

# BEHAVIORAL HEALTH NEWS™

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WINTER 2014

FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

VOL. 1 NO. 2

## Integrating Mental Health and Substance Abuse Treatment

By The Substance Abuse and  
Mental Health Services Administration  
(SAMHSA)

**I**ntegrated treatment produces better outcomes for individuals with co-occurring mental and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly. Mental health and substance abuse authorities across the country are taking steps to integrate systems and services, and promote integrated treatment.

Systems and Service Integration  
Are Closely Interrelated

*Systems Integration* involves the development of infrastructure within mental health and substance abuse systems to support integrated service delivery. It can occur in systems of any size, including an entire state, a region, county, agency or program.

Systems integration focuses on reorganizing the framework within which agencies and programs operate. It in-



cludes integrated system planning, implementation, and continuous quality improvement including developing mechanisms for addressing: financing, regulations and policies, program design and certification, interprogram collaboration and consultation, clinical "best practice"

development, clinician licensure, competency and training, information systems, data collection, and outcome evaluation

*Services Integration* refers to the process of merging separate clinical services to meet the individual's substance abuse, mental health, and other needs. Services

integration has two levels: Integrated programs are changes within an entire agency that help practitioners provide integrated treatment; and Integrated treatment occurs at the individual-practitioner level and includes all services and activities.

Services integration means providing at a *minimum*: integrated screening for mental and substance use disorders; integrated assessment; integrated treatment planning; integrated or coordinated treatment; and continuing care. The overall vision of an integrated system is to effectively serve individuals with co-occurring disorders no matter where they enter the system.

Develop a Shared Vision  
For an Integrated System

The key to a successful integrated mental health and substance abuse system is developing a shared vision before integration begins. The mental health and substance abuse systems may co-exist well, but each has its own distinct culture and language. If these differences are not recognized when system integration

*see Integrating on page 8*

## We Don't Treat Brains, We Treat People

Andrew Tatarsky, PhD  
Founder and Director  
The Center for Optimal Living

**T**he US government estimates there are 80,000,000 Americans with diagnoses of substance abuse, dependence or binge drinking patterns, and we treat a tiny, tiny fraction of them effectively. We spend billions on the war on drugs, on research and on treatment and yet have little overall impact on the epidemic. As Dr. Richard Juman recently noted on TheFix.com, when you look at the repertoire of addictive behaviors evidenced by Americans, we have become a "nation of addicts." Is addiction untreatable or are we simply going about it the wrong way?

The American Society of Addiction Medicine has re-affirmed what several NIDA directors previously declared, namely that "addiction is a brain disease." This is a sophisticated and evidence-based restatement of Jellinek's Disease Concept of addiction, which has organized the field for

over half a century. The idea that addiction is a brain disease relieves the addicted person of some responsibility for the negative consequences of his or her behavior and helps with the crippling shame and guilt commonly felt. This idea also suggests that greater understanding of the brain aspects of addiction will lead to advances in the medical aspects of treatment and, in fact, we are seeing an increasing number of medications that show some promise of helping in the treatment of addiction.

On the other hand, we don't treat brains—we treat people. And, while there is no doubt that the brain is involved in addictive behavior more and more as an addiction intensifies over time, these proclamations can be misleading and make it easy to lose sight of the individual into whose life the "brain illness" has intruded. As examples, many addiction treatment programs throw people out of treatment if they don't quickly stop manifesting the disease behavior that brought them in and refuse to work on critical psychic and interpersonal issues because the patient is "not ready" to begin under-

standing his own existential position. Then, when the patient fails to return because his needs are not being met and feels shamed and punished by the provider, the program tells him (and itself) that he has to "hit bottom" before he's ready to be helped. What other helping profession systematically operates in such a patently absurd and ineffective way?

The Psychobiosocial Model

Accumulating data and clinical experience support a "psychobiosocial" model in which biology and behavior intersect with meaning and social context in complex ways that are unique to each person and give rise to the problematic and addictive behavior. Alongside the brain changes associated with acute and chronic use, and the powerful conditioning of habits that accompanies them, the multiple personal and social meanings that substances carry and express are powerful motives for continued use in the face of negative consequences. From a dynamic/meaning perspective, the "addictive proc-

ess" may be understood as an experiential behavioral syndrome that both expresses and, in some cases, disguises multiple aspects of the person: feelings, wishes, needs. Without addressing the meaning of addiction for the unique patient, as Stanton Peele suggested in 1985, attempts to resolve these problems are doomed to fail with most people. To the extent that these factors are operative, the resolution of the addictive process requires that they are identified, brought into awareness and integrated into one's life such that new less harmful, more satisfying modes of expression and satisfaction can be discovered. We don't have the science to determine in advance with each patient how much each factor contributes. This must be determined over time in treatment with a deepening collaborative assessment between the clinician and patient. An appreciation of the meaningful reasons people use, the personal, subjective, often hidden dimension of drug use, is critical to every aspect of treatment: engagement,

*see People on page 12*

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# Prevention, Treatment, and Recovery in Substance Use and Mental Illness

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

With the changes brought about by the growth of managed care, evidence-based practice and the advent of the Affordable Care Act, we increasingly recognize that substance use disorder and mental illness are behavioral health issues often found together in the same patient.

The field of behavioral health offers a way for substance abuse and mental health practitioners to work in concert with a coordinated approach to prevention, treatment and recovery for patients struggling with substance use disorders and mental illness.

## Prevention

At OASAS, we believe that substance abuse disorders are preventable, and prevention programs need to address not just the individual but the larger community as well. The broad category of mental, emotional and behavioral disorders, including depression, conduct disorder and substance use disorders among youth, often occur together and share some common and early developmental risk factors, including, a family history of addiction or mental illness, living in a family in conflict, and community availability of alcohol, drugs and other substances.

I am pleased to report that OASAS supports more than 180 prevention service providers operating in schools and community-based organizations delivering evidence-based education programs, environmental efforts to reduce underage drinking, and early interventions for adolescents. The evidence-based programs and strategies (EBPS) delivered by our programs improve community, school, family and youth risk factors that will also address the development of other mental, emotional and behavioral disorders.

Our EBPS programs, such as "Life Skills Training" and the "Too Good for Drugs" curricula, are delivered to K-12 students. These programs teach personal and social skills to better manage emotions, reduce the effects of peer pressure to use drugs and lower other risk factors. According to the Washington State Institute for Public Policy, these programs



OASAS Commissioner  
Arlene González-Sánchez, MS, LMSW

have been shown to be cost effective.

OASAS supports the implementation of liquor store and tavern compliance checks, alcohol server training, local social host regulations and other strategies through our providers and a network of more than 145 anti-drug coalitions supported by our regional Prevention Resources Centers (PRCs). These strategies are designed to change the community, social, and economic contexts in which people access alcohol, tobacco, or prescription drugs.

OASAS supports two early intervention services for teen and adult substance users: "Teen Intervene" and "Screening, Brief Intervention, and Referral to Treatment" (SBIRT).

"Teen Intervene" is a school-based program that helps youth identify the reasons they have chosen to use alcohol or other drugs, examine the effects of substance abuse in their lives, and learn to make healthier choices. "Teen Intervene" has been shown to result in greater abstinence, less binge drinking and less marijuana use among young people in the program.

SBIRT is used primarily in healthcare settings and is more adult-focused, but it has the potential to be a good early intervention strategy for young people, as well. In 2012, OASAS launched a preliminary SBIRT project in two school-based health clinics in the Bronx and Nassau County. This year we began working

with three additional school-based health clinics in upstate New York. If successful, we will work to integrate SBIRT into additional school settings statewide.

Initial research also shows that SBIRT can be used effectively to reduce depressive symptoms. For example, Wisconsin's "Initiative to Promote Healthy Lifestyles" showed depressive symptom scores dropped by 55 percent over six to eight weeks with a simple intervention that promotes engagement in behaviors shown to ameliorate depressive symptoms.

## Treatment

It is clear that the field of substance use disorder treatment has been evolving for many years as our understanding of addiction has changed. For centuries, alcoholism and addiction were seen as a moral failure on the part of the individual. Society's treatment consisted of commitments to prison or inebriate asylums. We've seen that medical and psychiatric approaches to treatment were largely unsuccessful through the 1930's.

With the beginning of 12-step programs, such as Alcoholics Anonymous and Narcotics Anonymous, self-help became a major component of treating alcoholism and addiction. These approaches were effective in treating many people, but for those who did not succeed in this model, a lack of readiness or not yet having hit bottom, were often thought to be the reason. While some people may not have been ready, for many there were other reasons for a lack of success.

Over the years, the addiction treatment community has relied heavily on individuals in recovery to help those wishing to attain it and their contribution has been invaluable. But the system did not have an adequate understanding of the issues of mental health. Debilitating mental health issues could have a major impact on a person's ability to connect with a sponsor, talk in group counseling and be successful in treatment. Depression, bipolar illness, anxiety disorders, personality disorders, as well as psychoses could greatly impair someone's compliance with treatment.

We now know that addiction treatment programs often lacked psychiatrists or other professional staff with mental health experience, making them poorly equipped to assess, understand and be effective with the mental health population. Similarly, the mental health community often lacked

staff with experience treating addictions and addiction certified physicians. Patients who suffered simultaneously from addiction and mental illness often got caught between each system.

By the mid 1980's addiction and mental health professionals began to recognize the need to more effectively treat this population. This problem went through several different names: dual diagnosis, mentally ill chemical affected (MICA), chemical abuse and mental illness (CAMI), before coming to be known today as co-occurring disorders.

Our programs then tried simultaneous but uncoordinated treatment of the issues. Our lack of coordination led to programs working against each other instead of working together. As we strengthened coordination between substance use disorder and mental health treatment programs, uncoordinated treatment lessened. Fully integrated treatment has started to become the standard. In this newer model, one physician or other healthcare professional works with the patient to provide a unified treatment plan and approach. We have a much better understanding today of the neurochemical components of substance use disorder and of certain mental illnesses. The same brain chemistry vulnerability that can lead to substance use disorder may also be implicated in depression and anxiety.

As our understanding of co-occurring disorders has improved, we have also recognized the impact of post-traumatic stress disorders and traumatic brain injury, while incorporating trauma-informed care into our approaches. Similarly, we have become better at recognizing the impact of personality disorders on treatment approaches.

One of the major developments in healthcare in recent years has been the Health Home. OASAS is playing a critical role in the selection, development and implementation of Health Homes for Medicaid recipients.

The Health Home seeks to fully coordinate all aspects of an individual's care, e.g., physical health, substance use disorder, and mental health. The Health Homes build networks of providers and support services, e.g., housing, education and vocational training, to meet the person's needs in a truly coordinated fashion.

Clinical approaches incorporating evidence-based practices have improved the

see OASAS on page 37

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# Early Childhood Social-Emotional Development: Building Healthy Foundations For A Lifetime of Success

By Lily M. Tom, DSW, Assistant Commissioner, Bureau of Children, Youth, and Families, NYC Department of Health and Mental Hygiene

A seminal publication in 2000 *From Neurons to Neighborhoods, The Science of Early Childhood Development* has established the importance of early childhood experiences on lifelong well-being (JP Shonkoff & DA Phillips, Eds., 2000). Ongoing research continues to demonstrate that the early years in life are a critical period for physical and emotional development and health. Young children's cognitive, language, motor, and social-emotional development are greatly shaped by environmental influences as well as their relationships with parents and caregivers. Infants and toddlers learn to express and manage emotions, explore the environment, and gain knowledge by having close and secure attachments with parents and caregivers (Zero to Three, 2012). Growing evidence shows that negative early experiences impact brain development and can lead to biological adaptations with lasting ill effects. These disruptions to development, if not met with nurturing adult support can persist into adolescence and adulthood, and research shows, can cause both physical and mental health impairments later in life. Therefore, promoting positive early childhood mental health and psychological well-being creates a foundation to support children to be successful in school, social relationships, and as adults in work, family life, and society.

Early experiences impact the developing brain and the stress response and immune system (SB Johnson, et al., 2013). Young children exposed to challenging circumstances such as poverty, domestic violence or abuse are likely to have an activated biological stress response system. Research indicates that if this stress is not matched by buffered protection with support from invested adults, then the child's stress-response system is not restored to baseline, and this can lead to disruption to the brain architecture, which adversely affects other organs, and contributes to an increased risk for persistence of problems into adulthood (JP Shonkoff, 2010). This prolonged stress resulting from intense adversities has been called toxic stress.

Further, there is extensive evidence from research on adults and over time, that childhood adversities and trauma are linked to adult disease and illness. The Adverse Childhood Experiences (ACE) study has found associations between childhood trauma such as abuse, neglect or family dysfunction and later health and well-being including risky behaviors, depression, suicide attempts, illicit drug use, alcoholism, and health conditions such as lung, liver and heart disease throughout the lifespan (ACE Study, CDC, [www.cdc.gov/ace/index.htm](http://www.cdc.gov/ace/index.htm)). The more types of adversity an individual experiences in childhood, the greater the likelihood that he/she will develop one of these conditions in adulthood.



Making early investments in children's well-being has long-term health, mental health and social benefits for individuals, communities and society. Cost-benefit studies show that there are positive returns on high quality early childhood programs for at risk children. The Center on the Developing Child at Harvard University reports that "Three of the most rigorous long-term studies found a range of returns between \$4 and \$9 for every dollar invested in early learning programs for low-income children. Program participants followed into adulthood benefited from increased earnings while the public saw returns in the form of reduced special education, welfare, and crime costs, and increased tax revenues from program participants later in life" (Five Numbers to Remember About Early Childhood Development, 2007). Ensuring children have positive experiences before they reach school is likely to lead to better outcomes in adolescence and adulthood, generating a worthwhile return on investment.

The NYC Department of Health and Mental Hygiene (DOHMH), has the opportunity to focus on early childhood mental health through NYC Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), a five-year project funded by the Substance Abuse and Mental Health Services Administration. NYC Project LAUNCH promotes social and emotional development and provides services in two high-need neighborhoods, East Harlem in Manhattan and Hunts Point in the Bronx, for children from birth through eight years and their families.

Because the parent-child relationship is critical to child's social and emotional development, NYC Project LAUNCH provides parenting classes that promotes attachment. Using the evidence-informed Circle of Security® Parenting Program, Family Advocates from Family Resource Centers provide an eight-week model focused on teaching parents with young children (ages 0-5 years of age) to recognize their own strengths and challenges around parenting and to improve their responsiveness to their children's needs. Group sessions involve participants responding to videos of parent-child interac-

tions and examples of healthy caregiving with reflective dialogue, story sharing, and interactive exercises.

It is also important to support providers and systems that serve children and families such as in primary care and early care and education settings. Providing mental health services in primary care settings can increase early identification, access to services and normalize and destigmatize behavioral health care. Young children routinely go to their primary care provider for well-child visits, and social and emotional development (mental health) is an important domain to be integrated into this care. A recent report by the SAMHSA-HRSA Center for Integrated Health Solutions says, "Most children and youth with mental health conditions that result in functional problems are more likely to be seen in their primary care setting than in the specialty mental health system" (Integrating Behavioral Health and Primary Care for Children and Youth, 2013). Through NYC Project LAUNCH, we are providing mental health screening, consultation, evaluation, short term treatment, and referrals for young children within pediatric clinics at a municipal hospital and at a Federally Qualified Health Center by co-locating mental health clinicians in these settings. Social and emotional development screening is conducted by using standardized measures (Ages and Stages Questionnaire: Social-Emotional and Pediatric Symptom Checklist). When there is a positive screen or other concern, the mental health consultant provides consultation to staff and families, and when indicated makes referrals to resources that may include mental health, Early Intervention or the Committee on Preschool Special Education.

Mental health consultation in early care and education settings, such as preschools and childcare, is another approach that can offset challenges to social and emotional development and provide the education workforce and families with tools to promote psychological well-being in young children. NYC Project LAUNCH also provides mental health consultation in select childcare sites that offers overall consultation to school staff

to improve classroom management, communication with families, and provide an educational environment that supports children's social and emotional health. The mental health clinician also works with school staff when a child is exhibiting emotional or behavioral concerns by conducting screening with standardized tools, consulting to staff and families regarding specific concerns, and making referrals in collaboration with school staff to other services such as mental health or the Committee on Preschool Special Education. This model works by providing training and support to school staff so that over time they can become better informed about mental health and competent in providing quality childcare that address social and emotional development once the consultant leaves the school setting.


In addition, at childcare settings, NYC Project LAUNCH trains teachers by using an evidence-based curriculum, Incredible Years, to acquire skills that promote positive interactions among children, and develop a culture that promotes positive behaviors and builds self-esteem and confidence in children. "Research studies show positive outcomes related to [Early Childhood Mental Health Consultation] ECMHC services, including a decrease in parental and teacher stress and an increase in the competence among childcare and preschool staff to recognize and address challenging behavior, reduce young children's expulsions and reduce children's externalizing behaviors such as aggression" (Project LAUNCH Technical Assistance Series, Brief 1: Early Childhood Mental Health Consultation).

As part of the NYC Project LAUNCH program evaluation, we are tracking outcomes to assess the impact of these interventions and services. For example, we are measuring the impact of the mental health consultation and teacher training on students in the childcare settings by examining improvements in children's behavior such as self-control, attention, and ability to form positive relationships. We are also measuring the impact of the parenting classes on parent participants' parent-childhood relationship and parent stress. These results will help us identify strategies and interventions that produce improved outcomes and will benefit from ongoing support.


The sustainability of this initiative will be critical to the success of NYC Project LAUNCH. One strategy is leveraging existing resources to build capacity for mental health clinicians to treat young children in evidence-based treatment models. Additionally, New York State Medicaid Redesign presents an opportunity for us to advocate for policies in Medicaid managed care that will promote and reimburse collaborative care models that integrate mental health services into pediatric primary care settings. We are advocating for services such as mental health consultation, and evidence-based treatment for the youngest children. We are also working to continue our partnerships with colleagues who serve young


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# Implementing Best Practices – Seven Core Processes

By Brian Mundy, LCSW, Matt Wofsy, LCSW-R, and Elizabeth Cleek, PsyD, Institute for Community Living (ICL) and Nancy Boyd-Franklin, PhD, Rutgers University

Implementing best practice care for persons struggling with mental illness and substance use in real world settings can be challenging. At the Institute for Community Living (ICL), where we provide behavioral and physical health care for a widely diverse population and place strong emphasis on innovation, best-practice, and evidence-based care implemented through a trauma informed, integrated health, and recovery oriented perspective, we recognize that clinicians working with persons with dual diagnoses must continuously navigate an ever-evolving web of theory, research, and technique while negotiating the demands of organizational policies, managed care, and multi-systemic factors.

As a group committed to implementation of best practice care in real world settings, we set out to develop ways to facilitate uptake and implementation of empirically validated treatment across an urban environment where clients are involved with multiple systems and who may experience extreme poverty, serious medical and mental illness, substance abuse, and histories of trauma. Additionally, we sought to identify common elements and themes across evidence-based models. For example, an individual with Type II diabetes and Bi-polar disorder who feels estranged from their family supports, distrustful of doctors and the mental health system, and is battling the stigmas often associated with chronic physical and behavioral health problems would benefit from a clinician who understands the importance of providing psycho-education, meeting the individual at her stage(s) of change, supporting the individual with understanding the relationship between thoughts, feelings, and behaviors, and inspiring hope and optimism within a recovery-oriented perspective. Emphasizing core elements of treatment that have been empirically validated allows for the flexibility inherent in combining research-informed practices and the complex demands of real world clinical settings.



In the first iteration of the evidence-based movement, there was the direct handoff of a sacred volume of EBPs, with step-wise instruction and expected word for word delivery of the evidence-based model. This, however, would often prove unsuccessful as people would report that manualized treatment felt cumbersome and non-inclusive of clinician training and the myriad of presenting issues encountered. Over time, a more collaborative approach emerged, facilitated by both research and a partnership among researchers, practitioners, advocates, and clients. In this spirit, we set out to identify evidence-based models that resonated with staff and clients, and common elements across practices that could be used as a foundation of care. Our goal was to develop a concise framework from which therapists can navigate systemic issues as well as the flood of new therapies and developing trends. Clinicians are expected to be facile in individual, group, and family therapy with diverse clients from many cultural backgrounds and to adjust their care in accordance with the systems requirements of clinics, agencies, hospitals, schools, communities, and private practice settings. However, we believe that seven core processes (Wofsy & Mundy, 2012) are consistent across settings and interventions and can be utilized to promote client-driven care that is research-informed:

1. Joining and Establishing the Therapeutic Relationship
2. Psychoeducation and Recovery Principles
3. Stage of Change Orientation
4. Motivational Interviewing
5. Cognitive Behavior Therapy
6. Mindfulness and Acceptance-Based Principles and Practices
7. An emphasis on Relapse Prevention, Trigger Management, and the Completion of Treatment

These 7 processes provide a flexible, research-informed framework to complex care. More specifically, no successful practice delivery can occur independent of a well-established, non-judgmental therapist-client relationship. This relationship sets the stage for therapists and clients to develop a mutual understanding of presenting issues and related, reputable scientific information that exists to help contextualize symptoms and treatment. Meanwhile, clinicians must honor each individual's stage of readiness, and identify, and help resolve ambivalence about change. Once a person is ready to make a change, incorporating a perspective that

works to strengthen the relationship between thoughts, feelings, and behaviors is necessary to off-set symptoms and promote ongoing skill acquisition. Additionally, fostering the capacity for mindfulness and acceptance can assist individuals with increasing their flexibility in response to difficult thoughts and feelings. Ultimately, the client is empowered to lead a rich, meaningful life with the understanding that triggers will arise and that sustained recovery is an ongoing, dynamic process.

Clinical science is an ever-evolving process reflective of the spirit of ongoing improvement that these core processes embody. Practices that have been researched and validated are an imperative, and providing clinicians with a framework of core elements that provide a foundation for care further help to facilitate effective treatment. We look forward to dialogue and ongoing collaboration with the client, provider, colleague, and research communities as we continue to develop these processes.

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*The authors have recently published this framework, several years in the making, in a book published by Guilford, entitled *Therapy in the Real World*.*

## References:

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## Integrating from page 1

begins, the process may be difficult. Bridging cultural gaps can be thorny for practitioners unfamiliar with the operations, approaches, knowledge base and treatment philosophies of other systems of care.

### An Ideal Integrated System is Based On A Common Vision.

Planners need to agree on system goals and objectives, and how to measure effectiveness. A shared vision guides the development of programs and policies, and the allocation of scarce resources.

The first step in promoting integration efforts is to articulate and disseminate the shared vision. A shared vision can be

thought of as a set of principles that recognizes and validates the role of mental health systems, programs, and approaches along with addiction systems, programs, and approaches.

### Stakeholders Need To Be Involved

Create the shared vision by allowing stakeholders to develop and share their goals for the integrated system. Significant stakeholder involvement and input from the grassroots are essential for the vision to be meaningful and effective.

Stakeholders who participate in the development of a shared vision work hard to address differences in philosophy, culture, and terminology between systems.

Stakeholders who are active in the

process tend to appreciate the differences in agency culture. For example: How each partner operates; Different communication styles; Greater understanding of each other's role; and Appreciation for each others' approach to serving their individuals with co-occurring disorders.

Shared visions can also lay the basis for future key documents, like policy directives, state charters, and logic models. There is much value in revisiting the shared vision periodically to ensure it remains relevant, especially when changes occur.

### Workforce Development Activities Promote a Shared Vision.

Cross-training or shared curricula can help practitioners from each system un-

derstand their different infrastructures, operating procedures, values, and cultures. Activities like these build personal relationships, increase teamwork across systems, and foster respectful working relationships.

Interagency training around common interests and needs can be particularly valuable. Training can promote dialogue to explore common ground, including values. Interactive training with breaks and meals can help build new relationships and refresh existing ones. In addition, training on the "ins and outs" of each other's systems is essential.

Here are a few examples of how to create and promote a shared vision: Use a

*see Integrating on page 16*



# Mental illness isn't the problem. Attitudes to it are.

Respect. Realize.  
Reconsider.



**Ignorance is not bliss.** 1 in 4 adults suffers from a diagnosable mental disorder each year.

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## Embracing Harm Reduction

**By Karen Rosenthal, CPRP**  
**Director of Training**  
**Community Access**

**M**any of the people we serve in supportive housing use drugs and alcohol; some in ways that disrupt their lives. That is a fact. Behavior change is hard. That is a truism, and a fact. It is our job as supportive housing providers to serve people who may have struggled for most of their lives with the side effects of poverty, with psychiatric difficulties, adverse effects of drug use and chronic health conditions. It is not our job to ignore that reality, to say “come back when you are ready, we have a home for you when you have overcome your struggles.” For many of us, that has been easier to see when talking about mental or physical health issues, and less clear when thinking about drug and alcohol use.

At the end of the day, they are part of what we signed up for, and as a community with power over access to a scarce resource, it is our job to make harm reduction a standard part of our practice. Overcoming struggles with drugs or alcohol should not be a hoop that people need to jump through in order to have a place to live. The time for controversy is long gone. Harm reduction is a pragmatic response to the reality of the lives of many of the people we serve. The phrase “Housing Works, Shelter Kills,” coined by ACT UP Housing Committee members as they formed Housing Works in 1990, described a fundamental fact about supportive housing – that it is in and of itself a harm reduction strategy.

Despite this, for years many in supportive housing failed to adequately promote and endorse the philosophy of harm reduction and some have even taken an oppositional stand against the idea that harm reduction could be an effective or ethical approach to working with individuals with mental health conditions.

We have made progress since that time, and today while many mental health providers and agencies articulate utilizing a harm reduction approach, the extent to which harm reduction is utilized can vary widely. It is often limited to endorsing the use of motivational interviewing, referring individuals to syringe exchange programs or having safer sex barriers available for tenants. And while a few supportive housing agencies in New York City promote harm reduction as part of their core mission and values, many others are still ambivalent or disinterested.

This is only in part linked to a long-standing belief in abstinence-only based approaches; it is often in some part because of the real challenges that exist when adopting harm reduction policies and prac-



tices in a supportive housing environment.

Community Access has a deep understanding of the dilemmas and difficulties of implementing harm reduction because we have been working intentionally for over a decade to improve our harm reduction practices and activities. While we don't claim to have it all figured out yet, harm reduction continues to inform our work in substantive and meaningful ways. Indeed, it is increasingly inseparable from the other core tenets of our work: self-determination, trauma informed services, healing, recovery and human rights/social justice. We realized some time ago that we cannot simply talk about principles and values if the structures and policies of our agency are working against those same things. So we have worked to ensure our policies are in line with our value of harm reduction.

Just one example of this has to do with our intake process. Utilizing the harm reduction principle of “low-threshold services” we do not put artificial barriers in place for individuals to be able to access our housing. We believe in “Housing First” and so years ago eliminated the concept of “readiness;” instead we work to support individuals to be successful in the housing of their choice. We do not have sobriety/abstinence requirements.

We work to eliminate stigma and discrimination in our day to day work, through our behaviors, language and judgments (e.g. we ask workers to refrain from using words such as “promiscuous”) such that we are not serving up shame with our services. We explore topics such as “what is sex positivity” and then how to “get some” so that we can more effectively engage individuals in conversations about relationships, sexual health and wellness. We seek out and promote concrete harm reduction tools for individuals in our programs, such as safer smoking crack supplies, and even educate ourselves about innovations we don't currently have in

New York, but that exist in other countries, such as Insite, a supervised injection facility in Vancouver, British Columbia. We look forward to the day that this sort of evidence-based intervention might be located here in New York City.

We teach harm reduction in our core trainings with our program staff. This includes understanding motivational interviewing and stages of change as ways to approach and engage individuals. However we've found that these tools, though useful, don't adequately address the issues of stigma and discrimination faced by individuals who use drugs. So we also focus attention towards educating each other about how the War on Drugs, Stop and Frisk, racism, classism and heterosexism greatly contribute to the poor health, legal, and economic outcomes for individuals using drugs.

For us, harm reduction is everywhere! Therefore we practice it in the context of psychiatric drugs, diabetes, self-harm, sex work, hoarding, inter-personal violence and tobacco use to name just a few.

We appreciate that with any movement or culture change, we need some change agents who can guide and support harm reduction work for others. We have a long-standing “Harm Reduction Committee” focused on the work of infusing harm reduction into our agency. It is made up of Harm Reduction Specialists and other individuals with expertise in harm reduction who not only lead agency projects and activities, e.g. promoting Overdose Awareness Month, holding HIV testing days and even hosting parties so both employees and program participants can see that harm reduction can be fun, but also spend regular time on self-education and peer support so as to help sustain themselves in their work in guiding the agency's harm reduction services. Our Harm Reduction Specialists have amazing creativity and compassion to engage both program par-

ticipants and staff in the ways that harm reduction can help us all.

We frame our practices and work so as not to be enforcers of house rules, but as support for people to reflect on *their* experiences, perspectives and goals. We understand that there will always be individuals who use drugs, for a variety of reasons, and believe in responding to the reality of the lives of the people we serve, not some imagined life we might wish them to have or believe they should have. One way our practice reflects this concretely is in a “money management” service - workers helping tenants to create budgets that include planned drug use, as well as rent, food and other critical expenses.

A number of challenges, however, remain. One of the most prevalent involves the tension that exists between the rights of individuals versus the rights of the community in supportive housing. This becomes even more challenging where individuals are sharing rooms in transitional housing and one individual is using drugs while the roommate is trying to abstain. Our approach is to assist individuals who are making complaints to be able to address the behavior(s) of concern themselves (e.g. neighbor to neighbor, or roommate to roommate), help them think through what avenues are available to them as tenants in NYC (e.g. 311, making a complaint to our property management company), help them problem-solve what they themselves can do to protect themselves from the nuisance they are experiencing, give them a space to vent their frustrations and ultimately educate them about what is and what is not possible in housing in NYC. We also work to assist in community building in our housing, so that over time social norms in buildings are created through the tenants themselves.

We also find it difficult to keep as connected as we would like to the important harm reduction advocacy that happens in the world of substance use services, as our systems are still so “siloeed.” For example, when we attend mental health events and conferences, there is often no mention of harm reduction issues at all. We are still working to build relationships with harm reduction organizations for support and collaboration to help us improve our practice and policy work.

With the changes occurring in our healthcare system, we at Community Access are eager to continue growing and pushing harm reduction to have a greater role in the mental health and supportive housing community. Our future as effective service providers depends upon open doors, policies that do not discriminate against the people we exist to serve and a field that embraces the challenges of that reality.

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therapeutic alliance, assessment, diagnosis, treatment planning and successful outcomes for the entire spectrum of substance use problems. A treatment approach that integrates psychotherapy and biological and social interventions can dramatically increase our ability to help people with substance use problems heal, grow and create positive change in their lives. Failure to adequately appreciate this is a key contributor to treatment's poor success.

**The Meaning Dimension**

The acute effects that drugs have on the brain are rewarding and become meaningful in relation to the whole person in his or her social context. People use drugs because they feel good and are reinforcing in some way. People who use drugs in problematic and addictive ways do so for reasons that feel vital to the user's well-being or survival. The pleasure, satisfaction, escape or high is always in relation to suffering and pain. There are several broad categories of suffering that render people vulnerable to problematic substance use.

**Self-Medication - Self-Regulation  
And Self-Soothing**

Dr. Edward Khantzian of Harvard coined the "self-medication hypothesis" in 1985 to describe the use of substances as an adaptive attempt to heal or self-treat suffering. "Fixing" may actually refer to an attempt to fix something that feels bro-

**Andrew Tatarsky, PhD**

ken inside. Depression, anxiety, stress, grief, boredom, despair, rage are common companions of problematic substance use. The turn to the substance may also reflect inadequate capacities to self-regulate feelings, soothe or comfort oneself such that feelings are experienced as overwhelming, confusing and frightening. In these cases the substance may feel necessary to one's psychic survival and to maintain a sense of control of feelings and behavior. **Rebelling against the Inner Critic**

The release afforded by the drug effect is frequently a release from a generalized sense of inhibition, an inability to express

one's feelings, needs and vulnerability spontaneously in life such that one feels dead, cut off, disconnected and tense. The inhibition may be a response to a demanding, perfectionistic, self-critical personality style related to a harsh "inner critic." The critic may not allow one to relax because one's work is never done, one's achievements are never good enough, one may be filled with anxiety about the threat of failure or depression over feeling that one has already failed. The substance is hard to give up if it is the only key to one's liberation from the tyranny of the inner critic.

**Interpersonal Meaning**

The reliance on a substance as a form of self-care frequently also reflects serious difficulties in interpersonal relating: profound mistrust of others, shame at expressing needs to others, and so on. Here the substance may become the more reliable parent, friend and lover. Drug use may also free people to express feelings and needs in the act of using that people are unable to express in words interpersonally, such as anger at feeling controlled by a boss or spouse that one feels too vulnerable or insecure to express directly. One patient said, "While I don't feel safe enough to tell my partner that I resent the way he speaks to me when I drink too much, I can continue to drink too much to defy his efforts to control me and express my anger by killing him off in my mind when I am drinking." Another patient said, "my drug use is my cry for help, the way I express my need to be cared for, my way of saying I am in ago-

nizing emotional pain and never learned how to ask for help in the abusive family I grew up in. Please don't reject me as my parents did, help me learn how to care for myself in a healthier way."

**Social Meaning**

The pleasure afforded by the substance may be particularly important in relation to a life in which there are few other sources of pleasure and satisfaction available such as lives of poverty, homelessness or increasingly common work lives in which the hours demanded leave little time for self-care and recreation. Mary is a 38-year-old attorney and mother of three young children. She is deeply dissatisfied with her husband in many ways, including sexually. She has great difficulty feeling and expressing anger and tends to direct anger and criticism toward herself. She has been injecting Oxycontin for the last year, originally as a way to treat severe back pain, but increasingly to manage the stress of being a perfectionistic care taker of others, to quell her dissatisfaction and growing despair about her marriage and because she experiences the hit she gets when she injects in the following way, "the syringe is like my lover delivering the most perfect feeling like a wonderful orgasm."

**Trauma and Dissociation**

Sometimes the reasons for using are very much in the user's awareness. However, in people who have experienced

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# Drinking For Two: Why We Need to Prevent Alcohol Use During Pregnancy

By Margo B. Singer, MPA, FASD  
State Coordinator, Bureau of Prevention  
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It was forty years ago that Fetal Alcohol Syndrome (FAS) was first diagnosed by Drs. David Smith and Kenneth Jones at the University of Washington, when a group of babies born to different mothers who consumed alcohol during pregnancy were noticed to have similar physical and behavioral problems. In 2004 the term "Fetal Alcohol Spectrum Disorders" (FASD) came into use, recognizing that children born to women who drank during pregnancy may exhibit a range of physical, mental, and behavioral problems, including learning disabilities. FASD is a descriptive term - not a diagnostic term; FAS is the medical diagnosis in the International Classification of Diseases (ICD).

Because this is a spectrum disorder, problems that are experienced due to prenatal alcohol exposure can range from moderate to severe in an individual, depending on the dose, frequency and timing of when the mother drank, along with other maternal and genetic factors. All types of alcohol are potentially harmful. The alcohol consumed by the mother passes through the placenta to the developing fetus, where it cannot be metabolized because the baby's liver is not yet fully developed. The baby absorbs all of the alcohol, resulting in the same blood alcohol content as the mother. It is important to note that not all babies prenatally exposed to alcohol will be adversely affected; however, there is no way to predict which fetus will have an FASD - since each person metabolizes alcohol differently. The only safe amount of alcohol to use during pregnancy is none.

Combined 2011 and 2012 data from the National Survey on Drug Use and Health (NSDUH) indicate that 18% of pregnant women drink alcohol during early pregnancy (first trimester). The study did show that the level of alcohol use dropped sharply among pregnant women in their second and third trimesters, suggesting that many pregnant women are getting the message and abstaining from alcohol use during pregnancy.



Margo B. Singer, MPA, FASD

nancy.

Studies show that even low levels of alcohol consumption during pregnancy (a range from one drink per week to one drink per day) have been associated with measurable and long-term effects on the growth and behavior of children. "Light drinking" has also been associated with stillbirth, miscarriage and spontaneous abortion. In 2004 the National Institute on Alcohol Abuse and Alcoholism stated, "Thus far, a threshold below which no fetal damage will occur has not been established." This led to the Surgeon General's recommendation in 2005 that the safest course is for women to abstain entirely from drinking alcohol during pregnancy. In 2010 the 7th Edition of the *Dietary Guidelines for Americans* upheld the finding that no safe level of alcohol consumption during pregnancy has been established.

Alcohol is a teratogen, meaning that it can permanently damage the developing fetus during pregnancy. Alcohol is the most common used teratogen by pregnant women, making alcohol use during pregnancy the leading known preventable cause of intellectual disabilities. The prevalence of FASD is nearly the same rate as Autism; and is more prevalent than Down Syn-

drome, Cerebral Palsy, SIDS, Cystic Fibrosis, and Spina Bifida combined.

According to a report from the Institute of Medicine (IOM), "of all the substances of abuse (including cocaine, heroin, and marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus." Binge drinking (defined as four or more drinks in one sitting for women), which exposes a developing fetus to high blood alcohol concentrations, is particularly harmful, and nearly 1 in 8 women in the USA binge drink about three times a month. Statistics from the federal CDC indicate that women aged 18-34 and high school girls are the most likely to binge drink.

No one knows for certain how many individuals are born each year with an FASD or living with an FASD. According to the SAMHSA FASD Center for Excellence, it is estimated that 1 in 100 live births are affected by prenatal alcohol exposure annually, and approximately 1 in 1,000 live births are diagnosed with FAS. It is estimated that nationally, 40,000 babies are born each year with an FASD. These figures suggest that it is imperative to make women aware of the risks of drinking alcohol during pregnancy.

Many women do not realize they are pregnant until well into the first trimester, and drink alcohol during this time. Research indicates that teenagers tend to recognize their pregnancies later than adults. An estimated 40% of the 60 million US women in their childbearing years do not practice contraception, and approximately half of all pregnancies in this country are unplanned.

Requiring services across the lifespan, FASD is a lifelong disability with health costs for an individual with FAS ranging from \$860,000 to \$4.2 million. The cost of FASD in the United States exceeds \$6 billion annually, and individuals living with FASD are found in every system of care, including: child welfare, mental health, developmental disabilities, vocational services, juvenile and adult justice systems, substance abuse, housing, and physical health. If FASD goes undiagnosed and unaddressed, research shows that these individuals are at high risk for secondary disabilities, such as substance abuse, mental health, dependent living, unemployment, homelessness, and incar-

ceration.

Additionally, this being identified as a spectrum disorder, not every individual with prenatal alcohol exposure will face the same issues as others with FASD. In general, the kinds of issues faced by a person with FASD can include: lower IQ, impaired ability in reading, spelling, and arithmetic, and lower level of adaptive functioning, which can be more significantly impaired than their IQ. Overall difficulties can include: taking in information, storing information, recalling information when necessary; and using information appropriately in a specific situation. Typical problems might include: sensory integration, memory problems, executive functioning, self-esteem and personal issues, and information processing functions.

FASD is 100% preventable if a pregnant woman abstains from drinking alcohol. Reducing the rate of alcohol use during pregnancy must be confronted on several fronts, including raising awareness among the general public and the media, educating service providers who assist pregnant women and women of childbearing age, and intervening with women who are at risk of having an alcohol-exposed pregnancy. There are many successful programs that work to help women directly -- two such programs are Project CHOICES and alcohol Screening and Brief Intervention (SBI).

Project CHOICES is an evidence-based program developed by the federal CDC. It is designed to prevent alcohol-exposed pregnancies by addressing both risky drinking and ineffective or no use of contraception. Project CHOICES has been implemented with women of childbearing age (as well as pregnant women) in a variety of settings: substance abuse treatment, mental health facilities, jails, primary care, OBGYN clinics, and other community-based settings. The intervention uses either a 2-visit or 4-visit model, plus a contraceptive visit. Project CHOICES relies on Motivational Interviewing techniques to help facilitate positive behavior change. It is relatively brief and can positively impact treatment engagement and retention for women enrolled in addiction treatment.

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# Addiction 2.0

**Mary Pender Greene, LCSW-R, CGP  
President  
MPG Consulting**

**W**hen we think about addiction, we associate the word with an addiction to substances, such as alcohol, tobacco, pills or other drugs. But in recent years, researchers have been studying behavioral addiction, an overwhelming desire to engage in a particular behavior or action. Some of the characteristics of substance addictions and behavioral addictions are similar, including lack of compulsive or obsessive behaviors, lack of control, and continuing to engage despite very negative consequences.

Behavioral addictions leave us distracted, frustrated, empty, and not as productive as we could be. However, they are so common that they are considered socially acceptable, making the addiction harder to identify and treat. Although self-destructive, these addictions can easily go by unnoticed. Let's look at 7 things that some people — maybe even you — might not even realize you're addicted to:

## Social Media

Researchers in Norway have published a new psychological scale to measure Facebook addiction, the first of its kind worldwide. They write about their work in the April 2012 issue of the journal *Psychological Reports*. Heavy use of Facebook has been linked to mood swings. Researchers are calling this "Facebook depression." Psychologists divide Twitter users into "informers," those who pass along interesting facts, and "meformers," those who pass along interesting facts about only themselves.

## Dieting

We've all seen how addictive dieting can be and how some people end up anorexic or bulimic, but what is it about dieting that makes it addictive? Dieting is something where you see gradual improvement over time, or incremental rewards for your effort. It is possible to continuously check your progress by measuring your weight (especially with today's



new apps) — a continuous reward and motivation to try harder while providing a constant source of pride. Many chronic dieters often have an underlying emotional cause for their addiction — such as feeling they do not have much control in their real lives. On an unconscious level, they use dieting as a way to feel in control.

## Lottery Tickets

A review of the literature suggests that lottery players are distinct from non-players, and that addicted gamblers differ from normal gamblers. Excessive lottery playing may be a manifestation of a general compulsive consumption trait that is evident in other consumption areas. Surveys reveal that lottery players are getting younger and have less income and education than non-players. Heavy players are found to have less income and to fantasize more than light players. Very heavy lottery players share characteristics of addicted gamblers: they are older, higher in income, fantasize more, and engage in other forms of gambling. A subset of them also exhibits compulsive consumption in the forms of browsing and heavy buying, sensation seeking, and risk-taking. The dream of winning the lottery seemingly accommodates their strong fantasy needs.

## Checking Medical Data

All the medical data available online has created a class of people known as "cyberchondriacs." Dr. Rosen examined how the constant use of technology may be rewiring our brains. One study he cites calls the impact on memory the "Google effect," that is, an inability to remember facts brought on by the realization that they are all available in a few keystrokes via Google.

## Work

In an article in *Forbes*, Dr. Bryan E. Robinson calls work addiction the nation's "best dressed addiction." Work addicts have desks stacked high with projects; they're always working, they're very demanding, and constantly sweating the small details. They're perfectionists with no life outside the office. "It's not about long hours," says Robinson, a psychotherapist and author of *Chained To The Desk: A Guidebook for Workaholics, Their Partners and Children, and The Clinicians Who Treat Them*. "It's about the inability to turn it off. It's a question of balance." Corporate pressure doesn't create workaholics. Robinson notes that workaholics often come from dysfunctional homes and have learned that putting in long hours helps calm their anxiety about other aspects of life. A workaholic

is driven to put in long hours by internal needs, typically a desire to escape intimacy and social relationships. Like heavy drinking or overeating, workaholism only masks the underlying problem while creating other difficulties.

## Technology

Some experts believe that social media sites may spawn narcissism and how constantly checking our wireless mobile devices can lead to obsessive-compulsive disorder. Others believe technology addiction can lead to attention-deficit hyperactivity disorder. Larry D. Rosen, a California psychologist and author of *iDisorder: Understanding Our Obsession With Technology and Overcoming Its Hold on Us* believes there is a very real possibility that mobile devices may be making some of us mentally ill — especially those who are prone to narcissism, depression or obsessive-compulsive disorder. Another issue is the lack of verbal and in-person communication. Communication via device can be very isolating. Eye contact, social cues, voice modulation, and body language are all critical to communication and they are lost.

## Online Games

Like Tetris before them, *Farmville*, *Bejeweled*, *Candy Crush*, *Angry Birds* — a mobile phone game in which players use a slingshot to propel birds at tiny little green pigs — has been a runaway hit since its 2009 release, with more than 700 million downloads. NPR's Neal Conan described the fascination with and addiction to "stupid games" as a phenomenon. The game's basic mechanism — using your index finger to pull back a slingshot, over and over — is described as the perfect use of the new technology of the touch screen: "simple enough to lure a suddenly immense new market of casual gamers, satisfying enough to hook them."

For those combating some form of techno-addiction, such as iPhone, iPad or iPod, Dr. Rosen advises regularly stepping away from the device for a few minutes and connecting with nature. Interestingly, research shows that just standing outside and staring at the trees has a way of resetting our brains.

## People from page 12

significant trauma early in life, substance use may become meaningful in ways that are outside the user's awareness. If you ask these users why they use, they may not be able to say more than "I felt like getting high." Trauma is typically coped with by dissociating, cutting off feelings and ridding oneself of parts of the self that threaten to bring about more trauma by overwhelming one's capacity to function. Anger, sadness, grief, shame, humiliation, aliveness, curiosity all may become threatening and need to be suppressed and denied. These vital parts of the self may live in vague discomfort, just out of awareness, leaving the trauma survivor feeling tense, dead, tuned out, like a

ghost, or "like Frankenstein" as one of my patients described himself. The substance use can provide the user a temporary experience of being able to connect with these parts and feel alive. In these people, excessive substance use is a meaningful reaction to trauma as an attempt to cope with what may otherwise be unmanageable pain.

## Treatment Implications

When drugs carry and express important meanings for the user, the thought of giving the drug up or cutting back may be experienced as a threat to one's psychic survival and capacity to function in the world. Trying to get someone to relinquish substance use without helping the

person understand the role it served, and providing him with unique alternative coping strategies jointly discovered in treatment, is a recipe for failure. Unless the user has identified its meanings and discovered new healthier solutions, attempts to stop using are likely to be met by understandable resistance. Psychotherapy is an essential ingredient in the treatment process. As the meanings and functions of the drug use are clarified it becomes possible to explore alternative less harmful routes of expression or satisfaction. Harm reduction strategies that minimize the risks associated with active substance use may be vital to the user's health and safety. Some include using clean syringes, switching to safer substances and routes of administration, re-

ducing amounts and intensity of use, not using alone, being attentive to general healthcare and nutrition. The harm reduction principles of meeting people where they are even if they are not ready, willing or able to embrace abstinence, and of accepting all positive changes in substance use as successes, allows users to begin the therapeutic process wherever they are in terms of their motivational stage and goals. This harm reduction frame facilitates a therapeutic alliance that enables a collaborative assessment of the psychosocial variables that contribute to the addictive behavior. As the variables are identified it becomes possible to bring together biological, psychological and

*see People on page 36*





## Mary Pender Greene, LCSW-R, CGP

Mary Pender Greene, LCSW-R, CGP is a psychotherapist, clinical supervisor, career/executive coach, trainer, and consultant with 20+ years of experience and a private practice in Midtown Manhattan. She is a thought leader in the social services industry, recognized for her novel ideas on coaching and mentoring. Mary works with individuals, couples and organizations. She coaches and supervises therapists, and helps them to start and build their practices. She helps clinicians to enhance their psychosexual awareness and address sexual expression in clinical practice.

Mary also works with organizations to enhance clinical capacity and improve overall leadership development. The MPG Consulting team brings to organizations a wide range of experience as clinicians, trainers, managers, and organizational consultants in mental health, child welfare, and other settings. The team enhances clinical capacity and performance by offering training and consultation on:

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Mary's background includes executive management roles at The Jewish Board of Family Services in NYC. She gives inspiring keynotes and has been honored many times for her professional contributions. Mary has a popular blog on Tumblr and is frequently quoted in the press on mental health and business topics.

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# Brief Overview of Treatment and Prevention of Substance Abuse and Mental Illness

**By Nabil Kotbi, MD, Chief, The Haven and Addiction and Recovery Service NewYork-Presbyterian Hospital**

**S**ubstance abuse and psychiatric conditions frequently co-exist. According to NAMI, most mental health services are not adequately equipped to address both conditions. This makes treatment and prevention of substance abuse in the presence of mental illness a challenging task due to several moving parts.

Firstly, there are two separate bodies that regulate treatment guidelines. The Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) have different regulations. Patients with dual diagnoses frequently have difficulties obtaining the appropriate services they need to attain and sustain stability, and end up bouncing back and forth between emergency rooms, psychiatric hospitals and addiction rehabilitation units.

Secondly, clinicians in the trenches know that it has become increasingly difficult to secure coverage for these services as different insurance carriers have specific criteria for what they consider medically necessary care.

Other important factors include an aging population with complex medical presentation in addition to the ever-changing, highly addictive and toxic street drugs. This does not exclude overuse and diversion of prescribed tranquilizers, analgesics, hypnotics and others which have



**Nabil Kotbi, MD**

become easily accessible given rapidly advancing technology and a world that no longer has borders.

This article will review what we have been implementing at NewYork-Presbyterian Hospital to assist those in recovery achieve the best possible outcome. We begin with a comprehensive diagnostic assessment that takes into consideration the psychological, neurological, medical and addiction issues which ultimately guides treatment and the discharge plan. Our treatment team is run by a psychiatrist and consists of addiction profes-

sionals from psychology, nursing, pharmacy, social work, addiction counselors, psychosocial rehabilitation and psychiatric mental health workers as well. This multidisciplinary treatment team frequently meets with patients to review their progress during their inpatient treatment, and makes the necessary changes to medications and other interventions.

Evidence-based clinical guidelines influence the treatment approach. The essential components to successful outcomes include a respectful approach when treating patients afflicted with addiction and/or mental illness because stigma is rampant in this population. While our program is abstinence-based, an individualized approach is often used to move patients from the pre-contemplation to the action phase. The use of cognitive behavioral therapy, motivational interviewing techniques, individual, group and family therapies is essential to achieving the patients' ultimate goals of stabilization, sustaining sobriety and remission from both ailments. Additional emphasis that includes relapse prevention, coping skills and ways to develop a sober network is woven into every aspect of the therapeutic program by all disciplines. These modalities are supported by nightly AA and/or NA meetings.

Paying attention to the medical comorbidities is essential and requires the internal medicine, neurology and pharmacy teams to work hand in hand with the treatment team in order to optimize care. This partnership is also instrumental in the complex treatment of pain manage-

ment, which is also on the rise and complicates addiction treatment in general.

## Discharge Planning

Due in part to the reality that the covered length of hospital stay is decreasing, the importance of carefully crafted discharge plans is increasing. Once the treatment team has determined the complete diagnostic picture, they begin to partner with patients and families around the discharge plan, which needs to factor in a whole host of variables including the patients' motivation to maintain sobriety, financial resources, available aftercare and supports.

Aftercare is essential to the life-long recovery process and can be simplified into two main options: intensive outpatient programs or residential therapeutic communities. Choosing a pathway depends upon the constellation and severity of the dual diagnosis. The reality is that despite the best efforts from treatment teams and families, some patients require longer or more intensive programs.

In summary this article does not claim to cover all treatment and prevention, rather it opens an opportunity for a genuine dialogue to improve the care of a growing population that affects the community at large. As a society, we can no longer turn a blind eye while this topic continues to touch each and every individual in our country. Recent tragedies, which affected every family all over the United States, mandate us to have honest, serious and well-informed discussions.

## Integrating from page 8

"wiki space" to create a consensus document, allowing stakeholders to provide input for the basis of the shared vision; Sponsor a meeting of supervisors systems that includes modules on co-occurring disorders to promote dialogue across systems; and Create a shared curriculum for practitioners within different systems.

### Build Consensus Across Service Settings

Integration takes time and requires commitments. At a minimum, consensus is needed across three levels: administration; mid-level management; and field or direct service

It is a fluid, rather than a static process. The right attitude is the most essential ingredient for successful integration. Stakeholders should expect the process to be both challenging and frustrating, but also rewarding. Commitment to open communication is paramount. Dedication among administrators needs to come early, so they can serve as a model for the vision of working towards an integrated system.

In order to succeed, the benefits of integration must be clearly articulated for each stakeholder. Stakeholders must be allowed to define their needs and see some progress towards shared goals to stay engaged over time. Clearly defining goals and objectives avoids confusion.

Build respect by treating stakeholders as equal partners working for the general good of the community.

Time strategic communications so that they occur when change is near to maximize momentum for change. Announcing integration efforts too early can increase frustrations if service systems are not yet ready to support change.

As with any major change, efforts to integrate systems and services may initially result in stakeholder resistance. Early resistance can be countered through consensus-building activities such as the following: Solicit input from those who will be affected by change; Create and share a common vision; Articulate the benefits for each stakeholder group; Distribute basic information including goals and progress achieved; Celebrate achievements.

Conducting activities specifically designed to build consensus can be effective. A variety of methods can be used. It may be helpful to develop a written communications plan to guide outreach to significant target audiences, such as: elected and government officials; other agencies; practitioners; individuals with co-occurring disorders and their families; and advocacy groups.

Build a shared vision of what systemic change would mean by sharing information through Web sites, listservs, and newsletters. Conducting a meeting of all stakeholders can "rally the troops" and provide information to a wide variety of stakeholders.

### Develop Long-Term Plans For Sustainable Change

Agencies or systems working towards system change or integration should consider creating a long-term plan for their work. Creating a plan formalizes the shared vision of integration and encourages partners to address specific areas such as: areas of conflict between the systems or agencies, differences in how the agencies or systems function, and barriers to coordinated care.

Plans also create a roadmap for effecting change by aligning goals, strategies and action steps across agencies and systems. By completing a plan, systems and agencies commit and invest in system integration. Even as agency leaders and staff experience turnover, the roadmap remains to help new staff understand the vision and pick up on tasks. Building capacity and the infrastructure needed to integrate systems takes time and focus. A plan sets up a way to build towards a lasting change.

A successful, transformative long-term plan must show:

- Presence of leadership and authority from each system or agency
- Willingness to invest time and resources to transform systems
- Commitment to change

- Meaningful participation by individuals with co-occurring disorders and their families
- Commitment to cultural competence
- Steps that promote sustainability
- Mechanisms for demonstrating effectiveness such as benchmarks and outcomes
- Ability to hold the agency or system accountable for performance

States undertaking this work have learned that integration requires short- and long-term planning, with concrete goals and realistic timelines. States have learned that embedding changes into policies, administrative rules and procedures is an important vehicle for sustainability. Another valuable way to guide planning for integration efforts is to set up demonstration projects to model the systems change. Plans for sustainable change must also pay careful attention to resource requirements.

### Some Models

- Connecticut developed planning tools such as a logic model, a diagram of activities, a timeline of events, a map of co-occurring locations, and a system model.

*See Integrating on page 30*



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## Odyssey House Family-Focused Programs Offer a Trauma-Informed Approach To Treating Substance Abuse and Mental Health Disorders

By Justin Mitchell, LMHC,  
Vice President, Adult Residential  
Services, and Peter Provet, PhD,  
President & CEO, Odyssey House

Women who have been physically, sexually, and/or emotionally abused are at a significantly higher risk of abusing alcohol and other drugs. As many as 90 percent of women with mental health and substance abuse disorders have histories of physical, emotional, or sexual abuse. It is impossible to effectively treat women without also incorporating clinical services which target trauma and its connection to substance abuse and mental health disorders.

In the past two decades, significant progress has been made in the integration of substance use and mental health disorder treatment. This progress is the result of years of research that supports the efficacy of treating co-occurring disorders in an inclusive manner. Providers have been slower, however, to recognize and treat co-morbid traumatic stress as it relates to substance use and mental health disorders. While treatment providers have made efforts at integrating trauma-informed and trauma-specific services, more providers need to undertake the programmatic changes that are necessary to effectively treat traumatic stress in relation to substance abuse and mental health disorders.

Odyssey House has undertaken this treatment imperative, and over the last four years we have implemented organizational changes that allow us to evolve our family program into one which is both trauma-informed in its delivery and which provides access to specific clinical services that address trauma, substance abuse, and mental health disorders.

### Understanding Treatment Needs Of Women and Children

Women and children have long been at an increased risk of exposure to trauma. This risk only increases when we look at women and children who are struggling with mental health and substance abuse disorders. Research has



Justin Mitchell, LMHC

demonstrated that between 48 to 90 percent of women with mental health and substance abuse disorders also have histories of interpersonal abuse (Lipschitz et al, 1996) and, according to Jahn Moses et al (2003), "Fifty-five to 99 percent of woman substance abusers report being victimized at some point in their lives." Women with substance use problems are also significantly more likely than men to exhibit recent physical, emotional or sexual abuse (Gentilello et al, 2000); and children of substance abusers are almost three times more likely to be physically or sexually assaulted, and more than four times as likely to be neglected than children whose parents are not substance abusers (CASA, 1999).

Traumatic events experienced by these at-risk women and children include: physical, psychological and sexual abuse; domestic violence; witnessing violence against others; and preventable accidents in the home. In "Women and addiction: A gender-responsive approach," researcher Stephanie Covington states that "a history of being abused drastically increases the likelihood that a woman will abuse alcohol and other drugs," and suggests that by "integrating trauma treat-



Peter Provet, PhD

ment with addiction treatment, we reduce the risk of trauma-based relapse."

### Choosing Best Practice Models For Holistic Family Treatment

In 2009, we began the implementation of a new holistic family treatment model. We called it *Healthy Mothers Healthy Families* (HMHF) because the program addresses the unique life circumstances and needs of pregnant and postpartum women and their children. Funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), this intensive service combines evidence-based trauma and parenting therapies with substance use disorder treatment in a model of care that incorporates the whole family unit, not just the individual in treatment.

To address clients' histories of trauma and prevent trauma-related relapse, we implemented four evidence-based trauma-specific services that support clients in treatment for substance abuse and mental health disorders.

The first, Seeking Safety, is a present-focused coping skills approach designed to simultaneously treat substance use dis-

orders and disorders related to histories of trauma. This practice is based on five key concepts: safety as the treatment priority; integrated treatment; a focus on ideals; attention to clinical processes; and the inclusion of cognitive, behavioral, interpersonal, and case management content areas.

The second practice, Trauma, Recovery and Empowerment Model (TREM), is a group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psycho-educational, and skills-training techniques, the gender-specific group emphasizes the development of coping skills and social support. It addresses both short-term and long-term consequences of violent victimization, including mental health symptoms, post-traumatic stress disorder (PTSD), depression, and substance abuse.

The majority of women in treatment at the Odyssey House Family Center are parents. At any one time, 60 parents and 60 children under six years of age live in our residential center in East Harlem or community residence in the Bronx. For these women, and other participants who are seeking custody of their children, we utilize an evidence-based practice specifically designed for families with a history of substance abuse. Nurturing Parent Program for Families in Substance Abuse Treatment and Recovery (NPP) is built on the principles of relational development: that parents and children are highly affected by their relationships with each other; that parents and children develop a sense of self through their relationships with each other; and that the parent-child relationship requires a sense of connectedness in order to experience healthy growth and mutual satisfaction. All activities in this practice are designed to help participants learn how to nurture themselves as individuals and in turn lay the foundation for a nurturing family unit.

Approximately 15 percent of women in our family programs are pregnant when they enter treatment. For these vulnerable women, extending their treatment stay through delivery and the postpartum

see Family on page 35



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## Substance Abuse Among Veterans: Challenges and Hope

By Scott Thompson, MS, MDiv,  
LMHC, Director of the Veterans  
Mental Health Coalition of NYC at the  
MHA of NYC

**C**oping with the invisible wounds of war is the new front line for hundreds of thousands of soldiers returning from multiple deployments in Iraq and Afghanistan. Sleepless, on high alert, and waiting in fear for something terrible to happen, countless veterans turn to alcohol or drugs to try and keep the nightmares at bay. The behavioral health community must be prepared to help veterans cope.

While it doesn't garner as much media attention as post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI), the abuse of alcohol is one of the most prevalent problems that veterans face. Twenty-seven percent of Army soldiers screened three to four months after deployment to Iraq, met criteria for alcohol abuse and were at increased risk for related harmful behaviors, including driving intoxicated or using illicit drugs. In addition, prescription drug abuse doubled among U.S. military personnel from 2002 to 2005 and almost tripled between 2005 and 2008. Drugs or alcohol were involved in 30% of the Army's suicide deaths from 2003 to 2009 and in more than 45% of non-fatal suicide attempts from 2005 to 2009. Of returning veterans from the war in Afghanistan who have been treated at a VA hospital for drug addiction, 27,000 veterans have been diagnosed with "nondependent use of drugs," and 16,200 have been diagnosed with Alcohol Dependence Syndrome. In New York State alone, programs that are certified by the Office of Alcoholism and Substance Abuse Services treated nearly 14,000 veterans in the past year, but the Substance Abuse and Mental Health Services Administration reported that there are over 75,000 New York veterans suffering from alcoholism or chemical dependence.

Historically, excessive drinking has been associated with military culture, and was considered just a facet of 'being a man.' One in eight soldiers returning from Iraq and Afghanistan between 2006 and 2008 were referred for alcohol counseling. The National Household Survey on Drug Abuse reported that more than half of the male veterans in the U.S. use alcohol, 23% binge drink, and 7% drink heavily. Female veterans drink less, with 41% using alcohol, 14% binge drinking, and 2% drinking heavily.

Fortunately, more active duty soldiers and veterans are seeking help than ever before. From 2007 to 2012, the number of soldiers enrolled in treatment after being diagnosed with alcohol problems increased by 56%. Despite this increase, far too many soldiers are not getting the treatment they need. In fact, of the 12% of soldiers who reported an alcohol problem post-deployment, less than 1% percent are



**Scott Thompson, MS, MDiv, LMHC**

being referred to treatment. This could be due to the fact that in the military, referrals for alcohol treatment are not confidential. The military's current policy requires that "accessing alcohol treatment triggers automatic involvement of a soldier's commander," which can impact their career prospects. According to the military's Mental Health Task Force, "Concerns that self-identification will impede career advancement... may lead service members to avoid needed care, even at early stages when problems are most remediable." It is likely that the policy of automatic command notification is the most significant barrier to troops' receiving alcohol abuse treatment.

In addition to alcohol, drugs have long been part of the military during conflict. While many soldiers returning from Vietnam brought heroin addictions home from war, today we find returning soldiers more at risk from the drugs given to them legally. A 2010 Army study found that one-third of its soldiers were on prescription meds, and nearly half of those — 76,500 soldiers — were taking powerful and addictive opiate painkillers. Last year, researchers at the San Francisco VA Medical Center published a paper that found VA doctors prescribed significantly more opiates to patients with PTSD and depression than to other veterans — even though people suffering from those conditions are most at risk of overdose and suicide.

Advances in medicine have also meant that many more military personnel are surviving serious injuries, further increasing the demand for drugs to control pain. In 2009, military doctors wrote 3.8 million prescriptions for narcotic pain pills — four times as many as they did in 2001. The Army also reported the number of amphetamine prescriptions doubled between 2006 and 2009. More drugs have meant more drug problems among service members. Last year, a study of more than 450,000 Iraq and Afghanistan veterans found that 4.5 percent had a substance use disorder diagnosis — more than double the civilian rate — adding that the rate

was likely to be even higher because of the VA's poor screening process. The same study noted that VA funding for chemical dependency services had declined in comparison to other healthcare services. It also noted the military continued to do a poor job screening patients whose mental conditions put them at greater risk of drug abuse.

We know that drugs and alcohol frequently co-occur with many mental health disorders. Six out of ten people with a substance use disorder also suffer from a mental illness. Even in soldiers whose comorbidities do not occur simultaneously, research shows that mental disorders can increase vulnerability to subsequent drug abuse and that drug abuse constitutes a risk factor for subsequent mental disorders. Therefore, diagnosis and treatment of one disorder will likely reduce risk for the other, or at least improve its prognosis. The need to develop effective interventions to treat both conditions concurrently is strongly supported by research, but has been difficult to implement in practice. Health care systems in place to treat substance use disorder and mental illness are typically disconnected, dis-coordinated and inefficient.

For some veterans, the use and abuse of drugs brings them into contact with the justice system. Sometimes mental illness plays a role in the crimes committed by veterans, often because it's untreated. More than 33% of troops who were convicted of criminal acts in Afghanistan or Iraq had committed offenses while under the influence of alcohol or other drugs.

In the past five years, new community solutions have arisen to address this in the form of special courts. The courts are similar to drug and mental health courts, but designed specifically for veterans, who have both substance use and mental health issues. There are now about 88 veterans' courts in 26 states. It makes a big difference for veterans to have a community wrap itself around them, help them adhere to treatment and gently hold them accountable for their actions. On the day the veteran's case is heard, the courtroom is filled with people to help him sort out his problems—physical health, mental health, legal and practical. Additionally, peer-based services, which expand the continuum of services available to veterans with co-occurring disorders, provide veterans with a unique opportunity to develop linkages and relationships with other veterans who have similar lived experience and develop options for involvement in new communities of hope.

One of the most critical aspects to mitigate and prevent substance use and abuse is to stabilize important elements of the veteran's life. This includes employment, housing and community supports. The unemployment rate among veterans ages 20-24 is 15%, three times the national average for this age group. Younger veterans who may have joined the service immediately after high school

express difficulty transferring their military skills to the civilian work force. These veterans may have limited education and no civilian work experience. Some veterans are re-enlisting because they are discouraged by the lack of opportunity in their local job markets. By stabilizing employment, we reduce the abuse of substances and ensure that they have successes in other areas.

A number of employers have committed to hire and support veterans in the workplace. Over 100 major U.S. firms have pledged to hire 100,000 veterans and military personnel over the next several years. The Veterans on Wall Street initiative, a partnership of five banks, provides career development, support, and retention of veterans throughout the financial industry. President Obama established a Veterans Employment Initiative in order to transform the federal government into a model of veterans' employment. We all must do our part. As members of the behavioral health community, we must join together to address the complex mental health and substance abuse challenges among our nation's heroes by promoting:

- Increased access to comprehensive recovery oriented civilian based mental health and substance abuse supports that are competent in military culture. Availability of community based resources is critical for veterans who cannot or will not use the VA for care.
- Expanded use of peer-to-peer supports that have proven effective with helping veterans recover and reintegrate
- Support for families of veterans and service members
- Enhanced outreach and public education to provide information about mental and substance abuse problems and sources of help for veterans and their families
- Expanded suicide prevention efforts to build awareness of signs of suicide risk among veterans and how to respond
- Expanded supports in educational and employment settings to increase veteran retention and success
- Enhanced confidentiality of soldiers and veterans seeking alcohol counseling in the DOD and VA care systems

To help advance these policy and practice recommendations, join the Veterans Mental Health Coalition of New York City, a diverse group of over 950 stakeholders united and committed to improving care for veterans, service members and their families. Veterans have sacrificed on our behalf, now it's our turn to ensure that they get the help they need and deserve so they can lead successful lives and contribute to our communities.

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## — The NYSPA Report —

# DSM 5: A New Diagnostic Perspective

**By Glenn Martin, MD, DFAPA**  
**President**  
**New York State Psychiatric Association**

**W**ith much fanfare and no small amount of controversy the American Psychiatric Association (APA) released the 5<sup>th</sup> version of the Diagnostic and Statistics manual, DSM-5 in May of this year. Since its release it has been a consistent best seller and is still ranked #19 of all books on Amazon in October, 2013. Planning for the edition dates back to at least 2003, and that process alone has generated over 200 journal articles and involved hundreds of researchers and clinicians, many of whom live and practice outside the United States. Coming in at 947 pages the DSM-5 is bit larger than the 129 page first edition, but it is actually 41 pages shorter than the its immediate predecessor. The total number of discrete disorders has also dropped a bit from 172 to 157, obtained by the elimination of 2, the addition of 15, and the consolidation, many of them in the substance use categories, of 28 disorders.

Interestingly criticism of the DSM-5 has come from both directions. It has been categorized as a collection of relatively minor adjustments to DSM-IV which has not fully tracked research developments or the new emphasis on brain circuitry as captured by the Research Domain Criteria (RDoC) system currently being advanced by the NIMH as a framework for funding and promoting research activities. (See the NIH's Dr. Thomas Insel's April blog comments (<http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml>) and his May joint statement with the APA President for more information (<http://www.nimh.nih.gov/news/science-news/2013/dsm-5-and-rdoc-shared-interests.shtml>)). Alternately, it has been criticized for the wholesale repackaging of certain disorders, e.g. autism and related disorders, substance abuse/dependence, and as a book that advances the medicalization and treatment of normalcy, e.g. the elimination of the bereavement exclusion from the diagnosis of depression.

It is simply not possible to summarize all of the changes in this edition of the DSM in the limited space of this column, so I will highlight a few things of note and recommend to the reader a synopsis found at (<http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf>).

Actually one of the biggest conceptual changes is the reorganization of the chapters, or metastructure to better track with the International Classification of Disease (ICD)10 and the upcoming ICD 11. The reorganization tries to better group the spectrum of disorders we encounter and their progression across the lifespan. In addition it will allow for better tracking of the DSM disorders to the ICD codes, which practitioners are mandated to use when submitting claims for billing purposes.

The multi-axial diagnostic system has ended. There is no longer a separation of personality disorders from the rest of psychiatric diagnosis and there is no mandate



**Glenn Martin, MD, DFAPA**

to use the Global Assessment of Functioning (GAF) and list all psychosocial stressors in the diagnosis. This aligns psychiatry with the rest of the house of medicine. Comprehensive medical and psychiatric care should always reflect patient function and pertinent life issues, and these factors should be reflected in the care plan, but it is not part of a diagnosis.

**Substance Use and Addictive disorders:** Gone are the 2 distinct categories of abuse and dependence, as they have been combined into a single substance use disorder, with a severity rating across a continuum that includes mild, moderate, or severe substance use. The 2 categories had been “invented” in a previous edition of the DSM and there is no compelling scientific data to support the separation. This tracks well with the experience of clinicians who have long known that one can be physically dependent without abusing a substance and one can heavily abuse a substance with life destroying consequences and never be physically dependent. The “legal consequences” diagnostic criteria has been removed as the legal difficulty associated with drug use may be more related to social standing and residence than the degree of use/impairment. Many would point to stop and frisk statistics in NYC as an example of this disparity. And the criteria of craving was added, a key feature of the pathology that was missing from the previous definitions.

Gambling Disorder has now been added as the first behavioral addictive disorder, having been moved from the impulse disorder categories. Found in the DSM's section 3 “are “conditions for further study” that are promising candidates for future inclusion but which lack enough scientific evidence to support full recognition at this time. Both Caffeine Use Disorder and Internet Gaming Disorder have been included in Section 3.

**Schizophrenia:** The various subtypes of schizophrenia have been removed as they have not been shown to have sufficient stability or predictive outcome value. In addition the special treatment of bizarre delusions and “special” hallucinations are also removed, and finally criteria have been clarified that at some point a

patient has to have had delusions, hallucinations, or disorganized speech to receive the diagnosis.

**Autism Spectrum Disorder:** A single spectrum diagnosis replaces autistic disorder, Asperger disorder, Childhood Disintegrative Disorder, Rett's Disorder and pervasive developmental disorder not otherwise specified. This decision was strongly supported by the scientific literature that demonstrated that our previous distinctions could not be supported. There was significant controversy mainly centered on a fear of loss of eligibility for special education and other programs. As DSM5 specifically allows the inclusion of all persons already diagnosed under DSM-IV it is likely this fear during the transition from IV to 5 is overblown.

**Intellectual Disability (Intellectual Developmental Disorder):** This disorder now replaces the outmoded term mental retardation. The diagnosis is now longer strictly driven by IQ, but takes into account other areas of functioning.

**Depression:** One significant change includes the elimination of the so called bereavement exclusion, so it is now possible to diagnosis someone with depression even if they recently suffered the loss of a loved one. There is a very real effort in the supporting text to provide guidance to clinicians to distinguish depression from normal grieving. The change was made to recognize that loss, like any major stressor

can trigger a pathologic response, depression, which may need specialized and focused treatment. There have also been modifications to the diagnosis of dysthymia and its overlap with depression by the introduction of persistent depression. The anxious features of depression are now pulled out for special attention as an independent specifier in the diagnosis as it may predict higher rates of suicide and poorer outcome.

And finally no discussion of DSM-5 can be complete without highlighting the fact that the authors and the APA are very aware that the DSM will continue to need to be modified and refined, and more frequently than every 20 years or so. The challenge will be to find the right balance between introducing important empirically supported change, and maintaining stability in the field for billing, clinical and long term follow up research purposes. Updates on that process, current FAQs refining diagnostic criteria and addressing insurance and billing issues, errata, as well as an online form to complete to ask questions or suggest improvements are all available at [www.Dsm5.org](http://www.Dsm5.org).

*Dr. Glenn Martin, MD, DFAPA, a practicing psychiatrist, is the President of the New York State Psychiatric Association and is the Recorder of the Assembly of the American Psychiatric Association. He chaired the Assembly Committee on DSM-5*



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## Making the Connection: Treatment Innovations for Individuals With Cognitive Disabilities and Substance Use Disorders at ACCESS Community Health Center

By Shelly Levy, PsyD  
AHRC Health Care, Inc.  
Access Community Health Center

The emerging problem of addiction among individuals with Developmental and Intellectual Disabilities (DD/ID) paralleled the movement of these individuals from institutional to community based settings. Integration into the community meant exposure to alcohol and other drugs. In addition to specific risk factors noted below, most DD/ID providers are unfamiliar with addiction and many addiction providers in traditional program settings feel ill equipped to work with individuals with developmental disabilities. In the early 1990's keenly aware of these problems, AHRC New York City developed the first licensed substance abuse program and prevention programs specifically tailored to the needs of this population. The Access Community Health Center (AHRC Health Care, Inc.) program, which is a non-intensive outpatient OASAS Part 822 program, was developed by AHRC New York City in response to outstanding client needs. From its origins as a support group, a dedicated and licensed clinical service developed. The opening of this first NYS licensed outpatient alcohol and substance abuse clinic for people with developmental

disabilities dates back to 1992.

As expertise with treating DD/ID and substance disorders grew, the expansion of services to another district group of individuals with cognitive disabilities - TBI-was introduced. The repatriation of individuals with TBI and substance use disorders from out of state nursing homes was facilitated by available of specialized addiction services. An understanding of both cognitive support needs and psychosocial factors effecting patterns of substance use in these client populations informs the work. The multidisciplinary team traditionally included staff with backgrounds in working with individuals with developmental disabilities. The team, currently under the direction of Access Community Health Center's medical director, is expanded and composed of CASAC's, and those with clinical training in creative arts therapy, social work, mental health counseling and neuropsychology. Prevention services provide an additional level of resources. A multidisciplinary team, with access to psychiatrists familiar with differences in dosing and medications most efficacious for clients with cognitive disabilities enhances the treatment. Availability of medical and rehabilitation providers familiar with the physical and cognitive sequelae of these disabilities contributes to the recovery process by addressing additional needs in

a sensitive manner. Team members share expertise and collaborate on ways their clinical perspectives can individualize treatment and contribute to the optimal modified approach.

Working with specialized client populations demands creativity, flexibility and willingness to learn about the complexities of the disabilities and their co-occurrence with substance use disorders. Treating both the cognitive and recovery needs of individuals is clinically indicated and valuable. Assumptions about the inability of individuals with DD/ID, TBI, and substance use disorders to succeed in recovery should and can be disputed. This article offers an overview of ways to modify and innovate, leading to improved outcomes, sense of belonging and efficacy for clients, and commitment to the recovery to all of those who seek to reap its rewards.

*Substance Abuse and Treatment in the DD/ID and TBI Populations:* Recovery is an arduous, painful, and ultimately rewarding process for most individuals, though often fraught with personal challenges. Individuals with substance use disorders and co-occurring cognitive disabilities face even greater challenges. Difficulties with pace of learning, comprehension, abstract reasoning, and generalizing behaviors outside sessions into functional, "real life" situations are common. Individuals with cognitive disabilities

often demonstrate significant difficulties with memory, problem-solving self-awareness, language, and social skills which make traditional treatment programs daunting. Both the individual and the clinician may experience frustrations as cognitive disabilities can pose an obstacle to successful recovery when not accommodated or understood. This article presents innovative treatment approaches in working with individuals with two specific types of cognitive disabilities: Mental Retardation/Intellectual Disabilities and Traumatic Brain Injury/TBI.

Along with some common cognitive and learning issues which can respond to similar interventions, it is essential to recognize that these two disabilities are very different in some essential elements. Mental retardation/intellectual disability always manifests during the developmental stage, and as such is a type of developmental disability. Therefore the phrase DD/ID will be used throughout this article. In order to be diagnosed with DD/ID, the individual must have an IQ score on a standardized test that falls below 70, deficits in at least two areas of adaptive functioning, and onset of the disability prior to age 22. Estimates find up to 3% of the general population has DD/ID. Traumatic, or acquired, brain injury can occur

*see Connection on page 38*



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## Intensive Outpatient Programs: When More is Better

**Joe Ruggiero PhD, Assistant Clinical Director, Addiction Institute of NY, Director of Crystal Clear Project, St. Luke's Roosevelt Hospital Center**

The world of substance abuse treatment has gone through a great deal of change in the last decade. In the past, when a person entered substance abuse treatment, there was an immediate assumption that they needed a 28 inpatient rehab in order to "recover". However, this standard has been changed due to managed care restrictions as well as research that indicate that people can improve and reach their goals with outpatient treatment. While there is the necessity for inpatient treatment, there also needs to be more creative outpatient options.

Outpatient options need to address the complexity of the clients we are attempting to engage in treatment. For many outpatient programs, there still exists the dilemma of how to provide significant structure and support to clients who are just beginning to make changes in their use. Often these clients have very limited supports and have a multitude of substance abuse problems (e.g. legal issues, lack of relapse prevention skills) as well as mental health concerns (e.g. depression, anxiety, PTSD). In addition they may be struggling with concrete problems like voca-

tional issues such as lack of work or dissatisfaction with their profession as well as housing concerns. Some treatment centers use intensive outpatient programs which include 2-3 hours of treatment several times a week (IOPs) and outpatient rehabilitation programs (4+ hours a day; five days a week) to address the multitude of issues and provide much needed support.

In addition, in an age where we are looking to integrate substance use and mental health care, the intensive programs seem perfect in the way they address addiction from a variety of angles. They allow us to address the unique needs of a person by offering a variety of group options while also using individual therapy and psychopharmacology as well.

These programs can be tailored to address the population being addressed. They may provide much needed support for clients who have co-morbid psychiatric issues and who have difficulty getting into psychiatric day programs that require stability in terms of drug use. They not only can help to stabilize these clients in terms of their use but they begin to build skills for these clients to manage depression, anxiety, etc. and to work on affect regulation. They may provide education regarding mental illness and around medication, medication management and the interaction of emotion and drug use.

More specifically these programs provide "traditional" drug treatment such as

CBT, relapse prevention, 12-step facilitation, and motivational interviewing and "orientation" to drug treatment. They also can offer DBT, skills building, and socialization groups. More holistic treatment can be incorporated such as yoga, exercise, and arts and crafts. Clients have also benefitted from medically oriented groups that involve psycho-education about the impact of their use and about topics related to addiction such as hepatitis, STDs, and HIV as well as nutrition and exercise as clients begin to care again for their bodies. These groups can provide psycho-education about a variety of topics that relate to drug use and psychiatric functioning. Having supervised these programs for over 15 years it has also been helpful to have "open" groups that can be tailored to a particular community. Therefore community members have at times asked for more meditation and mindfulness, journaling, as well as other topics.

In addition it can be useful to have a group that helps people transition from these programs as they transfer to less intensive care and ongoing therapy groups once they stabilize or return to school or work. Though these programs can be powerful, they can be difficult to transition from with regard to ongoing treatment. Clients can process their feelings about leaving this level of care and returning to work and continuing in ongoing less intensive care.

In my experience, there is also a healing power to these programs that is somewhat intangible but quite powerful. Walant (1999) discusses the need for clients with drug problems to wean off their powerful attachment to a substance and to engage intensively in a replacement. She discusses how a therapist may notice that clients need greater support from their therapist early in the therapeutic process. These intensive programs can provide this new, healthier attachment. A powerful sense of community can build in these programs that allows people to connect to something larger than themselves and to also build a support system. This process may be similar to self help programs. Members often want to attend and do better for themselves and to not let the community down.

Because most of the treatment is group psychotherapy, therapists can see their clients in an interpersonal context and better understand how they relate with others. This helps us look at the barriers towards great social support. In addition these communities provide role models for clients early in this process. More senior, stable community members can provide hope for clients who are just beginning to make changes. They also teach clients to utilize therapy and groups in order to understand themselves better

*see Outpatient on page 37*



**ROC** is the training and development branch of Recovery Innovations. ROC was founded in 2005 to provide recovery focused training and consulting to organizations who are interested in creating an integrated workforce and a strong recovery culture.

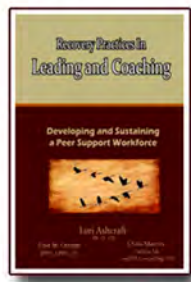
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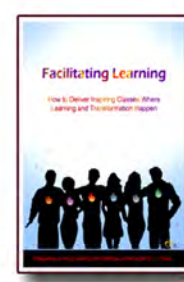
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## Services for the UnderServed Promotes Health and Wellness Through Organic Produce Harvested at Urban Farms: Program Leads to Employment, Meditation and Community Engagement

Staff Writer  
Behavioral Health News

**S**ervices for the UnderServed residents experienced the true meaning of enjoying the fruits of their labor as they showcased the organic produce they planted, tended and harvested as part of SUS' Urban Farms Program at the Third Annual Harvest Luncheon held on Friday, September 27<sup>th</sup> in Bedford-Stuyvesant, Brooklyn.

"SUS is so proud of the Urban Farms Program," said Donna Colonna CEO of Services for the UnderServed. "The participants grew the produce, cared for the crops and are now not only able to see the end result of their efforts but were able to join with friends, family and other urban farmers to feast on the fruits of their labor."

SUS' Urban Farms Program is open to all individuals served by SUS who are interested in agriculture as an employment pursuit or casual hobby—formerly homeless veterans and individuals with histories of mental illness, intellectual/developmental disabilities and HIV/AIDS.



**Services for the UnderServed CEO, Donna Colonna celebrates the Third Annual SUS Harvest Luncheon held in Bedford-Stuyvesant, Brooklyn. SUS' Urban Farmers planted the organic produce which was featured in many of the menu items served at the luncheon.**

Through the program, urban farmers have opportunities for part- and full-time employment. At the event, urban farmers explained the program's impact on their health, job skills development and overall quality of life.

Produce from the farms is shared by SUS residents, extending health and wellness benefits beyond just those who work on the farms. The luncheon featured selections made from eggplant, tomatoes, cucumber, herbs, pickles, kale, corn, squash, figs and legumes harvested by the SUS urban farmers.

This year the program has added a new farm site in Bedford-Stuyvesant, restoration of a therapeutic garden in Long Island City, construction of a terrace vegetable garden in Ozone Park, and will introduce new programming to sites throughout Brooklyn, Queens, and the Bronx.

*Services for the UnderServed (SUS) serves individuals and families faced with mental illness, people with intellectual/developmental disabilities, individuals living with HIV/AIDS and veterans. For more information about SUS' programs and services, please visit us at [www.sus.org](http://www.sus.org) and follow us on Twitter @susincnyc.*



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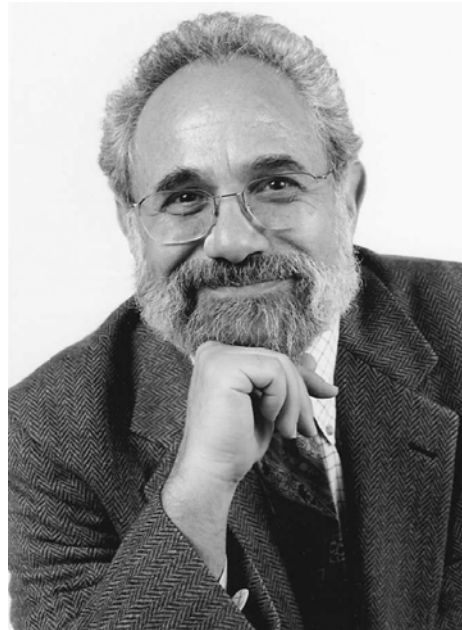
## Better Pain Management is Essential For Reducing Addiction to Prescription Painkillers

By Michael B. Friedman, LMSW  
Behavioral Health Policy Advocate

**L**imiting use of prescription painkillers has become a major public health goal in the United States in large part because these drugs now cause more overdose deaths than cocaine and heroin combined.<sup>(1,2)</sup> Much of this effort focuses on persuading physicians to limit the frequency and the amount of their prescriptions. This makes great sense, of course, but it neglects the fact that many, perhaps most, people addicted to prescription painkillers live with terrible pain. Yes, doctors should prescribe more carefully; but they should also do a better job of helping their patients to eliminate, reduce, or tolerate pain that otherwise can make life unbearable.

Seems obvious, doesn't it? Maybe. But it wasn't obvious to me when I wrote about the problem of addiction to prescription painkillers last year<sup>(3,4)</sup> and apparently it's not obvious to the Centers for Disease Control, which have a number of alarming posts on their web site about controlling access to these drugs, but I could not find any posts about the pain management.

I first became clear about the importance of improving pain management after I published an article on *The Huffington*



Michael B. Friedman, MSW

*Post* called "Prescription Painkillers: When Are They Too Much of a Good Thing?" In this article, I, and my co-author, identified eight signs that you may be addicted to or otherwise abusing prescription painkillers. Well over 100 people responded—a very large number for that kind of article. A few thanked us or said they wished they had known what to look for before they became addicted.

But most criticized—even excoriated—us. Of these, some were clearly addicts in denial. But most were people who told us we couldn't possibly understand how much pain they live with. They knew they were addicted; but, they said, without painkillers they couldn't stand up, couldn't work, couldn't feed themselves let alone their families, couldn't think clearly, couldn't engage in social conversation, couldn't go out for some fun. These people believed, and they may have been right, that they needed painkillers to have a life.

Ironically, at about the same time that I heard from so many people living with terrible pain, the minor, annoying pain I had been living with became severe and disrupted my life. I could not drive without great pain. I couldn't sit for more than a short time, making working on a computer and socializing, extremely difficult. The distances I could walk became shorter and shorter. Teaching for two hours at a time became almost impossible. Meetings with colleagues, going out to dinner with friends became more than I could bear without taking a prescription painkiller. Because I was afraid I would become addicted, I lived with as much pain as I could tolerate and withdrew from some activities instead of using the medication I feared.

My search for a health care professional who could help me became central

to my life. Over two years I saw numerous health care professionals including primary care physicians, orthopedists, neurologists, pain management specialists, an acupuncturist, two osteopaths, a physical therapist, and who knows how many radiologists. The pain got worse and worse as did my life, until I got lucky. An MRI revealed a large tumor inside my spinal column. We had identified a cause and a treatment for my pain.

Not everyone is so lucky. One day while waiting to see a doctor at a highly regarded pain clinic, I chatted with a woman who appeared to be exceedingly anxious and depressed. She told me she was "at the end of her rope" (Think of the literal meaning of that expression). She was, she said, addicted to opiates, which she began to take after an automobile accident that broke several bones, including vertebrae in her back, and left her immobile for months. Now she could walk—slowly—and could get out for medical appointments; but, she said, she would not be able to get out of the bed in the morning without the painkillers. Even with them she was not able to work because the pain filled her mind, making it impossible to stay focused. She was also taking an anti-depressant and sometimes Xanax to quell her sense of dread when it

see *Pain* on page 38



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# Optum's NYC BHO Peer Support Initiative Promotes Behavioral Health Recovery Through Effective Provider Collaborations

By Optum

**O**ptum supports recovery-focused care for mental health and substance use conditions. This approach is best achieved when services are delivered in collaboration with providers and organizations that embrace the principles of person-centered care that is strength-based and recovery-oriented. Optum has successfully developed and implemented community based collaborations that bring together service organizations that support a continuum of care. Resiliency is promoted when Peer Support Services provide community-based assistance that foster hope and empowers recovery.

In New York City, Optum has developed key partnerships with recovery oriented organizations that can provide a full spectrum of services for mental health and substance use conditions. As the New York City regional Behavioral Health Organization (NYC BHO), Optum subcontracted with a consumer run organization to pilot a peer services model that would target individuals hospitalized for a psychiatric or substance use disorder diagnosis in order to enhance community tenure upon discharge and reduce the need for further hospitalizations. The two collaborators for this project include the Kingsboro

Addiction Treatment Center and the Baltic Street Resource and Wellness Center. These are both person-centered facilities that provide a safe and supportive environment to promote sobriety and foster recovery.

The Kingsboro Addiction Treatment Center, located in Brooklyn, NY, provides inpatient addiction treatment for up to 70 adults. As a state-operated provider of addiction treatment, Kingsboro admissions are among the most complex with high acuity for comorbid physical health concerns and co-occurring mental health diagnoses. Their core mission is to provide care in a nurturing, safe, and supportive environment. This is achieved through core values that support teamwork, respect and dignity, honesty, accountability and a commitment to excellence. The Kingsboro program offers inpatient recovery-focused services to empower consumers to attain and maintain sobriety beyond their involvement in the program.

The Baltic Street Resource and Wellness Center, also located in Brooklyn NY, is a peer-run organization that provides peer support, advocacy, and culturally competent social skills development to empower adults who experience substance use and mental health conditions to foster hope and promote recovery. Baltic Street provides a relaxed, friendly, com-

munity-based environment where people can gather, get assistance for their basic needs, socialize and help one another. In particular, Baltic Street's peer-led services help people establish a recovery plan and support for their long-term maintenance. Peer staff assist people with the identification of personal goals and help develop strategies and supports necessary to achieve them. The focus of the plan is promote not only the recovery and whole health of the individual, but to encourage better engagement and integration into the community where they live.

The inpatient residential program at Kingsboro is designed to assist individuals with their challenges and struggles to overcome alcohol and chemical dependency conditions. In order to be eligible for services at the facility there must be a need to have 24-hour supervised care, which is often determined by failures at less restrictive or intensive levels of care. This highly structured program includes medically supervised withdrawal services, physical and psychiatric evaluations, social work services, and counseling groups. Person-centered care guides all services, and recovery-oriented goals support long-term sobriety. In partnership with the Optum BHO, Kingsboro identified a need to better serve those individuals who left the treatment against medical advice and were open to implementing creative and

innovative evidenced-based practices to address this need.

In order to improve transfers between levels of care, the Optum NYC BHO partnered with Kingsboro and Baltic Street to implement a peer support program in March 2013. In this pilot program, peer specialists from Baltic Street actively engage consenting individuals on the inpatient unit during their stay at Kingsboro's detox or inpatient rehabilitation. During both the hospitalization and the post-discharge transition, the peer specialist works closely with the individual to establish a wellness and recovery plan that may include weekly face-to-face meetings or phone contacts, and post-discharge support.

Baltic Street's peer support services are an effective resource to help connect people to others to foster hope and demonstrate that recovery is possible. People will often disclose issues in their life to a Peer Support Specialist that they have not previously told other service providers. The trusting and safe connection that can be established in peer support may be one of the first opportunities that someone has had to share their experiences, fears, and hopes for the future. The Baltic Street program provides these services and expands the continuum of services that are available to foster resiliency and promote recovery.

*see BHO on page 37*



## With Hope, All Things Are Possible.

Reframing treatment around recovery and resiliency offers new hope and a bright future for those who live with mental illness. While everyone must follow their own path to recovery, and every local community offers a unique set of supports, a few key principles can help ensure success:

- Person-directed support for the whole person, regardless of their age or stage in life
- Building on the strengths and abilities of each individual
- Cultural competence
- Techniques, tools, and technology to empower people to live purposeful lives
- Peer support from others who have been there
- Flexibility and innovation at every step
- Inspiring hope to drive recovery

At Optum™, we put these principles into action every day, serving individuals and communities in 38 states. We're proud to partner with state, county, community, and provider stakeholders in their efforts to further individual recovery.



**Integrating from page 16**

- Michigan developed its long-term plan for systems integration using a cross-agency working committee. Michigan also developed clarifications for funding sources and availability to align funding goals.
- Pennsylvania's planning document to integrate services for co-occurring systems of care includes their vision, guiding principles, and strategies.

**Define Integrated Services and Treatment**

Once systems agree on a shared vision, it is important to define how services and treatment will be provided in an integrated way. Many states have found the following tools and resources helpful in defining integrated services and treatment:

- Integrated Treatment for Co-Occurring Disorders is a part of SAMHSA's Evidence-Based Practices KIT Series. Formerly called Integrated Dual Disorders Treatment, the model and corresponding benchmark measures are used in many states to guide mental health agencies in developing co-occurring capability. Dartmouth Psychiatric Research Center continues to test and enhance the model. Dartmouth has partnered with Hazelton to produce additional resources on this model. (<http://www.samhsa.gov/co-occurring/>

topics/healthcare-integration/codi-kit.aspx)

- Substance Abuse Treatment For Persons with Co-Occurring Disorders TIP 42 is a part of SAMHSA's Treatment Improvement Protocol (TIP) series. The protocol is used in many states to guide substance abuse treatment agencies in developing co-occurring capability and training practitioners. (<http://www.samhsa.gov/co-occurring/topics/healthcare-integration/tip42-codi.aspx>)
- Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Mental Health Treatment (DDCMHT) are process measures to guide addiction treatment settings in developing co-occurring capability. Parallel measures are available for mental health treatment settings. Agencies use these measures and the corresponding guides to identify strengths and weaknesses, create action plans and implement changes. (<http://www.samhsa.gov/co-occurring/topics/healthcare-integration/ddcat-ddcmht-index.aspx>)
- Comprehensive, Continuous, Integrated System of Care (CCISC) is a model that can be used by either mental health or substance abuse service organizations seeking to become co-occurring capable. The model is based on eight principles and includes 12 steps that promote systems, services and treatment integration. The guide for this model includes

tools for assessing organizational and practitioner competencies. (<http://www.samhsa.gov/co-occurring/topics/healthcare-integration/ccisc-model.aspx>)

**Establish Benchmarks And Measure Progress**

States have used these resources and tools to develop specific guidance and criteria for agencies and practitioners. Many states have adopted or adapted a combination of measures to set benchmarks and assess progress over time. States have used measures to:

- Determine which aspects of integrated treatment are already in place
- Define priorities for change
- Determine training needs
- Inform service planning by comparing progress between agencies
- Target resources

**Agencies use measures to:**

- Guide quality improvement
- Establish concrete action steps
- Provide feedback to practitioners
- Gauge progress over time

Defining integrated services and setting benchmarks helps states and agencies maintain a focus on the goals of integra-

tion. Demonstrating results using standardized measures also helps when building wide-spread consensus for integration and seeking new funding streams.

**Develop Infrastructure For Systems Integration**

Creating an integrated system of care for individuals with co-occurring mental health and substance abuse disorders requires states to examine policies, financing, program standards, licensing, performance measurement, and management information systems. Changes across these multiple levels provide a foundation to support practitioners in providing integrated services and treatment.

- Reviewing state statutes, policies, regulations and administrative rules (<http://www.samhsa.gov/co-occurring/topics/healthcare-integration/develop-infrastructure.aspx#statutes>)
- Making changes in financing or budget appropriations (<http://www.samhsa.gov/co-occurring/topics/healthcare-integration/develop-infrastructure.aspx#budget>)
- Developing interagency agreements and joint guidelines, policies and procedures (<http://www.samhsa.gov/co-occurring/topics/healthcare-integration/develop-infrastructure.aspx#agreements>)
- Refining management information systems

*see Integrating on page 32*



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## Hurricane Sandy Kids Need Substance Abuse Services

**By Fern A. Zagor, LCSW, ACSW  
President and CEO  
Staten Island Mental Health Society**

**T**he catastrophic destruction of property and psyche on Staten Island wrought by Hurricane Sandy last October devastated thousands of our residents. The monster waves and tidal surges that overwhelmed communities on the Island's East and South Shores destroyed 500 homes, sweeping some completely off their foundations, and sweeping away homeowners as well. Of the 43 New York City deaths related to Hurricane Sandy, 23 occurred on Staten Island, more than in any other borough.

We know that children and adolescents exposed to disasters such as this Superstorm, including even those whose families are not personally impacted, are at great risk of developing symptoms associated with Post-Traumatic Stress Disorder, which can dramatically affect the child's ability to function at home, at school, and with peers. We also know that intervention by qualified mental health professionals can head off or alleviate the syndrome, and that is part of our agency's mission.

Ironically but fortunately, the tragic aftermath of the storm gave the SIMHS new opportunities to mobilize and address the needs of our clients and others who suffered severe impacts. The fact that we are Staten Island's "go-to" agency for the highest quality mental health and related services for children - based on our more than 100 years of experience and achievements in the field - spurred private, foundation, and government funders to provide immediate grants that enabled us to reach out and begin to heal children and families. The predominant beneficiaries of services set in motion by these grants were children living on the South Shore whose lives were so disrupted when Hurricane Sandy created unprecedented turmoil in and out of their homes.

For example, the SIMHS was one of the first agencies recruited as a primary provider of crisis counseling for children, adults and families through Project Hope, a city/state/FEMA partnership; a federal Emergency Head Start grant enabled us to reopen our Dongan Hills Head Start Center, providing urgently needed counseling and other services to 57 preschoolers who had been displaced and traumatized; utilizing two private grants, we relaunched our Summer Therapeutic Program, with counseling, education, and recreation services benefitting 60 children ages 4 to 12 who suffered the storm's ill effects.

Still, one of the most serious and life-threatening of the hurricane's trauma-inducing impacts has been a dramatic increase in substance abuse among the Island's preteens, teens, and young adults.



**Fern A. Zagor, LCSW, ACSW**

Some background: For the last decade, Staten Island has been "Ground Zero" for adolescent substance abuse, with the highest rates of preteen and teenage alcohol and drug use - including OTC and prescription drugs - in New York City and State. This rate has truly reached epidemic proportions, with one death every nine days due to prescription drug overdoses. Adolescent substance abuse was particularly high on the Island's South Shore even before it was battered by the Superstorm, but in the past year, the problem has escalated even further.

Why? The psychological impact on youth and families who lived in the hard-hit areas of Staten Island has been devastating. Children reported seeing dead bodies floating past their windows. Families spent the night trapped in their houses or standing in water up to their necks. Individuals tried to swim to safety, and scores had to be rescued by the National Guard. As a consequence of these events, young people were more likely to experience PTSD, with its attendant nightmares, depression, aggression, acting out, and flashbacks. To cope with these emotional stressors, they often turned to alcohol and/or drugs and engaged in high-risk behaviors to numb their feelings. They also put themselves at great risk of developing ongoing substance abuse addictions.

As one of the only children's agencies in our borough licensed by the New York State Office of Alcohol and Substance Abuse Services, in support of our reputation as a long-time, respected provider of effective substance abuse services exclusively for disconnected and at-risk adolescents and young adults through our Teen Center, and as a successful provider of services for challenged youth transitioning into adulthood, the SIMHS is in the

forefront of designing new "rescue" services for this growing population of storm-trouble youth.

We are in the process of applying for funding to develop an innovative, one-year program that will work intensively with close to 100 youngsters, ages 14-24, living on the Island's Sandy-impacted South Shore who are exhibiting symptoms of stress-related substance abuse. The program would use the evidence-based, TIP (Transition to Independence Process) model that helps at-risk and high-risk youth function effectively within their communities by targeting the domains of school, work, peers and family, and helping the youth make the right choices by using the resources around them.

The targeted population of young people have voiced motivation for change, but immobilized by their reactions to the Superstorm, have not effectively engaged in any of the existing local substance abuse prevention or treatment programs. They do not successfully use available community resources that could provide them with healthy and positive alternatives, and they often begin to fail in school, a precursor to dropping out or unemployment.

Unlike most treatment models that focus on problems and weaknesses, the TIP approach builds on the strengths and interests of each participating youth. A key element of treatment is the Life Coach, who works with each youth on an intensive and individual basis to help develop and implement a feasible plan to reach personally identified goals. Recruiting available human resources, including family members, peers, significant others (school teachers, coaches, etc.), and other community resources/services, the Life Coach builds "virtual" teams focused on helping the young person move beyond the trauma and towards accomplishing his or her goals, which might include college, employment or vocational training.

The Life Coach would make personal contact with each young person, most likely in the home, or at an agreed-upon community location, often after school and on weekends. Working in tandem with the Life Coach, an SIMHS substance abuse specialist would employ evidence-based therapeutic techniques that are separate and distinct from adult services. These adolescent-centered techniques recognize alcoholism and substance abuse as potentially life-threatening diseases that create physical, psychological, and emotional suffering for young people and their families. Treatment stresses a "safe haven," a place where there is an empathetic, supportive relationship between the client and therapist, a personal plan to resist peer pressure, as well as group and family counseling with intensive participation by parents.

Referrals for our envisioned TIP-model program would come from community providers who have been unsuccessful in directing targeted youth and their families to community-based services. For example, SIMHS provides emotional health screenings on the College of Staten Island campus and will offer additional access to screening appropriate clients for referral. Grass roots groups will provide another source of referrals.

The SIMHS, in partnership with public and private funders, is grateful that we have been able to serve thousands of youthful trauma victims of Hurricane Sandy. They sought our help and we gave it. We understood and cared, we listened and talked, and they began to heal. This year and in 2014, we are confident that we will also be able to provide urgently needed services to the hundreds of youngsters who have turned to alcohol or drugs to cope with the emotional injuries inflicted by the storm, so they can heal completely and face the future with new confidence.



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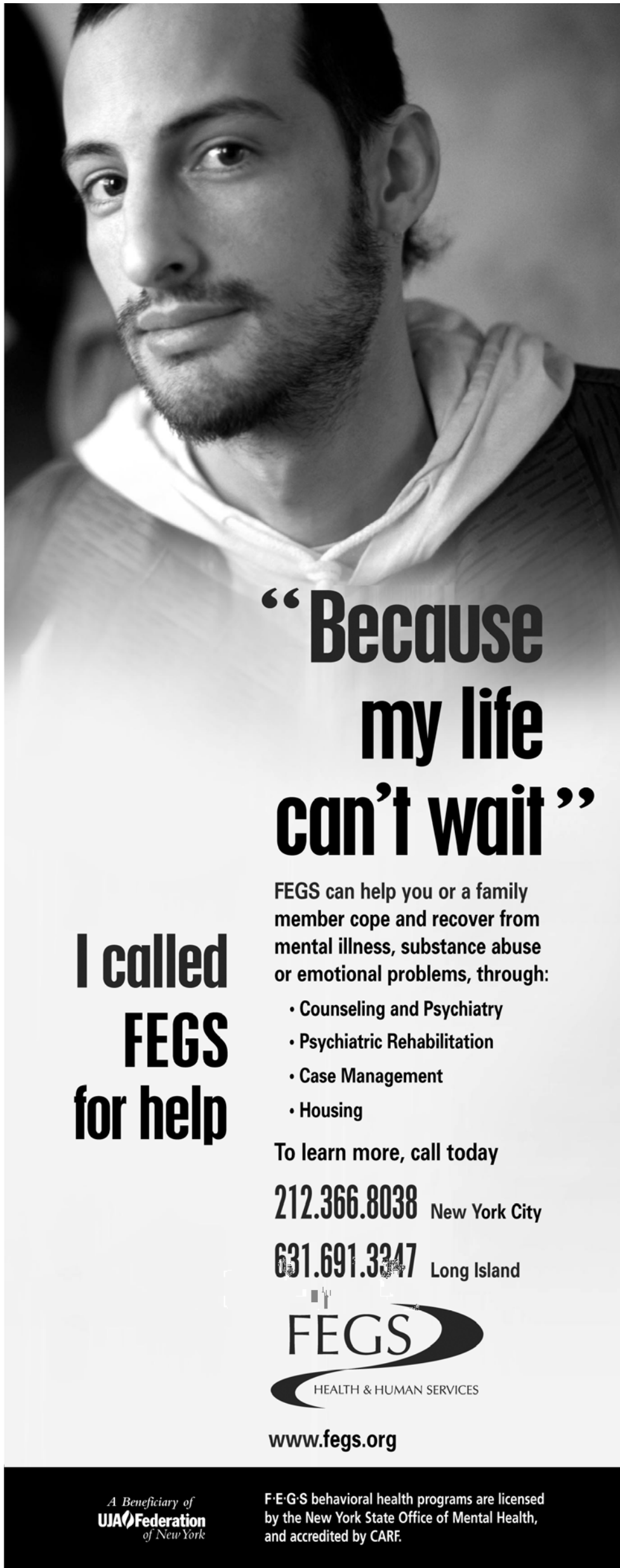
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(<http://www.samhsa.gov/co-occurring/topics/healthcare-integration/develop-infrastructure.aspx#information>)

#### Reviewing of State Statutes, Policies, Regulations, and Administrative Rules

Policy documents formalize a shared vision of integrated services and link this vision to particular standards and requirements. Examples include:

- The Connecticut Department of Mental Health and Addiction Services created a Commissioner's Policy Statement and Implementing Procedures which lays out definitions and guiding principles for the provision of services to individuals with co-occurring disorders. They also implemented a statewide requirement that all state-operated and department-funded mental health and addiction treatment programs administer standardized admission screenings. (<http://www.ct.gov/dmhas/lib/dmhas/policies/chapter6.4.pdf>)
- The Commissioner of the Maine Department of Health and Human Services established an integrated care policy requiring all agencies to be co-occurring capable. Language was also added to the MaineCare (Medicaid) regulations so that the definition of every relevant service, such as comprehensive assessments or intensive outpatient services, includes explicit mention of co-occurring disorders. (<http://www.maine.gov/dhhs/cosii/provider/documents.shtml>)
- Missouri has added co-occurring skills to its core certification requirements for agencies.

#### Making Changes in Financing Or Budget Appropriations

Systems may develop flexible funding streams by combining funding from multiple sources, such as federal block grant funds or state funding. SAMHSA has released a position statement with guidance on blending Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant funds to support services for individuals with co-occurring disorders. Other strategies include:

- Modifying Medicaid regulations regarding service definitions and billing codes so that co-occurring services are reimbursable
- Negotiating for Medicaid-managed care contracts to cover integrated care
- Creating performance-based contracts that align financial incentives/disincentives with system goals

Through contracts, systems can require specific service models and payments can be linked to performance. For example:

- In Illinois, separate state mental health and substance abuse treatment authorities provide cross-over funds to agencies in the other system so that they can extend their services to

include care for people with co-occurring disorders.

- Alaska incorporated language into requests for proposals and contracts that required agencies to develop action plans for integrating services.
- In South Carolina, service organizations can be reimbursed by Medicaid for screening for co-occurring disorders.

#### Developing Interagency Agreements and Joint Guidelines, Policies and Procedures

Interagency agreements or guidelines can spell out how agencies will work together. Areas of collaboration might include use of common

- Screening instruments
- Intake tools
- Data collection instruments
- Performance indicators

Agreements may also define the referral process and guidelines for sharing client information. Joint guidelines can ensure that agencies are using common practices to provide care. For example:

- In South Carolina, to comply with HIPAA requirements, the Departments of Mental Health and Alcohol and Other Drug Abuse Services have signed a Memorandum of Understanding to protect the confidentiality of protected health information. The agreement also defines guidelines for collecting and sharing de-identified data among the Departments to improve treatment. (<http://www.samhsa.gov/co-occurring/topics/healthcare-integration/develop-infrastructure.aspx#south-carolina-memo>)
- Maine has developed a resource manual outlining clinical guidelines for integrated care. It guides policy, programs, and staffing relating to provision of services. The guidelines address eleven different areas, including screening and assessment, client records, and integrated programming. (<http://www.ccsme.org/userfiles/files/ME%20Clinical%20Guidelines%202010.pdf>)
- The Arizona Department of Health Services has developed a Practice Protocol that outlines best practice guidelines for assessment, treatment, and psychopharmacology of individuals with co-occurring disorders. (<http://www.azdhs.gov/bhs/guidance/pph.pdf>)

#### Refining Management Information Systems

One key to sustaining integration efforts is refining or integrating management information systems across mental health and substance abuse agencies. Integrated management information systems help states to collect data on the following:

- Prevalence of co-occurring disorders within the state
- Needs of individuals with co-occurring disorders

*see Integrating on page 37*



## Food Addiction: Chemical Dependency's Twin

By Dianne Schwartz, CASAC, Director  
Food Addiction Treatment Services  
Realization Center

Most addicts start on the path to addiction using food as the first drug. The addict "to be" starts life with a genetic predisposition. Whatever was happening in the future addict's life to set him/her on the addiction journey (with this genetic vulnerability), happened at an early age. The young "Addict in Training" couldn't say to his/her family, "You're not meeting my needs, you're abusive or absent or nuts, I'm packing my bags to live with the Jones family down the street, they are a nice, warm, loving, open, nurturing, supportive, functional family."

Since the "Addict in Training" couldn't leave the situation, s/he needed a coping mechanism - and food was there! And it worked, to distract; to numb; to comfort; to fill the emptiness. And, most likely, the family was also using food for the same reasons. As the addict grows and finds "better living through chemistry," the food may or may not take a back seat. But it is always there.

Food addiction is not about weight, but about "using" a substance for distraction, for numbing feelings, for comfort, and for a mood change. Food addiction involves biological, psychological and social factors as does alcoholism/drug addiction.

When the addict comes into recovery, and puts down the alcohol/drugs, food, especially sugar and refined carbohydrates, still remains as a major coping tool. And, it most likely has been an important support for the addict to put down, and keep down, the alcohol and/or drugs and deal with/continue to medicate the emotional pain lurking underneath.

The addict views himself, as does the lay population and the treatment and recovery world as now switching to food. In reality, the addict is only returning to or continuing number one substance—the one that has been there the longest and is most deeply rooted.

Those with alcohol dependence and/or drug addiction commonly hit bottom with those substances before hitting bottom with their food addiction. What are your answers to the following questions: "Now that I'm sober and clean, is my eating out of control?" "I am concerned that I behave with food as I did with alcohol/drugs?" "Am I preoccupied with eating?"

Just visit any AA meeting with their serving of coffee and sugary bakery items, i.e., cookies, Danish, etc. The eating of sugar (as candy or chocolate) is also recommended in the "Big Book," (that's the pet name for "Alcoholics Anonymous," the text of AA).

The phenomenon of craving is the curse/scourge/tormentor of any addict. In order to deal with the cravings, the addict uses sugar (in any form) to satisfy the cravings. So a candy bar, cookie, sugary soda, etc. will help the addict not pick up a drug or a drink. The problem is that eating sweets/refined carbs satisfies the cravings only to have them return when, in processing the sugar/refined carbs, the body's glucose (blood sugar) levels start



Dianne Schwartz, CASAC

to plummet (crash) and the addict has to then get more sugar (or other quickly absorbed refined carbs) to bring blood sugar levels back up again.

That's why addicts gain weight in recovery. They are looking to the food to help them feel OK. Also note that smoking/nicotine is also a substance/behavior that works in the body in a similar fashion as sugar.

Many people with solid sobriety, actively recovering in AA or NA, have a lack of willingness to seek help in treatment or attend 12-Step food recovery focused fellowships (OA, FAA, CEA-HOW, FA). Often the key "rationale" for the resistance is that their compulsive eating (overeating, binge eating) is not thought of as an addiction or a serious medical disease. Even as those alcoholics and drug addicts have celebrated their recovery, there is often ongoing denial in them and others regarding the seriousness and impact of their "using food" to deal with their lives.

Their "disordered" eating behavior is justified, rationalized by the thoughts of "It's better than picking up a drink or a drug," "My weight is OK," "It's just a Twinkie, a candy bar, a soda, etc.," "I'm not doing anything illegal." For others, suffering is dealt with more secretly and silently—adding to the unmanageability and shame they already feel as a result of having food addiction.

There is also the general attitude in AA and NA, as in society in general, that those who have eating problems should just exercise a little more "will power." That is, there is an unwillingness or inability to apply the principle of "Step 1" (powerlessness and honesty) to their relationship with food: "Surely I'm powerless over drugs and alcohol, but eating is something I SHOULD be able to control."

There is much more denial within our society about the dangers of food addiction (eating disorders, especially compulsive overeating). It is much easier to blame fatalities on coronary artery disease or heart attack rather than food addiction, a disease that requires a recovery solution to keep it in remission, one day at a time.

If the food addiction is not concurrently treated, the addict is vulnerable to relapse and is short-changed in achieving a level of self-esteem in recovery that only emerges when a person is not "using" a substance to deal with life.

Cross-prevalence of food addiction with alcohol and drug addiction is high. Food addiction and chemical dependency are two sides of the same coin. Both are biologically based, affecting the reward pathways of the brain, and both are addictions that make a person's life unmanageable. And, it is common for addicts to switch back and forth between the behaviors.

We know that female food addicts who, as part of their illness, are preoccupied with their weight and body image and attempt to control their weight by dieting and in some cases purging. Some of these women, maybe starting in adolescence, as a form of purging, find and use alcohol, speed (amphetamines), cocaine or other stimulants which causes them to lose their appetite and to lose weight. What magic! But now, they have another problem—alcohol dependency and/or drug addiction! (That's what happened to me—and launched me into a 20 year addiction to amphetamines!) In some cases, these individuals jockey back and forth—using alcohol and/or drugs to not eat, and sometimes using the food to not drink or use drugs. What a trap!

Most observers of alcoholics and drug addicts and addicts themselves believe

that when they put down the alcohol and drugs their eating becomes more significant—less controllable—more important. I agree with this view but I disagree with the idea that the addict has now "switched" to food as his/her substance.

Since I believe that all addicts start on the road to addiction with using food as a substance before they find "better living through chemistry (alcohol and drugs)," I don't believe that when they put down the alcohol and drugs they then begin using food. The food has been there from the "get-go" and maybe took a "back burner" position when the addict discovered drugs and/or alcohol. When the addict comes into recovery and embraces sobriety, the food is there—and has been waiting patiently to be called to the forefront of the addict's need to deal with cravings and feelings.

Insofar as addiction is an issue of brain chemistry imbalance (see ASAM's latest definition of addiction), poor diet, deficient in essential nutrients, prevents the body from adequately producing important neurotransmitters. That's what precipitates the onset of anxiety and increases the urge to self-medicate.

Healthy diet, which tends to be overlooked by many traditional treatment programs and 12 Step fellowships, is one of the most crucial aspects of holistic recovery. Studies show that improper nutrition perpetuates the cycle of addiction.

see Food on page 37

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## Chris Copeland Named New Chief Operating Officer at ICL

Staff Writer  
Behavioral Health News

**T**he Institute of Community Living (ICL) has announced the promotion of Mr. Chris Copeland, LCSW to Chief Operating Officer (COO), effective immediately. Most recently, Mr. Copeland held the position of Acting COO, as well as Chief Program Officer until his promotion. He will continue to report to David Woodlock, ICL's President/CEO and the agency will begin actively interviewing replacement candidates for the Chief Program Officer position.

Mr. Copeland joined ICL in 2011 and served as the agency's Chief Program Officer (CPO) responsible for providing leadership and oversight support for all residential, clinical and homeless services programs. Chris will ensure that the agency continues to produce quality outcomes that meet the demand of the Triple AIM of: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

An experienced leader and innovator, Mr. Copeland brings to the position his over 30 years of clinical and administrative healthcare experience both in the United States and England. Prior to joining ICL, Mr. Copeland lived in Maine where he took on progressively more re-



**Chris Copeland, LCSW**

sponsible positions at the Tri-County Mental Health Services, before ultimately assuming the position of CEO. At Tri-County, he led the agency through a time of serious financial stress. Mr. Copeland's expertise in combining the need for fiscal responsibility with clinical excellence, particularly when funding and resources are severely compromised served the

agency well. Mr. Copeland was also very active at the state level and was subsequently voted President of the Maine Association of Mental Health Services.

Recognized for his expertise in identifying the role that trauma plays in the seeking and receiving of social and health care, and transforming service systems to be "trauma informed," Mr. Copeland has instituted the Trauma Informed Care initiative at ICL. His leadership in this endeavor has resulted in a myriad of successes for persons served. "I am eager to continue my work with the ICL Board of Directors, Executive Leadership Team and staff to ensure that the agency is prepared for the plethora of changes associated with managed care," asserts Copeland. "ICL has a rich and diverse history, one that is rooted in recovery and hope and I will endeavor to create opportunities for partnership and collaboration that serve our clients and their various supports well."

"ICL is grateful to have Chris as part of its leadership team. His commitment and innovative ideas helps ICL live out our motto that people can and do recover from developmental and emotional challenges and more and importantly, they *Get Better With Us*," says ICL President and CEO David Woodlock. "I look forward to collaborating with Chris in his new role to identify new approaches to advancing ICL's mission, vision and values and reaffirming our dedication to the field."

Mr. Copeland received his social work degree in England in 1985 where he worked in inner city projects and subsequently as an administrator for a psychiatric social work team at St James University Hospital in Leeds, England. He is married, has one son and has made his home in Queens, NY.

*Founded in 1986, the Institute for Community Living (ICL) is an award-winning, not-for-profit human services agency that provides physical and mental health care, family support, residential assistance, and treatment to almost 10,000 adults, families and children throughout New York City. ICL is a national leader in pioneering effective, evidence-based solutions and innovative treatments for people with psychiatric, intellectual, and developmental disabilities, providing integrated comprehensive care to help individuals struggling to overcome enormous obstacles and to improve communities by fostering acceptance, inclusion, and hope. ICL offers a comprehensive system of clinical treatment options and operates over 1,500 housing units, a Brooklyn shelter for women with mental illness, and a transitional residence for 243 veterans in Queens.*

*For more information about the Institute for Community Living, visit [www.ICLinc.org](http://www.ICLinc.org) or contact us at (212) 385-3030.*

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## SBIRT: Stopping Addiction Before it Starts

**By Howard P. Meitiner**  
President and CEO  
Phoenix House

**T**he facts are clear: in our country, there is an imminent need for substance abuse prevention and intervention as early in the teen years as possible. A recent study in the *Archives of General Psychiatry* found that the 15 percent of U.S. high school students who abuse drugs and alcohol began using at 14 or 15. "When the first exposure occurs in younger versus older adolescents," explains Professor Didier Jutras-Aswad of the University of Montreal, "the impact...seems to be worse in regard to many outcomes such as mental health, education attainment, delinquency and ability to conform to adult roles."

We know that kids who do not develop an addiction problem by age 21 are unlikely to become addicted later on. Plus, the adolescent brain continues to develop judgment and the ability to resist foolish or dangerous behavior until around age 25, which means that the teen and young adult years are a particularly vulnerable time for the risk-taking that often characterizes them.

Phoenix House, for more than 45 years, has been dealing with the consequences of drug use and addiction, and during that time teen drug use has continued to grow while the drugs of choice are always changing. According to a Gallup



**Howard P. Meitiner**

poll, 48 percent of Americans in 1968 deemed drug use a serious problem in their community; by 1995, 63 percent said it was a serious problem and an additional 31 percent called it a "crisis." As have other organizations, we have engaged in prevention efforts to try to minimize the impact of teen risk-taking and experimental attitudes towards substance use. Still, a truly effective solution has yet to be found and implemented on a national level.

Because of our commitment to prevention and early intervention, it was only natural that Phoenix House would offer Screening, Brief Intervention, and Referral to Treatment (SBIRT) programming as developed by the Substance Abuse and Mental Health Administration (SAMHSA). This protocol originated in emergency rooms, doctors' offices, and other clinical venues and it has been proven scientifically to be an effective tool for people who have substance use issues at various stages, whether they're thinking about using, just beginning to experiment, or have already escalated to problematic use. However, SBIRT primarily targets drinkers and drug users who are not yet chemically dependent, so that intervention can be provided before their substance use escalates to a level where extensive treatment is necessary.

Basically, SBIRT is about stopping serious substance abuse problems before they start, thereby saving lives and saving the healthcare system a great deal in preventable costs. It gets a "foot in the door" to educate and opens up a dialogue that can prevent experimentation and early use from leading to long-term damage. It also integrates substance abuse screening and treatment components into the larger-scale healthcare system, ensuring that an individual's substance use isn't interfering with any treatment he or she may be receiving for a medical issue such as diabetes. Overall, SBIRT has the potential to link community treatment services with a

network of intervention and referral activities in medical, educational, and social service settings.

Realizing the potential to leverage SBIRT from a prevention perspective, our clinicians at Phoenix House teamed up with the Philadelphia-based Treatment Research Institute (TRI) and the University of Pennsylvania (UPENN) to develop technology that assesses teens' and pre-teens' risk of substance use or abuse. Seeking to build on SAMHSA's work with SBIRT, we proceeded to introduce the delivery of SBIRT into two public schools in New York State.

We recognized that there would be many barriers to working within the school system since school funding is already scarce. So together with TRI, we funded an initial SBIRT test program at a school in Suffolk County, NY. The concept involved screening all students for substance use and abuse, evaluating results, and offering subsequent intervention if necessary. The program provided a confidential outpatient setting within the school that both students and faculty could take advantage of, and the results were extremely promising. Students were willing and excited participants. "The project has helped me in so many ways," one student told us. "It showed me how drugs affect me and the risk that I take if I do drugs."

As a result of our testing success, Phoenix House and TRI will implement a

*see SBIRT on page 37*

### *Family from page 18*

period is a critical goal. The fourth evidence-based practice, Motivational Enhancement Therapy (MET), is designed to improve retention of women who were pregnant entering treatment. The results of applying this practice are particularly heartening. Almost twice as many women who participated in MET remained in treatment for 30 days compared to pregnant women who enrolled in treatment in the three years prior to the implementation of this therapeutic model.

#### Data-Driven Results Support Efficacy of Intensive Residential Model

Over the course of the four-year HMHF grant, we served 150 women, 61 of whom were pregnant at the time of admission. Using intake and six-month follow-up screenings the data showed significant positive rates of change in all major areas measured. The largest increases at follow-up were observed in employment/education with one in three women in school or employed compared to one in 10 at intake (177 percent increase), and a 150 percent increase in abstinence. Criminal justice involvement was reduced, with 98 percent of women reporting no involvement at follow-up compared to 88 percent at intake, and almost 100 percent of participants reported improved social connectedness and no consequences of substance use.

The HMHF model has been effective at working with women to see a psychiatrist, if indicated at screening. This re-

sulted in an 83 percent increase in the number of women prescribed medication for psychological or emotional problems, and a significant improvement in participants' mental health, including a 40 percent reduction in depression, 18 percent reduction in anxiety, and 32 percent reduction in trouble understanding, concentrating or remembering. In addition, 60 percent of the women reported reduced trauma symptoms at follow-up and a 27percent reduction in difficulty controlling violent behavior.

#### Future Development of Best-Practice Substance Abuse and Mental Health Treatment

Odyssey House clinical experience points to the essential benefits of trauma-informed services when treating women with substance abuse and mental health disorders. The most effective model is a comprehensive service that screens and treats trauma-related symptoms using the following criteria:

All clients, especially women, should be screened and assessed for PTSD. Clients identified with histories of traumatic experience should receive treatment that explores the relationship between substance use/mental health disorders and the traumatic experience.

Evidence-based trauma-specific services should be incorporated into the program structure.

For further information on Odyssey House treatment services for women and children, please call: 212-987-5100, or write to: [info@odysseyhouseinc.org](mailto:info@odysseyhouseinc.org).

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**People from page 14**

social interventions to address them. Ignoring the powerful personal motives for using will subvert well-meaning efforts to support positive change.

#### Social Collusion with Addictive Dissociation

Might our culture's tendency to neglect or ignore the multiple meanings of addictive behavior actually collude with and reinforce it? If addictive behavior expresses meaningful aspects of the self that the user disowns, might the cultural ignorance of the disowned meaning support the disowning of meaning in the user? The relatively greater national emphasis on punishing and incarcerating drug users and sellers and trying to get drugs off the street, an absurd and impossible fantasy, rather than emphasizing treatment and education reflects this ignoring of the meaning dimension. The "drug war", against heroin in the 60s and 70s, crack in the 80s, crystal meth in the 90s, focused on the drug rather than the question of why are so many people drawn to these potentially devastating substances and other risky activities? I believe that in the minds and writings of addiction as brain disease advocates, their model does not preclude meaning but without an equally loud and clear proclamation that addictive behavior is meaningful activity, the brain disease statements can be interpreted to mean addictive be-

havior is a purely biological phenomenon that can be treated by purely biological methods: abstinence and medications.

So let's remember that people use substances initially and throughout their using careers for multiple meaningful reasons that must be understood and respected so that they can be brought into treatment in ways that make new solutions and modes of expression possible. This renders substance use less appealing and vital to the user and supports an integrative treatment approach that addresses all aspects of the person involved with problematic substance use.

*Dr. Tatarsky is Founder and Director of the Center for Optimal Living in NYC, a treatment and professional training center based on Integrative Harm Reduction Therapy (IHRP) for the spectrum of substance misuse and other high-risk behaviors. He is a Clinical Advisor to the Office of Alcoholism and Substance Abuse Services of New York State, Founding board member and President-Elect of the Division on Addiction of New York State Psychological Association, Chairman of the Board of Moderation Management Network, founding board member of Association for Harm Reduction Therapy and Chairman of Mental Health Professionals in Harm Reduction and Faculty, Advanced Specialization in Family and Couple Therapy, The Post-doctoral Program in Psychotherapy and Psychoanalysis, New York University. This article was reprinted from Professional Voices on thefix.com, October 12, 2012.*

**Childhood from page 6**

children in other systems to improve services to these children and their families in a more coordinated way.

NYC DOHMH recognizes the importance of ensuring the youngest children with mental health needs are

able to get their needs met as early as possible. As the body of science grows and there is increasing awareness of the mental health needs of young children and their families, we are continuously striving to meet the needs of the youngest New Yorkers and their families.

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**OASAS from page 4**

treatment community's ability to provide "person-centered" care. Person-centered and person-directed practices have allowed us to find a common language and understanding of the treatment of patients that has moved the fields of substance use disorder (SUD) and mental health (MH) treatment together in the same direction. Evidence-based or promising practices have become the standard of care in both SUD and MH treatment, and together with the movement towards recovery-oriented care, we have laid the foundation for our continued movement toward more effective care.

We at OASAS have worked to improve the addiction field's understanding of mental health issues. We now know that 60 to 80% of patients have co-occurring mental health issues. We have encouraged our programs to use mental health screening tools like the Modified Mini to identify potential co-occurring issues. At OASAS, training on the treatment of mental health and substance use disorder is a priority. We recognize that improving the outcomes for our population with multiple issues is an important responsibility.

**Pregnancy from page 13**

The use of alcohol screening and brief intervention (SBI) to address risky drinking has been endorsed by the U.S. Preventative Services Task Force. For pregnant women, any amount of alcohol would be considered risky behavior. The elements in effective brief interventions are generally consistent with the 5-A's approach (assess, advise, agree, assist, arrange) to behavioral counseling interventions adopted by the Task Force in 2004. There are several evidence-based screening tools that have been validated for use with women and pregnant women. SBI can be administered easily, effec-

**Outpatient from page 26**

(Washton, 1999). They help members become better therapy clients.

Community meetings are often parts of these programs and provide roles and jobs (e.g., making coffee, community leader) for people in order to connect to the community. These roles help members who may not be as comfortable with verbal processing and facilitate greater connection to the community. The roles have therapeutic value and can allow members to build a sense of responsibility in their lives and to their community.

There are always ways that these programs can get problematic. As op-

**SBIRT from page 35**

privately funded second phase of our SBIRT program in order to ensure support for this protocol from the key government health and education stakeholders. We believe this phase will prove that this adaptation of SBIRT can succeed with three-fold benefits (educational, medical, reduction in addiction), rendering it an extremely sensible and worthy investment.

The success of SBIRT is, and will continue to be, multifaceted. Phoenix

**Recovery**

Along with prevention and treatment, recovery is the third and equally important part of OASAS' approach to providing behavioral health services for people suffering with substance abuse disorders.

Recently, the treatment community has focused on developing a recovery-oriented system of care (ROSC). This hopeful new treatment technique involves changing from the current recovery approach, which treats addiction and mental illnesses as acute crises, to understanding that recovery is a journey which often requires long-term supports and services, particularly for those with co-occurring issues.

OASAS also supports the training of peer-based recovery coaches and participates in public awareness efforts such as celebrating Recovery Month each September.

The field of behavioral health is changing rapidly as the Affordable Care Act and Governor Cuomo's Medicaid Redesign Team's policies are implemented. OASAS is responding to this climate and will continue to deliver prevention, treatment and recovery services to provide a better quality of life for the people of New York.

tively, and fairly quickly within a diversity of health care settings. Implementation of the Affordable Care Act includes coverage of certain preventive health services, including alcohol screening women who are pregnant or trying to get pregnant.

The federal government, through the Substance Abuse Services Mental Health Administration (SAMHSA) FASD Center for Excellence, is currently working with states and local communities to spread the implementation of these two evidence-based strategies. These efforts will go a long way in our efforts to reduce the prevalence of Fetal Alcohol Spectrum Disorders in our society.

posed to traditional group therapy where clients often do not connect outside of group, clients in programs may interact in ways that are concerning such as using together, having sexual and romantic attachments, as well as financial ones. In my experience, the pros of these programs outweigh the possible problems. When assessing new clients, a question of the level of support and structure a client needs is as important as assessing psychiatric issues, legal and vocational issues. When clients are in need of greater support, these intensive programs may provide the support, the repetition, and variety of care that people may need.

House invested in this program because we believe in the youth of this country, and because we take it as our responsibility to promote positive change. In the words of Steve Jobs, "You have to be burning with an idea, or a problem, or a wrong you want to right. If you're not passionate enough from the start, you'll never stick it out." The substance abuse crisis among teens in our country is a wrong that we want to right. We in the treatment field must have the passion to see it through.

**Food from page 33**

In addition, chemical dependency combined with poor diet can wreak havoc on the immune system and lead to emotional turmoil. In order to restore healthy brain function, it is imperative that harmful junk foods, sugar, caffeine and starches be removed from the person's diet.

A growing number of experts readily agree on the fact that biochemical intervention (proper diet along with supplements, i.e., vitamins, minerals, and essential fatty acids) has the power to heal the root symptoms of chemical dependency, i.e., depression, anxiety, sleep problems, mood swings, etc. There is much evidence that biochemical repair leads to a dramatic drop in the addict's symptoms and diminishes the likelihood of relapse—which is common among recipients of traditional treatment approaches.

Also, it important for the "recovering" chemically addicted person to know that often their symptoms of depression, anxiety, mood swings, low energy and sleep disturbances will, in time, abate with abstinence from alcohol and drugs, abstinence from over/undereating by following a structured food plan that normalizes blood sugar levels, moderate exercise and sufficient sleep.

Often these symptoms are direct biological consequences of the alcohol/drugs rather than symptoms of an underlying psychological condition.

It's a sad reality that the brain is being damaged during drug/alcohol use. But the brain has an amazing ability to repair itself—with the help of good self-care.

Clinicians agree that compulsive behaviors for both chemicals and food must be addressed for a person to achieve and maintain recovery from chemical dependency. Most also agree that the chemical addiction must be tackled first, unless the

eating problems are so severe that the person requires immediate medical attention. "Most people think the best way to treat someone with both problems is to address the problems concurrently," says Elke Eckert, MD, professor of psychiatry and director the Eating Disorders Clinic at the University of Minnesota. "Yet you can't treat the eating disorder without first dealing with the chemical issues. It doesn't work. If people are using substances, they are not cognitively aware enough to deal their eating disorder. If they are still using chemicals, that [the work involved in food recovery] all goes out the window."

At Realization Center, clients focus on their chemical dependency first, but they also begin learning about how their chemical use and food addiction are connected. Food addiction does not cause chemical dependency, nor does chemical dependency cause food addiction, but the two aggravate each other and may contribute to dual relapse. Our clients learn that for "True Recovery," their eating behaviors must be addressed.

*Dianne Schwartz developed and has been the Director of the Food Addiction Treatment Program at Realization Center for 18 years. She provides weekly psychoeducation series to all clients on the relationship between food addiction and chemical dependency and the importance of changing/improving eating patterns for relapse prevention and improving overall functioning. Dianne has presented numerous times at trainings to various treatment facilities and presentations to Community Organizations on Eating Disorders. She mostly recently presented at the NASW - 45th Annual Addictions Institute - Innovations in Addictions Treatment Conference: "Exploring the Real Culprits in Food Addiction - It's Not Broccoli!!"*

**Integrating from page 32**

- Services provided to individuals with co-occurring disorders across systems
- Outcomes
- Cost of treatment

Refinements to management information systems include coding data to allow cross-system comparisons, developing capacity to share information across systems and establishing data elements that specifically identify co-occurring disorder services.

**BHO from page 29**

Through this unique collaboration the Optum NYC BHO, Kingsboro and Baltic Street are integrating peer specialists into the inpatient multi-disciplinary teams. The peer begins engaging and working with individuals while on the unit and continues this work into the community. Peer Support Services can be particularly effective at engaging people with necessary services, helping to activate them for effective illness self-care, and promoting long-term recovery goals and strategies.

The mission of the peer program has been to support, encourage, and foster wellness and recovery through a supportive community. As an active member of the supportive community, the peer specialist helps the participant establish healthy community connections. They engage people and provide community-based supports including transporting participants to the food pantry, doctors' appointments, the pharmacy and parole or probation. Participants have indicated high

levels of support and satisfaction for this program, and have reported that the peer specialist's accessibility, active support and problem solving had helped prevent additional hospitalizations and the need for crisis services, and in some cases even the violation of conditions of probation.

Optum supports services for people with substance use and mental health conditions that are designed to be person-centered, strength-based, and recovery-oriented. This care must span the full continuum of needs that individuals have, and make successful health outcomes a priority. This is accomplished by helping to assure that people get the care that is necessary, at the appropriate level of service and setting, and engages them in the design and implementation of treatment and recovery plans that focus on the individual. Individually, the Kingsboro and Baltic Street programs are examples of these types of services. Together with Optum, their collaboration promotes a full continuum of resources and assures favorable recovery-focused outcomes.

### Connection from page 24

at any time across the life span. Most common causes are falls, motor vehicle accidents, assaults, or stroke. TBI has become known as the “signature injury” of the Iraq and Afghanistan wars and has raised awareness of this disability, which affects 5.3 million Americans according to the CDC. Individuals with DD/ID may begin using substances to fit in and make friends but are often manipulated in these situations. Individuals with TBI may increase their substance use or begin using in an attempt to cope with changes following an acquired disability. While individuals with DD/ID are born with and face a lifetime of learning difficulties and problems integrating into the community, individuals with TBI have years if not decades of normative development which can change in a matter of seconds. Loss of abilities, intellect, place in the world, and identity are common.

Individuals with either DD/ID or TBI frequently present with a multitude of other disabilities including mental health care needs, seizure disorder, movement/gait difficulties, and aphasia or other language disabilities. Without necessary accommodations individuals with cognitive support needs may not have treatment needs fully addressed and are less likely to be successful in recovery. Providers unaware of the modifications that can be offered or unfamiliar with how to implement such modifications may feel less confident about treating both these groups of individuals. Attitudes can become their own barrier.

Accommodations which are beneficial to both our populations address the way information is presented, length of time to complete treatment, openness to redefining success, and extra doses of patience on the part of clinicians/counselors. Specific intervention modifications being used include being concise, defining words and avoiding use of abstract language or concepts, using visual cue, picture icons, maps, and diagrams for people

with reading problems, repetition breaking down complex information, summarizing statements and asking clients’ to list key points to check on their comprehension, and behavioral rehearsal of new recovery coping skills. Amount of time in treatment needed to attain abstinence and connect with community supports is likely longer and it is important for regulatory agencies and insurers to be flexible and understanding. Success is often measured in small steps and changes that demonstrate evolving new patterns of behavior, use of relapse prevention strategies, or understanding a trigger. Making a call to a friend, going to a new store that does not sell beer, walking on the other side of the street to avoid the dealer or keeping appointments for services are all celebrated.

**DD/ID: Adaptive Recovery Model (ARM)**—In order to support cognitive limitations in insight and comprehension of psychoeducational materials used by traditional treatment providers, this approach focuses on changing behaviors through establishing daily routines to support sobriety and abstinence (Annand, J. 2002). Progress may be measured by the proportion of abstinent days to days used rather than an initial emphasis on complete abstinence. Treatment follows four distinct phases and the client’s natural supports should be incorporated to the extent possible to help generalize and reinforce positive behavioral changes. Individuals with ID/DD face frequent failures and may cover up their difficulties to avoid embarrassment and deflect negative reactions from others. The ARM approach builds in success through repetition, introducing activities that are highly likely to yield success, and presenting information broken down into readily understood bits over brief time intervals due to reduced attention span. Rather than focusing on reflection and self-exploration or inventories, the emphasis is on behavior and *doing*.

The ARM approach uses worksheets to develop a 24 hour plan filled with activities that counter using, and a series of exercises that develop an awareness of

causes and effects of AOD use for the individual. In addition to the accommodations noted above, the use of worksheets and structured recovery plans is integral to the treatment approach (Annand, Jerry, 2002). The ARM approach is the organizing process for our recovery treatment.

Creative arts and drama therapy are interwoven throughout sessions to enhance nonverbal communication in order to assess feelings and thoughts that may be difficult for clients to label or otherwise communicate. Certified creative arts therapists are key members of the multidisciplinary team.

**TBI:** A fully integrated treatment approach for individuals with substance use disorders and TBI needs to be comprehensive in its scope. Three key components recommended are the use of modified treatment interventions to accommodate disabilities due to TBI, psychoeducation about TBI and coping with its changes, and psychoeducation about substance use after TBI.

Psychoeducation about TBI includes basic brain anatomy and functions and physical/cognitive/emotional changes likely to occur after TBI. Support around adjustment to disability and the significant changes in sense of self and lifestyle which typically follow TBI is anticipated and offered. The importance of peer support available in groups which permits psychosocial adjustment to a shared disability and experience cannot be underestimated.

Equally important is the use of compensatory strategies for memory, language, and problem-solving difficulties which occur commonly after TBI. Many clients are exposed to these strategies for the first time while others who have completed extensive rehabilitation and benefit from a review and reinforcement of the continuing use of these strategies. Compensatory strategies, meant to be used as tools to get around post-TBI cognitive difficulties, should be presented to group members and embedded in all aspects of treatment by the counselor or clinician. A

sampling of strategies includes: datebooks, calendars, cell phones to record appointments, notebook to log important information and notes from groups or individual counseling sessions, wristwatch alarms as reminders to take medication, go to appointments/sessions, post-its or written notes, and tools to recall names (i.e., association, rhymes, visual imagery). These strategies are considered both best practices and are evidenced based (Brain Injury Association of America: Cognitive Rehabilitation—The Evidence, Funding, and Case for Advocacy on Brain Injury 2006), Society for Cognitive Rehabilitation: Recommendations for Best Practices: Acquired Brain Injury, 2004, NIH Consensus Statement on Brain Injury Rehabilitation, 1998).

Alcohol and other drug use pose unique risks for individuals who have acquired brain injuries. Providing information about the risks can be both preventative and therapeutic particularly for those still using as a motivation to move ahead in stages of change. For individuals who acquire their TBI as a direct result of substance use, for example, a cocaine related stroke or alcohol induced Wernicke’s syndrome, psychoeducation enhances understanding about their choices and potential consequences. All clients with AOD history can benefit from information about other risk factors. Among known risks increased danger of additional brain injury and increased potency of substances on the injured brain (Corrigan, John, 1999, 2010; Ohio Valley Center for Brain Injury Prevention). Memory problems and difficulties with social skills or self-reflection can be due to TBI, even when intelligence is unaffected. It is vital that clinicians/counselors appreciate their origin and these should not be addressed as resistance or denial.

*For technical assistance and a list of resources, please contact Barbara Caddler, LCSW, CASAC, Director of Sobriety Services, Access Community Health Center, New York, NY 212-780-2570*

### Pain from page 28

became overwhelming. She was hoping that this pain clinic would find a way to treat her pain without opiates. Then she would go into rehab, she said, to get clean. I could see the emotional toll that unrelieved pain had taken on her. I marveled that she still had hope.

Yes, it is true that some people take prescription painkillers to get high, but a great many people who become addicted are just trying to live with pain. Modern medicine has a long way to go to help them.

The problem of pain has not gone unnoticed, of course. In fact, the Affordable Care Act (aka Obamacare) required the Institute of Medicine to do a study about pain and its treatment. The results were reported in 2011<sup>(5)</sup> and were quite startling. Over 100 million Americans suffer from “chronic” pain, according to the report. That’s one in three Americans.

I found this very hard to believe at first, but when I thought about the number of people with chronic or recurrent back problems, arthritis, neuropathic pain in their feet, etc. and when I thought about the number of ads on TV for over-the-counter painkillers, it began to seem plausible that one in three people live with pain.

Not, however, the kind, the intensity, or frequency of pain for which opiates are (or seem to be) necessary. Over the counter painkillers, non-steroid anti-inflammatory drugs (NSAIDs), steroids, anti-depressants, and other medications can relieve pain for some people some of the time. Stretching and exercise can also relieve pain. People in pain and their physicians should try these before opiates. When they jump to opiates too quickly or in excessive amounts, addiction is a real and unnecessary risk.

So, yes too many prescription painkillers are used when alternatives may work. And, yes, physicians need to be far more cautious about prescribing them. But physicians also need to take pain seriously and learn how to help their patients to deal with it.

*This general truth may be all the more important in the treatment of people with serious mental illness who are, one has to believe, more likely to be living with pain than people without serious mental illness.*

Why? Because they are more likely to have histories of physical trauma, more likely to be victims of violent crime, more likely to have severe physical illnesses, and more likely not to have adequate healthcare.

In addition, there is some evidence that primary care physicians are more likely to prescribe opiates for pain for people with serious mental illness than for people who are not mentally ill.<sup>(6)</sup>

So it may be that people with serious mental illness are somewhat more likely than others to be addicted to opiates, not to get high, but to deal with terrible physical pain.

It’s distressing, it seems to me, that this is not a common topic of conversation in discussions of co-occurring mental and substance use disorders. We talk frequently about self-medication to cope with emotional distress; but I have almost never heard talk about people with serious mental illness becoming addicted to opiates because they suffer from severe physical pain.

I am convinced that addressing physical pain is critical for many people who have a serious mental illness, but I am also convinced that addressing physical pain more effectively is critical to effectively deal with the growing problem of addiction to, and overdose deaths from, prescription painkillers. Just blaming doctors for poor prescribing practices will not bring about the kind of change that is necessary to reduce the abuse of these

drugs, which can be a savior or much too much of a good thing.

*Michael B. Friedman retired in 2010. At the time, he was Director of The Center for Mental Health Policy, Advocacy, and Education of the Mental Health Association of New York City. Currently, he is Adjunct Associate Professor at Columbia University School of Social Work. He can be reached at [mfb395@columbia.edu](mailto:mfb395@columbia.edu).*

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