."

In the field, we call this process "building recovery capital." CCAR has listed no less than 32 individual lifestyle items under this heading, including housing, employment, education, finances, community. The engagement with a recovery coach will last as long as the individual/client finds value in this capital-building collaboration – or until insurance cuts off the funding, but that's a different issue!

The National Council for Behavioral Health (2018) has quantified several benefits of introducing recovery professionals into the continuum of care. These benefits include reduced treatment re-admission rates, rapid turnaround following re-admission, decreased hospitalizations, and reduced length of hospital stay, all of which results have positive implications for the bottom line. Even more personal outcomes such as increased recovery capital, community & civic engagement, and realizing personal potential, have also been identified. As NCBH's Tom Hill, formerly of SAMSHA, concludes, "Recovery is an expectation." What's not to love?

Traditionally, recovery coaches have been seen as bridging the gap between treatment and a life in the recovery community, the very gap I experienced when

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# The Impact of Youth Peer Advocates: An Early Look at Findings

**By Darren Cosgrove, LMSW**
**Thomas M. LaPorte, PhD and**
**Margaret Gullick, PhD**

The incorporation of peer support in the treatment process for individuals experiencing mental health challenges has been increasing over recent decades (Campbell, 2005). Adults with mental health conditions have pursued roles as facilitators in recovery-based work (Mead, Hilton & Curtis, 2001), and attained roles as peer support providers in diverse settings (Chinman et al., 2008; Gopalan, Lee, Harris, Acri, & Munson, 2017). More recently, youth have also filled critical roles as peer support providers, as young people with mental health challenges may relate better to another young person with lived mental health experience.

A further development in peer work is the recent inclusion of Youth Peer Advocates (YPAs) in High Fidelity Wraparound (HFW; Walker, Baird, & Welch, 2018). HFW is an intensive care coordination model for children with complex mental health challenges. The New York State System of Care (NYS SOC) initiative, a pilot study of HFW implementation, encourages YPA involvement in the HFW process. Here, YPAs tend to work one-on-one with youth HFW participants and collaborate with members of the care team, including caregivers, care managers, and family peer advocates.

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**Thomas M. LaPorte, PhD**

**Margaret Gullick, PhD**

Including YPAs in the HFW process would appear to offer several advantages over HFW as usual. However, research on the impact of youth peers, particularly in HFW, is currently quite limited. This article describes some of the positive enhancements YPAs can bring to the HFW process, and some potential challenges of involving YPAs in HFW, both theoretically and in preliminary findings from our ongoing evaluation of the NYS SOC initiative. While the research described here is qualitative and exploratory, the findings may provide directions for future efforts to integrate youth peers in HFW.

Potential Impacts of YPAs in HFW

HFW uses a team-based process in which a care manager works with youth and, when applicable, their caregivers, as well as other providers and supporters, to address needs through strategies that capitalize on families' skills, interests, and abilities. Establishing trust early in the process can lead to better family, and particularly youth, engagement, allowing for fuller implementation of HFW and maximizing its intended outcomes. Research on adult peer-to-peer services has demonstrated that peer support can foster the trust and rapport needed for effective service delivery and connections with service systems (Chinman et al., 2008; Hardiman, 2004; Sells, Davidson, Jewell, Falzer, & Rowe, 2006); programs involving youth and young adult advocates have suggested similar benefits (Lombrowski, Griffin-Van Dorn & Castillo, 2008; Silva, Petrilla, Matteson, Mannion & Huggins, 2019). In HFW, YPAs' common mental health histories and similar ages afford youth participants a confidant during the critical rapport-building phase, promoting trust and reducing isolation. Further, YPAs remain confidants throughout the

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# The Center for Practice Innovations: A Resource for the Behavioral Healthcare Workforce

**By Nancy H Covell, PhD,**
**Sapana R. Patel, PhD,**
**Paul J. Margolies, PhD,**
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**Ilana Nossel, MD and**
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**Columbia University and**
**New York State Psychiatric Institute**

The New York State Office of Mental Health (OMH) and the Department of Psychiatry, Columbia University, established the Center for Practice Innovations at Columbia Psychiatry and New York State Psychiatric Institute (CPI) in 2007 to promote the widespread use of evidence-based practices developed for adults throughout New York State (NYS). CPI supports the behavioral healthcare workforce by offering free training, with continuing education, and technical assistance to staff working in not for profit behavioral healthcare agencies throughout NYS. By providing this free support to increase staff competence and support implementation of evidence-based practices, CPI also hopes decrease staff burnout and turnover. Additionally, the provision of free continuing education may help lower wage earners keep their licensure and accreditations without incurring additional out-of-pocket expenses.

CPI has six core initiatives: treating co-occurring mental health and substance use disorders (called "Focus on Integrated Treatment" or FIT), assertive community treatment (ACT), supported employment/education via individual placement and support (IPS), wellness self-management (WSM), first episode psychosis (called OnTrackNY), and suicide prevention (SPTIE). CPI also supports other state training initiatives including Adult-BH Home and Community Based Services, the Uniform Clinical Network Provider training, increasing the use of clozapine, cognitive health, treatment of tobacco use disorder (as part of the FIT initiative), and treatment of obsessive-compulsive disorder.

CPI also offers training in clinical core competencies for the behavioral health workforce including topics like care transitions and care management, cognitive-behavioral therapy, social skills training, cultural competence, engagement and outreach, ethics, evidence-based prescribing, family and community support, group psychotherapy, integrating medical and behavioral health services, working with the LGBTQ community, justice-involved individuals, managing challenging behaviors, motivational interviewing, peer services, person-centered treatment planning, recovery, risk assessment, shared decision making, stage-wise treatment, substance use, and trauma informed care. Staff can also choose curricula that are built around these core competencies (e.g., motivational interviewing) or CPI certificate programs (e.g., violence risk management).

CPI offers both online and in-person training. Working closely with content experts and instructional designers, CPI has developed over 120 highly interactive online modules that use personal recovery stories, clinical vignettes, interactive exercises, and frequent knowledge checks to engage the learner. CPI also offers several regional and on-site agency face-to-face training across different content areas.

While training is necessary, CPI recognizes that it is rarely enough to change practitioners' daily actions and achieve high quality implementation of the desired practice. For this reason, CPI offers empirically driven technical assistance to supervisors, managers and practitioners focused upon their implementation efforts. This often includes interactive webinars, an online resource library with practical tools (e.g., group manuals and fidelity checklists), consultations (both in person and by telephone), learning collaboratives, and monthly conference calls for participants in specific initiatives during which program staff share successes and receive expert consultation from peers and implementation experts on their implementation challenges. Consultations may follow difficulties with licensing reviews or staff turnover or are provided upon request for technical assistance. CPI's efforts are guided by dissemination and implementation science and embedded within a practice change model that considers the policy, regulatory and financial environment of practice change as well as organization-level factors such as program-practice fit, leadership investment, organizational culture, time and resources available for practice implementation.

To join a learning collaborative, participating programs form implementation workgroups that develop an implementation plan and oversee the work toward the goals of that plan, participate in learning collaborative meetings, and collect and submit performance indicator data. In many cases, these learning collaboratives use fidelity self-assessments to help guide programs through continuous quality improvement projects. This data allows programs to identify challenges in implementation and work with CPI staff to address these challenges. It also allows OMH to identify and support quality improvement efforts.

As of March 31, 2019, 36,040 staff had completed 412,240 online modules. Programs participating in CPI initiatives are geographically dispersed through New York State, reaching 61 of the 62 counties (the remaining county, contained fully within a State Park, is the least populous in NYS).

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# Enhanced CRPA and CHW Training and Workforce Transformation

**By Victoria Njoku-Anokam, MPH, and William D. Myhre, MPA, Staten Island Performing Provider System (SI PPS)**

The Certified Recovery Peer Advocate (CRPA) and Community Health Worker (CHW) are two emerging workforce roles in health care. A CRPA is a person who uses lived experience with substance use disorder (SUD) and who have been certified to provide peer support services including non-clinical coaching, support, information, guidance and motivation to those seeking or sustaining recovery from a substance use disorder. A Community Health Worker is a front-line public health worker who helps individuals and families to connect to healthcare and social service resources that will further support their wellness.

Across New York State and other parts of the country that are experiencing an opioid and other substance misuse epidemic, there is an increasing need for peer support professionals. This is especially true for CRPAs who can provide billable services in licensed substance use disorder treatment programs, particularly outpatient clinics licensed under the Office of Alcoholism and Substance Abuse Services (OASAS). Similarly, there is a growing need for community health workers who can work in clinical and community-based settings to assist individuals to

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better navigate the healthcare system and access appropriate health and social services. Such high demand of these two emerging workforce roles requires innovative models to develop and expand the workforce effectively. The Delivery System Reform Incentive Payment Program (DSRIP) is a federal program under the MRT 1115 Waiver that aims to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program and reducing avoidable hospital use by 25% over 5 years. The Staten Island Performing Provider System (SI PPS) has utilized an enhanced model for CRPA and CHW workforce development and expansion. This innovative model focuses on these four phases:

*Phase 1: Workforce & Training Needs Assessment:* In 2015 to early 2016, there were two Certified Recovery Peer Advocates on Staten Island, one of five boroughs in New York City. At that time, Staten Island was in the midst of an opioid epidemic with the highest per capita mortality rate in NYC. Alcohol and other substance use disorders also remain concerning in this community. In order to tackle the crisis, new DSRIP funded initiatives were developed which required the integration of peer support professionals in the emergency department, criminal justice system as well as in outpatient clinics, residential programs, and other clinical and community-based settings.

Addressing social determinants of health and clinical needs have become an increasingly important focus within key DSRIP-funded initiatives to support Medicaid recipient. This is especially true for people with behavioral health needs who overutilize preventable hospital inpatient and/or emergency services or have difficulty accessing healthcare services due to cultural, language, and/or socioeconomic barriers. CHWs are trained to extend the reach of providers into underserved communities, reducing health disparities, enhancing communication, and improving health outcomes.

Initiating and sustaining these initiatives required more certified recovery peer advocates and community health workers on Staten Island. The first

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# Integrating the Social and Cultural Determinants of Health into Peer Advocates Training

**By Helen-Maria Lekas, PhD and Crystal Fuller Lewis, PhD, at the Nathan Kline Institute for Psychiatric Research and Joanne Trinkle, MSW, NYS-OMH Division of Integrated Community Services for Children & Families**

The phrase social and cultural determinants of health has entered the lexicon of medical and social service providers and is often mentioned alongside health disparities. Since the early 90s, public health researchers have been suggesting that a person's socioeconomic characteristics, including race, ethnicity, socioeconomic status, gender and age, largely influence one's health (Link and Phelan, 1995). These characteristics determine our place in the social structure and consequently, the resources or lack thereof to protect and manage our physical and mental health. In addition to resources, cultural beliefs and ideas about our lives and health are also associated with these determinants. Health disparities, systemic differences in health care and health outcomes among populations, have been attributed largely to the interaction between available resources and aspects of one's culture. The realization that policies, programs and services must also attend to the social and cultural determinants to achieve health equity is now a commonplace to our collective understanding of health. However, best practices for identifying and addressing these determinants remain under discussion and are being evaluated for effectiveness as we aspire to decrease disparities.

*The professionalization of the role of youth and family peer advocates:* Over the past three decades, there has also been a growing appreciation for the role of peer advocates in providing resources, supportive services and enhancing the health of different communities and especially of persons with behavioral health conditions. Peers provide advocacy, empowerment, coaching and services coordination in many clinical settings and in the community, and successfully engage in services socially disenfranchised, often stigmatized, groups. Many peer advocates have direct, lived experience in navigating health and social services systems and communicating with service providers and can translate their experiences into skills and insights that help those they serve.

Building on this unique skillset of peers, several statewide trainings and credentialing programs have emerged to support them in the workforce. As a result, peer advocates increasingly are being hired as full-time paid employees, especially in the field of mental health. Under the auspices of Children and Family Treatment and Support Services in the state of New York, services provided by credentialed family and youth peer advocates will become billable under Medicaid, as of July 1, 2019 and January 1, 2020 respectively. Although this recognition of the critical role of peer advocates in providing services has been long overdue, rendering their services billable enhances their integration into the workplace and denotes their professional value in the healthcare system.

*A novel component of the Wraparound Training of peer advocates in New York State:* The New York State (NYS) Office of Mental Health (OMH) has been training in and implementing Wraparound with providers serving youth with serious emotional disturbances and their families. This training, offered by the Wraparound Training & Implementation Institute of NYS OMH and funded by a SAMHSA Systems of Care expansion grant, creates a framework for comprehensive, holistic and family-driven service delivery. One of the distinctive features of New York State's Wraparound program is the formation of a provider triad: a care manager, a family peer advocate, and a youth peer advocate. This triad ensures a team approach to services and is designed to effectively weave the skills and perspectives of all three providers aiming to more effectively address the family and youth needs.

As part of this program, the Wraparound Training & Implementation Institute, in partnership with C-CASE (Center for Research on Cultural and Structural Equity in Behavioral Health) at the Nathan Kline Institute, has incorporated a novel and theoretically-guided social and cultural competency training tailored specifically for peers. Guided by the health lifestyle model, peer advocates are trained in using the family story to identify the social and cultural factors that shape a family's available opportunities to address health-related matters and the health-related choices the make (Cockerham, 2013). This model suggests that the interplay between opportunities and choices generates lasting dispositions or orientations towards health, which include the tendency to access or avoid mental health services, to seek or not seek community supports, or to adhere or not to adhere to recommended treatment. These tendencies are defined as health habitus and they sponsor our health behaviors. Over time, and with repetition of the same behaviors, a health lifestyle is formed.

The training team's decision to integrate this health habitus-driven model into the peer advocates' training stemmed from the following three advantages. First, the model provides a clear depiction

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# Rural Workforce Development: Critical Challenges

**By Rachel W. Bush, PhD**
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The critical challenges that are associated with rural workforce development remain a significant issue in America. We have an obligation to explore the best ways of caring for the underserved rural population. Currently we have a health professions crisis unfolding. The federal government projects a shortage of over 20,000 primary care physicians in rural areas by 2025 (Nielson, et. al., 2017).

How can we guaranty that excellent health care is available for everyone? What are the most effective and useful pathways to insure professional competence and the acquisition of essential resources? We know and continue to be aware of the fact that evidence based rural workforce policy is an enduring challenge (Wilkinson, 2003). Ongoing infrastructure support remains inadequate (Lyle, 2002).

Stigma

Unfortunately, the stigma associated with pursuing behavioral health evaluation and treatment is heightened in small cohesive rural communities. Within this context there are a limited number of mental health professionals to provide essential mental health care. Privacy and confidentiality are always paramount and yet more difficult to insure within the rural context. Miller (2011) has highlighted some of the essential clinical, professional and social challenges of practicing rural medicine. She argues that complicated interpersonal dynamics occur in sparsely populated areas where privacy is hard to come by. Being the sole medical resource for a community potentially can lead to isolation and physician burnout.

**Rachel W. Bush, PhD**

Professional Training

Inequities between rural and urban health will grow unless we ameliorate the situation. In 2010 the Patient Protection and Affordable Care Act and other federal legislative fund initiatives were developed to recruit physicians to rural areas and decrease geographic inequities. Mareck (2011) argues that the federal government has been developing programs to increase the desirability for physicians to pursue careers in rural medicine. Area Health Education Centers (AHEC), Federally Qualified Health Centers (FQHC) and the National Health Service Corps (NHSC) have included scholarships requiring rural medical service as a payback. The goal of providing community driven patient directed comprehensive, culturally competent quality primary care has also been highlighted in the growth of mental health telemedicine. Between 2004-2014 the annual growth rates in this area have reached 45% (Mareck, 2011). In terms of medical education and medical residencies and fellowships, rural training has been quite limited in scope. For example, we know that 99 percent of residencies are located in urban and suburban settings.

Demographics

Older patients comprise one half of all hospital admissions in rural settings (Nielson et. al.,2017) where older patients in urban settings account for just 37 percent of hospital admissions. This may be explained in part by the fact that older patients in rural communities also suffer from multiple chronic diseases and their primary care physicians often do not have the support of sub-specialists, emergency physicians and hospitalists. It is a vicious cycle that involves primary care physicians struggling with medical breadth, depth and courage to perform medical procedures outside of their comfort zone (Miller, 2011). This, in addition to primary care physicians having limited access to sophisticated medical technology. Treating sicker patients with complex issues in rural settings therefore can be frustrating. Another determinant of health and wellbeing is rural poverty. Rural patients often travel farther for their medical care, struggle with social isolation and the lack of access to affordable nutritious food and medicine (Nielson, et. al., 2017).

Patients resistances to obtaining quality care at times can feel insurmountable and are associated with feelings of instability, anxiety and helplessness. In 2004 Worley used the powerful image of rural communities always being one doctor away from a crisis and the ongoing struggle of being without sufficient resources. As a result, locum tenens recruiters have been responsible for filling gaps in medical care in remote regions. These physicians have the professional flexibility to travel and also control the scheduling of work intensity and commitment for brief periods of time. As a result, notwithstanding the fluidity of providers, underserved regions are capable of receiving necessary care.

Professional Benefits

Rural medicine affords a special sense of professional and personal importance for providers. Rural practitioners have the opportunity to develop long term relationships with patients and their families. They frequently are viewed as important community leaders serving multiple important roles. For example, it is not uncommon to be in the position of treating acquaintances, close friends

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# CoveCare Center Hosts 2nd Annual LGBTQ+ Pride Event

**By Staff Writer**
**Behavioral Health News**

Close to 100 members of the community recently attended CoveCare Center's 2nd Annual Pride Clinic, learning about topics such as mental health and substance use issues within the LGBTQ+ population; pronouns and gender identity language; the history of the Pride movement; and LGBTQ+ youth.

The clinic began with a workshop focused on the use of LGBTQ+ inclusive language led by CoveCare Center's Diane Lotto, LMSW, CSW-G, Senior Partnership Services Team Leader and Krista Zanfardino, LCSW, Associate Vice President at CoveCare Center. "Diane and I developed this training to educate the community about the importance of understanding the difference between concepts such as gender identity, gender assigned at birth, sexual orientation, and gender expression. The way we talk to and about people goes a long way in making them feel included rather than ignored," commented Krista.

**CoveCare Center Staff**

CoveCare Center would like to thank the Putnam County Department of Health; GLSEN Hudson Valley and Putnam PFLAG (Parents, Families and Friends of Lesbians and Gays); The Loft LGBT Community Center; the Dutchess County Pride Center; and Planned Parenthood for sharing important information and resources with all who attended the clinic. "We had excellent community organizations join us this year. Many people in the LGBTQ+ community can feel left out or alone, and having these other agencies share their information helps individuals who may feel isolated connect with the resources they need," commented Krista.

CoveCare Center is the only private non-profit agency providing recovery-based mental health and substance use treatment and prevention services in Putnam County, NY. CoveCare Center offers hope and healing to people of all ages through a comprehensive range of services including individual and group counseling, care coordination, family advocacy, parenting education, community outreach, and medication management. CoveCare Center is a member of Coordinated Behavioral Health Services (CBHS), a non-profit 501 ©(3) membership organization of forward-thinking, community behavioral health and disability service providers in the Hudson Valley Region whose shared goal is to promote recovery-oriented and outcome-based services designed to ensure high quality and low costs.

*For more information about CoveCare Center and its services, please visit www.covecarecenter.org or visit them at www.facebook.com/covecarecenter or call (845) 225-2700.*

# Investing in the Integrated Care Workforce

**By Andrew Philip, PhD, Senior Director, Laura Heath, MD, MPH, NYAM Fellow, and Kristin Potterbusch, MPH, Senior Program Manager, Primary Care Development Corporation**

**Andrew Philip, PhD**

**Laura Heath, MD, MPH**

**Kristin Potterbusch, MPH**

It is no longer a new idea that the mind and body are intrinsically connected; Socrates via Plato, described this around 360 B.C. Yet, we still separate and silo these aspects of care; treating behavioral health needs like schizophrenia in mental health clinics and physical issues like diabetes in primary care clinics. Although primary care providers increasingly treat common behavioral health issues such as depression and anxiety, they still only reach a fraction of people who need these services and have not historically provided high-quality care for people with these diagnoses (Barkil-Oteo, 2013). Meanwhile, those living with serious mental illnesses (SMI) generally lack adequate primary medical care and are more often seen in behavioral health settings (Olfson et al., 2019). This dichotomy in care fails to address the realities of comorbidities and whole-person needs.

Integrating behavioral health and primary care bi-directionally (providing primary care in behavioral health settings and behavioral health services in primary care clinics) is a powerful and necessary tool to address a wide range of needs both for staff and patients (Skillman et al., 2016). While there is much work to be done to transform our policy and payment systems to support integrated care, a more tangible yet often overlooked necessity is preparing the behavioral health workforce to deliver integrated care. We can equip our staff through three key mechanisms: interprofessional collaboration, clinical competency, and supervision.

Interprofessional Collaboration

Often behavioral health staff have trained in discipline-specific settings (e.g., schools of social work, psychiatric clinics, or psychotherapy settings) and may not be familiar with methods for communicating with and sharing clinical responsibilities across other disciplines. Health organizations can overcome billing, scheduling and infrastructure barriers to integration only to find that a breakdown in communication between team members stalled an entire organization's integration efforts. A traditionally-trained behavioral health professional may never have written a brief, quickly digestible note germane to primary care setting records, nor be familiar with how to contribute their skill and perspective within a cross-discipline team huddle or curbside consultation. Integrated settings often illuminate differences in staff priorities and goals (e.g., changes measurable by lab results and screening), language (e.g., terms like 'patients' vs 'clients', 'primary complaint' vs 'patient goal'), and expectations such as metrics and clinical encounters per day.

To sustain buy-in, cooperation, and collaboration between team members, early wins and shared goals should be established. Screening can be one valuable starting point. Whether improving depression screening or screening for colorectal cancer, both behavioral and medical staff can identify opportunities to

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# Creating a Family Peer Support and Services Workforce

**By Marleen Litt, LCSW, Yudelca De la Cruz, MSEd, Onicka Miller and Veronica Worley JCCA**

For the caregiver of a Medicaid-eligible child who has a behavioral diagnosis, or demonstrated loss of a physical health diagnosis, Children & Family Support & Services (CFTSS) provide unprecedented support, advocacy and resources. On July 1, 2019, the fourth CFTSS component, Family Peer Support Services (FPSS) will become reimbursable under Medicaid Managed Care. Many young people stand to meet eligibility and with the emphasis on family support, it is a service that the whole family can benefit from.

This service differs from other CFTSS and Home & Community Based (HCBS) services in that it stabilizes and supports caregivers through a unique model of peer support. FPSS providers must demonstrate that they have "lived experience" navigating multiple systems of care for their child/ren. Among other benefits, a mounting body of research demonstrates that family peer support provides caregivers with a better understanding of their child/ren's behaviors, increases their engagement in community and health resources, and reduces the rates of missed medical and behavioral health appointments. In addition, it validates the lived, personal experience of FPSS Providers and empowers them to help others. It further increases the pool of qualified service providers for clients, and provides a pathway to meaningful employment for individuals without a formal education in child development or social services. Currently, more than 35 agencies serving New York City have been designated to provide FPSS. However, there are considerable obstacles to the recruitment, onboarding, supervision of potential FPSS providers, as well as fiscal viability issues for the agencies employing them.

In various shapes and forms, JCCA has provided peer advocacy and support to families for quite some time, and can offer instrumental insight into the challenges of building and maintaining the FPSS workforce. JCCA, a child & family services agency in the New York metropolitan area, has provided home & community based services, foster care, preventive, mental health, and residential treatment for almost 200 years. The staffing pipeline is clear: almost every JCCA program works with motivated, resilient parents/caregivers who successfully navigate child welfare and/or behavioral health systems and emerge "on the other side" with newly developed strengths, skills, and knowledge. They are prime candidates to become advocates. However, their experience can leave parents and caregivers feeling exhausted and drained. Even the most resilient can harbor feelings of anger and resentment and need time to process, heal, and recover.

Credentialing FPSS providers poses another obstacle. Once employed, FPSS provider must be Credentialed Family Peer Advocates. To obtain a provisional credentialing, one must complete a multi-day online Level I training as well as an application with an attestation and two letters of reference. While providers do not need a formal education, this process can be challenging for prospective advocates who may not have recent work experience. For others, a written attestation recounting personal experiences is a deterrent. For Level II, the FPSS worker must obtain 1000 hours of experience before completing the training and submitting a new application; recertification is required as well. These same credentialing qualifications do not exist for other CFTS services.

Once they begin work, the Family Peer Advocate is expected to share their own experience, yet maintain boundaries. This is a difficult balance. The FPSS provider needs to have ongoing training, regular supervision, and an ability to process therapeutically the impact of vicarious trauma. Yudelca De La Cruz, the director of JCCA's Family Resource Center and Parent Advocate program, encourages staff to seek outside therapy but finds that individuals, who are often parents with limited spare time, rely on their supervisor to manage both their work performance and their emotions.

Lastly, for employers who maintain a per-diem workforce structure, the multi-day training can make onboarding costly. The credentialing is at no charge, but providers must be compensated for their time even before they provide a billable service. Additionally, the rates for new Family Peer Support & Services are inadequate to sustain full-time staff. State-negotiated FPSS rates are nearly $10 less than the rates for Psychosocial Rehabilitation, a service that can be provided by a high-school educated worker without personal experience, credentialing, or additional training. JCCA and other agencies provide this service using a per-diem workforce, paying workers for the hours they work at a maximum of 20 hours per week—without benefits or vacation time. Turnover is high, as providers leave for opportunities with better wages, more

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***Stress from page 22***

Stress Scale which included questions such as "Conditions at work are unpleasant or sometimes even unsafe" and "I find it difficult to express my opinions or feelings about my job conditions to my superiors." Five categories of workplace stress were scores: No Stress; Low; Moderate; Severe; and Profound. We also used the 10-item compassion satisfaction subscale of the Professional Quality of Life Scale (ProQOL Scale). (Stamm, B.H. (2010). The concise ProQOL Manual (2nd ed.). Pocatello, ID: ProQOL.org., p.12). Sample items include: "I like my work as a helper;" and "I have happy thoughts and feelings about those I help and how I can help them." The responses were categorized as: "low," "average" and "high" compassion satisfaction. In addition, we asked respondents their level of agreement to two statements: 1) "I am valued as a professional in society;" and 2) "I am glad I chose social work as my profession." The five response choices ranged from "strongly agree," to "strongly disagree." Basic demographic information data were obtained.

Description of Responders

The mean age of our respondents was 46 (S.D.=13), with 89% reporting that they were female, 83% white, and 55% Christians. The mean number of years working as a social worker was 16 (S.D. = 11), with 80% having an MSW. Thirty-nine percent were working directly with clients, 23% of were doing indirect work, and the rest did both. A small number (12%) worked solely in private practice. Majority worked in the field of "mental health" (61%), followed by "children/adolescents" (50%). Here's what we found:

*Workplace stress:*. When compared with a 2001 national Harris Interactive survey of U.S working population (Parmar, K., Solanski, Parikh, M., & Vankar, G.K. (2015). Gender differences in stress at work place among doctors and nurses. GCSMC Journal of Medical Science, 4(2), 108-113), we found that 20% of social workers scored in the highest two stress categories (Severe and Profound) vs. 11% in the general population, and 48% scored in the lowest two stress categories of the scale vs. 68% of the general population. It is clear, that compared to the general workforce, licensed social workers in the U.S. experience higher levels of stress.

*Compassion satisfaction:* Nearly 60% of participants working directly with clients reported high levels of compassion satisfaction, with less than one percent reporting low levels.

*Valued as a professional in society:* 57% of respondents felt that they felt valued as a professional by society.

*Glad chose social work as a profession:* 82% agreed or strongly agreed with the statement that they are glad they chose social work as a profession.

*Workplace environment issues:* Social workers indicated that were satisfied with Receiving Sufficient Training (82%); Access to Technologies (80%); being Safe from Physical Harm (79%), and having Sufficient Workspace (78%). Not surprisingly, the lowest score was for Satisfied with Salary/Income (47%). Only 60% of respondents felt that they receive good supervision, 66% felt that the size of their caseloads was manageable, and 71% felt valued in their workplace as a professional.

*Demographic factors:* Issues of race/ethnicity, religion, and age were all found to be significant factors in compassion satisfaction and are discussed below.

*In Summary:* This study of licensed social workers found that although average workplace stress levels were above those of U.S. workers, the helping aspects of the profession are rewarding for many. It also found that levels of workplace stress and compassion satisfaction were inversely correlated, implying that too much workplace stress negatively impacted on their compassion satisfaction. The greatest factors impacting on these aspects were workplace environment issues, highlighting the importance of increasing salaries, sense of feeling valued as a professional in the workplace, improving the quality of supervision and limiting caseloads. In addition, they indicated a need for greater support at the workplace for social workers with mental and physical health problems. Another notable finding is that although only 57% of the respondents expressed that they felt valued as a professional in society, 83% were glad that they chose social work as their profession.

The most surprising finding related to the impact of race/ethnicity on compassion satisfaction and workplace stress with black and Latino social workers expressing higher levels of compassion satisfaction and lower levels of workplace stress than white social workers, while Asian social workers had the same views as white participants. Further research to understand these dynamics is certainly needed.

In addition, social workers who identified as Buddhist, demonstrated higher levels of compassion satisfaction than Christian social workers. Finally, as found in other research, older age was associated with higher levels of compassion satisfaction. However, years of experience was not associated with compassion satisfaction or workplace stress. Social workers who engaged in both indirect and direct practice roles were more likely to score higher in compassion satisfaction than those who only engaged in direct practice. In regard to workplace stress, it was not surprising that child welfare was a predictor of higher workplace stress. The only other field of practice that predicted increased stress was working with immigration and refugees (note: the data were collected before the election of President Trump), with lowest stress experienced by those working in employee assistance programs, as well in the area of "housing and homelessness." The latter result is indeed quite surprising and needs to be further investigated.

In conclusion, the findings of this study add to the limited research data regarding licensed social workers in the US and the factors affecting their work. Additional research is certain needed to further explore the issues discussed in this article.

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jointly improve a single metric or outcome. In these efforts, staff may find ways to reduce duplicative processes (in the case of depression screening), or to learn from one another about risk factors for disease and opportunities to jointly address different components impacting a single issue (such as improving rates of colorectal cancer screening). Shared initiatives will provide opportunities for staff to cross-train, improve fluency in behavioral or medical terminology, and build strong communication.

Clinical Competency

The ability to effectively deliver evidence-based clinical interventions can help behavioral health staff feel efficacious in their work and comfortable in their role within the integrated team. For example, individuals living with SMI are highly likely to also experience chronic sleep difficulties (50-80%; Harvard Medical School, 2019) and numerous other chronic health conditions. At the same time, poor sleep broadly impacts much of the general population seen within primary care clinics, worsening other medical conditions and potentially even increasing or exacerbating the presence of budding mental health conditions (Khurshid, 2018).

Evidence-based behavioral interventions for insomnia (i.e., cognitive behavioral therapy for insomnia) are now recommended by groups such as the American College of Physicians and the American Academy of Sleep Medicine as gold-standard treatments, often more effective and safer than available medications. Chronic, comorbid conditions such as insomnia carry significant behavioral components, presenting an opportunity for integrated behavioral health providers to impact a common medical condition and assist patients in self-management. Unfortunately, relatively few behavioral health providers offer this line of treatment or see themselves as primarily responsible for addressing insomnia, and similarly few primary medical providers are aware that this may be an option for their patients.

There are ample opportunities to grow clinical competencies in the integrated behavioral health workforce, but the first and perhaps most important step is finding a starting point. When developing a new clinical offering, a few key steps can be helpful:

• Explore the electronic health record, frequently used billing codes, or simply ask clinical staff: what are the most prevalent health conditions within the clinic? If there are behavioral health components to any these (which exist for most chronic medical conditions), it is probably a good area for intervention.

• Consult with relevant subject matter experts or examine the literature to determine an appropriate evidence-based behavioral health intervention. From insomnia to tobacco cessation, weight management to chronic pain, there is almost always an opportunity for integrated behavioral health providers to help the team and their patients address chronic medical conditions.

• Training and consultation should be utilized to ensure competent practice and can usually be obtained both in person and at-distance and can be informed by each discipline's professional organization.

• Map a pathway to address the identified clinical need and consider perspectives of all members of the care team. For example, what are the criteria and means by which nursing staff, medical assistants, peer support staff, or others can identify and refer patients for treatment? If a physician identifies a patient in need of behavioral intervention, have they been trained in quickly discussing this with patients and is there a plan for the behavioral health provider to be available to address this need?

• Ensure a full communication loop. If a patient is referred or handed-off for this new intervention, will the referring staff get feedback or recommendations to address next time they see the patient? How will they know if the effort they put into referring the patient for treatment have been fruitful?

• Finally, develop a realistic plan to determine if this new area of intervention and pathway to care has been successful. If addressing insomnia, it is possible that not every patient diagnosed will be asymptotic after one month, but perhaps after a few months there is a decrease in first-line zolpidem prescriptions within the clinic.

There are success stories of enhanced clinical competencies in integrated settings. Smoking cessation, which straddles both the behavioral and physical health realm, is increasingly a competency for both primary care and behavioral health professionals. Both groups should feel comfortable asking, discussing, using motivational interviewing techniques and giving evidence-based advice to clients who use nicotine products. Both primary and behavioral health providers can support the use of multimodal nicotine replacement and counseling. This increase was the result of years of cultural and educational change efforts. Today, the same sustained change needs to be accomplished for a wider range of needs.

Supervision

Developing staffing infrastructure to

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*Workforce Crisis from page 1*

and de-professionalization (a positive in my view).

Education and Training

I will not say much about education and training. Professional schools, particularly, have increasingly provided education in "evidence-based" practices that probably have better outcomes than intuitive clinical practice. And training programs abound. In New York, for example, social workers—who provide most the nation's mental health services—now are required to get continuing education credits. New training is flourishing, much of it on-line, just one example of how new technology can contribute to improved professional—and paraprofessional quality.

Recruitment

Recruitment, of course, is key to increasing the size of the mental health workforce. And critical to this is **HIGHER PAY**—especially for "lower level" staff. It is appalling that residential counselors and case managers without a master's degree can sometimes make more money flipping burgers at MacDonald's than they can providing vital services for people with serious mental illness. And it is appalling that some social workers and mental health counselors with master's degrees have to moonlight as servers in restaurants to get by. And **the indifference of government, which relies on professionals and paraprofessionals working in not-for-profit organizations to fulfill its obligations to people with behavioral health conditions, is sad in the extreme.**

**Michael Friedman, MSW**

But pay is not the only way to attract people to vital jobs. Loan forgiveness, in a nation in which most people go into debt to get an education, is frequently on the recruitment agenda. Unfortunately, it's on the recruitment agenda for every vital, but not terribly popular, job, creating huge competition for the little money that is made available to help people pay off their loans.

Beyond the money issues, recruitment depends on creating the sense that work in the field of behavioral health opens up a range of professional and career opportunities—that include increasing pay over time, the expectation of promotions to supervisory and management positions if desired, and access to experiences that add value to the work professionals do such as participating in research, attending conferences, publication, etc. Unfortunately, such opportunities often require very high levels of education and jobs devoted less to service than to academics, so they are effectively closed off to the very workers for which the system has a crying need.

In addition, the mental health professions face a problem of social status. I don't want to overstate this. There are some high-status roles, being a psychotherapist, for example. But psychiatry is apparently a lower status role among physicians, and social work, for sure, doesn't get the kudos it deserves.

How to increase the social status of behavioral health work is a tough question. I have always thought it would be useful to have positive images in the movies and on TV. But it strikes me that psychiatrists and social workers, among others, are often ridiculed in the popular media. We need far better public relations!

De-professionalization

Finally, the shortage of professional staff has been, and can continue to be, addressed by "unbundling" functions and thus de-professionalizing them. For example, in the medical world in general, there are now nurse practitioners, physician assistants, and administrative staff who have taken over part of the workload of physicians.

In psychiatry there has been a vast change since I entered the field 50 years ago. Then, psychiatrists not only did diagnosis and treatment planning; they also did virtually all of the individual treatment while social workers handled families and life planning. Now, most treatment is provided by social workers. Psychiatrists still do some treatment—especially in private practice—but in organizational settings such as clinics, psychiatrists more and more oversee treatment, handle difficult diagnostic questions, prescribe and monitor medication, and do assessment of homicidal and suicidal risk. Quite a change!

Social work has also changed. Many years ago, it created a Bachelor's in Social Work degree (BSW) so as to step down some of the work that social workers previously had done—especially case management and dealing with the concrete needs of people having a tough time managing to lead safe and satisfying lives. Whether this was a wise change is still open to debate, but it has unquestionably been a way to provide more service to more people.

Can more functions of psychiatrists and other professionals be unbundled and turned over to other professional or paraprofessional staff? I have no doubt that this is possible. For example, I believe—and this is very controversial—that psychologists, nurses, social workers, and mental health counselors can all be trained to prescribe psychiatric medications and that, with appropriate training, they can be relied on to sign off on treatment plans that now call for psychiatrists. This would not be a total response to the lack of psychiatrists in many locales in the United States, but it would help.

*see Workforce Crisis on page 34*

***Parity from page 6***

E/M codes should be limited to new patients, patient re-evaluation after a series of treatments, or a significant change in a patient's condition."

This policy is in direct conflict with the conventions of CPT, which provide that psychotherapy may be billed using a combination psychotherapy code, comprised of an E/M code and a psychotherapy add-on code. Psychiatrists regularly provide E/M services in all settings – inpatient and outpatient - and there is no clinical reason why this service cannot be provided at each patient visit. This policy also conflicts with New York Insurance Law 3224-b, which requires insurers (and all health plans) to accept and initiate processing of all health care claims submitted by physicians in a manner consistent with the current version of CPT. Further, guidance issued by the New York Department of Financial Services requires insurers to accept and initiate processing of E/M codes from any physician, including a psychiatrist, for the treatment of mental, nervous, or emotional disorders or ailments.

Finally, a policy of this nature also runs afoul of the federal HIPAA statute and regulations because a failure to provide identical reimbursement rates for the same CPT code for a behavioral health claim vs. a non-behavioral health claims would be an illegal non-comparable treatment limitation.

In order to address this concerning issue, NYSPA immediately contacted the American Psychiatric Association and our two organizations worked collaboratively to draft a letter to the carrier to raise our significant concerns regarding its E/M policy. The following is an excerpt from the joint letter:

"There is nothing in the Federal Register or CPT to support [the carrier's] position that psychiatrists are prohibited from providing an E/M service for every single outpatient/office visit, whether or not the psychiatrist also provided an add-on psychotherapy visit in addition to the E/M service. All physicians, regardless of specialty, who see a patient in their office first bill an outpatient/office E/M code for every patient visit and then include billing for any other procedures provided during that office visit. There is absolutely no basis for restricting or limiting the use of E/M codes by one specialty – psychiatry. Not only is [the carrier's] position not supported by CMS, Medicare, or CPT, it violates federal parity laws."

NYSPA and APA await a response from the carrier on this important issue.

Utilization Review

NYSPA continues to work to assist its members in connection with the ongoing utilization review activities of insurance carriers. Many NYSPA members report that a variety of health insurance carriers continue to conduct medical necessity reviews of behavioral health treatment similar to those detailed in the California lawsuit. Often, the medical necessity review will consist of requests for treatment records and/or a phone interview with the provider to permit the carrier to make a determination regarding the medical necessity of services under review.

Similar to the treatment of other chronic illnesses and conditions, such as diabetes, hypertension, coronary artery disease and rheumatoid arthritis, treatment of chronic mental illness focuses on disease management, not cure. The goal of treatment of chronic illnesses and conditions is symptom reduction and improvement in functioning. After addressing symptoms and dysfunction to the extent medically feasible, the goal of treatment then shifts to maintenance of gains to prevent return of symptoms and loss of function.

While health plans are legally permitted to limit covered benefits to only medically necessary care and treatment, some utilization review efforts appear to be conducted solely in connection with claims for mental health treatment or are more restrictive and more stringent than medical necessity reviews of treatment for non-behavioral health conditions. Further, as the Judge in the California class action suit found, such reviews may be performed using medical necessity criteria that are improper and do not conform to generally accepted standards of care.

A typical scenario is a covered patient being seen once or twice a week by their psychiatrist for treatment of a chronic mental illness on an out-of-network basis. A representative of the health plan will contact the treating psychiatrist and request a telephone interview to provide information justifying the need to continue the treatment at the current frequency. Despite the provider's demonstration of medical necessity for the services in question, these reviews often result in the reduction or even termination of further reimbursement. Reviewers often make a determination that the patient can be seen at a lower frequency or that further treatment is simply not medically necessary.

Access to Care

Another troubling parity issue that impacts both providers and patients is reduced access to care resulting from inadequate reimbursement for mental health and substance use disorder services. In the out-of-network context, without adequate reimbursement, patients may be unable to pay out-of-pocket for their care and may be forced to discontinue treatment. In this way, inadequate reimbursement acts as a barrier to care because the quality of an out-of-network benefit is measured by the reimbursement that the patient will receive under the terms of their health plan. In some cases, reimbursement may be so low as to effectively constitute no benefit at all. Further, it is important to look carefully at what is paid out-of-network for behavioral health benefits compared to what is paid for non-behavioral health benefits.

On the other side of the coin, if in-network mental health fees are so low that they fail to represent reasonable compensation for the provider's time and expertise, many providers will not want to accept the plan's fee schedule as payment in full. As a result, providers may refuse to join networks or drop out of networks. In both the in-network and the out-of-network context, ensuring discrimination in payment is a key factor in ensuring adequate access to psychiatric care and treatment.

Despite recent gains, inequities in reimbursement and utilization review for behavioral health services persist. NYSPA is committed to working with the provider community, government regulators and other stakeholders to ensure adequate and fair reimbursement for the treatment of mental illness and substance use disorders, both for providers and patients alike.

*Rachel A. Fernbach, Esq. is Deputy Director and Assistant General Counsel of the New York State Psychiatric Association and is Vice-Chair of the Mental Health News Education, Inc. Board of Directors.*

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***How Far from page 17***

Behavioral health executives need to make decisions and respond quickly to changing markets. They need digital dexterity, using data for strategy and change and using technology to reengineer processes and relationships with staff and patients. This requires leaders schooled in business, not just social work or psychiatry.

We wanted to decrease stigma and we have. Now, the demand for mental health and addiction services far exceeds supply, and we need leaders who can participate in solving the treatment gap.

We need leaders who can operate in a transactional economy, creating networks across communities and even states; forming independent practice associations (IPAs); and negotiating for capitations, case rates, and bundled payments.

We need leaders that embrace local, state, and federal advocacy as fundamental to their jobs. Leaders ready to advocate for the most viable way to ensure the availability of effective community behavioral health care – CCBHCs. With unemployment at a 49-year low, we need rates that cover competitive salaries, and prospective payment is how federally qualified health centers have closed the primary care treatment gap. It's time for parity in the safety net.

We need leaders who understand that our patients live in a world of responsiveness and convenience. They can watch a movie, call for a ride, or order groceries at the touch of a button. Agencies that are mired in "they way we've always done things" will falter. Challenge time-based assumptions. Eliminate patient waiting, friction, and cumbersome forms and procedures. The National Council has been preaching same-day access for more than a decade because it works!

Finally, we need leaders who question beliefs even when doing so makes some people uncomfortable. Can harm reduction in the form of supervised injection sites co-exist with abstinence-based addiction treatment?

What does it really mean when we talk about the social determinants of health? When people who are poor in this country die 13 years earlier than people who are not, doesn't that mean that poverty is bad for your health? We need government policies that pave a pathway out of poverty.

What about the terms, "trauma competent," "culturally competent," and "military competent?" All are important, but we need care that is clinically competent. If we want better outcomes, we need to be teaching the basic skills of making connections, establishing relationships, and delivering effective treatments. Never forget that we got into this business to help people.

Fifteen years goes by in the blink of an eye. The National Council has grown from a $2 million organization with a staff of 12 to a $54 million organization with a staff of 140. Along the way, we've become a force to be reckoned with. We've passed legislation. We've changed practice. We've saved lives. Our good work continues under the capable leadership of our new president and CEO, Chuck Ingoglia.

As I step down from the National Council, I'm not setting down my mantle. This work is too important to me, to the people we serve, and to the nation. I'll be continuing my board and advisory work with government, philanthropic, and business sectors, and I'm especially honored to be joining the Columbia University Department of Psychiatry as Professor of Mental Health Policy and Director of External Relationships. I look forward to fighting alongside you for effective, respectful care for all people with mental illnesses and addictions.

*Please visit the National Council at www.thenationalcouncil.org or contact me at Lindar@thenationalcouncil.org.*

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***Care from page 25***

my treatment program concluded. Increasingly, however, coaches are also being deployed in emergency rooms as part of triage teams.

"Recovery coaches support patients admitted as a result of an opioid overdose or other drug or alcohol related crisis," says Phil Valentine, CCAR Executive Director. Speaking to results, Valentine adds, "Coaches have demonstrated effectiveness in linking Emergency Department patients with treatment and community-based recovery resources."

In truth, recovery coaches can embody the potential of recovery for anyone at any point in the continuum of care from prevention through to a sustainable life in recovery.

Let's agree to share that strengths-based definition of "recovery": A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." (SAMSHA, 2011). Anything less is not enough.

*Ruth Riddick is a Certified Addiction Recovery Coach and a CCAR-designated Recovery Coach Professional. She serves as Community Outreach at Alcoholism & Substance Abuse Providers of NYS, as a Coach/Trainer/Mentor at Sobriety Together ™ and as a peer recovery subject matter expert in a variety of settings. She has been honored for her work by Caron Treatment Centers, Crossroads of Maine, and Irish America magazine.*

***Outreach from page 25***

benefits, and physical plant. Employees' candid narrative comments offer even richer feedback, presented in a manner that further guarantees anonymity and confidentiality.

In order to decide what changes and investments need to be made by a company to retain its workers, leadership needs to create safe opportunities for staff voices to be heard. Workforce studies emphasize that employee engagement is critical in sustaining employee retention. Encouraging Outreach employees to participate in the survey process each year for Best Companies is one avenue. As a result of these surveys, creative staff initiatives, HR policies and practices have been implemented involving improved benefits, staff appreciation and recognition, and innovative ways for staff voices and ideas to be heard. Outreach continues to regularly and routinely assess and listen to our employees.

## Professional Development Opportunities Within Outreach

Providing opportunities for workforce development through continuing education and training is not only essential for furnishing core skills to support good patient outcomes, but a key component of employee engagement. Outreach has the strategic benefit of operating an in-house training institute that offers a calendar of professional development and continuing education trainings year-round.

Known throughout New York for its Credentialed Alcoholism and Substance Abuse Counselor (CASAC) certificate program, Outreach's training institute has advanced in recent years to also provide quality training to professionals already in the behavioral health field. Focused on enhancing skills and command of evidence-based practices and provide continuing education hours required for credentialed and licensed clinical staff. More importantly, the benefit of an in-house training institute is realized through an internal culture where supervisors encourage their staff to take part in professional development training opportunities.

Participating in evidence-based practice trainings, such as trauma informed care, motivational interviewing, and mapping-enhanced counseling, not only improves delivery of care, but expands the horizons of our staff. The opportunity to participate in professional development trainings has consistently been valued by staff across various ages and disciplines: Outreach observes these comments in the Best Companies surveys, and also from satisfaction surveys that are administered after each of the institute's trainings.

## Conclusion

While there is no universally definitive approach to employee engagement, recommendations ultimately encompass elements such as: inclusive hiring, accessible learning, and career advancement. Workforce training, skills-training, and a culture that permits these are paramount to employee engagement: they furnish much-needed core skills and competencies while steadily providing expansion of talent and career growth opportunities. Emphasis on a culture that promotes (and allows for) professional development of staff is only one strategy in which Outreach engages its employees, but a critical one that is more infrastructurally available to us than salary increases.

Though Outreach has maintained strides in retaining much of its workforce, we still share in experiencing our field's workforce crisis. Our field continues to encounter a shortage of qualified health professionals, and just as important, the salaries with which behavioral health workers are paid are not enough to sustain our workforce. To preserve and expand our field's ability to meet the needs of our communities, as providers, we need to fiercely advocate in unison for vital legislative items, such as Costs of Living Adjustments (COLAs) for our workers. It is incumbent upon us to continue to educate policymakers at the federal and local levels about the impact of these shortages on the availability and delivery of care, toward enacting legislative and policy initiatives that foster a lasting solution.

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greater financial security and a change to engage in meaningful work.

## Transcending the Role

As we move toward a greater acceptance and acknowledgement of the true value peers bring to the behavioral health workforce, we must think of peers as also transcending the role. Federation has many individuals who have achieved great success and moved up to managerial and higher level positions who possess lived experience with mental illness, either their own or with someone close to them. These individuals utilize their unique perspective to better inform their practice and give them a keen insight into the challenges both members and staff face on a daily basis. To be able to see and truly understand multiple perspectives is something that cannot be learned rather it comes from one's own life narrative. They are true examples that your diagnosis does not define you but contributes to your value as a whole as they continue to work on their own recovery while leading satisfying lives. These individuals are proof that there are role models everywhere and the possibility of moving beyond your diagnosis is absolutely attainable.

As a social service organization, we must continue to push other organizations, managed care companies, healthcare providers, and the greater public to understand the value of peer support. We must help them see that the peer support component can and will work in tandem with other behavioral health services for a more cohesive and holistic plan of care. The trusted bond formed through the peer-to-peer model can be the foundation on which other services can be built upon.

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hours, or benefits.

As JCCA embarks on providing this service, some suggestions are offered:

*Recruitment:* Not every service recipient is prepared to become a Family Peer Advocate, and especially not right away. Onicka Miller and Veronica Worley, Parent Advocate (PA) Coordinators in JCCA's PA program, provide insight on theirs and others' experiences transitioning from recipient to provider. The experience was draining, and individuals may need some distance before becoming advocates. Others feel unqualified and need repeated encouragement to gain confidence with their developed skills. When Ms. Miller and Ms. Worley first attempted to recruit participants at JCCA's Family Resource Center parenting and anger management group graduations, they were not always successful. Instead, the Coordinators began simply collecting names and contact information at graduation, finding better results when they reached out six weeks to three months after the end of services, giving potential providers time to feel less overwhelmed and more confident in their abilities. Therefore, maintaining long-term contact with an established roster of clients, who demonstrate advocacy skills and interest, can improve the recruitment of viable candidates for the future.

*Onboarding:* The onboarding process, as noted previously, can be laborious. It is essential to identify candidates early on who appear capable of completing the requirements for the provisional credentialing. Through their experience, the Parent Advocate Coordinators have found that past work experience, especially in advocacy, can predict a peer's ability to follow through with and complete the lengthy onboarding training and credentialing process.

*Supervision:* The Family Peer model must take into consideration training and opportunities for ongoing therapeutic processing. JCCA has found that staff relate positively to supervisors with lived experience. Supervision needs to be on a regular, ongoing basis with opportunity to debrief when needed as soon as possible and regular training on vicarious trauma. Staff new to work may require more intensive managing. It is also vital to instruct staff on boundaries as they leverage their lived experience without oversharing. It is notable that longevity, in comparison with other staff of the same level, is much higher, even among the per-diem staff. Intensive supervision can be noted as a factor.

*Fiscal Viability:* Research has shown that, in order to be a sustainable career option, peer advocates would need to be increased at least $16 per hour. At New York State's current rate, it is difficult to create many positions or a true career trajectory for FPSS providers. On-going government advocacy work aims to address the differential in wages.

A strong, committed workforce is waiting to be recruited, trained and put to work. With so much potential to strengthen and benefit caregivers confronting challenging medical and behavioral diagnoses, the innovative FPSS model requires an innovative approach to workforce development. JCCA's "lived experience" demonstrates how to leverage this exciting opportunity for clients, agencies, and the providers they employ.

*Marleen Litt, LCSW Assistant Vice President at JCCA with oversight of the CFTSS, HCBS, Parent Advocate & Family Resource Center programs. Contributions by Yudelca De la Cruz, MS.Ed Director of the Family Resource Center & the Parent Advocate program, and Onicka Miller & Veronica Worley, Parent Advocate Coordinators in the Parent Advocate program.*

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***Investing from page 30***

support the needs of providers working within integrated systems is critical. Behavioral health staff new to integrated settings may feel overwhelmed and underprepared in helping to address medical concerns, seeing a higher volume of patients, or switching between very different presenting concerns. Supervision should be a built-in component within the workflow of health care organizations, crucial to the development and maintenance of new staff competencies, preventing burnout, and fundamental to integration. Supervisors should themselves be clinically competent in integrated care models, and ideally be experienced care providers in this area. Regular meetings to discuss complex cases, and constructive feedback on clinical performance are key components of a supervisor's role. In analyzing workload and clinical hours, supervisors in integrated settings should understand expected issues such as ramp-up time for a full clinical load, and a need to build in unique integrated care elements such as consultation time and space for patient hand-offs.

Supervisees should be encouraged to consider potential deficit areas in knowledge and experience and seek opportunities to develop these skills further. A fully-integrated system should enable physicians to seek experience and feedback from behavioral health professionals and vice versa, as part of continuing professional development. Organizations can be well-served by also developing supervision and training programs with graduate education programs; this helps develop a pipeline of qualified staff and helps graduate programs see a need to prioritize integrated training.

An integral and necessary investment in transforming our systems of care is investment in the people that deliver this care. By empowering integrated teams to function cohesively, equipping staff with effective tools for change, and ensuring adequate and meaningful supervision, we have an opportunity improve patient experience, decrease provider burnout, and better address a full range of complex and interwoven health needs. Integration cannot be "won." It must continually be earned via strategic investments in a skilled workforce as well as policy and regulatory improvements.

*The Primary Care Development Corporation is a nationally recognized nonprofit providing strategic investment and technical assistance to support and expand health care – primarily in low-income, underinvested communities – to achieve health equity. For more information visit pcdc.org or call (212) 437-3900.*

***Health from page 27***

and understanding of how our tendencies to manage our health in particular ways are shaped by social and cultural determinants. This realization deflects the stigma and blame from a family or youth that chooses to address their behavioral health needs in their own way. This view is also consistent with the Wraparound principles of family voice and choice, cultural (and structural) competency and individualized strategies (Walker, Bruns, VanDenBerg et al. 2004). Second, the model also reveals how the parents' and caregivers' health habitus contributes to the youth's orientation towards their health, and this can inform the team-based support and services offered to the family. Finally, the health habitus model recognizes that there is a lasting effect of one's long term opportunities, or lack thereof to address their health. This perspective is invaluable in developing a care plan and supports the Wraparound principles of unconditional, persistent and outcomes-based provision of services.

*Components of the Health Habitus Integration training:* The Health Habitus Integration training consists of five components: (1) a didactic phase familiarizing trainees with the model and its significance; (2) a practice activity where trainees write about their own health habitus; (3) a didactic phase on conducting an in-depth interview designed to elicit the family's and the youth's health habitus accompanied by practicing one's interviewing skills; (4) a practice activity where trainees organize the information about the family and the youth's health habitus into a note, that can be enriched and revised as peer advocates increase their rapport with and understanding of the family and the youth through multiple meetings; and (5) a discussion phase on potential strategies for integrating the health habitus information into the peer advocates' one-on-one meetings with the family and the youth, but also in the triad's meeting with the care manager and both peer advocates.

The integration of the health habitus information in the peer advocates' interactions with the family, the youth and their team members has the potential to: strengthen the family and the youth's engagement in care, strengthen self-advocacy and empowerment, contribute to the identification of community and natural supports, and to the development and implementation of a family-centered strengths-based plan. The training is offered by expert facilitators and consists of six hours. Four to five weeks after the day of the training, a one-hour booster session is provided through webinar that focuses on discussing a family's health habitus note and strategies for integrating the information in the note into the peer advocates' family meetings.

*Preliminary evidence on the training utility:* Based on baseline and follow-up evaluation surveys, the implementation team has found that most trainees, over 90%, perceived the health habitus training to be useful. As one peer advocate said, "Health Habitus can help me during the intake and subsequent contacts to learn the family story and engage them." Writing one's own health habitus was identified as the most beneficial component. As another peer advocate explained, "Writing my own health habits was very helpful in looking at my own barriers and influences. It helps me empathize with barriers others come up against." Further, the training enhances the trainees' humility and understanding of the families they serve: "Gives the opportunity to look at the family in a non-judgmental way by looking at choices and opportunities," as a third peer advocate suggested.

*Conclusion and looking forward:* The health habitus integration training of peer advocates throughout New York State and the evident opportunities to also train care managers is one strategy for integrating the social and cultural determinants of health into the perspective and practice of teams that work with families and youth with behavioral health conditions. Adding the health habitus integration training into the peer advocates' repertoire of skills builds professional competency and supports efforts to reduce social and cultural barriers that contribute to health disparities.

Thank you to our peer advocate coaches, Daphnne Brown, Ashley Rivera and Bianca Logan, for their insights and contribution to the health habitus integration training.

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***Workforce Crisis from page 31***

Looking Ahead

Prediction is notoriously uncertain and arrogant. But here's a few stabs at how the behavioral health workforce will evolve.

First, there will be continuing unbundling/de-professionalization of roles.

Second, this will include increasing use of peers to provide services hitherto not seen as part of their bailiwick.

Third, technology will be used in increasingly innovative ways, not just to provide communication with traditional providers but also to provide innovations that will be therapeutic in effect and designed to address the social determinants of behavioral health conditions.

And fourth, old people—like me—will increasingly be seen as being able to provide help and not only as people in need of help. We can become a vital part of the mental health workforce both as paid, experienced workers and as volunteers.

Details, of course, need to be filled in. Another time, perhaps.

*Michael B. Friedman, MSW has been working in the field of mental health for over 50 years—as a direct practitioner, an administrator, and largely as a mental health advocate. He taught health and mental health policy at Columbia School of Social Work for twenty years. He has just moved to Baltimore to spend more time with his grandchildren, who are, of course, cuter than most. He will also continue writing and will take on new adventures yet to be determined. He can be reached at mbfriedman@aol.com.*

***Lippman from page 21***

substance use disorders, convening of Amida Care's DSRIP PPS partners to create program efficiencies and meet milestones and goals, as well as collaborating with the CEO to conceptualize a statewide HIV/AIDS Accountable Care Organization (ACO) and strategize on other innovative service delivery models.

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***Retrospective from page 21***

read by many hundreds of thousands of consumers, family members, and service providers in the autism, behavioral health and substance use disorder communities. Too numerous to mention here, you can find all back issues of both publications on MHNE's two websites which are posted for all to read.

Visit Behavioral Health News at www.mhnews.org and the Autism Spectrum News newly designed, searchable website at www.AutismSpectrumNews.org.

***Perceptions from page 24***

considered "secondary" or "inferior" are no longer true as a growing number of mental health professionals are extending their reach through these modalities. This is an opportunity for the field to shape practice innovation by developing students' and mental health professionals' competence and confidence to effectively deliver telephonic mental health services.

*About the authors. Micaela Mercado, PhD, is Director of Research; Virna Little, PSyD, is Chief Operating Officer; and Eunice Kim, LCSW, is Director of Training at Concert Health. All correspondences can be directed to Dr. Virna Little at virna@concerthealth.io*

***Providers from page 24***

initiatives. In the following years CBC developed a citywide Health Home, which is currently one of the largest of its type in NYC. CBC has launched effective gap-filling service programs for low-income New Yorkers that build on the expertise of its community-based service network. CBC "knits together" affiliated programs to holistically address individuals' treatment and recovery needs, while assessing community deficiencies and connecting individuals to needed support.

*For further information, please contact Jorge R. Petit, MD, at CBC, (646) 930-8800, or Richard M. Tuten, JD, at CBHS, (914) 703-0453, tutenr@cbhsinc.org.*

***Succeeding from page 15***

For the two peers in our discussion group, the opportunity has been life-changing. One spoke about participating in peer training after receiving support from S:US following the death of his mother, when he needed recovery support for alcoholism co-occurring with depression. After completing a free Recovery Peer Advocate Training, he sought out other classes related to recovery services.

"My S:US caseworker sent me to someone to help me revamp my entire resume. I was coming up around two years clean. After working with her colleague on my resume, I got an interview with my current director," he said. "Every question she asked me I had an answer for, because I was fresh out of school. And the next thing I know, I'm employed for S:US as a Peer Specialist. I had never done it in my life. They had to teach me how to use the copier. This was six months ago. Now, I have a case load of 12. I do service plans. I do one-on-ones, I run men's groups. Before, I couldn't even turn on the computer!"

Peers provide services that are centered on what the individual wants for themselves and their life, not dictated by the peer or other staff.

"All our notes must reflect a person-centered approach, where the person's going to tell you what they need. This has changed from the old traditional method of 'you're going to do it this way or I'm going to report you to your mandating agency.' We now meet people where they're at…It makes me feel so good to know what I could help somebody, because I got helped. It's paying it forward, it's amazing. My life just transformed, and S:US really played a big part."

What We Need to Keep Succeeding

Our group discussed some of the factors that allow us to maintain our employment and be successful once we have been hired. Many of us mentioned needing continued support from our mental health care providers, who can help us build confidence and see things differently in our lives. We also utilize outside resources like the VA or other providers, because it can be almost impossible to maintain a job when we aren't able to manage our health and safety.

"Living at S:US and having a place where I can lay my head, where it's clean and it's safe, has been very helpful," one of us stated. "That's what helped me earn my Master's, being able to just go home and not worry about where you're going to live and how you're going to pay the rent. That is very supportive, along with the Wellness Coaches there."

Another in our group spoke about following a concept used in the field of addiction recovery which focuses on balancing eight dimensions of wellness: emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual.

We also touched on the importance of coping with job stresses. Listening to music, watching favorite TV shows, and knowing when to use our vacation time were all mentioned as important self-care strategies.

As our discussion concluded, a sense of optimism and contentment could be felt in the room. Each of our stories contributes to reversing stigma in the workforce about people with mental health challenges and other disabilities. With our visibility, this can only continue to grow and our workplaces, community, city, and country will be the better for it.

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***Millennials from page 10***

Investing in Technology

Up-to-date technology is an essential requirement when attracting and keeping millennials. This generation has grown up in the digital age. They have been exposed to technology and innovation from childhood and are comfortable navigating social media and adapting to new technologies and applications quickly and fluently. They expect organizations to stay current with workplace technology and invest in applications and training that take advantage of their digital skill set.

Shared Values, Shared Purpose

Meaningful work, engagement in decision-making, investment in technology, opportunities for professional advancement through education and training, and flexible schedules are more important to millennials than traditional benefits of job security, a pension, or guaranteed retirement.

For millennials like Elizabeth and Wendolin, making a difference and being engaged in socially-minded services are qualities Odyssey House is proud to value and share with its employees.

*Odyssey House helps New Yorkers in need overcome drug and alcohol abuse, improve their physical and mental health, and defeat homelessness. For more information, please visit odysseyhousenyc.org or call 866-888-7880.*

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***Award from page 23***

such as individuals with substance use disorders or those in the Adult Home Settlement Class and we are about to launch 4 new teams with OneCity Health PPS | NYC Health + Hospitals as well as a unique PH Team working with Medicare recipients that have co-morbid chronic medical and behavioral health conditions. It's been an amazing journey and I'm excited to see it continue to grow."

*Photo details: Aja Evans, LMHC, Director, Pathway Home, CBC; Jorge Petit, MD, President and CEO, CBC; Mark Graham, LCSW, Vice President, Program Services, CBC; Barry Granek, LMHC, Senior Director, Pathway Home, CBC; Sasha-Marie Robinson, MA, LMSW, Senior Regional Director, Services for the UnderServed (S:US); Joan Sass, LCSW, Clinical Director-Pathway Home, Queens TransitionTeam, Catholic Charities; Sylvia Andreatto, RN, Pathway Home Team Leader, Services for the UnderServed (S:US)*

***Self Care from page 8***

health workforce experiences unique stressors that arise from providing care for, among others, those who have experienced psychological trauma or are recovering from serious mental illness. Self-care is not a "nice extra" for behavioral health professionals; it is an essential skill that we need to leverage for our own health so that we can continue to do our work well and with satisfaction.

Second, we need to understand our own unique responses to workplace stress to address it. We should pay attention to how we are feeling physically, emotionally, and mentally so that we can gauge when stress is taking more than a usual toll. For example, we might notice that stress causes us to feel more anxious, have difficulty concentrating, remembering things and getting our work done. We might find ourselves coping in ways that feel good in the short-term, but that have a long-term negative impact on our health, such as eating too much, sleeping too much, or using or overusing alcohol, drugs and cigarettes. We might find ourselves isolating from others, neglecting our responsibilities and not participating the activities we normally enjoy.

In recognition of the impact of workplace stress, particularly on those whose work is primarily to serve others, Vibrant Emotional Health developed a toolkit called Staying in Balance: Healthy Solutions for Managing Workplace Stress. This toolkit is a free, downloadable resource that can be found at https://www.vibrant.org/wp-content/uploads/2018/10/Vibrant_Toolkit_Staying-in-Balance.pdf. It provides resources for organizations to encourage a culture of wellness, and also provides tools that staff members can use to support their self-care.

Two key resources available in the toolkit include: 1) a self-care assessment to identify how well we are taking care of ourselves and where we might choose to increase our self-care activities; and 2) a personalized self-care action plan that helps us identify what we can commit to doing daily, weekly, monthly or as needed to support our own well-being. In addition, a module is devoted to helping supervisors and other organizational leadership understand the elements of establishing a culture of well-being at work, including: 1) key questions to ask when assessing organizational stress; 2) tips for identifying solutions to mitigate the impact of stress; and 3) determining if the implemented solutions are working as intended.

Workplace stressors will always exist. Even in "good times," the behavioral health workforce is often understaffed and overburdened; in less than good times, the workforce faces demands to do ever more with increasingly less. While the vagaries of budget cycles will continuously impact our sector, we still have opportunities to foster wellness at work. Organizational commitment to employee well-being, coupled with supporting staff in their own self-care efforts, is essential to the continued welfare of our workforce. We know we are capable of innovation and implementing creative solutions to meet challenges; our commitment to our work compels us to make workforce well-being a cornerstone of our sector.

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***Challenges from page 28***

and even family members. The role of being the town doctor comes with many hats and the unique opportunity to have private individualized relationships with a wide range of patients (Miller, 2011). In addition to a lower cost of living and slower pace of life, physicians report very positive doctor-patient relationships as a primary motivator to practice in a rural setting.

In conclusion, we have identified some of the critical challenges and opportunities associated with rural workforce development. For example, job satisfaction and job stability rather than workload and pay are factors that prevent professional burnout. A survey of hospitals in the US shows that richer benefits such as health insurance and vacation time are the most common incentives used to recruit physicians (Zen et. al., 2004).

In addition, hospitals that offer other benefits including flexible hours, tuition reimbursement and signing bonuses based on experience or length of commitment reinforce professional staff with the incentives of stability and continuity. Practitioners who are valued, offered interesting training opportunities and are satisfied with promotion remain the most dedicated and motivated individuals in the workforce.

"When I was in the depths of depression, it was as if I was standing at a door pushing against it to try and keep the pain from coming in. The harder I pushed the weaker I became. One day I finally decided to open the door and let my illness in. That was the day my recovery finally began."

— Ira H. Minot, LMSW, Publisher

***Toolkit from page 21***

specialists. For example, the roles of peers have often been poorly defined, without clear expectations, which frequently results in confusion of other employees, and assignment of either mundane office work, or, on the flipside, clinical tasks, either of which fall outside the realm of a peer's role, and fail to draw on the strengths that peers can contribute to an organization and its service recipients.

Other areas that respondents identified as needing improvement included salaries, opportunities for advancement within the peer role, and leadership-oriented training and supervision. The practices that were identified to address these were divided into categorical domains of practice.

Nine areas of practice are included in the assessment of organizational readiness: Recruitment; Attitudes and Beliefs; Diversity and Inclusion; Finances and Sustainability; Role Clarity and Workflows; Career Advancement Opportunities Supervision; Orientation and On-Boarding; and Program Monitoring and Evaluation.

Benefits of a Customized Toolkit

In this rapidly transforming healthcare environment, the appreciation of person-centered care has advanced, bringing forth a recognition that the needs of service recipients are varied. Particularly when collaborating across disciplines, organizations, too, should receive support and training that is specific to their needs.

The process of employees' collaborative engagement in the self-assessment process embodies the integrative and supportive practices that organizations may aim to strengthen. An organization's encouragement of a self-assessment process communicates a commitment to the perspectives of its employees, which is a core ingredient in sustaining buy-in in a supportive workplace.

When using the toolkit, organizations can also download a PDF summary of their responses with their customized toolkit resources. This record provides a measure to use in identifying domains of practice for improvement, addressing those practices with the help of the selected resources, and later, re-assessing readiness and continuing to monitor progress over time.

Dissemination and Next Steps

The Consortium has extended an offer to provide toolkit-focused guidance to organizations looking to strengthen their understanding, and capacity to make full use of, the Needs-Based Toolkit. Organizations can consider the level and type of support needed and contact us to discuss a range of available options, including: Informational introduction, with an overview of the content, purpose, and structure of the Needs-Based Toolkit; Live training with hands-on, step-by-step practice using the Needs-Based Toolkit; and Advanced implementation-oriented training on the role of the Needs-Based Toolkit in translating assessment to action

The toolkit is available to all online. Information about, and direct access to, the toolkit is provided on the DOHMH website, and can be accessed here: https://www1.nyc.gov/site/doh/providers/resources/supporting-peers-and-community-health-workers-in-their-roles

The release of the Needs-Based toolkit marks an important milestone for all. The Consortium is confident that this needs-based toolkit can contribute to a strong foundation for the implementation of best practices, and help to further drive integration. We look forward to continuing our work with stakeholders as we witness the long-awaited changes that are driving more supportive, individualized, and recovery-oriented care, alongside the growing appreciation of the peer workforce.

We are available to respond to any questions or concerns about the toolkit. For more information, please email the Consortium: peerconsortium@health.nyc.gov.



***Resource from page 26***

Learn more about CPI at: www.practiceinnovations.org. If your program has not yet signed up for CPI's training and resources, complete an application at: https://cumc.co1.qualtrics.com/jfe/form/SV_7UiDOZnSqJw7hyJ

*For questions related to this article, please contact the author, Nancy Covell at: nancy.covell@nyspi.columbia.edu.*

***Staff from page 20***

learned the material and subsequently incorporate it into their practice? How do we adequately supervise incorporation of new skills?

As we address these and other challenges, supporting staff through their specific professional development track and providing the highest quality service remains an ongoing priority and commitment at MHA.

***Transformation from page 27***

challenge to address the lack of CHWs and CRPA was to determine what curriculum/skills were needed by partners and create a common curriculum which partners would accept. A common curriculum would break the old single employer, silo approach to employee learning and development. The SI PPS in partnership with the College of Staten Island (CSI), Staten Island Partnership for Community Wellness (SIPCW), and other community partners joined forces to develop robust CRPA and CHW training and workforce programs using the four-phase model. The model begins with conducting a current state analysis and needs assessment of the Peer Advocate and CHW workforce. During this phase, SI PPS community partners share information on their projected demand for CRPA and CHW staff. SI PPS with the CSI use this information to develop target goals for each training program including class size, funding, and job placement resources.

*Phase 2: Curriculum Development:* The second phase involves creating a new curriculum or leveraging an existing curriculum, reviewing and gathering feedback from community partners/employers during structured discussions to develop the training curriculum. Based on real workplace needs and CRPA/CHW roles and responsibilities, community partners/employers share input on their expectations of what the training should entail.

Certified Recovery Peer Advocate (CRPA) Training Program: SI PPS and CSI adapted the NYACH and Queensborough Community College curriculum and incorporated additional elements from community partners to establish the CRPA training program. The CRPA training curriculum includes Advocacy, Mentoring/Education, and Recovery/Wellness Support and Ethical Responsibility as well as other professional and soft skills development. The program's key objectives for students are to: Learn the standard skills and knowledge needed to succeed in the CRPA role; Receive personalized support from the program's dedicated student advisor; Prepare to sit for the peer recovery certification exam; Work with the program's developer to create a resume and prepare for interviews; and Connect with employers on Staten Island.

Community Health Worker (CHW) Certificate Training Program: SI PPS and CSI developed a new Community Health Worker certificate training program which has four tracks. One specific track has a behavioral health focus to train future CHWs who will work in behavioral health settings and other settings with people living with mental health and/or substance use disorders. The CHW Certificate Training Program provides learners with the skills and knowledge to enter the workplace as a CHW, Advocate, Navigator, Outreach or Resource Coordinator, whether in community-based organizations or clinical provider organizations. The CHW training program's goals are to: Learn about the chronic physical and behavioral health disorders impacting community members; Help clients make positive changes using Motivational Interviewing skills; Build awareness of the importance of culture in healthcare; and Provide college credit through the study of Anthropology , an effective tool for CHW's to understand the communities they serve.

*Phase 3: Post-Training Job Placement Assistance:* The third phase focuses on job placement assistance for students who graduate from the CRPA/CHW training programs. The College of Staten Island works closely with SI PPS, SIPCW, and community partners to match graduates to appropriate employer sites based on current job needs, roles and responsibilities, as well as the graduate's needs and interests. To support the recruiting and job placement process, CSI has dedicated a Job Developer Staff to identify employers and their needs and prepare students for interviews with those employers. In addition, for CRPAs, the SI PPS with SIPCW has also dedicated a Peer Integration Services Coordinator staff to support partner employers with the recruitment and job placement process as well as orientation and workflow improvement upon CRPA employment.

*Phase 4: Curriculum Refinement with Community Input:* The fourth phase involves the collection of critical feedback from both employers and graduates of the training programs to further enhance the training curriculum and job placement process. Structured discussions including focus groups are conducted to understand how effective the current training curriculum is, as well as to identify any additional elements and recommendations to improve the experience of future students and to prepare graduates more for employment. Focus groups and curriculum review meetings occur routinely to gather information from both employers and graduates to ensure that the expectations of the CRPA and CHW job roles align with the classroom experience and employment readiness of CRPA and CHW candidates peer advocate. Input from employers, for example, have ranged from increased role playing to test motivational interviewing skills, diverse employer site panel or spotlight discussions to understand different work settings, to special workshops on navigating the HR, background clearance, and legal documentation process during hiring.

This four-phase model with DSRIP funding have been critical to transforming and expanding the CRPA and CHW workforce on Staten Island. The CRPA workforce has grown from 2 to 30 from 2015 to 2018. In 2018 alone, SI PPS and CSI graduated 11 CRPAs of which 8 are working as CRPAs at different partner employer sites. Similarly, between 2017 and 2019, SI PPS with CSI have graduated 31 CHWs and all graduates have gained new employment or upskilled their role with current employers.

*Victoria Njoku-Anokam, MPH, is Director of Behavioral Health and Care Management Initiatives; and William D. Myhre, MPA, is Senior Director Workforce Transformation/HR, at Staten Island Performing Provider System (SI PPS). For more information, please visit our website at www.statenislandpps.org.*

***Training from page 18***

Training Philosophy

Training at Melmark is designed to increase the professional skills of employees, which in turn increases life outcomes for the individuals we support. Melmark trains based upon the principles of competency-based instruction, performance-based instruction (e.g., Brethower, D. & Smalley, K., 1998. Performance-based instruction: Linking training to business results), and behavioral skills training (e.g., Parsons, M. B., Rollyson, J. H., & Reid, D. H., 2012. Evidence-based staff training: a guide for practitioners. Behavior Analysis in Practice, 5, 2-11.) Competency-based instruction is utilized throughout trainings and is seen in the form of guided notes, fluency timings, and written exams. Performance-based instruction links training to expected job duties; establishes minimum criteria to demonstrate successful performance of job duties; utilizes performance feedback; and trains via observation, guided practice, and demonstration of mastery (sometimes referred to as "I do, we do, you do").

The professional development department is responsible for implementing the training model and ensuring all trainings align with the mission and vision of the organization. All members of this department have at least a bachelor's degree, previous experience supporting individuals with disabilities, and demonstrated competence on all training procedures prior to training. On average, the department conducts 5-15 trainings per week across various programmatic settings, and all training needs are derived from federal, state, and local regulatory requirements; policies and procedures; clinical practice guidelines; and evaluations of the organization and employee performance. The descriptions of Melmark's training processes can be found below and are fully developed and are being increasingly implemented across all service divisions. These training processes are targeted for full implementation in 2019.

Orientation

All new employees are required to complete a three to four-week orientation. The first week of training provides new employees with foundational knowledge of Melmark and the individuals served. The second week provides employees with a comprehensive overview of applied behavior analysis and how it is implemented. The training topics align with the BACB RBT® Task List (see https://www.bacb.com/rbt/). Employees are provided with an orientation binder containing organizational information, materials to aide in the acquisition of knowledge, and all competency assessments. This aspect of training has been implemented in all state divisions.

On-the-job Training

At the beginning of the third week of orientation, new employees observe colleagues performing job duties and receive department-specific training. Training is competency based and focused on teaching employees the specific skills needed to perform their job. Similar to orientation, each new employee receives an on-site training binder that contains department-specific material and competency assessments. The on-site training supports the first 90 days of employment. This aspect of training has been implemented in at least one state division with plans to implement across all locations.

One-year Plan

To guide new employees' professional growth during their first year, all staff are provided with a one-year training plan specific to their job. The first 90-180 days of each plan is dedicated to orientation and on-the-job training. The third and fourth quarters emphasize career path development by providing opportunities for professional growth (e.g., cross training for positions that would be a promotion). This aspect of training is currently being rolled out in one state division with plans to implement across all locations.

Professional Development Plans

Professional development plans serve as a planning tool for employee growth and development. This tool prompts supervisors to define professional goals, align goals with internal training and professional development activities, and coordinate goals with external training and professional development activities. Internal activities might involve completing various organizational trainings (e.g., expert speaker presentations), observing and learning job requirements of closely related positions, and receiving mentorship. External activities might include professional conferences, training workshops, and university courses. Melmark offers a tuition reimbursement benefit to create an avenue for employees to further their professional development.

Outcome of Training Program

Previous research has indicated (e.g., Kazemi, E., Shapiro, M., & Kavner, A., 2015. Predictors of intention to turnover in behavior technicians working with individuals with autism spectrum disorder, Research in Autism Spectrum Disorder, 17, 106-115; Novack, M. N., & Dixon, D. R., 2019. Predictors of burnout, job satisfaction, and turnover in behavior technicians working with individuals with autism spectrum disorder, Review Journal of Autism and Developmental Disorders, DOI 10.1007/S40489-019-00171-0) that the enhanced training model described above would increase retention of DSPs. Since the implementation of the program, Melmark has seen an 36% decrease in staff turnover (i.e., 47% to 29%). Compared to the national average of 45%, Melmark currently is 16% below the average. This increased retention directly impacts the individuals served because it is 91 positions that did not need to be hired and trained during the year. Melmark is committed to achieving a manageable rate of staff turnover and to creating a highly skilled workforce to better support our employees and the individuals we serve.

Conclusion

The DSP workforce crisis is a current issue with projections indicating it will continue to worsen. As shown by various entities, there are several variables to act upon that will lessen the crisis. In relation to occupational identity and job training, there are big picture opportunities such as state credentials (e.g., State of New York Competencies) and accredited organization credentials (e.g., RBT®). Additionally, organizations can move to adopt training and professional development practices that encourage these same outcomes.

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***Change from page 14***

inasmuch as it drives expenditures in Medicaid, Supplemental Nutrition Assistance Program (SNAP) benefits, Safety Net Assistance (SNA), and other publicly funded programs that would be easily avoided with modest investments in an undervalued workforce.

Continuing neglect of the nonprofit social services sector is surely misguided and immoral, but it also perpetuates an inefficient and ineffective practice characteristic of our broader health and social welfare infrastructure that incurs considerable cost and produces mediocre results. The U.S. bears a dubious distinction among industrialized nations for its outsized healthcare expenditures. They consume nearly a fifth (17%) of our GDP, whereas major European nations commit considerably less (about 10% of GDP on average) but achieve better outcomes on several key measures of population health (Butler, 2016). Such disparate outcomes may be attributed to many factors, but one cannot ignore the primacy of the social safety net in other industrialized nations and its impact on population health and social welfare. Major nations within the Organization for Economic Cooperation and Development (OECD) spend nearly twice as much on social services as healthcare (about $1.70 on social services for each $1 on health services). By contrast, the U.S. spends merely 56 cents on social services per healthcare dollar (Butler, 2016). This practice effectively ignores an emerging body of evidence that suggests Social Determinants of Health (SDoH) (i.e., individuals' economic and housing opportunities, education and employment status, etc.) are more determinative of population health than healthcare.

New York State has an opportunity to learn from its partners abroad and to alter a longstanding trajectory of neglect of its social services sector. This would surely be to the benefit of an immensely dedicated and undervalued workforce on which the state depends for the fulfillment of its policy objectives. Most importantly, it would enhance the health and welfare of our population and honor our solemn commitment to the most vulnerable among us.

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wraparound process and can help youth advocate for themselves (Lombrowski, et al., 2008; Silva, et al., 2019). For example, YPAs may guide youth in determining their goals, provide coaching and preparation before team meetings, or help youth articulate their needs in meetings.

Additionally, participation may benefit the YPAs themselves. YPAs may experience a sense of purpose and meaning through their efforts, and develop valuable work experience and skills (Walker, Baird, & Welch, 2018). HFW involvement thus provides another opportunity for YPAs to pursue their own recovery: while not a primary goal of HFW, increased wellness for YPAs is both a positive outcome and could allow them to be more effective within HFW.

But peer support services are not without challenges. Adult peers have reported a lack of role clarity and job expectations, as well as feelings of isolation from professional team members (Chinman et al., 2008; Kemp & Henderson, 2012). Hierarchical social structures may also result in less emphasis on peer input versus the opinions of professional team members. These barriers make it difficult for peers to collaborate effectively with other team members, and have the potential to be magnified among YPAs, who are particularly vulnerable to being under-valued or dismissed by providers who prioritize professional views (e.g., Delman & Klodnick, 2017; Walker et al., 2018). In particular, when YPAs' views about the best course of action conflict with the perspectives of caregivers and other team members, they may be ignored, limiting the ability of YPAs to effectively work with care teams and advocate for the youth participant. Additionally, these negative experiences may hinder the YPA's own recovery.

## Preliminary Findings on the Impact of YPAs in HFW Implementation

As part of our evaluation, we collected interview and survey data from individuals in many roles in HFW, including YPAs, youth participants and caregivers, family peer advocates, and care management agency administrators.

*HFW Enhancements from YPAs:* Across roles, participants spoke about how YPAs' common mental health experiences and similar ages were key drivers in building trust and engaging youth participants in the HFW process. As one caregiver stated, "I adore [FPA] and [YPA] - they're amazing. They 'get it,' they 'get us.'… [They're] all about helping and they listen to both sides - no judgment. I feel I can open up to them about anything." YPAs further described how common experiences helped encourage trust in the HFW process. One YPA felt that "being able to say I've come through it gets more buy-in than I went to school and I know all about it." Some suggested that YPA's similar age helped transcend generation-based cultural barriers. One YPA shared, "I'm like them. I have Instagram, snapchat, et cetera. Older people might not have that knowledge or relationship with youth. I'm like an older sibling, easier to relate." As an YPA noted, "you can't educate [sic] that empathy."

Further, YPAs were able to keep youth's perspective centered. As one YPA noted, her focus is on "…reminding the family about youth; talking to and empowering the youth… Youth know for the first time that these meetings are about the youth. Other systems don't do that." A family peer advocate observed, "[Youth] could share experience with YPAs. Share hope. [Youth]'s face would light up. [Youth] felt heard. [Youth] could share their voice without fear of being disciplined – [YPA] facilitated that." As such, YPAs were able to coach youth so they could share their opinions, and then reinforce those positions to ensure that the youth's perspective honored in the HFW process.

These relationships promoted engagement with the HFW process and youth progress. One youth participant related, "I have a good bond with the YPA. That helps. If the YPA didn't join the program, I don't know if I'd be doing as well as I am." Similarly, a care manager offered, "Sometimes the strongest relationship in the unit is between the YPA and the youth and we rely on that to drive the case forward." Taken together, these findings suggest YPAs facilitate youth participation and movement through the HFW process.

*Challenges in YPA Involvement:* One frequently noted challenge was the perception of built-in role-based hierarchies that kept YPAs from being perceived as equal contributors. Some YPAs felt their work was unappreciated and that other HFW participants tended to discount them, taking care managers and clinicians more seriously. YPAs reported that some HFW participants tended to discount them and their input, taking care managers and clinicians more seriously. Care managers also weighed in on role hierarchies, stating that they felt the need to oversee YPAs to ensure they fulfilled tasks.

Interviewees noted that YPAs may struggle with working with youth with complex mental health challenges due to a lack of specialized training. A family peer advocate remembered that an YPA felt, "working with difficult cases can be very intimidating." Another YPA shared, "There should be more credentialing in place. More than a high school degree – [it's] not appropriate to send [YPAs] out to work with these families. Crisis calls, CPS, probation, hospitalizations, you have to know how to do that. That concerns me." These findings suggest that YPAs need additional training and support specific to working in HFW, such as guidance on their role in responding to such crisis situations or how to support youth when they may be involved with other service systems (e.g., child welfare or juvenile justice).

## Conclusion

Youth Peer Advocates have the potential to enhance High Fidelity Wraparound by facilitating family trust in the process, elevating youth perspectives, and fostering youth engagement through their lived experiences and relationships with youth. However, YPAs may need enhanced training to meet complex family needs, and avoid being relegated "to the sidelines" within the care team. As such, future HFW instantiations looking to include YPAs should consider the supports needed to maximize their potential value in the HFW process.

The Center for Human Services Research at the University at Albany evaluates the New York State System of Care initiative. The Center has over 25 years of experience conducting evaluation research. See more at https://www.albany.edu/chsr/.

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***Shortages from page 19***

professional. Historically community-based providers have been contractually obligated to engage a minimum of physician services, limiting alternative solutions to meet their patients' primary care needs, especially when these other qualified medical providers are often better suited to meet the demands of this population and are much more cost effective. As advocacy leaders and champions of our mission, we have realized the benefits of primary care integration within our industry and advocate to adopt federal regulatory changes which include strategies for alternative medical providers within community-based nonprofit settings. In light of the diminishing physician supply, alternative models of care are not just a good idea but have more than ever become necessary. These long-standing barriers to integration, financial pressures, and lack of federal funding are now making every provider wary of further decreases in the pool of patient care revenue. Primary care providers will be cautious about losing potential reimbursement to increased mental health services unless they feel they can benefit from the cost savings in the utilization of primary health care. Comparably, the groups that control mental health revenue tend to protect their shrinking pool of dollars rather than face the unknown of collaboration with primary care providers. These struggles contain the opportunity for a renewed recognition of the interaction between the physical and mental life of patients, as well as the need for the reintegration of care. Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing diseases, reducing unnecessary disability and premature death, and achieving health equity for all Americans.

## Research in Progress: National Survey to Behavioral Health Providers on the Adoption of Integrative Practices

Policymakers must focus on particular subgroups that are most at-risk for high cost and poor quality, such as the one proposed our ongoing study. This is necessary to improve the quality of health care and reduce costs. If rectified, it could provide community-based organizations with more patient-centered, cost-effective models of care coordination that broaden organizational vision and mission to include holistic care. Decades of economic strain for an already inadequately funded safety net of providers has hastened the need for public policy leaders and researchers to support alternative models that provide quality primary care services for all. To that end, data is currently being gathered through a national survey being distributed to nonprofit community-based providers to examine in greater detail how physician shortages with reduced funding and unequal regulatory requirements, have impacted integrative practices.

## Special Request: Short Survey on Behavioral Health and Primary Care Integration Funding

Dear Nonprofit leader,

We are conducting a short survey at The University of New Haven on primary care integration funding within the nonprofit, behavioral health sector. The results of this survey will enable us to analyze funding needs, and the support required for these essential services. Please feel free to take and forward this survey to any of your nationwide nonprofit colleagues. If you have any questions regarding this survey, please contact me directly at rpetitti@newhaven.edu or at (203) 479-4704.

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***Addiction Workforce from page 5***

To incentivize CRPAs OASAS provided $500,000 in scholarships over the last 2 years to help them obtain their certifications. There is also a planned increase in the Peer Service reimbursement rates and the number of Peer Services that can be performed in a day has also increased considerably to incentivize the adoption of Peer Services in OASAS outpatient clinics. OASAS provides onsite Peer Integration services for all OASAS providers and have formulated a toolkit which can be found at: https://www.oasas.ny.gov/recovery/OrgReadinessTool.cfm. Additionally, Peer Services are also now a required component in OASAS' outpatient settings.

Only by strengthening the addiction workforce to meet the expanding needs of those suffering from addiction, and finding gainful employment for those recovering from addiction, will we be able to increase the capacity of competent and effective prevention, treatment and recovery services and reduce the stigma of those impacted by addiction.

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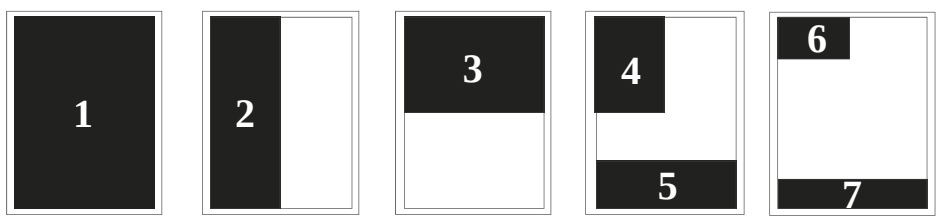


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