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Addressing the Psychological Fallout of The Coronavirus Pandemic

By Michael B. Friedman, LMSW Mental Health Policy Advocate

he coronavirus pandemic in the United States has led to great efforts to prevent the spread of the virus and to prevent fatalities. But the problems that people will face due to the pandemic will go beyond medical issues. In addition, it will be important to address a variety of psychosocial issues. Of particular concern are (1) covering the cost of testing and treatment for all people in the United States for whom testing is medically advisable including people with no health coverage, (2) dealing with the impact of disruptions such as school closures, layoffs, lost income, lack of in-home services, loss of access to social and behavioral health services, difficulty getting food, loss of family caregiving, etc., and (3) dealing with the psychological fallout for those who get the disease, their families, and their caregivers.

This article highlights the behavioral health challenges that will need to be met.

Although it is unlikely that many people will develop new mental or substance use disorders as a result of their experience during the pandemic, some will, and



it is likely that many will experience exacerbations of PTSD, anxiety disorders, depression, and psychosis. In addition, many people will experience emotional challenges due to stress, isolation, confrontation with mortality, and grief.

This is of particular concern for the courageous people who will work directly with people who contract COVID-19.

In general, it is important to develop plans for diverse populations including varying social-economic status groups, ethnic and racial groups, household composition, ages, and lifestyles.

Psychological Fallout of A Pandemic

Below is an outline of psychological issues that need to be addressed. It is not intended to be comprehensive or detailed or to provide specific solutions. That has to happen through planning processes that hopefully will soon address the psychological fallout of the pandemic. The purpose of this article is simply to note areas to be addressed.

Prevalence of Behavioral Health Conditions

Although most people living through a pandemic or natural disaster generally will not develop new diagnosable mental or substance use disorders, some will. Many will experience exacerbations of PTSD, anxiety disorders, depression, psychosis, or substance abuse. And the risk of relapse—especially for people in recovery from addiction--is significant for people experiencing great stress and/or cut off from their usual sources of help.

In addition, a great many people will experience less severe, but very troubling emotional issues. The stress of major disruptions in life and of responsibility for the survival of family and friends can be very difficult to manage. Loss of income can be deeply troubling. Isolation due to quarantine or the loss of in-home supports for people with disabilities can have significant psychological consequences. For some people, confronting mortality may also stir up troubling emotions. And the deaths of people one cares about will

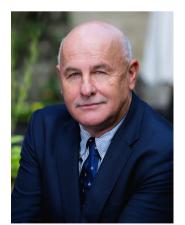
see Coronavirus on page 24

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Fall 2020 Issue: "Treating Trauma Victims and Survivors" Deadline: September 16, 2020

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The Importance of Housing for People on the Road to Recovery

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

Housing is a critical factor in anyone's overall health. Goodquality, affordable and safe housing is a vital component for individuals living with mental illness. Housing that enables individuals to live in fully integrated settings in their home communities is the cornerstone for successful recovery.

Recently, the Office of Mental Health (OMH) conducted interviews with service recipients who had moved from institutional settings to their own supportive housing apartment. One of them, whom we'll call Mr. W, said, "This is something I never would have dreamed of... this is what I've always wanted... to start my life over in my own apartment."

And Ms. M, who also moved recently, said she never wanted her family to visit when she was in an institutional setting. "That wasn't my house, but THIS is my house... now they can come over anytime!" A third recipient, Mr. A, said he loves his new apartment and enjoys the freedom to shop for and cook his own meals. He also enjoys the responsibilities of doing his laundry and maintaining his home. "This is my apartment, and I'm proud of that," he said.

New York leads the nation in providing more than 46,000 community-based mental health housing units and has pioneered model programs that have since been copied throughout the nation. We recognized early on that treatment of homeless individuals with mental illness often cannot even begin until they are safely housed.

Governor Cuomo understands the importance of safe and stable housing, and although this is a difficult budget year for New York State, his proposed Executive Budget increases support for OMH housing initiatives by an additional \$20 million for existing residential programs. Since 2015, OMH support for these programs will have increased by \$70 million.

The Executive Budget proposal also includes \$60 million in capital to maintain and preserve community-based residences. In addition, the Governor's proposed budget also provides \$12.5 million for certain individuals living in transitional adult homes in New York City who



Ann Sullivan, MD

wish to make the move to more-integrated settings in the community.

OMH oversees a large array of adult housing resources and residential rehabilitation programs -- including licensed community residences, licensed-apartments treatment, single-room occupancy residences, and scattered-site supportive housing. Each residential setting is designed to provide the supports and services necessary for individuals to live in the leastrestrictive setting possible. You can find more information about the many different housing programs licensed or operated by New York State at the end of this column.

The populations being served are varied and expansive – ranging from individuals who are homeless with SMI, to youth leaving foster care, to persons facing life challenges such as domestic violence and substance abuse.

This wide range of individuals often have multiple behavioral health and physical problems and their need for supports and services straddle multiple programs to address these needs. For example, a homeless individual living with HIV may also be coping with mental health and substance abuse issues. It is important that effective care coordination and care management services be readily available.

As part of Governor Cuomo's 15-year plan to fund 20,000 new supportive housing units statewide, he created the Empire State Supportive Housing Initiative (ESSHI) and an interagency workgroup of nine state agencies that has successfully completed four rounds of funding, with a fifth round set to begin in April. Under the last ESSHI funding round, more than 5,400 conditional awards for services and operating funding were made for projects around the state. These awardees are working with state, local and private sector partners to secure development financing to construct these new supportive units.

Of course, successfully treating people in their own community requires a commitment to strong community services. OMH has fulfilled this commitment by reinvesting savings from the closure of vacant and unnecessary inpatient beds into community services, allowing us to provide individuals with mental illness the right service, at the right time, in the right setting.

Since 2014, with a commitment of more than \$100 million in annualized investments thus far, we have been able to provide services to more than 67,000 NEW individuals, bringing the total to approximately 800,000 people served in the public mental health system.

In addition to funding new supportive housing, reinvestment has allowed us to enhance state-operated community services – including crisis residences, sustained engagement support teams, and mobile integration teams that have served more than 14,000 additional individuals.

We have also funded a wide range of locally operated community-based programs – including peer crisis respite services, firstepisode psychosis, community support teams, and home and community-based waiver services for nearly 34,000 individuals.

Because these community services are available, New Yorkers can get the support they need to avoid hospitalization and access inpatient services only when needed. As a result, more people living with mental illness are able to thrive in their own communities and their own homes.

As mentioned earlier, below is a list of the different housing programs that are either operated or licensed by OMH:

• Community Residences are transitional, rehabilitative programs that teach skills, offer support, and help residents achieve the highest level of independence possible. These residences are single-site facilities, with private or shared bedrooms, for up to 48 individuals. Meals are provided, as well as on-site rehabilitative services and 24-hour staff coverage. This level of housing is appropriate for individuals who can benefit from rehabilitative services in a non -hospital setting prior to placement in more -permanent community-based housing.

•Supported/Single Room Occupancy units provide long-term or permanent housing in which residents can access the support services they require to live successfully in the community. Front-desk coverage is provided 24 hours per day and providers must make any necessary services available to residents.

• Apartment Treatment provides a high level of support and skills-training to individuals in apartment settings. This licensed program is designed to be transitional, with an average length of stay of 18 months. Residents gain skills and independence, learn to use community programs, and develop a community-support system of friends and family. Apartment sites are usually scattered-site rental units located in the community.

• Community Residence/Single Room Occupancy are service-enriched, licensed, extended-stay housing with onsite services for individuals who want private living units, but who need assistance with self-maintenance and socialization skills. Living units are usually designed as studio apartments or as suites with single bedrooms around shared living spaces. There is 24-hour front desk security and services available, such as case management or life skills training.

• State-Operated Community Residence are licensed residential program that provide a therapeutic living environment for residents with mental illness. SOCR assists residents to develop skills necessary for successful reintegration into the community at their own pace.

• Supported Housing enables individuals to live independently in their own community. Many Supported Housing recipients are able to live in the community with a minimum of assistance, but support is available when needed. These are permanent community-based apartments, typically located in scattered site, privately-owned apartment settings.

This wide array of housing types enables individuals to choose the housing that fits their goals and needs as they pursue their recovery journey. The goal is always to enable each person to reach their fullest potential in the community of their choice.

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Permanent Supportive Housing: A Foundation for Wellness and Recovery from Chronic Mental Health and Substance Use Conditions

By Lorraine Coleman, Interim Senior Vice President, Real Estate Management & Tenant Services

Acacia Network, Inc.

hree years ago, Jeannette Lewis and her 16-year-old son spent Christmas in a homeless shelter in the Bronx. With a history of chronic substance use and a disability due to a traumatic brain injury, Ms. Lewis struggled to maintain stable housing and care for her family. Her two older sons no longer lived with her. Although she had been sober for almost two years after completing a chemical dependency outpatient program, Ms. Lewis still had a long road to recovery ahead of her. After years of moving from place to place, always on the brink of homelessness, she knew the first step in that journey was to find a home.

Safe and stable housing has long been recognized as fundamental for recovery from mental health and substance use disorders. In 1943, Abraham Maslow's Hierarchy of Needs theory described five requirements that were essential to achieving wellness and health: physiological needs, safety needs, love and belonging, esteem, and self-actualization (A.H. Maslow, A theory of human motivation, 1943). Proposed as a tieredpyramid, Maslow believed the needs at the bottom of the hierarchy physiological (i.e. shelter) and safety must be satisfied before individuals can attend to needs higher up the pyramid. Today, housing is still considered central to recovery. In 2014, the Substance Abuse and Mental Health Administration included housing as one of the four required dimensions in its mental health recovery paradigm (SAMHSA, Working definition of recovery updated, 2014).

Housing is necessary for recovery, but for people with complex medical, mental health and/or substance use conditions, it is not always sufficient. For them, additional support is needed to maintain stable housing and make progress toward recovery. Permanent supportive housing, an evidenced-based model that pairs affordable, stable housing with voluntary and flexible services, can provide that additional support.

Since its inception in 1966, the Acacia Network, the largest Latino-founded integrated-care organization in New York State, has recognized the critical role that housing plays in a person's recovery. Acacia's vision of healthy communities has always been firmly rooted in providing quality housing. Today it provides a full continuum of housing services, including residential services, individual residential alternative group homes, transitional housing, affordable housing, and permanent support housing.

Acacia developed its first supportive housing program in 1993, and over the last three decades has expanded it to meet the needs of people experiencing homelessness who have complex physical or behavioral health conditions. Today, it operates 15 congregate and scattered-site supportive housing programs for some of NYC's most vulnerable populations. All supportive housing tenants are offered a wide range services to support their recovery both on-site and through Acacia's Integrated Care Model. Through Acaciaaffiliates, tenants have access to primary care, mental health services, and substance use treatment along with an array of wrap-around services, including child care and after-school care for families, parenting skills, nutrition education, employment and job training support, and life skills training. Supportive housing case managers work with tenants to develop a care plan that is tailored to their needs, empowering them to draw on their capabilities to achieve their recovery goals.

Ms. Lewis and her son moved into Acacia's Continuum of Care Supportive Housing Program for individuals and families with chronic substance use conditions in February 2016. The supportive

housing staff helped them make the transition, and taught Ms. Lewis basic skills to help her maintain housing, such as paying bills on time and keeping up with home maintenance. Using a holistic, personalized approach, the supportive housing case manager worked with Ms. Lewis to establish goals and ensure she received the services needed to meet those goals and live independently. She began receiving mental health services at Acacia's Westchester Center of Excellence and medical services at its La Casa De Salud health center shortly after moving into the residence, and has continued to engage these services while in the housing program.

At their core, permanent supportive housing programs pair affordable, safe housing with voluntary and flexible supportive services, but exemplary programs go far beyond that. Importantly, supportive housing provides a foundation from which tenants can access the services—a foundation that connects the services in an integrated and seamless manner. Tenants are at the center of their recovery, with case managers arranging, coordinating and collaborating with other providers to ensure the appropriate wrap-around care can be provided. Supportive housing case managers are in a unique position,

see Foundation on page 30



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Deinstitutionalization Did Not Cause Homelessness: Loss of Low-income Housing and Disability Benefits Did

By Michael B. Friedman, LMSW Mental Health Policy Advocate

recently read yet another article that blames homelessness on deinstitutionalization. Yes, a disproportionate number of homeless people have long-term mental disorders, and yes some—perhaps a third—of these people would have been in state hospitals 65 or 70 years ago when that was pretty much all that was available for people with severe mental illness. And yes, changes in mental health policy are needed to address homelessness. But the conclusion that they are homeless **because** there are now very few beds in state hospitals is wrong.

At the height of deinstitutionalization in New York (1968-1973), people who were discharged (with wildly inadequate discharge plans) were not homeless. Most went to live with family. Some went to adult homes. Many went to nursing homes because they had dementia. And quite a few went to single-room occupancy hotels (SROs) and other places where poor people lived. To be sure, this resulted in huge family burden, inadequate care in adult homes, transinstitutionalization to often unprepared nursing homes, and squalid sometimes dangerous living conditions in SROs and poor neighborhoods.

In fact, the scandal that led to the crea-



tion of the community residence program for people with mental illness in NYS was not homelessness. It was the squalid and dangerous conditions in SROs. Numerous articles in the New York press reported on the horrible living conditions and the dangerous mix of people living in these hotels including sex workers, pimps, drug addicts, and other less than savory people in addition to highly vulnerable, severely mentally ill people. The story that probably had the most impact was of the murders of nine mentally ill people in the Park Plaza Hotel between 1973 and 1974. These were particularly dramatic and frightening serial killings, but they were, sad to say, not the only murders of people with mental illness that took place in West Side hotels.

As the scandal built, with heated debate about what to do about the clearly inadequate mental health system, the Chairman of the NYS Senate Mental Hygiene Committee, Senator Frank Padavan (R-Queens) convened hearings to confront the issues and to develop solutions. To oversimplify, some argued that state hospital beds should be re-opened, and some argued that the community services that had been promised as part of deinstitutionalization should be put in place. The outcome was the development of (1) the Community Support System Program, which provided state funds for psychiatric rehabilitation and other supports and services in the community and (2) the development of the community residence program, designed to facilitate a transition from hospitals to independent living.

Rapidly, communities rose up against having people with psychiatric or developmental disabilities in their neighborhoods. "Not in my backyard," yelled otherwise kind people, some of whom genuinely cared about the fate of these populations.

Senator Padavan responded heroically with a law that overrode local zoning restrictions on housing programs that had 14 or fewer beds. These were more like family homes than institutions, Padavan insisted, and he defined a site selection process that allowed local communities to oppose homes that were in "oversaturated" neighborhoods and authorized the Commissioners of Mental Health and of Mental Retardation

see Homelessness on page 30

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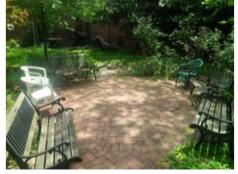
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Aging in Supportive Housing: One Fall Away from Institutionalization

By Rebecca Heller, LCSW and Lisa Furst, LMSW, MPH

ucy is a 62 year old woman who has lived in supportive housing for over a decade. She has been treated for bipolar I disorder and has a history of suicidality. Like many older adults with mental health challenges, Lucy has several chronic health problems which are monitored by her primary care physician, including atrial fibrillation, hyperlipidemia, and Type II diabetes. Recently, Lucy fell in the community room of her residence and was treated in the emergency room. Doctors put her right leg in a hard cast after it was found that hardware pins from a previous surgery had shifted. Lucy was told to not bear any weight on her leg for at least three months, since it could lead to an infection and possible amputation. She was given a wheelchair and sent back to her home. Lucy's Medicaid is inactive, so she does not currently qualify for home health care. She lives on the fourth floor walk-up in a building without a wheelchair accessible entrance. Not only is Lucy unable to get the assistance she needs to live safely and independently - her home has also effectively become a prison, since the lack of accessibility forces her to be homebound. In Lucy's current state, she is at risk for nursing home placement because her current needs cannot be met in supportive housing.



Rebecca Heller, LCSW

The social determinants of health and mental health are commonly recognized as important factors of client care, particularly for those living with behavioral health challenges, with housing ranking among the most critical. New York State has one of the most robust supportive housing systems for people living with serious mental illness in the country, with over 50,000 units (https://shnny.org/ supportive-housing/what-is-supportivehousing/history-of-supportive-housing).



Lisa Furst, LMSW, MPH

But even our relatively healthily endowed housing system does not effectively serve older adults with mental health needs, despite the fact that people with serious mental illness are living longer lives than ever before. In the last decade, the number of older adults in New York State increased by 26% (https://nycfuture.org/ research/new-yorks-older-adult-population -is-booming-statewide) and is expected to continue to grow as the baby boom generation ages – meaning that there will be more older adults living with serious mental illness who will need supportive housing.

What makes the current supportive housing system so challenging for older adults? And what has to be done to make housing "age friendly" for older adults living with behavioral health challenges?

As Lucy's story illustrates, accessibility is a paramount issue for older adults in supportive housing. Typically, doorways are not wide enough to accommodate wheelchairs or other assistive devices, while the buildings themselves are often walk-ups, or at the very least have stairs at the entrance, without ramps. If apartments are of older housing stock, they are more likely to have infestations, leaks, and poor lighting – all of which contribute to health risks. In addition, older apartments often lack adequate storage space that can accommodate specialized equipment or supplies, which increases the likelihood of clutter in the apartment. All of these issues increase the likelihood of falls, which are one of the leading causes of morbidity, premature mortality, and transfers to higher levels of care for older adults.

The environments in which supportive housing may be located can also contribute to challenges for older adults. Apartments are often more affordable in more distant areas, which may lack easy access to public transportation – which itself may not be accessible for older adults with

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Emotional Health

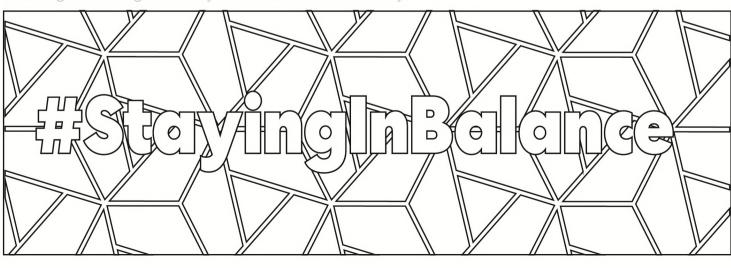
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Investing in Whole Person Care in Supported Housing: Improving Health, Enhancing Recovery

By David Kamnitzer, LCSW-R, Chief Clinical Officer/SVP, Marcia Titus-Prescott, RN, Nursing Care Manager, AMH SH and TAP Programs, and Elisa Chow, PhD, VP Outcomes Evaluation, ICL

t ICL, we offer a range of housing opportunities for people with serious mental illness – people who have been homeless, living in a shelter or on the streets, with long histories of mental health and substance use issues; some with HIV/ AIDS; many from prison, state hospitals and adult homes. Whoever they are and wherever they have come from, we are committed to their recovery and leading more fulfilling lives.

ICL was one of the first human services agencies to offer supported housing in the community after deinstitutionalization of the mentally ill in the 1980s. Much of course has changed since the 1986 opening of ICL's Stepping Stone Residence on Nevins Street in downtown Brooklyn. In fact, the building that was once a congregate care residence for people coming out of state psychiatric hospitals 34 years ago is being transformed into brand new modern apartments for people with mental illness who will be part of a mixed used housing complex that also includes affordable housing.

The physical transformation of housing for people living with mental illness represented by the Nevins Street project opening 2021 - has been coupled with significant programmatic transformation over the past ten years. Until that time, the process for admitting people into supported housing remained simple and straightforward. If they met basic qualifications, individuals would be screened by an assessor-usually a licensed clinician who helped the prospective resident understand what to expect from the housing provider. Many clinicians had an approved HRA application in hand prior to the screening – meaning many residents had already been cleared prior to the interview. This additional layer of oversight though offered a safeguard for the provider as the social workers approval for "Level 1- Community Care," was often viewed as sacrosanct. For the residents, being accepted into the housing program was a critical milestone. Extensive histories of homelessness and long periods in state or psychiatric institutions made many believe this day would never come. It did and lives were saved as a result.

A New Era of Care and Recovery

Today, ICL operates some 2,500 units of supported housing in scattered site units or congregate-style, community residences. For each resident to reach their highest level of independence, ICL offers a carefully designed program starting with case managers connecting them with health and mental health care and to jobs and other community resources. In congregate care settings, specially trained



David Kamnitzer, LCSW-R

staff address issues such as substance use, nutrition and healthy eating, and socialization challenges.

While supported housing used to simply mean access to an apartment and basic support to manage one's home and life, much has changed in recent years. The fact that nutrition and healthy eating are standard program components at ICL housing services underscores a much more fundamental change that might be summed up in two words – whole health. Over the past ten years, there has been much greater attention to and appreciation of a supported housing resident's "whole" - physical and mental health. health While just getting housing used to be the end goal, residents began to benefit from a much greater understanding of the link between physical and mental health and the social determinants of health – that taken together have tremendous effect on each individual in care and the larger community in which they live.

A shift to a whole health approach coincided with growing concern around the skyrocketing costs of care particularly for people with chronic physical and behavioral health issues. The people served in supported housing were this population, the group health care payors and providers considered the hardest and most expensive to treat. As a result, the supported housing model began to be examined in the context of a larger consideration of health care costs and outcomes.

People coming into supported housing were bringing a host of medical challenges and behavioral needs that took them far beyond requiring just a roof over their heads. To meet these increasingly complex needs, providers accepted greater risk leading to more public and payor scrutiny and oversight. Residents themselves were becoming better selfadvocates, more keenly aware of the help they could be getting that in turn put greater demands on providers to better meet those needs.

So how does a whole health approach look in practice at ICL residences and apartment programs? By institutionalizing



Marcia Titus-Prescott, RN

health measures at the beginning of a person's entry at our housing program, we know from the start their behavioral, medical, and/or social determinants of health needs. Addressing these from the outset and supporting them throughout their time with ICL has meant avoiding much more costly care down the road that usually occurs if these matters are left unattended. So not only are people getting better, costs to the healthcare system are significantly reduced, resulting in true preventive care.

From their first day, residents set goals for managing their health and mental health. ICL's strengths-based approach helps each person move through the spectrum of housing options and plan the next stage of their lives. Staff are trained on the TRIP model that focuses on traumainformed, recovery-oriented, integrated, person-centered care.

Whole Health as Sound Clinical Practice

What we see over and over again is that asking questions about behavioral, medical and social determinants of health leads to improved health outcomes and cuts unnecessarily high costs.

Take the example of Larry, a 68-yearold Vietnamese man who has lived in an ICL supported apartment since 2017. His diagnoses include schizophrenia, diabetes, hypertension, and arthritis. Larry selfmanaged his behavioral and medical needs with a blending of Eastern and Western perspectives. He used a cane to ambulate and traveled weekly to shop for traditional foods and socialize with peers that spoke his dialect. His care team respected his cultural background and worked with him on medication management and supported his use of traditional medicines to also manage his conditions.

But when he could not travel to shop for traditional groceries and to visit friends, Larry began isolating himself in his apartment. Having fallen while walking in his neighborhood, Larry had to make several trips to the Emergency Department. His daily living habits were



Elisa Chow, PhD

noticeably deteriorating and his case manager was his only human contact. The case manager and nurse care manager made a joint home visit to assess his situation including his medical and social needs. Shortly after, a case conference was held to determine whether supported housing remained a viable setting for Larry.

During the case conference, he confirmed he was challenged by his declining mobilization which exacerbated his behavioral and medical conditions. He worried he could not remain in the apartment he called home for the past three years. But the team was determined to see Larry resume his more independent life. He was open to using a walker and accepted a home attendant that spoke his dialect and agreed to needed home modifications. Thanks to the support and collaboration of the staff team, Larry is doing well with no recent visits to the Emergency Department and improved daily living skills. Grab bars were installed in his bathroom. The upkeep of his apartment is better as well. The nurse care manager continues to meet quarterly with Larry in his apartment to provide diabetes education and medication management. Using his walker, he is back to traveling to shop for traditional groceries and meet with friends accompanied by his new Vietnamese home attendant.

As housing providers, it is our responsibility whenever possible to help people remain in their homes and out of the hospital, nursing home, or skilled nursing facility. This requires an organizational culture shift in ideology that starts with the initial interview and goes throughout the person's tenure in supported housing. ICL's whole health program was supported by a number of initiatives the agency instituted in 2011 that made the inextricable link between health and mental health come into sharper focus. At all of our mental health programs, we introduced questions around health issues and made clearer and more demonstrable connections between physical, mental and even spiritual well-being.



Every night, some 2,500 people spend the night with the Institute for Community Living.

At ICL, People Get Better with Us is much more than a slogan. We want every person who comes to us for help to <u>feel</u> better, <u>do</u> better, and <u>live</u> better.

ICL housing programs support residents on the road to recovery to address their health and mental health needs and live as full, rich and independent a life as possible.

Brownfield Award Recognizes ICL Residence!

We are proud to be the recipient of the **2020 Community Outreach Award** from the **New York City Brownfield Partnership** for the **ICL Myrtle Residence**, magnificent new apartments and program space. The award recognizes ICL as a committed partner in strengthening the Bed Stuy and Bushwick neighborhood for all its residents.











To learn more about housing opportunities at ICL, contact Central Access at (888) 425-0501 or central access@iclinc.org.

Working with High Risk, High Need, High Utilizers In a Mixed Use Setting: One Agency's Experience

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

n a post DSRIP era, where sources of value based funding are scarce and community based organizations are still struggling to find a foot in the door partnering with the managed care industry and hospital settings, I thought it would be worth highlighting a few successful initiatives Concern for Independent Living launched in recent years that demonstrate how housing can be the lynchpin for healthcare and recovery.

In 2016, Concern for Independent Living opened the first single site Medicaid Redesign (MRT) mixed use supportive housing program in The Bronx (Norwood Terrace), a 115-unit supportive SRO for high cost Medicaid users living alongside affordable households. In 2017, Concern opened a second MRT mixed use housing program, Renaissance Village (123 apartments) in Middle Island on Long Island.

A pilot program under Medicaid redesign, these pioneering single site programs offer fully furnished studio apartments to chronically homeless adults with the highest healthcare expenses under the working philosophy that "Housing is Healthcare", that by offering someone a safe and beautiful place to live with limited on site supports, perhaps their healthcare outcomes would improve and costs would eventually go down. MRT housing has since become a well promoted concept in the supportive housing industry and is now a funding requirement of Empire State Supportive Housing Initiative (ESHHI) and other development awards.

While MRT projects have been piloted on a scattered site basis, Norwood Terrace represented the first time in New York (and the across the United States for that matter) that a single site supportive housing program had attempted to integrate 100% of their supportive tenants from a high utilizer pool into one building, alongside affordable households. It required a distinct partnership between multiple government agencies (OMH, DOH, HRA, DHS and HPD) and nonprofit community partners (care coordination, outpatient programs, outreach and crisis respite care).

At Norwood Terrace, 58 individuals with healthcare expenditures in the upper deciles (over \$45,000 Medicaid expense in 11 months, or over \$85,000 in 13 months) were transitioned from chronic homelessness into studio apartments in a permanent supportive housing setting with on-site case management supports. Staff worked with mobile integration teams, such as Pathway Home through Coordinated Behavioral Care (CBC) and

other health homes to link tenants to local outpatient supports and provide ongoing care coordination and skill building. Not only did this help fill a huge gap in care for a population that accounted for a large percentage of health care costs, it provided a central construct to finally begin to address their social determinants of health (neighborhood and physical housing, community and social context, healthcare system, economic stability, food insecurity and education). Many tenants were originally from the Bronx, or returning to the Bronx, now to a challenged neighborhood with one of the highest concentration of preventable ER visits and with a rent burden over 63%. However, with the right complement of services, Concern was able to make a marked difference in tenant use of crisis services within the first year of occupancy, cutting medical and psychiatric ER visits and inpatient mental health care expenses in half. A recent pre/ post cost analysis prepared by DOH showed an average costs savings of \$12,471 per tenant based on Medicaid claims data (equal to almost \$750K in savings) in the first year of operation alone. In addition, the shared residency in a building between supportive and affordable households (there are 53 children also living at Norwood) has also served to demonstrate that fully integrated residential buildings are

the hallmark of community integration and tenant social determinants of health are often the same.

Similarly, at Renaissance Village on Long Island, an analysis of estimated costs savings for the 123-unit supportive housing program for individuals transitioning from homelessness and expensive nursing home settings forecasted annualized savings of close to \$2 million. Clearly, both programs are closing gaps of care in both urban and rural communities. Their sustainability has gained attention from health care and insurance providers looking at practice based approaches examining value based payment proposals as a model that can be fiscally viable in addressing homelessness and healthcare in a comprehensive and localized manner. Concern has since partnered with Empire HealthPlus as part of the pioneering Corporation for Supportive Housing's Bronx Frequent User Service Initiative (Bronx FUSE) to engage high cost utilizers around supportive housing needs in a value based demonstration project that aims to funnel federal healthcare savings into housing through enhanced service provision. Alongside three other nonprofit/ MCO partnerships, BronxFUSE is the first partnership of its type with managed care and has the potential to set the

see One Agency on page 26

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Supported Housing Saved My Life

By Aubrey, Jerry, Mary, Jeffery, Daniel, Jose, GG (Golden Girl), Andrea, Jennifer, and Rhonda

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

We are all tenants of various supported housing residences run by Services for the UnderServed (S:US). Each of us has experienced mental illness, a substance use disorder, trauma, disability, or other challenges, including unstable housing. We came together one day to discuss how supported housing has saved our lives.

The residences we live in around New York City have different eligibility crite-

ria: a diagnosis of mental illness and/or HIV/AIDS, a history of homelessness, a substance use disorder, etc. Our residences all have dedicated staff and support services that help us overcome our challenges. All of the quotes in this piece represent sentiments expressed directly by one of us.

Lack of Affordable Housing

Because of the high cost of housing in New York City, we all expressed in different ways our gratitude for the housing that S:US affords us.

One of us said, "I worked all my life. I lost it all when the financial crisis happened in 2008. I got laid off. It was such a traumatic experience after being such an independent woman. I left my lovely home before I got evicted. I spent all my financial resources living in hotels and also living with family members and friends. I knew I had to enter the system and I was traumatized, scared, heartbroken, and lost. Words can't convey what I went through. I finally had a housing interview with S:US and was approved for an apartment. Today, I am living in my little nest in the Bronx. The Program Director and her kind staff are always approachable, with a smile, what a pleasure. I thank God every day for S:US. It's a blessing to have affordable housing. I'm very proud of myself. My battle wasn't easy but I won that traumatic experience because God had my back."

Housing Provides Safety, Security, and Stability

Having a roof over one's head is more than protection from the elements. Housing is at the core of everything. A safe, secure home is the place we go to reflect, to unwind, and to feel grounded. Home is a foundation for growth and health, and a basic human need. One of us who has been an S:US tenant for several years has contributed to supporting her housing community as stated here.

"As President of the Consumer Advisory Board, one of my jobs is to advocate for the tenants. We help a lot of tenants in the building, making sure their voice is heard. I also go with them to appointments and court visits."

Housing is an Essential First Step In Addressing Other Health Needs

Supported housing offers an opportunity to New Yorkers like us who need a little extra help to turn our lives around. Some of us had serious problems, like substance use challenges and histories of homelessness, that supported housing has helped us overcome.

One of us said, "This is my second apartment in two years. My plan was to get my act together and get off the street. I was in a shelter where there was lots of drug activity, prostitution, and fights. I couldn't focus and make my life better. I got caught up in it. I became homeless for eight months. Now I have a single room and I'm glad I am living in S:US supported housing. I can now focus, make positive changes in my life, and I have

see Supportive Housing on page 27

Are you looking for a supportive environment and providers who will partner with you on your wellness and recovery journey?

Services for the UnderServed (S:US) is here for you.

Learn to manage your wellness at S:US' Wellness Works Clinics, offering:

- Individual and group therapy
- Support in substance use recovery
- Medication-assisted treatment
- Ancillary withdrawal services
- Medication management
- Peer support
- Located in Brooklyn, Manhattan, and the Bronx.

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- Crisis management and crisis respite
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Using the Fair Housing Act to Obtain Housing for People with Disabilities

By Robert L. Schonfeld, Esq.

n 1988, President Ronald Reagan signed into law amendments to the Federal Fair Housing Act (FHA) that extended the provisions of that law to persons with disabilities. The FHA prohibits discrimination in housing on the basis of disability. In 1990, President George H.W. Bush signed into law the Americans with Disabilities Act (ADA), which prohibits discrimination against persons with disabilities by State and local governments.

Both of these laws have been used successfully in combating discrimination by municipalities, landlords, condominiums, and cooperatives against persons with mental disabilities and persons recovering from alcoholism and substance abuse. Providers of housing to people with disabilities have also used the laws to obtain housing for the persons they house.

> Persons Covered by the Anti-Discrimination Laws

The FHA covers housing for persons with disabilities. A disability as defined by the FHA is a person who has "a physical or mental impairment which substantially limits one or more of such person's major life activities, a record of having such an impairment, or being regarded as having such an impairment." 42 USC Section 3602(h). With some minor excep-



Robert L. Schonfeld, Esq.

tions, the FHA applies to all housing. The ADA has the same definition of disability as the FHA, 42 USC 12102[2], but only applies when the discriminatory act is performed by a governmental entity, such as in government housing, the denial of permits necessary to establish housing for people with disabilities, or zoning laws that preclude housing for people with disabilities.

The United States Court of Appeals for the Second Circuit, which has jurisdiction over New York, has held that persons recovering from alcoholism and substance abuse are persons with disabilities covered by the FHA and the ADA. RECAP v. City of Middletown, 294 F.3d 35 (2d Cir. 2002). However, the FHA does not cover persons who have been convicted of "the illegal manufacture or distribution of a controlled substance." 42 USC 3607(b) (4). Likewise, the FHA does provide protection to persons "whose tenancy would constitute a direct threat to the health or safety of other individuals or whose tenancy would result in substantial physical damage to the property of others." 42 USC 3604(f)(9).

Providers who provide services to persons with disabilities can bring actions under the FHA and the ADA. Human Resource Research and Oxford House v. County of Suffolk, 687 F.Supp.2d 237 (E.D.N.Y. 2010). As the provisions of the FHA and the ADA are relatively similar, it is usually not necessary to bring an action under both laws.

Actions Covered under the Anti-Discrimination Laws

The FHA and, when applicable, the ADA, prohibit the refusal to sell or rent or otherwise make unavailable a dwelling to a person with disability because of that person's disability. 42 USC 3604(f)(1). The law specifically applies to the actual persons with a disability or "any person associated with that buyer or renter." 42 USC 3604(f)(1)(A), (C). As defined by

the law, a "person" under the law could be an individual or a corporation. 42 USC 3602(d).

Actions covered by that provision of the law would include the refusal of sellers, condominium and cooperative boards, and landlords to sell or rent premises to persons with disabilities because of their disabilities. It would also include municipalities which have zoning laws that exclude housing for people with disabilities or deny permits to housing providers because of the disability of the prospective residents.

The FHA also prohibits discrimination against any person in the "terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services of facilities in connection such dwelling" because of the disability of a person or any person associated with the person with a disability. 42 USC 3604(f)(2)(A), (C). For example, if persons with disabilities are precluded from using certain facilities such as a swimming pool or an exercise room because of their disabilities, that would be in violation of this section of the law.

Another example of this type of discrimination was found in Cason v. Rochester Housing Authority, 748 F.2d 1002 [W.D.N.Y. 1990] where the court held that a housing provider could not ask medical questions of people with disabilities different from those asked of other prospective tenants.

see Fair Housing Act on page 26



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Leaders To Be Honored at Our June 30th Reception in New York City



Marco Damiani Chief Executive Officer AHRC New York City Excellence in Autism Award

By Staff Writer Behavioral Health News

ental Health News Education, Inc. (MHNE), the nonprofit organization that publishes *Autism Spectrum News* and *Behavioral Health News*, will be honoring four outstanding champions of the autism and behavioral health communities at its annual Leadership Awards Reception on June 30, 2020, at the NYU Kimmel Center in NYC from 5:00 pm to 8:00 pm. See pages 16 and 17 for full registration information.

Debbie Pantin, MSW, MSHCM, President and CEO of Outreach, and MHNE Board Chair, made the announcement stating, "MHNE has selected four prominent leaders from well-known New York organizations who represent some of the very best in the fields of autism and behavioral health. We are honored to pay tribute to them in recognition of their many years of dedicated service to the autism and behavioral health communities"

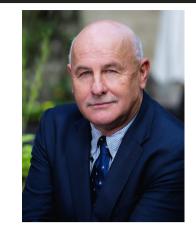
Ira Minot, Founder and Executive Director of MHNE stated, "We are so pleased to have this opportunity to recognize these champions of the communities MHNE serves. I am also pleased to announce that Anita Appel, LCSW, Senior Health Care Consultant, at Sachs Policy Group, and Matt Loper, CEO, of Wellth, who are both MHNE Board Members, will serve as Event Co-Chairs for our 2020 Leadership Awards Reception."

David Minot, Associate Director of MHNE stated, "Our 2020 Leadership Awards Reception is attended by over 200 recognized leaders from the autism and behavioral health communities who gather to share comradery and network with each other before the summer. This year's event will be an evening to remember, as we pay tribute to our distinguished honorees, their friends, family and colleagues.

Proceeds from this event will go towards expanding and developing the nonprofit educational mission of *Autism Spectrum News* and *Behavioral Health News*.

Marco Damiani CEO AHRC New York City

Marco joined AHRC New York City with a varied and progressive career in the field of intellectual and developmental disabilities (I/DD), behavioral health and



Kenneth Dudek Senior Advisor Fountain House Lifetime Achievement Award

general healthcare as a clinician, consultant and agency executive. Founded in 1949, AHRC NYC is one of the largest organizations in the nation supporting 20,000 people with I/DD and their families. AHRC NYC has over 5,500 dedicated staff, an annual budget well over \$300 million and provides a broad range of programs, services and supports across the lifecycle. Marco's career began at FEGS as a direct support professional and clinician, shortly after the implementation of the landmark Willowbrook Consent Decree and progressed through the years with positions in New York State government to Executive Vice-President at YAI Network where he led a broad and expansive portfolio of health and behavioral healthcare, research/program evaluation and a large community-based support, information and referral program, to Executive Vice President at Cerebral Palsy Associations of NYS, to his most previous position as CEO of Metro Community Health Centers, a network of 5 Federally-Qualified Health Centers in NYC devoted to supporting patients of all abilities.

In addition to his executive leadership positions, Marco was previously Chair of the Manhattan Developmental Disabilities Council and Chairman of the Alliance for Integrated Care of New York, the first Medicare Accountable Care Organization in the nation focused on individuals with I/DD. Marco is a Mayoral Appointee of the NYC Community Services Board I/ DD subcommittee, a Board member of the Inter-Agency Council of I/DD Agencies, New York Disability Advocates and Care Design NY, an I/DD Health Home, and is also an Appointee to the New York University College of Dentistry Dean's Strategic Advisory Council. In recognition of Marco's contribution to the work of its school and to the field of oral health, and for his leadership and advocacy in promoting healthcare innovation models for people with disabilities, the NYU College of Dentistry awarded Marco with the College's highest honor, the Kriser Medal.

Marco earned a BS in Psychology from Manhattan College, a Master's Degree in Developmental Psychology from Columbia University and pursued doctoral studies in Educational Psychology at New York University. He attributes his success to the extraordinary collective work and shared vision of his many colleagues over the years, their enduring commitment to pro-



Allison Sesso Executive Director RIP Medical Debt Behavioral Health Advocacy Award

moting social justice for people with disabilities and his never-ending quest to being more than just a so-so guitar player.

Kenneth Dudek Senior Advisor Fountain House

A recognized leader in the mental health field, Kenneth J. Dudek has directed Fountain House and the development of clubhouses since 1992. He has pioneered programs that address the housing, employment, educational, and health needs of people living with the most serious forms of mental illness. Kenn retired as President of Fountain House in September 2019 but continues as a Senior Advisor.

During his 27 years of service, Kenn created and implemented a strategic vision that positioned Fountain House as a leader in the global search for cost-effective, humane and successful solutions to the ongoing humanitarian crisis of serious mental illness. Through public-private partnerships, Kenn developed cutting-edge programs that respond to the evolving needs of people with serious mental illness and to changing social trends.

During Kenn's presidency, Fountain House became the first mental health organization to receive the largest and most prestigious recognition of humanitarian efforts, the Hilton Humanitarian Prize. The organization is lauded by academics, researchers, practitioners, psychiatrists, government officials, and others in the mental health field in the US and internationally.

Kenn has never lost touch with his roots as a social worker and established relationships, comradery, and trust with Fountain House members – people living with serious mental illness. Kenn is modest and unassuming but full of passion for the underserved and marginalized. His confidence in the capacity of members has empowered many individuals with serious mental illness to represent the organization and advocate for issues impacting their lives in the broader community.

Kenn's work deserves special recognition because it focuses on the most seriously mentally ill. This differentiates what he does from the majority of mental health programs. Kenn focuses on those who need help the most. Many have no family, no friends, no social network, no housing, and no treatment until they join Fountain House.



Ian Shaffer, MD, MMM, CPE VP and Executive Medical Director Healthfirst - Behavioral Health (Retd.) *Corporate Leadership Award*

Kenn is highly regarded as a dedicated, tireless, leader by the Fountain House Board, staff and members, and within the larger sphere of programs based on the Fountain House model locally here in New York, and globally.

Prior to joining Fountain House, Kenn was Director of Community Support at the Massachusetts Department of Mental Health where he created 25 model clubhouses and many other community-based mental health programs.

> Allison Sesso Executive Director RIP Medical Debt

Allison Sesso has served as the Executive Director of the Human Services Council of New York (HSC) since March 2014 and previously served for many years as the Deputy Executive Director. HSC is an association of 170 nonprofits delivering 90% of human services in New York City.

Under her leadership HSC has pioneered the development of nationally recognized tools designed to illuminate risks associated with government contracts, including an RFP rater and government agency grading system known as GovGrader.

During her tenure at HSC she has led negotiations with government on behalf of the sector and partnered on the development of policy and procedural changes aimed at streamlining the relationship between nonprofits and government. In 2017, Allison led the Citywide "Sustain our Sanctuary Campaign," which successfully pushed for investments in human services contracts totaling over \$300 million to address the nonprofit fiscal crisis.

When the largest human services nonprofit in NYC abruptly filed for bankruptcy, she turned tragedy into opportunity by organizing a coalition of experts to evaluate the systemic operational challenges facing human services nonprofits; resulting in a nationally recognized report, New York Nonprofits in the Aftermath of FEGS: A Call to Action, with nine recommendations viewed widely as a roadmap to long-term sustainability of human services nonprofits.

Allison also organized and led a commission of experts focused on social determinants of health and value-based-payment structures that recently completed a highly anticipated report, Integrating Health and

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Celebrating Leaders Making a Difference in People's Lives

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Marco Damiani Chief Executive Officer AHRC New York City Excellence in Autism Award



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Allison Sesso Executive Director RIP Medical Debt Behavioral Health Advocacy Award



Ian Shaffer, MD, MMM, CPE VP and Executive Medical Director Healthfirst - Behavioral Health (Retd.) *Corporate Leadership Award*

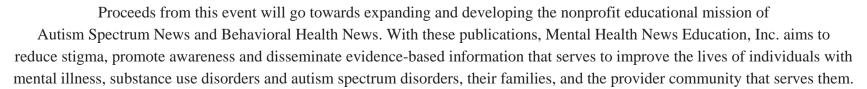
Tuesday, June 30, 2020 5:00 PM - 8:00 PM

5:00 pm Networking Reception - 6:00 pm Awards Presentation

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Housing Heals: How MHA of Westchester is Making a Difference

By Ruthanne Becker, MA Senior Vice President, Rehabilitation Services, MHA of Westchester

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he philosophy of The Mental Health Association of Westchester's (MHA) housing services and supports is rooted in the principles of person-centered practice and the belief that individuals with behavioral health conditions—even those with histories of instability or little experience of living in the community-have the right to make choices with regard to their living, working and social environments, and that making their own choices will speed recovery. The person-centered approach relies less on the service system by establishing truly individualized, natural, and creative supports to achieve meaningful goals based on the individual's strengths and preferences. The personcentered approach facilitates the creation of a team of people who know and care about the individual, who come together to develop and share a dream for the individual's future, and who work together to organize and provide the supports necessary to make that dream a reality.

Lorraine (not her real name) and Karlyn Jackson, Program Director of MHA's Supportive Housing, have worked together at MHA for more than a decade in order to make Lorraine's dream a reality. When Lorraine was first referred to MHA's Supportive Housing, she was living in a shelter for women whose lives were impacted by domestic violence. She had been at the shelter for about a year. During this time Lorraine was in and out of the hospital dealing with the physical impact of her attack. She was involved with a variety of social service agencies dealing with the trauma she had endured as well as with the District Attorney's (DA) office, which was trying to ensure that her abuser remained behind bars. When asked about this time in her life, Lorraine is very candid but remembers very little. However, the one thing that remains very clear to her is that she walked away with nothing. "Just the clothes on my back," she recalls. Karlyn adds "She left her life without her clothing, memories, furniture or ID." Lorraine describes feeling very scared - scared to leave the shelter, scared to even think about living on her own. Lorraine and Karlyn knew safety would be their first priority. With Karlyn's help, Lorraine decided that she wanted to move back to her hometown, "near mom."

Both recall driving around that town looking for apartments to rent, and they acknowledge that it was during these rides and the related meetings where they looked at "For Rent" advertisements that their relationship developed. In a 2004 study, Recovery-oriented Professionals: Helping Relationships in Mental Health Services (Berg et al., 2004), the authors found that "Human qualities seem to matter much more than titles, professional training backgrounds or methods used. Unexpected acts and ways of being, and helpers that go out of their way to give something extra are greatly valued. When



Ruthanne Becker, MA

both helper and user are willing and able to expose their 'human' side, daring to be themselves and disclosing a bit of who they are on the inside, mutual collaboration seems to be more likely. More than just collaboration, this shared disclosure is in itself experienced as important if not essential in recovery." Lorraine acknowledges that she was just learning to trust again and that Karlyn's persistence, care and warmth made it easy to accept that this person wanted to help and not hurt her. At the same time, Karlyn says that Lorraine was teaching her about resiliency, risk taking and learning to trust again.

Eventually, Lorraine found an apartment that she felt safe in, and Karlyn worked with Lorraine, the landlord and the DA's office to secure permission and funding to add additional locks to the front door. For Karlyn, handing the apartment keys to Lorraine still stands out as a momentous day in her career. Once housing was procured, Lorraine and Karlyn started the process of looking towards the future. Furniture and household items were selected and purchased. One of the priorities that Lorraine identified was to find a psychiatrist who was near to home and who would be consistent - she struggled with telling her story over and over. Karlyn was able to connect her to someone close by whom Lorraine still continues to see. Next was Lorraine's strong desire to return to work. It took some time, but eventually Lorraine returned to work and she currently works part time in a job she truly enjoys.

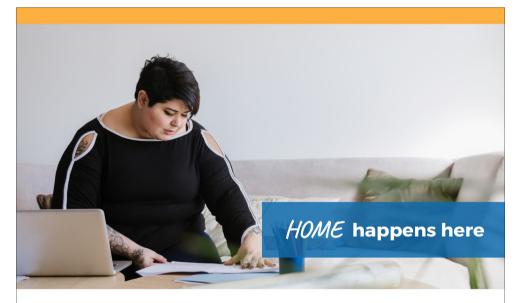
Lorraine reports that most days she is happy and healthy, but on those days and even weeks when she is struggling, she knows she has someone to whom she can turn for support and guidance. Karlyn has been there through the good and bad. She has been a consistent helper who doesn't judge or act punitively. Lorraine frequently speaks of Karlyn's kindness and compassion, and both acknowledge that each has helped the other to grow and change. Because Supportive Housing is permanent housing, Karlyn and Lorraine have enjoyed a long working relationship which has enabled them to collaborate on short- and long-term goals. According to Lorraine, the consistency of having one person over a long period of time has enabled her to see her own growth and progress. She also notes that when she is struggling, Karlyn will often be the first to notice. This is a common assertion of Supportive Housing tenants and staff because visits take place in the tenant's apartment/home and staff can observe subtle and not-so-subtle changes in the home and interpersonal relationships with friends and family.

Lorraine's story is special but not unique. Supportive Housing has been recognized as an Evidence Based Practice for decades. Unfortunately, the need for Supportive Housing services far surpasses the number of Supportive Housing beds that are available in Westchester County. According to the Program Director of Community Support Services at Westchester County Department of Community Mental Health (DCMH), in 2019, 1,385 individuals were on the Single Point of Access (SPOA) waitlist for Supportive Housing. According to DCMH, "[DCMH] established SPOA to remove barriers to successful community living for adults with serious mental illness. The goal of the SPOA is to ensure service access to high-need individuals while increasing integration and community tenure." Upon submission of the application and appropriate supporting documentation (comprehensive psychosocial assessment, psychiatric assessment including DSM-V diagnosis, hospital admission and discharge plan as appropriate, and consent to release information form), each request for service is reviewed at the housing and/or care management SPOA meeting. A service provider is assigned based on the type, level and availability of the service requested.

Supportive Housing is often lauded as the cornerstone of recovery. As one MHA Supportive Housing tenant said, "housing heals." Without safe and affordable housing, it is extremely difficult to have the strength or the necessary supports to focus on recovery. Like Lorraine, many participants of Supportive Housing describe that it is more than the actual apartment that provides the healing. Often it's the relationship with the Supportive Housing team that helps spark a new sense of self. Tenants of MHA's Supportive Housing have expressed that staff assistance with learning about and participating in their new community enables them to create or re-create their identity. They no longer identify with being "mentally ill", "homeless", or "a patient" but instead see themselves as a neighbor, a friend and a community member. This transition has been crucial to the tenants' recovery as well as decreasing overall stigma in their communities.

Because Westchester County has one of the highest per capita income levels in the country, the problem of homelessness and lack of permanent housing, particularly for individuals with disabilities, is underestimated and hidden. Housing is

see Housing Heals on page 26



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

n abundance of evidence now confirms what most behavioral health professionals have suspected for many years – safe and stable housing, coupled with appropriate health and social support services, reduces recipients' reliance on costly emergency and institutional care services (Martinez & Burt, 2006). The development of an adequate stock of supportive housing for vulnerable individuals is therefore essential to the fulfillment of various transformative initiatives presently underway. Enactment of the NYS Value Based Payment (VBP) Roadmap, maintenance of gains achieved under the Delivery System Reform Incentive Payment Program (DSRIP) (notwithstanding the federal government's denial of a request to renew this initiative), and the continuing deinstitutionalization of individuals formerly housed in state-operated psychiatric facilities, nursing homes, and adult care facilities (i.e., adult homes) require a supportive housing infrastructure of sufficient size and specialization to accommodate a rapidly rising demand. Key stakeholders to our supportive housing system anticipated this need at the outset of the foregoing initiatives and advocated for sweeping changes accordingly. Some changes have followed, but much work remains to be done if our housing services are to fulfill their emerging mandates.

There have been at least some auspicious developments to this end. For instance, the Empire State Supportive Housing Initiative (ESSHI) was enacted in 2016 and provides for the development of "integrated" housing for individuals with special needs in accordance with the NYS Olmstead Implementation Plan. This Plan constitutes the state's response to a decision of the U.S. Supreme Court (Olmstead v. L.C.) that affirmed the right of individuals with disabilities to reside in the "least restrictive settings" practicable. Housing developments funded under the ESSHI allocate "supportive" and "affordable" housing units in equal measure. That is, a "typical" ESSHI development allocates approximately 50% of its units for individuals with behavioral health conditions or other special needs and the balance for individuals who qualify in accordance with economic criteria (but do not necessarily experience chronic health conditions or other special needs). Thus, ESSHI developments integrate special needs populations with the "general" population. They do not segregate persons with disabilities as other housing models do. This approach, regarded by many as considerably more progressive than its antecedents insofar as it includes independent, mixeduse, and fully integrated residential accommodations for individuals with special needs, has surely advanced some of the goals described above. Nevertheless, unlike other models that rely on existing housing stock, ESSHI developments cus-



Ashley Brody, MPA, CPRP

tomarily entail the construction of new housing units or rehabilitation of structures that are no longer serviceable. These are daunting and time-consuming tasks, to be certain. Housing developers must navigate a byzantine labyrinth of fiscal and regulatory challenges that include restrictive and often exclusionary zoning ordinances; community opposition (i.e., "nimbyism"); and identification of parcels suitable for individuals with special needs and of limited means (i.e., accessible to public transportation, retail establishments, and other essential community resources), among many others. The ES-SHI is currently in the fourth of five "rounds" through which it aspires to develop a total of 6,000 new units of supportive housing throughout NYS. Not surprisingly, it has fallen far short of this goal. Regulators, policymakers, and other key stakeholders would do well to reexamine many of the foregoing impediments to housing development if the ESSHI and related initiatives are to fulfill their objectives and provide an adequate supply of integrated housing for eligible individuals.

Initiatives that promote the construction of new housing units for individuals with special needs are surely essential to the attainment of the state's policy goals and the amelioration of our affordable housing crisis. Nevertheless, they are insufficient to satisfy the housing needs of a rapidly growing population marked by increasingly complex and acute service and support needs. The existing continuum of Office of Mental Health (OMH)licensed and funded supportive housing programs must operate in synergy with emerging models in order to accommodate such complexity. Regrettably, however, the fiscal and regulatory underpinnings of the existing continuum have failed to evolve in concert with the changing landscape. Several of the supportive housing models presently in operation were established decades ago in order to provide stable living arrangements for individuals exiting institutional care settings, many of whom required little more than a modicum of support services in

order to achieve enduring stability and community tenure. These housing models now accommodate individuals with increasingly acute and complex needs for which commensurate resources are required. That is, Community Residences, Service Enriched Single Room Occupancy (SRO) programs, and other supportive housing models must now support individuals with mental health conditions, comorbid substance use disorders, and frequently debilitating primary (physical) health conditions that elevate their risk of adverse outcomes. Naturally, many of these individuals require more intensive support services than are readily available within these settings, and this disparity between needs and resources has increased markedly in recent years. According to an analysis by the Association for Community Living (ACL), a membership and trade association that represents supportive housing providers throughout New York State, funding for these programs has eroded significantly during the past three decades (up to 70% for some) when measured against inflation (Association for Community Living, 2020). Moreover, Cost of Living Adjustments (COLAs) for the human services workforce has been deferred

by the State Legislature nearly every year since it was codified in statute. This has compounded the economic crisis that afflicts supportive housing providers, making it exceptionally difficult for them to recruit and to retain personnel with the requisite qualifications to serve their current clientele. In short, an unfortunate confluence of ever-increasing needs and dwindling resources has strained portions of the existing continuum to their virtual breaking point. This jeopardizes society's most vulnerable individuals - the ones for whom the supportive housing infrastructure was developed - and hampers our collective effort to achieve the laudable aims of healthcare transformation.

The adage "Housing is Healthcare" is often invoked among proponents of Social Determinants of Health who recognize their primacy in the healthcare equation. Nevertheless, housing, essential as it is, cannot deliver on its promise absent an adequate supply coupled with support services of sufficient scope and flexibility for those who require it most.

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Managing Burnout and Compassion Fatigue Through Self-Care Strategies

By Michael Selbst, PhD, BCBA-D and Ashley Zultanky, PsyD Behavior Therapy Associates

e care about our family members, close friends, our clients, our students, and many others in our lives. We experience their accomplishments and excitement as well as their struggles and despair. Because we care about others and want to do all that we can in their best interests, this relationship can often contribute to our own emotional distress, including burnout and compassion fatigue.

There are many things that contribute to our burnout and compassion fatigue, including: juggling a busy schedule, educating students, working with challenging clients, managing challenging behavior, adhering to best practices in our respective work, keeping up with the paperwork, collaborating and communicating with others, attending to one's own family, and attending to one's own needs.

Psychological barriers often get in the way of us moving forward and successfully managing our daily lives, especially when our compassion level is moving toward empty. These may include selfstatements such as: "I can't do this"; "The drive is way too long"; "This person is just too difficult to work with"; There is too much uncertainty"; "What if I don't



Michael Selbst, PhD, BCBA-D

do a good job?"; "I'm not as smart as others think I am"; and "I don't think I'm being helpful."

According to a 2014 survey by the American Psychological Association, American Institute of Stress, the primary cause of stress in America is job pressure, specifically, co-worker tension, work overload, and poor relationships with employers. Furthermore, over 70 percent of



Ashley Zultanky, PsyD

Americans surveyed regularly experience physical or psychological symptoms caused by stress. More than 50 percent also endorse work as the leading cause of relationship stressors.

Burnout and Compassion Fatigue

Burnout is a special type of stress that caregivers and professionals may experi-

ence, including a sense of reduced accomplishment and physical and/or emotional exhaustion. Compassion fatigue encompasses a much greater level of stress and exhaustion, occurring as a result of helping others who experience emotional or physical pain, oftentimes referred to as the "cost of caring;" however, someone presenting with compassion fatigue shows a significant decrease in the ability to empathize with others.

Compassion fatigue is a type of secondary traumatic stress, which occurs as a result of helping or wanting to help others who are in need. Though they share similar features, burnout generally develops more slowly over a period of time, while compassion fatigue may have an unexpected onset and can occur without warning signs. Professionals and caregivers who experience compassion fatigue may react to situations differently from the way in which others typically respond, due to an erosion of "compassion skills." A majority of individuals in any kind of helping profession experience at least some degree of burnout or compassion fatigue in their lives.

Minimizing and managing one's stress are important for self-care and living life more fully. This leads to greater selfcompassion, including self-kindness, mindfulness, and our shared humanity.

see Self-Care on page 28



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Housing as an Innovative Solution in Medicaid Redesign

By Jason Lippman Founder & Principal Jason Lippman Solutions, LLC

s state leaders and stakeholders look to contain spending growth in New York's Medicaid program, one proven way to a more cost-effective care system with better outcomes, is through supportive housing services for high-cost Medicaid recipients.

Housing and health are deeply interconnected. Without a safe place to live and enough food to eat, it is extremely challenging to tend to the most routine of healthcare needs, let alone chronic behavioral health and medical conditions. For instance, people experiencing chronic homelessness have higher rates of chronic medical and behavioral conditions, such as diabetes, hypertension, HIV/AIDS, severe mental illness and substance use.

When care is needed or a crisis escalates, individuals who lack stable, permanent housing often seek treatment in costly inpatient and emergency-based settings. In fact, only a small percentage of Medicaid recipients drive up costs from high use of hospital and emergency room services. According to data from the U.S. Department of Health and Human Services, the top 5% of Medicaid recipients account for more than half of all Medicaid spending.

Community-based providers that offer supportive housing-—a targeted and cost effective intervention that offers longterm rental assistance and supportive services—empower individuals and families who experience chronic homelessness to live in the community, in their own apartments and take care of their medical and behavioral health needs. Supportive housing, especially when coupled with Health Home coordinated care, is a key component to improving health and reducing expenditures in the healthcare system, including significant savings in the Medicaid program.

Enter MRT II

New York State is working to fill a significant hole in its Medicaid budget, which is constrained by a state-imposed global cap on spending. In response, Governor Andrew M. Cuomo has reconvened the state's Medicaid Redesign Team (MRT) to find \$2.5B in savings in the Medicaid program. Known as MRT II, the team is tasked with finding solutions to contain spending growth. They are charged with accelerating the strategies that have proved to be successful from the first MRT, which was established in 2011 and shall now be known as MRT I. Members of MRT II are tasked with quickly putting together a plan with recommendations that, among others components, address models of healthcare delivery to improve care management for beneficiaries with complex health conditions, and strengthen the sustainability of safety net providers serving vulnerable populations, including through regulatory reform.

MRT II meetings have commenced to establish a process and deliberate pro-



Jason Lippman

posed recommendations. In addition, the MRT quickly assembled public comment forums which drew the ire of several interested parties already concerned about the transparency and inclusivity of the MRT II's procedures. Although never seen as perfect at the time, the structure of the MRT I, in comparison to MRT II, was more broadly shaped by stakeholder engagement and greater consumer and community representation. With more time and a more diversified set of objectives, MRT I sought input from 10 work groups focused on issues that addressed health disparities in the system and opportunities for return on investment (ROI) through interventions such as affordable housing initiatives.

Under MRT I, the NYS Department of Health (DOH) heard from providers and advocates in the community, who organized tours of supportive housing developments and formal meetings with state officials, to demonstrate how permanent housing improves health, reduces avoidable hospital use and decreases healthcare costs. In response, an MRT Affordable Housing Workgroup was established within the larger MRT delegation. In doing so, DOH recognized housing as healthcare and a key social determinant of health (SDOH).

In close collaboration with stakeholders and colleagues, I felt fortunate to serve on the MRT's Affordable Housing Workgroup. Together, we assessed the state's entire supportive housing portfolio, identified barriers to implementing supportive housing and recommended solutions to overcome them. We identified Medicaid savings and service improvements from the investment of new resources or through more efficient use existing means. Included in our final recommendations was the advancement of an MRT Supportive Housing Program, paid for with state Medicaid savings, for highcost Medicaid recipients. The program included funding for capital, operating expenses, rent subsidies and services.

MRT I realized that supportive housing is a key component to reducing physical and behavioral healthcare related expenses, including substantial savings in the Medicaid system. In fact, several studies have indicated how supportive housing investments can be offset from savings achieved by reduced use of the healthcare system and even generate a net positive return on investment. Additionally, combining supportive housing interventions with medical services and Health Home care coordination programs can produce a continuous flow of improved outcomes and cost savings for reinvestment back into the healthcare system with exponential rates of return.

During budget negotiations and after the completion of the MRT II process, the state must not miss this moment to innovative and redesign for a Medicaid system that meets consumer social determinant of health needs such as housing, living wage employment, education, food and transportation.

Housing in Integrated Care Networks

By scaling up a supportive housing infrastructure with coordinated care and outreach, we can leverage the power of community-based organizations (CBOs) to reach the hardest to serve and costliest users of Medicaid, treat complex health conditions and bend the cost curve downward. Moreover, with growing Medicaid enrollment, along with the aging of highneed subpopulations, and increasing rates of homelessness, integrating care and focusing on social determinants of health can have lasting effects on whole health outcomes and Medicaid spending.

By building an integrated care network that leverages the local and regional expertise of CBO's that are successful in addressing the needs of people living with chronic care conditions, we can continually reach people who are unengaged in care and/or experiencing homelessness, and connect high-need consumers to housing and quality behavioral health and medical care in the community. Furthermore, by taking a total cost of care approach that incentivizes integration, value -based payment and data-sharing arrangements, we can foster a more cohesive system of care and reduce the presence of chronic homelessness and behavioral health comorbidities as significant drivers of Medicaid expenditures.

By convening the right partners, we can create a future vision where provider associations, health plans and Independent Practice Associations (IPAs), etc., can work together under a total cost of care model, pay for innovative services to solve social determinant of health issues, and establish data needed to demonstrate their full value.

By replicating best practices learned from the Delivery System Reform Incentive Payment (DSRIP) program and other Medicaid reforms that were able to utilize more flexible arrangements around housing, workforce, crisis stabilization, peer services, care coordination, integration, etc., we can enable more consumers to tend to their existing health conditions in the community instead of through hospital -based and emergency room services. New York should pursue the adoption of successful DSRIP pilot programs more broadly and improve upon them, particularly from examples where PPSs sought more robust ways to collaborate with community-based providers to solve SDOH needs. According to state data, the DSRIP waiver program was successful at reducing avoidable hospitalizations by 21% and readmission rates by 17%.

Advancing SDOH Innovation

By breaking down the administrative and regulatory barriers that prevent community-based entry into Medicaid innovation programs we can strategically advance SDOH interventions. Many nonprofit providers continue to lack adequate infrastructure to sufficiently work with multiple Medicaid managed care organizations (MCOs), which also affects consumer access and continuity of care. Also, MCOs are not incentivized to pay for SDOH services or contract with behavioral health IPAs or other value-based entities. Behavioral health providers and consumers are still unable to take full advantage of specialized services intended for high-need recipients, like Home and Community Based Services (HCBS) offered in behavioral Health and Recovery Plans (HARPs). Navigating the eligibility and access barriers set up in the HCBS process is especially complex and troublesome for supportive housing providers and the consumers they serve.

Furthermore, the state should take measures to incentivize collaborative approaches to advancing social determinant interventions, like housing, where providers and payers alike can align, innovate and better serve better serve people caught in the intersection of chronic health conditions and homelessness. Housing is a key SDOH solution that should not be overlooked in MRT II.



Hoarding Disorder Condition: There Is Hope

By Max Banilivy, PhD Director of Internships, Education and Community Awareness WellLife Network

any wonder as to when collecting, saving and accumulating large quantities of things becomes a problem known as hoarding. When individuals collect items that are useless, is not functional to them or others, the individual rationalizes a need to have and are unable to let go of. So when does a desire and interest in collecting an item of interest cross the line to just collecting almost anything and even having a hard time throwing away obvious trash/garbage.

A significant number of families, care takers and service providers are challenged by individuals with a Hoarding Disorder (HD). It is one of the more difficult conditions to treat and work with. Many family members, significant others and professionals in different fields are rendered frustrated and helpless in trying to assist these individuals in their own homes and/or in housing programs potentially affecting every aspect of these individuals' lives.

Hoarding – A Common Disorder

Hoarding problem is far from being rare



Max Banilivy, PhD

and has proven for many to be resistant to change. Anywhere from 2-6 percentage of the population is affected by this condition with a level of severity that falls on a continuum. It affects both male and females; however, there is some indication that is more prevalent among males. The older adults 55 years and older are more represented and there is an indication that more are single with a high divorce rate. In many cases the inclination and interest in collecting starts in adolescence.

A great many individuals with hoarding problems are not in treatment and even if they are, do not admit to having a problem. Of those in treatment programs and housing services, many are not motivated to change this very difficult behavior. In the absence of initial intrinsic motivation to change the behavior, often others out of frustration resort to threats and even force that not only does not do any good but also in many situations reinforces the need for the individual to maintain unhealthy behavior that seems to serve an emotional function.

More often than not legal, safety, health, living circumstances and interpersonal conflicts serve as the external forces facing the individual, creating pressure.

A Complex Disorder Difficult to Treat

In view of the many consequences that the hoarding problems bring about for the many people isolated by this hard to address condition, it is essential to note that without families, service providers and other professionals understanding the psychological underpinnings of this disorder there will be little chance of effectively and collaboratively engage the individual in their own process of recovery. Understanding the emotional reasons and benefits of being surrounded by things that do not leave you, keep you company and provide some degree of emotional safety may serve as the basis of the initial conversation. Individuals with psychological challenges may find this conversation relevant. The conversation needs to go beyond the behavior and reluctance to want to part with seemingly useless things.

It would be simplistic to think of Hoarding Disorder as just related to depression, anxiety or Obsessive Compulsive Disorder (OCD). Treatments with better chances of long term effectiveness are Cognitive Behavioral Therapy (CBT) in nature and aside from needing to be collaborative, need to consider the slow and challenging course of the condition. Treatment can be effective with a multifaceted approach.

WellLife Network not only provides trainings in this area but also serves as consultant to the families, organizations, and professionals in private practice and in housing and other programs and fields.

Mansour (Max) Banilivy, Ph.D., is a clinical psychologist and is the Director of Internships, Education & Community Awareness for WellLife Network. Dr. Banilivy provides comprehensive multidisciplinary behavioral and emotional health services, training and consultation nationally to school districts, private and nonprofit community as well as the government, including military agencies.

For further information, please contact Max.Banilivy@WellLifeNetwork.org.

Dr. John Ngai Named Director of NIH BRAIN Initiative

By The National Institute of Health

ational Institutes of Health Director Francis S. Collins, M.D., Ph.D., announced today the selection of John J. Ngai, Ph.D., as director of the NIH's Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. Dr. Ngai is expected to join NIH in March.

"The BRAIN Initiative aims to revolutionize our understanding of the brain and brain disorders," said Dr. Collins. "We welcome Dr. Ngai's leadership in steering this groundbreaking 21st century project."

The NIH BRAIN Initiative is a largescale effort to accelerate neuroscience. Since it was launched in 2013, the initiative has funded hundreds of research projects that have led to several breakthroughs, including the creation of a selftuning brain implant that could help treat Parkinson's disease patients, the development of a computer program that can mimic natural speech from people's brain signals and the construction of a brain cell inventory. BRAIN funded researchers have also shown the ability to make high-speed, high-resolution, 3D films of a nervous system in action.

"Recent technological and scientific advances are transforming our understanding of the brain," said Dr. Ngai, who is currently the Coates Family Professor of Neuroscience at the University of California, Berkeley. "I am deeply inspired by



John J. Ngai, PhD

these advances and look forward to my new role in enabling BRAIN Initiative investigators to unlock the secrets of the brain and lay new foundations for treating human brain disorders."

Dr. Ngai will oversee the long-term strategy and day-to-day operations of the initiative as it takes on the challenges of the next five year plan, just announced a few months ago. Congress has enthusiastically supported BRAIN through the appropriations process and the 21st Century Cures Act. "Dr. Ngai's appointment marks a new chapter in the BRAIN Initiative," said Walter J. Koroshetz, M.D., director of NIH's National Institute of Neurological Disorders and Stroke. "He will provide the initiative the clear vision the project needs to navigate through this critical period."

Dr. Ngai earned his bachelor's degree in chemistry and biology from Pomona College, Claremont, California, and Ph.D. in biology from the California Institute of Technology (Caltech) in Pasadena. He was a postdoctoral researcher at Caltech and at the Columbia University College of Physicians and Surgeons before starting his faculty position at the University of California at Berkeley.

During more than 25 years as a Berkeley faculty member, Dr. Ngai has trained 20 undergraduate students, 24 graduate students and 15 postdoctoral fellows in addition to teaching well over 1,000 students in the classroom. His lab uses a wide array of tools and techniques to study the cells and molecules behind olfaction, or the sense of smell, including fundamental research on how the nervous system detects odors and turns them into neural signals sent to the brain. Dr. Ngai is also interested in unraveling the diversity of cell types in the brain and understanding how the nervous system repairs itself following injury or degeneration. His work has led to the publication of more than 70 scientific articles in some of the field's most prestigious journals and 10 U.S. and international patents. Dr.

Ngai has received many awards including from the Sloan Foundation, Pew Charitable Trusts, and McKnight Endowment Fund for Neuroscience.

As a faculty member, Dr. Ngai has served as the director of Berkeley's Neuroscience Graduate Program and Helen Wills Neuroscience Institute. He has also provided extensive service on NIH study sections, councils and steering groups, including as previous co-chair of the NIH BRAIN Initiative Cell Census Consortium Steering Group.

"Dr. Ngai has the diverse skills and experience that are needed to build on the early successes of the BRAIN Initiative," said Joshua A. Gordon, M.D., Ph.D., director of NIH's National Institute of Mental Health. "We are tremendously grateful that we were able to recruit him for such an important leadership position."

The NIH BRAIN Initiative® is managed by 10 institutes whose missions and current research portfolios complement the goals of the BRAIN Initiative Disorders and Stroke. NIH, the nation's medical research agency, includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical, and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.

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Coronavirus from page 1

undoubtedly result in grief.

Costs of Behavioral Health Care

Although most people in the U.S. have health coverage, behavioral health services are rarely fully covered, and co-pays may be prohibitive. It is essential to cover the full costs of behavioral health services for those suffering from the psychological consequences of the pandemic. This includes eliminating cost sharing in all forms of insurance--Medicare, Medicaid, employer-based health insurance, etc. And it includes covering costs for the millions of people living in the United States who have no health care coverage at all. This includes many self-employed people, day and gig workers, undocumented immigrants, and foreign travelers, among others.

Access to Behavioral Health Services

Access to behavioral health services is limited in the best of times. During a pandemic, it will be more difficult to provide behavioral health services due to:

• Increased need

• Increases in homebound populations due to quarantine

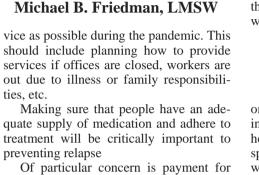
• High staff outages

• Preventive measures that limit allowing people with coronavirus onto treatment sites

• Limited reimbursement for telephonic services and other forms of tele-behavioral health.

Preparation by Behavioral Health Providers

Organizations and private practitioners providing behavioral health services will need to prepare to maintain as much ser-



Of particular concern is payment for telephonic and other off-site services and remaining financially viable if traditional service delivery is impeded.

Management of Risks in Congregate Care and Group Settings

For programs that provide residential services and/or group programs such as day treatment and psychiatric rehabilitation, managing health care risks without locking people out of service will be a particular challenge.

> Behavioral Health Services in the Home

Behavioral health services in the home are in short supply ordinarily. If

there is a pandemic, this will become a crisis. Home care workers may themselves be out of work due to illness, or they may be unwilling or precluded from entering the homes of people who are quarantined.

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Telehealth in various forms will be essential to serve people who are homebound. There will need to be changes in the reimbursement rules regarding telehealth services to cover these costs.

Psychological Support for Health Care Workers

The stress of providing health care for people with a highly contagious and possibly fatal disease is enormous. Staff burn -out is common. The people who do this courageous and vital work often need help themselves to manage the stress they live with.

Telephonic and On-line Information and Referral and Crisis Intervention

There are a number of telephonic and on-line information and referral and crisis intervention services. These hotlines and helplines will need to be prepared to respond to needs related to COVID-19. It will be particularly important for them to maintain information in real time about service closures and service availability.

There is a national Disaster Distress Helpline 1-800-985-5990; or Text: "TalkWithUs" to (66746), but there needs to increased public awareness and additional funding to handle greater volume.

It will also be important to provide public information about mental and substance use conditions that can arise during a disaster and how to deal with them.

Training for People Providing Services During a Pandemic

It will be important to provide training for people providing services regarding how to manage psychological and behavioral issues during a crisis. This includes primary health care providers, EMTs and other first responders, staff of social service and other helping organizations, staff of congregate facilities including community residences, assisted living, nursing homes, shelters, etc.

Training is also essential for behavioral health personnel regarding the physical aspects of the virus.

Impact of "Disruptions"

Disruptions such as school and workplace closures, canceled events, etc. will be emotionally difficult for people with adequate financial and other resources. They will create great emotional challenges for people who will be devastated by the disruptions, such as people who live from paycheck to paycheck or from day-job to day-job and for people for whom stability is key to well-being such as those with mental disorders, those in recovery from addiction, those with dementia, family caregivers, and others.

For these populations, assistance needs to be available to provide childcare, adequate income support, and essential services. They will also need psychological support.

> Behavioral Health Services in Community Settings

One of the lessons of responding to behavioral health needs during a disaster is that it is critical to provide psychological support (such as mental health first aid) in community settings where people seek help for other reasons. This includes houses of worship, food banks, senior centers, etc.

Addressing Issues of Particular Populations

Behavioral health conditions vary from population to population. In preparing for the psychological fallout of coronavirus, it

see Coronavirus on page 27



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Using Social Determinants of Health For the Field of Intellectual and Developmental Disabilities

By Arthur Y. Webb Executive Director New York Integrated Network for Persons with Intellectual and Developmental Disabilities (NYIN)

he concept of social determinants of health (SDOH) is particularly useful for the field of intellectual and developmental disabilities (IDD). Of course, this is not new news because the field has been engaged in building the social determinants of health for over 40 years. By just looking at longevity of persons with IDD, we can see the beneficial - indeed extraordinary - impact of all that has been accomplished in the field.

In fact, the aging of people with mild IDD appears to be equal to that of the general population.

Foremost, I am proposing that the field first understand the importance of SDOH, adopt its framework, and dig into gathering the data to capture the success of the field.

Social determinants of health are defined by the World Health Organization as "the conditions in which people are born, grow, live, work and age," which are "shaped by the distribution of money, power and resources." They include income, education, employment, housing, neighborhood conditions, transportation systems, social connections, and other social factors. Social determinants of



Arthur Y. Webb

health operate at multiple levels but are not the same as population health.

In "Meanings and Misunderstandings: Social Determinants of Health: A Lexicon for Health Care Systems," authors Hugh Alderwick and Laura M. Gottlieb (Meanings and Misunderstandings: Social Determinants of Health: A Lexicon for Health Care Systems The Milbank Quarterly, 2019. Published by Wiley Periodicals Inc.) state that: "The language of the social determinants of health is currently in vogue in U.S. health care. Yet the same words and concepts, such as social determinants of health and population health, are often used in different ways sometimes with very different objectives."

Writing in Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health (Health Affairs Blog. January 5, 2020.) Brian Castrucci and John Auerbach (Health Affairs) tell us that many articles on SDOH "aren't about improving the underlying social and economic conditions in communities to foster improved health for all - they're about mediating patients' individual social needs. If this is what addressing the social determinants of health has come to mean, not only has the definition changed, but it has changed in ways that may impede efforts to address those conditions that impact the overall health of our country.'

The New York State Department of Health has fully embraced SDOH and has formed a Bureau of Social Determinants of Health (SDH) to work with health plans, providers, community-based organizations, Performing Provider Systems (PPS), and Value Based Purchasing (VBP) contractors on special initiatives. Included are supportive housing, nutrition, and education.

The good news is that investments are being made in SDOH and the other good news is that this area has become a legitimate area for research. Slowly but directly the whole concept is being embraced by the health care sector. Public policymakers need to balance the use of Medicaid to solve larger social issues while ensuring fiscal solvency and continuation of Medicaid core services. In New York, there is a serious fiscal crisis with ongoing funding of Medicaid that might compromise fiscal stability of providers thus making it hard to support SDOH investment. Although New York State is making investments in affordable and special housing—long overdue.

For the field of intellectual and developmental disabilities, there is great appreciation of how individuals persevere in making the best of their circumstances. Persons with IDD are resilient and have learned to tolerate all the newest policy reforms thrown at them even in the face of all the good intentions of making their lives better.

Health-care stakeholders in a national survey said that they face several barriers in trying to address social determinants in population health programs and in clinical care. A few factors were checked off: the lack of payment structures for non-medical approaches lead the way; the lack of effectiveness metrics for non-medical solutions; and the limitations on data sharing.

Conclusion

New York State has made a real commitment to persons with IDD and the vast

see Social Determinants on page 26

Four Considerations for Behavioral Healthcare Design

By Doug Lovegren, AIA Associate Principal and Project Manager Svigals + Partners

well-designed healthcare environment is essential for successful treatment. This is especially true for the millions of vulnerable Americans utilizing behavioral healthcare and addiction treatment facilities. These spaces must be designed with treatment of the whole patient in mind. We adhere to a number of protocols that have proven to be effective in the design of this type of environment.

Case studies referenced in this discussion include a rehabilitation facility for Community Mental Health Affiliates (CMHA), New Britain, CT; Yale Child Study Center (YCSC), New Haven, CT; headquarters for nonprofit provider Continuum of Care, New Haven, CT; Cornell Scott-Hill Health Center in New Haven, West Haven, and Ansonia, CT; and while not strictly related to behavior health, the Ronald McDonald House of Connecticut, in New Haven.

Engagement in the Process

Involving a suitably wide constituency in the design process provides valuable input as well as community enthusiasm and en-



Doug Lovegren, AIA

ergy for the project. It is imperative that we gain an understanding of who will inhabit the finished space, since a good design cannot come solely from the architectural practitioners. This collaborative process ideally involves stakeholders including administrators, care providers, the communities they serve, and the design team. A key goal of the engagement process is to collectively develop a project charter, and ultimately an inspiring vision of the final space. The organization's staff should propose participants for the engagement process, as they will have insight as to who will be most helpful. But the project team must be sure they include a crosssection of users: those who know the programs well and others with alternate perspectives that can be just as valuable, and members of various age groups, genders, and backgrounds. The Svigals + Partners has conducted numerous workshops with mental health and addiction clientele, as well as facility users transitioning into the community following incarceration.

Inviting the greater community into the engagement process can be helpful in more ways than one. It allows community members to share their input on the design as well as become advocates for a facility of this type, often stigmatized with issues of desirability and perceived safety.

According to Patti Walker, president of Continuum of Care, providers value a commitment to collaboration and engagement, noting that the process "resulted in a building that truly feels like home for us."

Layout and Space Arrangement

Since individuals are unique and react differently to various paths of treatment, behavioral health and addiction facilities should be designed to support multiple methods of care. This means among other things providing a variety of spaces, such as open and semi-private areas sensitive to the various needs of different users and moods, an approach applied to the recently completed facility for Yale Child Study Center. For example, convertible spaces that serve as meeting areas one day, can be used for treatment on another. In social settings, clients benefit by manipulating furniture and having the ability to control their environment.

Similarly, the new layout for the CMHA rehabilitation and vocational facility includes activity rooms, a reading area, fitness space, and a full kitchen where meals are prepared and served by members, who also operate and patronize a small retail counter. The layout reinforces the program's mission, to instill habits that increase independence and successful community functioning.

Facility layouts should generally support a sense of control and understanding, with residential-scaled stairs and cohesive circulation to reduce any sense of feeling disconnected or disoriented. Utilizing color motifs related wall finishes and flooring can support wayfinding. Where possible, windows at end of corridors, as used at a Ronald McDonald House in New Haven, provide both cues for orientation and natural light. Access to secure

Fair Housing Act from page 14

The FHA also requires a landlord to permit a person with a disability to make reasonable modifications of an apartment (at the expense of the person with a disability), if such modification is necessary to afford such person full enjoyment of an apartment. 42 USC 3604(f)(3)(A). For example, a landlord must permit a tenant to retrofit a kitchen or bathroom if necessary to accommodate the tenant's disabilities.

A landlord or other housing provider must also make "reasonable accommodations in rules, policies, practices, or services when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling." 42 USC 3604(f)(3)(B). That might include permitting a person with a disability to have a dog if necessary in a no-dog building or granting a person with a disability a parking space closer to the building than a non-disabled person.

Another little-used section of the FHA makes it unlawful to "coerce, intimidate, threaten or interfere" with a person with a disability living in a dwelling or using the FHA to enforce a right under the law. 42 USC 3617.

Using the Anti-Discrimination Laws

There are basically three ways in which a housing provider or a person with a disability can prevail in an action brought under the FHA.

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The first way is to show that someone has acted with "discriminatory intent." That would entail showing that a seller refused to sell premises, or a landlord refused to rent premises, or a municipality refused to grant a necessary permit because of the disability of the future residents. A "discriminatory intent" case could also include a challenge to zoning laws that on their face prohibit or make more difficult the establishment of housing for people with disabilities. For example, in Human Resource Research and Oxford House v. County of Suffolk, supra., the Court held that a law that placed land use requirements on housing for persons recovering from alcoholism and substance abuse not placed on others was discriminatory on its face and that the law was discriminatory and violative of the FHA because the municipality was unable to demonstrate a legitimate justification for such law.

A second way is to show that an action had a "disparate impact" on a person with a disability because of that person's disability. In other words, a law or a policy that prevented a person with a disability from obtaining or using housing that had a greater impact on persons with disabilities than non-disabled persons. For example, in Oxford House, Inc. v. Town of Babylon, 819 F.Supp. 1179 (E.D.N.Y. 1993),

the Court found that a law that prohibited transients from living in a residential neighborhood had a disparate impact on people recovering from alcoholism and substance abuse than non-disabled persons because people recovering from alcoholism and substance abuse were, because of their disability, more likely to live in a residence for a shorter period of time than a non-disabled person.

Finally, a third way is to show that a landlord failed to make a reasonable accommodation to a person with a disability to allow that person to have an equal opportunity to enjoy their housing. For example, in Shapiro v. Cadman Towers, Inc., 51 F.3d 328 (2d Cir. 1995), the court held that a building had to make a reasonable accommodation by providing a parking space for a person with a physical disability that was close to the building. In Roe v. Sugar River Mills Assoc., 820 F.Supp.636 [D.N.H. 1993], the court held that a landlord was required to make a reasonable accommodation to a tenant to allow that tenant to remain in the apartment.

Under the FHA, a person with a disability has the right to file a complaint with the United States Department of Housing and Urban Development ("HUD"). 42 USC Section 3610. However, a person with a disability does not have to go to HUD and can go directly to either Federal or State court and file an action under the FHA against one who

discriminates. 42 USC Section 3613. A person with a disability can seek a temporary restraining order or a preliminary or permanent injunction against a discriminatory action as well as damages. 42 USC 3613(c)(1). If a person with a disability wins a case under the FHA, that person would also be entitled to attorneys fees. 42 USC 3613(c)(2). The statute of limitations under the FHA is two years from the occurrence of the discriminatory practice. 42 USC 3613(a)(1)(A).

Finally, both New York State law (Executive Law 296), New York City law (NYC Administrative Code 8-107), and the laws of other municipalities such as Nassau County can be used to fight housing discrimination against persons with disabilities.

Conclusion

With a proper understanding of the FHA and the other anti-discrimination laws, those laws can be and have been used to successfully combat housing discrimination in a variety of different circumstances.

Robert L. Schonfeld is of counsel to the law firm of Moritt Hock & Hamroff LLP. He represents housing providers and people with disabilities in actions against municipalities and landlords under the Fair Housing Act. He was formerly an Assistant Attorney General with the New York State Attorney General's Office.

Social Determinants from page 25

array of services available to the field in New York.

The leaders in the field know from first-hand experience what the beneficial impact of SDOH is on persons with IDD but lack the data to present a compelling case. I would promote the idea that the framework of SDOH is a valuable way to examine the field of IDD and one that fairly presents the impact the field has had on the well-being of persons with IDD.

A simple step would be to start using the emerging language of SDOH as a way to describe what the field does. Our field is well known for sensitivity of language in referring to the individuals we serve.

Of course, the age-old challenge is to

One Agency from page 12

trend in addressing gaps in our housing and healthcare systems.

So there you have it. One agency's experience with attempting a bold and innovative practice-based endeavor with two large mixed use projects, with a special focus on program rollout/ lease up transition, tenant healthcare outcomes/ needs and the delicate balance between servicing supportive and affordable households in both urban and rural neighborhoods. Social determinants of

health can be both measured and leveraged in a single site setting and additional supports/ local partnerships are truly needed to make a MRT project successful in the community (including in this instance, CBC network health home partners to provide valuable care coordination between the housing setting and healthcare sites, access to usable real time health care data, and vital crisis respite and diversion programs focused on keeping tenants out of expensive cycles of institutionalization and in their homes). Housing is healthcare and it works!

put together a data platform that help describe and measure the success of the field.

Arthur Y. Webb was the former commissioner of OMRDD (now OPWDD) from 1983 to 1990 and Executive Director of Division of Substance Abuse Services (now OASAS) from 1990 to 1992. Mr. Webb has held several senior executive positions in government and the nonprofit sectors. For the last ten years, he has been a consultant working with numerous nonprofits to translate public policy into innovative solutions. Presently is the Executive Director of the New York Integrated Network for Persons with Intellectual and Developmental Disabilities (a nonprofit collaboration of 12 providers).

For more information please contact arthur@arthurwebbgroup.com or call 917-716-8180.

Housing Heals from page 18

critical for individuals impacted by domestic violence, behavioral health and/or substance use issues. Affordable housing is only available in Westchester County as a result of government-assisted programs. This housing is consumed within weeks of becoming available, and there are long waiting lists for any future developments. NYS Homes and Community Renewal (HCR) mandates this housing always be marketed via a lottery, due to high demand and limited availability. Adults living with long-term disabilities rely on Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) to cover living expenses, but the benefit amounts have not kept up with the cost-of-living increases. Without participation in Supportive Housing or Section 8 Rental Assistance where rental amounts are 30% of an individual's income, one could easily spend 100% of one's monthly income on housing alone. While most of our clientele are eligible for Section 8 Rental Assistance, many have been on waiting lists for years.

Without stable and affordable housing, individuals diagnosed with behavioral health and co-occurring conditions can become trapped in a cycle of recovery and relapse. This cycle is often characterized by the repeated use of expensive community services such as hospital emergency rooms, inpatient hospitalizations and jails. MHA continues to explore opportunities to expand its Supportive Housing program in order to serve additional individuals and promote community inclusion. In 2019, MHA was one of four agencies in Westchester County conditionally awarded funding through the Empire State Supportive Housing Initiative (ESSHI). ESSHI is one component of the Governor's \$20 billion, five-year plan to create or preserve more than 100,000 affordable and at least 6,000 Supportive Housing units. The conditional awards are for service and operating funding needed to operate permanent Supportive Housing units. The award will allow MHA to secure separate capital funding to finance the development and construction of additional housing. Although in the early stages of development, MHA is hoping to eventually house 70 individuals: 35 individuals diagnosed with serious behavioral health issues who are currently homeless and 35 individuals who meet the eligibility requirements for low income housing. MHA will continue to provide warm, compassionate care, because we know that "housing heals".

For more information about MHA's Residential Services, please contact Ruthanne Becker at beckerr@mhawestchester.org or visit MHA's website at www.mhawestchester.org.

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will be necessary to make special provisions for certain of these populations including:

• Adults with long-term psychiatric disability, who are likely to be particularly challenged by disruptions of service and poor access to medical care

• People in recovery from addiction, for whom relapse is a distinct possibility due to great stress and/or loss of access to treatment and supports, such as sometimes daily self-help groups.

• Children and adolescents, for whom services are in short supply in the best of times

• Older adults, who are at highest risk of mortality if they contract coronavirus and may experience increases in existential anxiety and demoralization

• People with dementia, for whom environmental disruptions and changes in routine are especially challenging

Supportive Housing from page 13

privacy. Now where I'm at it's more like living. I am looking forward to progress."

Another one shared, "I came in with a serious problem. I spent five years on the streets without a stable home, sleeping in hallways and door frames, suffering thirddegree burns, and continuing to battle addiction. But God had a different purpose for me. I finally decided to change my life. I've had strokes and pneumonia. I'm three years sober because I have support. I am grateful and appreciative. I'm thankful to be where I'm at today."

Longevity and Commitment

One of us has only been in S:US housing for six months, but several of us have been here for many years. The person who • People with developmental disabilities such as autism or intellectual disability, for whom disruptions of routine can also be extremely troubling

• Family caregivers, who are under great stress and suffer burn-out in the best of times

• People who are living in isolation, who are at high risk of mental disorders

• People in grief, of whom there will be an increasing number if the pandemic is severe.

Effective Communication of Information for the Public

Although much information is available about the coronavirus pandemic, it does not adequately address psycho-social concerns, nor does it appear to be guided by psychological insights about effective behavior change communication.

In general, communication of public information needs to be geared to varying social-economic status groups, household composition, ages, and lifestyles.

This includes placing information where diverse populations will see/hear it, not just

has been here the longest has been living at

an S:US residence for 19 years and is

never been in a shelter and I'm thankful

for that. I first met S:US at the Brooklyn

Clubhouse. My case manager referred me

to the Clubhouse because I was in the

process of being evicted. I lost my job and

was going through health challenges.

When I got my first apartment, I was fear-

ful because I didn't know how long I was

going to have it. Now I come and go as I

please. There were many adjustments to

make. Before S:US I was suicidal for

many years. I am now 72 years old and I

Challenges

The support of staff in our residences

am so happy to be alive."

This is what this person shared: "I've

passionate about supported housing.

on websites and reported in the news. This should include public service announcements on TV, radio, and social media.

Particular attention needs to be paid to how to reach such populations as people who are homeless or otherwise estranged, people who are poor or otherwise disadvantaged, people who do not speak English or Spanish, people with impaired vision or hearing, and more.

Public information also needs to address what people need to know to take personal action including what symptoms call for testing and how to seek testing. These questions are especially important for people without personal physicians, including people who use emergency rooms, urgent care centers, and the like.

In addition, messages regarding preventive actions, such as staying home from work, and preparations for quarantine, including stockpiling food and other necessities, need to address people who have no sick leave and/or insufficient income and savings and not only those who have a regular source of income and adequate savings or employee benefits.

In general, messaging should be designed to avert dysfunctional anxiety as

is vital, and building genuine trust with

staff helps us make real progress in our

recovery and health. When the staff we

have grown to trust leave their jobs, it is

here for about 17 years, and I'm thankful

to S:US. But over the years there have

been staff turnover, and this has been a

We Appreciate S:US Supported Housing

S:US staff and the physical beauty and

uplifting atmosphere of our buildings.

Some of us live in residences that include

urban farming spaces run by S:US. These

spaces not only beautify the grounds of

the buildings but provide a therapeutic

outlet for us through gardening and farm-

Many of us expressed appreciation for

One of us explained, "I've been living

difficult to adjust.

real challenge."

well as to avoid the implicit ageism of providing reassurance by noting that young healthy people are not at significant risk of death due to COVID-19; only old and sick people are.

Plans Are Needed Now

No doubt, meeting the medical issues of the COVID-19 pandemic is the highest public health priority. But people will suffer not just from the illness but also from lost income, lack of essential services, and from behavioral health challenges including mental and substance use disorders and difficult emotional disturbance.

Plans are needed now to take on the psycho-social challenges of the pandemic as well as the medical needs.

Michael B. Friedman, LMSW has been a mental health policy advocate for over 40 years. He was Director of the Center for Policy and Advocacy of the Mental Health Association of NYC when he retired in 2010. He continued teaching at Columbia University School of Social Work until 2019 when he re-located to Baltimore to be closer to his grandchildren.

ing. Supportive, positive features like this add to our sense of comfort and safety.

One of us said, "I live in an environment where my self-esteem is lifted. I can't help but improve my life because I am in a good place. I love my social workers, they work hard. I have a great view and am near a bus stop."

Another remarked, "I'm grateful for the chance to live in supported housing. In Jamaica, where I'm from, this opportunity is not available."

A third person shared, "I've been living here for 11 years. The social workers here allow me to think. I've been able to improve my life because of them."

Our individual stories are diverse, but we found shared conclusions about the challenges, and ultimately, the value of supported housing in providing us a pathway toward stability.

Behavioral Health News Upcoming Theme and Deadline Calendar

> Summer 2020 Issue: "The Suicide Crisis in America" Deadline: June 17, 2020

Fall 2020 Issue: "Treating Trauma Victims and Survivors" Deadline: September 16, 2020

Winter 2021 Issue: "The Behavioral Health Technology Field" Deadline: December 23, 2020

Spring 2021 Issue: "Employment for People with Mental Illness and SUD" Deadline: March 18, 2021

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Common signs of compassion fatigue include irritability, anxiety, agitation, frustration, and anger; depersonalization and feeling disconnected from others; decreased feelings of empathy and sympathy; increased and chronic psychological and emotional fatigue; apathy, disinterest, or dread related to working for or taking care of others; physiological and physical discomfort; difficulties in interpersonal relationships; and noticing thoughts about being "unfulfilled" in the role of professional or caregiver.

Stress is Part of Life

It is important to recognize that stress is a part of life, and it is easy to experience burnout and compassion fatigue when we do not move off of our "automatic pilot" way of steering through life instead of taking the steering wheel, recalibrating, and moving carefully and calculated in a values-driven direction. In fact, all humans will and do experience discomfort, including stress, self-doubt, fatigue, and fear. It is our attempts to eliminate discomfort that are doomed to fail at some point. We find that the more you try to get rid of discomfort the more you "got" it (just like trying to "get out" of the Chinese finger trap). We eventually realize that our solutions to eliminate discomfort now become the problem. This can exacerbate our burnout and compassion fatigue. Instead of focusing on selfcare, we incorrectly focus on trying to keep digging and digging within the hole we have found ourselves. Yet, analyzing how we got in the hole or blaming the hole or the shovel does not help at all. We need to stop "struggling" with the stress and take active steps to do something different, something aligned with who and what we care about. This includes steps to care for yourself.

If you did not care you, you would not experience discomfort and there would be no potential struggle. However, there does not have to be a "struggle." There can and is a better way of managing the situation, our thoughts, and emotions.

Self-Compassion

Individuals who practice self-compassion are more likely to endorse increased positive mood, decreased negative mood, lower depression symptom severity, and lower levels of anxiety. Self-compassion may protect against experiencing anxiety in response to significant stressful situations. Overall, increased self-compassion is associated with lower levels of mental health symptoms. Conversely, lower levels of self-compassion were associated with higher levels of psychopathology.

Deciding to make changes in your life requires acceptance that you need to do something different. This includes becoming self-compassionate and self-caring, disentangling yourself from the psychological barriers like "I can't..." We can look to evidence-based practices for guidance.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) is an evidence-based therapeutic approach that emphasizes processes such as psychological flexibility, mindfulness, acceptance, and values in assisting people in overcoming obstacles in their lives. ACT operates under the basic assumption that discomfort, self-doubt, suffering, and fear are a normal and unavoidable part of human experience. An individual's attempts to control or avoid painful experiences eventually lead to long-term suffering. The goal of ACT is not to eliminate certain parts of one's experience of life, but rather to learn how to experience life more fully, without as much struggle, and with vitality and commitment. Further, goals of ACT include reduction of suffering, increase of psychological flexibility, and an increase in one's opportunity to change their behavior and engage in committed action toward their valued goals and outcomes.

Acceptance incorporates the ability to notice and experience all thoughts and feelings as they occur organically, without trying to reduce or eliminate any unpleasant thoughts and feelings, or to replace them with positive alternatives. Values reflect who or what is important and who or what we truly care about. "Values are your heart's deepest desires for how you want to behave as a human being. Values are not about what you want to get or achieve; they are about how you want to behave or act on an ongoing basis" (Harris, 2010). One exercise designed to practice values and committed action is replacing the term "but" with "and;" for example, "I want to stop this behavior and it's very difficult to change what I have always done."

Self-Care

"Taking care of yourself doesn't mean me first, it means me too" (L.R. Knost). In order to practice self-care, there needs to be present moment awareness of stress and fatigue levels, as well as personal accountability that previous efforts have not worked effectively. As you notice that these thoughts and feelings "get in the of moving toward desired values. wav" there exists an opportunity to choose actions consistent with what or who is meaningful. Self-care practices that minimize or protect against compassion fatigue include mindful eating, exercising, connecting with others, maintaining a consistent sleep schedule, planning and committing time for meaningful leisure activities, and increasing vitality.

It is important to create a Self-Care Plan in different areas: physical, social, emotional, workplace / professional, etc. Here are examples with the underlined words serving as those that you would include to personalize each plan:

• Physical Self-Care Plan may include the following: I choose to exercise on the treadmill. I will do this every day (frequency) at 6:00 am (time) for 30 minutes (duration) when I am at home (location).

• Social Self-Care Plan may consist of: I choose to join my friends for breakfast. I will do this the 1st Saturday of each month (frequency) at 9:00 am (time) for 2 hours (duration) at the Diner (location).

• Emotional Self-Care Plan could include: I choose to keep a reflective journal. I will do this every day (frequency) at bedtime after I change into my pajamas before I brush my teeth (time) for 5 minutes (duration) when I am in my bedroom (location).

• Workplace Self-Care Plan could have the following: I choose to consult with my colleague. I will do this every Monday (frequency) at 3:30 pm (time) for 15 minutes (duration) when I am at work (location).

It is critical to scheduled these selfcare events and to commit to them as if were the most important they "appointment" you have scheduled that day. Gary Keller (2018), author of "The ONE Thing: The Surprisingly Simple Truth Behind Extraordinary Results", provides excellent advice when he explains that you need to say "Yes" to scheduled time for yourself and say "No" to other events that could get in the way of your own committed time. Alternatively, saying "Yes" to anything else is equivalent to saying "No" to yourself. If you're experiencing burnout and compassion fatigue, it is likely that you have been saying "Yes" to many things and to others at the cost of your own well-being. You may notice "stinking thinking" that shows up like "I want to work out but I'm so tired." Replace this with "I want to work out even though I feel tired." Additionally, when your thought of "I don't deserve time for myself' shows up, notice how this puts you right back into the hole and into a negative feedback loop. It is important to stick to the plan and notice the "stinking thinking" that is already there.

Many people find that keeping a Thought Diary / Journal is helpful. This may include writing down one's thoughts and feelings about the day. It is important to notice and accept your thoughts and feelings for what they are, rather than question, challenge, or try to change them or minimize them. You might tell yourself, "I'm noticing I'm having the thought that...", or "Thanks mind for telling me." This changes the relationship you have with your thoughts and feelings, allowing you to "lead" your mind where you want to go (toward self-care and self-compassion), instead of allowing your mind to take you where it wants to go.

For those working in the healthcare (mental health and medical) and education fields, it is particularly important when engaging in self-care practices to be aware of potential obstacles that impede your ability to be successful. This includes setting boundaries with others (clients, patients, students, colleagues), maintaining ethical and legal guidelines regarding communication with others, and taking a break when necessary. For those struggling with burnout and compassion fatigue who have difficult turning off the "struggle switch" to engage in better selfcare, it may be helpful to contact a mental health professional. Executive coaching is another effective method of managing stress, in which the coach focuses on increasing an individual's potential and level of awareness. The coach and client work collaboratively in a forward-moving direction to act consistent with the client's values.

Conclusion

Professionals in the healthcare and education fields are at a greater risk for developing burnout and compassion fatigue due to excessive practice of compassion-focused skills. Yet, we are all susceptible to this where and when we care. When one notices negative thoughts and feelings related to their ability to provide care and support to others, there are effective coping strategies to bring them back to the present moment. These strategies include taking a deep breath, identifying values, and determining what, if any, solutions are actually problematic. Through choosing to accept negative thoughts and feelings as a part of life and moving toward identified values with committed actions, individuals create distance between thoughts and feelings and do not allow themselves to be controlled by the narrative they created. This leads to a more fulfilled life. Perhaps the Dalai Lama said it best: "If you want others to be happy, practice compassion. If you want to be happy, practice compassion.'

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Investing from page 10

With continued pressure to demonstrate positive outcomes and cut costs in health and human services, it's increasingly important for providers to be proactive and innovative in providing good clinical, whole-person care. They need to show the value of whole heath and integrated care to the wellbeing of people living with mental illness that also reduces costs to the system. Building community linkages and new partnerships also create sustainable pathways to greater health. Creating multidisciplinary care teams in supported housing, including clinical specialists, nurse care managers, and peers, helps mitigate behavioral and medical risks and increases support at every level. Through this approach, we offer integrated care that is person-centered, trauma-focused and recovery-oriented at ICL supported housing programs and throughout the agency.

ICL has become one of the leading voices in the country advocating for integrating whole health into housing support as a vital tool for recovery. The evidence shows we are succeeding, as measured by our twice a year health surveys of mental health clients, including our housing programs. The numbers support our belief that greater attention to physical health leads to improved overall health. We're consistently seeing that 98% of mental health clients feel they can impact their own health as well as a continual decline in ER and hospital stays for mental and physical health reasons. We are proud that, year after year, people living in ICL supported housing are doing better, feeling better and staying better.

Design from page 25

outdoor space also supports health aims. As examples, both the multipurpose space at CMHA and the cafeteria at behavioral health provider Cornell Scott-Hill Health Center provide access to the outdoors for fresh air and socializing. Just as it is important for members of these communities to know they have support and friendships, they also must have suitable places to nurture those relationships.

Design and Aesthetics

Evidence-based studies suggest that architecture and design can have the power to relax patients, make them more receptive to treatment, and elicit positive behavioral responses. This is especially true of biophilic design, in which approaches and elements reinforce connections to the natural environment. This was a primary focus for the new facility for Yale Child Study Center, where staff and caregivers serve children of varying ages and behavioral needs and their families. Themes, patterns, integrated artwork and wayfinding elements are inspired by nature, including wood-finished spaces and

Leaders from page 15

Human Services: A Blueprint for Partnership and Action, examining the challenges of operationalizing relationships between health and human services providers and offering seven recommendations. She also served on the New York State Department of Health's Social Determinants (SDH) and Community Based Organizations (CBO) Subcommittee helping to formulate recommendations around the integration of CBOs into Medicaid managed care.

Allison has overseen disaster recovery and preparedness efforts on behalf of the nonprofit sector, including coordination with government and was tapped by the Mayor to serve on the Hurricane Sandy Charitable Organizations and Houses of Worship Recovery Task Force and served as its chair. She was also appointed to the OneNYC Commission; responsible for developing a comprehensive plan for a sustainable and resilient city that addresses the profound social, economic, and environmental challenges ahead.

Sesso's past professional experiences include working at a prominent investment bank, at the New York Public Interest Research Group, and as the coordinator of a

a palette of colors and finishes that subtly evoke the natural world. In the waiting room, a ceiling installation of white curvilinear acoustic panels hung below a blue ceiling suggests the sky, while a more overt gesture is a full-height tree sculpture of brown and green wood veneer and laminate wrapping a structural column. Linda C. Mayes, MD, Arnold Gesell Professor of Child Psychiatry, Pediatrics, and Psychology, and chair of the CSC, says it is great to see the excited look on children's faces as they walk through the doors of the new space. "I think it's the respect they feel by the beauty of it. It doesn't feel traditionally medical. It feels welcoming and caring."

Furthermore, these nature-themed and biophilic design elements tend to require less maintenance as facility occupants treat them better. This raises the importance of durable materials and finishes which are valuable for behavioral health settings but need to avoid an institutional sensibility that can contribute to negative patterns. Color and lighting are two valuable tools in this regard: Finish colors should be enlivening and warm, but not dramatic or high in contrast. Natural colors such as blues and greens work well,

program for victims of domestic violence

and sexual abuse. She holds a Master of

Public Administration degree from Baruch/

Allison is the Board Chair of the non-

profit Hollaback!, a global movement to end

harassment powered by a network of grass-

roots activists. Additionally, Allison serves

on Fund the People's Advisory Council, a

national group that aims to encourage in-

vestments in the nonprofit workforce as the

best way to increase performance and im-

services sector has led City & State to rec-

ognize her as number 8 on the Nonprofit

Power 50 in 2018, and as one of the 25 most

influential leaders in Manhattan in 2017 and

New York City's 100 "Most Responsible"

Ian Shaffer, MD, MMM, CPE

VP and Executive Medical Director

Healthfirst - Behavioral Health (Retd.)

Vice President and Executive Medical

Director, Behavioral Health for Health-

first responsible for behavioral health

program management. Prior to this he

Ian Shaffer, MD, MMM, CPE, is

Allison's work on behalf of the human

CUNY's School of Public Affairs.

pact across the social sector.

in 2016.

balanced with wood tones, as employed by CMHA and Ronald McDonald House. Lighting fixtures should avoid institutional solutions in favor of warmer illumination more closely associated with residential design.

Art Integration

Similar to the benefits of biophilia, applied and integrated artwork can elevate the function and feeling of a behavioral health space. Artwork, including sculpture and murals integrated into the overall design, is a powerful way to bring behavioral health facilities a positive distraction, as well as lending warmth and a recognizable identity to the facility.

Providing an added level of thought and consideration, the double-height entry at the Yale Child Study Center presents a colorful, overhead sculptural installation depicting a shimmering school of fish, curated by the art consultant Nancy Samotis, of Art for Healing Environments. The sculpture introduces the facility's biophilic theme and encourages use of the stairs instead of an elevator. For the Ronald McDonald House of Connecticut, a theme of families led to the application

was Vice President Behavioral Health Program Design and Research for Health Net Federal Services responsible for behavioral health program design and research with a specific focus on the military and veteran populations and their families. Previously at Health Net, Inc., Shaffer was MHN's Chief Medical Officer, responsible for setting the company's clinical policies and guidelines and ensuring clinical excellence. Dr. Shaffer oversaw MHN's quality improvement and disease management units and was accountable for the coordination and quality assurance of clinical care.

In addition, Dr. Shaffer has overseen quality and outcomes monitoring for the Military & Family Life Consultant Program services and collaborated with his Health Net Federal Services colleagues to ensure optimal care and service delivery for TRICARE beneficiaries.

Prior to joining MHN in 2003, Dr. Shaffer served as executive vice president and chief medical officer of a national managed behavioral health organization, working closely with several Fortune 100 companies. He three times served as chairman of the Association for of figurative elements to the building exterior, which is visible to occupants and visitors from various areas of the facility.

The pre-design engagement process will often inform the choice of artwork. Working with Continuum of Care's clients, these discussions revealed how the organization helps clients become integrated into their communities. The provider's logo was formerly a house with circles. However, during the engagement process the team heard stories about what Continuum means to its clients. These stories were translated into hand-drawn sketches by Svigals + Partners architect and artist Marissa Mead depicting home and community themes. Ultimately, the design was adopted as the organization's new logo and laser-cut into aluminum panels that were applied to the building's exterior, a welcoming image of domestic comfort and interconnectedness.

Doug Lovegren, AIA, is an Associate Principal and Project Manager with Svigals + Partners, New Haven, Connecticut. Doug joined Svigals + Partners in 1998 as a graduate of The College of Architecture & Urban Studies at Virginia Tech in Blacksburg, Virginia.

Behavioral Health and Wellness (ABHW) (formerly the American Managed Behavioral Healthcare Association - AMBHA), and he has also served on several federal government committees, including a three-year term on the National Advisory Committee for the Center for Mental Health Services arm of SAMHSA. He remains involved in national behavioral health policy issues, including parity and autism.

As the President of Behavioral Health Management Solutions, LLC Dr. Shaffer has provided consultation to a variety of startup and ongoing behavioral health programs that have been redesigning to meet the changing needs of health care delivery and reimbursement.

Dr. Shaffer, a Life Fellow of the American Psychiatric Association, is board-certified in psychiatry and addiction medicine, and has received fellowship training in child psychiatry. He received his medical degree from the University of Manitoba and psychiatry and child psychiatry training at the University of Southern California. Dr. Shaffer, a Certified Physician Executive also holds a Master's degree in Medical Management from Tulane University.

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Aging from page 8

or mobility impairments. If sensory neighborhoods in which supportive housing units are located have a high incidence of community violence, are poorly lit, or without well maintained sidewalks, residents will be less comfortable and less able to safely navigate in and out of their homes as they grow older. Additionally, if supportive housing units are located in areas with increased gentrification, such as in many neighborhoods in New York City and other locations, older adults may find it progressively more difficult to buy basic necessities or feel connected to the community.

But supporting older adults living with mental health needs to age in place in the community goes well beyond ensuring physical safety and accessibility. Successful aging in place requires effective coordination between housing, mental health, medical and home health providers to ensure that chronic and emerging needs are met. It also requires the ability to bring in additional services, such as occupational therapy and in-home nursing that younger populations living in supportive housing might not yet need. If older adults living in standard supportive housing develop an unforeseen medical condition, or acquire a disability resulting from a fall, they may end up prematurely transferring to a higher level of care, which not only costs the service system more, but also takes a tremendous emotional toll on the older adult resident.

To meet the needs of older adults with behavioral health challenges in supportive housing, we need to:

• Ensure individualized in-home support to navigate systems, including securing benefits and entitlements, homecare enrollment, manage transportation and connection to medical and other necessary appointments;

• Fund thereto-fitting of housing units to promote accessibility and more units reserved for and made available to older adults;

• Engagement with social and day treatment programs focused on serving older adults with psychiatric disabilities;

• Ensure payment mechanisms for interventions such as occupational therapy, inhome nursing and in-home behavioral health treatment;

• Advocate during hospital admissions for short term rehab services, appropriate discharge referrals, and care in the least restrictive settings to promote independence, dignity, and aging in place.

Are you wondering what happened to Lucy? The good news is that Lucy is being served by The Bridge, one of the few supportive housing providers whose portfolio includes an Aging Services program, which provides occupational therapy, nursing, social work, case management services and peer support. This program provides ongoing support to Lucy which would otherwise have been impossible, as she didn't qualify for any outside services beyond what The Bridge offers. The occupational therapist ensured Lucy's home had no clear fall risks and provided support to manage her activities of daily living, while helping Lucy remain engaged with stimulating activities that kept her off of her affected leg. The nurse provided medical and medication support to manage Lucy's pressure ulcers and diabetes.

As Lucy struggled emotionally after her fall and subsequent upheaval, she received individual in-home supportive counseling to cope with the transition, while her case manager delved into benefits and entitlements applications to advocate for Lucy to qualify for, and obtain, homecare. Fortunately, The Bridge was able to locate a vacancy and move Lucy temporarily to an accessible unit until the appropriate paperwork could be completed to facilitate a permanent move into a unit with an accessible entrance and elevator on a lower floor. Without The Bridge's varied housing options and individualized support through the Aging Services program, Lucy would have been at risk for severe medical repercussions, such as an amputation, and an unnecessary transition to a higher level of care due to a lack of housing accessibility. Now, Lucy can maintain her independence and continue to age in place in a lower level of care, while saving taxpayer dollars.

Unfortunately, Lucy's ability to remain housed in the community after a fall and subsequent temporary disability is the exception, rather than the rule. There are thousands of Lucys currently living in supportive housing who are one fall or medical complication away from losing their homes in the community. We must do better - we owe it to taxpayers who subsidize more expensive higher levels of care to which older adults are prematurely moved, we owe it to our communities who benefit from diversity and inclusion, and we owe it to older New Yorkers who deserve to age in place with dignity and independence.

Rebecca Heller, LCSW is Director of Aging Services at The Bridge, Inc., and Lisa Furst, LMSW, MPH, is Director of the Geriatric Mental Health Alliance of New York and Assistant Vice President at Vibrant Emotional Health.

Foundation from page 6

interacting with tenants on a regular basis and cultivating strong relationships with them. Case managers are aware first-hand of the progress tenants make and challenges they face, and have the personal, in -depth knowledge to provide the followup support that is needed.

Supportive housing also provides a springboard to community integration. Social connectedness is critical to health, well-being, and recovery, yet many people with mental health and substance use conditions are socially isolated. Acacia's supportive housing units are located in communities or in buildings where a

majority of units are not reserved for people with disabilities, allowing tenants to interact with neighbors who do not have mental health or substance use conditions. Case managers employ strategies to help tenants to make social connections in their communities, such as identifying support networks, facilitating those connections, and providing transportation to visit family or friends. They help tenants find and participate in community activities that are aligned with their interests, and present opportunities to create social connections by arranging recreational activities such as on-site social gatherings or outings to community events.

Today, after almost three years in Acacia's supportive housing program, Ms. Lewis is thriving. She has been sober for six years, is a model to other tenants who have gone through a similar life experience, and is providing her children with a good life and a stable home. Her son is doing well in school and is running track with his high school team. Ms. Lewis is actively developing her parenting skills and the family's bonds by taking advantage of the supportive housing resources. In addition to completing an on-site domestic violence workshop as well as classes on parenting and anger management. Ms. Lewis enrolled in Strengthening Families, an evidenced-based prevention program designed to improve family coping skills and strengthen family bonds. She has been involved in this program for over a year now, rising as a leader and being recognized as a peer specialist. She remains engaged with her supportive housing case manager as she continues to work toward her long-term goals. Through Acacia's supportive housing program Ms. Lewis has found a home, a community, and a promising future.

The author may be reached at (718) 893-6555 Ext. 6530 and by email at lcoleman@basicsinc.org. Information on the Acacia Network can be found at acacianetwork.org.

Homelessness from page 7

(now Developmental Disabilities) to make the final decision whether the site was acceptable or not.

Over time thousands of "beds" in residential programs emerged for people with serious mental illness despite continuing opposition and political pressure, and now about 40 years after the program began, there are nearly 40,000 beds in the mental health housing program in NYS.

Progress? Yes, but not nearly enough to overcome homelessness.

Ironically, homelessness emerged more than a decade after the most aggressive period of deinstitutionalization began and after the initiation of the housing program. Why? Because there was a major push for gentrification in NYC and elsewhere and because many people with Social Security Disability Insurance (SSDI) lost their benefits when the Reagan administration ordered a review of the federal disability program in order to root out cheats.

In NYC alone, over 100,000 units of

very low-income housing were converted to luxury housing thanks to a tax incentive created by Mayor Koch in the late 1970s. Obviously, the community residence program, which was in its start-up doldrums, could not, and did not, keep pace with numbers of people evicted from buildings that became luxury housing.

In addition, nationally, hundreds of thousands of people with severe mental disorders lost their SSDI. In states with inadequate Supplemental Security Income (SSI) programs, people became homeless because they could not afford even lowincome housing. New York was better than most of the rest of the country in this regard, but the loss of SSDI contributed to increased homelessness here, nevertheless.

The policy implications of the history of the emergence of homelessness are obvious.

• First, preventing homelessness among people with severe mental illness requires **more housing** designed for people with long-term, serious mental illness. 40,000

units of mental health housing just are not enough for 225,000 people with serious and persistent mental disorders.*

• Second, preventing homelessness also requires **protection of income supports**—SSDI and SSI. And we should be paying careful attention to the Trump administration proposal to do what the Reagan administration did. Without doubt, requiring people with psychiatric disabilities to go through stringent eligibility reviews will result in many losing coverage.

Of course, it is also important to keep the promise of deinstitutionalization and provide a broad range of clinical and community support services. The failure to do this has had dreadful consequences and contributed to homelessness.

And it may be that adding hospital beds would be of some value. For some people who are homeless or who are living in squalid and dangerous conditions or who are in jails or prisons, the option of being in a hospital might be beneficial—if additional inpatient capacity is not as gruesome as state hospitals were in the mid-20th century.

But the core causes of homelessness historically were loss of housing and of disability benefits. Addressing these must be at the center of efforts to reduce homelessness among people with psychiatric disabilities.

* There are currently about 15 million adults in NYS. Estimates of the prevalence of serious and persistent mental illness range roughly from 1.5% to 2.5%. Using the low end of this range suggests that there are about 225,000 adults with serious and persistent mental illness in NYS today.

Michael B. Friedman, LMSW was an Adjunct Associate Professor at Columbia University School of Social Work until he moved to Baltimore to be closer to his very special grandchildren. He can be reached at mbfriedman@aol.com.

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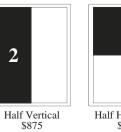
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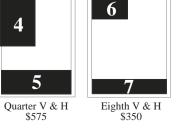
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