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WINTER 2017

FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

VOL. 4 NO. 2

Transforming Systems of Care for Children

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

Although frustrated efforts to build collaborative systems go back to Biblical times (think Tower of Babel), the specific form of collaboration known as “system of care for children and adolescents with serious emotional disturbance” (SOC) goes back only about 35 years. It has been at the heart of child mental health policy in the United States ever since.

But recently, and especially since the passage of the Affordable Care Act (ACA), ambitious new goals for child mental health have emerged, emphasizing hopes to prevent emotional disturbance and to serve all children and adolescents with emotional struggles, not just those whose functioning is already quite limited.

Have these ambitious new undertakings made SOC largely irrelevant? Would it matter if it were displaced?

I am not at all sure what the answers are. On the one hand, SOC rests on im-



portant values that need to be preserved. On the other hand, even after 35 years, systems of care do not exist or exist only partially in most localities in the United States. Perhaps the goal of service integration will be more broadly achieved

through new managed care structures that are now being planned.

Perhaps, but the new ideas are untested, and what we can imagine is always better than what we can achieve in reality. We will have to see what unfolds.

Background

The concept of systems of care for children and adolescents goes back to 1982 when Jane Knitzer published *Unclaimed Children*.¹ She maintained that a significant majority of children and adolescents with serious emotional disturbance do not get the treatment they need and that the care they get is dysfunctionally fragmented among various child-serving systems, including mental health, education, child welfare, juvenile justice, pediatrics, developmental disabilities, and more. The solution—build local systems of care that bring together the various child-serving systems to work cooperatively to help children and adolescents with serious emotional disturbance and their families.

The idea caught on quickly. In 1983, the National Institute of Mental Health began the Child and Adolescent Service System Program (CAASP). In 1984 Congress provided a bit of funding. In 1986, the federal Comprehensive Mental Health

see *Systems* on page 34

Re-Visioning Residential Treatment Facilities in a Managed Care World

By Ann Marie T. Sullivan, MD,
Commissioner, and Donna Bradbury,
MA, LMHC, Associate Commissioner,
Division of Integrated Community
Services for Children and Families,
New York State Office of Mental Health

It wasn't long ago that the only options available for intensive treatment of children and youth with severe emotional and behavioral problems were inpatient hospitals or residential care. Before the creation and expansion of community-based mental health services, some children spent many months or years of their lives in a hospital or a “home for children,” separated from their families, schools, and communities.

The availability of community-based services for those with social, emotional, and behavioral problems was not present until President Kennedy signed into law the Community Mental Health Act in 1963. This led to the creation of Community Mental Health Centers and made it possible for children as well as adults to receive treatment in the community rather

than in a hospital. As these services took hold over the years, there was a collective realization that, not only are these community-based services more affordable, they also provide good clinical outcomes and quality of life for youth and their families. But there just weren't quite enough of these services to meet all the needs, so institutions continued to fill the gap.

Over the years, the NYS Office of Mental Health has worked toward filling that gap with an array of community-based services for children and adults. For children, we have a range of services including outpatient clinics, family support, day treatment, and community residences. We were also one of the first states to offer Home and Community Based Services (HCBS) through a Medicaid Waiver. The HCBS Waiver provides children and youth at risk of institutionalization with care coordination and support services designed specifically to keep them at home, in the community. Over the past ten years, we have seized various opportunities to invest new money, and reinvest money from the closure of hospital beds, to grow the HCBS Waiver pro-

gram, providing even more opportunity for youth to get the supports they need without going to a hospital or into residential services. In addition, our HCBS services form the foundation on which we are building a redesigned children's behavioral health system in preparation for the transition to Medicaid managed care.

In the 1980's, Residential Treatment Facilities (RTF) were added to the service array as an option for offering residential services to children and youth with severe mental health problems. In some instances, RTF can be an alternative to hospitalization, but more often it is used as a step-down for children and youth recently discharged from inpatient psychiatric treatment.

The NYS Office of Mental Health defines Residential Treatment Facility as an inpatient psychiatric facility that provides comprehensive mental health treatment for children and adolescents between the ages of 5-21. RTFs are certified by OMH to provide comprehensive mental and primary health care services including but not limited to: case coordination services, verbal therapies, medication therapy, thera-

peutic recreation services, task and skill building vocational training, creative arts therapy, and on-campus school program. The objective of the program is to help a child improve his or her daily functioning, develop coping skills, support the family, and to develop or strengthen community linkages and supports.

While for many years, the RTFs have provided very good care and have helped many children and families, the current research indicates highly effective outcomes can be associated with real access to community supports, meaningful integration into the community, and family involvement in treatment. The current RTF model, including programmatic, regulatory, and reimbursement aspects, can and should be modified to facilitate providers' continued success in meeting the needs of children and families.

Despite the evidence that keeping children in the community whenever possible is desirable, the reality is that, today, children and youth and their families don't always get the help they need in order to

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Theme & Deadline Calendar

Behavioral Health News Theme and Deadline Calendar

Spring 2017 Issue:
“System Reform - Progress Report”
 Deadline: January 1, 2017

Summer 2017 Issue:
“Meeting the Needs of Our Vulnerable Populations”
 Deadline: April 1, 2017

Fall 2017 Issue:
“The Vital Role of Housing in the Recovery Process”
 Deadline: July 1, 2017

Winter 2018 Issue:
“Addressing the Opioid and Suicide Epidemics”
 Deadline: October 1, 2017

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Transforming the Medicaid System of Care for Youth and Their Families in New York

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

Like many states, New York's system of care for children had developed into a system of silos. Substance Abuse, Mental Health, Foster Care and Healthcare each had their own domains with specialized services, Federal waivers and cultures. To further complicate the situation, the educational system had its own array of services. However, while the various systems were frequently treating the same issues (substance abuse, parent/child conflict, emotional disorders and school problems, etc.) they rarely worked together.

The problem was that the kids' issues weren't mutually exclusive. Many youth experienced substance use problems as well as mental health issues, both impacting family and school. But as families chose a system (SUD, MH, Foster Care) to access help, they were often limited to the services that system offered. Within the systems there was little knowledge of what other systems offered. Many specialized services were only available if you were in the right system.

Parents, Youth and Advocates have long complained that the silo-ed systems did not provide the full range of care that the children and families actually needed. For example, a youth engaged in services in the Substance Use system could not access needed specialized services that were only available to youth enrolled in a Mental Health waiver program. Without access to appropriate services, the youth's ability to recover was impeded.

As part of Governor Andrew M. Cuomo's Medicaid Redesign effort, the state agencies responsible for working with youth in their systems were charged with the mission of creating a better, more integrated system of care. These agencies include the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the State Office of Mental Health (OMH), its Office of Children and Family Services (OCFS) and the NYS Department of Health (DOH). This led to unprecedented cooperation among the various state agencies, including formation of an inter-agency workgroup that has met weekly for a number of years to develop and implement a new model and has held regular meetings with advocacy groups and consumers to ensure their input into the design.

The essential goal of the new model is to keep children on their developmental trajectory by: (1) Identifying needs early; (2) Maintaining the child at home with support and services; (3) Maintaining the child in the community, in least restrictive settings; and (4) Preventing longer term need for higher end services. The model incorporates:

- *Moving all Mental Health and Substance Abuse services into the Medicaid Managed Care benefit package.* In mov-



NYS OASAS Commissioner Arlene González-Sánchez at the August 25, 2016 Grand Opening of Creative Connections Clubhouse, a First-of-its-Kind Recovery Center For Teens and Young Adults Located in Amsterdam, New York

ing all of the services into Managed Care, we can achieve better care coordination, monitor progress and establish provider accountability for care. Under the previous fee for service system, the lack of coordination and accountability led to higher costs while children frequently experienced worsening of their conditions. When services are covered by the plan, Managed Care companies become financially and contractually responsible for the well-being of the children. Further, through contracts and payment arrangements, Managed Care companies can hold providers accountable for the outcomes of their services.

- *Implementation of Children's Health Homes.* Health Homes will serve youth who have significant physical and/or behavioral health needs. The care management delivered by the health homes is designed to ensure that the youth have access to needed services and that they are actually receiving those services. The care manager can coordinate across systems to develop treatment plans that address all of the youth's needs and the necessary services. Depending on the youth's/family's needs, varying intensities of care management services are available.

- *Consolidating 5 separate waiver programs into one array of new State Plan services and Home and Community Based Services (HCBS).* New York's system of 5 waiver programs has been very complicated. Families frequently complained that it was almost impossible to negotiate the system and access these services. By consolidating the waiver programs, New York will expand services and facilitate access. Access will now be based on need alone, rather than on whether a youth has enrolled in a program in the proper system. Six new State Plan services represent some of the most frequently needed interventions that will be available to all Medicaid eligible children. The new services include Crisis Intervention, Community Psychiatric Supports and Treatment (CPST), Psychosocial Rehabilitation, family and youth peer supports ser-

vices and Other Licensed Practitioners. Additional HCBS services are higher need interventions that will be available to children/families that meet eligibility criteria. These HCBS services will span all of the NYS systems of care rather than being linked to just one. Included in the HCBS array are respite care, caregiver/family support Services, day habilitation, pre-vocational services, skill building, supported employment, non-medical transportation, community advocacy and support, palliative care, adaptive/assistive equipment, accessibility modifications, customized goods and services and HCBS Home care coordination.

- *Development of a "universal" functional assessment tool.* New York has worked with the developer of the Child and Adolescent Needs and Strengths assessment tool to develop the CANS-NY. The CANS, developed by Dr. John Lyons, has been the national standard in functional assessments for youth. Long used in New York, the tool has been modified for two purposes. First, to determine HCBS service need/eligibility. It differentiates among Level of Care (LOC) children who are at imminent risk of institutionalization, Level of Need (LON) children who have significant impairment but not at imminent risk of institutionalization, and children who fall below those thresholds. Second, the CANS-NY will determine the level of care management intensity needed within the Health Home program.

- *Focus on Family.* One of the most consistent concerns from family members is that they are not included in the decisions made about their children. They believe that their input and perspective is not valued, and that their needs for support are not considered. A significant component of NY's system redesign is to recognize the importance of the family in the healing process. Expectations about including family members in treatment decisions made by treatment providers and care managers are key to the children's redesign model. There are also services specifically for the family, including family peer

support, HCBS caregiver/family support services, and respite care.

In addition to the changes occurring in services generally available to youth and their families, the array of available Substance Abuse services in New York are also undergoing a great transition.

Residential Redesign. New York is proud of its extensive system of residential services. These programs have long provided a vital part of the treatment continuum. Frequently based on traditional therapeutic communities, NY's residential programs often relied on senior residents to lead much of the programming. Traditionally, the staffing models did not allow for various clinical, nursing and medical services that could meet the needs of the population's growing complexity. Given the changing landscape in substance use treatment and increasing recognition of the need for a more comprehensive continuum of care, a new intensity based model was developed that identified three levels of residential services; stabilization, rehabilitation and reintegration. The Stabilization level is designed to address individuals who may be experiencing physical and/or emotional instability. This is accomplished by adding clinical, nursing, and medical staffing to the model. The second level, Rehabilitation is focused on preparing the individual to develop strong recovery skills for daily use. The clinical/medical/nursing services are less intensive at this level. The third level, Community Reintegration focuses on engaging the individual in community activities (work, schooling, recreation, etc.) while maintaining a safe living environment. At this level, residents receive any necessary clinical and medical services in the community.

This new residential model will be used for adolescent services also. A key feature of the model is that individuals do not have to go through each level, step by step. An assessment of the persons needs will determine which of the three levels is most appropriate when an individual present for treatment and how long a person stays in a particular setting.

In Community Services. New York has a vast system of ambulatory community based outpatient programs that have served the needs of youth and their families. With the shift of SUD services into a managed care environment, NY submitted a state plan amendment adding community based ambulatory rehabilitative services. These services will be delivered by NY's certified clinic providers both within their traditional clinic settings and within the community.

Implementation of a new Level of Care (LOCADTR) tool for SUD services. Through our experience with Managed Care it became clear that a more transparent process for determining level of care for SUD services was needed. One of the complications in this process is that the levels of care operating under NYS

see Medicaid on page 35

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The NYSPA Report: Transforming Systems of Care for Children

By Victor Fornari, MD
and David Kaye, MD

Children's mental health needs are widespread and treatment is often limited and inadequate. Epidemiologic studies report that 20% of children and adolescents have a psychiatric disorder, and 10% have severe impairment. This translates to 1 million children and adolescents in New York State with a disorder, and 500,000 with severe impairment. Despite the prevalence and impact, less than 50% get any kind of treatment and fewer get mental health treatment. Of those who get treatment it is generally of low intensity and duration. Many of these children could benefit from child psychiatric services and yet there is a dearth and maldistribution of child and adolescent psychiatrists, making access extremely difficult in most situations.

In New York State, child and adolescent psychiatrists are concentrated in urban regions. Out of 62 counties, 26 have no child and adolescent psychiatrists (CAPs) and 9 more have only one. Even in New York City it is difficult to get appointments with CAPs and many do not accept insurance, limiting access further. This story is similar, or worse, in the rest of the Country.

What to do? One prominent solution has been to look to primary care to pick up more of the responsibility for assessing and managing patients with mild to moderate mental health issues. Currently, PCPs prescribe the vast majority, perhaps as much as 85%, of the psychotropics prescribed in the pediatric population. Despite this, PCPs generally feel ill-equipped to assess and manage these conditions. Residents in pediatrics and family medicine receive limited training in child mental health during residency and enter modern day practice needing further training and support, clinically and administratively.

For the past several years several states have developed child & adolescent psychiatry access programs to meet this need. The State of New York Office of Mental Health, under the umbrella Project TEACH, funded two programs (CAP PC and CAPES, child and adolescent psychiatric education service) beginning in 2010. The larger of these programs, Child and Adolescent Psychiatry for Primary Care (CAP PC) has been funded for the past 5 years and recently was renewed for 5 additional years through 2020. CAP PC covers the upstate, New York City, and Long Island, while CAPES covers the eastern part of the state. Each Program aims to provide education and consultation services to PCPs in their catchment regions, although the programs differ in their approach and process. CAP PC has been the 2nd largest child & adolescent psychiatry access program (CPAP) nationally in terms of phone consultations and the largest provider of formal education for PCPs. CAP PC has provided over 15,000 CME hours to over 1000 PCPs.

The goals and vision of CAP PC have been to improve the public health of children and adolescents across New York State by addressing the unmet need for



Victor Fornari, MD

mental health services by (1) Bolstering PCPs' ability to assess and manage *mild-moderate mental health problems*, and (2) Promoting collaboration and integration of health and mental health services.

CAP PC has done this by providing formal education to PCPs together with phone consultation support, assistance with linkage/referrals, and face-to-face evaluations in selected situations. CAP PC is unique in its collaboration among 5 university-based child & adolescent psychiatry divisions at the University at Buffalo, University of Rochester, Columbia University Medical Center/NYS Psychiatric Institute, SUNY Upstate Medical University in Syracuse, and Hofstra Northwell School of Medicine. The 5 collaborating sites each have a site team with 2-3 senior CAPs and 1 Liaison Coordinator, who assists with the program broadly, and specifically is responsible for appropriate linkage and referral support for PCPs. The program has one toll-free phone line (1-855-227-7272) and rotates coverage among the 5 teams, with each team covering one day per week. Beginning in 2015 the program expanded to accept calls from all pediatric prescribers, including psychiatrists and child psychiatrists. The phone consultation and linkage/referral support occurs in real time Monday-Thursday 8am-7pm and Friday 8am-5pm. Calls from a CAP are returned on average within one hour. The numbers of calls have increased over time and last year there were over 1600. From inception almost 1900 PCPs have registered for the program and have called to consult about nearly 6000 children and adolescents. One time face-to-face consultations with Program CAPs are available for selected cases, and are scheduled within 2 weeks. The CAP PC Team works closely together to coordinate planning and assure communication and consistency across the Program in clinical cases.

CAP PC has partnered with the REACH Institute (www.thereachinstitute.org) in the delivery and development of educational programs. The flagship education program has been the REACH-developed Mini-Fellowship in Child and Adolescent Mental Health. This interactive, adult learning, 28 hour CME program focuses on the most



David Kaye, MD

common child mental health problems (ADHD, anxiety, depression, and aggression) and was specifically developed for primary care physicians. CAP PC has delivered the REACH training to nearly 600 PCPs in New York. Our internal evaluations as well as an external evaluation have confirmed the success of the program. Beginning in 2013, in order to reach more PCPs, CAP PC began to produce several shorter education programs to PCPs, including teleconferences, webinars, and "core trainings", a 5 hour on-site program at PCP offices that cover the basics of assessment and management of common problems. All CAP PC programs are provided free of charge to PCPs and include CME credit.

The program has a website you can visit at (www.cappcn.org) that archives many of the educational programs and

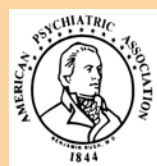
houses commonly used rating scales and questionnaires, vetted annotated websites, a quarterly newsletter, and other public domain articles. The website has had over 30,000 unique users and over 200,000 hits in the past 3 years.

From the beginning CAP PC has worked closely with the leaders of the New York State and regional Chapters of the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) to evolve the Program. CAP PC has also worked closely with the New York State Office of Mental Health, as well as many other mental health and primary care leaders to promote knowledge of the program.

CAP PC has been extremely well received by PCPs. Overall, 93.4% of consultations were thought to be very helpful or extremely helpful, and 99.2% would recommend the program to other PCPs. These numbers have been consistent from year-to-year. The Program has also conducted annual surveys of PCP participants, and the State has organized 2 external evaluations, all of which strongly support its effectiveness.

In summary, child & adolescent psychiatric access programs are gaining ground nationally as a way to address the dearth of CAPs and expand access to services for children with mental health needs. CAP PC is a collaborative consultation program covering 80% of New York State that is nearly six years old and is uniquely a collaboration of 5 university-based divisions of child & adolescent psychiatry. CAP PC represents a step forward for CAP access programs by combining substantial and robust formal education along with CAP consultation support. By emphasizing formal education the goal has been to "teach PCPs to fish" rather than to

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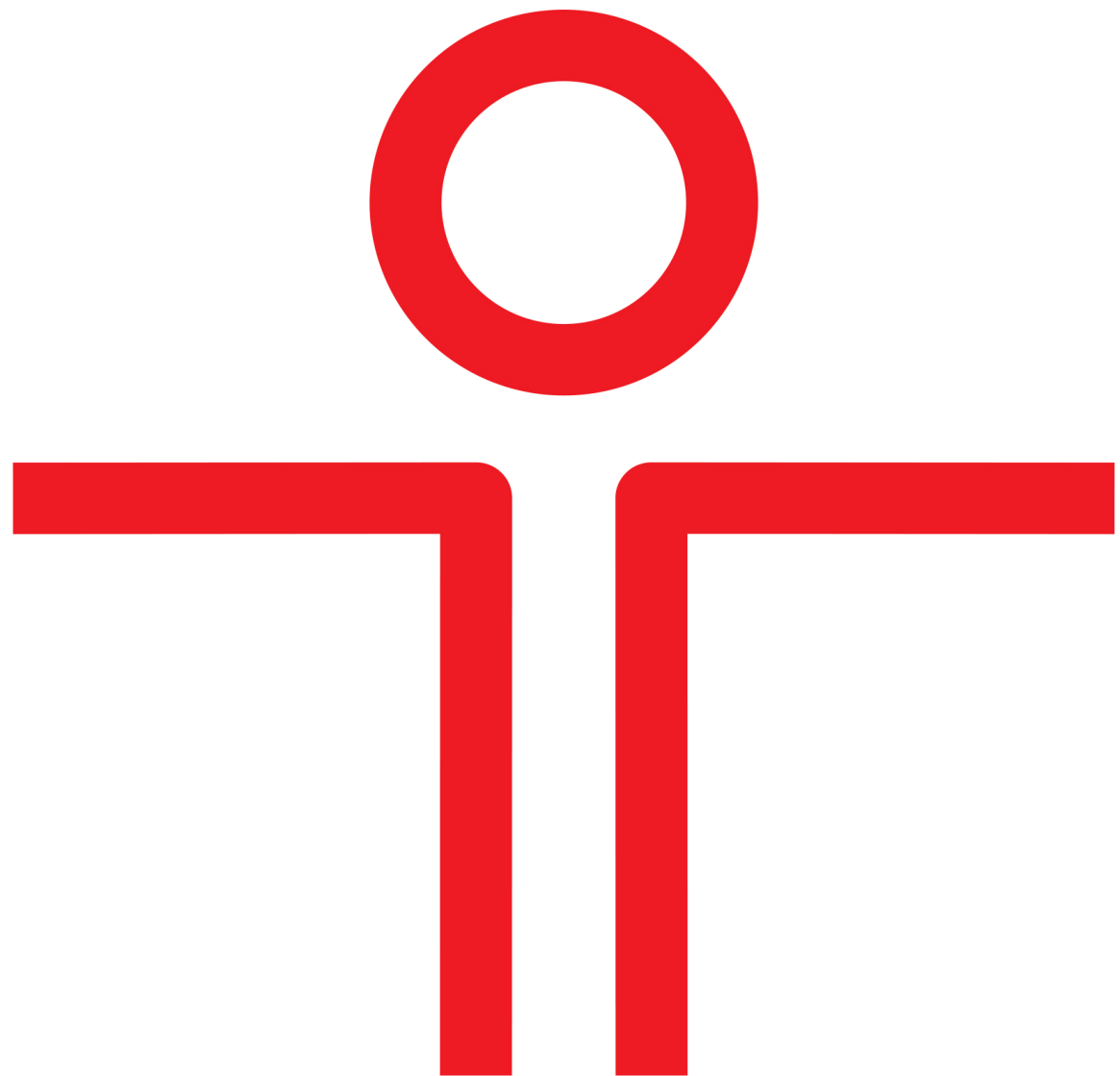
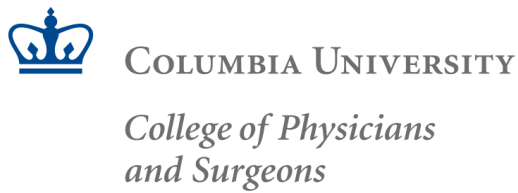
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Charting a New Course for the Future of its Publications New Leaders Join the Board of Mental Health News Education, Inc.

Staff Writer Behavioral Health News

Constance Y. Brown-Bellamy, MPA, incoming Board Chair of Mental Health News Education, Inc., (MHNE), publisher of *Behavioral Health News* and *Autism Spectrum News* has announced the appointment of four new board members. “We are delighted to welcome four outstanding and well-known leaders from the behavioral health and autism communities to our

ance on statutory and regulatory issues affecting psychiatrists, advocacy on issues of importance to psychiatrists and their patients, and training and various lectures on legal and practice management issues.

In addition, Ms. Fernbach is an attorney in private practice with the law firm Moritt Hock & Hamroff LLP, located in Garden City, New York. Ms. Fernbach concentrates her practice in the area of not-for-profit, health care and corporate law, representing health care providers that provide programs and services for indi-

Josh was also the Vice President and Chief Operating Officer of the Mental Health Association of New York City (MHA-NYC), a leader in services, advocacy and education for people with mental illness and their families. MHA-NYC and its subsidiary, Link2Health Solutions, Inc. operate a wide range of behavioral health services, including residential, rehabilitation, child and adolescent and family support services as well as the National Suicide Prevention Lifeline, Veterans Crisis Line and NFL Lifeline.

Her quest and success in acquiring awards of new contracts for the agency has proven to be one of her hallmarks, thus establishing a position of creating opportunities with a continuum of care for the benefit of individuals with special needs. Under her leadership, UPS has grown from a \$16 million company to the present \$22 million and has received several contract awards as a result of winning grant proposals. These include funding from New York City Department of Health and Mental Hygiene under the Ryan White HIV/AIDS Program, addi-



Rachel A. Fernbach, Esq

board. They are: Rachel Fernbach, Esq, Josh Rubin, MPP, Yvette Brissett-André, MPA, and Dr. Robert Ring, PhD,” stated Ms. Brown-Bellamy.

According to Ira Minot, LMSW, MHNE Executive Director, “MHNE is embarking on an exciting new chapter in its 16-year history which will reshape how our publications are made available to our growing readership.” David Minot, BA, Associate Director of MHNE added, “Our vision for the future is to transform our publications into a more modern print and digital media presence which we believe will have an even greater impact on educating and supporting individuals and practitioners in the mental health, substance use and autism communities.” Let’s introduce you to our new board members.

Rachel A. Fernbach, Esq.

Rachel A. Fernbach, Esq. is an attorney admitted to practice law in New York and New Jersey and is a graduate of Tufts University and The George Washington University Law School. Ms. Fernbach is currently the Deputy Director and Assistant General Counsel of the New York State Psychiatric Association (NYSPA), the medical specialty association of psychiatrists practicing in New York State and a division of the American Psychiatric Association. She has held this position since 2013 and previously served as NYSPA Staff Attorney from 2001-2013.

Ms. Fernbach’s work with NYSPA includes providing legal and policy guid-



Joshua Rubin, MPP

viduals with mental illness, intellectual disabilities and developmental disabilities. Ms. Fernbach was previously an associate at the law firm Stein & Schonfeld LLP and a staff attorney at the Greater New York Hospital Association.

Joshua Rubin, MPP

Joshua Rubin, MPP is a Principal in Health Management Associates’ (HMA) New York City office. His specialty over his nearly two decades of service to New York City’s mental hygiene service system has been service funding conversions, strategic planning, agency mergers, internet-based treatment, disaster preparedness and response, housing and homelessness, day and vocational services, and crisis services, including suicide hotlines.

During his time with HMA he has been deeply involved in New York State’s Care Management for All initiative—especially the behavioral health and care management for all carve-ins, DSRIP, CCBHCs, and Value Based Payments. Prior to joining HMA,

Josh was a government official, service provider and advocate. During his government service he was the Assistant Commissioner for Mental Hygiene Policy for the City of New York Department of Health and Mental Hygiene. During his years of City service he also served as the Assistant Commissioner for Chemical Dependency Services, and the Division of Mental Hygiene’s Chief Policy Officer and Chief Administrative Officer.



Yvette Brissett-André, MPA

Prior to joining MHA-NYC, Mr. Rubin was the Director of Policy and Planning for YAI Network, and was on the staff of the Coalition of Voluntary Mental Health Agencies. Josh has a Master of Public Policy degree from the John F. Kennedy School of Government at Harvard University and a bachelor’s degree in religion and the humanities from the University of Chicago.

Yvette Brissett-André, MPA

Yvette Brissett-André, MPA, joined Unique People Services (UPS) in 2008. She oversees the organization’s budget of \$20.6 million and a staff of over 230 employees. She is responsible for executive planning, contract management and real estate negotiations. Her expertise includes over 20 years of experience in the areas of finance and budgeting, program development, contract negotiation, low-income housing development and proposal writing. Yvette ensures that the agency’s programs are well funded and operate at effective levels of service.

Yvette Brissett-André brings to Unique People Services a wealth of knowledge regarding federal and state funding regulations through her work with the New York State Office of Mental Health, New York City Department of Homeless Services, Office for Persons with Developmental Disabilities, and the New York City Department of Health and Mental Hygiene, among many other government funding sources.



Robert Ring, PhD

tional funding through Human Resources Administration HASA Scatter Site.

Over the years Yvette has worked with community officials and boards in the agency’s program service areas throughout the Bronx, Manhattan and Queens. She is one of the founding members of Advanced for Greater New York; a member agency formed to mobilize the Developmental Disabilities programs towards managed care, currently is a member of the executive team of Fortune Society, sits on the Interagency Council of NY Board and was the past Board Treasurer of Adolescent and Family Comprehensive Services in the Bronx.

Yvette is instrumental in initiating the agency’s first major fundraising strategy and public relations campaign. With full support and leadership from the Board of Directors, she is at the forefront of the development and implementation of these two ambitious achievements. Under the fearless leadership of Yvette, in 2017, UPS endeavors to open a 69-unit housing development for low-income New Yorkers.

Yvette holds a Master’s degree in Public Administration from CUNY/Baruch and a Bachelor’s of Science from SUNY/Plattsburgh. She is a National Urban Fellow and was one of the first participants in their America’s Leaders of Change program.

Robert Ring, PhD

Dr. Robert Ring is a seasoned Research and Development (R&D) leader, with 16

see Leaders on page 40

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Drs. Jorge Petit and Barry Perlman Announce New Slate of Officers at Mental Health News Education, Inc. (MHNE)

Staff Writer
Behavioral Health News

Mental Health News Education, Inc., (MHNE) is pleased to announce the election of its new slate of Officers. Jorge R. Petit, MD, has stepped down from his position as Chair and Barry B. Perlman, MD, has stepped down from his position as Vice Chair of the Board of Directors. Dr. Petit joined the Board in 2008 and has been Chair since 2014. Dr. Perlman joined the Board in 2003 and has served as Vice Chair since 2009. Their leadership as Officers has been outstanding, and to show their dedication to helping to build on the mission of MHNE, both have agreed to remain on as Board Members for another three year term.



Jorge R. Petit, MD



Barry B. Perlman, MD

Peg Moran, LMSW
Secretary

Peg Moran, LMSW, is Vice President for Operations, at WMCHealth PPS. As Vice President for Operations, Peg is responsible for the financial, administrative, behavioral health, workforce and cultural competency/health literacy functions at the PPS. WMC Health PPS is the Project Management Office, implementing New York State's Delivery System Reform Incentive Program (DSRIP) in an 8 county region in the Hudson Valley. DSRIP is a five year project to transform healthcare and improve health outcomes for people receiving Medicaid.

Peg has extensive executive experience in the private and public sectors, has focused on behavioral health and on implementation of evidence based practices for vulnerable populations. Her prior hospital



Constance Y. Brown-Bellamy, MPA

Constance Y. Brown-Bellamy, MPA
Chair

Constance Y. Brown-Bellamy, MPA is the President and CEO of Brown Bell Consulting, LLC. She is a seasoned government and community relations expert with almost 20 years of combined experience as a proven leader in the areas of strategic planning and facilitation, public affairs, advocacy, crisis management, community and government relations, and business etiquette. She possesses a well-rounded set of experiences in the non-profit, government, university, international and health care industries.

Ms. Brown-Bellamy is also an adjunct professor teaching master's level courses in public administration to non-profit managers at Metropolitan College of New York (MCNY). She is constantly seeking to encourage and inspire others and is adept at combining her theoretical knowledge with her practical experience.

Ms. Brown-Bellamy is certified by The Protocol School of Washington®, the leader in business image coaching, etiquette and protocol services, as a business etiquette and international protocol consultant. She utilizes her expertise to provide individuals and business clients with customized trainings to help them outclass



Debbie Pantin, MSW, MSHC Mgmt.

the competition and succeed in effecting change to promote increased career advancement opportunities.

In March of 2015, Ms. Brown-Bellamy was honored as a 2015 Women's History Maker by the Brooklyn Caribbean American Chamber of Commerce (CACCI) for her many years and commitment to community service and advocacy.

Ms. Brown-Bellamy graduated cum laude from Norfolk State University with a BA in Political Science/Public Administration and received her Master of Arts in Public Administration (MPA) with Honors from Howard University in Washington, DC.

Debbie Pantin, MSW, MSHC Mgmt.
Vice-Chair

Debbie Pantin joined VIP Services in September, 2013, as the Associate Executive Director. In July 2016, Ms. Pantin was promoted into Interim CEO Position. She has over 25 years of experience in the human services industry, specializing in the fields of mental health, substance use disorder treatment, homelessness, supportive housing, vocational and employment services, primary care, and HIV prevention and services. Leading agency-wide changes and managing organizational transitions are the hallmarks of Ms.



Peg Moran, LMSW

Pantin's experience and reputation. Her professional experience includes staff training and development, and conference presentations and planning. She participates in various national, state, and local boards. Ms. Pantin has extensive knowledge of program development and services, as well as budget management.

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



Kimberly A. Williams, LMSW

leadership positions were at Mt. Sinai, Four Winds, and St. Vincent's. She also served as Senior Vice President at FECS Health and Human Services, and as Director of State Operations at the New York State Office of Mental Health.

Peg received her MSW from Syracuse University, and held a faculty appointment at New York Medical College. She is on the Executive Committee of Behavioral Health News, and has served on numerous professional boards and committees.

Kimberly A. Williams, LMSW
Treasurer

Kimberly A. Williams, LMSW is the Executive Vice President of Integrated Policy and Program Services at The Mental Health Association of New York City (MHA-NYC). In this role she oversees MHA-NYC's efforts to advocate for better behavioral health policies, to provide educational opportunities for providers and members of the public, and to strategically maximize MHA's direct service programs in the changing health care environment. Ms. Williams also oversees and has formed cross system coalitions to advocate for system changes including the

see Officers on page 32

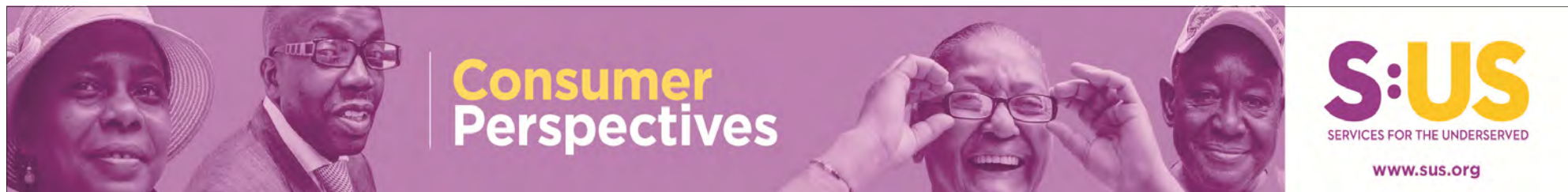


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Youth in Transition

By M.T., S.D., T.W., Q.B., and T.D.

This article is the third in a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The young authors of this column came together as a focus group of peers to discuss their experiences and collaborate on this piece. Kick-off questions were posed to the peers in order to generate thoughts, insights and a sense of the challenges being faced by youth who are either currently or formerly in foster care. Thanks to JCCA for gathering our group of young people together and providing perspectives on the challenges of the foster care system. JCCA (formerly Jewish Child Care Association) is a NYC nonprofit, nonsectarian, multi-cultural child welfare and family service agency with preventive, foster care, mental health and educational services.

Nobody Wants to Be in Foster Care

Our experiences in foster care have been really mixed. It is pretty common for a kid in foster care to have multiple placements in different foster homes. They can be great or horrible. A lot of times it comes down to chemistry or lack of chemistry. And, when all is said and done, there's still a feeling that we'll always be missing something that resembles a real childhood - almost like it got stolen from us.

Sometimes, it seemed like the person who is asking to be a foster parent already had a lot of issues themselves, making it very hard to provide a stable, loving home. Other times, the foster parents really know how to do things right. But in general, we would like there to be a more serious and rigorous screening process in place that would weed out those people who might be doing this for the money or for other reasons that are not appropriate - because the effect on kids is not good.

Mrs. Rodriguez is an example of a great foster parent, and she helped me come out of my shell, become a strong person, feel secure in my home situation, and know that I was loved. I've been with Mrs. Rodriguez for six years. She helped me forgive my birth mom for the stuff that happened between us when I was younger.

Some of the reasons our foster care histories are so tough is because of mistakes we made when we were kids. It

seems like you never finish paying the price for those things, even if they were just innocent, stupid mistakes that we look back on and wish we could fix - but we can't. The reality is that kids in foster care are asked to make decisions and do things that no kid should have to know how to do—like manage all the different people who they are accountable to from their bio parents, to their foster family to their social worker, their lawyer, the case worker, their vocational specialist and education coordinator. It is confusing and overwhelming and in general not what a kid would have to deal with if they weren't in foster care.

One of the biggest mistakes I made was allowing myself to be adopted. My social worker and attorney thought it was a good idea but I had serious doubts. I hoped, at the time, that this would fix a lot of things and give me security - but it didn't. Instead, it made things worse and me and my new parents wound up being very bad at communicating with each other. I guess the lesson here is that adoption isn't always the right answer, and when a kid is uncomfortable in a situation, we've got to be able to talk to someone who will really listen and help us make a change.

What makes a home a home is love and listening, not money. I feel like I have a good relationship with my foster mom. She's a good person. She cares about me. She gives me \$5 every day so that I am never walking around with no money. She took me to Puerto Rico on a vacation to meet her family and it was the most amazing trip of my life. She believes in me and tells me that I can be whatever I want to

be. She listens to me, and that takes time sometimes, but she does it no matter what else is going on.

Finding a Home is Hard And a Little Scary

Staying positive is probably the biggest challenge any of us is going to have as we move away from what we've known and into the independent world where we have to take care of ourselves. Being in foster care is a little bit like being institutionalized. You start to depend on others all the time and expect that everyone else will be taking care of you, when in reality, that isn't the truth. When you're about to leave foster home or kinship home or even an adopted home, no one is really there for you except yourself - so you've got to make a plan to stay on top of things and make things work, even if it's hard. Working to get your housing application in to New York City Housing Authority (NYCHA), and doing so early so that you have the best chance of getting good housing when you need it, is the first wake up call.

I've got a baby girl on the way, and as the dad, it's important for me to try to make sure this child grows up feeling safe and cared for. But I'm still living in foster care myself, and the baby's mom lives with her grandmother in kinship care, so it's going to be really tough making all this work out. I'm working on my application for housing, and I've been training for a job looking after people with developmental disabilities, so hopefully - I'll get things on track and be able to deal with all this

responsibility, but it's a lot when you are only 19 and nobody has your back.

Working as a youth advocate means I try to be a positive role model for other kids. My life has been pretty happy, I'm a junior in high school now and I think I can do whatever I set my mind to doing. But yeah, I worry about what is going to happen to me when I need to be on my own. It is like a big cloud hanging over my head and I know that is how a lot of us in foster care feel.

I'm living in a shelter-type situation, in an SRO, and it is pretty rocky, but I'm looking for housing and a job and that's what will get me to a stable place.

Maybe if I hadn't been so defiant and if I had let my walls down, I would be in a better place. But the hardest thing for me is to trust. I don't trust anyone, and I know I can't go through life that way - but right now, that's how I feel.

Dreams, Hopes and The Future

It's hard to imagine the future when the day to day is so rocky, but dreams persist and there are things to shoot for. In general, we agree that:

- We have to keep a positive outlook, for ourselves but also for the younger kids coming up, who we could be role models for. We can't let our past hold us back.
- Housing is key. Without it, all of these other services are useless. There's no address to get mail, you can't get a credit card or driver's license or passport or anything. There's no pride in living on other people's couches, feeling like a burden and wondering when you are going to be asked to move on. The city needs to get focused on this in a big way not just with buildings but with supportive services to help kids learn how to make it on their own. Any system without true, integrated, community-based permanent housing for kids aging out of foster care is just a Band Aid.
- Even though we've been through a lot, we have also learned a lot and most of us could be, or are, therapists for our friends. We really appreciate the people who have taken the time to help us and are ready to try helping other people who are going through what we have gone through. We can relate to the struggles that people have and that can help us be better listeners. It's just another one of those ways that we're strong.

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Mary Pender Greene, LCSW-R, CGP, is the President & CEO of MPG Consulting. She is a psychotherapist, career & executive coach, trainer and consultant with a private practice in Midtown Manhattan. She is a thought leader in the social services industry, recognized by her peers for her novel ideas on coaching, training and mentoring. She has 20+ years of experience helping individuals, couples, companies and non-profit organizations. MPG Consulting provides culturally competent and anti-oppressive (anti-racist, LGBTQ affirming, non-sexist) coaching and professional development to individuals at all levels, and specializes in working with senior management and executive leaders.



Helping Kids Make Real Progress: A Systems Approach

By Howard Savin, PhD,
Joseph J. Hess, Jr., MSW, MBA,
Lisa B. Eisenbud, MSW,
Matthew J. Hess,
and Valery Bailey, MPA

There is a set of givens supported by years of research and the evolution of Children's Systems of Care that informs the development of effective care for children with intellectual and behavioral challenges: (A) The earlier services begin the better; (B) Services need to be tailored to the individual needs of children and their parents or care takers; (C) Complex issues facing a child require an interdisciplinary approach; (D) Collaboration and close coordination among the key people involved in a child's life (family members, caregivers, therapists, physicians, teachers, etc.) improves outcomes and reduces costs; and (E) For there to be a true continuum of services, providers should consider expanding their range of services, including comprehensive behavior support and assistive technologies in order to productively focus on what is appropriate and effective for the individual served. Providers often focus on one method of treatment, typically Applied Behavior Analysis or Cognitive Behavior Therapy, to the exclusion of others and miss the opportunity to maximize the effectiveness of their services. Better clinical outcomes and cost effectiveness can align.

First Children's Services operates in New Jersey where the public system of care for children with intellectual and behavioral challenges is aligned with the principles above, which sets a foundation to meet our objective of flexibly meeting the needs of families regardless of payers. The NJ Children's System of Care, (CSOC) managed under the Department of Children and Families (DCF) has evolved over fifteen years and offers a variety of behavioral health services based on the needs of the children it serves including traditional one-to-one therapy as well as behavior support services utilizing paraprofessional and professional staff. NJ CSOC is an example with statewide architecture and operations including 365/24/7 access, screening, mobile response, assessment and service planning, and case management without any barriers related to insurance, language, or geography. In 2013, NJ became the first to integrate youth with IDD into the statewide system of care.

While there is broad agreement as to major SOC principles nationally, many other service delivery systems don't follow them due to resource limitations. This article addresses practical approaches for integrating key principles into a comprehensive and effective children's behavior health system of care for children with intellectual and behavioral challenges. The following examples define key strategies and illustrate why they have been employed to benefit child and family consumers.

1. *Early Screening and Referral.* The CDC encourages pediatricians and other primary care physicians to use basic developmental screening tools during rou-



tine "well-baby/well child" visits. Unfortunately, many pediatricians still fail to incorporate developmental screening as a routine part of care. This results in a missed opportunity to identify issues that can be addressed early in a child's life and improve outcomes.

As a remedy, reliable screening tools, such as the MCHAT 2 are available at no cost and physician's staff can be briefly trained to have a parent complete a short questionnaire, score and file it in the medical record for the physician to review during a child's office visit. If the doctor's observations and MCHAT findings both suggest the possibility of developmental deficits, timely referral should be made to an appropriate specialist, e.g., developmental pediatrician, neurologist, child psychiatrist or psychologist, for a comprehensive diagnostic evaluation. To achieve this integrated care approach, systems need to adapt by augmenting practice within specific types of diagnostic professionals to exponentially increase who can screen young children, through training and continuing education.

In our current healthcare system, integrated medical and behavioral health care innovation is a hot topic but medical providers are often not reimbursed for behavioral health screening. If a specific emotional, behavioral or developmental diagnosis can be confirmed or ruled-out, or if a diagnosis is confirmed, parents can be supportively referred to a clinician. Screening and early intervention for children improves the likelihood of good functional outcomes and this does not occur often enough in many states.

Systems of care should also tackle the longstanding nightmare for families of disconnected silos by creating seamless early intervention, insurance funded services and services provided by school districts as part of IDEA - this is good public policy that arguably could demonstrate significant savings in the lifetime cost of care. In NJ the Department of Health operates a separate network for Early Intervention outside of the Children's System of Care. Systems vary nationally, but the goal should be to eliminate a family's challenge to navigate access, affordability, coordination and continuity of care for early intervention on to child behavioral health and education services.

2. *Simple Communications Strategies.* A pediatric neurologist who presented to a group of special educators stated: "just a simple handwritten note from the child's teacher letting me know what's happening in school would be a huge help!" Despite all of the technology employed by professionals in the field today we seem to have overlooked the simplest solutions. Communication as a Best Practice goes a long way toward identifying issues before they become major problems. Providing vital feedback can be used to productively modify various interventions including medications, and clinicians can use input to interpret data and evaluate the effectiveness of their interventions.

Some public systems of care, like NJ DCF CSOC, have developed centralized communications systems, including shared electronic case management and health record, and routine family case conferencing in order to gather vital information from a child's treaters.

Provider software solutions are also available to achieve desired communication strategies. A practice management system can include mechanisms to prompt therapists to share certain data with other members of the treatment team. Notes are available on the system for all therapists to see and can be easily and automatically emailed to external users (e.g. pediatricians).

3. *Use of a Wide Range of Behavioral Interventions.* Most providers recognize that in the age of EBT clinical accountability is required. Accordingly, when addressing children's behavioral problems, "one size doesn't fit all" with regard to treatment approaches. Providing individualized intervention strategies, including person centered planning, is essential to an effective children's system of care. Those services should include early intervention, intensive individual therapy, parent training, and family therapy, along with social skills group training and a breadth of behavioral support services aimed at helping a child integrate into the community, school and family system.

Behavior Therapy offers an overarching treatment model that incorporates a flexible array of evidenced-based interventions. Specific interventions include cognitive behavior therapy, structured social skills training, behavioral parent

training, behavioral self-management and Applied Behavior Analysis. All treatment services should be delivered under the philosophical umbrella of "Positive Behavior Support" to insure use of positive reinforcement, encouragement, pursuit of autonomy and freedom from aversive techniques.

4. *Adapt Services to the Needs of Families.* To provide effective services within a public system of care, one has to recognize that not all families with children experiencing behavioral, emotional or developmental challenges have the same needs, resources, schedules, ability to commit to services, and cultural mindset concerning therapy. Provider agencies need to be flexible, creative and have a broad range of programs and clinical specialists to achieve desired treatment outcomes.

Placing the needs of families first can result in adoption of practical service delivery models. While in-home behavioral services are the increasing choice of SOC payers, parent schedules and other family obligations often result in limiting factors with the overall effectiveness of service. Clinic-based services can be a clinical and cost-effective SOC component in circumstances where group treatment or group parent training is indicated and when access to needed treatment services can be facilitated. At FCS we provide therapy services to young children in our child care program. Families drop their kids off for much needed therapies and opportunity to interact with other children who may or may not have behavioral challenges. We have taken similar approaches with school-aged children in some of our educational contracts. This permits continuity of care as the same therapist who works with the child in school often works with the child and family after school and then at home.

Transcending the communication and practice boundaries between school districts and public human services permits a unified approach to meeting the comprehensive needs of children and families. Under NJ's Children's System of Care there is evidence of cooperation among the education and children service entities. In NJ and in most states nationally, there is an enormous opportunity to improve outcomes and support working families who have children with intellectual behavioral health needs.

In summary, effective systems of care for children with behavioral, emotional and developmental challenges begins with a commitment to certain tried and true principles: use of multiple evidenced based interventions with a focus on positive behavior supports; early screening and intervention; individualization of treatment; multi- and inter-disciplinary approaches; and basic communication among all of those impacting a child's life. SOC's need to be developed and implemented as early as possible, in response to an in-depth understanding of the needs of children and their families. Along the way we just might calculate the financial benefits of better outcomes, family support and continuity of care.

see Progress on page 42

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From The Publisher's Desk

"The Handshake of Hope"

By Ira H. Minot, LMSW
Founder and Executive Director
Behavioral Health News

With the holiday's only a month or so away, I recall a true story I wrote about several years ago in this publication. It began with, "Let me tell you a story about a simple handshake that saved the life of a man from New York suffering with mental illness."

The year was 1987 and he was 38 years old. He had always been a happy and productive person throughout his entire life. He had earned a Master's Degree in Social Work and worked for many years in nonprofit organizations that were helping people in the community.

Suddenly, out of nowhere, he began to experience severe anxiety and depression. His mother had recently lost a heroic battle with cancer a few years before, and he had been separated from his 8 year old son due to a recent divorce.

In a matter of weeks he was in the throes of a most severe form of depression that would last 10 years. His illness caused him to endure such despair and hopelessness that he tried to end his own life on several occasions.

He watched in horror as his life slipped away from him, and was further tormented that his young son—the love of his life—was growing up under the shadow of his illness. In the end, he was left homeless and destitute. During his last inpatient hospitalization before his health insurance ended, he was offered Electroconvulsive Therapy (ECT) as a last chance to save him from a most horrible end—being sent to a dark ward at a nearby state hospital. Miraculously, the ECT worked in his case, and over the coming months he felt the dark curtain of his depression lifting.

It was now 1997 and he was living in supportive housing and attending outpatient treatment. To fill the other lonely hours of his day he began attending a newly opened consumer-run drop-in center. He hoped that by keeping busy and sharing the comradery of others would help set him on the path to recovery.

One day at the drop-in center, Jim, the director, was giving a tour of the facility to a supporter who happened to be a well-known local banker. Seeing the two men dressed in business suits walking through the center reminded him of how he used to dress and collaborate with colleagues and community leaders before he became ill. He was a taken aback and a bit embarrassed when the director and banker came over to where he was sitting.

The banker extended his arm and our recovering man stood up and shook the outstretched hand. The banker smiled at him, patted him on the shoulder, and told him, "Keep up the good work."

It was a simple gesture, but that handshake had a profound and lasting impact. For many years after that day, the man in recovery often referred to that kind banker and his reassuring handshake. "It made me feel like things were going to be OK and I would finally get well again."



David and Ira Minot

You see, that man was me. With the kind encouragement of that banker and the many other people I met along the path of my recovery, I was inspired to create this publication in 1999. Through the following years, in what has seemed like an instant, I was able to rebuild my life. I just celebrated my 65th birthday in July, and this publication has been in existence now for over 16 years !!

I didn't understand it at the time, but it turns out that it was my desire to help others that was the key to helping myself get better. I wanted to find a way to provide education, resources and hope to people who were lost and struggling (as I had been) with mental illness.

My son David, who was inspired by my recovery and vision to help others joined me as my Associate Director in 2008 to publish *Autism Spectrum News*—now a leading publication helping thousands of families and individuals cope with the challenges of autism spectrum disorders. Today, *Behavioral Health News* and *Autism Spectrum News* reach over 160,000 hardcopy readers across New York State and beyond. Our plans to enhance our online delivery and presence has the potential to expand our educational mission to numbers even beyond our greatest expectations.

This Holiday Season, we need your support more than ever before. We are a small organization with a vital mission. Please look for our Annual Fall Appeal letter that will be arriving in the coming weeks - take a moment and consider us in your annual giving plans. You can also make a donation directly on our website at: www.mhnews.org/donate.htm

Please help us to continue providing hope to people with mental illness, substance use, and autism spectrum disorders. Your tax-deductible contribution to *Behavioral Health News* and *Autism Spectrum News* this holiday season will be a meaningful and heartfelt "Handshake of Hope" to someone out there who is lost and alone right now. We need to reach more people like that, shake their hand, and give them the encouragement they need to move forward and improve their lives. As simple as a Handshake may seem, it has been proven to save a life and start something wonderful.

What If?

By David Woodlock
President and CEO
ICL

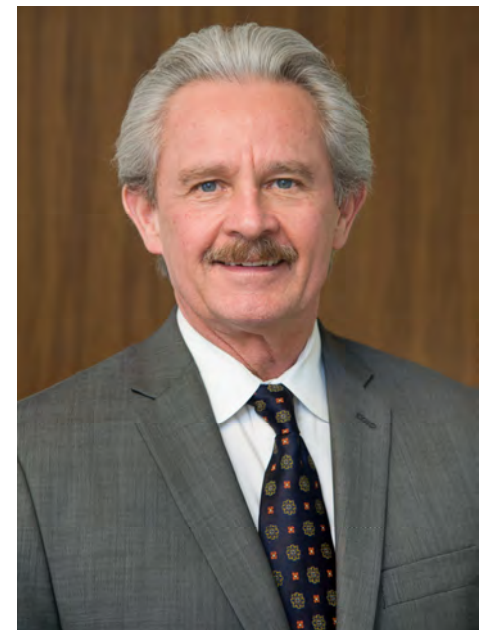
What if... We had a children's system that made sure that Mom and Dad (however that's defined) had all the things they needed to care for their newborn and growing child. This process would start during the mother's pregnancy with regular visits from a nurse.

At the first postpartum doctor's visit, in addition to a health check, Mom and Dad would be given a tool kit with activities and toys that would help them emotionally connect with their newborn.

During the preschool years, the pediatrician would check the child's progress along a Social and Emotional Growth Chart right after the Height and Weight Chart. If the child is falling behind, a home visit would be arranged where a family advocate and a developmental specialist would observe parent and child interactions and make suggestions on activities aimed at stimulating growth and attachment. If needed, a specially trained parent partner would come to the home two afternoons a week to work with the parents and child.

During the early school years, the teachers, pediatrician, and the parents would all share information on the child's social and emotional development and would all work on the same set of skills and abilities. The school curriculum would focus on social and emotional skills in equal measure to math, social studies, and grammar. If the youngster is falling behind, a 6th grade mentor would be assigned for guidance and role modeling. Before and after school programming would be available and would focus on interpersonal skill development and emotional self-regulation skills. The child's whole family would be encouraged to participate and if they are unable to, the school counselor would be happy to visit at home accompanied by the 6th grade mentor. The pediatrician is pleased with the interventions.

During middle school, non-digital means of interpersonal communications would be formally taught as part of health classes along with coping strategies and conflict resolution skills. Pediatrician visits continue to chart progress along the Social and Emotional Growth Chart and there would be regular communication among parents, pediatrician, and school personnel. If challenges arise, in-home family counseling would be available



David Woodlock

when convenient for the family and a skilled peer counselor would be available after school and on the weekends.

What if the transition to high school weren't such a challenge for so many? Health classes would focus on recognizing stress and developing healthy coping strategies. Volunteerism, mentoring, and prosocial behaviors would be rewarded in equal measure to sporting achievements. The routine communication between parents, schools and pediatricians that began in the early school years would continue with the inclusion of the young person. The peer support for both the parents and the child begun during middle school would also continue, deepening relationships and trust. If a youngster gets off-track, individually defined resources could be brought to bear that support and guide the family back onto a successful course. These might include anything from intensifying the already existing supports to an in-home psychiatric visit that could help determine whether medication would be helpful. It might also mean creating new connections to a trusted adult resource and engagement in personally meaningful activities.

What If...

New York State's policies on children encouraged, supported, and built family unity so that all children and families in New York could develop strong social and emotional skills so that the next generation of young adults are well armed to face life's challenges. What if...

NYSPA from page 6

give them fish. Increasing PCP geographic penetration, calls, and awareness of the Program is evident. CAP PC further demonstrates that large-scale collaborative consultation models for primary care are popular with PCPs, feasible to implement, and provide access to child & adolescent psychiatric expertise for patients who would otherwise have none. Outcomes evaluation projects have sup-

ported their value, although more are needed.

Dr. Fornari is the Director of Child and Adolescent Psychiatry at the Zucker Hillside Hospital and Professor of Psychiatry and Pediatrics at the Hofstra Northwell School of Medicine. Dr. Kaye is Professor of Psychiatry and Vice Chair for Academic Affairs at the University of Buffalo Jacob School of Medicine. He is the Medical Director of the CAP PC program.

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

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

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NYS Office of Mental Health Announces “1,700 Too Many” Statewide Suicide Prevention Plan

By The NYS Office
Of Mental Health (OMH)

The New York State Office of Mental Health today announced the release of an extensive, multifaceted plan for suicide prevention, aimed at reducing New York State's suicide rate. To guide suicide prevention statewide, 1,700 Too Many: New York State's Suicide Prevention Plan will empower communities, healthcare professionals, and researchers with the tools they need to decrease the number of deaths by suicide.

“New York State is taking action to save the lives of our family, friends, and neighbors from suicide, the most preventable cause of death,” said New York State Office of Mental Health Commissioner Dr. Ann Sullivan. “This plan presents the most extensive suicide prevention framework of any state in the nation, with lofty goals and detailed plans on how to make it happen. By working together under the common cause of suicide prevention, we will honor in the best way possible those whom we have lost to suicide, by letting potentially suicidal individuals know that we care about them and that help is always available.”



1,700 Too Many was developed after New York State was chosen to receive a grant from the Substance Abuse and Mental Health Services Administration to integrate suicide prevention into healthcare settings and provide prevention specific training to healthcare providers. New York is one of only four states to receive such funding. The plan is the centerpiece

of the inaugural New York State Suicide Prevention Conference occurring today and tomorrow in Albany.

“More and more New Yorkers are receiving their mental health services from primary care providers,” said New York State Office of Mental Health Suicide Prevention Office Director Dr. Jay Caruthers. “It is of utmost importance that

we train our medical professionals to address suicide risk more directly. It's one of the various components of our plan that will have a significant impact on reducing suicides in New York State.”

“The new state plan shows why New York State remains a leader in suicide prevention. To truly have an impact, no one intervention is enough,” said Suicide Prevention Center of New York Associate Director Garra Lloyd-Lester. “We need a coordinated systematic response, in our health system, in our schools and in our communities. And that's exactly what the plan calls for.”

1,700 Too Many Brings a Three-tiered Strategy to Suicide Prevention.

1. *Integrating Suicide Prevention into Health and Behavioral Health Settings:* Many individuals who die by suicide have contact with the health care system just prior to death. Yet, health and behavioral health systems have never been explicitly designed to reduce suicide deaths. The plan will work to change this through the adoption of a systematic approach: The Zero Suicide Model. All healthcare settings – mental health and substance use treatment centers, emergency rooms,

see Suicide on page 39

Residential from page 1

stay in the home and be safe. There is a tremendous need for crisis intervention, skill building, and respite that the current system can at best only partially meet. And, while we know that there will always be some children and youth who have a need for residential services at some point in time, what should that service look like? Where should the beds be? In what format? Under what reimbursement structure?

We are able to ask these questions, and have dialogue about the answers, because of a unique set of circumstances at this moment in time in New York State. The convergence of Medicaid Redesign and the Affordable Care Act is providing us with a golden opportunity to make significant reforms to the children's behavioral health service delivery system. Over the past four years, there have been a number of Medicaid Redesign Teams working to make New York State's Medicaid service delivery system more effective for those who rely upon it for their healthcare. There is a Children's Medicaid Redesign Team which is currently working to create and implement a Medicaid Managed Care Behavioral Health benefit package for children and their families. The Children's Medicaid Redesign is ambitious and comprehensive, and consists of three parts: care coordination via Health Homes, an expansion of Medicaid State Plan Services, and an expanded availability and alignment of existing and new Home and Community Based Services.

We believe the successful implementation of this expanded service array will make a redesigned and more effective RTF more possible. A new vision of resi-



Ann Marie T. Sullivan, MD

dential treatment is one in which children and youth have ready access to short-term, effective treatment and stabilization services in a residential setting when this level of care is necessary. Inherent in this vision is the availability of the above-referenced continuum of home and community based services and intensive care coordination which work both to prevent and limit the need for residential services in the first place, and to effectively receive the child back into the community after a brief residential stay.

The Delivery System Reform Incentive Payment Program (DSRIP) is the primary mechanism by which NYS is



Donna Bradbury, MA, LMHC

operationalizing Medicaid Redesign. The primary goal is to reduce unnecessary hospitalization. New York State was required to submit to the federal government a multi-year plan for payment reform in order to ensure the long-term sustainability of DSRIP investments; so the State created a Value Based Payment (VBP) Roadmap. VBP can create some interesting opportunities for innovative service delivery, and we are currently working together with providers and the Department of Health toward understanding how VBP options may further the evolution of residential treatment for children and youth in New York State.

This creates the potential for RTF to be redesigned and to be thought of more as simply another good option in a continuous array of services.

OMH envisions this redesigned RTF as a program which could help fill critical gaps in the children's mental health service system, divert children and youth in crisis from emergency departments and hospitals, and provide a transitional step-down program following psychiatric hospitalization. No matter what shape these RTFs ultimately take, critical to their success is the meaningful involvement of families, the engagement of youth, individualized service planning, and culturally and linguistically competent care.

The new model would include crisis and skill building services led by experienced staff able to assist families in their ability to build on their own strengths and to avoid crisis situations in the future. Family and youth peers with lived experience will be essential to provide needed support services to individuals and families in a non-threatening, culturally competent manner.

As a step-down program, residential providers would work with hospitals and the youth's treatment team to offer support in transitioning back to the community from the inpatient program. As a respite program, providers could offer support to individuals and families by offering a short break from the current living situation, so as to improve everyone's ability to cope with various stressors. Coordination and collaboration with current behavioral healthcare providers must be included in all the above program elements.

see Residential on page 39

Partnerships Provide Effective Alternatives To Unnecessary Inpatient Care for Children and Youth

By Tracy Luoma, Executive Director
Optum Salt Lake County

There is a high personal, psychosocial and economic toll for children and youth who experience mental, emotional and behavioral disorders. These challenges also impact their families and the communities in which they live, study, and grow up. Research suggests that in any given year, between 14 and 20 percent of all young people will develop one of these disorders, and about half of all diagnosable mental illnesses begin by age 14 (National Research Council and Institute of Medicine, 2009).

Optum believes that providing care for this population requires an integrated and comprehensive systems approach to prevention, timely and effective health and social services, and community-based resources to effectively support the needs of children and their families. So they have developed programs that help communities advance their systems of care for children and youth through effective partnerships among providers, community resources, and care coordination in order to assure evidence-based services and improved health outcomes.

In Salt Lake County, Utah, Optum has implemented the Family Access to Stabilization and Treatment (FAST) program.

This collaboration between Optum and the Division of Youth Services in the county serve Medicaid-covered youth ages 6 to 17. These services are targeted for at-risk youth requiring hospitalization for behavioral health conditions, or post-hospital transition back to their homes and communities. In order to be enrolled in the FAST program, youth must be in the custody of their parents, and not in custody of the Division of Youth Services.


The primary outcome objectives for the FAST program are improved systems of care and the reduction in the number of children placed in acute inpatient psychiatric facilities where alternative community-based treatment is appropriate, as well as the reduction in recidivism to acute inpatient facilities for children. Therefore, the program promotes care for those they serve that is in the least restrictive and safest environment possible. In addition, because a child in a behavioral health crisis situation affects the entire family, the program connects family members with the full continuum of health, social, and community-based resources to address their needs as well as the immediate crisis situation. The FAST program's recovery and resiliency model of care also empowers parents and families with tools and strategies to successfully maintain their children with mental illness in their homes, schools and communities.

Referrals to the FAST program can come from a range of sources, including crisis mobile outreach teams, emergency rooms, local police, and hospitals and other facilities. Crisis intervention services are available 24 hours per day, 7 days per week through the University of Utah Mobile Crisis Outreach Team (UNI MCOT). Following their initial assessment, this multidisciplinary clinical team will help the child and family develop a community-based care plan and coordinate the necessary services to implement the plan. If the involved youth is not in a life-threatening situation and can be managed in their home environment, a range of interventions are initiated through a provider (or providers) with a local short-term crisis program that provides in-home therapeutic support and guidance to ensure the safety for the entire family. The provider has a multidisciplinary clinical team of licensed professionals who offer in-home services such as individual therapy; family therapy; peer support; case management; behavior assessments and planning; parenting counseling; respite care; and medication management. Optum supports the coordination of care and services that bring together all of the needed resources to effectively help address the crisis situation with the goal of helping families manage the crisis within their own communities.

When care is required in a secure environment, Optum arranges for participants in the FAST program to receive short-term out-of-home care. This is provided by local Division of Youth Service facilities, which also conduct family crisis interventions aimed at stabilizing these situations. Their services may include: individual and family counseling; limited "time out" hours at youth services; overnight stay for age-appropriate youth; short-term residential care with family therapy; in-home services; Family Resource Facilitator services to help secure necessary supports and services; and family educational classes and group supports.

While children are enrolled in the FAST program, Optum arranges for all of their needed day treatment and school services. A key goal of the program is the successful transition of participating youth back into their family and community environment. Services that support this include home visits and therapy services for the whole family. Follow-up services include continued coordination of care, and individual and family therapy. Educational and in-home transition services are also provided along with substance use treatment as needed. The FAST program also employs a team of Family Resource Facilitators, who are family

see Partnerships on page 38



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The Transformation of New York's Children's Behavioral Health System: Specialty Care Matters

By Jorge Petit, MD,
Richard Sheola, MA,
and Heather Mermel, MPH
Beacon Health Options

The Children's Health and Behavioral Health Subcommittee of the Governor's Medicaid Redesign Team (MRT) conveyed, in the context of several important recommendations, that our State's children's behavioral health system needed significant reform with respect to service access and earlier intervention for children and families. These recommendations, if thoughtfully implemented in the context of New York's overarching goal of transitioning public behavioral services to health plan management, would fill gaps in services and produce better long term outcomes. A leadership team of executive staff from the New York State Department of Health, Office of Mental Health, Office of Alcoholism and Substance Use Services and the Office for Children and Family Services have collaborated on the design of this significant system transformation, which is scheduled to be implemented in four phases, beginning July 1, 2017. Beacon Health Options (Beacon) is proud to serve as one of the original 22 members of the Governor's MRT Behavioral Health Work Group.



Overview, Target Populations, Guiding Principles, Benefit Design and Timelines

In the context of this multi-faceted Medicaid reform effort, the following groups of children, youth and families have been identified as the priority populations:

- Children and youth diagnosed with a serious emotional disturbance (SED)
- Youth with substance use disorders (SUD)

- Medically fragile/complex children

• Children and youth placed in foster care who are either: living with a serious emotional disturbance; intellectually/developmentally disabled (I/DD); medically fragile, or have experienced trauma.

Considering the unique needs of these high risk children and families, the transformation will be guided by important core public service values and principles, including:

- Family and youth-driven service planning
- Child and family-centered care management
- Assured continuity of care, treatment and supportive services
- A system-wide embrace of recovery-oriented, evidence-based practices
- Networks that can and will be characterized as comprehensive, responsive, accessible and well-managed systems of care
- Practice level integration of physical and behavioral health services
- Provisions for separate identification and reporting of physical and behavioral health spending
- Ongoing savings reinvestment to strengthen service systems going forward
- Health plan and provider payments tied to outcomes
- Cross-systems oversight and collaboration to ensure that the significant needs of children and youth known to our child welfare authorities, and particularly those living in out-of-home placements, are

see Specialty on page 36

Beacon Bikes for Mental Health Advocacy 30 Days - 2,000 Miles -100% Awesome: A Journey to Raise Awareness

Amy Sheyer, AVP, External Relations
Beacon Health Options

On Friday, September 16, Beacon Health Options (Beacon) employees, friends and family, will embark on the Awesome Beacon Bike Ride, a 2,000-mile cycling journey from Boston to Miami. Throughout the 30-day trip, riders will serve as "spokes" men and women to raise awareness about the stigma surrounding mental illness.

Beacon is also sponsoring the ride to raise funds for the Mental Health America (MHA) and National Alliance on Mental Illness (NAMI), both of which are nationally recognized for their advocacy and services for individuals with mental illness and their families.

Anyone can participate. For more information about the Awesome Beacon Bike Ride or how to register to ride in one or more of the one-day rides, please visit the bike ride's web page. There, you can also view a video to learn more about the ride. Beacon offices in Colorado Springs, Colo., Cypress, Calif., and the United Kingdom will also host one-day bike rides.

"This ride has three goals: camaraderie, advocacy and health," said Beacon Associate Chief Medical Officer Emma Stanton, MD, and the ride's lead organizer. "These principles unite all of us

who work at Beacon. We care about raising awareness of mental illness, and this is just one more way that we can show it."

"We are proud to support the important work of NAMI and MHA. They have championed the rights and needs of individuals with mental illness for nearly 150 years, combined," said Beacon President and Chief Executive Officer Tim Murphy. "We have so many Beacon employees who have embraced the Awesome Beacon Bike Ride, many of whom will be out on the road as cyclists and volunteers to help our members and others who are on their own roads to recovery."

The funds raised from the bike ride will help support MHA's "B4Stage4" initiative, which promotes prevention of, and early intervention for, mental illness. This program spreads the important message that when we think about cancer, heart disease, or diabetes, we don't wait years to treat them, nor should we for mental illness.

"Mental Health America is honored to be one of the nonprofits supported by the Awesome Beacon Bike Ride," said Paul Gionfriddo, president and CEO of Mental Health America. "This ride will bring together Beacon employees, family members and friends from across the world to spread awareness and demonstrate that it is okay to speak out about



mental health. The more we talk about mental health, the sooner we can reach individuals early on in the disease process -- before Stage 4."

NAMI will use the donation for its education and support programs for individuals and families affected by mental illness, as well as initiatives to build public awareness of mental health conditions and end the stigma that surrounds them. NAMI's programs are offered at no cost to participants so everyone affected by these conditions and their loved ones have the knowledge and support needed to facilitate recovery and resilience.

"NAMI is grateful to all the "spokes" men and women who are cycling to raise awareness about mental illness," said Mary Giliberti, CEO of the National Alli-

ance on Mental Illness. "One in five Americans live with a mental health condition so it is critical that we work together to change the way the world sees mental illness and learn to see the person, not the illness."

To follow the journey during the month-long ride through, pictures, stories and videos, visit www.beaconhealthoptions/bikeride or check out the #BeaconBikeRide on our social media accounts, www.facebook.com/beaconhealthoptions and www.twitter.com/beaconhealthopt.

About Beacon Health Options

Beacon Health Options is a managed behavioral health care company that serves 50 million individuals across all 50 states and the United Kingdom. On behalf of employers, health plans and government agencies, we manage innovative programs and solutions that directly address the challenges our behavioral health care system faces today. Beacon is a national leader in the fields of mental and emotional well-being, addiction, recovery and resilience, employee assistance, and wellness. Partnering with a network of providers nationwide, we help individuals live their lives to the fullest potential.

For more information, visit Beacon online at: www.beaconhealthoptions.com.

see Bikes on page 38



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Progress and Challenges in Accessing Treatment for People with Autism

By Amy Weinstock, MArch, BA
Director, Autism Insurance Resource
Center, Eunice Kennedy Shriver Center
UMASS Medical School

Debora Thivierge, BCaBA, CBAA, attended her son's high school graduation last spring, and looked on with pride as he started college this fall. This rite of passage was not something doctors who diagnosed her son with autism 16 years ago would have encouraged her to strive for. It's a sign of the tremendous progress that has been made in the systems of care for people with autism. This has occurred largely through the efforts of incredible parents like Debora, and thousands of others across the country who have devoted years to expanding access to treatment and services for people with autism.

Autism is a complex neurobiological condition requiring care and assistance on multiple levels. One in 68 children in the U.S. is diagnosed on the autism spectrum, according to the Centers for Disease Control and Prevention. It is about 4.5 times more common among boys, with 1 in 42 boys and 1 in 189 girls having autism.

It was Thivierge's experience as a parent of a child with autism that led her to establish the ELIJA School and Foundation on Long Island, New York, in 2002



with the goal of improving programs and services by providing training on best practices in autism treatment. She will be the first to tell you how many barriers and challenges they had to be overcome, and how many still exist.

A major catalyst for the expansion of access to treatment has been legislative mandates passed in New York and 43 other states, requiring insurance to cover medically necessary treatment for autism, including, but not limited to, Applied Be-

havior Analysis (ABA) Therapy, one of the most widely prescribed and efficacious therapies for autism. For parents like Thivierge and this author, who led the grass-roots effort to pass a similar law in Massachusetts, the legislation has only been a first step. It's taken a tremendous amount of time, effort, and enforcement for families to actually be able to access the treatment mandated under the law.

In New York state, the challenges became apparent shortly after the autism

insurance reform law was passed in 2011. For two years, families were blocked from accessing ABA because insurers required the nationally board certified behavior analysts (BCBAs), to obtain a New York state license to qualify for insurance reimbursement. The problem was that the state had no process to license behavior analysts at that time, and it took two years before a licensure process was established. Even now, providers must complete a program at a New York-approved educational institution to obtain a license, but there are not many programs and only a few out-of-state programs are approved by the state. Meanwhile, families are unable to access treatment, often during a child's younger years, where research shows that treatment can dramatically change the developmental trajectory for a person with autism. Autism advocates in New York are working to expand education and training options for individuals who would like to obtain a license.

In Massachusetts, regulators blocked similar attempts by insurers, and required them to reimburse BCBAs for treatment when the law went into effect starting in 2011. (A behavior analyst licensure bill was subsequently passed and went into effect in early 2016). However, Massachusetts families encountered other

see Autism on page 35



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Circle of Security Parenting Program: A Wise Early Intervention Investment to Promote Healthy Futures

By Giselle Stolper
and Kimberly Williams
MHA-NYC

As New York State transitions children, youth, and family services into Medicaid managed care, there must be far greater attention, capacity, and investment in tools and strategies that promote early childhood development. According to The Heckman Equation, investment in early development is a cost effective strategy that not only leads to gains in education, health and productivity but can reduce deficits and strengthen the economy.¹

Childhood experiences, both positive and negative, have a tremendous impact on lifelong health and wellbeing. It is widely known that Adverse Childhood Experiences (ACEs), a term coined by the seminal research study of the same name, are traumatic childhood events that can have negative, lasting effects on health and well-being, affecting a child's brain development in profound ways.² ACEs include physical, emotional or sexual abuse, parental divorce or incarceration of a parent or guardian. Significant adversity in childhood is strongly associated with unhealthy lifestyles and poor health decades later. These experiences show up as adult onset of chronic health conditions,



mental health disorders, perpetration of and suffering from violence, early death, and overall lower quality of life. As the number of ACEs increases, so does the risk for these negative outcomes. Repeat exposure to ACEs can lead to a toxic stress response, a prolonged activation of stress response systems in the absence of protective relationships. When toxic stress response occurs continually, or is triggered by multiple sources, it can lead to poten-

tially permanent changes and long-term effects on brain development and have a cumulative toll on an individual's physical and mental wellbeing for a lifetime.³

The wide-ranging health and social consequences of ACEs underscore the importance of preventing them before they happen. So while we know that the effects of ACEs can last a lifetime, they don't have to if we intervene early. Understanding health, social, and economic risks that re-

sult from ACEs can help improve recovery and prevention efforts. The social and physical environment can serve as an important safeguard to these negative experiences. Early nurturing, responsive relationships with caring adults as early in life as possible can lead to healthy brain development thus preventing the damaging effects of toxic stress response.⁴

Parents and caregivers play a vital role in building a healthy future for their children. The quality of the relationship between caregiver and child in the first years of life is central to a child's later functioning. One approach to building the foundation for healthier lives is by promoting secure attachments between young children and their parents and promoting healthy social-emotional development. Research evidence shows that attachment quality has an important influence on the success of a child's developmental pathway toward successful adulthood.⁵

A leading relationship based early intervention program that is designed to enhance attachment security and strengthen relationships between parents and children is Circle of Security Parenting Program (COS-P), a universal primary prevention strategy that has been used nationally and internationally. COS-P focuses on how parent/child relationships

see Parenting on page 41



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“Children’s System of Care” in Westchester County, New York

By Carol Hardesty, MSW, MPA,
Executive Director, Family Ties of Westchester
and Michael Orth, MSW, Deputy Commissioner,
Westchester County Department of
Community Mental Health

The System of Care concept for children and adolescents with mental health challenges and their families was first published in 1986 in an article by Beth Stroul and Robert Friedman. They articulated a definition for a System of Care along with a framework and philosophy to guide its implementation.

The original concept was offered to guide the field in reforming child serving systems, services, and supports to better meet the needs of children and youth with serious mental health challenges and their families. The concept has shaped the work of many communities across the country, and Westchester County has been a System of Care Community under the federal model, since 1999. The System of Care concept is a vision with continued potential to transform the systems which serve children with social, emotional and behavioral challenges. During the past two decades, the concept and philosophy have laid the foundation for such transformation.

As initially described by Stroul and Friedman, a System of Care is a spectrum of effective, community based services and supports for children and youth with

or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community and throughout life.

Westchester has long recognized the following core values as basic to the System of Care concept: (a) Being community based; (b) Family driven and youth guided; (c) Culturally and linguistically competent; (d) Cross system in approach; (e) Employing a “never give up” philosophy; and (f) Having a strength based foundation, with services individualized for each child.

Westchester’s investment in a “system of care” framework began long before we became a federally funded System of Care community in 1999. In the early 1990’s, Westchester County embarked on a mission to re-engineer its service delivery system for over 3,000 children with diagnoses of serious emotional disturbance. For the Westchester County Department of Community Mental Health (DCMH) this represented a fundamental change from a non-family focused, medical model approach to a family focused, strength based value system. A system of care, we decided, was not a program, but a philosophy and a framework for a changed way of “doing business” for youngsters with high end service needs

and their families. These ideas were recognized by New York State and resulted in the State’s early system of care effort known as the Coordinated Children’s Services Initiative.

Westchester used its successes as a pioneer in the New York State driven Coordinated Children’s Services Initiative and its county level successful Network model to apply for and win a Substance Abuse and Mental Health Services Administration (SAMHSA) CMHS system of care grant in 1999. Westchester’s System of Care effort has been known as The Westchester Community Network, and employs a multi-tiered approach in nine communities throughout Westchester. There are also Early Childhood and Aging Out/Transitional Networks. Network, utilizes a “wraparound approach”, a dynamic, interactive process for children, youth and families identified in the community at the highest level of need, where no single system has been able to provide sufficient help. These families often feel “under siege,” rather than helped, by the multiple service systems involved in their lives. Children and families are invited to Network by someone who knows them and has worked with them in the community. The family is encouraged to invite people who have helped and supported them, including family, clergy, friends, former workers, therapists, etc. The first person a family meets at Network is another parent from a similar background and culture

who can explain the process to them. An older adolescent will also meet with a peer. The strength based assessment takes the form of a “public conversation” which is supportive and affirmative and establishes broad community support and recognition for the family.

The Networks themselves are complex and consist of a number of different relationships, associations, and regular meetings. On a monthly basis the Networks hold community organization meetings that bring together all of the agencies and support groups to share information, work on better coordination, and review service needs and resources. On a weekly basis, Network family-centered meetings (described above) are held. The family organization, Family Ties, plays a major part in orchestrating these meetings, supporting the participating families and guiding them through the process. From the family centered meetings, child and family teams for each family are organized which provide continuous support and services for the family. The plan of care for the child and family is developed here and is adjusted and revised over time as the needs of the child and family change. Finally, each Network is linked to a Community Planning Council that consists of local program administrators, religious and business leaders, and other community leaders who support the work of the Network and

see Children on page 34



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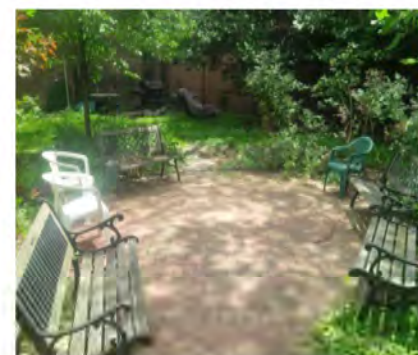


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The Essential Role of Early Childhood Educational Services in Residential Family Substance Abuse Treatment

Aries C. Young, MEd, Deputy Director of Early Educational Services, and Annise Weaver, M.S. Ed., CRC Senior Director of Admissions and Residential Support Services

Parents battling substance and alcohol use disorders often face significant challenges and obstacles to accessing treatment. These include the stigma of substance use disorders, fear of loss of child custody, and limited treatment options for women who are pregnant. These obstacles often result in community isolation, continued engagement in risky and potentially traumatic behaviors and increased contact with the child welfare system. Parents diagnosed with substance use disorders oftentimes end up with a tough choice: voluntarily separating from their children or risking the loss of their children and families temporarily, and in many cases permanently, due to child welfare intervention.

At Odyssey House, mothers and fathers do not have to choose between treatment and caring for their children. Since 1973, the Family Center of Excellence has allowed parents and their young children to access residential treatment together as a family. Because pregnant women and parents with children can stay together, Odyssey House is able to build stronger

and more stable families. We assist parents in creating nurturing relationships with their children and provide an opportunity for parents to address a wide array of issues including managing emotional stress, addressing co-occurring medical and mental health issues, ameliorating childhood developmental delays and identifying safe and secure housing.

While parents engage in a host of clinical services, our Early Educational Center focuses on assisting children in reaching their full developmental potential. Our Early Educational Center is licensed by the New York City Department of Health and Mental Hygiene, and in partnership with Northside Center for Childhood Development, offers Early Head Start programming. Odyssey House operates five on-site, licensed daycare and preschool classrooms serving children from two months to six years of age. Classrooms operate from 8:30 am to 3:30 pm Monday thru Friday. Evening childcare services are provided from 5:00 pm to 6:30 pm Monday thru Friday to allow for parent participation in therapeutic group activities.

Parents and Children Learning Together

Working with children of substance abusing parents who are engaged in intensive residential treatment is both complicated and challenging. The majority of

parents who enter treatment are mothers (sometimes fathers) with one or two young children. They may have been referred to treatment from a homeless shelter, by the child welfare system, by family members, or reached out themselves for help. However, they might arrive at Odyssey House, several things are clear: the mother and/or father love their children; they share a desire to become better parents; and they want to maintain custody of their children while they begin their recovery process.

The Early Educational Center strives to create a nurturing environment where vulnerable parents feel welcomed and supported as they make efforts to engage in and understand their role in a child's development. When children arrive in treatment our role as early childhood educators is to make each child feel safe in a world that has often seemed overwhelming and quite unsafe, and to reassure parents that they have made the right decision for themselves and their children. We focus on building a positive, therapeutic relationship between the teacher, the child, and the parent. This relationship underpins everything we do. It is based on mutual respect, trust, and empathy for the young child and the parent who are both adjusting to the demands of a treatment environment and a life based on the principles of recovery.

The developmental and environmental issues involving children exposed to substances in utero have a direct effect on the field of early education. The children oftentimes come from chaotic environments where they may have been isolated, neglected and/or had limited exposure to positive adult role models. Many of the children present with learning impairments, cognitive and physical deficits, and developmental delays. Early Educational Center staff, as members of an interdisciplinary team, are tasked with rapidly engaging parents and children in services, assessing critical needs and deficits, developing educational plans and, where indicated, referring children for special educational testing.

Our early educational approach is intentionally designed to support a young child's developmental and emotional abilities. The evidence-based Creative Curriculum, used in each of our five classrooms, balances both teacher-directed and child-initiated learning, with an emphasis on responding to children's learning styles and building on their strengths and interests. The curriculum defines the teacher's vital role in connecting content, teaching, and learning for infants, toddlers, and preschool children.

At the Family Center, the teachers are advocates for the children. They act as role

see Education on page 32



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Supporting Youths in Their Recovery Journey to Adulthood

By Andrea Smyth
David Rossetti
and Leonardo I. Rodriguez

The New York State children's behavioral health community is in the last stages of redesigning the children's behavioral health Medicaid benefits. Once approved by the Centers for Medicaid and Medicare (CMS), the new benefits will represent the most significant expansion of children's services since the 1990's when the Office of Mental Health (OMH) added the 1915c Home and Community Based Waiver services to the benefit package. The redesign includes an innovative array of new state plan services, the development of a Health Home (care coordination) infrastructure to support "care management for all," and an effort to break down "silos" and align services across multiple child-serving systems including: health, substance use, mental health and foster care. Most importantly, the redesign revises the age eligibility for behavioral health services, which historically allowed serving children ages 5 to 17, to now encompassing all children and youth birth to 21 years of age. This change will enable a longer continuum of age-appropriate services, enable earlier identification of transition appropriate skill development and support young people more during the critical years of transition into adulthood. The goal is to facilitate more



seamless "hand offs" when adult systems and supports are needed.

Based on the exciting opportunities this redesign affords our system of care, this article focuses on how the behavioral health provider community envisions using the new state plan benefits, care coordination and Home and Community Based services to better support the success of youth-in-transition (YIT). For the purposes of this article YIT are young adults needing behavioral health and substance use treatment between the ages of 15 and 21.

Background

Youth with psychiatric and behavioral disabilities travel a daunting road into adulthood. The YIT research indicates consensus that this population has been neglected in public policy discussions and offers a history of identifying the obstacles to successfully serving YIT. The research offers few viable service solutions and even fewer have been developed widely or sustained. Common obstacles include cross systems eligibility contradictions, lack of

accountability for the public system responding to the need of this age group, fragmentation in programs and funding streams, and differing eligibility requirements in terms of clinical eligibility and age appropriate service availability.

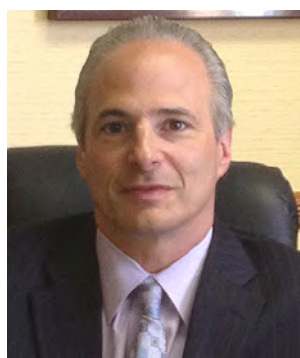
The statistics on this population drove the decision to expand the age of children's services to 21 and the inclusion of treatment and support services that build skills needed by independent adults.

Among the Statistics

- There are over 2.4 million transition age youth (ages 18-26) who had serious mental illness in the United States in 2006. This is a low estimate given that institutionalized individuals were not included in the report. (Government Accountability Office [GAO] Study 2008)
- An estimated 20% of youth receiving treatment for emotional or behavioral problems have either contemplated suicide or attempted suicide. (Bazelon Center for Mental Health Law: Facts on Transitional Services for Youth with Mental Illnesses)
- Over 60% of young adults with a serious mental illness were unable to complete high school (Bazelon Center for Mental Health Law: Facts on Transitional Services for Youth with Mental Illnesses)

see Recovery on page 39

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SIMHS SafeTY.net Early Intervention Program Fills Gaps in Services For Staten Island Youth Battling Trauma-Related Substance Use/Abuse

**By Fern A. Zagor, LCSW, ACSW
President & Chief Executive Officer
Staten Island Mental Health Society**

For more than a decade, Staten Island has been harboring a shameful secret that is only recently coming to light. Our Island outranks each borough, as well as the whole of New York City and State, in the rate of adolescent drug and alcohol abuse, including binge drinking and use of prescription drugs and illegal substances from marijuana to heroin.

Adding to the crisis, is the fact that community-based early intervention services are close to non-existent in the state. There is a serious gap in the continuum between prevention and treatment services for youth and young adults, whether they are at the early stages of substance use/abuse or their dependence is spiraling out of control. Changing the trajectory of abuse for these youngsters requires transforming the system of care within the community.

Experience has shown that the best approach to healing is a community-based, early intervention model that provides intensive case management supports with wrap-around services and goals that are clearly identified and driven by the youth's future aspirations.



Fern A. Zagor, LCSW, ACSW

For many years the SIMHS has created and maintained programs to fill, if not close this gap. For example, our Teen Center services, exclusively for adolescent populations, boast over three decades of successful experience helping youngsters overcome chemical dependencies. Our highly effective SafeTY.net program

for youth transitioning to adulthood, addresses the needs of those with behavioral health diagnoses that often include chemical dependency issues. SafeTY.net uses an evidence-supported, community-based early intervention model, Transition to Independence Process, TIP, developed at the University of South Florida.

In the aftermath of Hurricane Sandy in 2012-2013, we received funding from The American Red Cross and the Staten Island Foundation to create a SafeTY.net offshoot focused on reaching the burgeoning young population on the South and East Shores of Staten Island who had turned, or were turning in increasing numbers, to chemical addictions in large part as a reaction to the traumas caused by the Superstorm, which had devastated that region's families and communities.

Although the area's substance abuse problem was recognized prior to Sandy, it now was increasing to epidemic proportions. This was not surprising, given that substance use increases due to stress, and the Superstorm resulted in extraordinarily high symptoms of PTSD. *But it represented a challenge.*

To meet that challenge, we developed Sandy SafeTY.net, targeting high-risk youth, ages 16-24, from hurricane-impacted communities with the highest rates of substance abuse and overdose deaths.

The SafeTY.net/TIP model proved extremely effective. In the course of one year, 481 youngsters not connected to any prevention or treatment services were assessed, 86 were engaged in the TIP process and made significant strides towards accomplishing healthy, life affirming goals, and 31 were admitted to either a mental health or substance abuse clinic for treatment. All of these high-risk youth and young adults would have been lost to substance abuse without this intensive, community-based, individualized early intervention approach.

Although children who experienced the Superstorm disaster are now several years older, the majority of survivors live in communities that are still experiencing after-effects. A NYC Department of Health and Mental Hygiene (NYC-DOHMH) door-to-door assessment of people directly affected by Hurricane Sandy found one in three children between the ages of 2 and 17 still reporting symptoms such as sadness, nervousness, trouble sleeping, and physical complaints that increased since the storm.

Our Hurricane Sandy funding has ended. However, with the unwavering advocacy of our City Council member Joseph Borelli, and the support of NYC-DOHMH and OASAS, we were fortunate

see SafeTY.net on page 41



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Are We There Yet ? Reflections on the 5 Years of Children's Medicaid Transformation

By Kristin M. Woodlock
Chief Executive Officer
Woodlock & Associates, LLC

It is hard to believe that five years have passed since the New York State Children's MRT Subcommittee released its blueprint to address the unique and complex needs of children in Medicaid Managed Care. In many ways the time has flown by yet today, New York State's target date to fully integrate specialty child welfare and behavioral health services into the Medicaid Managed Care Program remains over a year away. In this important edition of Behavioral Health News, dedicated to the transformation of children's services, it is timely to step back to reflect on our current position in the context of the October 2011 Children's MRT Recommendations.

The Children's MRT included the voices of families, youth, providers, advocates, educators and thought leaders. In representing the diversity of the State, the MRT offered the following points of emphasis:

- An effective children's system should intervene early in the progression of behavioral health disorders. Early identification and intervention is effective in keeping



Kristin M. Woodlock

children on track developmentally, improving educational and vocational futures and in reducing long term health care costs.

- It is essential that children and families have access to the right service at the right time in the right amount.

- Accountability across all payers must be established. Children are covered by a variety of insurance (public/private) products with historic cost shifting to Medicaid and State general funds to support behavioral health needs, which increase the demand on state and county funded services.

- We have to find a way to make our service delivery system easier to navigate and less siloed. Families are often served by a disjointed, overlapping, non-comprehensive and costly series of services. Medicaid redesign must better align systems to yield continuity of care, access and cost efficiency, and promote greater integration of primary care and behavioral health. Special considerations are required to address the complex needs of children in the foster care system.

- The current behavioral healthcare system for children and their families is underfunded. Per capita investment in behavioral health for adults far outweighs investment in children, which could be remedied through reinvestment of existing resources.

- The Managed Care benefit package and processes for children will require innovative and targeted focus on children with special needs.

- The Managed Care initiative must develop outcome measurements and standards to review program performance that are targeted to children with special needs.

The principles articulated in October 2011 remain relevant and collective efforts to advance a strong system of care for children have been steadfast. The New York State Children's Team, the Children's MRT and key Advocates have worked seemingly non-stop over the past five years. And yet, the ability to translate State policy for inclusion of specialty children's services in Medicaid into the day-to-day operations of service providers remains elusive and the future pathway unclear.

Refocusing on the "Why"

Let's face it, we have been working towards Children's Health Home, Waiver Reform, transitioning kids to Medicaid Managed Care for what seems like an eternity! Over time our conversations and gestalt have shifted from focus on our future vision to one limited by the next implementation step or hurdle before us. Have you completed your CANS-NY Training? Do you have a Business

see Reflections on page 38

The System-of-Care Movement Through a Trauma-Informed Lens: Implications for Systems Transformation

By Andrew Bell, PhD
Program Director of Children's Mental Health, Westchester County Department of Community Mental Health

Trying to change systems is never an easy task. Efforts to encourage, argue, incentivize, and mandate change, are often met with piecemeal results, only to revert back to business as usual. On rare occasions however, profound change can happen quickly and even effortlessly. These changes often unfold in unplanned, unexpected and novel ways, and they typically accompany substantive shifts in underlying core values, assumptions and world-views.

The System-of-Care (SOC) movement marks one such shift in our recent history. In the 1980s, family members and youth felt that child-serving systems stigmatized and blamed parents, pathologized children, operated in compartmentalized silos, and devalued community and culture as driving forces of recovery and growth. The movement was a response to an implicit bias in traditional child-serving systems, which favored the perspective of providers and institutions over the lived experience of parents and children.

The SOC approach delineated "core values" that emphasized the importance of being family-driven and youth-guided, leveraging strengths rather than focusing on deficits, and providing individualized care through collaboration among provid-

ers, natural supports and community resources. These values were readily embraced by many providers who intuitively understood their importance, and catalyzed a sea change that rippled to local, State and Federal levels. To this day, SOC values and practices occupy an important place in policy, grant funding, and best practices. These values offer a lens that informs many non-traditional community-based interventions such as wraparound care, respite, family support, and youth-peer support.

Despite these gains, the SOC movement still operates largely within a service delivery environment that is often at odds with these values. Remnants of a disease model pervade much of our child serving systems, and medical necessity, levels of care, severity of illness, stabilization, and functional deficits can obfuscate the fact that symptoms and behaviors are almost always embedded in a situational and interpersonal context within which issues of survival and adaptation play a silent but important role. Providers can easily find themselves occupying two incompatible worlds, and often seek to split the difference by combining services based on system-of-care values, with those based on a disease model.

An encouraging recent movement, often referred to as "trauma-informed care," offers an alternative to the more traditional medical model approach, and fits quite well with the SOC perspective. An important contribution of a trauma

lens is that it offers a neurobiological basis for understanding why and how SOC values and practices are important. It essentially offers a new "medical model" that counterbalances lingering biases of the disease model. Rather than viewing symptoms and behaviors as evidence of an underlying pathological process, a trauma-informed approach views them as potentially adaptive efforts to survive.

Over the course of evolution, our brains and bodies have developed at least three distinct survival strategies, each of which has its own way of perceiving, feeling, reacting, remembering, and learning. The fight/flight response prepares us for explosive instrumental action when our lives are in danger; the freeze response shuts us down when the threat seems inescapable; and our most sophisticated survival strategy, the "social engagement system" comes online only when we feel relatively safe. Traumatic stress occurs when the more primitive fight/flight and freeze responses are activated too easily, too often or in the wrong situation; or when people get stuck in these states. And recovery, growth and resilience occur when people learn to recruit their more evolutionarily advanced social engagement systems to circumvent, traverse and get out of primitive survival states.

The social engagement system is optimally activated and becomes strengthened over time in response to experiences of positive attachment characterized by safety, trust, predictability, transparency,

mutuality and empowerment. For this reason, trauma-informed treatment is guided by the client, strengths are emphasized, and traditional power differentials are leveled in favor of recognizing the respective expertise of both client and provider in a mutually collaborative effort. Trauma-informed perspectives also emphasize the key role of mind-body integration in recruiting and strengthening the social engagement system, and they embrace the value of community, cultural and spiritual traditions.

Such an approach aligns closely with SOC values and practices. Wraparound practices emphasize the voice and choice of families and youth in determining strengths and challenges, choosing services and interventions, and deciding whom to invite to meetings. Attachment and mutuality lie at the core of system-of-care values, as does collaboration, and connection to community and culture. In many ways, it could be argued that SOC values and practices were trauma-informed before the term ever existed. They evolved out of common sense, local knowledge, and the timeless wisdom of cultures and communities, rather than MRI scans and psychophysiological studies of trauma survivors; yet, both movements converge on the same values, principles and approaches.

In Westchester County, the synergy between these two movements promises to be a powerful catalyst toward systems

see Transformation on page 37

PSCH Opens 58 Bed Apartment Complex

Mixed-Use Residence Heralds Affordable Housing in the Bronx

Staff Writer
Behavioral Health News

When you visit 165th Street in the Bronx you'll see it has an attractive new addition to its neighborhood skyline. A 10-story 58 unit apartment building opened on September 13, 2016. This facility increases the supportive housing capacity in New York City, targeting certain populations in need of rental assistance and mental health services in order to live more independently in the community. This project coincides with New York City Mayor Bill de Blasio's affordable housing projects.

The building became a reality through a joint partnership among state and city supporters. Funding for this project was made possible through the New York State Office of Mental Health and The Richman Group. PSCH is proud to partner with CSD Housing, LLC, a leader in building affordable housing communities. The design of this contemporary structure was created by Urban Architectural Initiative (UAI) and contracted by MEGA Contracting Group.

Tenants will enjoy modern kitchens and baths, with such amenities as laundry facilities, an exercise center, bike storage,



PSCH's New Affordable Housing Residence Opening

a multi-purpose community resource room and spacious outdoor landscaped recreation areas.

Thirty-eight units will be reserved for individuals with severe and persistent mental illness, who are in need of daily living skills assistance. The remaining 20 units are reserved for individuals with or without a mental health diagnosis, who meet low-income eligibility criteria. There will be 46 studio; 6 one-bedroom units;

and 6 two-bedroom units. The building will have 24/7 front desk coverage on on-site support services.

Research has shown that when offered a stable housing environment first, an individual is better equipped to set and achieve personal goals. PSCH has assembled an expert team of case managers, peer specialists and a program director who will work in tandem to refer each tenant to a variety of supportive services

to ensure their successful reintegration into the community.

During the opening ceremonies, guests heard from state, city and community leaders.

Jonathan Soto, Senior Community Liaison, New York City Community Affairs Unit said, "When we talk about an agenda of equity for this city, we also need to talk about dignity. Being able to walk into this beautiful space with state-of-the-art facilities, meant to take care of the New Yorkers who need it most, not only warms my heart, but is something our Mayor and First Lady greatly appreciate."

"PSCH's mission is realized in this building. The building itself is beautiful," commented Moira Tashjian, Associate Commissioner, Division of Adult Community Care Group, New York State Office of Mental Health. "What happens within its walls is even more beautiful. Individuals now have a safe place to live – affordable, permanent, and a place where they can move in their recovery."

The Honorable Aurelia Greene, Deputy Bronx Borough President thanked PSCH on behalf of Borough President Ruben Diaz Jr. and the residents of the Bronx for making this facility possible, "It is a beautiful structure that will change lives."

see Residence on page 38



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Early Identification of Childhood Disorders in Primary Care

By Virna Little, PsyD
and Jessica Neufeld, MPH
The Institute for Family Health

Primary care providers are usually the first clinicians to identify behavioral health problems in children. Children with disruptive behavioral problems show symptoms during their primary care visits and their families rely on their primary providers for information, resources and support.

Currently, the Institute for Family Health, the largest federally qualified health center in New York State, is assisting in an evidence-based preventative program that provides family-centered group therapy to children with disruptive behavior problems and their families. This program called the 4Rs and 2Ss model establishes supportive outlets for these families while providing their children specialized mental health treatment. This intervention also prioritizes integration of health providers, pediatric mental health clinicians and family partners for sustaining the multiple family group structure.

The 4Rs and 2Ss model stands for Rules, Respectful Communication, Relationships, Responsibility and Stress and Social support. The family group dynamic creates cohesion, and support, while reducing negative parent-child exchanges, parental stress and disobedient behaviors in children before symptoms worsen (McSilver Institute for Poverty, Policy, and Research, 2013). The group goal is to produce a significantly greater impact on child outcomes over time relative to support, responsibilities and respectful communication.

Over the past year, the Institute has identified a 20% prevalence rate among our school age children who identify with conduct and behavior problems at our centers. Previously, during these primary care visits, a provider was unable to offer referrals to these patients. With the 4Rs and 2Ss model, the primary care provider can inform patients about this opportunity and



refer the patient's families to these groups. The provider can participate in their patients' treatment while sending them and their families to groups managed by behavioral health providers at our centers.

Now, physicians can refer children to preventative treatment programs before behavioral disorders become more problematic. By engaging patients in primary care, we are changing the current delivery system before behavioral disorders develop into more serious diagnoses. The ability to identify children in primary care setting prior to the development of more serious mental health problems will be transformational in prevention efforts.

For more information about the Institute for Family Health visit us online at www.institute.org.

Virna Little, PsyD, LCSW-r, MBA, CCM, SAP, is Senior Vice President Psychosocial Services/Community Affairs, at The Institute for Family Health. Jessica Neufeld, MPH, is Special Projects Coordinator at The Institute for Family Health.

It Takes a Village

Paige Pierce, Chief Executive Officer
Families Together in New York State

When we hear the phrase "It takes a village to raise a child", we think of the African apologue, or maybe Hillary Clinton's book about larger societal responsibilities. But in the children's behavioral health system, it is also true. Throughout the history of this system, there has been a drumbeat, from families and other experts, that no one part of a child's life is unrelated to the rest. And that meeting children's multiple needs requires coordination and collaboration. Coordination of the many systems in a child's life and collaboration among the many stakeholders who can help determine their success.

Experts in the children's behavioral health system (including families) have long maintained that these are necessary components of a system of care. Even the words "system of care" have been used by the children's mental health system for decades. In fact, SAMHSA has awarded System of Care grants to counties across the country for over two decades that support the premise that the many stakeholders in a child's life are each important assets in ensuring success for that child, particularly if they have behavioral health needs. There is a recognition that wrapping supports around a child and family makes good sense. These can, and often do include "natural supports" like family members, professionals from other systems, people from that child's community and community based organizations. Terms like "Home and Community Based Services" (HCBS), Coordinated Care, and Peer Support all stem from the the children's behavioral health system.

The Adult behavioral health system has rightfully adopted these concepts because they are effective... for everyone. Coordination of the many components of a person's life prevents costly duplication while reducing the frustration that can come with an uncoordinated, confusing system.

So now that we are transforming the children's behavioral health care system for Medicaid eligible families, we have the opportunity to put these terms to practice in a systemic way. Some of the work has been done regarding the concept of care management and coordination of care. At least the understanding and acceptance of the philosophy already exists in this system. And health plans are recognizing the benefits of these types of services. Benefits like reduction in no-show rates, reduction in expensive out-of-home placements, fewer ER visits, and healthier, more satisfied consumers and family members. All of these assisting in their goals of better health outcomes while reducing costs.

The transformation of the children's system provides the opportunity to employ strategies that have already been

determined to be effective and offer them in an organized, managed way that will expand the philosophy that "it takes a village". So it's actually less about transforming the existing system and more about improving upon the model and making it more accessible. The new system will include "SPA" (State Plan Amendment) services for all Medicaid eligible children and their families. These services include Youth Peer Support and Family Peer Support.

Peer support is one of the most critical services in this new system. As is often the case, people with "lived experience" are often the best resource for identifying what their needs are, what empowers them, and how systems can be helpful. Fortunately, through the transformation process, stakeholders in the children's system, namely families, have been consulted and included in this design. Their expertise will significantly aid in the success of the overall effort.

Children with behavioral healthcare needs frequently have involvement in multiple systems. Coordination of these services has often fallen on the families to manage. Parents have been "Care Managers" for their children. They have become well versed in the various systems and learned to navigate them, sometimes while overcoming barriers to access that were initially designed to be helpful. Now, these families are expert navigators who have the opportunity to be trained and credentialed to help other families manage, navigate and coordinate their child's care. In addition to their training and credentialing, these Family Peer Advocates (FPA) bring credibility to the table with their lived experience. A level of trust is established when engaging with a peer, someone who has been in their shoes and will not judge. In addition to their expertise as navigators, FPAs assist with engagement and empowerment, both of which are critical to the delivery of effective community based services. So now, families contribute on the system level as providers of peer support and at the individual level as informed, engaged members of their child's team and as critical members of the village.

Families Together in New York State is a statewide family-run organization representing families of children with behavioral health needs navigating multiple systems, these systems include Juvenile Justice, Mental Health, Developmental Disabilities, Child Welfare, Education, Addiction, and Physical Health.

Through training, education, advocacy, policy work, and system coordination Families Together is actively involved in New York State's Medicaid redesign ensuring all families have access to Family Peer Support services.

Families Together facilitates the Training, Credentialing and workforce development for Family Peer Advocates statewide. For further information please visit our website: www.ftnys.org.

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but in rising every time we fall" - Confucius*

Transforming NJ's System of Care Through Collaborative Efforts

By Lauren Agoratus, MA
and Tatsiana DaGrosa

A system of care is a big picture approach to how, when, and where services and supports are offered. The System of Care approach to service delivery for children began in the 1990s as communities were looking for ways to improve the well-being of children with serious emotional and behavioral disorders. It is important to note that not all states have Systems of Care on a statewide level, as some are local or county-based (see Resources).

Initial Efforts: Originally, the State of New Jersey had a vision for a single point of entry for children's mental health needs. Stakeholders, such as state human/social services departments and divisions, providers, family organizations such as the Statewide Parent Advocacy Network and the NJ Parents Caucus, families, and advocacy organizations such as the Association for Children of NJ (now Advocates for Children of NJ) sought to streamline the various silos of services available to children with mental illnesses. This culminated with the State of New Jersey establishing the Department of Children and Families (DCF) in 2006.

DCF is the first Cabinet-level department in New Jersey devoted exclusively to serving and safeguarding the most vul-



nerable children and families of our state. This also means that children's services were now housed in one department, creating an ease of access for stakeholders and consumers.

Consolidation of Efforts: The New Jersey Children's System of Care (NJ CSOC) is a division of the New Jersey Department of Children and Families. Previously known as the Division of Child Behavioral Health Services, the vision of NJ CSOC first began as a federal grant program in 1999. In 2006, along with input from families, NJ CSOC was transitioned

to be a part of DCF, and was expanded to provide services statewide.

The New Jersey Children's System of Care partners with PerformCare, a company that has served as the Contracted System Administrator for NJ CSOC since 2009. PerformCare provides 24/7 access for families, and coordinates care for over 50,000 of New Jersey's children a year.

Some of the services to which NJ CSOC PerformCare can help families connect include: Care Management Organizations (CMO); Family Support Organizations (FSO); and Mobile Response

and Stabilization Services (MRSS)

Care Management Organizations (CMO) are county-based, nonprofit organizations, responsible for face-to-face care management and comprehensive service planning for youth and their families with intense and/or complex needs. The CMO uses a wraparound approach to planning for each youth and provides a single point of accountability for the services and the supports needed to maintain stability.

Family Support Organizations (FSO) work collaboratively with PerformCare, Care Management Organizations, state agencies, and other providers to offer face-to-face family support to families and ensure that the System of Care is responsive to the needs of children and families.

FSOs work closely with families to provide support from their own shared experiences, offer guidance on ways to maximize available resources, make connections to other community supports, and facilitate advocacy to make sure a family's needs are heard. The NJ Alliance of Family Support Organizations, NJ's Federation of Families for Children's Mental Health State Organization, provides support to the network of 15 FSOs.

In New Jersey, information and support for parents is available at the county level and can be accessed at www.njfamilyalliance.org. The site is available in several languages via

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Improving Children's Health by Focusing on Value

**By Kate Breslin, MPH, MCRP
President and CEO, Schuyler Center
for Analysis and Advocacy**

New York State is well down the path to instituting significant changes in how the State pays for health care for low-income and disabled individuals, many of them children. Like many other states, New York is testing new payment methodologies in an effort to achieve positive changes in how health care is delivered and in individual and population health. An important component of the newer methodologies is payment for improved health outcomes rather than paying for visits and procedures.

New York State is using Medicaid, the health insurance program that covers people who have low incomes and/or a disability, to drive system transformation. Medicaid is public coverage, funded approximately 50% by the federal government and the other 50% by State and county government. Covering 5.6 million people, Medicaid is the largest single payer for health care services in New York State. New York State Medicaid provides health insurance coverage for 46% of all births in the state and 43% of New York's children. With this amount of market share, Medicaid's policies and practices – how and what it pays for -- have the capacity to influence how the medical care system works.

The guiding principle of New York's payment and delivery system reform initiatives is the Institute for Healthcare Improvement's Triple Aim (www.ihl.org): Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and Reducing the per capita cost of health care.

Until now, most of the attention on new payment and care delivery models has been focused on populations of adults with chronic conditions and significant behavioral health needs. This is because a substantial proportion of expenditures are associated with medical care for a relatively small number of people with significant health care needs, primarily due to more than one chronic condition and/or behavioral health conditions. Many of the recent initiatives are seeking to generate better health and medical savings in the short-term by improving care management for this population. While a small proportion of children have significant and disparate health care needs, most children are relatively physically healthy and thus have not been the focus of health system transformation.

Despite a lack of discussion of the unique needs of children in the State's deliberations about value-based payment (VBP), the approaches being suggested (shared savings, shared risk, bundles, capitation, and continued fee-for-service approaches for preventive services) would be applicable to payment for services for children in New York Medicaid. It is likely that the current investment in children's health is low compared to what could be most effective for long-term outcomes, especially as it relates to early childhood development and prevention.

Thus, applying adult-focused VBP principles to the child population could further systematize underspending. In addition, to the extent that system transformation efforts currently underway aim to fundamentally change New York's health care delivery system, the current focus on adults poses the risk of New York creating a system that, by design, ignores the developmental trajectory of children.

Together with the United Hospital Fund, the Schuyler Center for Analysis and Advocacy commissioned a report, written by Bailit Health, proposing a child-centered approach to value-based payment in Medicaid (Value-Based Payment Models for Child Health Services, Bailit Health, July 2016, www.scaany.org). Grounded in data on children's utilization of health care services, literature on children's health and medical care, and expert interviews, the report concludes that there are substantial differences in children's health care utilization compared to adults and differences in the "value" of children's health care. It argues for a distinct approach to value-based payment, not modeled on approaches that were designed for adult populations. Many of the report's conclusions are rooted in two key observations: first, "unlike adults, most children are generally healthy," and second, "the management of childhood adversities and chronic conditions has pay-offs many years into the future." The report pays particular attention to the detrimental effect that childhood adversity has on early childhood development. "Given the increased recognition of how profoundly social determinants of health (including Adverse Childhood Experiences or ACEs) affect childhood development and adult health and social productivity, payment models need to consider how to motivate and support attention in this area."

The New York State Department of Health (DOH) has a Value-Based Payment Workgroup, composed of large institutional providers; payers; community-based providers of physical and behavioral health; consumer advocates; State agency staff from an array of agencies; and other experts. In addition, there are several subcommittees and clinical advisory groups, all working on different aspects of VBP implementation. A newly formed subcommittee and clinical advisory group will develop recommendations regarding value-based payment for children. The Schuyler Center recommends that the subcommittee and clinical advisory group consider the following:

Social determinants of health, including poverty. The World Health Organization describes the social determinants of health as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. People from lower-income families are more than twice as likely to face serious illness or premature death (PolicyLab at the Children's

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Dr. Josh Gordon- New NIMH Director

**By the National Institute
of Health (NIH)**

National Institutes of Health Director Francis S. Collins, M.D., Ph.D., announced today the selection of Joshua A. Gordon, M.D., Ph.D., as director of the National Institute of Mental Health (NIMH). Dr. Gordon is expected to join NIH in September.

"Josh is a visionary psychiatrist and neuroscientist with deep experience in mental health research and practice. He is exceptionally well qualified to lead the NIMH research agenda to improve mental health and treatments for mental illnesses," said Dr. Collins. "We're thrilled to have him join the NIH leadership team."

As NIMH director, Dr. Gordon will oversee the lead federal agency for research on mental illnesses. With an annual budget of approximately \$1.5 billion, NIMH supports more than 2,000 research grants and contracts at universities and other institutions across the country and overseas. In addition, the NIMH intramural research program supports approximately 300 scientists working on the NIH campuses. The mission of the NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure.

Dr. Gordon will join NIH from New York City, where he serves as associate professor of Psychiatry at Columbia University Medical Center and research psychiatrist at the New York State Psychiatric Institute. In addition to his research, Dr. Gordon is an associate director of the Columbia University/New York State Psychiatric Institute Adult Psychiatry Residency Program, where he directs the neuroscience curriculum and administers the research programs for residents.

Joining the Columbia faculty in 2004, Dr. Gordon's research has focused on the analysis of neural activity in mice carrying mutations of relevance to psychiatric disease. The lab studies genetic models of these diseases from an integrative neuro-

science perspective and across multiple levels of analysis, focused on understanding how a given disease mutation leads to a particular behavior. To this end, the lab employs a range of neuroscience techniques including neurophysiology, which is the study of activity patterns in the brain, and optogenetics, which is the use of light to control neural activity. His work has direct relevance to schizophrenia, anxiety disorders and depression, and has been funded by grants from NIMH and other research organizations. Dr. Gordon maintains a general psychiatric practice, caring for patients who suffer from the illnesses he studies in his lab.

Dr. Gordon pursued a combined M.D./Ph.D. degree at the University of California, San Francisco. Medical school coursework in psychiatry and neuroscience convinced him that the greatest need, and greatest promise, for biomedical science was in these areas. During his Ph.D. thesis, Dr. Gordon pioneered the methods necessary to study brain plasticity in the mouse visual system. Upon completion of the dual degree program at UCSF, Dr. Gordon went to Columbia University for his psychiatry residency and research fellowship.

Dr. Gordon has been a member of the Hope for Depression Research Foundation's Depression Task Force since 2012, where he works collaboratively with this international group to define the neurobiology underlying depression and identify novel treatment targets.

Dr. Gordon's work has been recognized by several prestigious awards, including the Brain and Behavior Research Foundation - NARSAD Young Investigator Award, Rising Star Award from the International Mental Health Research Organization, A.E. Bennett Research Award from the Society of Biological Psychiatry, and Daniel H. Efron Research Award from the American College of Neuropsychopharmacology.

"I want to recognize and thank NIMH Acting Director Bruce Cuthbert, Ph.D., for his exemplary leadership of the NIMH over the past several months," added Dr. Collins.

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models, acknowledge appropriate social behaviors, make daily routines as predictable as possible, limit interruptions, and focus on creating an engaging environment where the children come first.

Early Intervention Pays Off "One Family at a Time"

As the length of residential treatment stays has shortened, we typically have only a few months to make an impact on a young child's development, but the need for early educational services is critical to the family's long-term success.

Officers from page 10

Geriatric Mental Health Alliance of New York, which she co-founded and directs.

Ms. Williams serves on a number of advisory and planning committees including the New York State Interagency Geri-

Our goal for every child is to assist them in making gains in hitting developmental milestones. For the non-verbal child it is age appropriate speech; for the physically delayed child it is walking and running with his/her fellow classmates; and for our older children, it is the reintegration into mainstream schooling. Likewise, our goal for every parent is to provide them with the skills to nurture their child and assist them in understanding their continued role in their child's education and development.

Through the Family Center of Excellence, Odyssey House strives to break the cycle of addiction one family at a time.

atric Mental Health and Chemical Dependence Planning Council, the NYSHHealth Community Advisory Committee and the National Coalition on Mental Health and Aging, which she currently chairs. Ms. Williams is an adjunct lecturer at the Columbia University School of Social Work.

Crystal Jackson New Board Chair at Unique People Services

Staff Writer
Behavioral Health News

Bronx-based nonprofit Unique People Services (UPS) has appointed Crystal E. Jackson to lead its Board of Directors.

Ms. Jackson is a recent recipient of The Network Journal's 40 Under-Forty Achievement Award. As the Senior Vice President, Nonprofit Financial Services Group at Citi, she has been instrumental in providing creative financial solutions to help nonprofit organizations, like UPS, thrive and succeed. Prior to joining Citi, she served as a Vice President in the Not-For-Profit Group at JPMorgan Chase.

As the agency's new Board Chair Jackson hopes to "take Unique People Services to another level," through her knowledge of industry best practices and strong familiarity with the organization and management team. Prior to leading the UPS Board of Directors, Jackson served on the Board as an Audit Committee member for two years. She's also the



former Chair of UPS' Real Estate Committee. Her work has been vital in overseeing supportive housing and other initiatives, touching the lives of hundreds of New Yorkers in need.

Jackson's commitment to giving back extends throughout the New York community. She currently serves as a Youth Director, Board member and Elder for the historical Ephesus SDA Church in Harlem, and mentors inner city high school students through her involvement with the nonprofit organization, iMentor. Jackson is also Co-Chair of Career Development for Citibank's African Heritage Employee Networking Group.

Commenting on her new role at UPS, Jackson says, "I am excited and humbled to be appointed as Board Chair for such a great organization, especially in light of its 25th Anniversary milestone. I witnessed UPS' growth under the leadership of Executive Director, Yvette Brissett-Andre, and I am excited to be an integral part of the team to help build upon the agency's vision and strategy."

With more than 15 years of banking experience, Crystal's expertise will help to shape the financial landscape of the organization. "We are truly honored to have such an asset lead our Board," says Yvette Brissett-Andre, Executive Director, UPS. "We look forward to working collaboratively with Crystal in her new role to ensure the continuation of life-changing services for many more years to come."

About Unique People Services

Founded in 1991, Unique People Services, Inc. (UPS) is a New York-based nonprofit 501(c)3 that provides supportive housing and medical case management

services to individuals and families living with mental health challenges, developmental disabilities, and HIV/AIDS. Now celebrating its 25th Anniversary, UPS operates 24 supportive housing programs in the Bronx, Manhattan, Brooklyn, Queens, and Westchester County.

More than 500 New Yorkers call UPS' home, living in well-appointed residences where they receive meals and support services to help them achieve the highest possible levels of independent living and community inclusion. The transitional, long-term and permanent housing UPS provides has also become a safe haven for many formerly homeless individuals. With the opening of Lynn's Place in 2017, the agency will be embarking on a new affordable housing initiative, helping to transform the lives of low-income singles and families in the Bronx, while furthering the agency's mission of Understanding People, Providing Homes, and Serving Communities.

For more information about UPS, visit <http://www.uniquepeopleservices.org/>.

10th Annual NYC Conference for Working Peer Specialists

By Gita Enders
and Jonathan Edwards

The 10th Annual NYC Conference for Working Peer Specialists, aptly branded "Then, Now, WOW!" was held on July 14, 2016, at New York University's Kimmel Center. Nearly 300 individuals who identify themselves by a host of titles that contain the word peer attended this event, bringing greater visibility to NYC's peer specialist workforce.

Every successful event begins at the door! We would like to acknowledge Deborah Short, Pat Feinberg, Rachel Salomon, and Margie Staker for their graciousness and efficiency in greeting and registering participants, presenters, invited guests, and exhibitors. An enthusiastic group of Howie the Harp trainee volunteers under the direction of Lynnae Brown provided a solid foundation for the Conference, assisting with everything from early registration to prepping the resource room and providing invaluable assistance throughout the day's program. As people gathered near the breakfast tables they were provided with conference programs, lunch and raffle tickets, as well as a commemorative "Conference Players" keepsake booklet, created by Jonathan Edwards, containing photographs and biographies celebrating ten years of speakers and attendees. The booklet also acknowledged the efforts of the conference planning committee: Teena Brooks, Celia Brown, Lynnae Brown, Jonathan Edwards, Gita Enders, Sara Goodman, Larry Hochwald, Yumiko Ikuta, Desiree Moore, Digna Quinones, Deborah Short, Ellen Stoller,

Carlton Whitmore, and Moneer Zarou. Moneer, who supplied a video performance for the opening program, also received an award in recognition of his tremendous support and creative contributions to the committee and to the conference.

The conference opened with the Lavender Light Choir singing Seasons of Love, from the musical Rent, which asks what the proper way is to measure the value of "a year in a life." We chose it to open our 10th anniversary conference as a way to honor the passage of time, what we have achieved as a group, and what all peers have achieved in their lives. The chorus says that the most effective way is to measure in love. When Lavender Light was formed in 1985, it was the only lesbian and gay gospel choir in the world; they strive to offer strength, peace, and hope to their members and to their audiences—similar to messages of hope shared by peer specialists.

Following welcoming remarks by Celia Brown, Regional Advocacy Specialist, New York City Field Office of the NYS Office of Mental Health (OMH), Carlton Whitmore, Director, Office of Consumer Affairs, New York City Department of Health and Mental Hygiene (DOHMH), OMH Commissioner Ann Marie T. Sullivan, M.D., Myla Harrison, Assistant Commissioner, Bureau of Mental Health, DOHMH and Lynn Videka, Ph.D., Dean of the NYU Silver School of Social Work, a lively panel discussion, moderated by Peter Ashenden, Director of Consumer and Family Affairs for Optum Behavioral Solutions, set the tone for a hugely successful event. Panelists Celia Brown, Laverne Miller, Leslie Nelson, and Dr. Peter Stastny shared their histo-

ries as change agents and talked about their visions for the future of peer specialists and peer services.

Each year the Resource Room, overseen by Yumiko Ikuta, attracts more and more attendees, as our dedicated exhibitors provide useful information on job opportunities, educational, vocational, advocacy and health care options. In addition, wellness activities such as chair massage and Reiki were provided throughout the entire day. The Resource Room has grown in popularity from a "clearinghouse" for information, to a lively meeting place where people reunite, network, and gather resources. This year was particularly exciting with the new addition of several managed care and behavioral health organizations including Beacon Health Options, Optum and Empire Blue Cross Blue Shield.

We acknowledge and extend our gratitude to our community partners and stakeholders: Academy of Peer Services, Alcoholism and Substance Abuse Providers of New York State (ASAP), Baltic Street AEH, Inc., Beacon Health Options, City Voices, Coalition of Behavioral Health Agencies Center for Rehabilitation and Recovery, Community Access, Inc. Howie the Harp Advocacy Center, Empire Blue Cross Blue Shield Health Plus, Hearing Voices NYC, Jewish Board of Family and Children's Services, Mental Health Empowerment Project, Mental Health Association of Westchester, NYC Department of Health and Mental Hygiene, Office of Consumer Affairs, NYS Peer Specialist Certification Board, NYS Office of Mental Health, NYC Field Office, Office of Consumer Affairs, and UnitedHealthcare Community Plan.

Workshops and Activities

Our morning lineup addressed such topics as Medicaid Managed Care, Health Homes, supervision, and career development, while also exploring current issues involving suicide, trauma-informed care and advocacy, as well as the role of peers. The morning saw participants hard at work as they experienced interactive breakout sessions and activities. As a testament to the Conference as a whole, the afternoon workshops did not wane in comparison to earlier workshops and activities that set the stage for the day. Knowledge, inspiration, tools, skills, and creative expressions were as abundant as they had been in the morning workshops.

A selection of hearty box lunches was followed by a comedy program directed by David Granirer of Stand Up For Mental Health, which teaches stand-up comedy to people with mental illness as a way of building self-esteem and fighting public stigma. More about David and his exciting programs can be found at <http://standupformentalhealth.com>. Comedians included Angela Cerio, Jonathan Edwards, Gita Enders, Sara Goodman, Jeff McQueen, Digna Quinones, Laurie Vite, and Dennis Whetsel.

Raffles were held throughout the day, offering terrific prizes such as books donated by Darby Penney and Mary Ellen Copeland, and other products and tools, including candles and incense, promoting wellness and job readiness, and a lucky few were the winners of Galaxy tablets and a Fit-Bit device designed to keep track of fitness goals such as walking and heart rate.

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Systems from page 1

Services Plan Act called for integrated services for children with serious emotional disturbances through the development of systems of care. In 1992 the same act that created SAMHSA established a Children's Mental Health Initiative to expand SOC nationally.

Initially, federal funding was pitifully small, (\$4.5 million in 1993). But it grew over the next 20 years to over \$100 million per year, and cumulatively the federal government invested roughly \$1.5 billion in 300 projects to model and seed the development of systems around the country.^{2,3} States and foundations have also invested in the development of various models of SOC. In addition, most of the demonstration projects have used other funding sources such as Medicaid to pay for services, resulting in far more funding than SAMHSA's grants alone.

Currently, SAMHSA is funding over 100 grants to expand and/or sustain systems of care.⁴

What Is a System of Care?

As originally conceived, a system of care is designed to improve the lives and clinical conditions of children and adolescents with serious emotional disturbance and their families. These are children who often have been victims of abuse and/or neglect, are in foster care, are failing in school, are in trouble with the law, etc.

According to SAMHSA a system of care is: "A coordinated network of community-based services and supports or-



Michael B. Friedman, LMSW

ganized to meet the challenges of children and youth and their families. System of care services should be:

- child centered
- family driven
- individualized, strengths based, and evidence informed
- youth guided
- culturally and linguistically competent
- provided in the least restrictive environment
- community based
- accessible
- collaborative and coordinated across an interagency network."⁵

Improved mental health is one of the goals of a system of care. But there are other goals that are equally or even more important. They include:

- living in the community rather than an institution
- having a caring, preferably permanent family
- being physically healthy
- avoiding adverse, traumatic experiences, especially violence
- reducing risk of suicide
- getting an education
- avoiding substance abuse
- avoiding crime and detention for criminal acts
- and more.

Outcomes of SOC

Although evaluations of SOC have had mixed results, there appears to be a consensus that SOC is generally beneficial. SAMHSA claims that SOC participants show:

- improved clinical condition, including reduced symptoms of anxiety and depression
- reduced suicidal thoughts and attempts
- reduced use of inpatient care
- improved functioning
- improved educational outcomes
- improved living situations
- reduced law enforcement contact
- reduced caregiver strain
- reduced costs of care.⁶

Despite this evidence of success, SOC

has yet to expand to scale in the United States. Yes, the federal government has helped to fund 300 initiatives since 1993, but there are over 3100 counties in the United States.⁷ Many states have also funded some SOC efforts—such as the Coordinated Children's Services Initiative (CCSI) in New York State—but it seems safe to say that despite all of this, SOC has spread far more in concept than in reality.

Beyond Systems of Care

The passage of the Affordable Care Act (ACA), which is—unfortunately—generally referred to as "Obamacare", has led to a variety of efforts to restructure behavioral health service delivery and financing. This appears to be resulting in reduced efforts to expand systems of care as defined in the 1980s and 90s. Instead a process referred to in this issue of Behavioral Health News as "transforming systems of care" seems to be underway.

In fact, however, this process began a decade or more ago, some years before the ACA was enacted. For example, in 2006 Jane Knitzer herself argued that the child mental health system should move "beyond integration" and beyond the population of children and adolescents with serious emotional disturbance. She argued that the policy that arose from her own report in 1982 is "short-sighted public policy" and "no longer justified" and called, among other things, for providing early intervention for children and adolescents first exhibiting signs of mental illness and for preventive interventions that

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Children from page 24

assist in resource development.

In successfully implementing a system of care approach in Westchester, leadership staff in the Department of Community Mental Health needed to win inter-agency and family stakeholder consensus. A long history in Westchester of working together across systems helped to accomplish this and to collectively articulate a shared vision and principles. The Department strongly supported the establishment and growth of the family movement, working with Family Ties as equal partners in the process. Achieving community ownership of the change process was integral to its success and the community basis of the Networks, representing the unique cultural and linguistic needs of each community helped to make this a reality. An oversight body was created using our standing Coordinated Children's Services Committee as its base. This Committee continues to this day as the County's longest standing cross system children's planning entity and is co-chaired by DCMH and the Westchester County Department of Social Services.

Westchester County DCMH staff also understood that it was critical to identify strong leaders across systems and agencies in order to move vision from concept to reality. A leadership group was formed and met weekly to keep the approach on track and to develop and sustain new leadership. During Westchester's five years as a federally funded System of Care grant-site we were identified as a model implementation of a system of care, and were asked to serve along with Wraparound

Milwaukee and the Dawn Project, as one of three Host Learning Communities, and then as Team Learning Centers for the rest of the country. As such we were asked to demonstrate how to create an evolving oversight body to promote system level change, how to design, transform and sustain infrastructure development, how to organize at the community level within a county/state structure, how to provide direct access for families, and how to employ a "theory of change" model that addressed the needs of families and communities.

Westchester's accomplishments as a System of Care have included first and foremost establishing true partnerships with families and the family movement, enabling them to serve as the driving force in policy development, program planning, service delivery, advocacy, research and training. Families/Youth were included as members of all standing planning and oversight committees, were paid for their time as such, became paid members of the research team, were involved in program planning and were members of a cross system hiring process for new workers in the System of Care. As the result of its growth and development in the federally funded System of Care effort, Family Ties became an independent 501c(3) with 35-50 employees. Resource Centers for families were developed in six communities.

Effective structures for Wraparound coordination were also built. Child and Family Networks were created in 9 Westchester communities serving over 300 families yearly. Networks worked to: create initial individualized wraparound

plans derived from strength based assessments; utilize resources of the community making them uniquely culturally and linguistically driven; create ongoing support circles to maintain/adjust the plan over time; conduct community organizational meetings; and use the Family Group Conferencing Model to enhance cultural competency in situations where "bottom line" issues with serious consequences existed. Non-traditional clinical practices and wraparound designs flourished in the Westchester System of Care model. Mobile, family driven, community-based care coordination including respite and crisis components was instituted as was Safety Programming (Clinical and Case Management) for youth with sexually aggressive/sexually reactive behaviors. Risk Assessment and Strategic Community Safety Planning for youth with fire-setting behaviors was begun in a cross system community based effort with fire departments and child welfare staff as well as mental health professionals.

A Network, clinical case management and peer support approach for young people aging-out of the Children's Mental Health System was developed, as well as an Early Childhood System of Care model. The Westchester Community Network also embraced Positive Behavioral Interventions and Supports (PBIS) in schools across the county. True systemic change required ongoing expansion of the infrastructure. Single Point of Entry/Return Committees for Residential Care were created to examine the situations of each child referred for residential care in the County child serving systems, to ensure that wraparound plans had been examined

to avert such placements, and that the least restrictive settings of home, school and community were applied. A Single Point of Access (SPOA) for Children's Intensive Services in the mental health system was also adopted (1994) and eventually became required by the NYS Office of Mental Health across all counties in the state.

Cross system planning committees were instituted in the areas of: high risk adoption; bilingual/bicultural family support; co-occurring developmental disabilities and mental health needs; transitional/aging-out services; high risk mental health/child welfare situations; integrating evidence based practices into the System of Care; fire-setting behavior; sexually aggressive/sexually reactive behavior; as well as parents with mental health, substance abuse and developmental disabilities. Each committee, using the Westchester System of Care's theory of change, examined the issues locally; gathered state and national data; looked at successful national and local programs and recommended clinical, case management, and training to be instituted as part of the System of Care. The latest additions have been the Subcommittees on Trauma and Community Partnership for Undoing Racism which have both profoundly affected the System of Care and has adjusted the framework in new ways.

Westchester's System of Care has also created a social marketing and training plan which includes a System of Care orientation series for all new workers; cross system trainings; Strength based assessment training; specialized training

see *Children on page 42*

Governor Cuomo Announces Ground Breaking of \$250 Million South Beach Psychiatric Center Inpatient Building

By the Office of NYS Governor
Andrew M. Cuomo

Governor Andrew M. Cuomo today announced the ground breaking of a new \$250 million inpatient building at South Beach Psychiatric Center in the Ocean Breeze neighborhood of Staten Island. The new 232,000-square-foot facility will replace the Psychiatric Center's 47-year-old buildings that are currently below New York State flood zone height requirements.

"Extreme weather is the new normal and New York's infrastructure and facilities need to be hardened to withstand the severe storms and flooding that Mother Nature is throwing at us more and more," said Governor Cuomo. "The Staten Island health campus sustained millions of dollars in damage during Superstorm Sandy, and today's ground breaking begins a new chapter and exemplifies our efforts to build a stronger and more resilient New York for all."

The \$250 million project is funded with capital bonds issued by DASNY to the New York State Office of Mental Health. The project is projected to employ 400 workers during the time of construction. Development of the facility will include a number of flood prevention meas-



Andrew M. Cuomo

ures to mitigate the effects of future severe weather events. To raise the elevation of the building site, over 186,000 tons of soil has been moved onto the health campus to create a berm to support its foundation and protect the building against flooding. In addition, the residential and recreation areas of the building will be located 20 feet above sea-level, in excess of the minimum heights required by federal and state regulations. New drainage systems have also been installed

throughout the campus to expedite the removal of flood water during storms and prevent damage to buildings.

The five-story facility will feature 250 adult beds and 12 children beds, in secure, separate areas specifically designed to support recovery. The building will maximize natural light, reduce noise levels and provide a calm, homelike environment for patients. Amenities will include secure outdoor porches, communal living spaces, medical and dental clinics, a school, and separate recreation and therapy spaces for children and adults. The new inpatient building will also be connected to the recently-constructed Central Services Building to expedite support services such as nutritional services, utilities, and maintenance support.

"The current South Beach Psychiatric Center inpatient buildings were constructed in 1969 and it is important to recognize how the care and treatment for mental illnesses have evolved over the last 47 years," said New York State Office of Mental Health Commissioner Dr. Ann Sullivan. "This modern, updated facility will reflect the goals of our agency: patient-centered care in a welcoming and safe environment focused on our agency's pillars of recovery and hope. We are excited about the future of South Beach as we continue to serve the communities of Staten Island and Brooklyn

who rely on our services."

"Delivering facilities like this one is DASNY's core mission," said DASNY President and CEO Gerrard P. Bushell. "As the nation's largest issuer of low-cost, tax-exempt bonds and one of its biggest public builders, DASNY is New York State's developer. Our work creates the foundation that helps communities thrive and we are proud to do it in partnership with the Office of Mental Health."

The building will be constructed to operate as an energy efficient building, with a pending goal of LEED-Silver certification from the United States Green Building Conference. The building features an environmentally-friendly "living roof" planted with native flora, helping to insulate the building, while absorbing rainwater and serving as natural habitat for wildlife.

During the first phase of construction, 26 percent of the workforce were hired locally from Staten Island. Additionally, the project expects to exceed a workforce goal that includes 45 percent minority and women workers, and exceed the state's required contract rate of 30 percent for Minority and Women Owned Business Enterprises, and satisfy a three percent contract rate for Service-Disabled Veteran-Owned Businesses.

see Center on page 42

Medicaid from page 4

regulations do not align exactly with some level of care tools, including more commonly known tools such as ASAM. OASAS worked with the National Center on Addiction and Substance Abuse to develop a brief, web-based tool (LOCADTR 3.0) to identify appropriate levels of care that align with the NYS system of treatment. It incorporates questions and algorithms that focus on the adolescent population. This new tool, completed after an assessment of the individual has been conducted, is a risk and resource based decision tree. It gives weighting to factors such as the risks involved with the substance being used (e.g. overdose potential) and the resources that the individual has (e.g. employment, family support, housing, etc.). NY requires that all Medicaid Managed Care Plans use this tool. NY also requires that all Commercial insurance plans that issue policies in NYS use this tool or other tools that have been approved by the OASAS Commissioner. Any tool that requires a "fail first" threshold before access to higher care levels is granted will not be approved by the Commissioner.

Clubhouses for Youth. A major challenge for youth entering Recovery is how to find safe and fun activities to engage in. All too often we here youth complain that there was nothing else to do but go party. New York is implementing seven Clubhouses designed to serve youth. These centers will provide a safe haven for those in Recovery or at risk of devel-



Steve Hanson

oping an SUD to socialize and receive ancillary services (education, recreation, vocational skills, etc.). New York is committed to this approach and will be opening more centers in the near future to provide statewide coverage.

All of these changes are designed to ensure quick and easy access to the appropriate levels of care, with a focus on providing services in the community to support young people in their Recovery. In these very dangerous times of opioid and synthetic drug crises, it is important that our treatment delivery system be aligned to meet the needs of our young people.

Autism from page 22

barriers with certain carriers. In February of this year, the Massachusetts Attorney General's Office reached a settlement with a health plan over allegations that it prevented access to coverage of ABA treatments by requiring parents to be present at 100 percent of treatment sessions and not covering ABA in day care or preschools. As part of the settlement, the health plan agreed to reimburse members who paid out-of-pocket for ABA therapy and providers who returned payments from the health plan because of its policies. But experience showed that most families affected by these restrictive policies simply went without treatment, and/or sought alternate coverage to access ABA, often at great expense.

Numerous other challenges face families. The autism insurance mandates vary by state, which results in different coverage, depending on where you live. They don't apply to companies that self-insure their own workers and some mandates set caps on annual dollar amounts or the number of hours of treatments, or set age limits.

Self-insured employers have been slow to adopt coverage. In Massachusetts, Harvard University adopted coverage for ABA in 2016, after five years of strong advocacy from parents and others. Massachusetts Institute of Technology and Boston University adopted coverage a few years earlier, but only cover ABA for children ages 3-6. Ironically, these are institutions that are at the forefront of cutting-edge autism research, yet their employees struggle mightily to obtain care for their children. Thousands of other families insured through federal employee plans, unions, and other large employers are

still unable to access treatment without obtaining alternative coverage.

And for those with insurance, Thivierge notes, "it's very difficult to find providers and it's very competitive." In many cases, providers take on unmanageable caseloads, and the quality of care suffers. As with other health care providers, parents and guardians need to consider the skill set of the provider, how long the provider has been practicing and where the provider was trained and educated. At the Autism Insurance Resource Center, we regularly provide families with reprints of an Exceptional Lives Blog post that outlines the 10 questions you should ask when searching for a quality ABA provider.

Insurance coverage for autism has been a catalyst for systemic change across the country in how people with autism access treatment and services. For those who are able to access treatment, it can be transformative. As one Massachusetts parent wrote to our center, "the treatments available are an integral reason my son continues to have the opportunity to live at home, stay in his community and remain in his school." But so much more needs to be done to eliminate barriers, improve access, and provide support to ensure that everyone with autism benefits. So that, like Thivierge's son, all children with autism will have access to treatments and have the opportunity to graduate from high school, attend college, and grow into adults who live, work and thrive.

Amy Weinstock is also an instructor in the University of Massachusetts Medical School's Department of Psychiatry. She can be reached by email at amy.weinstock@umassmed.edu or by phone at (774)455-4056.

Specialty from page 20

responsibly addressed in a sustainable fashion

- Transitioning the locus of care of these prioritized populations to their home communities.

Beyond the significance of the planned transfer of responsibility to Medicaid health plans for this specialty systems management (following and benefitting from the lessons learned in the ongoing adult transition) is the transfer of virtually all current and new behavioral health State Plan services. Those services, most of which are new to our health plans, include:

- Psychosocial Rehabilitation
- Family Peer Support Service
- Youth Peer Support and Training
- Community Psychiatric Supports and Treatment
- Crisis Intervention
- Other Licensed Practitioner-provided Community Services
- Children's Home and Community Based Waiver Services
- Care Coordination:
 - Respite: Planned and Crisis
 - Habilitative Skill Building
 - Pre-Vocational Services
 - Supported Employment
 - Family and Caregiver Support Services
 - Community Self-Advocacy Training and Support
 - Habilitation
 - Adaptive and Assistive Equipment
 - Accessibility Modifications
 - Palliative Care
 - Customized Goods and Services

The ambitiousness of the plan and its implementation timelines should not discourage us, and we should be comforted by the fact that neighboring states have successfully achieved significant reforms. Their experience warrants our careful review and consideration.

Massachusetts

For more than 20 years, Beacon has managed behavioral care service delivery to the majority of the Commonwealth's children and youth, including those in the care and custody of child welfare and juvenile justice agencies. Those responsibilities were expanded in 2009 to execute a statewide enhancement of the public behavioral health system that was child-centered and family driven, strengths-based, culturally responsive, integrated and improving continuously. Strategically, the initiative known as the Children's Behavioral Health Initiative (CBHI) prioritized:

- Increased timely access to appropriate services
- An expanded array of community-based services (mobile crisis and stabilization, intensive care coordination, family support and training, in-home behavioral services, therapeutic mentoring, in-home therapy services, etc.)

- Reduced health disparities
- The promotion of clinical best practices and innovation
- The establishment of an integrated behavioral health system across state agencies
- A strengthened, expanded and diversified workforce
- Mutual accountability, transparency and continuous quality improvement.

Given the importance of practice-level integration, several states have embraced Beacon's nationally recognized integration initiative, the Massachusetts Child Psychiatry Access Project (MCPAP) which supports over 95% of pediatric primary care professionals in Massachusetts. Hillary Clinton recently recognized MCPAP in her Comprehensive Agenda on Mental Health. MCPAP employs a public health model that emphasizes universal behavioral health screening, maximizes access to services in the appropriate setting and mitigates the lack of child psychiatry resources. Regionally-based teams help pediatric primary care providers (PCPs) build capacity to meet their patients' behavioral health needs through real-time telephone consultation with MCPAP's child psychiatrists. They also expedite face-to-face appointments when indicated for acute psychopharmacology or diagnostic evaluation and assist PCPs and families with prioritized access to community-based behavioral health services.

Connecticut

In 2005, responding to the over utilization of children's inpatient and residential care and the over reliance on emergency department interventions, Connecticut's Departments of Social Services (Medicaid) and Children and Families (child welfare, juvenile justice and children's behavioral health) developed the Connecticut Behavioral Health Partnership (CT BHP), an integrated public behavioral health service system for children and families enrolled in the State's Medicaid program and for other children with complex behavioral health needs. By integrating Medicaid-funded behavioral health services with those funded by the Department of Children and Families (DCF), the Partnership enhanced access to and coordination of community-based behavioral health services and supports leading to better outcomes for children. Specifically, the CT BHP was directed to:

- Expand individualized, family-centered, community-based services
- Maximize federal revenue to fund behavioral health services
- Reduce unnecessary use of institutional and residential services
- Improve administrative oversight and efficiencies
- Monitor individual outcomes and provider performance.

Since 2005, Beacon has served as CT BHP's specialty management partner, addressing the unique and complex clinical and psychosocial needs of the Medicaid and child welfare populations, including clinical outreach to members with

complex needs for whom treatment planning requires carefully supervised care management and coordination, peer support for families who need help navigating the system and network development and management. The children's services network now includes:

- Statewide network of children's emergency mobile crisis teams
- Crisis stabilization units
- Care coordination
- Extended day treatment programs
- Evidence-based or promising-practice models of intensive home-based services (Multi-Systemic Therapy, Multi-Dimensional Family Therapy, Functional Family Therapy, and Intensive In-home Child and Adolescent Psychiatric Services).

Committed to practice level integration and motivated by the success of Beacon's MCPAP, DCF funded Beacon to create ACCESS Mental Health CT to ensure that youth under 19 years of age have access to psychiatric and behavioral health services through their PCPs, irrespective of insurance coverage. The program is designed to increase PCPs' behavioral health knowledge base to better identify and treat behavioral health disorders more effectively and expand their awareness of local resources. As in Massachusetts, Regional Hubs, staffed with seasoned behavioral health professionals provide PCPs with immediate telephone consultation that, depending on the needs of the child and family, can result in referral to the team's:

1. Program coordinator or family peer specialist to assist the family in accessing local behavioral health services
2. Behavioral health clinician to provide transitional (interim) face-to-face or telephonic support to the child and family; or
3. Child psychiatrist for a face-to-face diagnostic evaluation or psychopharmacological consultation.

Rhode Island's State Agency-Involved Children

For almost 15 years, Beacon has managed the behavioral health care for Neighborhood Health Plan-enrolled children and youth who are either in the care and custody (Substitute Care) of the State's child welfare agency, or enrolled as children with special healthcare needs (CSN). Beacon and Neighborhood have collaborated with multiple stakeholders to build a children's system of care to include an array of diversionary services, including acute residential treatment, home-based therapy and case management services. Further, Beacon has enhanced the home-based treatment options to allow more flexible and targeted interventions, resulting in significantly reduced readmissions. In addition, we instituted a process of placing our case managers dedicated to the Substitute Care program within the regional offices of the child welfare agency. This co-location allowed closer collaboration on discharge planning to ensure children did not remain in the hospital due to a lack of post-discharge placement.

Comparing calendar years 2009 and 2010, we observed a 28 percent reduction

in admissions and an 11 percent reduction in readmissions (within 30 days) for this group. We found a 14 percent reduction in admissions and an eight percent reduction in readmissions for the CSN members for the same time interval, primarily based upon the impact of home-based services.

Conclusion

Regardless of a single or multi-health plan strategy, it is critical to recognize that specialty care does matter in regard to the engagement, responsive treatment and support of high risk children, youth and their families—strategies that are inextricably linked to their future wellbeing. The required cross systems challenges are daunting and inherently NOT in the "comfort zone" of most managed care entities. Clearly, trauma-informed clinical direction, translated into responsive network development and management, is critically important and essential to our collective success on this front. Individual and family empowerment and the related use of youth and family peers are also directly tied to improved outcomes, as is value-based purchasing which holds the promise to drive these outcomes and is essential to begin to address the challenges facing our provider partners.

Benefitting immensely from the opportunities we have in advancing similar agenda in neighboring states, Beacon recognizes the importance and complexity of the planned transformation of our children's system of care. Stakeholder collaboration is a key component to the success of the transformation and, to that end, we will continue to work hand in glove with our health plan and provider partners, state, county and city child-serving agencies and our advocacy organization colleagues.

Implementing this visionary transformation through multiple, competitive health plans with uneven public sector experience and network management capacity will be a challenge. Overcoming the historical fragmentation and the "silos of excellence" that characterize much of the City's public behavioral health system is imperative. As is our ensuring critical cross-systems collaboration among child welfare, voluntary foster care, education, juvenile/criminal justice and homelessness services, given the multi-systems involvement of these vulnerable children, youth and families. Finally, recognizing the complexity and multi-faceted challenges ahead, we, as managed care entities, must guard against a business-as-usual approach; embrace the significance of this trusted delegation of city, county and state systems oversight; and turn our collective focus to mechanisms that promote meaningful delivery system reforms. In doing so, we will begin to address the multi-generational impact of trauma, mental illness, substance use disorders, child abuse and neglect, juvenile detention and criminal justice recidivism that more often than not characterizes the lives of these high risk, high need and generally disenfranchised children, youth and families.

Jorge R. Petit, MD, is Regional Senior VP of the New York Region; Richard Sheola, MA, is Vice President, National Strategy and Development; and Heather Mermel, MPH, is Government and Community Liaison Manager at Beacon Health Options.

Transformation from page 28

and culture change. Westchester's system of care is relatively unique in that it is built on a community-organizing model, which makes it one of the oldest and most enduring in the country. There is a vibrant infrastructure involving several local Community Networks (CNs), each of which meets monthly and comprises stakeholders from diverse systems. Volunteers facilitate wraparound meetings for families. The CNs communicate closely with a cross-systems oversight and planning body run jointly by the County's Department of Social Services (DSS) and the Department of Community Mental Health (DCMH). This planning body in turn creates and supports various subcommittees, such as the Committee on Trauma-Informed Care, which meets monthly, and which also consists of a diverse group of engaged stakeholders. Each year, DCMH hosts a four-session "System-of-Care Orientation" for new employees. As a result, nearly every child-serving professional in the county is familiar and conversant in SOC values, and most have participated in wraparound meetings with families.

Westchester's SOC culture provides a valuable platform for discussing and implementing trauma-informed ideas, practices, and initiatives. Perhaps because of the philosophical alignment between both movements, buy-in across disciplines and stakeholders has been surprisingly easy. Multiple stakeholders have readily joined the Trauma Committee, which now comprises representatives from mental health agencies, child welfare, probation, universities, schools, family support, youth-peer support, and recreation centers, as well as yoga- and mindfulness practitioners, first responders, and others. Such balanced diversity has been instrumental in ensuring that trauma-informed ideas are not relegated to proprietary clinical treatment models, but embrace a "common factors" approach that is relevant across disciplines. This diversity has also encouraged creative discussions about how various tools and practices can be adapted to other service settings.

Finally and perhaps most importantly, the evolution of the committee itself over the past five years has engendered a sense of safety, trust and respect among members, which allow for rich, well-

balanced discussions. There is also a great deal of informal collaboration and partnerships. Members share their own and their agencies' struggles and successes; trainings are developed and delivered for various audiences on a wide range of topics and practices; and initiatives and conferences are combined to leverage synergy. Currently, the committee is assisting DSS and DCMH in a joint initiative to encourage a trauma lens among supervisors in foster-care, preventive-services, and mental-health agencies. Thus, Westchester's SOC provides an infrastructure and values-based culture that supports the trauma committee's spirit of inclusiveness, diversity and shared purpose, which in turn enriches the SOC in a variety of ways.

A more specific example of how Westchester's SOC encourages trauma-informed systems transformation is illustrated in the role that young adults have played in identifying and prioritizing policy issues. With the help and guidance of Westchester's family support organization, Family Ties of Westchester, a youth movement called the Bravehearts emerged. The founding members of the Bravehearts started as a small group of foster care alumni, who organized large weekly meetings, advised county government, and mentored individual youth. Family Ties initially helped them organize and receive a two-week curriculum on a variety of issues, including trauma and resilience.

Once engaged in this curriculum, the Braveheart leadership was quick to grasp how trauma and resilience related to their own lives, their friends and families, and even those who had cared for them in residential facilities. Many referred to this knowledge as "liberating," "empowering," and a way to understand, accept and have more compassion for themselves. They also generalized this understanding to a systems level in their recommendations to the county DSS. One was to have an ombudsman for foster care youth; another was to have every foster care youth learn about trauma, noting that it would have been immeasurably helpful for them to have this knowledge while they were in care. Looking back, the Bravehearts' enthusiasm and advocacy may have done more to build momentum for trauma-informed systems change than any other single group. The Braveheart leadership has continued to

pursue their interest in trauma-informed care by attending trainings in Trauma Systems therapy as well as a mini course at Fordham University designed for social work graduate students. Most recently, they organized a panel on trauma-informed care for a Juvenile Justice Re-entry Summit. Family Ties went on to adapt the trauma curriculum to wider range of at risk younger teenagers. As this example illustrates, Westchester's System-of-Care values, practices and infrastructure created conditions for youth voice to be heard and respected, which in turn helped catalyze efforts toward trauma-informed systems change.

Another example of the synergy between Westchester's system of care and trauma informed care is illustrated in the evolution of Trauma Systems Therapy (TST) within the county. In 2010, a meeting between the developers of TST and DCMH Children's Mental Health generated some intriguing possibilities for a novel application of TST within a System-of-Care context. Many elements of the TST model corresponded closely to those of the wraparound process, and Westchester's SOC infrastructure offered some interesting opportunities for multiple stakeholders to become conversant in TST practices across systems.

Shortly thereafter, DCMH and the Trauma Committee hosted a TST conference for a large diverse audience. With a small amount of seed money, along with considerable generosity from NYU Child Study Center and three separate agencies, four home-based programs engaged in TST training and ongoing consultation. Although two programs eventually dropped out, two remained actively involved and a third joined in. The enthusiasm generated from this small project led to an unprecedented partnership between Fordham University's National Center for Social Work Trauma Education and Workforce Development, NYU's Child Study Center and the entire agency of Family Services of Westchester (FSW) to bring TST to all its programs including mental health clinics, therapeutic foster care, group homes, a community residence, respite, and others. This agency-wide implementation crosses both mental health and child welfare systems, and has allowed for better communication and more integrated treatment for children and families.

FSW's implementation of TST within a system-of-care context enriched their agency-wide initiative while also benefit-

ing the system of care itself. For the past three years, the first day of the annual TST training for FSW employees has been open to outside stakeholders, including child welfare workers, supervisors and managers, therapists, family support advocates, the Bravehearts, school representatives and others. Last year, NYU facilitated an additional day of training to an even wider range of community stakeholders to discuss novel ways TST principles could be applied to systems outside of an individual treatment context. This year, an entire DSS unit of preventive services workers, supervisors, and managers will be receiving advanced TST training through the FSW project. In addition, a large school district will be providing TST to homeless students who have also experienced trauma.

As these examples suggest, systems transformation does not appear to be a linear process that can be boiled down to a series of cause-effect relationships, or a single top-down strategy. Rather it seems that SOC values, practices and infrastructure create conditions that allow trauma-informed ideas, innovations, and opportunities to unfold in novel and unexpected ways. A SOC culture places family- and youth voice front and center, and it values inclusiveness and collaboration across systems, silos and disciplines. A trauma-informed perspective offers a neurobiological basis for SOC values and practices, and is helpful in counteracting biases of a disease model and bridging conceptual gaps between clinicians and community providers. Together, they make for more productive discussions, better integration across disciplines, expanded partnerships, and a stronger shared purpose. Westchester County has by no means accomplished the goal of becoming trauma informed or fully embodying our system-of-care aspirations. However, we are hopeful that combining and integrating these approaches will continue to help us enhance collaborations, generate constructive solutions, and anticipate responses to future opportunities and challenges in a way that moves us ever closer to this goal.

The author wishes to thank Danielle Weisberg, Dr. Liane Nelson, Dr. Adam Brown, Polly Kerrigan, Dr. Virginia Strand, Michael Orth, and Carol Hardesty for their feedback and suggestions.

NJ from page 31

a dropdown in the top left corner.

Mobile Response and Stabilization Services (MRSS) are available for all children in crisis situations related to their behavioral or emotional needs, and/or intellectual or developmental disabilities.

MRSS staff will respond to the crisis, in person, within one hour of a call to PerformCare. Typically, the crisis is occurring in the home, but if it occurs outside the home and a parent is able to be present, MRSS staff may be available to assist in person.

With the input of the family and, when possible, the youth, MRSS staff help address the immediate crisis, identify family strengths and needs, and work to develop a plan to address the cause of the behavioral crisis.

Current Trends: The NJ CSOC has always provided supports to youth with

behavioral health challenges in the community as well as to those involved with child protective services.

In recent years, NJ CSOC also began serving children with developmental and/or intellectual disabilities and their families, and providing coordinated access to substance abuse treatment services for eligible youth. By consolidating these services in one division, it creates an ease of access for families in need.

One of the most promising recent developments at NJ CSOC is the formation of a Family Leader workgroup. Parents, guardians and caregivers volunteer on this workgroup to represent the voices of other families involved in the System of Care. Family Leaders bring system issues to the attention of PerformCare's leadership, which is in turn shared with NJ CSOC to ensure that the family perspective is included in service delivery decisions.

Families can also obtain information from the NJ CSOC Youth and Family Guide, which is available in both English and Spanish at <http://www.performcarenj.org/families/youth-family-guide.aspx>.

Transition: NJ CSOC serves youth until their 21st birthday, with a few exceptions. While services and interventions are designed to maximize the strengths and abilities of the youth and families served, NJ CSOC recognizes that a substantial number of youth will require ongoing supports as adults.

Transition to adult services for behavioral health and substance use is handled by the New Jersey Division of Mental Health and Addiction Services (DMHAS). DMHAS is the state mental health authority that plans, monitors, evaluates and regulates New Jersey's mental health and substance abuse prevention, early intervention, treatment and recovery efforts. You can visit the DMHAS website at www.state.nj.us/humanservices/dmhas/home.

New Jersey's Division of Developmental Disabilities (DDD) provides public funding for services and supports that help New Jersey adults ages 21 and older with intellectual and developmental disabilities live as independently as possible. Services and supports are available in the community from independent providers, and in 5 state-run developmental centers. Additional information on DDD can be found at www.nj.gov/humanservices/ddd/home.

By having a vision and bringing together various stakeholders, NJ CSOC has developed into a more streamlined system for families. Listening to the voices of families has helped with continuous quality improvement.

Lauren Agoratus is the parent of a child with autism/kidney disease. She is the NJ Coordinator of Family Voices, the

see NJ on page 39

Residence from page 29

Kim Blocker who lives in one of our mixed-use residences remarked, “I am truly grateful for PSCH – for their support, for helping me live independently, and for helping me to become a productive member of society. That apartment made a difference in my life. It has helped me become an active member in my community and for that, I am forever grateful.”

“Safe and affordable housing in New York City is a challenge for all New Yorkers. It is even more of a challenge for individuals coping with mental illness,” said Alan M. Weinstock, CEO, PSCH, Inc. “Our goal is to create a low-income mixed-use housing developments which offer supportive, safe and nurturing environments where all tenants feel a sense of cohesion and belonging to a larger community. That goal has now been met on 165th street and we are proud of this achievement.”

Ribbon Cutting Ceremony Photo Details: The PSCH 165th mixed-use residence is now open, through a joint partnership of New York State City and private support-



ers. In the photo left to right are: Mike Dehmler, Vice President, Christa Construction, LLC; Moira Tashjian, Associate Commissioner, Division of Adult Community Care Group, NYS Office of Mental Health; Jonathan Soto, Senior Community Liaison, NYC Community Affairs Unit; Honorable Aurelia Greene, Deputy Bronx Borough President; Alan M. Weinstock, Chief Executive Officer, PSCH; Sherry Tucker, Chief Financial Officer, PSCH; and Shavone Hamilton, Chief Operating Officer, PSCH.

Partnerships from page 19

members that have received specialized coaching and training and have developed working partnerships with Community Mental Health Center staff to represent a family voice at the time services are being delivered.

The Salt Lake County FAST program has demonstrated notable outcomes. In 2015, Optum and the FAST program served 43 children. Among these, 16 of the original referrals were sent to the FAST program rather than going to inpatient care, only two children required follow-up hospitalization, and one required care in a residential facility. The remaining 40 children received follow-up care in their home and community environments. The average length of stay in the FAST program was 23.3 days, and only 10 children needed more than 30 days of service. Among the 14 cases to-date in 2016, 10 have been diversions from inpatient care, and no children have required inpatient services. All care has been provided in outpatient, day treatment, and in-home settings, with Family Resource Facilitators being active in half of the cases.

Optum's FAST program demonstrates effective quality and cost-based outcomes, assuring evidence-based care for youth and their families, providing appropriate Inpatient diversions to the home and community, and reducing the expense

of unnecessary inpatient hospital costs. It is another example of how partnering with payers, providers, communities, consumers, and other health stakeholders can improve local systems of care and clinical outcomes.

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

Reference: National Research Council and Institute of Medicine. (2009). Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

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About NAMI

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, support and research, and is steadfast in its commitment to raising awareness and building a community of hope.

About MHA

Mental Health America (MHA) – founded in 1909 – is the nation's leading community-based nonprofit dedicated to helping Americans achieve wellness by living mentally healthier lives. MHA's work is driven by its commitment to promote mental health as a critical part of overall wellness, including prevention for all, early identification and intervention for those at risk, integrated health, behavioral health and other services for those who need them, and recovery as a goal.

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Agreement with a Health Home? Will you apply to be designated for the new SPA Services. Focusing on details is important, but keeping your eye on the prize is essential.

Any significant change or invention requires leadership and a clear and compelling purpose. The Children's MRT had and I would argue still has, deep commitment and vision to see a health care system that is wise in investing in early detection and intervention to help families raise their children to achieve their fullest potential. A healthcare system that is also expert in treatment and support of families and children with the most complex and intensive needs. One that has secondary gains in reducing the number of children in juvenile justice facilities and improving graduation rates for children with serious emotional disturbances.

The work of the MRT to craft a vision has been bolstered through the work of several child-focused experts. The United Hospital Fund (UHF) is expanding on our collective “why” through release of several documents. *Seizing the Moment: Strengthening Children's Primary Care in New York* documents the hope and possibility before New York to “improve the overall health and well-being of its youngest residents through a renewed focus on strengthening primary care to make it responsive to the healthy development challenges children face today.” The report knits evidence based practice, value-based payments, the importance of building solutions for social determinants and the need for child-specific outcomes together into a call for action.

UHF also authored a data brief and chartbook to provide supporting data on children served in the New York State Medicaid system. In *Understanding Medicaid Utilization for Children in New York State: A Data Brief and Understanding Medicaid Utilization for Children in New York State: A Chartbook* we are grounded by the following findings:

- Children account for nearly 40 percent of New York State Medicaid enrollees, but less than 20 percent of the program's expenditures.
- Nearly 90 percent of children averaged \$2,400 in annual expenditures (compared to \$11,154 for adults between the ages of 21 and 64 who were continuously enrolled in Medicaid).
- A relatively small group of 185,625 continuously enrolled children, approximately 10 percent of all continuously enrolled children, account for half of Medicaid expenditures on continuously enrolled children.
- Nearly 85 percent of continuously enrolled children had at least one outpatient evaluation/management or preventive care visit.
- Black and Hispanic children have much higher rates of inpatient hospitalizations and emergency department utilization than white or Asian and Pacific Islander children.
- Inpatient hospitalizations and emergency department utilization also vary by age, diagnosis, and geography.
- Children under age 4 have inpatient and emergency department utilization driven by

respiratory system diseases, including asthma; teenagers and older adolescents have a much higher portion of inpatient utilization driven by behavioral health conditions.

The United Hospital Fund and Schuyler Center for Analysis and Advocacy published Value Based Payment Models for Medicaid Child Health Services written by Bailit Health in July 2016. The document makes a strong case for separate value based designs for children. First and foremost, children do not have the significant medical cost spend that adult do. Value and savings are in making investments in the future in terms of child growth and development and long term health cost avoidance. Secondly, the smaller percentage of children with high medical costs are a diverse population and their health status is significantly impacted by social determinants of health that may be out of the scope of the clinicians and managed care plans. The report offers an analysis of value based payment approaches through a child-specific lens and highlights the lack of readiness for value-based payments across the provider system.

Re-Energizing the New York Child-Serving Sector for Implementation

There are two key areas where each of us -State official, Provider, Advocate, Family Member or Consultant can work to improve implementation of children's reform in New York.

The first is to remember the “why.” Perhaps we need a collective visual or mantra. Maybe it is as simple as creating a children's transformation statement for your Agency. For example, “With everything we do we seek to improve the health/lives of children and their families. We challenge the status quo and offer safety, health care, social supports and connections that are easy to access and deliver results.” This is not fluff. It is our shared commitment and sense of purpose that will keep us focused on the end goal.

If we can reconnect with the vision or “why” we need to rethink the “what” and “how.” This is about working SMARTER together – State, Provider, Advocates and Interested Parties, not simply working HARDER. The impact of periods of development followed by implementation delays has created a sense of implementation fatigue that is beginning to take its toll. Working smarter could include thinking of ways to create a steadier progression for the children's transition. One where, for example, 95% of the milestones are met on time. In order to build more realistic milestones, the BANDWIDTH of State Agencies to develop child-specific rates, outcomes and systems not to mention bandwidth to advance real regulatory reform will need to be extended. Providers similarly need to focus on keeping the current system running while we convert to an entirely new operating system. Children's Providers need to develop an operational vision and framework for delivering healthcare in ways which comport with a competition-based, product-driven market. Or as I like to say, becoming a Millennial Nonprofit®. An architecture within your agency for moving to the value-based world connects and inspires people inside the

see *Reflections on page 39*

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- Adolescents transitioning to adult hood with a serious mental illness are three times more likely to be involved in criminal justice activity than adolescents without an illness (Bazelon Center for Mental Health Law: Facts on Transitional Services for Youth with Mental Illnesses)

- Youth-in-Transition are four times less likely to be engaged in any gainful activities including employment, enrollment in college or trade school (Oregon White Paper)

Building a Better Lens and New Array of Services

When Governor Andrew Cuomo created the New York State Medicaid Redesign Team (MRT), a multi-agency, cross system stakeholder committee to guide the State's efforts to transition to Medicaid Managed Care, a Subcommittee on Children's Behavioral Health was appointed to focus on the unique needs of Medicaid-eligible children and youth. A strength of this "Kids MRT Subcommittee" was including cross-agency leadership, along with community based providers and advocacy representatives from various child-serving systems. The cross-systems approach highlighted many of the "obstacles" and gaps identified earlier in this article for YIT and resulted in service solutions being part of the redesign.

A key example is the early decision to expand the age of eligibility to be uniformly up to the 21st birthday for the new services. Previously, most mental health children's services were only available to those up to age 18, with a few exceptions (residential treatment).

Another example is the addition of Health Home, an individualized care coordination service, to the state Medicaid benefit package. Medicaid enrolled youth will be eligible to remain with a children's Health Home care coordinator up until their 21st birthday, whether they are determined eligible because of a chronic condition, their need for treatment to address serious emotional disturbance; or based upon their need for treatment to address complex trauma (a new eligibility category approved in New York's benefit - "first in the nation" by CMS). There is the ability for some care coordinators to specialize in the care coordination of YIT, as such they may be able to focus on assisting youth in finding adequate housing, identifying educational and vocational opportunities and accessing those opportunities, and promoting active participation in and direction of their treatment.

The highlight of the work by the "Kids MRT" was the addition of six (6) new state plan services to the children's Medicaid benefit. These services offer options that better address the needs of older adolescents and young adults, including:

Being able to serve young people where they are through Other Licensed Practitioner (OLP) which focuses on serving children and youth in the home or community, rather than being restricted to an office-environment. This service addresses the ability to achieve age-appropriate growth and development, and supports goals identified in the treatment plan to address behavioral health conditions in the home and community.

Through the availability of greater access to Crisis Intervention (CI) ser-

vices, youth experiencing a seriously acute psychological or emotional event can receive crisis response services, safety plan development, referral and follow-up to assure stabilization.

With the addition of the Community Psychiatric Supports and Treatment (CPST) service, youth can receive a wide array of supports that actively reinforce treatment goals and the skills necessary for age appropriate development such as, -independent living. These may include increased community participation, establishing positive peer support networks, maintaining self-sufficiency, and developing coping strategies in the social environment, work, home, school.

Similarly, Psychosocial Rehabilitation (PSR) provides "hands on" skill restoration and support to facilitate integration as a productive member of the community with minimal ongoing professional interventions. Enabling young people to prepare for the responsibilities and challenges associated with independence.

One of the most exciting new additions to the state plan service array is Youth Peer Support and Training. This service is provided by a young adult, aged 18-30, who has lived experience in the children's mental health system. They assist the youth in enhancing their ability to manage comprehensive health needs, strengthening resilience & self-advocacy, and developing competency to utilize resources and transition to adulthood.

Finally, the addition of Family Peer Support Services help to strengthen the family; to build advocacy skills of the family/caregiver; and to enhance family and home functioning. This service can assist youth and their families/caregivers in maintaining positive familial relationships into adulthood.

How the New Services Array Will Aid in Transitioning

Currently, the transition between the child-serving behavioral health system and the adult system is abrupt and often times inappropriate, especially when it comes to housing and employment expectations. The new service array, should support treatment that strengthens the ability of youth to build and eventually sustain enduring relationships as they learn develop skills needed to live independently. Relationships, housing and employment are the key developmental milestones for any young adult and maintaining independence depends on skill-building in those domains.

Lastly, some of these services can be provided in community settings. Youth concerned with the stigma of their treatment needs will not have to go to the clinic to receive the new services, as they can all be offered in normative settings. We believe this will improve treatment compliance for young people who definitely have social priorities that compete with their clinical needs.

New Home and Community Based Services Array

In addition to the new services that will be in the state plan and available to any eligible youth, New York will seek approval to re-align the existing array of services under various 1915-c Waivers

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Suicide from 18

primary care practices, hospitals – have an important role to play in reducing suicide deaths among New Yorkers. A core component of the plan relies on improved training for clinicians in the identification and treatment of at-risk individuals. OMH is ramping up training in this area for mental health and substance abuse providers, with plans to expand to other healthcare and social service settings.

2. *Coordinated Community Suicide Prevention:* Working together, communities can make a difference and prevent suicides. Research indicates that individuals who feel disconnected from others are at increased risk for suicide. The second strategy of the plan works to help at-risk individuals foster connections, encouraging them to remain integrated within their communities, throughout their lives. It calls for increasing efforts to intervene at the earliest signs of trouble, before an individual becomes suicidal. Research suggests that the promotion of mental wellness and supportive social connections can leave individuals less vulnerable to suicide, including those with little-to-

Residential from page 18

One expected outcome of this initiative is to demonstrate that by addressing crisis and hospital diversion needs, and by offering step-down services to the children and youth with the highest needs, quality of care will improve, costly admissions and readmissions will be reduced, and immediate Medicaid savings will be achieved. Another goal is to achieve improved and more sustainable outcomes for children, youth, and families. In order to demonstrate these expected outcomes, data collection and reporting will be a must.

Recently, RTF providers have formally joined with State leaders to formulate plans on how to redesign the model. Next steps will include obtaining feedback

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national network that works to keep families at the center of children's health care for children with special healthcare needs; in NJ, Family Voices is housed at the Statewide Parent Advocacy Network (SPAN), www.spanadvocacy.org. SPAN is also the home of the state's Family-to-Family Health Information Center. Lauren can be reached at (800) 654-SPAN or by email at familyvoices@spannj.org. Families can find free help in their state at www.familyvoices.org/states.php. Tatsiana DaGrosa is a Parent Group Specialist for the START Project (Statewide Technical Assistance Resource Team) at SPAN where she helps parents start and run

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organization and beyond. Agency leaders need to articulate a clear vision of what "value-based" means to them from the beginning, breaking it down into clear action steps, communicating what it will look like at mile-markers along the jour-

no contact with health and behavioral healthcare systems. The plan also continues New York's efforts to train the public in suicide prevention as well as develop, support and strengthen community suicide prevention coalitions and create 'suicide safer' school communities.

3. *Data-Informed Suicide Prevention:* Suicide is a complex problem. The third overarching strategy of the plan makes an ongoing commitment to collect better data in order to continuously inform the State's suicide prevention efforts. New York State is fortunate to have a number of resources that contain information relevant to suicide surveillance. This plan explicitly calls for leveraging existing data and developing novel ways to make the latest information more accessible to end users, such as policy makers, providers, and communities working towards suicide prevention. To that end, OMH is working more closely with other state agencies to make better use of new and existing suicide data.

Read the entire '1,700 Too Many': New York State's Suicide Prevention Plan, here: <http://omh.ny.gov/omhweb/resources/publications/suicide-prevention-plan.pdf>

from youth and families and other stakeholders, such as counties. In order to realize this vision, the State, counties, providers, advocates, youth and families need to work in concert to overcome systemic and structural barriers which have historically made change and the evolution of residential services challenging. Reimbursement methodologies, regulations, and even statute will need to be changed in order to achieve something real.

We must build relationships and improve communication and coordination between residential providers and community-based services providers, including family and youth peer specialists. Those connections, in conjunction with Medicaid Redesign, will help us to achieve clinical results we have only dreamed of to date.

local special education support and advisory groups. She also served as an SSRP (Superstorm Sandy Resiliency Project) Family Resource Specialist.

Special thanks to Matthew Franke, Senior Communications Specialist at PerformCare, for his review and revisions on this topic.

Resources

PerformCare NJ – 1-877-652-7624. <http://www.performcarenj.org/families/index.aspx>

Substance Abuse and Mental Health Services (SAMHSA) <http://store.samhsa.gov/shin/content/PEP15-CMHI2012-2013/PEP15-CMHI2012-2013.pdf>

ney, and translating it into a story that can be told and retold.

As zealots who have dedicated years of service in helping children to heal, grow and thrive we have to both reconnect with a vision of what the New York Children's System can be and be wise in our work to get there.

Systems from page 34

could reduce the incidence of emotional disturbance altogether.⁸

In 2008, the National Center for Children in Poverty followed up with a study entitled *Unclaimed Children Revisited*,⁹ which noted shortfalls of the SOC experience and called for adopting a public health approach to child mental health. Such a population health approach would move beyond children with serious emotional disturbance and make efforts to promote mental health, prevent emotional disturbance, intervene early, and provide high quality, evidence-based treatment and other interventions for all children.

The move to go beyond SOC has accelerated since the passage of the ACA. For example, Mary Evans from the University of South Florida—which was a major site of early work on SOC—has been working with other colleagues from around the country to identify new opportunities to improve child and adolescent mental health created by the ACA. They have edited a special section of the *Journal of Orthopsychiatry* to discuss these opportunities.¹⁰

Like the earlier work of Knitzer and Cooper, Evans and her colleagues stress the importance of developing a public health approach that stresses prevention as well as high quality interventions. They view the emphasis in the ACA on integrating behavioral health care with primary, physical health care and new structures such as “medical homes” as a great opportunity for early identification, early intervention, and even the promotion of emotional health for the overall population of children and adolescents.

But while they welcome new opportunities, they also emphasize the importance of building on the experience of SOC and of preserving its core values of community-based care that is culturally competent, family driven, and integrated across “administrative and funding jurisdictions.”

Matters of Concern

As much as I admire efforts to bring public health approaches to child mental health and share the hope we will ultimately treat emotionally disturbed children far more effectively than we do now

and perhaps even prevent the development of mental disorders, I suspect that the ambition to go beyond systems of care is a product of the brilliance of human imagination, but simply unrealistic.

Why am I Skeptical?

- After 35 years, SOC, despite its great popularity as a concept and less ambitious goals than the new public health approaches, still has not gone to scale. Will more ambitious redesign of systems be more successful?

- Current redesign of the child mental health system is largely being built on extensive use of managed care in Medicaid. How will these new systems reach the majority of America’s children, who are covered by private health insurance rather than by Medicaid? It is true that, for example, New York State’s Medicaid Redesign proposals for children speak to the need to link with commercial insurers.¹¹ But that is far easier said than done, especially on a national scale where there will be 50 different Medicaid redesigns and a need to link cooperatively with 50 different state insurance departments.

- Medicaid managed care still rests on applying a standard of medical necessity. Although there has been some movement towards seeing stable housing, for example, as a matter of medical necessity, we are still far, far away from using Medicaid to fund such non-medical services as special education, child welfare, and juvenile justice. Linkages across child serving systems are critical to improving outcomes for children and their families. It is not at all clear that Medicaid managed care can drive the necessary relationships and breadth of service.

- Requirements and incentives to integrate the delivery of primary physical health care and behavioral health services appear to be having limited impact—especially in the private sector where health providers have been slow to provide meaningful behavioral health services.

- Prevention—literal reduced incidence of mental and substance use disorders—is still more a hope than an achievable reality. It is true that the Institute of

Medicine¹² and others have produced reports that document successful examples of “prevention.” But a recent overview of meta-analyses of studies of preventive interventions concludes that while some show statistically significant positive outcomes, the effects are generally “small.”¹³ I’m afraid we have a long way to go for true and widespread prevention.

Conclusion

There are many reasons to doubt that the effort to “transform systems of care” will have the desired outcomes. But there are also reasons to hope that a powerful commitment to the multiple aims of the Affordable Care Act—better care, better health, and contained costs—will pay off in the long run.

I hope that my skepticism is misplaced.

Michael B. Friedman is an Adjunct Associate Professor at Columbia University School of Social Work, where he teaches courses on health policy and mental health policy. He can be reached at mfb395@columbia.edu.

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Leaders from page 8

years of diverse experience in executive, strategic and technical leadership roles in the pharmaceutical industry, non-profit sector and venture philanthropy space. Throughout his career, Ring has distinguished himself as an innovator, with a track record of accomplishment and collaboration across all stages of the translational research value chain. With his unique background, broad scientific expertise, and diverse management experience, Dr. Ring offers a portable skillset applicable to a range of different leadership opportunities.

Dr. Ring most recently served as the Chief Science Officer (CSO) of Autism Speaks (AS), the world’s largest science and advocacy non-profit operating in the rapidly expanding autism/neurodevelopmental disorder space.

Among his accomplishments at AS, Dr. Ring spearheaded a collaborative partner-

ship with Google to establish MSSNG, an unprecedented cloud genomics database featuring open-access, whole-genome sequence data from 10,000 multiplex families (www.mssng.org) with autism. He also helped establish and lead DELSIA, a venture arm of AS working to facilitate the commercialization of scientific innovations by entrepreneurs, academic institutions and small companies across the autism space.

Before joining AS, Dr. Ring served on the executive leadership team of Pfizer’s Neuroscience Unit, and headed the global pharma giant’s groundbreaking Autism Research Department. From basic target identification to phase 2 proof-of-concept studies, Pfizer’s autism program pioneered efforts to develop first in-disease medicines for autism and closely related neurodevelopmental disorders, with an emphasis on rare genetic syndromes such as Fragile X, Rett, Tuberous Sclerosis and Phelan McDermid. At the helm of the program, Dr. Ring

was centrally involved in developing the company’s research, regulatory and commercial strategies for this new therapeutic area.

Prior to Pfizer, Dr. Ring distinguished himself during decade-long tenure in CNS drug discovery and development at Wyeth Pharmaceuticals. Scientist, lab head, team leader, group leader and therapeutic area head – at Wyeth Ring earned his way to senior leadership through the traditional ranks of discovery roles. Through it Dr. Ring earned a deep, fundamental understanding of the drug discovery and development process. In addition to a strong track record of developing and leading cross-functional teams, Robert has extensive experience developing talent, strategic planning and managing externalized research programs and collaborations.

A neuroscientist by training, Dr. Ring earned his PhD in molecular neurobiology from the City of Hope National Medical Center in his native Southern California.

Today, he remains engaged academically, with faculty appointments (adjunct) at Mount Sinai School of Medicine (Dept. of Psychiatry), as well as Drexel University College of Medicine (Dept. of Pharmacology & Physiology) where he serves as an instructor in Drexel’s high-profile Drug Development Program.

Dr. Ring is a member of numerous professional boards and societies, and serves as a public member on the Inter-agency Autism Coordinating Committee (IACC), an appointment he received from HHS Secretary Burwell in 2015.

After stepping down as CSO earlier this year, Robert left AS to found the private consultancy practice (Autós). Autós has effectively leveraged Ring’s diverse professional experience and expertise to provide strategic planning, technical diligence, and expert advisory solutions to clients operating across the life sciences, including biotechnology companies, non-profit foundations, and philanthropists.

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can be strengthened, helping parents increase their awareness of their children's needs and effective ways to respond. Specifically, COS helps parents and caregivers enhance their observational skills, ability to reflect on their experience, capacity for emotional regulation, and empathy for their children's needs. By building more secure relationships between parents and children, children exhibit increased empathy, greater self-esteem, better relationships with parents and peers, enhanced school readiness, and an increased capacity to handle emotions more effectively. By strengthening the parent-child relationship early in the child's life, COS aims to alleviate the effects of early-life adversity on child development and may reduce the need for more intensive services later in the child's life.⁶

At the Mental Health Association of New York City we have been proud to partner with the New York City Department of Health and Mental Hygiene (DOHMH) since 2013 to implement the successful COS-P intervention for high risk families in New York City. When the project was initially started through NYC Project LAUNCH, a SAMHSA-funded young child wellness grant, the project evaluation examined the impact of COS-P on parent depression, parent child relationships and family well-being. The findings revealed that parents with mild to severe depression scores at the beginning of COS-P had a significant decrease in depression by the end of COS-P. Parents also showed significant improvements in parenting knowledge and nurturing attachments with their child.⁷

Over the next two years, we will be working collaboratively with DOHMH to significantly expand this intervention to parents and caregivers in high need communities in the Bronx and Harlem. We have an ambitious aim to reach thousands of parents providing them with the tools they need to build healthy secure relationships and futures for their young children. As Medicaid system reform for families and children offers new opportunities, we hope payers and providers will invest in this cost-effective early intervention model that can mitigate negative life outcomes and serve as a foundation for lifelong health and well-being.

For more information on MHA-NYC's COS Parent Coaching Department, visit: www.mhaofnyc.org

Giselle Stolper is the President and CEO of the Mental Health Association of New York City. Kimberly Williams is the Executive Vice President of Integrated Policy and Program Services of the Mental Health Association of New York City.

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SafeTY.net from page 27

to receive new city funding of \$300,000 to replicate this model as an Early Intervention Substance Abuse program that will clearly make a difference in the lives of young South Shore residents - pre-teen to young adult - at risk of dependencies and addictions, who have been left without these local community-based, intense care management services. (This region still exhibits the Island's highest rate of chemical dependencies among youth.)

The new South Shore SafeTY.net program will provide services in domains of education, employment, housing, sober socialization, life counseling/personal well-being and community living, to guide at-risk and high-risk youth function effectively without the crutch of alcohol or drugs.

The approach is positive and life affirming. Unlike most treatment models that focus on problems and weaknesses, TIP builds on the strengths and interests of each participating youth. A key staff member 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. Connecting family members, peers, significant others (school teachers, coaches, etc.), and other community resources/services, the Life Coach builds "virtual" teams focused on helping the youth move towards accomplishing chemical dependency-free goals.

The program utilizes seven guidelines across six domains:

- Engaging clients through relationship development, person-centered planning, and focus on their futures;
- Tailoring services and supports to be accessible, coordinated, appealing, non-stigmatizing, trauma-informed, and developmentally-appropriate;
- Acknowledging and developing personal choice and social responsibility;
- Ensuring a safety-net of support by involving parents, family members, and other informal and formal key players;
- Enhancing competencies to achieve greater self-sufficiency and confidence;

- Maintaining an outcome focus at the personal, programmatic, and community levels;
- Involving young people, parents, and other community partners at these levels.

The domains encompass:

- Employment/career - paid, unpaid, competitive, supportive or transitional work experience as an intern, apprentice or helper;
- Educational opportunities/career track training - vocational or technical certification, high school diploma or GED, workplace educational programs;
- Living status - supportive living, group home, independent living with a roommate, semi-independent living with off-site services coordinator, natural, adoptive, foster or extended family, residential center or crisis/detention center;
- Personal effectiveness/well-being - interpersonal relationships with family, friends, mentors, dating skills/development of intimate relationships, maintenance of relationships with mentors and informal key players;
- Emotional/behavioral well-being/self-determination - social problem solving, setting goals and plans to achieve goals, recognizing and accepting one's strengths and limitations, self-advocacy, communication through speaking and listening, reading and writing, and information gathering;
- Community-life functioning - conducting leisure activities alone and with others and creating interesting, safe, healthy and sober activities.

Most recently, we have received a grant from the NYS Office of Alcohol and Substance Abuse Services to establish a licensed Medication-Assisted Treatment Clinic open to South Shore youth who are using drugs and ready for detox. As an expansion of the SafeTY.net program, this further boosts our continuum of services and support, transforming the system of care for youth to foster healthy behaviors and a better quality of life for our young citizens.

Contact SI Mental Health Society, Inc. www.simhs.org and at (718) 442-2225.

Health from page 32

Hospital of Philadelphia, Spring 2015) and the vast majority of premature mortality and morbidity is attributable to social, behavioral, and environmental factors, yet we continue to spend most health-related money on medical care, not the social determinants. In March 2016, the American Academy of Pediatrics (AAP) issued a policy statement regarding the important role that poverty and "related social determinants" play in adverse outcomes across the life course (aap.org). Supporting decades of evidence about social determinants, a recent randomized clinical trial demonstrates the short-term positive outcomes for children, associated with screening for and addressing families' social needs (JAMA Pediatrics, 09/06/16). One important question will be how to improve payers and providers interest in and capacity to help address child and family social needs.

Family and caregiver health. A child's

physical, mental and social well-being is intimately connected to the health and well-being of her/his parents and caregivers, so in seeking better health and well-being for children, parental health is essential. Parental depression and stress, for example, is associated with children's poorer physical health and well-being (National Research Council and Institute of Medicine; Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. Washington, DC: National Academies Press; 2009; <https://www.nap.edu/catalog/12565/depression-in-parents-parenting-and-children-opportunities-to-improve-identification>). Ensuring improved health outcomes for children and their future selves requires addressing parental and caregiver health.

Early identification and connections. The AAP recommends linking families to appropriate services, in part by using screening tools with high sensitivity and

specificity (aap.org). The AAP's Bright Futures Guidelines also recommend that all children be screened for developmental delays and disabilities at well-child visits. Yet, evidence shows a significant gap between these recommendations and what happens in practice. Rather than simply require or incentivize screenings, a value-based payment arrangement could incentivize the outcomes expected when children are appropriately screened and connected to the right set of resources.

Risk adjustment for psychosocial and economic risk factors. Payers already use severity of illness in determining payment levels. A psychosocial risk score, based at least in part on a screening tool, should be considered in value-based arrangements (PolicyLab at the Children's Hospital of Philadelphia, Spring 2015). The Bailit Health team recommends capitation and a care coordination payment that are risk-adjusted for "medical and social risk factors" (Value-Based Payment Models for

Child Health Services, Bailit Health, July 2016, www.scaany.org).

We further urge investigation into maternal, infant and early childhood home visiting and other evidence-based practices that improve child and family health and measures outside of the health and medical realm.

Children whose social, emotional and physical needs are identified and met have a much greater likelihood of being healthy for a lifetime, while children whose needs are not met are more likely to be unhealthy. New York has great opportunity right now to improve children's health, generating improved adult health and system savings.

The Schuyler Center for Analysis and Advocacy is a non-profit organization that works to shape State policy for people in need. Learn more about the Schuyler Center at www.scaany.org or on Twitter at @SchuylerCenter.

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“System Reform - Progress Report”

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for those working with youth with high risk issues including fire-setting, sexually aggressive/reactive behavior, victims of sexual abuse, and adoption issues; parent skills training (conducted solely by Parents); training for parents of youth aging-out of the children's system (conducted solely by Parents); development of a System-of Care training manual and website.

The Westchester Community Network ended its period as a funded federal grant site in 2005. The System of Care has been sustained through cross system funding, creative use of newer, smaller grants, and through the efforts of those committed to the model across systems. The Westchester Community Network has a proven track record and long term perspective that allows it to provide data, information on infrastructure development, community change, cross system collaboration, cultural competency, family/youth empowerment, and sustainability. We believe that the measure of success for a system of care is multi-dimensional, not just clinical. SOC represents an investment in long term change.

The System of Care approach has allowed us to incorporate a trauma informed narrative that goes hand in hand with System of Care values and principles and the CCSI Committee has a Trauma Subcommittee (along with many other subcommit-

tees) exploring how to incorporate a trauma informed approach as we operate at the policy, program development, direct service, evaluation and training levels.

Westchester has truly sustained not only funding for its system of care, but more importantly the overarching belief system that allows for continued infrastructure development, reliance on a core set of values that drive programming, and a permanent “place at the table” for families and youth.

Our challenges include incorporating our new Managed Care requirements, implementing effective financing mechanisms for System of Care for those non Medicaid participants in the process, developing a skilled workforce through education, training, technical assistance, coaching, information dissemination and expanding provider networks, and providing a public health approach to children's mental health services.

For additional information on Westchester County Children's System of Care contact Michael Orth at (914) 995-5225 or email mmo6@westchestergov.com

Carol Hardesty, MSW, MPA, is Retired - Former Program Director, Westchester County Department of Community Mental Health and Executive Director, Family Ties of Westchester and Michael Orth, MSW, is Deputy Commissioner, Westchester County Department of Community Mental Health.

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into a uniform set of Home and Community Based Services (HCBS) under 1115 Waiver authority. Of specific interest to those hoping to address the needs of the YIT population are these 12 HCBS services, including: Habilitative Skill Building; Prevocational Services; Supported Employment; and Community Self Advocacy Training and Support.

To access HCBS will require both a Level of Care determination and a Level of Need determination as part of the eligibility determination. By aligning waiver services uniformly, the new array will break down silos, enable equal and seamless access for youth with multiple diagnoses, and address older adolescents and young adults more effectively with Pre-vocational and Supported Employment.

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Howard Savin, Ph.D., is Senior Clinical Advisor, First Children Services, and is transitioning from work with Beacon Health Options. Joseph J. Hess, Jr. MSW, MBA is the Founder and President of First Children Services. Lisa B. Eisenbud, MSW is the Principal of Get Going LLC consulting with FCS and a former Chief of Staff to New Jersey's Departments of Children and Families, and Human Services. Matthew Hess is co-founder of First Children Services and its Chief Operating Officer. Valery Bailey, MPA held senior positions at NJ DCF and DHS as well as at Mentor, Inc. and Covenant House before joining FCS as its Vice President of Behavioral Health Treatment Services.

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Peers from page 33

The day, much too soon, culminated in a reception that boasted colorful vegetable platters, bowls of creamy hummus, sinfully delicious chocolate brownie squares, and an assortment of chilled beverages. In these final moments, participants, still energized by who they saw, what they contributed, and what they learned, moved swiftly through the narrow reception space, completing evaluations, exchanging contact information, snapping final pictures, and languishing in the feeling of accomplishment. Yes, this was our 10th year of working and growing together, building the peer specialist profession, and creating many ways to share a message of hope. Above the Washington Square arch

Center from page 35

Site work for the South Beach Psychiatric Center Inpatient Building began in April 2016, with significant landscape remodeling. Starting in October 2016, more than 800 steel piles will be driven into the ground to support the foundation, and in April 2017, the structural steel of the building will be erected. In January 2018 the base building construction will begin. The project is expected to be com-

Conclusion: The new services array in New York State, and the ability provide services to youth up to their 22nd birthday, offers great promise for YIT. Updated services that can be provided outside the clinic walls and in normative settings, can focus on strengthening and maintaining functioning, to address untreated trauma and to treat each individual's diagnosis with an update array of clinical services. Most importantly, the new service array can assist youth in building emotionally health relationships with family and peers can offer a new foundation upon which successful transition aged youth services can be built.

Andrea Smyth is Executive Director of the NYS Coalition for Children's Behavioral Health; David Rossetti is Clinical Director of the Northern Rivers Family of Services; and Leonardo I. Rodriguez is Executive Program Director, Children's Residential Services at The Jewish Board.

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For further information about anything found in this article, please contact: Joseph J. Hess, Jr., President, First Children Services at jhess@firstchildrenservices.com.

the sun faded from bright yellow to amber. We were transformed. Hearts and minds fulfilled like never before, yet already looking forward to our next conference on July 13th, 2017. So please save the date!

Grateful thanks and acknowledgements are made to sponsoring agencies: New York State Office of Mental Health; New York City Department of Health and Mental Hygiene; NYC Health + Hospitals, Office of Behavioral Health; Community Access, Howie the Harp Advocacy Center; Baltic Street AEH, Inc.; The Coalition of Behavioral Health Agencies; YOUTH POWER!; NYAPRS; and Advocacy Consultation Services.

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plete in late 2019 or early 2020.

Senator Andrew J. Lanza said, “The groundbreaking of the new state-of-the-art inpatient facility at South Beach Psychiatric Center is welcome news to the people of Staten Island and especially those who will receive and provide treatment services there. The replacement of critical infrastructure will reduce the likelihood of damage from future flooding events and keep the people and resources at South Beach safe.”

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