

## Why Integrated Care for Co-Occurring Disorders Is So Important

By Michael B. Friedman, LMSW  
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**P**roviding integrated treatment for people with co-occurring behavioral and physical health disorders has become a central goal of mental health policy reform. Why?

In part the answer is that the failure to provide effective integrated care drives up the cost of care. But the answer also is that the length and quality of life of people with serious, long-term mental disorders depends on addressing both behavioral and physical problems.

### Premature Mortality

On average people with serious mental illness die considerably younger than the general population. It has become commonplace to claim that their life expectancy is reduced by about 25 years—roughly age 55 rather than 80. (Estimates actually range from 10 to 25 years.) But whether it's 10 or 25 years, the lost years of life are a tragedy that probably could be prevented.



**Michael B. Friedman, LMSW**

For the most part, the premature death of people with psychiatric disabilities reflects physical rather than mental causes. Yes, people with serious mental illnesses complete suicide far more often than those without, but that is not the

greatest driver of low life expectancy. Obesity, which contributes to high blood pressure, diabetes, and heart disease, is probably a greater factor. Smoking, which provides emotional relief to many people and is very common among people with serious mental illness, also is a major contributor. Excessive use of alcohol and other drugs also contributes to poor health. And people with psychiatric disabilities often have periods of hard homelessness that exposes them to terrible health risks including assault and rape as well as exposure to dangerous extremes of weather and to contagious diseases such as AIDS, hepatitis, sexually transmitted diseases, respiratory diseases, and more.

To make matters worse, people with serious mental illnesses often do not get decent health care. Sad to say but historically community mental health providers did not pay nearly enough attention to the physical health of the people they served, and physical health care providers did not—to put it mildly—welcome patients with serious mental illness.

All this has been known for a very long time, certainly since the late 1970s when physical health care was conceptu-

ally included as part of the Community Support Program. But funding drives action, and there has been no funding specifically dedicated to the physical health needs of people with serious and persistent mental illness. As a result, premature mortality emerged as a major concern only about a decade ago—at the same time, the cynic in me observes, as it became clear that co-occurring physical and behavioral disorders were the greatest drivers of Medicaid costs.

The good news is that awareness of the mortality gap has galvanized some mental health providers to develop “wellness” initiatives to fight smoking and obesity and to organize health care programs that they operate on their own or in partnership with community health centers and hospitals.

### Co-Occurring Substance Abuse

Many people with serious mental illness will have periods in their lives when they have co-occurring substance use disorders, which contribute to homelessness,

*see Integrated Care on page 10*

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## Understanding Co-Occurring Disorders

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

For decades, we have talked about substance use and mental health conditions as “co-occurring.” We have incorporated it into our language, for example, saying that a person “needs a co-occurring program.” Sometimes the term takes on a life of its own, prompting providers to view treatment of co-occurring disorders as an unduly burdensome undertaking that requires its own specialty. Some providers decline to treat people with co-occurring disorders, until one of the disorders has been addressed. This is a mistake.

All programs must treat co-occurring disorders; it cannot be avoided. Studies have found that up to 60 percent of people in substance use disorder programs and 40 percent in mental health settings have a co-occurring disorder. It is simply not possible to effectively treat a person without addressing both disorders in a single, integrated plan.

Mental health disorder impacts a broad range of emotional, cognitive and behavioral functioning, and ranges from mild impairment, to serious problems that can significantly impinge on all areas of a person’s life. Similarly, substance use disorders span a range of substances, patterns of use, severity and impact on life. The interaction of these disorders is often meaningful and critical to identifying an effective treatment.

There remain many misconceptions about prescribing medication and providing psychosocial interventions. Despite the consensus among experts that integrated care should be the standard, providers continue to deny treatment to people who are perceived to have instability in substance use disorder or mental health symptoms, when a co-occurring disorder is present. For example, I have heard about clients, who are experiencing hallucinations and disorganized thoughts and



Arlene González-Sánchez, MS, LMSW

using alcohol and cannabis, having difficulty accessing medication for any conditions, because providers are concerned of the risk, or lack the skills to assess or treat the clients. All treatment providers should be prepared to address the full range of a patient’s conditions, even if the patient is not fully ready to address them all.

Mental health and substance use disorders have similar etiology, and co-occurring disorders are often interconnected. A 2003 survey by Kaiser Permanente surveyed 26,000 people for Adverse Childhood Experience and found a high correlation between those experiences and substance use disorder. This mirrors similar finding for adult mental health disorders.

It is well known that early trauma impacts the brain in the areas of the hippocampus (memory) amygdala (arousal) and limbic system (emotion). These areas of the brain are also involved in anxiety, mood and substance use disorder. They also share common treatment approaches, including cognitive behavioral therapy, dialectical and behavioral therapy, motivational interviewing and family approaches to treatment.

Putting the principles of integrated care into practice can be challenging for programs. It is important that all staff are trained and feel confident in identifying both mental health and substance use disorders. Most programs have implemented a validated screening tool to identify people who have a high likelihood of having a mental health or substance use disorder. Once a person has screened positive, it is important to complete a comprehensive assessment. Co-occurring disorders are not monolithic. Someone at a substance use disorder clinic who has screened positive for a mood disorder will likely have a different symptom pattern than someone with a serious bi-polar disorder who screens positive for a likely substance use disorder at a mental health clinic. A comprehensive assessment should identify specific symptoms, history, remissions and exacerbations, successful strategies, and toxicology testing. The assessment should also include information from personal contacts such as family members.

Many people who experience both mental health and substance use disorders feel discouraged and overwhelmed. It is especially important for providers to convey confidence and hopefulness, to identify individual strengths and develop a plan using the patient’s own voice. It is also important to identify periods of remission and strategies the patient has used successfully in the past.

Clinical staff can also feel overwhelmed when a person seeking treatment presents a complex history or symptom pattern. This is true for co-occurring physical health problems too. Imagine if you or a family member suffered from high blood pressure, obstructive pulmonary disease and early signs of Parkinson’s disease. The most helpful message from a practitioner would be that “you have come to the right place.” Of course, the practitioner would likely need to reach out to specialists for help with the person’s care. However, imagine how dis-

couraging it would be if the practitioner said the person’s needs were too complex, that he or she needed to get one condition under control in order to treat the others, or were sent away with a referral card to another program.

If you work in or operate a program, you may be familiar with and even understand these messages. It can be daunting to think ahead about how to make sure a person gets good care, from the initial assessment through treatment, delivered by experienced and competent staff working within their scope of practice. There may be a need for multiple staff with individual expertise working as a team.

To successfully deliver integrated care, I would suggest that programs start from a strength-based approach. If you have been operating for a while, you have seen many individuals who have co-occurring disorders. Ask yourself which patients have done well and what about their treatment went well. After answering these questions, challenge yourself and your team. What resources would you need to adequately respond to the needs of everyone who sought out your program? Are there agencies in your community who would make good partners in providing integrated care?

Through the work of the New York State Medicaid Redesign Team, there have been many opportunities for providers to partner on seamless, cohesive integrated care. Whether you are pursuing an integrated license, partnering with a behavioral health collaborative, or working within a performing provider system, these opportunities can help solve some of the challenges to integration.

The time has come for all of us to recognize that co-occurring disorders are a normal presentation. They should be anticipated and met with compassion and effective treatment options. There is no reason to wait for all the answers. The consensus was reached a long time ago: we all provide care for co-occurring disorders. It is not possible to do otherwise.

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Office of Alcoholism and  
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# Managing Co-Occurring Substance Use and Mental Health Disorders

By Dr. Ann Sullivan  
Commissioner  
NYS Office of Mental Health

The combination of substance use disorders and mental illness is a common clinical problem – and a serious public health concern. The problem is widespread. At least one-third of people with anxiety and depression – and between half and two-thirds of people with more serious mental illnesses such as schizophrenia, bipolar disorder, and severe depression – have a problem with alcohol, illicit drugs, or both. When you include tobacco, this brings the figure up to nearly about 80 percent. The most commonly misused substances are tobacco, alcohol, cannabis, and cocaine – although opioid use is increasing in this population.

## Co-Occurring Disorders Cause Poor Outcomes

In addition to increased mortality, people with co-occurring disorders experience worse psychiatric symptoms, less engagement in treatment, challenges functioning in everyday life, higher rates of suicidal and violent behavior, legal problems, homelessness, and significant physical health problems. They also experience more frequent intensive health services use, with more emergency department visits and longer inpatient hospital admissions.

Clearly, co-occurring disorders present significant challenges for the affected people, their families, individual clinicians, treatment programs, and the larger healthcare system. Fortunately, the past several decades have seen growing evidence for treatment approaches that work.

## Treating Co-Occurring Disorders

At one time, mental health practitioners believed that addiction had to be treated before mental illness could be addressed and vice-versa. The working assumption was often that the substance use drove psychiatric symptoms, which would remit once abstinence was achieved. In turn, addiction treatment providers assumed that people could not benefit from treatment of substance misuse unless their psychiatric symptoms had been stabilized. The wisdom of this mindset has since been soundly refuted.



Dr. Ann Sullivan

While it is often difficult to figure out which came first – addiction or psychiatric symptoms – solving the “chicken-and-egg” puzzle is not necessary to effectively treat co-occurring disorders. We now know that treating both addiction and psychiatric illness simultaneously increases the chances that both will improve.

## New York State Initiatives

In 2007, OMH convened a joint task force with other state agencies to improve the prevention and management of co-occurring disorders throughout the state. This helped spur multiple initiatives, some of which are described here. Our partners include the Office of Alcohol and Substance Abuse Services (OASAS) and the Department of Health (DOH).

To promote Integrated Dual Disorder Treatment (IDDT) in all mental health settings across the state and strengthen the skills of clinicians in these settings, the *Center for Practice Innovations (CPI)* has an online training and implementation support initiative called *Focus on Integrated Treatment (FIT)*. In response to recommendations from the joint task force, FIT created 39 online training modules that are available for free with continuing education to licensed behavioral healthcare practitioners throughout the state. FIT also provides ongoing implementation support to promote state-wide dissemination of IDDT.

In 2006, OMH created a program to provide comprehensive, recovery-oriented services for people with serious mental illness called *Personalized Recovery Oriented Services (PROS)*. In addition to other evidence-based interventions including supported employment services, individual psychotherapy, wellness self-management, family psychoeducation, and psychiatric care, PROS offers IDDT to all participants. PROS program clinicians are trained through the FIT modules and can participate in ongoing FIT learning collaboratives.

*Assertive Community Treatment (ACT)* is considered the highest level of outpatient services available for people with serious mental illness in New York State, and has demonstrated efficacy for improving outcomes among the most difficult-to-engage people. All ACT teams must have a substance use specialist and the capacity to provide IDDT, and have access to CPI training, including FIT. In addition, 10 new ACT teams have been funded by OMH to serve homeless people in New York City, in partnership with the City Department of Health and Mental Hygiene and Department of Homeless Services. These new teams will receive extra training and support in opioid overdose prevention and medication-assisted treatment.

In order to make integrated behavioral health and primary care services available in more settings, OMH has recently partnered with OASAS and DOH to bring about the necessary statutory and regulatory changes to approve *Integrated Outpatient Clinic Services (IOS)*. There were 71 approved IOS sites across the state as of the end of 2017. In addition, New York State is in the process of creating a stream-lined *single license*. This will allow healthcare organizations to offer mental health, substance use, and medical services under a single license, through a single application process, supported by a single set of rate codes in an integrated setting without duplicative oversight from multiple agencies.

Another recent partnership between OMH and OASAS includes the *Dual Recovery Coordinator (DRC) Demonstration Project*, which funds 12 DRCs in 14 counties and New York City. Within their counties, DRC coordinators work to develop more seamless and integrated systems of care through training, technical assistance, and infrastructure development.

Recently, New York was one of only eight states selected to participate in a two-year demonstration project to develop new *Certified Community Behavioral Health Clinics (CCBHCs)*. CCBHCs will provide “no wrong door” access to services, treating people with mental illnesses and substance use disorders with a fully integrated approach, while also addressing physical health by providing primary care. The 13 CCBHC sites across the state will provide crisis mental health services; screening, assessment, and diagnosis including risk management; patient-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; targeted case-management; psychiatric rehabilitation services; peer support, counseling services, and family support services; services for members of the armed services and veterans; and connections with other providers and systems (such as criminal justice, foster care, child welfare, education, primary care, hospitals). In addition, all CCBHCs are required to obtain approval for IOS, which will enhance IDDT capacity.

## Managed Care for Medicaid

All of this work is being coordinated in the context of comprehensive transformation of behavioral health services in New York State, a cornerstone of which is a complete transition to *managed care for all Medicaid-funded behavioral health services*. In 2015, New York State moved almost all mental health and substance use treatment services into the Medicaid mainstream managed care benefit package.

New York State also began offering a specialized managed care program called a *Health and Recovery Plan (HARP)*. A HARP is a fully integrated benefit package that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs --- such as mental health or substance use. HARPs must be qualified by New York State and must have specialized expertise, tools, and protocols that are not part of most medical plans. There are currently more than 100,000 people with a serious mental illness, substance use disorder, or both, in the HARP program.

see OMH on page 37



## Promoting Recovery for Individuals with Unidentified Trauma and Co-Occurring Disorders

By Angela Mora-Vargas, LMSW  
Assistant Vice President of Programs  
MHA-NYC

**A**dvancement of recovery for individuals with Co-Occurring Disorders has been recognized as a significant principle for the transformation of behavioral health services. Co-Occurring Disorders is defined as a mental health disorder being experienced along with the presence of a substance use disorder. Customized attention and treatment for individuals experiencing co-occurring disorders provide the necessary supports to promote stability and continuity of care.

Individuals diagnosed with co-occurring disorders face many obstacles that impact their daily lives. They may experience increased challenges with obtaining affordable and appropriate housing, lack strong social supports as well as access to quality, accessible mental health and substance use treatments and supports. A greater risk of unemployment or problems at work as well as poverty or unstable income (Department of Mental Health, CPS Facts, DMH.MOU.Gov) are additional challenges experienced by individuals with co-occurring disorders. Co-occurring disorders impact 7.9 million individuals in the United States (SAMHSA's



**Angela Mora-Vargas, LMSW**

2014 National Survey on Drug Use and Health -NSDUH). Only 7.4 percent of individuals receive treatment for both conditions with 5.8 receiving no treatment at all (<http://media.samhsa.gov/co-occurring/topics/data/disorders.aspx>). Unrecognized trauma and its impact on co-occurring disorders creates additional challenges for

individuals in their journey to recovery and wellness maintenance. The lack of support through innovative, comprehensive and personalized programs prevent individuals with unrecognized trauma and co-occurring disorders from thriving in their communities.

Evidence-based treatments such as Integrated Dual Disorder Treatment have shown to effectively provide quality of life for individuals with co-occurring disorders and help to address both disorders at the same time (<https://www.centerforbp.case.edu/practices>). Integrated models of treatment provide individuals with co-occurring disorders and unrecognized trauma with better outcomes (Jerrell, J.M. & Ridgely M.S. 1999, Impact of robustness of program implementation on outcomes of clients in dual diagnosis programs, Psychiatric Services, 50 (1), 109-112).

Programs that enhance an individual's understanding of their diagnoses by providing ongoing psycho-education coupled with opportunities to be a part of a social / peer support model provide the necessary customized intervention for individuals to remain stable in their communities. Creating meaningful, self-directed futures is key to successful intervention. One such approach to intervention is the Personalized Recovery Oriented Services (PROS) model, a comprehensive solution that integrates rehabilitation, treatment, and sup-

port services for individuals with serious mental illness and substance use disorders. Key components of the model include services that are designed to engage and assist individuals in managing their illness, restoring their skills and supports necessary to live in the community. PROS services also provides an array of clinical services addressing individual needs; counseling, therapy and health assessments. There is availability of psychiatric evaluation, medical management and symptom monitoring.

The Mental Health Association of New York City's Harlem Bay PROS program is a comprehensive recovery program designed for adults diagnosed with mental health and co-occurring disorders by helping to promote control of their lives and develop the skills that they need to effectively negotiate life's challenges. Staff work collaboratively with participants to encourage and empower them to identify and pursue personal life goals, select the services that would best help them achieve their goals, and set their own pace for recovery. Participants are able to receive their treatment and individual support at PROS. A wide range of classes, matched with the participants' interests, are available. The class schedule is flexible to better meet participant's needs.

*see Recovery on page 31*

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## “I’m Not Strong - I’m Steel” Life and Recovery With Co-Occurring Disorders

By Juan, Richie, John, Dennis, Justin,  
Michael, Tanya, and Eugene  
S:US Consumers

**Y**ou may have heard it before: acceptance is the first step in recovery. Nothing could be truer, as was made abundantly clear as each of us shared our histories together in a discussion about *Behavioral Health News* “Understanding and Treating Co-Occurring Disorders” issue.

Trauma leading to more trauma, self-medication with illicit drugs, loss of families, homelessness, more self-medication, more trauma, more addiction. In and out the revolving door (sometimes with bars on them) and then, at some point, that “Ah-Ha” moment of diagnosis and eventually, acceptance. It’s a journey. It’s exhausting. It can knock the wind out of you even on a good day.

You could look at what we’ve been

through like the cycles on a washing machine: wash, rest, soak, rinse, spin, and finally – ready for the dryer. But at what point is a person “wrung out” enough to be ready for the dryer? That seems to be different for each individual, because everyone has their own threshold of how much they can tolerate, and how far they need to go before reaching their own personal “bottom.”

As we all talked about our lives, there were clearly some common threads to how we wound up sitting around the table at this time. For the veteran among us, a lot had to do with compassion and mindfulness. Having lost his mom and his son, he woke up from a coma resulting from a suicide attempt to ask himself, “Why did I have to survive?” After a lot of spinning, there came a diagnosis of bipolar disorder, therapy with a mental health professional and, eventually, a desire to help others through teaching. The courts made the right decision in realizing that an alternative to incarceration through

an S:US treatment program, rather than incarceration, was the way to work towards recovery.

Two others in the group talked about the ravages of heroin addiction, especially when coupled with schizophrenia. The heroin felt good for a while, kind of like the beginning of the wash cycle: wash, rest, soak. But then came the spinning. Drugs - Voices - Illusions - Cravings. Desperation. So wrung out that even jail had its upside. The diagnosis of schizophrenia was actually a relief.

But all of us struggled with acceptance of diagnosis because having a mental illness is seen by so many, including ourselves, as somehow different than say, heart disease. With heart disease, you’d never question that certain medications are needed to treat and manage the disease. However, with an illness of the brain and mind, there’s stigma about it somehow being your fault, and until we came to understand and accept that it’s no more our fault than having a leaky heart valve,

we just resisted and kept spinning. The only thing that finally really broke the cycle was acceptance, followed by getting into treatment where there was a real understanding of what was going on, and a real desire to get on with a different life.

The most senior member of our group, Eugene, spoke like a brother to all of us. Eugene was born in the rural south in the 1950’s, when racism reigned supreme and when “colored” and “white” water fountains were the norm. Eventually landing in New York, Eugene lived on the streets from the age of 15, fueled by a serious drug addiction, powered by anger, and willing to do anything, including rob banks. His innocent two-year-old daughter died in a fire that didn’t have to consume her life, if only the firefighters had gotten to her sooner. Eventually, sitting on a prison cot at Fort Dix in 105-degree heat, he had to face no one but himself.

*see I’m Steel on page 34*

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# Address Comorbidities with Tech-Supported Approaches to Integrated Care

By Candace T. Saldarini, MD, Medical Director; and Michael Jarjour, President and Chief Executive Officer ODH, Inc.

Consider this common scenario: Trying to assess a high-need patient with diabetes, a care coordinator with access only to the patient's physical health record is unaware of her history of depression. Conversely, a behavioral care coordinator reviewing her depression charts, may be unable to access her physical health records containing her diabetes history.

Lack of data sharing and communication between the physical and behavioral health worlds leads to suboptimal care including missed diagnoses and lack of treatment. Our fragmented system of care – behavioral and physical health each in their own independent silos – is a barrier to coordinating these interconnected aspects of health.

The scope of the challenge presented by comorbidities is significant:

- 34 million people – 17 percent of American adults – had comorbid mental health and medical conditions in 2011.<sup>1</sup>
- An estimated 8.1 million adults have both a mental illness and a substance use disorder (SUD), with less than half (48 percent) receiving either mental health care or SUD treatment at a specialty facility.<sup>2</sup>
- Individuals with comorbid conditions are at heightened risk of returning to the hospital after discharge.<sup>3</sup>
- Patients with both a chronic physical condition, such as diabetes, and a comorbid mental health disorder, such as depression, have a 200 percent higher mortality rate than individuals with only diabetes.<sup>4</sup>
- Monthly costs for a patient with a chronic disease and depression are \$560 more than for a patient with a chronic disease without depression.<sup>5</sup>

Caring for those with comorbid mental and physical health conditions – which may share common risk factors – calls for an integrated, holistic approach for identifying and managing these individuals in a population. The use of innovative technology tools can ease the path to getting there.

Of course, there is no one “correct” model for integrating care. At the most basic level of integration, providers periodically communicate about shared patients. Co-located care may involve slightly more integration – primary care and behavioral health providers share a common facility but maintain separate cultures and develop separate treatment plans for patients. At the next level, the two groups of providers share some information systems. At the most integrated level, behavioral, physical, social and pharmaceutical data is fully shared, and technology, work flows and care delivery are integrated and perhaps most importantly, providers approach patients' symptoms in a holistic way.



**Candace T. Saldarini, MD**

Common elements of advanced integration models typically include:

- Shared information systems that facilitate coordination and communication across providers and facilities
- Screening for depression, anxiety, and other behavioral disorders using validated screening tools
- Team-based care with non-physician staff to support primary care physicians and co-manage treatment
- Standardized use of evidence-based guidelines
- Individualized, person-centered care that incorporates family members and caregivers into the treatment plan
- Systematic review and measurement of patient outcomes using registries and patient tracking tools

Addressing comorbid conditions through integrated care approaches is gaining momentum. Colorado Medicaid, for example, recently selected five provider organizations to manage integrated physical and behavioral health services throughout the state. But the industry still has a long way to go. According to preliminary findings from ODH survey research, while eight out of ten health care companies say that data integration is important, only one-half have highly integrated behavioral, physical and social data.

Technology can facilitate integrated care in complex patient populations in several ways:

- Leveraging analytics to facilitate risk stratification
- Improving care coordination, thereby enabling providers to address gaps in care
- Expanding the reach of providers beyond the four walls of their offices
- Delivering cost-effective, evidence-based care



**Michael Jarjour**

Health care organizations are beginning to embrace developing technologies such as artificial intelligence, machine learning and predictive analytics that can help discern patterns among complex data sets and identify patients who are ascending the risk curve.

Consider a primary care physician who, upon noticing that the patient's diabetes is worsening, added a new prescrip-

tion to her medicine regimen, without realizing that the medication led to her hospitalization for a depressive episode. With its ability to recognize patterns, machine learning can help providers realize that the rate of refills or additional prescriptions is an indicator of severity in the patient's depression or other comorbid conditions.

A recent research paper co-authored by ODH executives found that machine learning methods and advanced predictive models can help improve health care organizations' ability to identify and predict future high-cost patients suffering from schizophrenia. The paper, “Predicting Future High-Cost Schizophrenia Patients Using High-Dimensional Administrative Data”, also found that the presence of comorbid physical conditions, such as diabetes and kidney disease, contributed to higher costs.

Another critical role technology can play is serving as a data repository to allow the sharing of information between key stakeholders such as payers and providers. Information sharing, which is at the heart of integrated care, fosters improved care quality by enabling providers to have a broader perspective beyond the services they provide.

As we move increasingly to a value-based model of care, payers' and providers'

*see Tech-Supported on page 34*

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# CBC Designated by NYC-DOH as Lead BHCC Agency for the New York City Region

By Staff Writer  
Behavioral Health News

**J**orge R. Petit, MD, CEO of Coordinated Behavioral Care (CBC) and member of the Board of Mental Health News Education, is excited to announce that CBC was designated by the New York Department of Health as a lead Behavioral Health Care Collaborative (BHCC) agency for the New York City region.

As described on the Office of Mental Health (OMH) website<sup>1</sup> the BHCC program funds activities undertaken by behavioral health providers in coming together and to share clinical quality standards, data collection, analytics and reporting capabilities with the goal of improving care quality and enhancing the network's collective impact in Value Based Payment (VBP) arrangements. Funding is available for both planning and implementation, and is used to support the development of a shared infrastructure.

CBC's BHCC consists of over fifty NYC network providers and an extensive group of affiliated members, all actively engaged in developing systems to participate in the NYS Behavioral Health Value Based Payment (BHVP) Readiness Program.



Jorge R. Petit, MD

CBC was awarded the maximum funding available, \$5,000,000, over three years. This funding enables CBC to support the development of shared infrastructure and information technology across a network of leading behavioral health agencies.

Behavioral Health Care Collaborative (BHCC)	Region	Award
Coordinated Behavioral Care (CBC)	New York City	\$ 5,000,000
Institute for Community Living (ICL)	New York City	\$ 5,000,000
Recovery Health Solutions IPA	New York City, Long Island	\$ 5,000,000
Mental Health Providers of Western Queens	New York City	\$ 4,901,000
Value Network	Western New York	\$ 4,611,000
Advanced Health Network (AHN)	New York City, Long Island	\$ 4,082,000
Genesee County	Finger Lakes, Southern Tier, Western New York	\$ 3,300,000
Lower East Side Service Center	New York City	\$ 3,001,000
Bailey House	New York City	\$ 2,583,000
Access Supports for Living	Mid-Hudson	\$ 2,571,000
The Guidance Center of Westchester	Mid-Hudson	\$ 2,421,000
Syracuse Brick House	Central New York	\$ 2,418,000
Equinox	Capital Region, Mohawk Valley, North Country	\$ 2,316,000
Finger Lakes Area Counseling and Recovery Agency (FLACRA)	Finger Lakes, Southern Tier, Western New York	\$ 1,767,000
Citizens Advocates	North Country	\$ 1,725,000
FCS of Cortland	Central New York, Southern Tier	\$ 1,641,000
The Neighborhood Center	Central New York, Mohawk Valley, Southern Tier	\$ 1,785,000
Hillside Children's Center	Finger Lakes, Southern Tier, Western New York	\$ 1,521,000
Children's Home of Jefferson County	North Country	\$ 750,000

CBC is excited to be a part of the BHCC and offers congratulations to the rest of the BHCC awardees listed in the chart above.

(1) NYS-OMH Value Based Payment Readiness for Behavioral Health Providers. Retrieved from Office of Mental Health: <https://www.omh.ny.gov/omhweb/bho/bh-vbp.html>.

## Integrated Care from page 1

incarceration in jails and prisons, and exposure to many other risks and barriers to achieving a satisfactory quality of life. For them too the efforts of the mental health, substance abuse, and physical health care systems have been feeble and inadequate.

Awareness of the problematic co-occurrence of mental and substance use disorders goes back to the very beginning of deinstitutionalization in the late 1960s and early 1970s. Over the years, there have been repeated announcements of efforts to integrate mental health and substance abuse services. Cross-training and inter-agency committees are old hat, and they've made some difference. But the schisms between the systems are still intact, driven by ideology, unwillingness to share power, competition for funds, and the inability to respond to clear data that integrated treatment is what's needed.

Hopefully, the recent push for integrated service systems will turn the tide on this old issue.

### Co-Occurring Depression and Serious Health Conditions

In addition to concerns about the unfortunate impact of physical illness on people with serious, long-term mental illness, awareness has grown in recent years about the impact of mental illness on people with serious chronic physical

conditions such as heart disease. It is quite clear, for example, that people with depression and heart disease are more likely to suffer premature disability or death than are people with heart disease who are not depressed. In part this is a chicken and egg issue. Serious, chronic physical illness—especially if it is life threatening or results in reduced ability to perform basic life functions—often precipitates demoralization. Lack of hope contributes to resignation, lack of effort to recover, and ultimately to greater physical deterioration. But whatever the direction of causality, it is clear that addressing co-occurring mental issues is key to maximum recovery for people with serious physical conditions.

### Opportunities for Early Identification and Treatment of Mental and Substance Use Disorders

Most people with diagnosable mental and/or substance use disorders go without diagnosis and treatment. One reason for this is the widespread reluctance of people suffering from emotional distress to seek treatment from mental health providers (we usually call this “stigma”) as well as the vast shortage of mental health providers in many parts of the country.

But people who will not seek help from a “shrink” generally do go to primary health care providers, who have an opportunity to identify, and to provide rudimentary treatment for, people who might benefit from behavioral health services.

Awareness of this fact has led to calls

for increased behavioral health screening in primary care—especially screening for depression—and for meaningful responses to positive findings including professional diagnosis and treatment or referral to treatment.

The problem, of course, is that most primary care physicians do not have the expertise to make sound diagnoses or to provide adequate treatment. According to the National Co-Morbidity Survey, more than 85% of people treated for mental disorders by primary care physicians do not get even “minimally adequate” treatment. Mental health providers are somewhat more likely to provide minimally adequate care, but about half of people referred to them do not follow up.

It's reasonably clear that primary care could do more to identify and treat behavioral disorders. Fortunately, there are some signs of improvement in the push for person-centered medical homes, which provide both behavioral and physical health services and require coordination of care if only through electronic medical records. And some medical practices now have behavioral health specialists on staff. Others—especially in areas with few behavioral health specialists—are using telepsychiatry for consultative advice or even to see patients via Skype and the like. More sophisticated medical practices are using one form or another of coordinated care management, which follows patients after diagnosis, prescription, or referral to be sure that they get the treatment they need.

## Suicide Prevention

Primary health care may also be a key place for suicide prevention. Now the 10<sup>th</sup> leading cause of death in the United States, suicide is gradually becoming a public health priority, though not fast enough to stop the rapid rise in suicides, which has spiked to over 40,000 deaths per year.

Since the discovery that a large proportion of people who complete suicide see a primary care physician within the 30 days prior to their death (the current estimate is 45%), there has been a perception that doctors ought to be able to identify people at risk and to intervene to prevent suicide. This, of course, is far easier said than done. Very few people reveal their suicide intentions to doctors, who, in any event, are usually ill-prepared to respond appropriately when patients share their suicidal thoughts.

As a result, there has been a widespread call for primary care practices to use one or another of the screening instruments that have been developed to flag depression, substance use, and other behavioral disorders. Recently, the Joint Commission has required the health care facilities that it accredits to screen specifically for suicide risk. This is highly controversial because according to the U.S. Preventive Services Task Force there is little evidence to support screening for suicide risk. They recommend screening for depression.

see Integrated Care on page 32

*If You Find Yourself Alone and In Despair - Do Not Give Up Hope  
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From Author  
**Samuel O. Ortiz,**  
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# The Sensory Comfort Cart: A Portable Resource to Assist in the Recovery of Patients with Co-Occurring Diagnoses

By Carolyn J. Castelli, MSN, RN, PMHCNS-BC; Ann O'Gara, MSN, RN, PMHCNS-BC; Aviva Fisher, MS, RN-BC, CADC; Catherine McQuade, MS, Rehabilitation Specialist; and Suzanne Colgan, FNP-BC, NewYork-Presbyterian Westchester Division

This article describes a brief history of sensory modalities in mental health and substance abuse treatment, the purpose and current use of a sensory comfort cart at NewYork-Presbyterian Westchester Division (NYPWD), early patient outcomes, and implications for discharge and recovery.

## Brief History of Sensory Modalities in Psychiatric Treatment

Ever since the mid-1800s, when the reforms of Dorothea Dix and discoveries of Florence Nightingale were introduced, cleanliness, fresh air, and natural light remain key elements in treating those suffering from mental distress and alcohol abuse. In the late 1800's, NYPWD (an all-psychiatric hospital, then known as Bloomingdale Hospital) was relocated from New York City to White Plains. Hospital trustees purposely chose rolling farmland for its beauty to provide a healing environment for patients. The hospital was built on a hilltop with expansive views of the valley below, and over 200 acres of park-like lawns with deciduous and evergreen trees and plants. Inside the stately buildings, tall windows and hallways invited light. The high ceilings exuded openness, grandeur, and respect for the dignity of the patients.

Influenced by the Wellness Movement of the late 1800s and early 1900s, and before most psychotropic medications were introduced, treatment for those with mental illness and alcohol addiction included physical exercise, warm and cold hydrotherapy, occupational therapy and diet prescriptions. In society, various abstinence/temperance societies were formed to help those with addictions. The late 1930s brought more scientific research to the study of alcoholism as well as the founding of Alcoholics Anonymous (AA).

"Integrated" medical and addiction recovery treatment for co-occurring disorders (formerly called dual disorders or MICA (Mental Illness/Chemical Abuse), officially began in the mid-1980s (Sciaccia, K, American Journal of Orthopsychiatry, 1996). After the first multi-sensory treatment room was introduced in the Netherlands in 1975 (Champagne and Stromberg, Journal of Psychosocial Nursing, 2004) alternative modalities were gradually added to the treatment of those with co-occurring disorders.

Based on research and evidence-based practice, NYPWD integrated the healing and sensory arts more intentionally into treatment in the 1990s. The therapeutic milieu was transformed to be both less restrictive and more engaging for patients. NYPWD was named as an official Planetree Hospital in 2004 because of the healing environment for patients and their families. An Integra-



Staff on 8 North at NYPH Westchester

tive Medicine Committee was established in 2012 to look at evidence-based ways to integrate traditional and alternative treatment for patient care.

In addition to the therapeutic milieu and individual, group, and family therapy, the hospital provides healing arts programs and integrative treatment modalities. Units offer patients comfort rooms for relaxation and decreased stimulation, aromatherapy, and a cornucopia of alternative offerings for stress reduction. There are opportunities for yoga, meditation, psychosocial rehabilitation, and healthy lifestyle and spirituality groups. Outdoor spaces include a courtyard with a meditation labyrinth, walking trails, tennis courts, and a swimming pool for patient and family use.

## The Purpose and Use of a Sensory Comfort-Cart at NYPWD

The Addiction Recovery Unit (8N) at NYPWD is a 14-bed open unit where patients with both substance abuse and psychiatric conditions are treated using evidence-based clinical approaches. An inter-professional team of MDs, psychologists, social workers, psychosocial rehabilitation specialists, nurses, and nursing support staff partner with patients and families to develop treatment goals and plans. Among various treatment approaches is the use of sensory modulation resources to provide healthy alternatives to the unhealthy coping mechanisms patients may have used outside the hospital for distress caused by anxiety, pain, and insomnia.

Over a year ago, nurses and psychosocial rehabilitation specialists on the Addiction Recovery Unit began to search the literature to identify additional innovative approaches in helping patients self-manage their distress. During the summer of 2017, a Family Nurse Practitioner joined the team to participate in a meta-analysis comprised of 17 studies. Evidence-based findings within mental health settings demonstrated "the usefulness of sensory approaches in supporting consumers' self-management of distress" (Scanlon and Novak, Australian Occupational Therapy Journal, 2015).

Sparked by the effectiveness of many forms of alternative therapies already in use and comfort carts at other hospitals, the possibility of a sensory comfort cart became an intriguing concept for the staff members on the Addiction Recovery Unit. The team chose a rolling cart with numerous drawers for its portability and convenience to store varied resources. After nurses and psychosocial rehabilitation specialists educated all of the staff members, the sensory comfort cart was officially launched in October 2017.

The cart is designed as a resource to help patients identify and learn to cope with the distress they may experience related to recovery from symptoms of substance abuse and/or mental illness. The cart is docked in the nursing station. When patients request help with their feelings of distress, the resources on the comfort cart are offered to patients, in addition to a prescribed medication, if indicated.

The comfort cart has resources that tap into the healing properties of the five senses. Patients and family members are given a fact sheet about the cart and the purpose of each item. A few examples of the resources are:

Sound: Music and Tabletop Chimes to Soothe and Relax

- Smell: herbal teas and aromatherapy oils specifically geared to calm various emotions

- Taste: herbal teas, peppermint candy, chewing gum, etc. to reduce cravings and help focus attention

- Touch: weighted gel lap pads, beanbags, stress balls, clay/putty, aromatherapy lotions, and coloring books for adults to comfort and reduce anxiety

- Sight: various colored glasses to help with different emotions

Using a feedback form on the cart, patients identify and document feelings associated with their distress as they choose a healthy sensory modality to help relieve their discomfort or anxiety. Nurses recommend the resource be used for at least thirty minutes to an hour to determine efficacy. Each time the sensory comfort cart is used, patients are asked to fill out the brief feedback form and then rank the level of distress before and after applying the sensory modality, using a Likert scale. Staff members describe and/or bring the comfort cart into patient groups at least weekly to discuss the resources, the evidence behind sensory alternatives, and to allow patients to practice using the alternative modalities. Nursing staff members replenish the contents of the cart as often as needed.

Practicing various sensory modalities in the inpatient setting allows for patients to discover what works for them. Patients are learning that healthy sensory modalities, along with prescribed medication, are effective in modulating feelings of distress. Staff members partner with patients as to how best to incorporate the resources into

their daily lives after discharge, either at home or in a residential treatment setting.

## Early Outcomes

In the first few months of use, the sensory comfort cart was primarily used either in the group setting with staff guidance or when a patient asked for a PRN (as needed) medication to help with anxiety, insomnia, cravings for nicotine, etc. While expressing interest in the sensory cart's modalities, actual patient use is lower than expected. Patients seem reluctant to fill out the feedback form, so staff members are encouraging and assisting as needed. Since the sensory cart was introduced, approximately 56 feedback forms were completed. Patients noted on 86% of the completed forms that the sensory modalities were effective for them.

Aromatherapy (sense of smell) in the form of an essential oil, alone or with putty (touch), was the highest ranked modality for distress reduction by patients. Of the oils, lavender was ranked most effective in distress reduction, followed by bergamot with lavender, orange, peppermint, and lemon. Taste ranked 2nd highest for relieving distress and included gum, followed by chamomile tea, and candy. Obtaining more ways for patients to listen to music or to view relaxation videos may add to a potential increase in the use of the senses of sight and sound for relaxation. Continuing data collection, along with staff and patient evaluation, will prompt changes to the use and processes of the sensory comfort cart.

## Implications for Discharge and Recovery

Patients are encouraged to create a "toolbox" of healthy coping strategies to take with them when they leave the hospital for both their psychiatric and substance abuse struggles. These might include calling their sponsor, attending daily AA or NA meetings, taking prescribed medications for their psychiatric illness, as well as using some of the effective sensory comfort cart resources. Recently a patient stated, "I find working with the clay/putty really helps my distress and I plan to use it when I get home." These resources are widely available to the public through retail stores or online.

According to Champagne and Stromberg (Journal of Psychosocial Nursing, 2004), "Sensory approaches strengthen the therapeutic relationships, promote collaboration and recovery, and are fully applicable across age groups, mental health settings, and consumer populations." A future survey of the usage of the sensory comfort cart resources by patients after discharge will add knowledge that staff can use to better equip patients with co-occurring disorders to achieve a more sustainable recovery.

A resource for both patients and practitioners can be found on the internet at [www.sensoryconnectionprogram.com](http://www.sensoryconnectionprogram.com). For more information about NYPWD's Addiction Recovery program contact: NYPWD Access Department at 1-888-694-5700.



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# The NYSPA Report: PTSD and Its Co-Morbidities

**By Madhu Gundigere Rajanna, MD**  
**Director, Mental Health Clinic**  
**Jamaica Hospital Medical Center**

**P**osttraumatic Stress disorder (PTSD) is a mental health problem that some people develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident, or sexual assault. The following data shows the gravity of the problem posed due to PTSD. The National Comorbidity Survey Replication study (NCS-R), conducted between February 2001 and April 2003, was comprised of interviews of a nationally representative sample of 9,282 Americans aged 18 years and older. PTSD was assessed among 5,692 participants, using DSM-IV criteria. The NCS-R estimated the lifetime prevalence of PTSD among adult Americans to be 6.8%. Current past year PTSD prevalence was estimated at 3.5%. The lifetime prevalence of PTSD among men was 3.6% and among women was 9.7%. The twelve-month prevalence was 1.8% among men and 5.2% among women.

The presence of PTSD has been prevalent through the ages, although it has often been identified by various names. In fact, clinical pictures suggestive of PTSD have been recorded since the times of Herodotus and Homer. Swiss physician Johannes Hofer coined the term Nostalgia in 1678 to describe symptoms seen in Swiss Troops which included melancholy, incessant thinking of home, disturbed sleep or insomnia, loss of appetite, anxiety and cardiac palpitations. Napoleon's Chief Surgeon prescribed a treatment for Nostalgia which consisted of regular exercise and listening to music.

In 1871 Jacob Mendez Da Costa noted the following symptoms in soldiers: chest-thumping, anxiety and breathlessness. These symptoms were referred to first as Soldier's Heart and later as Da Costa Syndrome. Following a series of deadly train accidents in Great Britain, the term Railway Spine was coined. Railway spine was characterized by "the manifestation of a variety of physical disorders in otherwise healthy and apparently uninjured railway accident victims."

In WWI the nomenclature changed to Shell Shock, of which symptoms included staring eyes, violent tremors, blue, cold extremities, unexplained deafness, blindness, or paralysis. During the World War II era, the disorder was renamed Combat Fatigue.

In the Diagnostic and Statistical Manual of Mental Disorders (DSM I), published in 1952, what we now know as PTSD was called "Stress response syndrome" and was purported to be caused by a "gross stress reaction." In 1968, DSM II lumped together trauma-related disorders in a category titled "Situational disorders."

Later, DSM III, published in 1980, first introduced Post-Traumatic Stress Disorder as a diagnosis. It was placed under a subcategory of anxiety disorders and there was a clearer organization of symptoms around three dimensions of stress response which included re-experiencing, avoidance and numbing, and physiological arousal. DSM-IV did not change these three core criteria.



**Madhu Gundigere Rajanna, MD**

However, the most recent version of the DSM, known as DSM-5, established new diagnostic criteria for PTSD, including the following: (i) the person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence; (ii) intrusion Symptoms; (iii) persistent avoidance of stimuli associated with the trauma; (iv) negative alterations in cognitions and moods that are associated with the traumatic event; and (v) alterations in arousal and reactivity that are associated with the traumatic event.

The treatment of PTSD is best accomplished by a multimodal approach. Combination of medication/s with various forms of psychotherapy is the main stay of treatment. Pharmacotherapy consists of SSRIs; other antidepressants like Mirtazapine; Prazosin (effective for nightmares associated with PTSD); older antidepressants; anticonvulsants (Topiramate- has shown promise) and D-cycloserine. Other novel treatments being explored include CRF/NMDA/NK-1 antagonists, hydrocortisone, and NPY enhancers. Use of benzodiazepine in PTSD has been controversial but in general should be considered relatively contraindicated for patients with PTSD or recent trauma.

Cognitive behavioral therapy, including Prolonged Exposure Therapy, Cognitive Processing Therapy, Stress Inoculation Training, and Trauma Focused CBT, and Eye Movement Desensitization and Re-Processing (EMDR) are considered to be effective treatments for PTSD.

It is not only important to explore for symptoms of PTSD in a patient exposed to trauma but also to be on the look out for the comorbidities that may develop either at the onset of PTSD or over the course of time. The comorbidities associated with PTSD may be classified broadly into medical and psychiatric comorbidities.

The most important medical comorbidities are traumatic brain injury (TBI), coronary heart disease and metabolic syndrome. PTSD has been associated with increased risk of coronary heart disease. In a retrospective cohort study of 253 veterans with PTSD (mean age 52 years; 92% males) 43 percent were found to have metabolic syndrome, a cluster of risk factors for

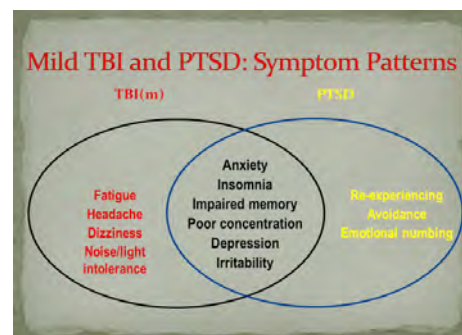
heart disease, stroke and diabetes. This article will focus on TBI due to the complexity of the presentation and the nature of the symptoms that are shared by TBI with PTSD.

## Traumatic Brain Injury (TBI)

"In order to understand the effects of the head injury, we must undertake full study of the individual's constitution. In other words, it is not just the kind of injury that matters, but the kind of head that is injured" - Sir Charles Symonds, 1937

Greater than 1.5 million Americans suffer TBI every year. It is referred to as the "signature injury" of Operation Enduring Freedom and Operation Iraqi Freedom and the major cause of disability in young adults. Approximately 18% of returning soldiers have been identified as having mild traumatic brain injury (TBI), primarily due to exposure to blasts.

TBI and PTSD present with common neuropsychiatric symptoms as seen below:



This overlap complicates diagnostic differentiation. Interestingly, both TBI and PTSD can be produced by overlap-


ping pathophysiological changes that disrupt neural connections termed the "connectome." TBI produces cognitive, emotional, behavioral, and physical disturbances.

Cognitive disturbances include impaired attention, memory, language, skills, and complex cognition (judgment, insight, problem solving). Emotional disturbances include depression, mania, affective lability, irritability, anxiety, panic attacks, PTSD, personality change, and rage or aggression. In addition, behavioral disturbances include diminished motivation/apathy, impulsivity, perseveration, and psychosis. Finally, physical disturbances include seizures, headaches, dizziness, balance and coordination problems, weakness or paralysis, visual disturbances, hearing impairments, and sensory impairments. Clinical presentations of TBI may include some or all of the following symptoms:

- Impulsivity (common reason that family wants evaluation)
- Disinhibition: no "filter" on thoughts or actions
- Poor control over primal urges
- Physical aggression
- Cognitive changes: inability to concentrate or focus
- Substance abuse
- Sleep difficulties

At present, there are no FDA-approved medications for psychiatric symptoms due to TBI and current recommendations are

*see NYSPA Report on page 35*



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**[www.ICLinc.org](http://www.ICLinc.org)**

# The Evolving Health and Social Service Landscape: Promise for Persons with Co-Occurring Disorders

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

A year has passed since the United States Congress enacted sweeping legislation to address deficiencies in our national behavioral health service infrastructure. The Comprehensive Addiction and Recovery Act (CARA) and 21st Century Cures Act, both passed by the 114th Congress in 2016, authorized a variety of initiatives to support individuals with serious mental illness (SMI) and substance use disorders (SUDs). The 21st Century Cures Act also authorized the appointment of an Assistant Secretary for Mental Health and Substance Use within the Substance Abuse and Mental Health Services Administration (SAMHSA) and the establishment of an Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). The ISMICC, operating under the authority of the newly-appointed Assistant Secretary, is charged to enhance coordination across federal agencies that serve individuals with SMI. These initiatives, although surely imperfect and prone to the bureaucratic malaise that afflicts other governmental actions, constitute a welcome recognition of the inextricable link between SMI and SUD and the need for a correspondingly integrated response to them.

The ISMICC recently released its first report to Congress, and it underscored both the prevalence of co-occurring mental health and substance use disorders and our failure to deliver integrated and evidenced-based care necessary to ameliorate them. Of the 10.4 million American adults diagnosed with SMI, 2.6 million (approximately 25%) are dually diagnosed with a SUD. Although two-thirds (63.2%) of this cohort received mental health care in 2016, only 14.3% received specialized care for substance use (Interdepartmental Serious Mental Illness Coordinating Committee, 2017). Thus, approximately 2.2 million adults with co-occurring SMI and SUD conditions did not receive specialized substance use treatment in 2016. In addition, individuals with SMI and SUD are exceptionally prone to physical health conditions that further compromise their overall health and lead to adverse outcomes including potentially preventable hospital readmissions and premature mortality. One study found individuals with serious behavioral health conditions incurred substantially greater medical expenses for physical health concerns than did individuals without behavioral health conditions (Melek, Norris & Paulus, 2014). This finding applied to all payers under review including public (e.g., Medicaid and Medicare) and commercial. A survey of New York State Medicaid expenditures revealed a similar finding via analyses of hospital readmission rates among individuals with and without behavioral health diagnoses. Individuals with behavioral health conditions incurred more than twice the cost in hospital readmissions (\$395 million) than did those without behavioral health conditions (\$149 million) (National Council for Be-



Ashley Brody, MPA, CPRP

havioral Health, 2007). Recent developments, most notably the scourge of opiate drug abuse that has ravaged communities across the nation, have only exacerbated the plight of those with behavioral health disorders. Although individuals with mental health conditions comprise less than one-fifth (17.9%) of the overall population, they received more than half of opiate prescriptions (51.4%) written during a survey period (Davis, Lin, Liu, & Sites, 2017). The foregoing findings appear to confirm the anecdotal accounts of many behavioral health service professionals. In short, individuals with co-occurring SMI and SUD are highly susceptible to the myriad health risks that afflict the general population and their comorbid behavioral and physical health conditions often result in adverse or tragic outcomes.

Healthcare reform efforts presently underway must address the needs of this vulnerable population in order to achieve desired improvements, and this must begin with a sober recognition of some enduring obstacles to reform. For instance, individuals with co-occurring disorders continue to have limited access to evidenced-based, integrated care essential to treating the unique manifestations of their conditions. In 2016, only 10% of those with co-occurring disorders received such treatment (Interdepartmental Serious Mental Illness Coordinating Committee, 2017). Thus, a substantial majority of individuals with co-occurring disorders must rely on "conventional" treatment modalities that target discrete symptoms of mental illness or substance use, as if the parts of their experience could be managed independently of the whole. These approaches are surely helpful to some, but they often fail to address the particularly complex experiences of individuals with both SMI and SUD. Moreover, these modalities remain deeply embedded within longstanding fiscal, regulatory, cultural and philosophical frameworks that frequently impede integration. For example, providers that deliver substance use treatment are subject to guidelines promulgated by the federal govern-

ment and New York State Office of Alcoholism and Substance Abuse Services (OASAS). Their fiscal viability depends on a byzantine network of reimbursement standards that vary considerably by payer. Some providers promote treatment predicated on abstinence from any and all substances and this may even preclude the use of psychotropic medication or Medication Assisted Treatment (MAT), whereas others embrace nuanced approaches that employ principles of Harm Reduction and multiple pathways to recovery. Such differential approaches to treatment often betray deep philosophical underpinnings that may not accommodate new or contradictory evidence. They are simply unnavigable for many individuals with SMI, so it is unsurprising that only 14% of them access such treatment as affirmed by the ISMICC report.

The application of appropriately integrated and evidenced-based care for individuals with co-occurring disorders is necessary but insufficient to achieve the outcomes envisioned by the pioneers of healthcare reform. Like members of other vulnerable populations, individuals with SMI and SUD frequently have limited access to Social Determinants of Health (SDH) essential to optimal health and stability. The Centers for Disease Control and Prevention (CDC) defines SDH as "conditions in the places where people live, learn, work and play," and it sug-

gests these conditions exert considerable influence on individuals' overall health and wellness (Centers for Disease Control and Prevention, 2017). An emerging body of evidence suggests healthcare plays a relatively minor role in overall population health, whereas social conditions, behavioral patterns and genetic predispositions are far more determinative of long-term outcomes (Schroeder, 2007). These findings confirm what intuition and anecdote have taught us for many years. Simply put, individuals with serious mental illness, substance use disorders or comorbid medical conditions cannot be expected to achieve lasting recovery without safe and stable housing, fulfilling personal relationships, income supports and avenues for personal growth via employment or other meaningful activity. Unfortunately, current social and economic policies fail to acknowledge the prominence of SDH in the healthcare equation as evidenced by marked discrepancies in spending for healthcare and social support services. The United States spends considerably more of its GDP on healthcare and less on social services than other developed nations, but its outsized investment in healthcare yields comparatively poor outcomes (Butler, Matthew, & Cabello, 2017). New York has generally mirrored

*see Promise on page 36*



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## Suicide and Substance Use

**By Jane Amsden, LCSW-R**  
**Program Director of Mental Health**  
**Counseling and Treatment Services**  
**CoveCare Center**

In America, one person dies by suicide every 13 minutes. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), it is the 2nd leading cause of death for teens, and the leading cause of death among people with substance use disorders. There is a strong association between mental health issues that may lead to suicide and substance use. The biggest risks of suicide include prior attempts, a current mood disorder, substance abuse, and access to means. Research also suggests that males are more likely to complete a suicide than females.

Most people who become suicidal will, when discussing their feelings, acknowledge that if the main stressors in their life were resolved, they would not feel suicidal. However, most feel suicidal because they do not see any hope of resolution. Talking a situation through with another person often yields thoughts, ideas, and new perspectives that had not occurred to the person before. Options are identified and despair is lessened. Therefore, taking the time to talk, listen, and support what a depressed person feels is essential. People need to know that those around them be-



**Jane Amsden, LCSW-R**

lieve them and believe in them, even (and especially) at a time in life when they may have difficulty believing in themselves.

Trained therapists play a vital role in helping identify and explore what someone may be experiencing. In therapy, counselors can ask the direct questions that others might want to shy away from like, "Do you want to kill yourself?" and "How would you do it?" These are critical questions to get the topic out in the open and possibly save a person's life. In addition,

nationally recognized tools can help reveal thoughts and plans for suicide in individuals of all ages, such as the CAMS model (Collaborative Assessment and Management of Suicidality) and the Columbia Suicide Rating Scale. While it may become clear that someone you know is in need of professional help, it is also important to consider yourself and other family members' needs and seek support through individual, group, or family counseling.

Suicide is often an impulsive act. Therefore, finding ways to slow down a possibly lethal impulse is key and limiting access to means of committing suicide is critical. Intoxication increases the chances of impulsive behavior, as the brain's ability to make appropriate decisions becomes impaired by use. According to Schoenbaum, Roesch, and Stalnaker (2006) the prefrontal cortex has a role in our executive functions. This area contributes to our ability to anticipate events, and to use that information to guide decisions. Damage or impairment to this area--that can be caused by substance use--leads to the kind of impulsiveness that is common in those who are addicted.

As above, SAMHSA reports that suicide is the leading cause of death among people with substance use disorders. Alcohol is present in 30-40% of suicides and drug related suicide attempts increased by 41% from 2004-2011. According to the

US Dept of Health and Human Services (HHS), "A review of minimum-age drinking laws and suicides among youths age 18 to 20 found that lower minimum-age drinking laws were associated with higher youth suicide rates."

The HHS also reports, "Substance use and abuse can be common among persons prone to be impulsive, and among persons who engage in many types of high risk behaviors that result in self-harm." Many people who are addicted are looking for relief from uncomfortable feelings or escape from the stresses in their lives. A parallel develops between their tolerance for substances and their tolerance for risk and self-harm. For those who might observe this pattern, they may discover that minimization is a standard defense of addiction. Thus, even as the risk grows, the addicted user insists that everything is fine. At the same time, the relief an addicted user finds includes lowering of inhibitions, which most substances, especially alcohol, provides. For someone who is feeling uncomfortable in their own skin to begin with, this is a dangerous situation, one in which one's lowered inhibitions lead them to impulsively act out in ways he/she would not do if sober. In this way, many people self-harm, or attempt or complete suicides who would not have done so had they not been intoxicated.

*see Suicide on page 34*



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# Champions of the Autism and Behavioral Health Communities To Be Honored at May 16<sup>th</sup> Reception in New York City



**Tino Hernandez**

**By Staff Writer  
Behavioral Health News**

**M**ental Health News Education, Inc. (MHNE), the nonprofit organization that publishes *Autism Spectrum News* and *Behavioral Health News*, will be honoring outstanding champions of the autism and behavioral health community at its annual Leadership Awards Reception on May 16, 2018, at the NYU Kimmel Center in NYC from 5:00 PM to 8:00 PM. To register, visit our website at [www.mhnews.org/AwardsReception.htm](http://www.mhnews.org/AwardsReception.htm).

Constance Brown-Bellamy, MHNE Board Chair, made the announcement stating, "MHNE has selected leaders from four of the nation's most prominent organizations to be honored at our annual awards reception this year." They are: NEXT for AUTISM Co-Founder and President, Ilene Lainer and Board Member, Michelle Smigel; Jim Spink, President, Tri-State/Mid Atlantic Region at Beacon Health Options; Mitchell Netburn, President and CEO of Project Renewal; and Tino Hernandez, President and CEO of Samaritan Daytop Village.

Ira Minot, Founder and Executive Director of MHNE stated, "We are indeed honored to have this opportunity to recognize these champions of the communities we serve. We are also pleased to announce that Joshua Rubin, Principal at Health Management Associates and MHNE Board Member, has graciously accepted to serve as Event Chair for our 2018 Leadership Awards Reception. Josh has served in leadership positions at many prominent autism and behavioral health organizations in the New York region."

In a joint statement, Debbie Pantin, CEO of VIP Community Services and MHNE Vice-Chair, and Josh Rubin remarked, "Both the autism and behavioral health communities will shine at our 2018 networking and awards celebration, and we invite all of our friends and colleagues to come out and join us in honoring our outstanding Leadership Awards recipients."

Proceeds from this event will go towards expanding and developing the non-profit educational mission of *Autism Spectrum News* and *Behavioral Health News*. With these publications, Mental Health News Education, Inc. aims to reduce stigma, promote awareness and disseminate evidence-based information that serves to improve the lives of individuals with mental illness, substance use disorders and autism spectrum disorders, their



**Ilene Lainer and Michelle Smigel**

families, and the provider community that serves them.

Ilene Lainer and Michelle Smigel  
Co-Founder and President / Board Member  
NEXT for AUTISM  
"2018 Advocacy Award"

Ilene Lainer, NEXT for AUTISM Co-Founder and President, is responsible for the strategic vision and tactical direction of NEXT for AUTISM. She became a leader in the autism community for both professional and personal reasons. Ilene co-founded NEXT for AUTISM because she is committed to transforming the system of services and pursuing the latest innovations, so that all families living with autism would have access to the educational, social, recreational, and support services they need. Formerly a partner at the law firm of Grotta, Glassman & Hoffman, P.A., Ilene practiced labor and employment law on behalf of management for nearly two decades, developing a strong interest in working with clients that were in the midst of internal structural change. Ilene has served on the Board of Classic Stage Company. She has published and spoken widely about autism topics, and is currently on the Board of Trustees of the NYC Autism Charter School and on Advisory Committees for Felicity House and the Center for Autism and the Developing Brain.

Michelle Smigel, NEXT for AUTISM Board Member, and Co-Creator of Night of Too Many Stars, was a young mom working toward a prominent position at the Museum of Natural History and occasionally writing the best parts of her husband Robert's Saturday Night Live cartoons, when her first son, Daniel, was diagnosed with autism. Like many parents, she was horrified by the lack of options and resources for kids with autism, and she and Robert started Night of Too Many Stars, a televised benefit that, since 2006, has raised over 30 million dollars for autism schools, services and programs all over the country. She is a proud mom of three perfect boys.

Jim Spink  
President, Tri-State/Mid Atlantic Region  
Beacon Health Options  
"2018 Leadership Award"

Jim Spink is the President of the Tri-State/Mid-Atlantic Region at Beacon Health Options - the nation's premier man-



**Mitchell Netburn**

aged behavioral healthcare organization. As a founding member of Beacon Health Strategies in 1997, Jim has held numerous roles within the organization, most recently serving as Beacon's President until the merger with Value Options in 2014. Building on an extensive background in behavioral health and developmental disabilities policy and program development, Jim has pioneered medical and behavioral health integration within payor and provider systems. Further, Jim has focused his education on the implementation of the American Disabilities Act (ADA), focusing on disability as a civil rights concern.

Mr. Spink received a dual degree in psychology and English literature from the University of Massachusetts at Amherst and a MPA in Public Administration/Disability Studies from Suffolk University in Boston, Massachusetts.

Mitchell Netburn  
President and CEO  
Project Renewal  
"2018 Community Service Award"

A native New Yorker, Mitchell Netburn has over 25 years of public interest experience. Since 2010, Mitchell has been the President and CEO of Project Renewal. At Project Renewal he is responsible for the strategic vision and management of the agency to ensure it fulfills its mission to end the cycle of homelessness for adults and children by empowering them to obtain health, homes and jobs. Mitchell oversees the agency's innovative and award winning programs which collectively serve 15,000 clients per year, including 2,754 people in shelters and permanent housing. Project Renewal has a staff of 900 employees and an annual budget of \$80 million.

Previously, Mitchell was the Senior Vice President at F-E-G-S Health and Human Services System where he directed a welfare-to-work initiative serving 24,000 disabled clients annually. Mitchell succeeded in tripling the number of clients moving from welfare to independence, gaining both national and international recognition for this holistic client-centered model. Prior to joining F-E-G-S, Mitchell served as the Executive Director for the Los Angeles Homeless Services Authority where he coordinated all homeless programs for the City and County of Los Angeles.



**Jim Spink**

Before moving to Los Angeles, Mr. Netburn was the First Deputy Commissioner at the New York City Department of Homeless Services where he ensured quality shelter and programs were provided to 23,000 people per night. Mitchell also held the positions of Chief of Staff to the NYC Deputy Mayor for Education and Human Services as well as the Agency Chief Contracting Officer and the Assistant Commissioner for the Ryan White CARE Act Program at the NYC Department of Health and Mental Hygiene.

Mr. Netburn has a J.D. from the University of Wisconsin-Madison Law School and a B.A. from Oberlin College.

Tino Hernandez  
President and CEO  
Samaritan Daytop Village  
"2018 Lifetime Achievement Award"

Tino Hernandez is President and CEO of Samaritan Daytop Village. Samaritan Daytop Village is one of the largest non-profit providers of community-based health and human services in New York State. Serving more than 28,000 people each year, the agency operates a network of more than 50 facilities, across 10 counties in New York City, Long Island, Westchester and upstate New York.

Tino serves on the Governor's Behavioral Health Services Advisory Council and sits on the Executive Committee of the Coalition of Behavioral Health Agencies. Prior to joining Samaritan Daytop Village, Mr. Hernandez was the second-longest serving Chairperson of the New York City Housing Authority (NYCHA) and oversaw a public housing and Section 8 system serving more than 675,000 New Yorkers.

Mr. Hernandez previously served as Commissioner of the NYC Department of Juvenile Justice, Chief of Staff to the Deputy Mayor for Education and Human Services, Deputy Commissioner for Adult Services at the Department of Homeless Services, and Assistant Commissioner for HIV Program Services at the City's Health Department.

A licensed social worker, Mr. Hernandez obtained a Bachelor of Science degree from Adelphi University and a Masters in Social Work from the State University of New York at Albany. Mr. Hernandez is married and resides in Manhattan. He is the father of two children.

AUTISM SPECTRUM NEWS and BEHAVIORAL HEALTH NEWS

Annual Leadership Awards Reception

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**Ilene Lainer and Michelle Smigel**  
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**Mitchell Netburn**  
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“Community Service Award”



**Jim Spink**  
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Tri-State/Mid Atlantic Region  
Beacon Health Options  
“Leadership Award”

**Wednesday, May 16, 2018**

**5:00 PM - 8:00 PM**

**5:00 PM Networking Reception - 6:00 PM Awards Presentation**

**NYU Kimmel Center - Rosenthal Pavilion, 10th floor**

**60 Washington Square South, New York, NY**

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**Final Registration Deadline - April 27, 2018**

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

**For more information contact Ira Minot, Executive Director, at (570) 629-5960 or [iramminot@mhnews.org](mailto:iramminot@mhnews.org)**

# Co-Occurring Fatigue: Compassion, Political, and Oppression Fatigue

## Understanding and Meeting Our Special Needs as Helping Professionals

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

For those of us who work in care-giving environments, we are constantly presented with emotional challenges. Compassion Fatigue symptoms result from the chronic stress of care giving work. Leading traumatologist Eric Gentry notes that people who are attracted to caregiving often enter the field already compassion fatigued. They strongly identify with suffering or traumatized individuals, or those in need. They also tend to display other-directed care giving. In other words, they may have been taught at an early age to care for the needs of others before caring for their own needs. In addition, ongoing self-care and self-nurturing practices may be absent from their daily lives. Sound familiar?

### What Is Compassion Fatigue?

According to Dr. Charles Figley, Director of the Tulane University Traumatology Institute, Compassion Fatigue is a state experienced by those helping people in distress. It is an extreme state of tension and preoccupation with the suffering of those being helped, to the degree that it can create a secondary traumatic stress for the helping professional. It has been often described as the “cost of caring” for others in emotional and physical pain (Figley, 1982). Sometimes it is characterized by deep physical and emotional exhaustion and a pronounced change in the service provider’s ability to feel empathy for their patients, their loved ones, and their co-workers.

### Compassion Fatigue: Signs and Symptoms

Compassion Fatigue is marked by increased cynicism at work and a loss of enjoyment of one’s career. It can eventually transform into deeper feelings of depression, secondary traumatic stress, and stress-related illnesses. The most insidious aspect of compassion fatigue is that it attacks the very core of what brought us all into this work: our empathy and compassion for others.

According to the Compassion Fatigue Awareness Project (2017), sufferers can exhibit several symptoms, including hopelessness, decreased pleasure, irritability, constant stress and anxiety, sleeplessness or nightmares, and a pervasive negative attitude. This can have detrimental effects on individuals, both professionally and personally, including a decrease in productivity, the inability to focus, and the development of new feelings of incompetency and self-doubt.

While the symptoms are very often disruptive, depressive, and irritating, an awareness of the symptoms and their negative effects can lead to positive change, transformation, and resiliency. Françoise Mathieu, M.Ed., a leading Compassion Fatigue specialist, notes that everyone has his or her own warning



signs that may indicate Compassion Fatigue. These include:

- Exhaustion
- Reduced ability to feel sympathy and empathy
- Anger and irritability
- Increased use of alcohol and drugs
- Dread of working with certain clients or patients
- Diminished sense of enjoyment of career
- Disruption to world view, heightened anxiety, or irrational fears
- Intrusive imagery or dissociation
- Hypersensitivity or insensitivity to emotional material
- Difficulty separating work life from personal life
- Absenteeism – missing work, or taking many sick days
- Impaired ability to make decisions and care for clients or patients
- Problems with intimacy and issues in personal relationships

The need for good self-care must not be overlooked. Good self-care and wellness begins with awareness. Heightened awareness encourages insights into past traumas and painful situations that are being relived within the context of symptoms and behaviors. The goal is to heal past traumas that currently serve as obstacles to wellness. A good therapist can be especially helpful. In addition, good self-care will require developing a consistent self-care regiment, including regular exercise, a healthy dieting, social activities, journaling, meditation and restful sleep.

The quality of the helping professionals’ work is closely related to the quality of the supervision that they receive. We can’t be personally falling apart and serve as an example of what good care-giving service is all about. We must take and appreciate down time for reflection and planning. To encourage others, we must take time for ourselves. This includes taking time for lunch and vacations, relaxation, meditation and peer support.

### What Is Political Fatigue and Activist Burnout?

In our current unpredictable and fear-provoking social-political climate, we are most susceptible to Political Fatigue,

which occurs when political agendas or policies (i.e., voter suppression, cut backs, anti-immigrant, and anti-LGBTQIA+ initiatives) create a nagging sense of hopelessness when it comes to the efficacy of political action or advocacy. It can lead to anger, anxiety, confusion, frustration and fear of an unsafe world, which can impact our physical, emotional, and psychological health and well-being.

When this extreme fatigue is experienced in the workplace, the organization suffers under many far-reaching symptoms of stress: friction among co-workers, staff-management tension, increased absenteeism, excessive medial issues, high turnover and rising workers’ compensation costs. Addressing fatigue within an organization requires stated and demonstrated value of staff, clear directions, good supervision, training, focus on staff relationships and morale, time, patience, understanding and a renewed vision for the future. Losing your vision can further stress and incapacitate staff. We must fortify ourselves and our staff by incorporating “self-care” into our organizational plans – which can motivate employees, energize the entire organization, and effect positive change.

According to Aliya Khan (Everyday Feminism, 2015), Activist Burnout is the feeling of pessimism and physical, emotional, and spiritual exhaustion that comes with advocacy and helping work. Many people become activists because they have passion about social justice issues and how these issues affect the lives of those we serve. In these challenging political times, it’s not unusual that by the time we reach the point of needing a break, we may be suffering from compassion fatigue. Activists who develop both professional and personal self-care and wellness strategies tend to be more resilient, and can shift, grow, and change course.

### What Is Oppression Fatigue?

Oppression Fatigue, a term coined by leading counselor, consultant, coach and educator Irene Greene, is the heavy exhaustion that comes from being oppressed – the emotional, psychological, spiritual and physical exhaustion that comes from enduring daily micro and macroaggressions of personal and collective violence, rejection, inequities, discrimination, invisibility and injustices caused by the sys-

tematic privileges of one group(s) over another group(s). As leaders, colleagues, and helping professionals it is crucial that we can identify, understand, talk about, and learn to address oppression and the intersections of race and racism with gender bias, LGBTQIA+ bias, gender fluidity bias, transmisogyny, class bias, bias against people with disabilities, xenophobia, and religious bias (including anti-Semitism and Islamophobia), plus other forms that bias may take.

We must also understand that the constructs of power, privilege, hierarchical rank and culture are always a part of the individual and institutional context and must be taken into consideration as we address racism and other oppressions. There are things that we can and must do as accountable leaders and colleagues. The first is to speak openly about our own struggles with compassion, political, and oppression fatigue. The conspiracy of silence within the profession about any fatigue that affects us as helping professionals is no different than the silence about bullying and sexual harassment in the past.

Also, remember that for helping professionals who are themselves struggling with the impact of Oppression Fatigue (due to daily microaggressions, rejection, inequities, discrimination, invisibility and injustices caused by the systematic privileges), the burden is heavy and exhausting. “If you see something, say something,” as using our privilege can greatly impact the quality of our work environment, our relationships with colleagues, morale and the overall health of our organization. We must engage with each other in a non-shaming, non-blameful, non-judgmental collaborative manner to create safe and brave work spaces. We can then tackle the challenging questions, engage in difficult discussions, and bring everyone’s authentic voice to the table as we address Oppression Fatigue within our workplace and offer our “collective best” to those we serve. Let’s examine how this Fatigue Cluster looks at the organizational level:

### Organizational Symptoms of Compassion, Political and Oppression Fatigue

- High absenteeism
- Constant conflict in co-worker relationships
- Inability for teams to work well together
- Desire among staff members to break company rules
- Outbreaks of aggressive behaviors among staff
- Inability of staff to complete assignments and tasks
- Inability of staff to respect and meet deadlines
- Lack of flexibility among staff members
- Negativism towards management
- Strong reluctance toward change
- Inability of staff to believe improvement is possible
- Lack of a vision for the future

*see Fatigue on page 36*



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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.



# Project Access: An Investigation of Access To Quality Mental Health and Addictions Care

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

**D**id you know that health insurers are mandated by government to offer panels of providers so that families can find easily accessible care for their loved ones—and not only for physical illnesses?

This requirement is known as *network adequacy*, referring to adequate networks of care. However, the problem of timely access for care is more complex and may begin with a family's hesitance to ask for help and to reveal that they are living with someone who is struggling with a mental illness or addiction.

## Project Access

To shed light on these issues, in 2017 North Shore Child & Family Guidance Center, located in Nassau County, Long Island launched *Project Access* and surveyed almost 650 respondents across Long Island, NY about their experiences regarding the ease or difficulty with which they were able to access mental health or chemical dependency care.

Project Access was supported by the Long Island Universalist Unitarian Fund of the Long Island Community Foundation. A task force of providers, parents and legislators signed on to support the



**Andrew Malekoff, LCSW, CASAC**

project. Our research partner in the effort was LIU-Post School of Social Work.

## The Problem of Access is Complex

Families coping with mental illness or addiction do not as readily seek help as they might for heart disease, cancer or diabetes. Why? As the results of the Project Access survey suggest, it could be related to personal indecision, often stemming from stigma and the shame it generates.

## Stigma Looms Large and Can Lead to Reluctance to Seek Help

When there is a mass shooting and the perpetrator is labeled mentally ill, it casts a shadow on all people with mental illness, despite the fact that this group of people is disproportionately the victims of violence. 36% of survey respondents cited stigma as an impediment to seeking care.

Attitudes like this reinforce stigma and can lead to reluctance for those in need to seek help in a timely manner to address issues including discrimination in school or in the workplace; and bullying, violence or harassment. These attitudes may lead to individuals believing that they can never improve their lot in life and feeling let down by health insurance companies and providers that do not meet their mental health needs.

The United States has chronically failed to treat illnesses above the neck the same as illnesses below the neck. For example, a parent who would not hesitate to reach out for help if their child was in an accident and appeared to have broken an arm might wait weeks or even months, if not longer, to ask for help if it was a mental health crisis or substance abuse problem.

Clearly, as this study reveals, despite any progress made in eradicating stigma, we still have a long way to go with respect to public education and mental health awareness.

## When Providers Do Not Accept Your Health Insurance

What makes the problem of stigma even more insidious is that once an individual or their loved ones pick up the phone to ask for help, they are told repeatedly by providers, "I'm sorry, I don't accept that insurance any longer, I only accept cash." Many cannot afford the rate charged by providers, and there is a chance they will give up.

When a parent gives up they risk their child deteriorating further. This is also true for adults with mental illness and increases the odds that they will ultimately need more costly care or confinement such as hospitalization or incarceration. Almost 40% of survey respondents identified affordability as an obstacle to seeking care.

A number of respondents chose to write about their experiences in more detail. As one of them remarked, "I work for a school district and we work with families on a daily basis where they cannot find a provider that will accept their insurance or they cannot afford the copayment. Personally, a family member within my household required therapy and we had difficulty finding a provider and when we did, scheduling was a nightmare because so many patients were trying to see him. I believe it was because he was one of the few willing to accept multiple insurance policies."

## The Challenge of Finding Accessible and Affordable Care

Almost 50% respondents indicated that it was more difficult finding help for men-

tal health or substance abuse/addiction problems than finding help for physical illnesses and most particularly when they were in crisis. Nearly 40% of respondents said that their insurance company did not have an adequate number of providers. These findings suggest that, despite federal parity law, more needs to be done to ensure adequate networks of providers for people living with mental illness and addiction.

## The Commercial Health Insurance Industry

After reviewing the research, Project Access committee member and educator Dr. Ilene Nathanson, Chair of the Social Work Department at LIU Post, concluded, "If the definition of insurance is protection then the gross inadequacies of our insurance system are laid bare in this study. Delays, lack of affordability, outright inaccessibility—all courageously endured by human beings in need of mental health care. *It is time that the insurance industry stepped up to the task of protecting.*"

## Monitoring and Enforcing Network Adequacy - A Call to Action

Governor Andrew Cuomo created the Department of Financial Services, charged with the responsibility to monitor private health insurers to ensure that they have adequate networks of care as a condition of their license. This means they must demonstrate the consistent ability to provide timely access to care for individuals and their families. Yet, data reveal that people experience long delays in obtaining necessary mental health and addictions care.

Private health insurers pay substandard rates of reimbursement for mental health and addictions care. Consequently, a growing number of providers including community-based organizations no longer participate in an insurance network because they cannot afford to accept such low rates. The insurers fail to carefully monitor their lists of providers and New York State fails to monitor and regulate the insurers for network adequacy.

According to New York State Senator Todd Kaminsky, an honorary Project Access committee member, "In this day it is disgraceful that mental health treatment is still not being taken seriously. Turning children and families in need away is simply unacceptable."

Senator Kaminsky, who cited complaints from numerous constituents, wrote to the New York State Department of Financial Services (DFS) expressing his deep concern about that lack of commercial insurance coverage for mental health services for middle class families on Long Island. In his letter, he wrote, "This lack of access to care is alarming and I hope DFS will immediately respond to my letter by commencing a thorough investigation of this issue." The lack of response led to the launch of Project Access.

*see Project Access on page 36*



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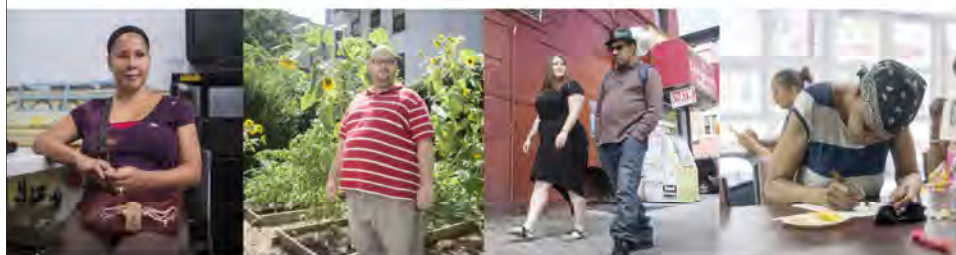
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Photo Credit: Aviva Klein for The Bridge

## Helping Long Islanders Thrive

By Staff Writer  
Behavioral Health News

**A**s opioid addiction continues to rise in Suffolk County and around the country, staff at Family & Children's Association (FCA) are working together to combat this growing epidemic.

With the support of agency partners Long Island Council on Alcoholism and Drug Dependence (LICADD), Families in Support of Treatment (F.I.S.T.) and the Long Island Recovery Association (LIRA), FCA opened Long Island's first recovery community and outreach center in March 2017. Located in Hauppauge, the Center is named "THRIVE" to represent the Transformation, Healing, Recovery, Inspiration, Validation and Empowerment the program seeks for its participants.

"When it comes to prescription drugs and heroin, Long Island is in the middle of a crisis," explains Dr. Jeffrey Reynolds, PhD, President/CEO, FCA. "THRIVE provides a place where people can gather in a safe and sober environment that strengthens their recovery."

Funding for the program is made possible through the New York State Office of Alcoholism and Substance Abuse Services (OASAS). With the opening of its recovery center, THRIVE is helping to fill a vital gap in the community. "While there's been a big push for prevention and treatment of addiction, we found that recovery services were lacking in the region," says Lisa Ganz, Program Director, THRIVE. "What happens *after* someone is discharged from a rehabilitation facility? By providing a hub for people to connect, those struggling with addiction can tackle challenges together and receive the support they need to return to a healthier, happier life."

The Center is comprised of offices, classrooms and a vast common area used for public education and social events. Peer-run support groups, navigation assistance, skill-building workshops, referral services and vocational readiness programs are among the many services provided.

"We maintain an open door policy with a focus on mind, body, spirit so par-

ticipants can achieve a sense of community and be able to experience recovery as *they* define it," Ganz says.

Unlike twelve step programs, THRIVE is not anonymous, although people's privacy is still protected. The involvement of loved ones is particularly essential, as family workshops and co-dependency support groups continue to see large turnouts each month. "Addiction is a family disease," points out Fran Monaco, Family Services Coordinator, FCA. "If loved ones are not onboard with a recovery plan of their own, it can prolong the chemical dependency and enable a person to keep using."

Many of THRIVE's 700 participants attend social events offering substance-free recreational activities. *Voices of Empowerment*, held monthly, provides opportunities for self-expression through poetry, music and storytelling. Other activities at the Center include meditation workshops, drum circles and yoga classes. Program participants also have the option of working out in a small gym located on the premises; those seeking a quieter space may grab a book and head to THRIVE's reading corner.

Services and activities are made possible through the help of 25 volunteers who generously donate their time to make sure people have the tools they need to thrive. The collaboration between staff and volunteers has forged a positive path for hundreds of Long Islanders living with chemical dependency.

Antonio V. is both a THRIVE volunteer and participant, grateful for a place to share his experience and knowledge with others. "This community center is a cutting edge model of what integration into recovery truly looks like, helping others find peace and common ground as they learn the necessary practices to fully become a contributing member of one's community."

For program participant Cait O., THRIVE is her home away from home. "I've met so many people I love who unconditionally love me back. My recovery has expanded so much since being able to be a part of this community, and every day I'm grateful for being able to give back to it."

For more information on THRIVE's services or to become a volunteer, visit [www.thrivel.org](http://www.thrivel.org).



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# Trauma and “Whole Person” Healthcare

By Yves Ades, PhD  
Principal  
Ades Integrated Health Strategies

Any effort to understand and treat co-occurring disorders cannot ignore the prevalence of trauma in the lives of those who are struggling with recovery from mental illness and addiction. A look at the trauma prevalence data in both general and behavioral health populations clearly makes the case. According to a report by The National Council for Community Behavioral Healthcare, 70% of adults in the U.S. have experienced some type of traumatic event in their lives, and 90% of individuals in public behavioral health have experienced trauma. These numbers make trauma a serious risk factor in nearly all mental health and substance abuse disorders.

We are in a period of unprecedented healthcare system reform, in which health integration and social determinants of health are recognized as key in achieving the best health outcomes of populations served. At this moment, it is difficult to consider the viability of any healthcare practice that does not attend to “whole person” health, each individual’s complex behavioral and primary health conditions and needs. The days of siloed and singularly focused practice are obsolete.

People with complex healthcare needs are challenging to health practitioners who



Yves Ades, PhD

have historically been lacking in the necessary literacy, competencies and resources to meet the demands of whole person health. Over the last 30 years mental health and substance abuse treatment providers have struggled with categorizing the co-incidence of mental health and addiction in the same person. Historically labels like MICA (Mentally Ill/Chemical Abuser),

CAMI (Chemical Abuser/ Mentally Ill), Dual Disordered, and, now, COD (Co-occurring Disorder) have assuaged practitioner boundary anxieties, yet, they have largely misdirected practitioner attention to the periphery of the person resulting in a fundamental failure to embrace the entirety and complexity of a person’s health condition and needs.

Additionally, chronic health conditions like Diabetes, Hypertension, Cardiovascular Disease, Asthma and HIV are inextricably entwined in the mental health and addiction profiles of populations with complex healthcare needs and cannot be ignored in the delivery of treatment and services aimed at achieving optimal health outcomes. The first step for practitioners adopting an integrated approach to healthcare is engagement, keeping persons served in treatment long enough to yield the best health outcome. This is where recognition of the high prevalence of trauma in the lives of the people we serve becomes critical. Without adoption of an integrated and trauma-informed approach to engage, support, and treat people with complex healthcare needs, the practice of “whole person” healthcare will not be realized.

Trauma-informed treatment is not a new concept, and trauma treatment models are being practiced in many behavioral health settings. However, in the interest of best practice, a trauma informed and chronic disease literate behavioral health practi-

tioner versed in a trauma treatment model is insufficient to promote lasting client engagement resulting in optimal health outcomes. Unless the entire health care practice or service is trauma-informed, from reception and intake to facilities management and maintenance, client engagement will be fragile, inconsistent and, consequently, inadequate to optimize health outcomes. Improving health outcomes of people with complex co-occurring chronic disease, mental illness and addiction disorders, necessitates that behavioral and primary healthcare providers examine and alter their organizational culture, a “whole organization” foundational endeavor designed to support the delivery of “whole person” healthcare.

“What does trauma-informed culture look like?” is usually the question I am asked in conversations with healthcare providers. It is a culture where every employee understands the prevalence of trauma in the people served by the organization. It is a culture that appreciates the negative social, emotional, cognitive and physical consequences of unrecognized trauma. It is a culture where practitioners are skilled and competent in screening for, and asking about, trauma in every initial client encounter. Finally, it is a culture that is willing to examine itself and change any and every aspect of its philosophical, practical and physical presence to prevent

see *Healthcare* on page 36

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## Community Announcements

➤ Alan Trager, LCSW, Chief Executive Officer of Westchester Jewish Community Services announced that Coordinated Behavioral Health Services (CBHS), a behavioral health IPA in the Hudson Valley, received a three year BHCC grant of \$2,571,000. The grant is part of the value based payment readiness program. Mr. Trager is a founding member and current treasurer of CBHS.

➤ Yvette Brissett-André, MPA, Executive Director and Chief Executive Officer of Unique People Services (UPS) announced that the Bronx-based nonprofit was among several organizations in NYC to receive State funding for supportive housing. UPS was awarded an almost \$2.3 million grant to buy two homes to house 12 residents. UPS will also receive \$1million annually to operate each group home and provide round the clock services for the residents. Unique People Services, which began in 1991, operates 16 certified residential sites, with each home maintaining a staff of about 15 to 20 employees, including nursing, behavioral health,, direct-care workers, and maintenance workers.

➤ Debbie Pantin, MSW, MS Healthcare Management, CEO of VIP Community Services, announced the offering of services under the Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA) Grant. This grant was awarded by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and VIP Community Services is one of three sub-grantee awardees. VIP Community Services will begin services under this grant as of 1/2/18. This project addresses the unique needs of the three high-risk counties (Bronx, Chautauqua, Dutchess) that OASAS has identified based upon the prevalence of opioid- related consequences: including deaths, emergency department visits, and hospitalizations. As a result of the award, VIP Community Services along with Lexington Center for Recovery and UPMC Chautauqua County WCA are established as Centers of Treatment Innovation (COTIs). The goal of the these COTI’s is to enhance existing substance use disorder services and build a robust capacity to provide the full range of medication assisted treatment options, evidence-based practices (EBP’s) and peer support services.

Send Us Short Announcements About Your Community  
And We Will Continue to Expand This Bulletin Board in Future Issues  
See Our Upcoming Issues Theme and Deadline Calendar on Page 32

# Understanding Co-Occurring Disorders: A Mother's Journey To Turn The Tide On An Epidemic

By Stephanie Marquesano  
Founder and President  
The Harris Project

Co-occurring disorders (COD) is the combination of one or more mental health challenges/ disorders and substance misuse/ addiction. My son Harris had COD, and died by accidental overdose when he was 19. I am so grateful that *Behavioral Health News* is devoting attention to this topic because Harris was far from alone: 22% of American teenagers ages 13-18 have a mental health disorder with severe impact; 50% of all mental health disorders arise by the age of 14 – 75% by the age of 24; approximately 70% of all those misusing/ addicted to substances have a co-occurring mental health challenge/disorder; and, approximately 10.2 million Americans meet the criteria for a diagnosis of COD. Teens and young adults, in particular, are in the crosshairs as they often try to find ways to cope and manage underlying, emerging, and existing mental health disorders through “self-medication”. My family and I founded the Harris Project, a 501(c)(3) nonprofit organization after Harris’s death.

Our Story

Harris was diagnosed with an anxiety disorder at 3 years old, and later with



Stephanie Marquesano

ADHD. To look at him you would never know the internal challenges he faced. He was handsome, popular, social, quick-witted, athletic, warm-hearted, and empathetic. Feeling like he was the only one facing these struggles, Harris developed a set of coping mechanisms that at times seemed incongruous with his diagnosis. This made it even harder for family, friends, and teachers to understand what he was going through. Harris received

professional help for his mental health disorders throughout his life, but there was never a discussion about the potential dangers of “experimentation” or “self-medication”. When Harris began smoking marijuana in 8<sup>th</sup> grade, no professional even raised a red flag. But, two weeks before he died Harris told me that he wished he never started smoking marijuana because of what it did to his already anxious mind. For him, he felt like he couldn’t stop, yet marijuana use often left him feeling unsettled. According to Harris, it was the gateway to his later misuse of prescription medications including opioids.

It was when Harris entered his first rehabilitation program - during his senior year of high school - that we initially heard the term “co-occurring disorders”. In each of the subsequent three in-patient and two out-patient rehabilitation programs, as well as under the care of several “addiction professionals”, this diagnosis was reiterated. Yet despite assurances that they effectively treated individuals with COD, each environment failed to address the mental health piece that brought Harris to use in the first place, and would be the cause of each relapse.

When Harris died everyone in our small town wanted to know where to make donations and what they could do to help. Somehow in the chaos I had clarity. Harris had COD: if Harris understood the dangerous link between his mental health

disorders and self-medication that could have been the first and best opportunity for him to make different decisions. The second thing I realized was that if the rehabilitation programs he entered had truly been “co-occurring capable” they would have provided an integrated treatment plan that met all of his needs. For the most part each of the in-patient rehabilitation programs: took away the substances (even those prescribed for his mental health disorders); put Harris into group therapy (based in large part on when you walked through the door); and provided little to no individual therapy/evidence based treatment opportunities to address his anxiety disorder and ADHD. How could anyone think this would work? Harris died on a Wednesday and his funeral was on the following Sunday. In those few days, I sat at my kitchen table and did the work necessary to lay the foundation for the Harris Project. As I eulogized Harris on that horrible Sunday, I also launched the Harris Project.

For our family, Harris’s death and the untimely deaths of so many young people was a call to action. the Harris Project concentrates its efforts on prevention and advocacy for integrated treatment. Our prevention programming focuses on early intervention for emerging mental health disorders, as well as paths to substance

see *A Mother’s Journey* on page 32



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# The Myths, Abuses and Pseudoscience Surrounding “Evidence Based Medicine”

By Joseph A. Deltito, MD  
Professor, Salve Regina University  
Newport, Rhode Island

There are 3 types of lies: Lies, Damn Lies and Statistics (Mark Twain). In approximately the last 10 years there's been great interest in the concept of Evidence Based Medicine as a unifying concept for teaching, evaluating data and practicing medicine. The concept goes back at least 150 years to France with renewed interest recently for specific purposes. Although evidence-based medicine (EBM) has applicability in all areas of clinical medicine I will focus my commentary as it primary relates to Psychiatry and Clinical Psychology. After all, what a great title, Evidence-Based Medicine! Is there anyone who could argue that the practice of medicine should not be based on the highest levels of evidence? Would anyone suggest that non-evidence-based medicine might be superior? The main argument regarding EBM comes in its relationship to what has been referred to as expert opinion (EO). The concept of EO is where the repository of clinical expertise comes from, a succession of expert clinicians and their overall experiences and knowledge. Certainly these concepts can coexist, and for the most part they do. Nevertheless there



Joseph A. Deltito, MD

are those within the healthcare industry who strongly push for the superiority, perhaps even exclusivity, of EBM being the unique path to medical proficiency.

The evidence of EBM can come from many sources but the vast majority accepted by those who champion it's supremacy come from either controlled clinical trials or large meta-analyses. Con-

trolled clinical trials represent the type of experimental study submitted to the FDA for an approval for a new medication. They're done with a great deal of precision. They use very special criteria for diagnoses, severity of disease, inclusion and exclusion criteria for entering a patient into a study. They are run for defined periods of time such as eight weeks for the use of a new antidepressants in treating unipolar depression or a 16 week module of cognitive behavioral therapy for the treatment of panic disorder. Dosages whether of medicines or therapy are determined previous to the initiation of the study, as is what is constituted as a cure or positive outcome. Many subjects interested in joining such clinical trials are denied because they do not quite meet criteria for inclusion. Meta-analyses are methods of combining data from numerous concluded studies supposedly treating a given illness with some common therapy.

EO would also rely on things such as clinical trials but in a much less rigid manner. The best arbiter of treatment in a difficult case is generally the most intelligent and experienced clinician who has encountered large amounts of patients during his career and therefore can counsel his/her junior colleagues. Clinicians undoubtedly do not rely on one person but in many people who may or may not have formally been their teacher. I personally

thank Gerald Klerman, Giovanni Cassano, David Sheehan, Athanasio Kukopoulos and Tom Hackett who in some particular ways have been mentors to me.

In EBM there are actually those who would take a position that if there is no research data behind a certain treatment that it is somehow improper to use that treatment. Interestingly this is a position rarely supported by clinicians such as psychiatrists, psychologists, or nurse practitioners. Those supporting such a stance are usually associated with the insurance industry, the government or hospital administrators. Some may actually believe that if there is no data behind a certain treatment it should not be used. Unfortunately, I've become jaded enough myself to believe that their support on EBM is more based on their ability to cut costs and deny the scope and depth of our treatments, especially when costly.

For example. A 44-year-old woman presents with her fifth episode of unipolar depression. She has some passive suicidal ideation but overall has shown some progress over the past four weeks since starting the medication regimen. You've treated her with supportive psychotherapy and Fluoxetine 40 mg per day. In the past she's been very difficult to treat and has gone on to make two significant suicide

see *The Myths* on page 35



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## Human Development Services of Westchester

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# A Human Right Still Unmet: Medical Treatment of Mentally Ill Prisoners

By Erin Falconer, PhD  
and Amy Joscelyne, PhD  
ODH, Inc.

Individuals with mental illness have the right to receive appropriate medical treatment in correctional settings and upon release. It sounds perfectly reasonable, but unfortunately, is far from reality. That was the consensus of a distinguished panel of mental health and legal experts who recently spoke at an event about the rights of the mentally ill in the criminal justice system.

The event was sponsored by the Working Group on Human Rights and Mental Health within the Non-Governmental Organization Committee on Mental Health, which consults with the United Nations to foster mental health awareness across the globe. The co-chairs of the event were Erin Falconer, Ph.D., Associate Director of Medical Affairs at ODH, Inc. and John P. Docherty, M.D., Vice President, Clinical Sciences, Digital Medicine Medical of Otsuka America Pharmaceutical, Inc.

According to U.N. conventions, all persons with mental illness, including criminal offenders, should receive the best available mental health care. Access to high-quality mental health care, in fact, is a basic human right and ethical responsibility, noted the panelists.

Various U.S. professional associations have also weighed in on the rights



Erin Falconer, PhD

of the mentally ill. For example, the American Psychiatric Association has stated that the fundamental goal of a mental health service should be to provide the same level of care to patients in the criminal justice process that is available in the community. And, according to the American Bar Association's standard on mental health, "severely mentally ill or persons with serious intellectual disabilities should be treated in a



Amy Joscelyne, PhD

mental health or intellectual disability facility."

Sadly, however, medical care for those with mental illness in the criminal justice system has not come close to meeting these standards. In the U.S. today, more mentally ill people are in jails and prisons than hospitals. And the proportion of prisoners with serious mental illness (estimated at 15 – 25 percent) is larger than the estimated prevalence of 5 – 8

percent found in the general population.

Many mentally ill prisoners receive inadequate medical care. In fact, for those placed in highly traumatizing environments, such as solitary confinement - which is associated with self-harm - their conditions may worsen, according to research studies.

Dual loyalty of medical providers who work in the prison system can lead to human rights violations, noted panelist Homer Venters, M.D., Director of Programs, Physicians for Human Rights in New York. These providers have an ethical obligation to advocate for the welfare of their patients, he noted. At the same, they are typically employed by public departments of correction or private prison operators whose primary objectives are maintaining security and reducing costs.

An example of dual loyalty is the practice of "clearing" patients for punishment in solitary confinement. Security staff members ask health staff to confirm that an inmate who has broken prison rules is physically and mentally sound enough to be placed in solitary confinement. This scenario does not reflect a provider-patient interaction that is in the patient's best interest, said Dr. Venters.

According to his research, prisoners who harmed themselves in solitary confinement felt that the mental health staff were not there to serve patients' needs but

*see Human Rights on page 36*

## Co-Occurring Disorders Among Social Workers

By S. Lala A. Straussner, PhD, LCSW  
and Josey Madison, LCSW  
NYU Silver School of Social Work

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2015 National Survey on Drug Use and Health (NSDUH), co-occurring mental health and substance use disorders (SUD) affected an estimated 8.1 million adults or 3.7% of the total adult population in the United States. This marked a slight increase from the 2014 findings, which indicated that 7.9 million adults were affected by co-occurring disorders (Center for Behavioral Health Statistics and Quality, Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. HHS Publication SMA 16-4984, NSDUH Series H-51, 2016). However, no data have been available regarding the rates of co-occurring disorders among mental health professionals, particularly social workers. The purpose of this paper is to provide such data as obtained in a 2015 survey titled "The Social Workers' Self-Reported Wellness" (SWSRW) study and to provide some comparison of these findings to national data regarding these problems.

The SWSRW survey collected data on mental health conditions and substance use from over 6,000 licensed social workers from 13 states across the U.S. The

study was developed and administered by Drs. S. Lala A. Straussner, Evan Senreich, and Jeff Steen. It received IRB approval from New York University and City University of New York, Lehman College (more information regarding the methodology can be obtained in Straussner, S. L. A., Steen, J. T., & Senreich, E. What Do We Know About Social Workers' Use of Heroin? Behavioral Health News, 5(2), Fall 2017, and by visiting <https://wp.nyu.edu/socialworkers>).

In the survey, the question inquiring about mental health problems was phrased, "At this point in my life, I am experiencing one or more mental health problems" with participants then selecting the response of agreement with that statement. The scale for response was "strongly disagree," "disagree," "agree," and "strongly agree." Participants later selected mental health problems they were currently experiencing and could select more than one.

Similarly, the question inquiring about substance use problems stated "At this point in my life:" with participants then selecting the appropriate response of either "I am experiencing serious problems with alcohol or other drugs most of the time," "I am sometimes experiencing problems with alcohol or other drugs," "I use alcohol or other drugs but this does not cause me any significant problems," or "I rarely or never use alcohol or other drugs." Participants were later asked to

identify which substances they were using and that were not used as prescribed by a health care provider.

**Mental Health Disorders:** National Data vs. Social Worker Study Participants: According to the National Institute of Mental Health (NIMH), in 2015 there were approximately 43.4 million adults (17.9%) in the U.S. population with any mental illness (AMI) in the previous 12 months (NIMH. Any Mental Illness (AMI) Among U.S. Adults. Retrieved from <https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml>). Kessler, Chiu, Demler, and Walters estimate that percentage to be as many as 30% of the U.S. population and specify that 18% of the population had an Anxiety Disorder, 6.7% had a Depressive Disorder, 3.5% had Post-Traumatic Stress Disorder (PTSD), 2.6% had Bipolar Disorder, 1% had Obsessive-Compulsive Disorder (OCD), 1.1% had Schizophrenia, and 9.1% have a Personality Disorder (Kessler, R.C., Chiu, W.T., Demler, O., Walters, E.E. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 62(6), 617-27, 2005, as cited by NIMH Prevalence Fact Sheets).

Among SWSRW study participants, the reported prevalence of Anxiety Disorders, PTSD, and OCD are similar to the national data, with 17% of SWSRW par-

ticipants reporting currently experiencing an Anxiety Disorder, 4% experiencing PTSD, and 1.4% experiencing OCD. However, SWSRW participants differed with regard to Depressive Disorders, Bipolar Disorder, Schizophrenia, and Personality Disorders, with participants reporting lower rates of Bipolar Disorder (1% vs. 2.6%), Schizophrenia (0.1% vs. 1.1%), and Personality Disorders (0.2% vs. 9.1%). On the other hand, the rate of Depressive Disorders among SWSRW participants was almost twice the national data (14% vs. 6.7%).

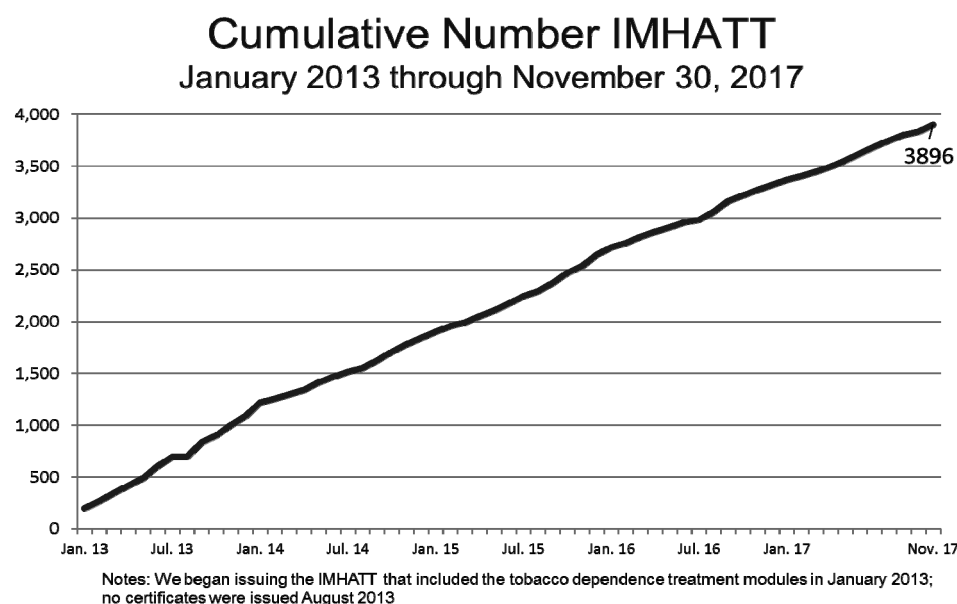
**Substance Misuse: National Data vs. Social Worker Study Participants:** The NSDUH reports that in 2015, 66.7 million people aged 12 or older reported binge alcohol use defined as four or more drinks for women and five or more drinks for men on the same occasion in the past 30 days. The NSDUH also states 17.3 million reported heavy alcohol use defined as binge drinking on 5 or more days in the past 30 days. Therefore, binge drinkers and heavy alcohol users account for 24.9% and 6.5% of the population, respectively, for a total of 31.4% collectively. Additionally, 13.6 million adults aged 26 or older (6.5%) were current users of marijuana, 1.1 million adults aged 26 or older (0.5%) were current misusers of tranquilizers, and 1.9 million people aged 12 or older were current users of

*see Social Workers on page 35*

# The Integrated Mental Health and Addictions Treatment Training Certificate (IMHATT)

By Nancy H. Covell, PhD;  
Forrest P. Foster, MSW, CPRP;  
Noah Lipton, LCSW, MPA;  
and Lisa B. Dixon, MD, MPH;  
New York State Psychiatric Institute

The New York State Office of Mental Health (OMH) and the Department of Psychiatry, Columbia University, established the Center for Practice Innovations at Columbia Psychiatry and New York State Psychiatric Institute (CPI) in November 2007, to promote the widespread use of evidence-based practices throughout New York State (Covell NH, Margolies PJ, Myers RW, Ruderman D, Fazio ML, McNabb LM, Gurran S, Thorning H, Watkins L, Dixon LB. State Mental Health Policy: Scaling Up Evidence-Based Behavioral Health Care Practices in New York State. *Psychiatric Services*. 2014;65:713-15). One of CPI's initiatives, Focus on Integrated Treatment (FIT), provides training in treating and implementing evidence-based treatment for people with co-occurring mental health and substance use disorders. As part of that training, CPI collaborated with key stakeholders and content experts to create 39 award-winning online modules covering screening and assessment of co-occurring disorders, treatment planning, stage-based treatment and treatment groups, motiva-



tional interviewing, cognitive-behavioral therapy, skills training, recovery, community supports, medications to treat co-occurring disorders, integrating medical treatment, tobacco dependence treatment, special considerations when treating adolescents, supervision skills, leadership skills, and tracking fidelity and outcomes. These online modules are made available for free to staff in not-for-profit behavioral healthcare licensed programs in New York State, and OMH encourages agency leadership to have program staff make use of the available training.

Beginning in August 2012, OMH and the New York State Office of Alcoholism and Substance Abuse Services collaborated with CPI to offer the Integrated Mental Health and Addictions Treatment Training (IMHATT) certificate, signed by Commissioners from both agencies. This certificate was initially awarded to people who completed the 26 core skills modules for practitioners. When the tobacco dependence treatment modules became available in January 2013, they were added to the certificate requirements so that the IMHATT now requires comple-

tion of 29 modules. People who complete an IMHATT are eligible to receive 24.25 hours of Certified Alcohol and Substance Abuse Counselor (CASAC), Licensed Mental Health Counselor (LMHC), and Social Work continuing education. Some modules are individually eligible for continuing medical education (CME).

As previously reported, in the four months before the certificate was offered, total module completions averaged 1,682 per month; in the four months after introduction of the certificate, completion rates soared to an average of over 6,000 per month (Covell NH, Margolies PJ, Myers RW, Sederer L, Ruderman D, Van Bramer J, Fazio ML, McNabb LM, Thorning H, Watkins L, Hinds M. Using Incentives for Training Participation. *Psychiatric Rehabilitation Journal* 2016, 39, 81-83). Participation in the IMHATT certificate program has remained steady through time (see Figure below).

Reports from the field suggest that the IMHATT has become a useful metric for behavioral healthcare programs and for OMH licensing. For example, some agencies have begun to include completion of this certificate as part of performance reviews for staff, with some even offering merit increases based upon this completion. Other agencies are including the IMHATT in the onboarding of new hires.

*see Certificate on page 36*

## Striving for Compassionate Recovery-Oriented Substance Use Care

By Gabriela Zapata-Alma, LCSW, CADC, and Tim Devitt, PsyD, CADC Thresholds, Chicago

Nationally, people with substance use disorders in the United States are often treated with an expensive acute care model that highlights inpatient treatment as the hallmark component of treatment. For many, recovery is a life-long process, and the focus on acute care is a missed opportunity for addressing the long-term needs of the individual and family in recovery. Rates of re-hospitalization and emergency room visits indicate that far too many experience adverse outcomes of substance use after returning to the community. Furthermore, treatment systems of care are largely designed to meet the needs of those who actively seek abstinence from all substances, and often miss opportunities to help others who are deemed by the treatment community as "not ready" for treatment or who fall out of care due to a recurrence in substance use behavior. This is reflected in the high rates of individuals who are in need of treatment, but do not access it, according to SAMHSA's National Survey on Drug Use and Health. The time in between treatment episodes has been referred to as "gaps" in care; a time when people are not motivated to engage in services. Some in the

field view this as a time during which people need to hit their "bottom" or "rock bottom" as part of shoring up the motivation to engage in treatment again. An unintended negative consequence of this belief is that individuals often develop more severe courses of the disorders that brought them into treatment in the first place. This results in much hardship for the person and their families, as well as more complex treatment needs and poorer long-term prognoses. Ultimately, the sad reality is that for many people the next "bottom" may be death or some other catastrophic consequence.

There is no argument that the acute care, such as inpatient and intensive residential substance use treatment, are necessary components on the continuum of care. However, treatment that only occurs outside a person's natural environment is not enough. As a treatment field, we need to confront the fallacy that people must experience hardship and crisis in order to engage in their recovery, and instead offer community-based recovery support services that meet individuals where they are, with an eye toward helping them develop enhanced motivation to make positive life changes. Thresholds seeks to confront the pervasive yet mistaken notions that people with substance use disorders need to hit "rock bottom" or be divorced from their natural environment before they can be helped.

Over the past 18 months, Thresholds in

Chicago has been working to provide community-based comprehensive treatment and recovery support services to serve people with substance use disorders over the arc of their recovery, and not just during the acute treatment episode. Essential components of this model are articulated below in our Philosophy of Care and Staff Commitments (below):

### Philosophy of Care

- **Holistic, Integrative, Person-Centered & Strengths-Based:** We approach each member as the whole and unique person that they are. We individualize our care by cultivating a deep bio-psychosocial understanding of each member, and building upon their resilience. We provide integrated services for mental health.

- **Culturally-Relevant & Gender-Responsive Care:** We recognize that culture(s), communities, and gender are vital aspects of our identity, and greatly influence our paths towards healing. Using the framework of Cultural Humility, we work to provide services that are affirming, inclusive, and relevant to all members, including lesbian, gay, bisexual, trans, queer, and gender non-conforming individuals.

- **Evidence-Based Treatment:** We provide access to factual information in a way that is nonjudgmental, and non-shaming. Our core interventions are selected on the ba-

sis of their strong research evidence. We continuously analyze our services in order to improve our quality.

- **Trauma-Informed Care:** We are sensitive to the effects of trauma and employ practices to avoid replicating it. We seek to understand, recognize, and respond to the effects of all types of trauma. Using the framework of Trauma-Informed Care, we support each member in rebuilding a sense of control and empowerment, and reclaiming their sense of self beyond trauma.

- **Harm Reduction:** We respect our members as the expert on their own lives, and seek to partner with them on their path towards recovery. We meet members where they are, and support them to develop goals in a nonjudgmental and non-coercive manner. We believe that members not only have the right and the capacity to make their own decisions, but that they are more likely to reach long-term recovery when we support their self-determination at every stage of recovery.

### Staff Commitments

- *To see you as the whole and unique person that you are.* We want to know what matters to you, what you value, and your life goals. We recognize your personal strengths, and together, hope to build on them.

*see Striving on page 37*

# Innovation Into Practice: The Future is Now

**By Jason Lippman**  
Executive Vice President  
The Coalition for Behavioral Health

Innovators and experienced providers are joining together to build the infrastructure required to meet the needs of people living with co-occurring mental health conditions and substance use disorders, as well as physical health care conditions. They are facilitating networks to address social determinants of health and collect data to measure quality and cost-effectiveness in a value-based payment (VBP) system, where providers are paid for outcomes instead of volume.

With New York State's behavioral health care system transforming into value-based arrangements, success requires not only a full understanding of its complexities, but the ability to revamp business operations and improve the integration of behavioral health and physical health care services. Many leading-edge providers are also confronting this daunting task.

On February 1, 2018, The Coalition for Behavioral Health will bring together over 300 individuals – comprising mental health and substance use experts from community-based providers, government officials, consumers, advocates and members of the business community – for our 2018 annual conference, entitled “Innovation Into Practice: The Future Is Now.” Experience transformation in progress with observations on behavioral health VBP readiness and Governor Cuomo's FY2019 Executive Budget from OMH Commissioner Dr. Ann Sullivan, OASAS Commissioner Arlene Gonzalez-Sanchez and NYS Medicaid Director Jason Helgeson; and New York City's perspective from DOHMH Executive Deputy Commissioner, Dr. Gary Belkin.

The conference will feature viewpoints from participants of The Coalition's business transformation grant, funded by the New York Community Trust (NYCT). Through this unique initiative, The Coalition is leading a project to assist our members in adapting their clinical practices and business operations to a value-based payment environment in which there is a strong hospital presence. By holding larger forums and smaller workgroups, the



**Jason Lippman**

business transformation initiative provided collaborative space for the sharing of candid conversations around organiza-

tional needs and challenges. Participants can interact with leaders from other community-based organizations facing similar challenges and can be linked with expert consultants and mentorship opportunities.

This year's conference is a chance to hear from a panel of experienced providers that are examining their own business operations and strategic planning as they seek guidance through a changing environment. Each of these organizations has a story to tell, and we invite you to hear how they face transformational challenges, conduct difficult conversations with their Board and executive leadership, to choose a path forward.

In addition, we will spotlight provider groups taking on value-based arrangements, including VBP innovators, Accountable Care Organizations (ACOs) and Independent Practice Associations (IPAs). This is an opportunity to listen and apply their learnings to your own organization or collaborative provider group entering into VBP arrangements, such as the emerging Behavioral Health Care Collaboratives (BHCCs).

BHCCs are networks of providers joining together to deliver the entire spectrum

of behavioral health services available regionally. Recently, Governor Cuomo announced \$60 million in funding awards to assist 19 selected BHCCs from across the state. Among the variety of healthcare improvement innovations possible, BHCC funding can be applied to enhancing quality of care through the assimilation of clinical, financial and community-based recovery supports; using data to manage quality and risk and commit to continuous quality and performance improvement; and building information technology infrastructures to collect, analyze and respond to data for the purposes of improving behavioral and physical health outcomes more efficiently (NYS, DOH, OMH, OASAS, Behavioral Health VBP Readiness Program Overview, 2017).

Given the health care discussions occurring on both the federal and state levels, and a political climate where Medicaid funding is at-risk, it has never been more critical for providers to become nimbler and to acquire the tools to deliver high-quality care more efficiently to people living with mental health conditions, substance use disorders and significant physical health needs. However, achieving this goal requires the successful implementation of operational and fiscal changes, and collaborating with other partners to fully integrate services.

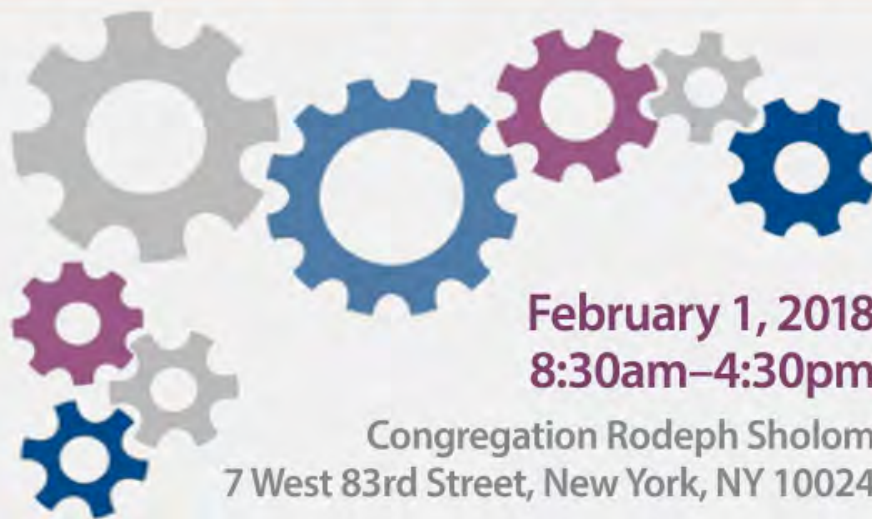
Behavioral health providers should become aware of all the VBP arrangements developing in their community. The Coalition's conference is an exciting opportunity for providers to join in the conversation about ongoing and emerging efforts, as they consider embarking on their own readiness endeavors. Hopefully, providers operating in collaborative networks will be able to leverage their shared expertise and be in a better position to negotiate value-based payment contracts.

Integrated care is pivotal to treating co-occurring disorders, but it is only part of a greater undertaking happening among the innovators of the behavioral health community. *The future really is now, as providers join to form collaborations to meet the complex needs of people living with behavioral health conditions.*

I look forward to seeing you on February 1<sup>st</sup>. Please visit [www.coalitionny.org](http://www.coalitionny.org) for full conference details.

The Coalition for Behavioral Health Presents

## INNOVATION INTO PRACTICE: THE FUTURE IS NOW



### Recovery from page 6

There are four services for participants to choose from:

- Community Rehabilitation and Support (CRS) assists with restoring skills and supports necessary for independent living. They may include job exploration, exploring the world of education, and stress management.
- Intensive Rehabilitation (IR) assists with attaining specific life goals, such as finding a job, returning to school and obtaining independent housing.
- Ongoing Rehabilitation and Support (ORS) offers off-site support by a job coach, to address the needs of maintaining stability in the workplace after achieving

employment.

- Clinical Treatment (optional) includes psychiatry and nursing services that promote medication management, overall healthy living, and goal-focused therapy.

The class topics offered on a daily basis for all enrolled participants at the Harlem Bay PROS program include trauma informed topics such as Trauma Recovery, Healing Through Art, Dual Relapse Prevention, Seeking Safety and Resolving to Recover. With about 44% of all enrolled participants having been diagnosed with co-occurring disorders along with having experienced unidentified trauma, these topics provide a holistic approach to wellness and recovery.

Participants have provided ongoing feedback on how the Harlem Bay PROS

program has provided them with individualized supports that have assisted them in reaching their goals. One such success story is Patrick\* who struggled with anxiety and alcohol use for many years. Patrick spent a large portion of his adolescence in foster care due his mother's substance use and subsequent death. His maternal grandmother also had a history of substance use and dependence on prescription medication which impacted on her ability to provide him with a stable home. He experienced unidentified trauma as a result of being placed in more than 7 foster homes and the specific traumas that he experienced during those years in placement are still unclear. Patrick enrolled in the Harlem Bay PROS program and bonded with staff members and several participants while actively being engaged in classes. He has received

Ongoing Rehabilitation and Supports services along with actively engaging in the clinical services provided at the program. He was able to participate in an internship opportunity and most recently has obtained competitive employment. Now, he is sober and has a job that he loves. He still attends the program to help him maintain his sobriety, his mental health stability and to maintain his active social life with other enrolled participants. He is a reminder that programs that provide a holistic approach to individualized supports can assist individuals with unidentified trauma and co-occurring disorders.

MHA-NYC is committed to providing integrated, customized supports through our Harlem Bay Network PROS Program and we successfully provide these

*see Recovery on page 36*

***Integrated Care from page 10***

Despite the controversy about what sort of screening to do, there is widespread consensus that primary care physicians need to pay far more attention to their patients' emotional distress in the hopes of averting the suffering of mental disorders and of reducing the rising incidence of suicide.

**Long-term Care Reform**

The issues I have noted above—the mortality gap, co-occurring mental and substance use disorders, the impact of depression on chronic health conditions, opportunities for identification and treatment of behavioral disorders and perhaps to reduce the incidence of suicide through primary care are the issues that most commonly drive concern about co-occurring disorders.

Less frequently noted is the importance of co-occurring disorders to long-term care reform. Simplistically speaking, the goal of long-term care reform is to reduce the use of nursing homes and to have more people with disabilities live in the community rather than in institutions. Most people in nursing homes, of course, have serious physical disabilities and/or dementia. Most of them—yes most of them—also have co-occurring mental and behavioral disorders including depression, anxiety disorders, psychotic conditions, etc. And these conditions contribute to behavioral problems that often make it very difficult to help people stay in their homes rather than in institutional settings. For example, distrust—often of paranoid proportions—can make home health aides unwelcome in the homes of people who need health care in order to survive; and bizarre or volatile behavior often makes them undesirable patients.

So, addressing mental illness as well as dementia and physical health conditions effectively is critical to being able to avert the need for nursing home care.

Sadly, the officials who are pressing for long-term care reform do not seem to understand that behavioral health services are critical to achieving their goals. For example, in NYS the Managed Long-term Care Program, which organizes and provides a comprehensive array of services and supports to people with severe disabilities so as to help them remain or return to the community, does not include a behavioral health benefit.

**Money Drives Hope**

As I said at the beginning, in large part the interest in providing managed, integrated treatment for people with co-occurring disorders arises from the realization that they are the drivers of high

Medicaid costs. Is it cynical to suggest that if it weren't for the need for cost containment, the system would coast on providing inadequate services on a fee-for-service basis? I have no doubt that the hope of cost containment is what has led the federal government and many states, including New York State, to invent very complex systems of integrated care for people with co-occurring disorders.

It is not at all clear how these adventurous experiments will turn out, but it's a lovely twist that for once cost cutting is driving hope for better care in a health and human services environment that is otherwise sadly bleak.

*Michael B. Friedman, LMSW is an Adjunct Associate Professor at Columbia University School of Social Work and is Chair of The Geriatric Mental Health Alliance of New York. He can be reached at [www.michaelbfriedman.com](http://www.michaelbfriedman.com).*

***A Mother's Journey from page 27***

misuse/addiction; while our advocacy work emphasizes the critical need for integrated and comprehensive treatment for those with COD. To achieve these goals, the Harris Project works in collaboration with governmental agencies, providers, community based organizations, schools and universities, and the private sector across the NY tri-state area.

Through the Harris Project, I get the incredible honor of presenting about COD to many populations, including: high school and college students, as well as administration and staff; parents and community members; healthcare professionals; those at local, state and federal agencies; and, more recently, with members of the private/corporate sector. I also work with colleges and universities to create learning opportunities for students choosing careers in the helping professions.

The growing opioid and heroin crisis has brought increased attention to this subject, and the Harris Project is rising to the challenge.

**Co-Occurring Disorders Awareness: CODA**

Not content with doing "one and done" presentations, the Harris Project designed a prevention program to empower youth to understand COD, remove the stigma associated with COD, and become positive decision-makers. CODA is a school-based program delivered through: presentations, workshops, activities, social media, and events to engage students throughout the school year. CODA encourages teens to explore why and how they turn to substances (for example: self-medication of mental health challenges/disorders, trauma, sports injury, wisdom tooth removal, etc.), as well as to understand the potential impact of what

some consider "experimentation" on the developing brain which makes all of our youth vulnerable. CODA is designed to:

- increase awareness and understanding of co-occurring disorders for youth
- increase early intervention for mental health challenges and substance misuse
- reduce the incidence of youth mental health crises, drug misuse, addiction, and overdose
- increase the likelihood that those already impacted by co-occurring disorders will seek help
- create a generation without the stigma typically associated with mental health challenges/substance misuse
- create youth leaders who can impact

their peers and communities.

With the support of Westchester County, the Westchester County Department of Community Mental Health, Putnam/Northern Westchester BOCES, Southern Westchester BOCES, Student Assistance Services, Inc., and many other community-based organizations, CODA launched in Spring 2017 with CODA Week, and last year alone reached over 13,000 students at 16 Westchester and Greenwich, CT high schools (including students in alternative settings) with incredibly positive feedback.

Under the banner of Westchester County's Project WORTHY (Westchester Opioid Response Teams Helping You) initiative, on October 16, 2017 the Harris Project partnered with the Westchester Department of Community Mental Health

*see A Mother's Journey on page 34*

**Behavioral Health News - Theme and Deadline Calendar**

Spring 2018 Issue:

***“Harm Reduction: Theory and Practice”***

Deadline: April 1, 2018

Summer 2018 Issue:

***“Spotlight on Research: Honoring the Brain and Behavior Research Foundation”***

Deadline: July 1, 2018

Fall 2018 Issue:

***“System Transformation: Challenges and Opportunities”***

Deadline: October 1, 2018

Winter 2019 Issue:

***“Changes in Our Children's System of Care”***

Deadline: January 8, 2019

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# Co-Occurring Conditions in Mild Autism Spectrum Disorder: Integrated Treatment Approaches

**By Elizabeth Roberts, PsyD**  
National Director, Clinical Support Services  
College Internship Program

Co-occurring mental health conditions are the rule rather than the exception in autism spectrum disorder (ASD). A full 70% of individuals with ASD have one co-occurring condition and 40% have two or more (Siminoff et al., 2008). Living with autism is a journey, and in talking to families, I often rely on a travel metaphor in describing ASD as “carrying suitcases.” This word picture helps families understand that ASD is the central condition, in dynamic interplay with others, and sets the stage for an integrated, multi-pronged approach to intervention.

Estimating the prevalence of co-occurring conditions in adults with mild ASD is complicated by the heterogeneity of ASD the condition and ASD research itself. Also until recently, subgroups of adults, females, and individuals with milder forms of ASD received much less attention. Research (Cassidy et al., 2014, Croen et al., 2015, Hofvander et al., 2009, Leitner, 2014, Leyfer et al., 2006, Muris et al., 1998, Simonoff et al., 2008; van Steensel et al., 2011) has identified the following prevalence rates for the most commonly occurring disorders: Anxiety, 40-80%; Attention Deficit Hyperactivity Disorder (ADHD), 37-85%; Depression, 26%; Mood disorder, 52%; and Suicidality, 66%.

Other conditions or problematic behaviors that co-occur less frequently (Cacola, Miller, & Williamson, 2017, Croen et al., 2015, De Vries et al., 2010, Haruvi-Lamdan et al., 2017, Hofvander et al., 2009, MacMullin et al., 2016) but require consideration when treating adults with mild ASD include: Psychosis; Schizophrenia; Gender dysphoria; Trauma; Excessive electronic gaming; and Learning disabilities in reading comprehension and compositional writing

## Developmental Coordination Disorder

An important and neglected area of study is the relationship between trauma and ASD, as individuals with ASD are vulnerable to experiencing higher rates of social rejection, bullying, abuse, and conflict across development. A new review of what is known about ASD and substance use disorder (SUD) indicates that these conditions co-occur more often than has been believed (Palmer & Kunreuther, 2018). Like other individuals with anxiety, individuals with ASD may be particularly at risk for cannabis dependence (Hill et al., 2017).

Medical and neurologic conditions that co-occur with ASD (Canitano & Vivanti, 2007, Cohen et al., 2014, Croen et al., 2015, Fombonne, 2003) include: Tic disorders; Seizure disorder; Sleep, eating, and elimination disorders; and Obesity.

Thus, careful diagnostic assessment is crucially important at the initial stage of treatment. This leads to a sophisticated case formulation that accounts for the inter-related nature of ASD, co-occurring conditions, and behavior embedded in the biopsychosocial context.



**Elizabeth Roberts, PsyD**

## Case Example

P.R. was a 21-year old young woman with average intellectual ability and language, enrolled in a young adult transition program. Previously diagnosed with ASD, ADHD, learning disabilities, and dysgraphia she had been treated with stimulant medication in the past. Over the previous six months, she had been re-started on a new stimulant to treat ADHD. She was not doing well. An already limited food repertoire had become further restricted, resulting in alarming weight loss. She was gaming several hours a day and her sleep-wake cycle was compromised. She had recently failed the one college course in which she had enrolled. Her social isolation had increased. Self-care and hygiene were poor. At a family meeting, she bore a hollow-eyed, haunted look. A staff clinician offered his interpretation that her behavior represented a wish to die. He affirmed that the team cared deeply for her. This decisive communication prompted her to disclose a daily, grinding experience of profound dread and hopelessness. Her mother began to weep and disclosed her own history of intractable depression. The team was then able to generate a set of interventions around now more clearly identified challenges. These included closer collaboration with the treating psychiatrist around the management of ADHD and depression and avoidance of appetite suppression, regular family sessions, psychoeducation concerning the interplay of ASD, depression, ADHD, sleep, nutrition, and excessive gaming, increased staffing to support nutrition, ADLs, and academics, and a behavior management program to support alterations in her relationship to gaming.

## Lumping, Untangling, and Other Quandaries

The DSM 5 makes it easier to avoid the pitfall of lumping symptoms under the ASD umbrella. While this may result in what may feel like a staggering laun-

dry list of “problems” families ultimately feel relieved at this “divide and conquer” approach. At the same time the strands that have been untangled then need to be re-woven. Over-zealous untangling can also lead to getting lost in the desire in therapist or client to find an exact one-to-one correspondence between a given behavior and a particular condition and so it is important for the process to remain focused on behavior change. Finally, it is crucial to appreciate the impact of the ASD symptomatology itself (including social and communication limitations) on the client’s experience of daily life, his insight and self-awareness, and capacity to receive help. The skilled clinician understands this and develops a comprehensive solution-based treatment plan.

## Integrated Treatment

*Individual therapy:* Successful treatment for ASD reinforces a client’s process of self-acceptance, self-determination, and self-advocacy. Intervention needs to be client-centered, engage the client’s sense of humor, and characterized by patience and careful management of the potential for misunderstanding due to cognitive inflexibility and limitations in social communication and theory of mind. Initial steps involve establishing a working relationship around client-identified goals. The next phase of treatment involves careful but non-intrusive diagnosis of co-occurring conditions and patient, appropriate psychoeducation. Clients are supported to positively frame their diagnoses as a means of understanding and accepting one’s whole self and a vehicle for getting help and joining communities.

Cognitive-behavior therapy (CBT) is the cornerstone of integrated treatment. Described by experts such as Valerie Gaus (2007), CBT is an established, evidence-based practice for the treatment of two of the most common co-occurring disorders in ASD—anxiety and depression. ADHD is best treated with well-researched CBT-based approaches developed for adults with ADHD (Ramsay & Rostain, 2015, Solanto, 2013), with modifications to manage ASD-related limitations in cognitive flexibility and pragmatic language. Integrated harm reduction therapy (IHRT), a treatment for substance use disorders (SUDs) that emerged in the 90s (Marlatt & Tapert, 1998), uses a CBT framework but draws on motivational interviewing (MI) and psychodynamic principles to support behavior change. While there is currently no research concerning IHRT for individuals with ASD and SUD, this may prove to be a promising approach in individual therapy.

*Family involvement:* When treating adults with ASD clinicians may rely on standard clinical judgment around confidentiality and defer contacting family. However, adults with mild ASD are typically dependent on others in many ways. Presenting problems revolving around dysregulation (tantrums), lack of initiative, perseveration, or other behav-

iors occurring within a system are best supported with family involvement. While remaining fully client-centered and organized around the client’s goals, family sessions and psychoeducation are often essential to supporting behavior change.

*Collateral therapies:* Individuals with mild ASD usually require additional therapies. In addition to interventions that support social learning, clients may benefit from: Vocational coaching; Occupational or physical therapy; Behavioral coaching; and Neurodiverse couples therapy.

*Psychopharmacology:* Clients benefit from referral to a psychiatrist to assist with diagnosis and treatment options for co-occurring conditions. Because many have been misdiagnosed or received inadequate psychoeducation, adults with ASD and often their family members are often unaware that medication sometimes helps. Past history of failed or iatrogenic medication treatment or experienced trauma in schools or healthcare settings are additional factors in this wariness. These need to be considered when making and managing referrals to treating physicians.

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*see ASD on page 37*

### A Mother's Journey from page 32

for a Youth Leadership Summit (YLS). Student teams and staff from 38 high schools across Westchester met for a day of education, empowerment, shared decision-making, and planning. With 400 youth in attendance, the YLS opened conversations about how the opioid crisis affects them, and what practical steps they can take to fight back. Among the issues tackled were the underlying causes of opioid and heroin addiction. Each team created an action plan and returned ready to engage their entire school community in the themes of CODA. As a result of this historic event and together with our partners, the Harris Project is on track to more than double its reach and will help facilitate CODA activities and programming across Westchester County.

*There is nothing like watching the faces of students when it clicks, and hearing things like: I had no idea so many teens had mental health disorders. I thought I was alone in this. You mean there's a relationship between mental health and misusing substances? Hey, I never thought of it like that - WOW. There are things I can do and people who can support me to not go down that path? Why isn't everyone talking about co-occurring disorders? How can I help spread the word?*

#### Transformational Systems Change Through Integrated Treatment

On the integration of services side, the Harris Project began work in this area in December 2015 with an initial plan of hosting a professional roundtable on best practices for the treatment of COD. There was commitment from then Deputy Commissioner from the Westchester County Department of Community Mental Health, Michael Orth, so I began putting together the list of invitees. I had the good fortune that a series of introductions led me to Dr. Ken Minkoff of ZiaPartners, Inc. Dr. Minkoff is a board-certified psychiatrist with a certificate of additional qualifications in addiction psychiatry. He is recognized as one of the nation's leading experts in recovery-oriented integrated services for individuals and families with co-occurring mental health, substance use, and health conditions. Also included are other complex needs like: trauma, housing, legal, disability, parenting, etc. Dr. Minkoff developed a welcoming, recovery-oriented, hopeful, strength-based, trauma-informed, and complexity capable integrated system of care implemented through a national consensus best practice model: the Comprehensive Continuous Integrated System of Care (CCISC). He was clearly my guy!

On April 8, 2016 (what would have been Harris's 22<sup>nd</sup> birthday), the Harris Project convened the Co-Occurring Mental Health and Substance Use Disorders Integration Roundtable with participation from the mental health commissioners and deputy commissioners representing Westchester, Putnam (who had already begun work with Dr. Minkoff) and Orange Counties, together with federal/state agencies (including the Substance Abuse Mental Health Services Administration and the Office of Alcohol and Substance Abuse Services), providers, hospitals, higher education, family members and peers. Dr. Minkoff participated long distance. At the conclusion, Dr. Minkoff helped the group

prioritize next steps. There were several follow-up meetings, and planning sessions. The initial plan was to have Dr. Minkoff lead a training with representatives from the 3 counties, but little did I know the reach was going to expand.

In October 2016, I was invited to attend an information session about the newly formed New York State Regional Planning Consortium (RPC). The RPC is designed to promote collaboration, problem solving and system improvements for the integration of mental health, addiction treatment services and physical healthcare in a way that is data informed, person and family centered, cost efficient and results in improved overall health for adults and children in our communities. There are 11 regions across NYS, and our local Mid-Hudson region includes Westchester, Putnam, Orange, Rockland, Ulster, Sullivan, and Dutchess Counties.

While the focus of the RPC is transformation within the Medicaid system, it was my belief that since its mandate supported developing a best practices, person-centered model, it had the potential to create a complexity capable, integrated behavioral healthcare system that could be applied in any setting, meeting the needs of anyone. I ran for a position within the Peer, Family, Youth stakeholder group, and in January 2017 was elected to the Board of the Mid-Hudson RPC.

I listened, learned, and shared. Harris's story featured prominently in my passionate appeals for a system of care that could be easily navigated and integrated services that could be delivered under one roof. In March 2017 the Mid-Hudson RPC was connected to Dr. Minkoff, and a regional workshop was given the green light. I was included on the planning team, and was gratified to see this come together with broad-based support.

On November 13 & 14, 2017 the Westchester Medical Center Health Performing Provider Systems (PPS) in conjunction with the Mid-Hudson RPC sponsored a 2-day forum on "Creating a Welcoming and Integrated, Trauma-Informed System for Addressing Those with Co-occurring Disorders" led by Dr. Minkoff and his partner Dr. Chris Kline. I had the surreal pleasure of introducing Dr. Minkoff to begin the event. All 7 counties of the Mid-Hudson RPC sent teams made up of county mental health directors, providers, hospitals, agencies, community organizations, family members and peers. Also in attendance were representatives from the NYS Office of Mental Health and the Office of Alcohol and Substance Use Services. Attendees worked in teams by county to contribute to the ongoing regional and county efforts to implement a more competent co-occurring system of care. Among the almost 200 participants were 10 members of our original 2016 Roundtable Integration Team! Dr. Minkoff encouraged participants to look at the populations they serve and why complexity should be viewed as the expectation – not the exception when addressing their needs. At the conclusion, there was commitment by all to continue this transformational work.

The number of lives being lost to overdose is tragic. the Harris Project hopes to turn the tide by bringing "co-occurring disorders: out of the shadows and into the light."

For more information about the Harris Project, Stephanie may be reached by phone (914)980-6112 or by email [stephanie@theharrisproject.org](mailto:stephanie@theharrisproject.org).

### I'm Steel from page 7

And he did. This life clearly wasn't working and it was now or never. Eight years ago, through The Fortune Society and S:US, he started to piece together just what co-occurring really meant for him. It meant being diagnosed with bipolar disorder and it meant replacing street drugs with medication to treat his illness. Now, like Eugene said, *he's not strong, he's steel*.

### Suicide from page 18

#### The Warning Signs of Addiction

- Increase of use of substances.
- Increased tolerance to substances.
- Irritated or minimizing response to other's comments about their use.
- Attempts to hide use.
- Neglecting or dropping obligations.
- Acquiring new but unhealthy relationships.
- Poor judgment.
- Chronic low level sickness.
- Isolation.

#### Some of The Warning Signs of Suicide

- Visible changes in behavior from what is normal or usual for that person, including increased irritability or hostility, or social withdrawal.
- Trauma or stress that the person does not seem able to get past.
- Talking about or threatening to hurt oneself.
- Seeking means to hurt or kill oneself.
- Talking about or writing about death, dying, or suicide.
- Statements such as, "I will just end it all."
- Hopelessness, feeling trapped with no options.

### Tech-Supported from page 8

interests will become more closely aligned. To make this happen, however, requires shared visibility into all the data that drives care decisions. Payers have some of this data in the form of claims, while providers have clinical data through their EMRs. The vision of data interoperability has yet to be realized, however, so health care organizations need to bridge this gap through portals and dedicated platforms.

Data sharing will facilitate the development of analytics and insights to segment populations, ensuring that they receive appropriate care, and to create the integrated, longitudinal patient view that is essential for care delivery for each individual.

Integrating mountains of data from multiple, disparate sources can be a daunting task. A good strategy, therefore, is to start slowly, perhaps by sharing just a small volume of data to develop insights about the patient, and then building from there.

Consider, again, the patient with comorbid diabetes and depression we introduced at the start of this paper. Simply by sharing diagnoses - so that her psychia-

The reason we're here to tell the tale around a table instead of a graveyard is because of the help we've gotten to face our demons, and the second, third, and fourth chance given to many of us through ATI (alternatives to incarceration).

Michael said it for all of us when he said he may not be up to loving himself just yet, but at least he's liking himself. That's a huge step in our recovery journey. Now we've got to just keep on going.

- Seeing no reason for living or purpose in life.
- Being unable to sleep or sleeping all the time.
- New or increased alcohol or drug use.
- Acting reckless or making very risky decisions with no care for the outcome.

Suicide and addiction are both preventable and treatable. Take the time to read, listen, and learn what you can do to help save a life.

If someone you know is in immediate danger, always call 911. Another important number is the National Suicide Prevention Lifeline at 1-800-273-8255 (TALK)

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trist knows about her diabetes - would prompt the psychiatrist to start asking her about her sugar intake, diet, exercise regimen and how her mood affects her compliance with her diabetes medications. That is a meaningful first step and a far better approach than simply sitting on the sidelines and falling behind the curve.

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**The Myths from page 28**

attempts. She seems to only tolerate Fluoxetine among the many antidepressants. She lives a good distance from your clinic and it would be difficult for her to come in five or six times a week for transcranial magnetic stimulation and you would rather avoid advancing her treatment to ECT. Having had patients similar to this one you feel the next best thing to do is to increase her Fluoxetine to 60 mg per day. You do so and enter it into the record. The next day you get a visit from a hospital administrator who questions your use of 60 mg of Fluoxetine in a patient with unipolar depression. He does so stating that there is no data supporting Fluoxetine at 60 mg being superior to Fluoxetine at 40 mg in unipolar depression (although there is data that supports it being useful in the treatment of OCD, and also safe for the patient at this dosage). The hospital administrator has a smug self-righteousness about himself suggesting

that he is “in the know.” Now there can be a lot of features deserving of comment, but let me focus on this one. No one has ever done a systematized, placebo-controlled, double-blind, random assignment study of 60 mg of Fluoxetine in the treatment of unipolar depression. In fact I would stipulate, especially from the point of view of somatic therapies, that the majority of treatments that we use have no strict, perfectly congruent underlining research supporting them. Clinicians certainly as part of a good standard of care do not just invent treatments or follow their own idiosyncratic ideas, but they most heavily rely on their experience and the experience of their teachers and colleagues.

Also the nature in which we define psychiatric diagnoses does not divide categories into a neat entities without overlap with other conditions. From the 1980s to the present, the evolution of DSM three to DSM-V was done by consensus of experts as to what best constitutes a given illness recognizing the inher-

ent heterogeneity and overlap of these conditions. The bulk of our diagnostic system was truly not based on the accumulation of controlled data. This further points out how EBM alone is inadequate to deal with the real life patients coming to us for help. Such real life patients also generally look very different from those that get enrolled into clinical trials. This is for many reasons, but the main one is the use of inclusion and exclusion criteria in our scientific research. If we have a new study for depression we will generally exclude anyone who is currently alcoholic, having uncontrolled endocrine disease, seizure disorder, cognitive decline, etc. This is because clinical trials search out the prototypical patient of a given category so as not to make the error of enrolling those who do not really have the disorder under study or who may have some factors that biases the sample into being particularly difficult to treat.

I have spent my career primarily designing conducting and analyzing con-

trolled clinical trials. There is no doubt that they are necessary. But their meaning can be abused or misunderstood. Also there are those that feel that if you can put some statistics to your clinical reasoning it is somehow more sophisticated and true. Statistics nevertheless remain among the most easiest of entities manipulated to serve one’s utilitarian purposes. Such purposes are not always on the side of the patient. I will therefore refer you back to the quote by Mark Twain at the beginning of this article.

In conclusion I would state that both EBM and EO are important in the development of clinicians and the practice of clinical psychiatry and psychology. “But buyer beware.” There will be those trying to influence your practice whose understanding of the clinical and therapeutic issues are overly simplistic or generated by something other than giving the best clinical care.

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**Social Workers from page 29**

cocaine (0.7%) and crack (0.1%) (Center for Behavioral Health Statistics and Quality, Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. HHS Publication SMA 16-4984, NSDUH Series H-51, 2016).

In comparison, the 873 SWSRW study participants who identified as ever having a problem with alcohol or other drugs (AOD) indicated a higher prevalence of current alcohol misuse when compared to the combined national sample of binge and heavy drinkers (46% vs. 31.4%) and a higher prevalence of marijuana misuse when compared to the national sample of marijuana users (8.4% vs. 6.5%). Additionally, the SWSRW participants who identified as ever having an AOD problem indicated a much higher prevalence of current tranquilizer misuse compared to the national sample (2.7% vs. 0.5%). Lastly, the participants indicated a lower prevalence of cocaine or crack misuse compared to the national sample of current users (0.5% vs. 0.8%).

**Social Workers with Co-Occurring Disorders - Study Results:** According to Straussner, Steen, and Senreich, 873 (14.9%) SWSRW participants identified as having experienced AOD problems at

some point throughout their lives and about one in six (16.1%) of those study participants reported currently misusing substances (Straussner, S. L. A., Steen, J. T., & Senreich, E. What Do We Know About Social Workers’ Use of Heroin? Behavioral Health News, 5(2), Fall 2017). Of those who reported current substance misuse, alcohol, marijuana, and tranquilizers and sedatives such as Valium, Librium, and Ativan, were the most highly reported substances misused out of a possible selection of 12 possible substances.

Of the total respondents to the study, 27% (n=1665) reported they are currently experiencing one or more mental health problems. When indicating which mental health problems they were currently experiencing, Anxiety Disorders (51.7%), Depressive Disorders (45.2%), and PTSD (11%) were most reported out of a possible selection of 13 possible mental health problems.

When examining reported mental health disorders and substance misuse together, there were 85 participants who reported both. Therefore, study participants had a rate that was less than half of the co-occurring disorders that were found in the general population (1.5% vs. 3.7%). Three co-occurring disorders stood out as the most common combinations reported by all social worker participants: Anxiety disorder with alcohol misuse (22.6%), Depressive disorder

with alcohol misuse (20.7%), and PTSD with alcohol misuse (6.6%).

**Limitations:** In addition to the generalizability issues of the SWSRW study sample to other social workers, it is important to keep in mind the limitations that exist when trying to compare data from the SWSRW study sample of licensed social workers to the general U.S. population. The SWSRW survey did not ask questions in the same way as national surveys. As identified earlier, the SWSRW survey asked questions on mental health and substance use problems in the form of a scale of agreement but did not collect or assess diagnostic criteria. Consequently, the above comparisons need to be viewed with caution. Nonetheless, they provide a first step in looking at the mental health and substance use problems among social work professionals within the context of the general population in the U.S.

**Conclusion:** Based on the findings of the 2015 survey of licensed social workers, we see that SWSRW study participants reported lower rates of Bipolar Disorder, Schizophrenia, and Personality Disorders than the general U.S. adult population. However, the SWSRW study participants reported a similar prevalence of Anxiety Disorders and a much higher prevalence of Depressive Disorders than the general U.S. adult population. SWSRW participants

who reported they had experienced AOD problems at some point throughout their lives were found to be experiencing somewhat higher rates of current substance misuse when compared to the general U.S. adult population. Additionally, the SWSRW participants reported Anxiety Disorders, Depressive Disorders, and PTSD combined with alcohol misuse, as the top three most experienced co-occurring disorders. Given the above findings it is critical that both the fields of mental health and substance misuse services address the needs of their social work services providers with co-occurring disorders, particularly those with depressive disorders, and not just their clients.

The authors would like to acknowledge and thank Dr. Evan Senreich and Dr. Jeff Steen for their contributions.

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**NYSPA Report from page 14**

based on experts’ opinions only.

When receiving treatment for TBI, patients should be cautioned to minimize benzodiazepines and anticholinergic, seizure-inducing or anti dopaminergic agents as they may impair cognition, increase sedation or impede neuronal recovery. Avoid caffeine in any form as it may cause agitation and insomnia. In addition, patients are advised to avoid herbal, diet or “energy” products due to the risk of inducing mania, hypertensive crisis, or aggression.

When treating TBI it is important to consider social causes of symptoms (e.g., abuse, neglect, environmental factors, family conflict) and to consider non-pharmacologic interventions, if possible. Finally, avoid large quantities of potentially lethal medications due to suicide

risk. The best approach in dosing medications is to “Start low – Go slow” and watch for toxicity and drug-drug interactions as patients are sensitive to side effects. Providers are advised to administer full therapeutic trials of medication before giving up as under-treatment is common.

**Psychiatric Comorbidities of PTSD**

80% of individuals with PTSD have at least one other psychiatric disorder. The commonest are depression mood disorders, anxiety disorders and substance use disorders. In addition to actual comorbidities, there are co-occurring problems which may be result of medical or psychiatric comorbidities or a combination of both. These may include suicidal behavior, anger or violence, insomnia, pain, marital or family disruption, impaired occupational functioning, and social with-

drawal or disengagement.

**Family Members and PTSD**

The discussion on co-morbidities with PTSD is never complete without understanding its impact on the family members as they are the “extended victims.” Specific PTSD symptoms like avoidance, alienation, detachment, social withdrawal, constricted affect, hyper vigilance, irritability/angry outbursts have a direct impact on family members. Other associated problems the family might face are social isolation, aggression/violence, addiction and vocational, financial or legal problems. The snap shot of a family affected by PTSD would look like:

- “walking on egg shells” and being on constant high alert
- limited emotional expression

- mourning the loss of the traumatized member

- shifting role responsibilities and the feeling that there is no end in sight.

Strategies that may help the families cope with the stress:

- Psycho-education
- Acknowledging what has been lost
- Understanding the changes in relationships
- Improving communication
- Active problem-solving strategies
- Emotional regulation strategies

In conclusion, it is not only important to treat PTSD but equally imperative to identify the associated co-morbidities and treat them. The outcome depends on both conditions being addressed effectively.

**Project Access from page 24**

We call on Governor Cuomo and the New York State Department of Financial Services to launch a thorough investigation of this issue. Be an advocate for children, individuals and families who desperately need care. We need you to stand up with us.

Please Contact the Governor's Press

**Certificate from page 30**

Further, OMH has included this certificate in their revised guidance documents and consideration of exemplary practice during licensing reviews. Following inquiries from consumers and other interested entities (e.g., managed care organizations) as to which providers offer integrated treatment, CPI began posting on its website a list, updated monthly, of the total number of IMHATT earned in OMH-licensed programs where at least one person has completed an IMHATT (<http://practiceinnovations.org/Initiatives/FIT-Focus-on-Integrated-Treatment>).

**Healthcare from page 26**

re-traumatization of the people it serves and to recognize and address the inevitable impact of vicarious trauma and compassion fatigue on its employees.

As I believe that readers of *Behavioral Health News* subscribe wholeheartedly to person-centered and recovery based approaches, it should come as no surprise that denying the impact of trauma on a person's overall health will undermine the power of those approaches for improving health outcomes. Similarly, in denying the re-traumatizing impact of non-trauma in-

**Recovery from page 31**

supports to 258 participants at any given time. We have a dynamic team of Advisors, Counselors, Team Leaders, Job Developers and Clinical staff that incorporate a strength-based, individualized and

**Fatigue from page 22**

Co-Occurring Fatigue: Compassion, Political, and Oppression Fatigue

Compassion, Political, and Oppression Fatigue can cause physical, emotional, and spiritual fatigue or exhaustion that can overwhelm staff and cause a decline in both morale and productivity. Over time, the constant outputting of emotional energy, typical in the healing professions, can lead to excessive fatigue within the management and the staff – especially during these scary, uncertain political times, when many of us are suffering from co-occurring fatigue, and advocacy and activism is a central part of our organization's function.

When this fatigue hits critical mass in the workplace, the organization itself suffers. Chronic absenteeism, spiraling Worker's Comp costs, high turnover rates, friction between employees, and friction between staff and management are among organizational symptoms that can surface,

Office: (518) 474-8418, or by Email at [Press.Office@exec.ny.gov](mailto:Press.Office@exec.ny.gov). To see the full Project Access report go to [www.northshorechildguidance.org](http://www.northshorechildguidance.org) and click on the Project Access tab.

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While completion of the IMHATT does not guarantee skilled practice, it does provide evidence that someone has completed the necessary training.

If you are an OMH-licensed or OASAS-certified not-for-profit behavioral healthcare program operating in NYS, you can complete an application to join CPI's learning management system where you can access the IMHATT and other free training resources and tools (go to the following link to access that application: [https://cumc.col.qualtrics.com/jfe/form/SV\\_7UiDOZnSqJw7hyJ](https://cumc.col.qualtrics.com/jfe/form/SV_7UiDOZnSqJw7hyJ)).

For questions related to this article, please contact Nancy Covell at [nancy.covell@nyspi.columbia.edu](mailto:nancy.covell@nyspi.columbia.edu).

formed environments in our healthcare system, we are ignoring barriers that ultimately prevent those who need care the most from getting it. Without acknowledging trauma in the lives of the people we serve, and without making our treatment and service environments and interactions feel safe, engagement in treatment and services of our most vulnerable populations will remain out of reach.

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trauma-informed lens to the work they do each day to ensure that each participant is successful in reaching their goals.

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creating additional stress and pressure on the entire organization.

Healing an organization takes time, patience, and most important, commitment. An awareness of the various forms of fatigue their far-reaching effects must be present at the highest level of management and work its way down, encompassing all staff as well as volunteers.

**Summary**

Compassion/Political/Oppression Fatigue causes physical, emotional and spiritual fatigue or exhaustion that can overwhelm staff and cause a decline in both morale and productivity. Fatigue is characterized by deep physical and emotional exhaustion and a pronounced change in the service provider's ability to feel empathy for their patients, their loved ones, and their co-workers. It is marked by increased cynicism at work, a loss of enjoyment of one's career – which eventually can transform into depression, secondary traumatic stress, and stress-related ill-

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rather, were part of the security apparatus.

The panelists also discussed how social determinants of health can help mental health professionals understand recidivism. Disadvantaged neighborhoods, communities with high rates of unemployment, poverty and substance abuse – which disproportionately affect people with severe mental illness – are associated with criminal justice involvement, noted April Thames, Ph.D., associate professor and clinical psychologist, department of psychiatry and biobehavioral sciences at the University of California Los Angeles.

She stressed the key role played by appropriate social support networks in preventing recidivism. Receiving behavioral health services, such as case management services, has also been associated with a significant reduction in risk for re-arrest (Falconer et al. Health and

**Promise from page 16**

this imbalance, especially within its Medicaid program. Until recently, New York boasted the largest Medicaid budget in the nation for which it enjoyed only mediocre (and in some respects dismal) results. This prompted Governor Cuomo to appoint a Medicaid Redesign Team shortly after he took office in order to enact much needed reforms.

The path toward integrated and holistic support for individuals with co-occurring disorders remains fraught with obstacles, but recent developments suggest a promising trajectory. A host of reform efforts presently underway (operating under a veritable alphabet soup of acronyms) aim to replace costly modes of institutional care with community-based alternatives, and many of these include new investments in SDH and other supports essential to individuals' enduring stability. The New York State Office of Health Insurance Programs recently established a Bureau of Social Determinants of Health in order to ensure SDH are addressed in value-based reim-

Justice, 2017;5:4).

Alternatives to incarceration were also reviewed by Cheryl Roberts, executive director of the Greenburger Center for Social and Criminal Justice in New York. She described Hope House, a residential treatment secure facility in the Bronx, N.Y., expected to open this year, which aims to offer clinical and therapeutic services to up to 25 people with serious mental illness who are charged with certain felonies.

The U.S. has the highest rate of incarceration in the world. Until we reorient the criminal justice system around rehabilitation instead of punishment, individuals with mental illness will continue to be victimized.

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bursement arrangements between providers and payers. Key stakeholders and constituents operating under the auspices of Clinical Advisory Groups, Regional Planning Consortia and similar forums have been charged to identify various recovery-oriented services and supports (including SDH) for inclusion in future service contracts. These stakeholders must identify specific services and the metrics through which their impact will be monitored and assessed. This is surely a tall order, but there is nearly universal recognition of its importance. The overarching goals of healthcare reform, as encapsulated in the vaunted "Triple Aim," will continue to elude us unless we employ a holistic and multifaceted approach to the treatment of individuals with co-occurring disorders. If we hope to reduce the cost of care, improve healthcare outcomes and enhance overall population health we must not neglect the unique needs of this population.

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nesses. Political Fatigue/Activist Burnout comes with political and advocacy and helping work in this uncertain, frightening political climate. Oppression Fatigue is due to daily microaggressions, rejection, inequities, discrimination, invisibility and injustices caused by the systematic privileges, the burden is heavy and exhausting. Good organizationally generated self-care and wellness begins with awareness.

**Resources**

Workshop and Training Topics Presented by Irene Greene ([www.irenegreene.com](http://www.irenegreene.com)). Care for Mental Health, Social Service and Medical Professionals, Social Justice Workers, Caregivers, and Healers; PTS: Political Trauma Stress: Self-Care in these Social Political Times; Professional and Personal Self-Care for Helpers: It's Much More Than a Massage; Professional and Personal Self-Care for LGBTQ+ Helpers; Vicarious Trauma, Burnout and Secondary Victimization; Compassion Fatigue Is Much More Serious Than Burn-Out; Oppression Fatigue and Healing Justice; Caring for Others'

Trauma When Dealing with Our Own; Self-Care and Relationship Care Plans for the Socially Conscious; When We White Helping Professionals Work with People of Color: Mixing Good Intentions, Good Practices, and White Privilege

**Books for Helping Professionals**

- Morrisette, Patrick J., *The Pain of Helping: Psychological Injury of Helping Professions*

- Figley, Charles, *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*.

- Saakvitne, Karen W. and Laurie Anne Pearlman, *Transforming the Pain: A Workbook on Vicarious Traumatization*

- Simon, David, M.D., *Free to Love, Free to Heal: Heal Your Body by Healing Your Emotions*

**Self-Care Books for Professionals**

- Borysenko, J. (2003) *Inner peace for busy people: 52 simple strategies for transforming your life*.

- Fanning, P. & Mitchener, H. (2001) *The 50 best ways to simplify your life*

**OMH from page 5**

Central to HARPs are Behavioral Health Home and Community Based Services (BH HCBS). Assessment for BH HCBS eligibility evaluates needs related to mental health, substance use, and physical health risk factors. BH HCBS can be used to support people with developing and strengthening skills related to self-advocacy, stress reduction, medication adherence, shared decision-making, healthy living, and disease management. This integration within payment and service coordination models presents an important opportunity to promote the IDDT approach for managing co-occurring disorders.

OMH knows that people struggling

with both mental illness and addiction need access to evidence-based, person-centered, and integrated services. When these services are available and high quality, outcomes improve, people recover, and lives are saved. We still have work to do, but recent initiatives in the context of systems transformation is giving New Yorkers with co-occurring disorders and their loved ones more reason for hope.

For more information on the co-occurring disorders task force, visit: <https://www.oasas.ny.gov/pio/collaborate/documents/CODTFReport.pdf>.

Sources of research for this article include Manseau and Bogenschutz, Substance Use Disorders and Schizophrenia, Focus, 2016.

**Striving from page 30**

• *To respect you as the expert on your life.* We believe that you have the ability to make your own choices, and we honor your personal journey towards healing.

• *To provide affirming, and inclusive services.* We recognize that culture(s), communities, and gender are vital aspects of our identity, and greatly influence our experiences and paths towards healing. Using the framework of Cultural Humility, we seek to provide services that are affirming, inclusive, and relevant to all who enter our services.

• *To be sensitive to the effects of trauma*

*and not replicate trauma.* We seek to understand, recognize, and respond to the effects of all types of trauma. We emphasize physical, mental and emotional safety for Members and Staff. Using the framework of Trauma-Informed Care, we seek to support everyone in rebuilding a sense of control and empowerment, and reclaiming their sense of self beyond trauma.

• *To provide evidence-based knowledge and services.* We provide access to factual information in a way that is nonjudgmental, and nonshaming. The services we offer are selected on the basis of their strong research evidence. We continuously analyze our services and participate

**ASD from page 33**

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in ongoing training in order to improve our service quality.

• *To never blame, shame, threaten, or attempt to control you.* We uphold your essential worth and dignity as a person, no matter whatever setbacks you may encounter in your recovery. If you ever encounter a setback, or something didn't turn out the way you had hoped, we are here to support you.

• *To partner with you in your recovery.* You are in the driver's seat, and we hope to help you map out your path towards recovery. We want your ideas, impressions, feelings, thoughts, experiences, and responses during each step of your treatment.

Thresholds is committed to offering compassionate community-based and recovery-oriented services that complement all levels of substance use treatment and strive to keep people engaged in recovery by sticking with them if and when they exhibit the recurrence of substance use symptoms that suggest they are most in need of our help. If society is to begin treating people with substance use disorders with more compassion, we as service providers have a responsibility to lead the way.

*Gabriela Zapata-Alma, LCSW, CADC, is Program Director, Substance Use Treatment Programs and Tim Devitt, PsyD, CADC, is Vice President, Clinical Operations at Thresholds in Chicago.*

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