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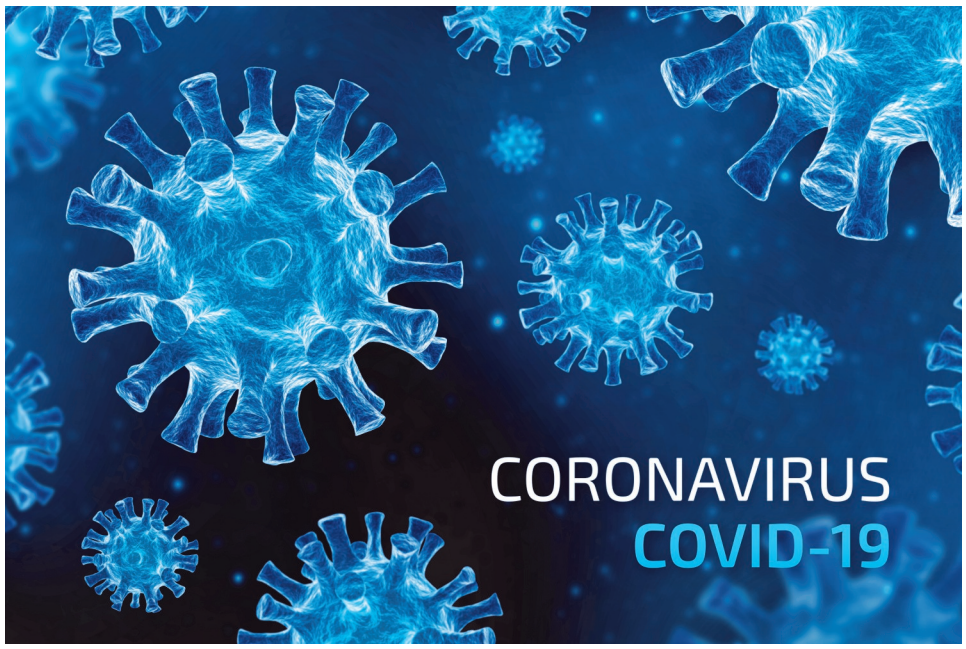
SUMMER 2020 ON MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT AND SERVICES VOL. 8 NO. 1

The Behavioral Health Community's Response to COVID-19

Behavioral Health During and After the Pandemic

By Michael B. Friedman, LMSW
Public Policy Advocate



The response of the behavioral health system to the COVID pandemic has been rapid and remarkable. But it is, of course, imperfect and incomplete. What are the challenges still to be met? And what will happen after the pandemic, hopefully, ends and we move on to a new normal?

What Has Been Done to Address the Psychological Fallout of the Pandemic

Over just a couple of months, governments, charities, local communities, volunteers, and behavioral health providers have stepped up to respond to the widespread psychological fallout of the pandemic. This has included addressing the needs of people with pre-existing behavioral health conditions, who are at risk of exacerbation and relapse as well as the needs of people who develop new mental and/or substance use disorders during the pandemic. It has also included efforts to address the emotional distress that many people, with and without diagnosable disorders, have experienced—fears regarding illness and death, isolation and loneliness, loss of a sense of control, hopelessness, family tensions, grief, and more.

Living through the pandemic has been challenging and emotionally charged for most people, but especially for people who are without adequate income, food, and shelter; for those who are at highest risk of sickness and death; for racial and ethnic minorities; and for the healthcare providers and other essential workers who are on the frontlines of this massive struggle to survive.

Responses to the pandemic that can help to contain the psychological fallout have included:

• Governments and charities have mounted relief efforts that address "social determinants" of mental health, i.e. income, food, shelter.

• Federal and state laws and regulations have been changed to permit and pay for tele-mental health services.

• Providers have used tele-mental health not just for standard therapies but also for **innovative approaches** to psychiatric rehabilitation, support groups, mutual aid meetings for people with substance use disorders, and even for mindfulness exercises.

see During and After on page 35

Behavioral Health News Launches NEW Website: www.BehavioralHealthNews.org

Key Elements for Providers to Address During COVID-19

By Steven A. Estrine, PhD
President and CEO
SAE & Associates

With the urgency in care for vulnerable populations during this current pandemic, SAE & Associates (SAE) understands providers are looking for answers and solutions to continue and possibly grow services to meet the needs of overall population outcome during COVID-19.

It is clear that, as providers of care for vulnerable populations, this is not the time to step back. However, the implementation of services and collaboration with new partners must still be critically aligned to your agency's mission and strengths. SAE's prior experience in emergency management has enabled us to make available a knowledgeable COVID-19 behavioral health response team whose members have developed a series of podcasts (available at http://saeandassociates.com/) that inform an effective response to this virus.

As with all organizational planning and the reshaping of agency operations in times of crisis, there are key components that must be addressed. The following are elements that are forward-leaning to implement services and care during COVID-19. Each element addresses core organizational planning and requires critical clinical and risk management decisions. Communication, structuring, and performing constant reviews of moving parts due to increasing risks and policy changes are necessary.

Providers are urged to consider addressing the following critical issues, which SAE has discussed over the course of the COVID-19 Podcast Series: Going from Reactive to Proactive in Response to the Coronavirus Pandemic.

Leadership — management preparation for service changes to help identify organizational areas of challenges, identify service-specific continuation during the pandemic, identify new collaborations with external partners to increase or offer internal resources, and resolve decisions/protocol for organizational risk mitigation. Develop workflow for decision-making and roles/responsibilities. Identify an emergency management team with leads for: operational security, health and safety, communication, data integrity and breach security, and employee wellness. Develop action plans, goals, and benchmarks for each emergency management team lead. Assist the team to organize and synthesize internal and external responsiveness for change/accountability with a roadmap for team implementation.

Triaging New Services and Business Activities — identify new services and activities responsive to COVID-19 and appoint personnel for leadership with accountability for oversight and management reporting. For example, if new services include teleservices, develop a crosswalk of current to new activities, ensure staffing capability fits with state requirements for the new services, communicate with health plans / payor to ensure fiscal responsibility, and identify quality management indicators for risks to new service implementation. This may include guidance on management reports for quality oversight across operational, administrative, clinical, personal, and revenue elements.

Screening and Protocol Development — adapt current internal clinical services to COVID-19 guidance and state requirements. Identify the protocols for service activity changes (such as teleservices, care coordination of members who are discharged after COVID-19 treatment, and support services like training programs). Identify clinical concerns such as minimizing trauma for those recovering from COVID-19, physical/health requirements and guidance on caring for individuals with reported symptoms, and provide support/wraparound services (such as providing food, medicine, and transportation) for families of those identified with COVID-19. Address clinical vulnerability issues such as elevated suicide risk, increasing depression/anxiety symptoms, and substance abuse issues or access to buprenorphine. Clinical vulnerabilities would also identify the most impacted

see Providers on page 32

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"The Suicide Crisis in America"
Deadline: September 16, 2020

Winter 2021 Issue:
"Social Determinants of Behavioral Health"
Deadline: December 23, 2020

Spring 2021 Issue:
"Trauma Informed Care and Policy"
Deadline: March 18, 2021

Summer 2021 Issue:
"The Behavioral Health Technology Field"
Deadline: June 17, 2021

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Managing Anxiety and Protecting the Vulnerable In the Midst of a Pandemic

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

Who could have predicted last Thanksgiving how fundamentally different our lives would become in the months ahead? The way we work, shop, and socialize have all changed dramatically, as have the ways in which healthcare providers serve our patients.

Even before the full impact of the COVID-19 pandemic was felt, we at the NYS Office of Mental Health knew we would have to take action on several different fronts. Our first priority was to reduce the risk of exposure to the virus for our patients and staff in 23 psychiatric centers across the state. This was especially important because many of our patients struggle with co-occurring disorders, including chronic obstructive pulmonary disease (COPD) and diabetes, putting them at higher risk from the virus.

We also recognized the need to support to our community providers, to ensure they have the resources to reduce risks of exposure and continue to provide treatment and services to their clients.

But as the coronavirus spread, interrupting daily routines and requiring social isolation, we quickly realized that many New Yorkers would experience increased anxiety, depression and stress, and we would need to help them cope with these feelings.

Thanks to the support and leadership of Governor Cuomo, OMH was able to quickly establish the Emotional Support Helpline (1-844-863-9314) to assist New Yorkers who are overwhelmed by the anxiety and loss caused by the COVID-19 crisis.

The emotional toll of a pandemic cannot be overstated. Many of us have lost family, friends and colleagues. Lives are disrupted; schools, businesses and recreational outlets are closed, and many people are facing severe financial difficulties. These losses as well as the need to isolate ourselves from others, can have a significant impact on our emotional state.

OMH implemented the Emotional Support Helpline on March 25, and as of May 6, more than 11,000 New Yorkers had called. Helpline volunteers have been

Ann Sullivan, MD

trained to help people cope with the typical stress reactions brought on by the COVID-19 emergency and can provide tips on managing anxiety, dealing with loss and strengthening coping skills. Helpline volunteers can also provide referrals for services, including mental health services.

The Helpline is accessible to all New Yorkers, including non-English speaking individuals and individuals who are deaf or hard of hearing. It is currently operating from 8AM-10PM, 7 days a week.

Callers to the Helpline come from all walks of life and every region of the State. There is also a dedicated line for healthcare workers. We are there for you and welcome anyone to call!

One caller, an older adult, was depressed she had not been able to attend church services or Bible study. A volunteer found a church conducting Bible study by phone. Another caller, whose husband is a physician, was experiencing intense anxiety because she worried that her husband would be exposed to the virus while doing his job. Although still fearful, she said she felt much better after talking to a volunteer.

One young man, a senior in high school, was upset that he would miss out on the graduation ceremonies and parties, and also worried that he wouldn't be able to work and save money for college over the summer.

And a woman who had been having great difficulty sleeping at night felt much better, learned some ways to help her sleep and was even able to laugh by the end of her call. She thanked the volunteer by saying "this interaction with a stranger really shows the beauty of human connection."

All these people, and many more, received the assistance they needed from a Helpline volunteer. But of course, the Helpline should NOT be used by people experiencing an urgent medical issue, or who are in crisis. In those instances, they should call 911 immediately. Anyone with thoughts of self-injury or suicide are urged to call 800-273-8255 or you text "Got5" to the Crisis Text Line at 741-741.

In addition, OMH has also developed and posted to our website, guidelines on managing anxiety. The guidelines offer advice on practicing self-care, understanding the difference between typical and atypical stress, and staying well-informed while avoiding information overload and unreliable news sources. In addition to general advice for the public, the guidelines also offer specific recommendations for:

• people receiving mental health services,

• mental health providers,

• caregivers of older adults and

• parents, including parents of children with pre-existing anxiety disorders.

Perhaps the most important message to caregivers, healthcare workers and parents who are trying to navigate these stressful times, it is critically important that you take the time to monitor and manage your own anxiety levels. Please visit the OMH website to learn how you can safeguard your mental health, just as you're taking steps to protect your physical health.

Protecting our Patients, Staff and Partners

As mentioned earlier, our first priority in addressing the COVID-19 crisis was to reduce the risk of exposure in our facilities. To do so we implemented numerous measures, including enhanced screening for all admissions, recommended cleaning and disinfection standards, and limiting routine interactions between staff and patients to those that could be carried out while maintaining social distancing.

We also made the decision to restrict visitors to adults in our psychiatric centers and limit visits to children's facilities to only those that are essential to the care and wellbeing of the patient. This was a difficult decision to reach because I know the important role social interaction plays in the recovery process. To compensate, we tried to utilize technology as much as possible to provide "remote visitation."

To support our community providers, we waived certain regulations governing telehealth services, streamlining the approval process to quickly allow more healthcare providers to utilize the practice for the duration of the of the COVID-19 emergency. This will help ensure their patients will receive the care they need while they are quarantined or isolating themselves to prevent the spread of the virus.

We also increased flexibility on State aid, allowing our local partners to pay for unplanned and unbudgeted costs related to the COVID-19 virus, including overtime costs and other personnel costs, increased infection control costs and the costs of setting up telehealth systems for their practitioners. The regulatory changes also include extending deadlines on certain financial reporting requirements.

A full list of the program guidance we provided to our community partners can be found on our COVID-19 Resource Page.

Certainly, the COVID-19 pandemic is a disaster that has challenged us like no other catastrophic event. Yet, as Governor Cuomo has said, the knowledge we have gained through this crisis gives us the opportunity to come back "stronger and better" with improvements in healthcare, emergency preparedness, effective use of technology and an even stronger sense of community. For now, though, lets all focus on staying safe and preventing the spread of the virus. Wear a mask whenever necessary, wash your hands often, stay home as much as you can and definitely if you feel sick.

Be safe and well!!

Behavioral Health News and Autism Spectrum News: Supporting the Community During the COVID-19 Crisis

By Ira Minot, LMSW
Founder and Executive Director
Mental Health News Education, Inc.,
Publisher, Behavioral Health News

The current pandemic shows us how difficult social distancing and sheltering in place have been for the general public. It has been especially hard for people with mental illness, substance use disorders, and people on the autism spectrum.

During my own 10-year battle with depression I experienced isolation, social distancing and stigma first-hand. These of course were some of the difficult side-effects of my illness. Now that we are all living with the COVID-19 crisis, my experience provides a unique perspective and understanding of the many issues affecting the behavioral health and autism communities and the organizations that care for and provide services to them.

Following my recovery, I founded Mental Health News, the precursor of what is now Behavioral Health News (BHN). One of the main reasons that drove me to start the publication was that, outside of the few hours a day I spent in out-patient programs, no one was reaching out to me where I lived.

I could have greatly benefited by having a resource like BHN to help alleviate the isolation I experienced in my lonely supported housing apartment. It would have also been helpful to stay informed on the latest mental health information and have access to a roadmap to the many programs, services and organizations in the community that could have helped me during my recovery; programs such as local drop-in centers and support meetings that were being held by organizations such as NAMI, MHA, NYAPRS, and ACCES-VR (formerly known as VESID - New York's employment program for people with disabilities).

Ira Minot, LMSW

MHNE Launches Two New Websites

Mental Health News Education, Inc. (MHNE), the nonprofit organization that publishes Behavioral Health News and Autism Spectrum News (ASN), has recently launched two new websites! They are in a totally new format in which articles and advertising are now presented as their own shareable posts. Also, now everything is searchable by title, subject matter and author, going back in time to the first issues of each publication. Now, articles can be easily shared between families and colleagues who will greatly benefit by our award-winning platform of ideas, resources and information.

In addition, each new website has social media integrated for an easy sharing experience to give more visibility to the content. We've seen a dramatic increase in traffic at BehavioralHealthNews.org and AutismSpectrumNews.org is now averaging 350 views per day; 11,000 per month; 132,000 per year!

Content That Speaks to the Issues

Through our quarterly print publications, two brand new websites and our social media channels, we are now reaching over 200,000 individuals each year, serving as a beacon of hope for individuals living with autism, mental health issues, and substance use disorders and their families. In just the last year, both BHN and ASN have addressed topics that speak to issues that are compelling and affect the communities that we serve. Here is a snapshot of last year's issues:

BHN Spring 2020 Issue
"Housing: An Essential Element of Recovery"

BHN Winter 2020 Issue
"Addressing the Nation's Opioid Epidemic"

BHN Fall 2019 Issue
"Examining Models of Integrated Care"

BHN Summer 2019 Issue
"The Behavioral Health Workforce"

ASN Spring 2020 Issue
"Supporting Girls and Women with Autism"

ASN Winter 2020 Issue
"Autism and Neurodiversity"

ASN Fall 2019 Issue
"Autism and Community Engagement"

ASN Summer 2019 Issue
"Supporting Older Adults with Autism"

Your Trusted Source

For over 20 years, Behavioral Health News has dedicated itself to being "Your trusted source of information, education, advocacy and resources on mental health and substance use disorder treatment and services." It has been our masthead slogan over these many years, and this issue accomplishes our mission by devoting the theme entirely to "The Behavioral Health Community's Response to COVID-19."

The Current COVID-19 Crisis: The New Normal for Our Community

Consumers, families and the organizations that provide services to them are going through monumental hardships and challenges during the current crisis. In the aftermath of the crisis, many organizations will have had to readapt to the changing times in terms of delivering services and the financial hardships they have suddenly encountered. The dust hasn't yet settled but many organizations that have suffered financial hardship during the crisis may have had to furlough or restructure staff and rethink the many services they can and perhaps can't provide. This new normal will result in a dire need for small organizations to fundraise in creative ways so that they don't have to shut their doors.

Behavioral Health News Future in Jeopardy

MHNE is a very small organization run by only two people: myself and my son David Minot - my Associate Director and Publisher of Autism Spectrum News. Many people think we have a large staff, but we haven't been able to hire support staff due to our small budget. The organizations we partner with are going through their own financial hardships during the COVID-19 crisis, and we've had to cancel our annual Leadership Award Reception fundraising event, we are in a very difficult financial situation.

We will be launching an emergency COVID-19 Appeal for funding on June 30th, the day when our event would have taken place. Our goal is to raise $40,000, and we invite you to please give as generously as you can to demonstrate your commitment and help sustain our award-winning publications.

Thank you so much for your compassion and generosity. We stand together and we will get through this as a community.

Mental Health News Education, Inc. Emergency Appeal to Supporters of Behavioral Health News and Autism Spectrum News

Please Help Us Through the COVID-19 Crisis
Which Has Caused Severe Financial Hardship to Our Organization

Your Support Will Help Us to Continue Our Vital Mission

I Want to Help Now

Helping Vulnerable Populations During COVID-19: Challenges of Mitigation in Congregate Residential Settings

By Jeanie Tse, MD,
Chief Medical Officer, and
Cynthia Summers, DrPH, MPH,
Chief Strategic Initiatives Officer,
Institute for Community Living

In New York City, tens of thousands of people with serious mental illness or developmental disabilities live in congregate housing or homeless shelters. For behavioral health agencies like the Institute for Community Living (ICL), the COVID-19 pandemic has presented an urgent challenge: With over 1,500 people living in congregate settings, the protection of residents was our paramount concern. We knew that would be extremely difficult for a number of reasons, the first and most important of which is the level of vulnerability of the populations living in our residential programs.

Residents in these facilities are among the very highest risk populations. To start with, people with schizophrenia and other serious mental illnesses have a life expectancy that is 25 years shorter than the general population because of higher rates of co-morbid medical conditions including obesity, type 2 diabetes, hypertension, dyslipidemia and nicotine dependence. People with intellectual and developmental disabilities also experience significantly greater morbidity and earlier mortality.

The significant vulnerabilities of people living with serious mental illness are further compounded by the physical and emotional impact of trauma so many have experienced. In addition, many of these individuals and their families have been affected by what are collectively referred to as social determinants of health, the results of living in poverty with a lack of adequate housing, education and nutrition, often amidst community and family violence, racism and discrimination. In New York City, people in congregate housing settings are disproportionately male, black, older, obese, hypertensive and smokers. All of these characteristics have been associated with COVID-19 morbidity and mortality. So in a tragic sense, housing for these populations offered the perfect storm for the spread of this deadly virus.

This pandemic imposed unprecedented challenges to all of ICL's housing programs, whose first priority instantaneously became keeping people healthy. And for those who became ill, we had to quickly develop protocols to care for them without compromising the rest of the community, clients and staff alike. An added danger for shelters is the fact that

Jeanie Tse, MD

Cynthia Summers, DrPH, MPH

their clients are very transient with new residents entering on a daily basis. We knew the people in our care would be among the hardest hit by the spread and virulence of COVID-19.

Strategies and Tactics Implemented

So how did we take charge of a situation that was escalating steadily in danger and complexity?

Early on, ICL set up an emergency response and strategy team that meets 7 days per week. Their charge was to monitor the pandemic, mitigate risk to clients and staff, plan for potential scenarios and situations, and ensure rapid dissemination of information, protocols and regulation changes. The following measures were taken:

• Increased facilities cleaning and availability of hand sanitizer

• Restricted visitors from residences

• Set up screening and isolation procedures for fever and cough

• Contactless temperature screening for residences for people with intellectual and developmental disabilities

• Tracking of reported symptoms and exposures, followed by contact tracing

• Collaboration with Department of Homeless Services to isolate shelter residents in hotels

• Enabled and mandated telecommuting for as many staff as possible across the agency

• Delivered outpatient services via telehealth

• Distributed donated masks to residences and shelters with highest number of cases and greatest crowding (unable to purchase masks in the first month of the crisis)

• Focused efforts on ensuring adequate staffing at programs with high prevalence of sick or exposed staff

Data Collection to Guide Present and Future

We knew that information gathering would be very important for our future planning and to share with the field, so we began a data collection effort to understand the impact of COVID-19 on different populations and how staff and clients were being impacted by changes in practice (e.g., the shift to telehealth and telecommuting).

We have already learned a number of important lessons about people living and working in behavioral health housing and treatment programs. A high incidence of infection was found, with the highest infection rate among people with intellectual and developmental disabilities; these clients had the greatest direct contact with staff and significant challenges with physical distancing and isolation. On the other hand, the tendency of people with serious mental illnesses to self-isolate may be protective in the setting of a pandemic. For this population, behavioral health workers visiting them in their homes may paradoxically present a risk of viral transmission. In this way, isolation to avoid infection runs counter to ICL's usual work in helping people engage with the community, and we will need to redouble these efforts once the pandemic passes.

On the other hand, perhaps telehealth is one solution to chronic social isolation. Our early data show that we are speaking with our clients more than ever before. Some clients who have had difficulty attending appointments due to chronic pain or disabling depression are now able to meet regularly on the phone. We are learning more about best practices around telehealth, but one thing appears certain: there will be a number of clients who will not want to return solely to face-to-face visits in the future.

We know that people with mental illness and developmental disabilities suffer extraordinary health disparities. Strategies to prevent an outbreak in these underserved populations are needed. Housing and homeless policies and practices, constrained as they are by the population density in New York City, need to consider the risk of contagion in group settings, with long-term implementation of personal protective equipment and physical distancing measures. Prioritizing widespread testing will expand the ability to control infections. Integrating primary care with behavioral health care will support the ability of behavioral health agencies to provide this testing and treat disease. Finally, creating more affordable/supported apartment housing will reduce the need for congregate housing, while supporting quality of life.

Where Do We Go from Here?

The primary focus of our agency continues to be keeping our current residents and staff healthy and getting those who are ill the medical attention they require. At the same time, we are actively planning for the next phase of ICL operations as the city slowly recovers and reopens. We look forward to working with our partners in the community as well as the government entities involved in the care of the people we serve. We must work collaboratively and creatively to come up with the changes and practices to continue fighting this virus and to be prepared for future challenges that can, as COVID-19 did, shake our institutions to the core.

Together we can come up with longer term solutions that ensure outstanding care that takes into account the critical factors that lead to better health and recovery. This in turn will enable us to continue to break through the generations-long stronghold on our community's health, particularly for people with the greatest health and behavioral health challenges.

COVID-19 changed all of our worlds in a matter of days.

Thanks to an extraordinarily committed and talented staff, all ICL programs remained open and our support of clients and families never wavered.

We continue to work side by side with our partners and supporters because the future of our city and its most vulnerable people are at stake.

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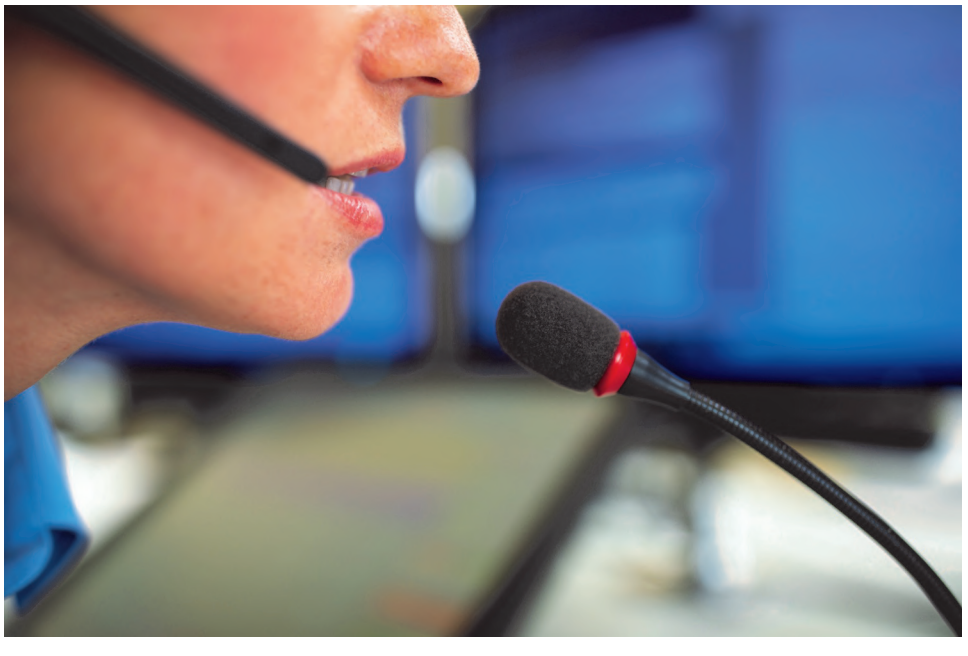
ICL

The image above shows part of a quilt created by women at ICL's Two Bridges Shelter. The project came to symbolize social distancing because though they could not work close to each other, each of the squares would be brought together just as the women eventually would be.

To learn more, visit www.iclinc.org

Anticipating Emotional Reactions During the Covid-19 Pandemic: What We Can Learn from Past Disasters

By Christian Burgess, MSW, Director, Disaster Distress Helpline, Vibrant Emotional Health



The national Disaster Distress Helpline (DDH) was launched by Vibrant Emotional Health and the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) in 2012 to guarantee that everyone in the United States has access to immediate crisis counseling and support throughout any phase of a natural or human-caused disaster, including public health crises. Calls (1-800-985-5990) and texts (text TalkWithUs to 66746) are answered 24/7/365 by trained counselors from a network of independently-operated crisis centers located across the country who explore coping and available social supports, offer referrals to local resources for follow-up care, and who, most importantly, listen.

It's through that listening that Vibrant and our network of crisis centers have learned from past disasters what emotional reactions we can anticipate in the weeks and months ahead as the Covid-19 pandemic continues to affect individuals, families, and communities across the U.S. From the tens of thousands of conversations our counselors have had over the past eight years, we know that many people will continue to be at risk for distress and other mental health concerns, while at the same time engaging in acts of heroism and adapting to aspects of life that may become a "new normal."

These patterns correspond with physical, cognitive, emotional, behavioral, and spiritual reactions commonly experienced throughout the "phases" of any disaster, as cited by Raphael (1986 When disaster strikes: How individuals and communities cope with catastrophe. New York: Basic Books.), DeWolfe (2000 Training manual for mental health and human service workers in major disasters (2nd ed., HHS Publication No. ADM 90-538). Rockville, MD: U.S. Department of Health and Human Services, Substance), Halpern and Tramontin (2007 Disaster mental health theory and practice. Belmont, CA: Brooks/Cole CENGAGE Learning), Miller (2012 Psychosocial capacity building in response to disasters. New York: Columbia University Press) and other experts in disaster behavioral health.

These phases are: *Pre-Impact or Pre-Disaster; Impact; Heroic and Honeymoon; Disillusionment; and Reconstruction.*

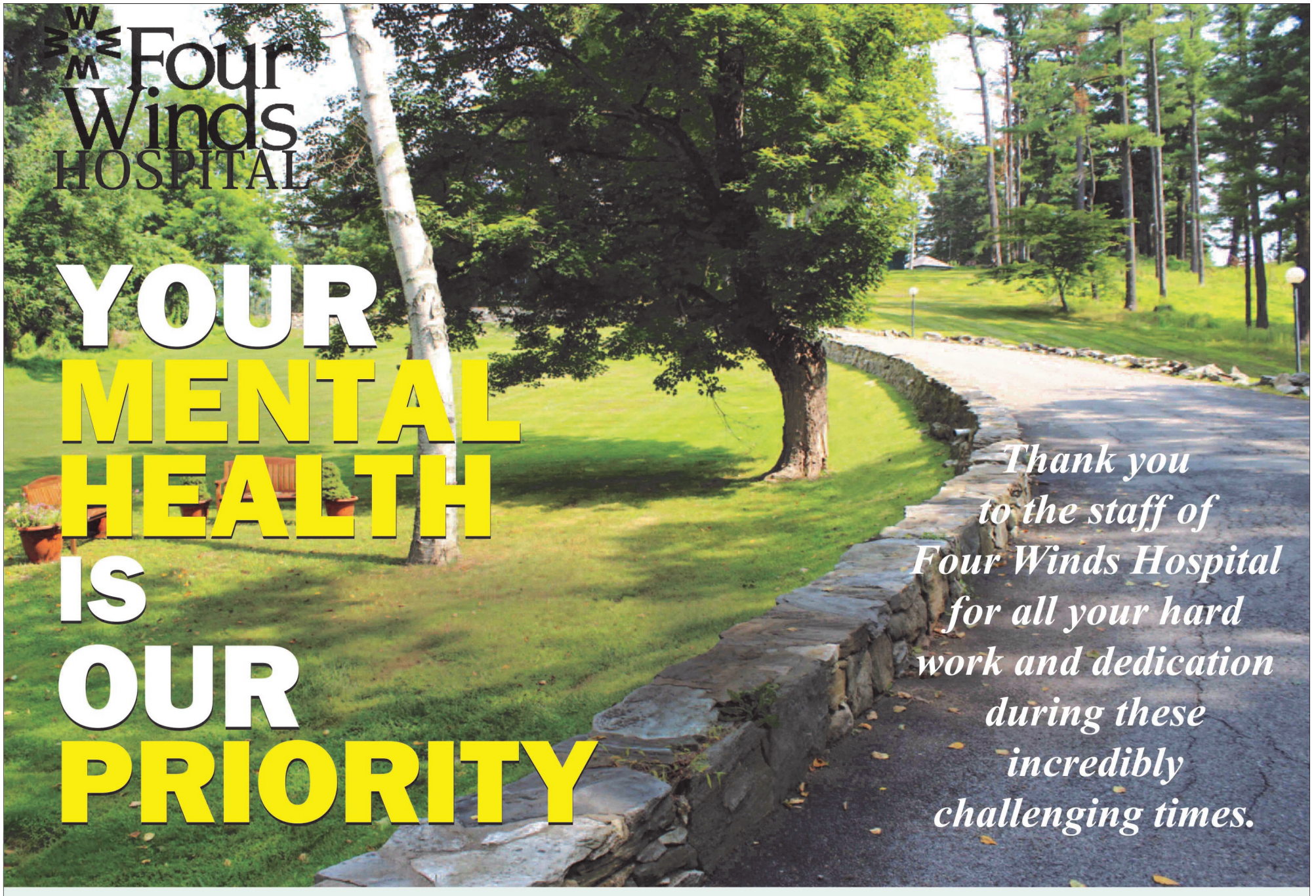
The phases of disaster aren't linear-they are marked by ups and downs, and some people may even find themselves taking "two steps forward, two back" at times. The phases also don't occur on an exact timeline -- people move forward on the path of recovery according to their own personal experiences with a disaster event.

Pre-Impact

The pre-impact or pre-disaster phase can last for days, such as when severe weather is forecasted, or mere minutes, such as when an active shooter is identified in the area. Calls and texts to the DDH during pre-impact commonly involve intense feelings of fear or anxiety of the "unknown."

As the first reports of the novel Coronavirus Disease 2019 ("Covid-19") began to emerge in China in December 2019 through to the first reported case in Washington in late February, DDH crisis centers reported no noticeable increase in related calls or texts. However, by early March, callers and

see Emotional Reactions on page 26



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Suicide Prevention Intervention and Postvention in the Time of COVID-19

By Max Banilivy, PhD
Director of Clinical Training,
Education and Field Placement
WellLife

Socioemotional challenges and crises are felt across the full spectrum of the population, not sparing any ethnic, racial, nationality, or age group. The personal and interpersonal consequences have been far-reaching in this current environment for both those with prior vulnerabilities and emotional challenges, as well as those with no prior noticeable or significant psychological hardship. It appears that everyone is affected to different degrees. Life as we knew it has been put on hold and is hostage to *A VIRUS, an entity that is one micron thick*. Everyone has made sacrifices and adjustments trying to cope, perhaps looking forward to a *NEW NORMAL* eventually emerging. These are unprecedented times for us all, and the uncertainty can be overwhelming.

Increased anxiety, despair, profound losses, isolation, loneliness, and overall much more stress and sense of uncertainty about the future are among the many factors having compromised our individual and collective sense of safety. These unusual global pressures have significantly contributed to the need for socioemotional support for millions of individuals and families with a notable increase in calls to hotlines and profound increases in uses of psychotropic medications, family discord, including domestic violence, economic constraints, the potential for substance abuse and many other unhealthy and self-destructive behaviors. Fear, stress, and uncertainty beg for all to try to establish a new sense of safety and balance and equilibrium.

It is difficult always to predict who gets more challenged with despair, depression, anxiety, and hopelessness/helplessness. Uncertainty and constant fear and worries wear down many defenses and coping skills. We need to be particularly concerned and vigilant about the plight/adjustment of those emotionally vulnerable needing more support and those with a history of suicidal thinking or attempts. Anyone may be at risk of suicidal thinking, given the gravity of the impact of COVID-19 on everyone's life and sense of safety and profound changes in terms of *life* as we knew it.

Max Banilivy, PhD

Given the known vulnerable groups and the unexpected increased risk in the general population, every individual and organization needs to be sensitive and prepared to attend to the needs of the adults and youth in this regard. Tragically, the number of people who have killed themselves or attempted suicide had already been increasing in society before the current global crisis. Already existing economic and other challenges resulting in increased hopelessness that is now further compounded coupled with the many losses of lives due to COVID-19 may contribute to an even more significant number.

What Can We Do to Prevent Suicide?

We know that the thoughts of suicide are not unusual and may cross many people's minds in harder times. Suicide is one of the more preventable causes of death. Although all suicides cannot be prevented, most can, as most people who may think about it, have some part of them that has not given up on life/living. In order for almost everyone in society to be able to be a helper, we need to continue to address stigma, biases, and myths associated with mental illness and suicide.

Education is essential. Almost everyone thinking about suicide is looking to be approached and open a discussion as to why they contemplate thoughts of suicide. Anyone can think about suicide. Many individuals work themselves out of it, and others take further steps. Individuals preoccupied with thoughts of suicide must know that they can share their thoughts and talk about it. Above all, they must be aware there are caring individuals in the community or their personal, social, and workplace who will listen. Necessary helping steps are simple, and anyone can learn them.

What Are Young and Old Looking for From Us?

Here are some basic concepts related to the three areas of *prevention*, *intervention*, and *postvention* for all individuals and organizations to keep in mind.

Prevention: Open lines of communication and messages about suicide. These messages need to convey that help is available. Messages should also communicate accessible resources and that many helpers are ready, willing, and able to discuss their concerns in a non-stigmatizing manner.

Intervention: The community of providers and laypeople do not need to be behavioral health professionals to learn intervention skills. Learning how to talk with someone with suicidal thoughts is a communication skill that is readily available and can be learned by anyone, including youth. Intervention skills are available through trainings and education. Any individual and members of any organization can learn to provide access, support, and create a suicide-safer working environment. This "first effort crisis assistance" helps individuals with suicidal ideations to keep themselves safe for now until other help can be engaged, if necessary. This is learned through suicide first aid skills

Postvention: Similarly, any community agency/organization must be prepared to address and know what needs to be done after a tragic loss due to suicide. Two basic concepts to take into account in order to be sensitive to the needs of the community. One is to assist with grieving and healing. We have to know and learn about all who may have been affected. The second is to always engage in safe messaging and providing factual information and education – knowing that many at-risk are listening and watching how others talk about and think of the person killing himself/herself and their action. It is important to emphasize that help is available, and many crises do pass. **How we handle a tragic loss to suicide has an impact on the future.**

Postvention is Prevention

Setting the foundation to develop a caring and suicide safer environment is everyone's concern. There are best practices education and training readily available to all members of the community, regardless of age and background.

A significant percentage of youth and adults think about suicide due to stress, hardship, or personal challenges. It is important to note that the vast majority of individuals at risk for suicide do not kill themselves. Having members of the community that are available with necessary skills goes a long way to SAVE LIVES. Today we need to be even more sensitive and ready.

Let us all work together to reduce stigma against mental illness and those thinking about suicide in particular. Please contact WellLife Network – Dr. Max Banilivy at Max.Banilivy@WellLifeNetwork.org to discuss training and resources. Let us focus on how you can work toward creating a safe and more receptive workplace for those with the thought of suicide and how to be more comfortable approaching others about their thoughts. This is a critical area we cannot lose sight of and we must acknowledge and utilize resources available to help ourselves, our loved ones and anyone else including our staff we are worried about.

"If You are concerned about someone, ask them if they have thoughts of suicide. You will be surprised how many say Yes and will be grateful that you asked."

The following numbers and websites among others to national and local crisis hotlines and resources should be readily visible and available to everyone:

1-800 273- TALK

Long Island Crisis Center:
516-679-1111

Response CrisisCenter.org:
631-751-7500

Preventsuicideny.org

Preventsuicideli.org

American Foundation for Suicide Prevention

Suicide Prevention Resource Center

New York City Mental Health Hotline:
1-888-NYC-WELL (1-888-692-9355)

Remote Access to Mental Health Care and Treatment During the COVID-19 Crisis

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

New York State has unfortunately become an epicenter of the COVID-19 public health emergency, with more confirmed positive cases than any other State in the nation. During the COVID-19 crisis, the use of telehealth and telemedicine has become an essential tool in ensuring continued access to mental health care and treatment for impacted individuals. Both the federal government and the State of New York have taken significant efforts to ensure that individuals in need continue to receive essential health care and treatment through telehealth when in-person visits cannot take place. On March 12, 2020, New York Governor Andrew Cuomo issued Executive Order No. 202.1 relaxing state requirements for the provision of telehealth in connection with the State disaster emergency, as follows:

Section 2999-cc of the Public Health Law and any regulatory provisions promulgated thereunder by the Department of Health, the Office of Mental Health, the Office of Addiction Services and Supports, and the Office for People with Developmental Disabilities, to the extent necessary to allow additional telehealth provider categories and modalities, to permit other types of practitioners to deliver services within their scopes of practice and to authorize the use of certain technologies for the delivery of health care services to established patients, pursuant to such limitations as the commissioners of such agencies may determine appropriate.

The next day, on March 13, 2020, President Donald Trump declared a national emergency and confirmed that United States Health and Human Services Secretary Alex Azar had been granted the

Rachel A. Fernbach, Esq.

authority to waive existing laws to enable the provision of telehealth services across the country. In subsequent days, the federal Centers for Medicare and Medicaid Services (CMS) and the New York Department of Health confirmed flexibility in the use of telehealth services to address challenges created by the public health emergency. Among other changes, this temporary flexibility allowed for the provision of telehealth in the private home of a Medicare or Medicaid beneficiary, not previously permitted under federal rules.

Coverage for Telemedicine

In general, telehealth and telemedicine services are billed using the same CPT® codes customarily used for all other in-person services. For example, a 45-minute psychotherapy session in an office setting may be billed using an evaluation and management code (often, 99212 or 99213) and an add-on psychotherapy code (90836). A 45-minute psychotherapy session provided via telemedicine is billed using the very same CPT® codes. In addition, CMS recently clarified that providers should continue to use Place of Service Code 11 (Office), along with a modifier, usually 95 or GT, depending on the carrier, to indicate the provision of telemedicine to a patient in his or her own residence. These billing instructions apply generally in the context of Medicare, Medicaid, commercial carriers and private pay patients. For Medicaid managed care plans or commercial plans, please contact the carrier to confirm any specific billing requirements in place.

New York Statute Telehealth Delivery of Services

Several years ago, New York State enacted legislation requiring health insurers to provide coverage and reimbursement for services provided via telehealth where the service is otherwise covered under a health insurance policy. However, the New York statute applies only to plans that are subject to insurance mandates under state law – typically, an individual or group health plan purchased by means of monthly insurance premiums. Pursuant to federal ERISA law, large multi-state employers, union health plans and self-insured businesses are not subject to the requirements of state law. Therefore, a self-insured plan or union health plan is not mandated to provide coverage for telehealth under New York law. In order to determine whether a plan is subject to the New York telehealth statute, the provider or patient must make efforts to determine the type and nature of the patient's plan and whether it is ERISA-exempt or subject to the requirements of state law – including the state telehealth statute.

HIPAA

The U.S. Department for Health and Human Services (HHS) Office for Civil Rights has indicated that, during the public health emergency, it will exercise enforcement discretion and will not impose penalties for the good faith use of telehealth communication services that are non-HIPAA compliant. This special accommodation will permit providers to use certain non-public facing remote communications products, such as FaceTime, Zoom, or Skype, in order to enhance access to services during the crisis. These more permissive rules apply to telehealth services provided for any reason, "regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19." Please keep in mind that the current enforcement discretion applies only to HIPAA security requirements in connection with the use of telehealth services and does not impact other HIPAA privacy and confidentiality requirements currently in place.

Prior Relationship Requirement

Certain federal rules regarding telemedicine require that a patient have a prior established relationship with the practitioner in order to participate in telemedicine. CMS has indicated that it will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

Virtual Check-In Services

In the event a patient is unable or declines to participate in telemedicine, another potential option is a Virtual Check-In, which has been made available by CMS and is approved for payment when provided to Medicare beneficiaries. Using this service, Medicare patients located in their homes may have a brief communication with their provider using telephone or other means of audio/video communication. A Virtual Check-In does not require the same audio and visual capabilities for real-time communication that are required for telemedicine.

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Caring for Older Adults and People with Mental Illness During the Pandemic

By Beverly and Barry

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

Services for the UnderServed (S:US) supports thousands of vulnerable New Yorkers, serving people with disabilities, people in poverty, veterans, people struggling with addiction and mental illness, and people facing homelessness. These are the people who are especially vulnerable to the COVID-19 pandemic and S:US remains committed to their safety and wellbeing. Additionally, communities of color are getting infected at disproportionately high rates.

Two individuals, who are both African-American, were ill with COVID-19 recently. Here are their stories.

Beverly's Story

I am a 57-year-old African-American woman. I live with my husband in Brooklyn and have received support from S:US for six years. One of S:US' care coordinators has been calling to check on me every week during the pandemic. I like my care coordinator—she is very nice and helps me with whatever I need, like filling my prescriptions. I have chronic obstructive pulmonary disease (COPD), an inflammatory lung disease.

Last month, I got very sick for about 11 days. My husband took care of me for as long as he could, but it got to a point where we decided I should go to the hospital. My daughter was scared that if I went to the hospital, I might not make it back home. But I decided I needed to go.

Going to the hospital was a scary experience: At the hospital, the medical team first told me that I had pneumonia, but then they tested me and confirmed that I had COVID-19. My COPD diagnosis (lung disease) made it worse for me because it was hard to breathe and my oxygen level was very low.

It was scary, in the beginning. When you're in the hospital, all by yourself, you can't see any of your family members. You're there for days without seeing anyone other than the doctors and nurses, and you don't know what's going to happen. They took good care of me, but it's something I wouldn't want to go through again.

Beverly's recovery is ongoing: The medical team gave me plenty of oxygen. Eventually my levels improved and I was able to go home. During my hospital stay and afterward, the S:US care coordinator called regularly to check on me. That made me feel good; it's nice to know somebody cares (other than my family). Because of the pandemic, no one can visit me.

I am still not completely recovered. I have shortness of breath and get lightheaded. I haven't been out anywhere. I'm basically all right as long as I'm resting… just taking it easy. Sometimes it feels like I'm doing too much—walking from one side of the house to the other, I feel like I'm losing oxygen. I have a walker and cane, in case I need them.

I have good days and bad days. Some days I get these crazy feelings, like shortness of breath and butterflies in my stomach. I can't wait to get back to my normal self.

Barry's Story

I am a 55-year-old African-American man. I live in a supported housing in the Bronx and I receive services from S:US. I have experienced homelessness, I have mental illness, and I am recovering from drug addiction.

Around March 30, I was very ill with a fever, nausea, and diarrhea. I thought maybe I had food poisoning until my primary care physician told me that those were symptoms of COVID-19. My doctor had two weeks of medicine delivered to my home and placed me on voluntary quarantine.

The first 15 days were a nightmare. S:US really helped a lot—they checked on me every few hours, made sure that I had food in the house and ate something, and that I was taking my medication.

Quarantine exacerbates mental

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Ensuring Best Outcomes for Children with Behavioral Needs and Adults with Medical Fragility in a Congregate Care Setting Amidst the COVID-19 Pandemic

By Rita M. Gardner, MPH, LABA, BCBA, President and CEO, Melmark, Helena Maguire, MS, LABA, BCBA, Executive Director, Melmark New England, Shawn P. Quigley, PhD, BCBA, Executive Director, Melmark Pennsylvania, and Mary Jane Weiss, PhD, BCBA-D, Senior Director of Research, Melmark

Rita M. Gardner, MPH

Helena Maguire, MS

Shawn P. Quigley, PhD

Mary Jane Weiss, PhD

COVID-19 abruptly thrust new challenges onto organizations providing intensive behavioral services in a congregate care setting to individuals diagnosed with intellectual and developmental disabilities. The novel virus and its many unknowns required organizations to respond to a rapidly evolving landscape, with employees at every level, from leadership to direct care staff, developing and carrying out a radically transformed service model in real time. All of these changes came while organizations maintained a hypervigilant focus on their overall mission. It's a scenario we will continue to see until a vaccine or scientifically therapeutic treatment is discovered.

Throughout the current pandemic, leadership teams at organizations like Melmark, which serves children and adults with intellectual and developmental disabilities, often accompanied by medical fragility, have developed new ways to meet the needs of a diverse population. The unique aspects of COVID-19 are unprecedented and have made it an elusive foe to combat. These characteristics include the ease of transmission, the relationship between social and physical contact and illness, and the large number of asymptomatic carriers. The virus has led to an increasingly complex set of challenges, which have required both creative and methodical approaches.

Assets Melmark already had in place included strong capabilities in complex care and extensive behavioral skills training systems for staff. These organizational capabilities made it easier to meet the demand for the new skills in public health interventions required in the pandemic.

Particular Vulnerability

A large number of those served by providers like Melmark, especially in the residential setting, are particularly vulnerable, due to underlying conditions that make them more likely to experience serious illness or death as a result of COVID-19. Whether due to medical fragility, a lack of mobility, or the inability to verbalize symptoms, children and adults with developmental disabilities in a congregate care setting require a particularly acute hyper-vigilant approach to mitigating viral spread while balancing their extensive day-to-day care needs.

Many of the individuals requiring this hyper-vigilance of care amidst COVID-19 include adults who are aging. Most have lived the majority of their lives in their current residential setting, and disruption to their routine and in the familiarity of their surroundings could be detrimental to their physical and mental wellbeing. Furthermore, many need specialized nursing care round the clock on a typical day.

The second group of individuals at highest risk are those who are not able to easily be served elsewhere due to severe challenging behaviors secondary to a diagnosis of autism or intellectual/developmental disability. Many of these children and adults may pose risk to him or herself and to others in their environments and are unable to socially distance or maintain wearing a mask. Methodical and systematic assessment is necessary to develop an individualized and tailored behavior intervention plan to address their challenges. Such plans require expert, trained staff, rich ratios of staff to clients, and the ability to implement the plans with fidelity and consistency. While some providers have the option of providing services through telehealth, meaning the individuals they serve could return to their family homes to ride out the pandemic, this is impossible for other organizations. Some of the residents have behavioral challenges too severe to be home due to risk of injury to younger siblings or even parents. Others have aging parents who require their own care, while some have no family to whom they can go home. Indeed, for many clients, the only location in which ongoing treatment is possible is in a congregate care residential setting, necessitating a quasi-medical model for prolonged viral management and mitigation.

Staff and Client Health

COVID-19 has also threatened the well-being of those employed and served by providers. COVID-19 is unusual in that there is significant community spread, and individuals who are asymptomatic are spreading the virus. It continues to be imperative that all parties be protected to the maximum extent possible. This is critical, as programs have self-quarantined and eliminated visitors, in order to ensure the safety of individuals served. In fact, now in many cases the only way a client can contract COVID-19 is from an asymptomatic staff. Most important and most challenging has been the acquisition of personal protective equipment (PPE) to mitigate these issues. With a shortage of N95 masks since the earliest days of the pandemic, obtaining PPE has required hours upon hours of phone calls,

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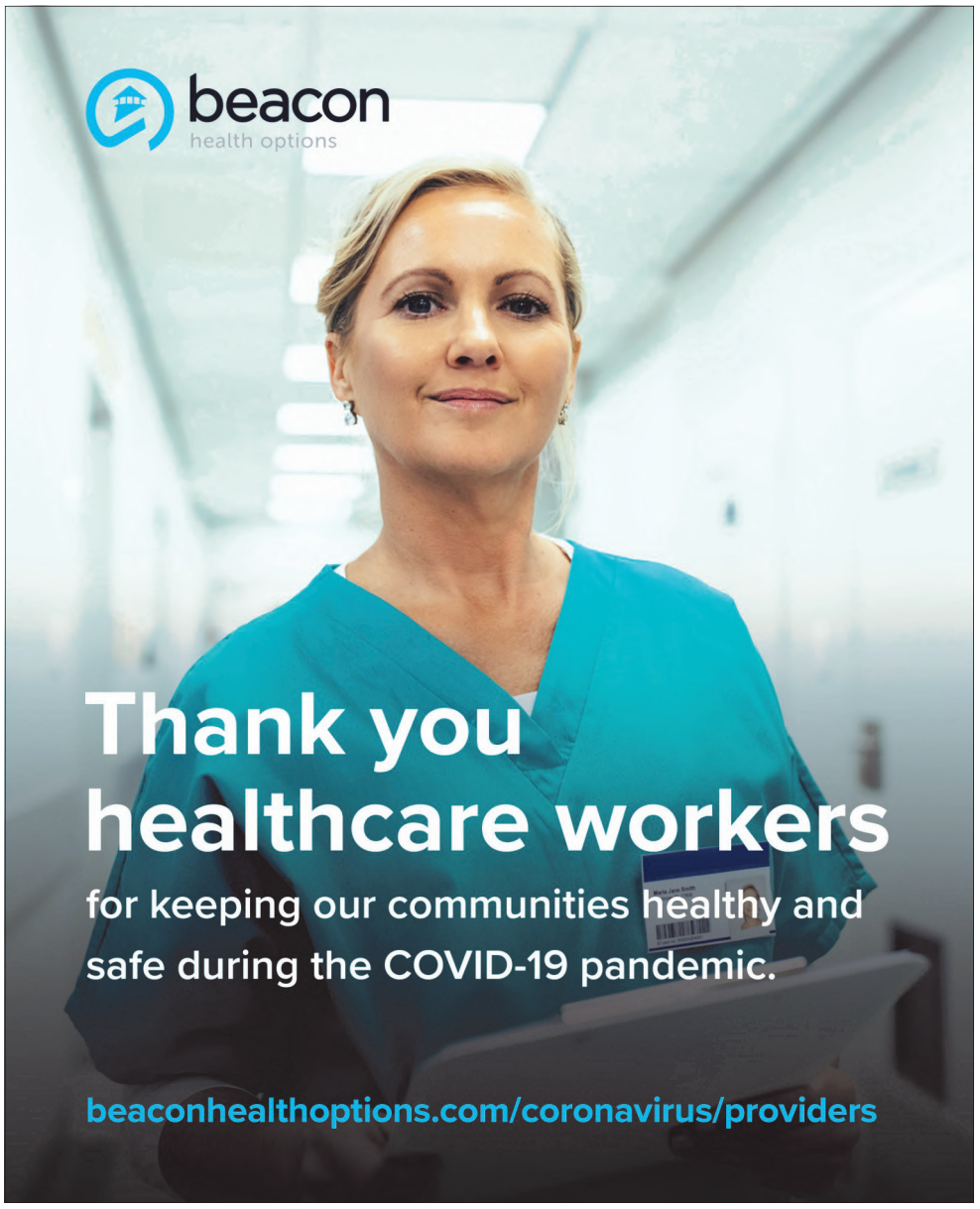

Outcomes from page 14

emails, orders, cancelled orders and delayed shipments. Due to the diligent work of Melmark's senior leadership team, every staff continues to have access to their own N95 mask, surgical masks, gloves, non-porous medical gowns (increasingly difficult to obtain), face shields and goggles. Resourcing has included unplanned purchases and donations.

Workforce Depletion

In addition to the factors above, many organizations face workforce depletion, due to a number of reasons including the loss of childcare in their own personal lives with childcare centers and schools closed, the necessity to care for a loved one at home who is sick, and illness or active symptoms. A field that already struggles to find highly skilled staff, due to funding gaps and below living wage reimbursements, continues to face the impact of a shrinking workforce amidst the pandemic.

These workforce issues have been met with a number of creative, effective approaches, such as: asking family members who could take their loved one home to do so, temporarily closing some residences to downsize work locations, implementing 'hero' or hazard pay, and allowing staff to voluntarily provide live-in care. Again, these actions and models amount to more unplanned expenses for an already underfunded field.

Maintaining a Mission-First Focus

Melmark provides an interdisciplinary, evidence-based treatment model and takes seriously broad ethical mandates. The use of an interdisciplinary team was crucial in first responding to this pandemic, with health care personnel partnering daily with behavior analysts to rapidly implement changing daily protocols to ensure the health and safety of the whole community. Such broad ethical principles are consistent with Melmark's core commitments, which include providing compassionate care and maximizing best outcomes. The Behavior Analyst Certification Board's Professional and Ethical Compliance Code for Behavior Analysts offers several guiding principles that have enforced our commitment to quality care during this pandemic. These include considering the best interests of the client, assuming responsibility for those in our programs, and promoting an ethical culture. These principles and core commitments were met in every decision while also adhering to all guidance from the CDC, governors in multiple states, and numerous regulatory agencies.

Communicating to All Stakeholders

Each division's COVID-19 Task Force, an interdisciplinary team of experts from across the organization, met daily to discuss measures to reduce risk, mitigate the impact of infection, and retool procedures to meet evolving challenges. These teams communicated regularly in a multi-platform approach including: virtual town hall meetings led by the President and CEO and hosting hundreds of staff members, supervisor to staff

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Healthcare Workers: Remember to Care for Yourself Too

By Susan Coakley
President
Beacon Health Options

Susan Coakley

The anxiety and fear resulting from the COVID-19 pandemic can be profound, and nowhere is that more evident than with frontline healthcare workers. Working long hours in substandard conditions with patients who are often very ill and highly contagious, they fear for their personal health and that of their families. Many feel let down by the system at-large due to a lack of pandemic preparation, including a proper supply of the most elemental line of defense – personal protective equipment.

The documented concerns of healthcare workers are real. Stress is a physiological reaction. Neurochemical hormones flood the brain and body to prepare us for fight or flight during times of stress, says psychologist Susan J. Mecca, PhD, and author of "The Gift of Crisis: Finding Your Best Self in the Worst of Times" Further, these chemicals' impact doesn't immediately dissipate; their effects can last for days or weeks. Short-term effects can include changes in eating habits, sleep difficulties, or irritability. Long-term effects can include emotional over-reactivity, depression, anxiety, poor concentration and more, according to Dr. Mecca.

Data bear out the reality of stress among healthcare workers. In one one study during an acute outbreak of SARS, 89 percent of healthcare workers in stressful situations reported having psychological problems.

Practical Steps to Getting Through It

In addition to good health and hygiene habits, below are steps that healthcare workers can take to help them navigate this extraordinarily stressful time.

1. *Create rituals to strengthen the boundaries between work and home.* Dr. Mecca says that it's important for people to find a way to let the workday go once they leave. Real-life examples include getting out of hospital scrubs and taking a shower. Some people will stop at a park near their house, to decompress and unwind, as part of letting go of a difficult day. Meditating or praying, especially at night or other specified times, can help people let the day go. Another tactic is to create a time when you let yourself think about your patients when not at work, but set limits so that you can have some 'down time.' For example, you might let yourself think about work during your commute home but then shift your attention when your commute ends.

2. *Engage in positive self-talk, gratitude and self-compassion.* Remember your natural skills for caregiving and that you know who to contact when you need help with a particular problem. Also, actively focus on things for which you are grateful. Gratitude helps people focus on the positive aspects of their lives rather than on the difficult ones, which as Dr. Mecca explains, "just want to stick in your brain". Have compassion for yourself when you feel you haven't performed at your best. Too much self-judgment can fuel negative thinking.

3. *Tap into a community of support and create "quality" time.* This is no time to be alone. Think about what you need from people to help you through these tough times. Then recruit, shape and maintain a support community that includes colleagues, friends and family. In these times of social distancing, that can mean virtual coffee breaks and other virtual social gatherings, or FaceTime phone calls and Zoom meetings. It can be playing online games, such as an ongoing Scrabble game. Here "quality" means time that is planned with family and friends when you don't discuss the pandemic. It's another way of setting boundaries.

4. *Set priorities.* Let go of or outsource the tasks that aren't critical. Focus only on what is absolutely necessary and use any other available time for self-care.

5. *Get intentional when dealing with the unknown.* It's important to recognize what you can and cannot control. Ultimately, you control you. "You can decide who you're going to be in this time of crisis," says Dr. Mecca. "Once you have that, you have a flight path." Also, write down a list of the challenges you're facing and circle the things you can control. Figure out the steps you can take to make that control happen. Let go of the ones you can't personally impact.

During this pandemic, we should all support our healthcare workers to be the best they can be by urging them to take care of themselves – physically, psychologically and emotionally.

HDSW's Living Room: Crisis Day Respite for the COVID-19 Crisis

By Kathy Pandekakes
Chief Executive Officer, and
Kelly Darrow, LCSW, Chief Program Officer, Human Development Services of Westchester, Inc. (HDSW)

Crisis in every form, including behavioral health, social, economic and medical, accompanies a pandemic. So what happens to face-to-face crisis services for vulnerable populations when needs are greater, access is more difficult, and social distancing and health risks turn already-fragile worlds upside down?

The Living Room, a crisis day respite program of Human Development Services of Westchester (HDSW) in Mamaroneck, NY, is finding out. Already an innovative alternative to traditional crisis services, The Living Room has had to adapt, to be creative, and further extend its reach while faced with growing constraints on resources. Since opening our doors in July of 2017, we have provided over 12,700 hours of face-to-face services, and hours of telephone support. We have learned many things about guests' needs and during this pandemic we continue to be as flexible as possible to provide what is needed. COVID-19 has increased the need for crisis services and supports and how those supports are offered. Since we know what to do and we do it well, it is our responsibility to embrace this challenge and to figure out how to do more for our guests, and in different ways, while still maintaining the quality of our services.

Kathy Pandekakes

Kelly Darrow, LCSW

The Living Room: Crisis Respite Filling a Need

HDSW launched The Living Room, the first crisis day respite service in Westchester County, NY, as an important alternative to emergency departments and inpatient hospital stays for those with behavioral health issues. Calling those who use the service "Guests" in addition to a "What Matters to You" conversation sets the tone for this unique service. The Living Room is a comfortable, non-hospital environment that offers those in escalating crises a safe and calming home-like setting in which to develop short-term and longer term crisis diversion plans, develop WRAP plans, and through assessment, referrals for Social Determinant of Health needs. Guests receive services, most often from a NYS Certified Peers Specialist.

The Living Room is open seven days a week, 8:30 am-8:30 pm, including all holidays and is better-suited than institutional care to support recovery, to reduce symptoms, and to de-escalate the immediate crisis. Guests tell us that there are times when all they want is a peaceful place to rest, and a place where someone will listen to and understand them. The Living Room is a place to promote personal wellness, be connected, to reduce symptoms, manage an immediate crisis and develop skills and resources to prevent or reduce future crises.

The Living Room is staffed by NYS Certified Peer and Recovery Specialists and experienced care managers with program oversight by a Licensed Certified Social Worker, a Registered Nurse is available for onsite collaboration. According to one guest, who uses emergency departments regularly, "Having the Living Room available allows me the opportunity NOT to go to the emergency room." Staff also make contact after the Guest arrives home and provides follow-up as needed for each episode of care.

In the time where agencies have competing financial needs the HDSW Board of Directors have made a commitment to this program. HDSW Board First Vice President, Stephen Gutmann states "The Living Room is important and lifesaving to people."

COVID-19: "Mask-to-Mask" Services and the "Living ZOOM"

A worldwide pandemic adds another layer of difficulty, and one that is dynamic with many unknowns, including duration and long-term impact, to an environment that is already under-resourced. As an essential agency, HDSW continues to follow all local, state and federal guidelines related to the ever changing environment. When other programs were decreasing in-person services and having to suspend some, due to distancing requirements, The Living Room quickly understood the importance of remaining available. Social distancing is particularly challenging when we are used to providing face-to-face services, now we are doing "mask-to-mask" with distancing in place.

HDSW quickly developed a plan for The Living Room's level of service and hours of operation. The layout of the Living Room allows us to maintain social distancing while remaining a place which feels intimate and supportive. We are mindful of how many guests and staff are in the program at any one time and amending the in-person hours allows us to maintain a sanitized environment. Telephone support has remained in operation from 8:30am to 8:30pm each day.

HDSW has found ways to fulfill its commitment to not only stay open, but also to reach out to additional guests. For guests who have heightened risks at home, HDSW has increased the number of phone consultations. The Living Room continues to be open 12 hours every day for phone support, reducing "mask-to-mask" times to the period of highest needs, 11am-7:30pm. For some, HDSW uses HIPAA compliant video conferencing technology to provide what feels like in-person visits. Through Zoom conferencing, HDSW is able to provide "Living ZOOM" services to offer Living Room crisis supports for Guests who feel unsafe and are too fearful to leave their homes. Although there was a decrease in the number of in-person Guests during this past month, those who came stayed longer to manage unpresented needs. Visits may have included additional meals, outreach to providers, assistance obtaining prescriptions or other resources. "It feels like the world is crashing in on me, if I couldn't visit and call The Living Room I am not sure what I would do." said a guest who uses both in-person and telephone support.

We have had to help guests to problem solve in many more areas of life during this pandemic. Both staying home and limited travel provided additional stressors and safety concerns for many.

SDH Needs: Societal Victims of COVID-19

HDSW is constantly assessing the needs of its Guests and the community in the multiple categories of Social Determinants of Health (SDH). Isolation, insufficient or lack of community engagement, food insecurity and many other SDH needs are what drive crises for guests. Our guests represent the full range of SDH concerns in addition to their medical and behavioral health issues. Guests may be homeless, living at home with family or in a congregate care setting, need help with safety planning, have experienced domestic violence and trauma, have financial and food insecurity, or have limited

see Living Room on page 33

Priming for Post-Traumatic Growth

**By Jenna Velez, LCSW,
Vice President of External Affairs,
The Mental Health Association of
Westchester (MHA)**

There is no shortage of media attention to the mental health impact of the current COVID-19 pandemic. It is so important to raise awareness of this, in order to diminish the stigma, normalize the experience, and help give people the tools they need to navigate through these challenging and unprecedented times. We have a long road ahead of us in terms of emotional recovery from this, and that should not be underestimated. Many people will require the help of mental health professionals and this needs to be normalized and encouraged. However, it is also important to highlight and reinforce that the majority of individuals will actually demonstrate resilience through these times. Furthermore, we can also anticipate seeing good numbers of people experiencing lasting positive change, referred to as Post-Traumatic Growth. We know this because outcomes following trauma and adversity fall along a bell-shaped curve, with Post Traumatic Stress Disorder and other depressive/anxiety disorders at one end, Post -Traumatic Growth at the other extreme, and resilience across the middle. This does not mean, however, that responses during the trauma are predictive of the later outcome.

While more than 50% of individuals will experience some trauma in their lifetime, only 7-8% of the population develops PTSD. This means the overwhelming of majority of those who experience a traumatic event will demonstrate resilience and return to their pre-trauma state of functioning. The majority of people enduring a traumatic or adverse event will experience at least some level of distress during and immediately after the event. This is expected and adaptive as the body enters a fight or flight state. The severity and longevity of the distress depends on many factors, including the cumulative effect of multiple traumas/adversity experienced in the past, emotional state prior to the trauma, meaningful impact of the event in multiple life domains, and amount of social support available. Conversely, there are factors that promote recovery and resilience following a trauma, including seeking out support (from social circles, professionals and/or support groups) and use of positive coping strategies.

This data is important, because it can help provide a framework for how to respond to the current situation. It is not an uncommon belief that the way to avoid post-traumatic stress is by avoiding traumatic experiences and extreme adversity, which of course is something that is largely outside of one's control. Since we are currently in a global state of adversity (albeit more extreme for some than others) this belief can inadvertently lead to an expectation that a negative outcome is probable. We are likely to see an increase in overall numbers of people experiencing post-traumatic stress and other associated mental health conditions, because such a

Jenna Velez, LCSW

vast number of individuals are exposed to the trauma of COVID-19 simultaneously. However, we can expect that the percentages noted above will hold, meaning that the majority will still demonstrate resilience.

There is a phenomenon known as self-fulfilling prophecy, in which a person's behaviors align with beliefs or expectations about outcomes and thereby elicit those very outcomes. Given this, it is vital that we share information that reflects what the data tells us. If you find yourself breaking down in tears, with lower frustration tolerance, experiencing difficulty with sleep or increased anxiety, the belief that you are headed for a negative outcome has the potential to actually worsen those symptoms. The knowledge that these are normal and expected reactions, that resilience is still the most likely outcome, and that there are things one can do to eventuate a positive outcome, has the potential to accelerate the process of recovery.

To promote resilience and prime people for post-traumatic growth, differences between the two concepts must be examined. Resilience is characterized by coming through an adverse experience without any lasting negative outcomes, maintaining relatively stable and healthy psychological and physical functioning. Life before and after the event are not drastically different. Remember, this is what most people will experience. Post-traumatic growth actually represents a lasting and positive change that is experienced after the trauma. While this is a realistic possibility for many, research suggests that it is an active process, with things we can do to elicit growth.

Post-traumatic growth involves creating a narrative that embraces a new way of viewing oneself and the world post trauma. This narrative is what allows for growth to be experienced. It's important to remember that post-traumatic growth does not mean the experience of distress is eliminated. In fact, the experience of distress, and often intense distress, is necessary to experience post-traumatic growth. Without the experience of the distress, there is no impetus to shake the foundation of one's existing belief systems and create a new narrative.

Post-traumatic growth is both a process and an outcome. It is not something that just happens and it does not occur in any particular timeframe. As increasing numbers of individuals seek out mental health treatment, it's important to introduce the concept carefully in order to avoid the possibility of minimizing the pain and distress that a person is experiencing. People are experts at their own experiences, and the process of rebuilding a narrative can only be done by the individual. Attempting to create a potential narrative for someone else is not likely to be helpful and could actually be harmful. Likewise, conveying the message that a traumatic experience can lead to growth and opportunity cannot be confused with the damaging message that an individual can or should put on rose-colored glasses. The process involves feeling distress very deeply, while holding onto the belief that it can be the doorway to something meaningful. If one believes that the most likely outcome from their situation is growth and opportunity, it is more likely they will own that and start the process of making meaning, but without the unnecessary pressure to not feel what they are truly and validly feeling.

MHA embraces the statements that Hope, Caring, Community, Healing and Recovery Happen Here. Our Certified Community Behavioral Health Clinic is built on the concept that a community of care supporting multiple areas of a person's life is vital to well-being. The integration of peer support services into clinical services has been essential to fostering hope. Through sharing of one's experience with mental health treatment and recovery, it conveys the message that this is possible for others, thereby priming individuals to start the process of making meaning in their own circumstances.

The question left to be answered is this: How do we encourage growth amidst this pandemic, while also holding space for the loss, pain and distress? The answer lies in our ability to embrace the paradoxes. If PTSD and post-traumatic growth can co-exist, then so can grief and gratitude, vulnerability and strength, loss and gain. We need to find ways to allow our narratives to take root. We need to keep talking about what's hard and what we're learning, sharing that in ways that opens the door for others to do the same. We can help people identify the risk factors for negative outcomes while sharing the tools for promoting resilience, including seeking support. If we see an increase in demand for mental health services over the next few months, we can embrace the paradox there as well. More suffering but also more growth.

The Perils (and Promise) of a Pandemic

By Ashley Brody, MPA, CPRP
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The COVID-19 pandemic has upended our lives unlike anything most of us have experienced. It has exacted an incalculable toll in terms of lives lost or forever altered, and its impact on our institutions and economies is beyond measure. It is exceptionally insidious in its effects on our relationships and communities, as the imperative to distance ourselves from others in defiance of our social nature is inimical to our emotional wellbeing. This is especially so for individuals with behavioral health conditions for whom positive and affirming connections are integral to recovery.

Research findings on the effects of social isolation abound, and most converge on a common conclusion. Actual and perceived isolation are not merely injurious to psychosocial health but associated with premature mortality (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Numerous studies suggest isolation and its attendant loneliness produce changes in blood pressure and increases in stress hormones and inflammation. Other studies associate isolation with an increased risk of depression, dementia, cardiac arrest, and stroke (Morris, 2020). The emotional and psychological dangers of isolation are similarly well documented. It has been proven to cause anxiety and depression and to exacerbate a host of symptoms among those with preexisting mental health conditions (Alarcón, 2020). Such adverse consequences of isolation warrant great concern for any populations to which they might be applied, but their implications for individuals with serious behavioral health concerns – a cohort plagued with a significantly diminished life expectancy – are particularly grievous. It is in these respects that COVID poses an existential threat to the behavioral health community and commands us to marshal our collective resources in defense of the most vulnerable among us.

Thankfully, we possess a robust arsenal of antidotes to the ill effects of isolation that may be deployed in response to this epidemic. Modern telecommunications technologies permit us to connect in ways we could have scarcely imagined a decade ago, and the healthcare sector is capitalizing on the use of these technologies in service of its clientele. For instance, the COVID crisis has produced an exponential increase in the adoption of telehealth enabled, in part, by the easing of regulations that heretofore restricted its

Ashley Brody, MPA, CPRP

use to select classes of service providers and for circumscribed purposes. Telehealth permits engagement of individuals who frequently experience difficulty keeping appointments with their health and social service providers even under "ordinary" circumstances. Nevertheless, its widespread adoption requires both a permanent reevaluation of formerly restrictive regulations and the resolution of other impediments to access. Many would-be recipients of telehealth do not possess telecommunications devices or broadband services equipped to accommodate this modality in a manner that is both reliable and compliant with prevailing privacy and confidentiality requirements. Therefore, investments in the telehealth infrastructure must commit additional resources to the provider and recipient communities alike.

The benefits of telehealth notwithstanding, it is not a panacea for the perils of isolation. Amelioration of isolation, loneliness, and their corresponding health risks requires a holistic orientation that accounts for multiple domains of wellness as espoused by the Substance Abuse and Mental Health Services Administration (SAMHSA). These eight distinct but overlapping "dimensions" of wellness include the spiritual, emotional, social, occupational, financial, environmental, physical, and intellectual, each of which must be addressed in order to ensure optimal health (SAMHSA, 2016). To this end, providers must develop innovative ways to engage individuals in managing their overall health and wellness amidst the challenges of forced isolation. This might begin with the identification and solidification of vital connections, particularly among those who support and encourage each other in their pursuit of desired goals and objectives within the foregoing dimensions. For example, those who share common spiritual concerns, some of which might be exacerbated by current prohibitions on conventional forms of worship, may support each other through virtual religious services or related gatherings (Health In Aging, 2020). Communities of this type can also promote other forms of connection and activities conductive to whole health. Proven cornerstones of mental and emotional health, such as maintenance of a daily routine, regularly scheduled exposure to the outdoors, and adherence to a nutritious diet and exercise regimen are often difficult to sustain in the absence of social support and reinforcement. Virtual classes or focused forums may nourish participants' motivation to attend to such matters while fulfilling their social and emotional needs (Rush University Medical Center, 2020). Perhaps most importantly, they may foster participants' sense of connectedness and thereby counteract the emotional and psychological consequences of physical isolation.

The COVID pandemic presents both an extraordinary challenge and a singular opportunity for growth. It also promises to deepen our appreciation for the ties that bind us but are too often neglected or taken for granted. Through forced physical separation from our families, friends, and fellows we may uncover novel means of reestablishing our connections and enhancing their value. In doing so, we will strengthen our communities and our collective mental health and reveal a hidden blessing within a global tragedy.

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Helping People Cope with Grief During Covid-19

By Gillian Rittmaster, LCSW
Bereavement Coordinator
WJCS

In these uncertain times of physical distancing, grievers are feeling more alone and isolated than ever. Many are craving physical closeness that is an integral part of the grieving process – a hug from a family member, lunch with a friend, someone dropping by to check on them.

The bereaved are missing "their person," the loved one with whom they would have shared this experience, the days' events, and their feelings. Grievers often have a sense of being unmoored and are now experiencing the loss of the anchor their loved one would have provided.

Grievers typically cope by keeping busy, filling their days with positive activities, and pushing through their grief. Now quarantined at home because of the coronavirus pandemic, grievers are feeling the loss of this forward motion and describe feeling stuck and claustrophobic.

Trauma cannot be overlooked when we talk about loss during COVID-19. Many who have cared for a loved one are bearing the recurring thoughts and feelings that accompany witnessing a loved one suffer. During COVID-19, trauma and mourning have reached an unthinkable stage with loved ones barred from hospital rooms and stripped of rituals, such as funerals, wakes, and Shiva, which would have normally provided comfort and human connection.

Gillian Rittmaster, LCSW

The bereaved are also showing a tremendous amount of resilience during this unsettled time. They are drawing on their past experiences and coping skills to find the strengths that have worked well for them. Grievers gain strength not only by getting but by giving as well; some are volunteering to bring food to the homebound elderly and others are supporting their peers through online grief groups.

What these grievers have experienced and witnessed is unprecedented and they need a safe and validating space to talk about sadness, anger, loneliness, trauma, and above all, the story of their loved one. As clinicians we need to provide this holding space for our clients and not push them away from gruesome details so integral to their narrative. How do we do this when the work is so emotional, sad, and overwhelming? Clinicians are no strangers to loss, which makes bereavement work so challenging. All of us have or will lose someone we love in our lifetime. As clinicians we have to understand our own grief story. Who have we lost and how has it affected us? What themes of loss will you bring to the therapeutic relationship that will be helpful to the client? Is there a loss in the past or present that is holding you back from effectively supporting your client? One thing that is helpful to keep in mind is that bereavement is not a diagnosis; it is a human condition that we share with our clients.

The client's story of the life and death of his or her loved one is more important than ever during these scary and unsettling times. Were they caring for a loved one at home whose condition worsened? Did their loved one die in the hospital alone? What did the client witness? Every client should be given the space to tell this story, as therapy may be his or her only safe space, and the clinician may be the only one willing to listen. The client may want to tell the story over and over again with each time new themes emerging. Clinicians will be able to help clients pick the bright spots out of the grim details pointing out resilience and strengths.

Clients need to tell not only the story of their loved ones death, but their life as well. Who were they and what did they mean to others? How will their legacy live on? Clients will need to examine what role they played in their loved one's life and who will they be now without them? As Isak Dinesen said "All sorrows can be born if you put them in a story or tell a story about them. When loss is a story there is no right or wrong way to grieve. There is no pressure to move on. There is no shame in intensity or duration. Sadness, regret, confusion, yearning and all the experiences of grief become part of the narrative of love for the one who died."

In our role as clinicians we need to help clients integrate the grief into their life and learn how to hold both loss and hope, all while keeping a connection to the deceased. There are many assumptions and myths surrounding grief that we, and our clients hold as truth. One myth is that grief is about letting go, detachment

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Telehealth Appointment Tips

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

1. Gather all the information you might need before your appointment. This might include your list of medications (with dosages), medical conditions, problems and symptoms you want to address, and a list of questions for the healthcare practitioner.

2. Find a private spot in your home so you feel comfortable and can talk openly to your healthcare provider.

3. Make sure you know if your appointment is supposed to be by phone or video chat.

4. Be sure that you are able to accept blocked calls since your provider may need to call you from a blocked number.

5. Accept any call that comes into your phone around the time of your appointment, irrespective of whether your appointment is supposed to be by phone or video chat because it could be your provider calling you.

6. If you are going to have a video chat appointment, make sure the lighting in the room is good so your provider can see you. They might miss important communications if they cannot see you.

7. Make sure your technology is ready and dependable. Have a secure and reliable Wi-Fi or internet connection if your telehealth appointment is by video chat. If you are doing your telehealth visit by cell phone, make sure you have a good cellular signal.

8. Mute your phone and eliminate any other distractions so you can focus on your appointment.

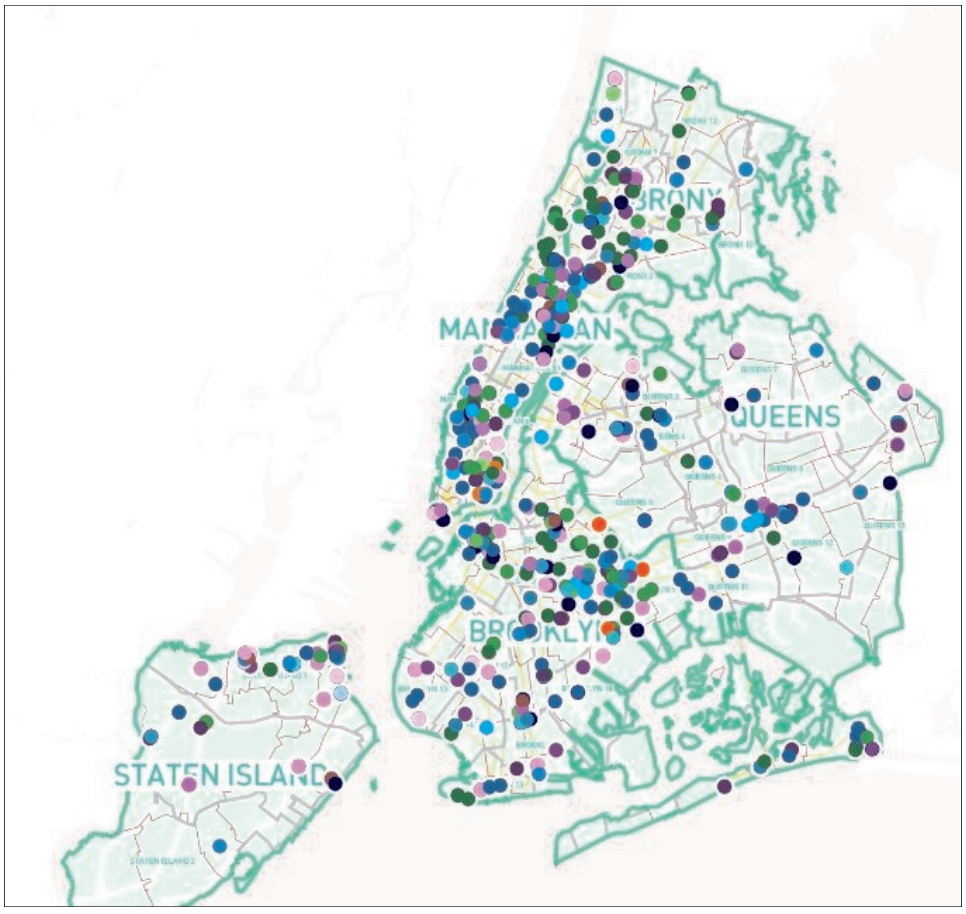
9. Give yourself extra time in case the appointment starts late or runs over its scheduled time.

10. Take a deep breath when you begin your session. Remember that the provider you are speaking to is there to help, not judge you. Think of your time with your provider as time spent talking to a trusted friend who is there to help you.

For more information about Telehealth services, please go to: www.wjcs.com/telehealth.

Using Data Geomapping for COVID Hotspotting

**By Khushi Shah and
Elise Kohl-Grant, MBA,
Innovative Management Solutions NY (IMSNY)**



Coordinated Behavioral Care (CBC) Independent Practice Association (IPA) has been developing over the last year a real-time interactive Geomap of all the network agencies, programs and services across the 5 boroughs using data from NYS OMH, OASAS, DOH as well as internal data sources.

When COVID-19 hit NYC, it became clear to CBC to use its technology and data analytic resources in order to assist behavioral health provider agencies in better understanding the potential impact of the crisis on the communities and populations they served. CBC expanded its Geomapping efforts by launching an enhanced **CBC Network Programs & Services Map** - powered by Tableau - with added COVID-19 related data at the zip code level in order to make the Geomaps more relevant to the current healthcare crisis.

As it became apparent that individuals 65 years and older are at higher risk for COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html), CBC updated the Geomap with the average number of people 65 years old and over in each zip code. When the CDC reported that 33% of people who'd been hospitalized with COVID-19 were African American (https://www.npr.org/sections/health-shots/2020/04/18/835563340/whos-hit-hardest-by-covid-19-why-obesity-stress-and-race-all-matter) and that race is related to heightened risk for poverty and various environmentally based chronic illnesses amongst other factors (https://labblog.uofmhealth.org/rounds/racial-disparities-time-of-covid-19), CBC chose to layer on data showing the percentage of individuals who do not identify racially as white in each zip code.

Utilizing these different data variables, the CBC COVID Geomap enables users to see what programs and services are available within the CBC Network in highly vulnerable and highly affected zip codes. Additionally, as an IPA whose mission is to provide support and advocacy to its network, CBC, in partnership with CBHS IPA and NYS OMH and OASAS, was able to use these Geomaps to successfully receive the Substance Abuse and Mental Health Services Administration (SAMHSA) 2020 Emergency Grants to Address Mental and Substance Use Disorders During COVID -19 (Emergency COVID-19) Award.

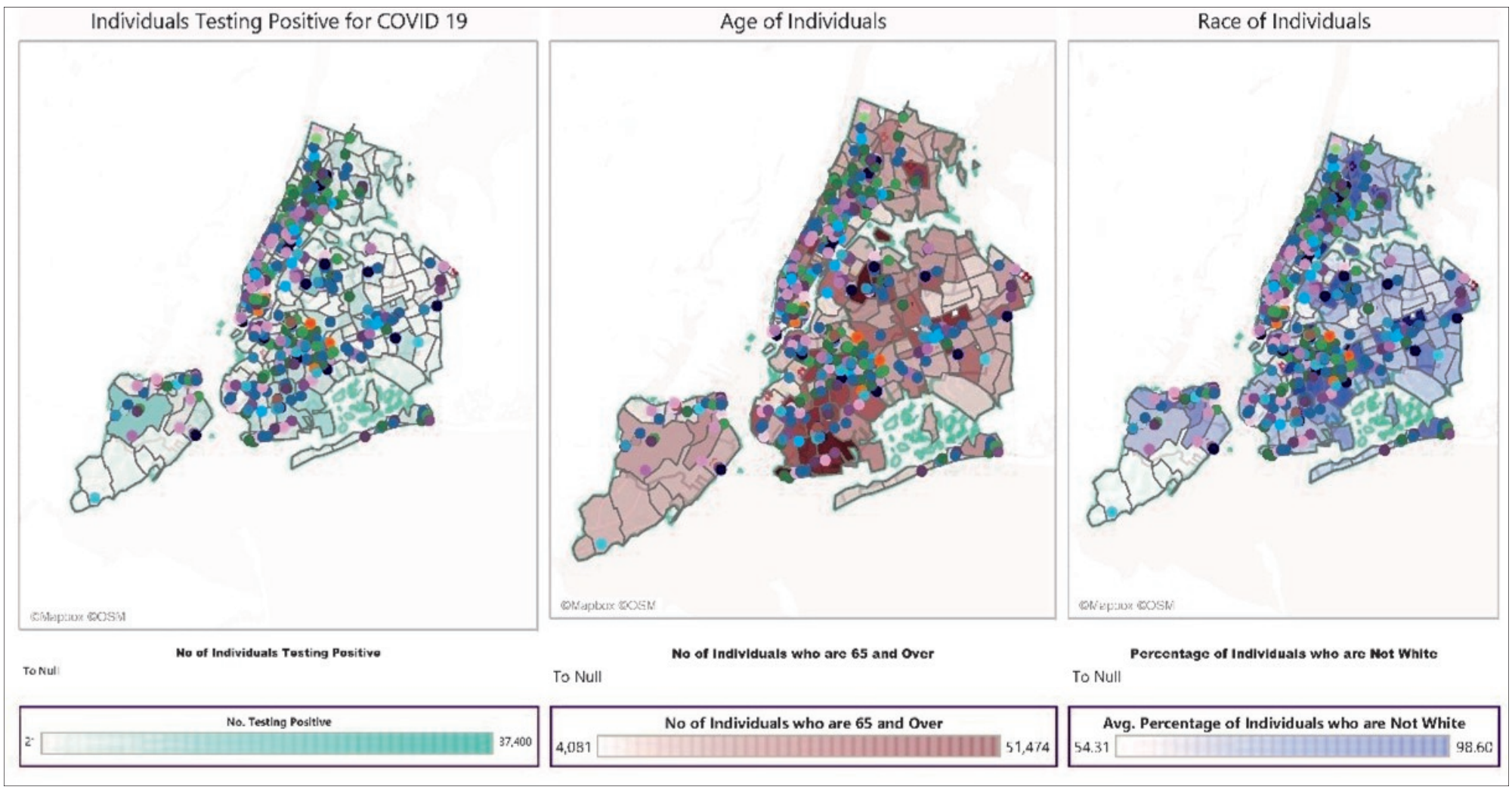
"SUS is using the data to monitor trends and establish need. We used the data this week to help with a funding application to demonstrate the need for additional funding in our communities."
—Services for the Underserved

"Staff appreciate having a tool to understand the impact of COVID-19 on the communities and neighborhoods CCNS serves, and to also support our clients with accessing necessary care and resources close to home."
—Catholic Charities Neighborhood Services

"This tool has been useful in identifying other outpatient supports beyond ourselves that are accessible and servicing COVID-19 cases in proximity to our membership throughout the five boroughs."
—Fountain House

"The information provided by the CBC COVID map is critical to agencies like JCCA that are on the front lines of supporting vulnerable children and families during the coronavirus crisis."
—Jewish Child Care Association

Any requests for help in accessing the map or questions regarding it can be directed to its creator Khushi Shah kshah@imsnhyhealth.org, Data Solutions Manager at IMSNY. www.imsnyhealth.com



The Unheralded Heroes of the COVID-19 Pandemic: Residential Addiction Treatment Workers

By Robert Anderson, LCSW-R, CASAC, CARC, CRPA,
Executive Director
The Educational Alliance / Center for Recovery and Wellness

COVID-19 has impacted our world unlike any health crisis during our lifetime. As this ravaging disease continues to spike in many regions, there are of course negative impacts on many other systems throughout society-including how we as individuals cope with the added stressors around us. The crash of our economy, many families facing life without basic resources or teetering on losing their jobs and homes, our educational system forced into tele-sessions, billions spent of saving our economy-the devastation is real. What one might not readily identify or think about is the behavioral health impact on our society.

Anxiety, depression, isolation, feelings of hopelessness, all have escalated to where people with strong coping skills and no mental health history are also finding themselves "stressed out". What we must not forget is that overdoses and the use of alcohol and illicit substances are also on the rise during this time. The country was still in the grips of an Opioid epidemic when the Coronavirus pandemic

Robert Anderson, LCSW-R

hit. We must not shift our attention to only the latest crisis, and forget that rising overdose rates and families are still being destroyed by addiction- as the use of drugs and alcohol will only continue to rise during this time of increased social isolation and a healthcare system strained to the point that unless you are hospital admission ready, you are likely not even eligible to be tested for COVID-19. I personally see addiction screening, referral and treatment flying below the radar of the necessary attention it deserves during the continued opioid epidemic- not by fault, just the overwhelming media coverage and general attention the Coronavirus pandemic commands. Really, how can you not be overwhelmed by the greatest health threat in generations, if not ever?

So thankfully we have systems in place for people facing the grips of addiction that need detoxification, outpatient, inpatient, longer term residential care, and recovery-based supports and coaching. While our primary healthcare brethren are fighting COVID-19 and other diseases on the frontline with less than ideal resources; they rightfully receive the praise and admiration of the world- they are heroes! While taking nothing away from them, all I would ask is: let us not forget the frontline essential workers attending to the residential addiction and co-occurring mental health disorder needs of people in our substance use disorder systems. These people continue along unheralded, dedicated, also facing infection head on, and are truly heroes themselves.

It is not as simple as prescribing the latest medication assisted treatment product. As noted in a past article in the Rosenthal Report (started by Phoenix House founder Dr. Mitch Rosenthal), Dr. Sally Slater reminded us: "What we need to know is this: Addicted individuals have the capacity to make choices.

The most effective treatment programs for addiction rely not on medications alone, but on sanctions and incentives to shape more healthy behaviors. Engagement in treatment is key to recovery, because the longer a patient remains, the better he or she fares." Using that logic, funding and maintaining inpatient levels of care and all modalities that combine into a full seamless continuum, are absolutely necessary to effectively battle the other epidemic we are still in the midst of: Opioid addiction.

Yet who will staff these high intensity, behavioral health specialty settings that require not only primary medical care teams, but kitchen staff, maintenance and janitorial workers, residential aides, let alone the obviously needed trained clinical professionals, in a time where there is already a workforce shortage of counselors, social workers and mental health professionals adequately trained in addiction? We then ask them to battle Coronavirus as well, but with one difference- these settings, while performing healthcare (integrated behavioral and primary in many cases) does not receive the same

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Supporting Mental Health of Frontline Healthcare Workers During the COVID-19 Pandemic

By Michelle A. Dunn, PhD
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The courage, dedication, and self-sacrifice of frontline healthcare staff, especially during the COVID-19 pandemic, are nothing short of heroic. However, this work takes a serious toll. A study of the psychological well-being of healthcare providers treating COVID-19 patients in China indicates significant mental health concerns. Of 1257 health care workers in 34 hospitals in multiple regions of China 50.4% reported symptoms of depression, 44.6% symptoms of anxiety, 34.0% symptoms of insomnia, and 71.5% psychological distress (Lai et al, 2020). Clearly interventions to support frontline healthcare workers must be implemented during and after this pandemic.

Coping with trauma is extraordinarily challenging. Anxiety, fear, sadness, and anger are normal reactions to tragic and catastrophic life events. We are battling an unprecedented pandemic. As a society, not only is our health threatened but our social, emotional, and financial resources as well. Encountering uncontrollable events

Michelle A. Dunn, PhD

and threats day after day leaves us feeling powerless and can put our psychological health at risk. While we must put intense emotions aside during daily tasks in order to function, true resilience (APA Help Center, 2005) involves acknowledgement and awareness of how our experience is impacting us, and active coping in this moment (Hobfoll et al, 2007).

Active coping means making focused efforts to: Control what you can, take care of your body, actively calm, connect with others, communicate emotions and experiences, evaluate your thinking, find meaning, look forward, and reach out for professional help when you need it. Ability to effectively, purposefully engage in these activities is the foundation of resilience. Active coping is a continuing process, which must be practiced each day to create the best possible life under the circumstances.

The following strategies are drawn from evidence-based interventions, including cognitive behavioral therapy (Flynn & Warren, 2014), dialectical behavioral therapy (Reutter, 2019; Linehan, 2014), and acceptance and commitment therapy (Twohig, 2017; Eifert, 2005)., which have empirical support for efficacy in treating both depression and anxiety associated with trauma.

Control What You Can - Let Go of What You Can't: Lack of predictability, uncertainty about the future and concerns about our ability to solve problems leave us feeling powerless. We need to acknowledge that we do not have control of a great deal right now, but there are things that we can control.

To the extent possible, plan and carry out consistent daily routines (Feise, 2002) which ground you, give a sense of self-efficacy, and engage you in what is healthy for you. Particularly in times of anxiety people benefit from structure, predictability, and focus on goals.

Take Care of Your Body: Having energy is essential for meeting the challenge of coping in our current situation. Get Adequate Sleep; Eat nutritious food regularly and hydrate; Avoid excessive sugar, caffeine, and alcohol; Get exercise each day (Dunn et al, 2001); Monitor and pace yourself – be mindful of your physical and emotional state. Take breaks when needed

Actively Calm: Use distress tolerance activities to calm. Breathe: Take time to focus on your breathing. Find a quiet place to sit or lie on your back. Breathe in for a count of 4 and out for a count of 8. Be mindful of the sensations of the breath coming in and going out. Set other thoughts aside. Do this 10 times. Focus on your breathing while walking. Determine the number of steps you take while exhaling. Breathe naturally for a bit, then increase the length of your exhalation by one step. Do this 10 times increasing your exhalation each time, inhaling naturally. Then return to your normal pattern.

Take a Break from the Stress: Push the situation away, refusing to think about the painful aspects for a while.

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Talking With Teens in Residential Treatment During COVID-19: The Opportunity in The Crisis

By John M. Venza, LCSW-R, LMHC
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Outreach Development Corporation

John M. Venza, LCSW-R, LMHC

Teenagers who make the bold decision to enter a residential treatment program for their mental health and substance use disorders are a unique subset of the adolescent population. They are a group of young people who have committed to temporarily separating from their families, schools, communities and friends with a goal of improving their mental health while commencing their journey of recovery from their substance use disorder.

This separation can be both transformative as it can be disruptive, and with the impact of the novel coronavirus and COVID-19 pandemic, providers have had to rapidly adapt to maintain a safe and stable treatment experience for teens in residential treatment. This article provides insights and opportunities specific to how teenagers in treatment have experienced COVID-19 and the impact on the treatment episode.

During the spread of COVID-19, as a society we have become accustomed to words and phrases like "the new normal," "crisis" and "pandemic" - concepts we are all challenged to fully comprehend. In so many ways, the struggle for individuals to adapt in social-interpersonal relationships, employment and family functioning has people moving outside their comfort zone as they adjust to new idiosyncratic roles (Marini, I & Stebnicki, M., 2018) in the best of circumstances.

As challenging as changes due to COVID-19 is for adults, in the already complicated world of the teenager, the impact of these changes can be profound. But exactly what effect? From my discussions with teens, the general consensus is that young people have struggled, even resisted, the concept of sheltering in place and not being able to be with their friends. Developmentally, this makes perfect sense considering the importance of peers during this life stage (Erikson, Erik, 1968). The absence of socialization at school each day, cancelled sweet sixteen parties, and long awaited proms and commencement ceremonies not to be, instills a common denominator of loss that is shared by teenagers across the nation as they recalibrate their lives during COVID-19.

Interestingly enough, the niche population of teenagers living in a residential treatment program have demonstrated their resiliency towards the adversity (Benard, B, 1991) stemming from COVID -19. Several factors that have contributed to their positive adjustment.

Structure and the therapeutic milieu. While teenagers in larger society are feeling a profound loss of their friends, the teens who have entered residential programs around the country have previously reconciled this difficult change long before COVID-19 reared its ugly head. The key difference is that teenagers entering treatment have acquired the support of the therapeutic milieu, clinical staff, and a new peer group sharing the journey of recovery. Residential treatment programs have a long-standing history of embracing the treatment community as a key component of change, historically referred in our field as "community as method." (DeLeon, G., 2000).

Another factor that has safeguarded teens in treatment is the structure that residential treatment programs provide. The uncertainty of the pandemic has prompted many of the guidance documents around COVID-19 to suggest the importance of structure and maintaining a routine. The design of residential treatment programs has long demonstrated the clinical value of daily activity schedules in the treatment approach. Consistency and set tasks are cornerstones to one's recovery and these elements have provided tremendous support for teens in treatment around the country. This structure contrasts a growing population of teens at home who may be developmentally and emotionally struggling with a newfound disruption in routine and lack of community and socialization opportunities due to the shelter-in-place restrictions placed on them. The dissonance between these two realities only affirms the benefits derived from structure and routine for young people during COVID-19.

Family involvement. Residential treatment programs have long recognized role of families as vital to the treatment process. COVID-19 and ensuing public health orders have resulted in the cessation of on -site family therapy, home passes and other family events and activities. This has prompted the need to shift to

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Crisis Management and Practice Transformation in the COVID Era: Working in the 'Neutral Zone'

By Mary Brite, LCSW, CASAC
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Mary Brite, LCSW, CASAC

In his landmark work on organizational transitions, William Bridges uniquely explains how external change gives rise to an internal transition process (W.Bridges, Transitions, 25th Anniversary 2017). He names the time between an ending but before a new beginning the "neutral zone," which is characterized by a sense of disorientation and confusion. The old way has ended, but the new way has not yet begun. At no time in recent years has this been truer for the behavioral health field than during the current COVID-19 crisis.

Substance use and mental health treatment providers who had been preparing to expand technologies to grow capacity and reach more individuals, families and communities in need, were suddenly challenged to add telehealth to our service continuum, and quickly accelerate its implementation, not only as a means of growth, but to avoid service disruption for existing clients - an organizational challenge further complicated by the personal challenges that staff and clients have inevitably experienced related to COVID-19. Despite the uncertainty of the "neutral zone," however, rapid and unexpected transition from brick and mortar programming to a virtual clinic can be done effectively, swiftly and (almost) painlessly.

Provider agencies and managers are well familiar with the nuts and bolts of program development, as State regulations, funding requirements and agency policies and procedures help to guide and structure implementation of new initiatives and models. But in a crisis environment, fraught with urgency, even the most experienced program manager may be overwhelmed with a plethora of new information and competing concerns. Bridges proposed that the antidote to disorientation in the neutral zone is structure, information and communication. Understanding that, the way in which we navigate through it is essential. By prioritizing structure, information and communication, we can provide clarity and target staff energies to the correct priorities and knowledge necessary to "get it done."

An optimal approach can assist crisis leaders in simultaneously building and running a virtual clinic, while ushering staff through critical change. These "tips" can ease the process:

Structure: Define What We Have and Where We Want to Go?

• Develop your crisis mission statement. This is clearly not the time to develop a comprehensive mission statement, but quickly and thoroughly establishing a crisis mission statement can serve as your North Star during the crisis period. An example might be: "During the current COVID-19 health pandemic, our program will prioritize the health and safety of all staff and clients, providing uninterrupted service delivery, while maintaining timely access to care for all in need."

• Organize and deploy your team. If you have a standing crisis management team (CMT), ask yourself: is the team adequately situated to address the crisis, or should an ad hoc team be developed to meet the emerging need? The CMT should be led by agency leaders who have a wide-ranging view of the environment, both within and external to the organization, and who have firm decision making authority. The rapidly changing COVID-19 environment may require us to look beyond titles and authority, and more to individual staff characteristics. Staff from all levels who have the ability to work well and quickly under pressure, and who present excellent communication and interpersonal skills, are a welcome addition to the CMT.

• Assess current resources in relation to crisis goals. Swift analysis of resources ensures that agency energy and focus are targeted in areas that will offer highest contribution to successful change. If uninterrupted service delivery is a goal during the shift to telepractice, how does agency technology shape up? Telepractice requires a reliable, HIPAA-compliant and easy-to-access platform. Staff must be well trained in the technology and should be able to assist clients in its use. If a crisis goal is "ensuring timely access to services for all in need," is current

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Points to Consider During the COVID-19 Pandemic That Are Impacting the SUD Community

By Roy Kearse, LCSW, CASAC,
VP Recovery Services and
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Samaritan Daytop Village

As a health care professional with close to 40 years of experience I have seen the behavioral health field and particularly the Substance Use Disorder (SUD) field face many challenges, but none like the current COVID-19 pandemic. I would like to share the following 5 points of observation.

Point 1: The COVID-19 crisis hit a SUD system that was just beginning to see some stabilization and reduction in the annual number of overdose deaths that had steadily been rising in America – having reached a high mark of over 70,000 deaths in 2017. In 2018 (according to the National Center for Health Statistics) they showed a 2.9% decrease in that number. It took the SUD field years of painstakingly hard work and innovation to accomplish that relatively small gain!

Point 2: History has shown us that in times of national crisis when society's anxiety levels go up, there is an increase in substance use and abuse, resulting in

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addiction levels rising. We saw this after 911 and continually in times of economic downturn or any other national adversity. The fact of the matter is that when people are afraid and uncertain, they look for ways to relieve that fear and uncertainty, and often times they may turn to alcohol, and other substances to relieve their anxiety.

Point 3: The COVID-19 pandemic has brought us to a crisis situation where healthcare workers in general, and SUD workers in particular are being asked to do more. Whether prevention, treatment, or recovery services, our SUD system is being stretched to its very core. Nowhere is this more evident than with providers of residential services who find themselves in the unenviable position of having to manage facilities where people often live in situations that pose density problems in a new world of social distancing. And while social distancing does not mean social isolation, residential providers have unique challenges in trying to provide care for their client population, while at the same time trying to safeguard both their clients and staff!

Point 4: Despite these seemingly insurmountable challenges the SUD field of providers has risen to the occasion. Daily, an army of professional peer workers, clinicians, support staff, and managers go to work to help some of the most vulnerable people in our society even while knowing that in some cases they are putting themselves in harm's way.

More broadly, providers continue to develop creative tele-practice models in order to continue to provide individual and group recovery supports through zoom and other telehealth platforms. Social distancing and daily personal health monitoring have become standard practice for health care workers and clients. Providers have secured through any means available safety gear of mask, gloves, sanitizers, and other items to the extent possible for their staff and clients. Providers have also quickly adapted to guidelines set by government bodies such as the CDC nationally, and DOH locally. Staff have been trained in how to deliver telehealth services, and clients have received an abundance of information on selfcare.

To illustrate the bravery, compassion and selflessness we see every day, I share the story of Christopher, one of our many invaluable recovery coaches at a major Bronx recovery facility. Christopher's main job is reaching out to program participants offering resources and support services to get them through these times and to let them know they are not alone. He offers peace, understanding and encouragement that helps to keep them on the path to recovery. But that's only part of the story. Twice a week, when he leaves his day job, Christopher volunteers on an overnight shift at the Red Cross from 7pm to 6am the following morning

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A South Asian Perspective on COVID-19 Trauma: A Short Overview

By Veera Mookerjee, PhD, LMSW
Founder and Director
Resolveera

On May 4th Washington Post published an article titled as follows, "The coronavirus pandemic is pushing America into a mental-health crisis." It talks about the rise in the mental health needs of communities and the increased call for telemental health services while mental health clinics are already overwhelmed. It narrates the traumatic situation that will remain as an inevitable environment for many days to come.

The trauma of this pandemic, COVID-19 is going to stay fresh in our memories forever. More than 60 days into the lock down and we are still struggling to find a way to resolve this problem, understand the days that are to come and imagine what is going to be our new normal. Life is not that simple anymore. We are in a complex state of human life, a state where we need to isolate ourselves to ensure to be with our loved ones. We need to be alone to be together. We are living in a state of contradictions and confusion. Our practices and approaches in behavioral therapy have been reversed.

I have been in the field for more than 15 years now in multiple roles. My current roles involve working full time as a Care Manager for a Managed Long Term Care company (MLTC), a mental health

Veera Mookerjee, PhD , LMSW

therapist in a Mental Health Clinic in New York City, in addition to running my consultancy Resolveera that works with parents of children with disabilities. This wide age range has given me the opportunity to see a newer and more complex versions of isolation & loneliness, stress, anxiety, depression, anger, frustration, helplessness, obsessiveness, adjustment disorders and trauma. It is interesting to see how behavioral therapists are using our skill sets to address the unmet needs of our clientele while we ourselves are facing the same issues. We are also scared and worried about the future, a potential global economic depression if the COVID -19 crisis persists longer. While our clients are facing lack of space, they are tied up in homes dealing with adjustment issues, or isolation because they have nowhere to go, on the other hand, we professionals are also juggling between our professional commitments and personal responsibilities. As a professional, I do not see a therapist and a client. Today, we are just "us" and we are all waiting for this exceptionally long and painful episode in life to reach its climax. It is not that we never face counter transference especially in behavioral therapy or that we do not practice self-care when the work gets to us but it is the way we have been dealing with our own stress and anxiety lately. The community, both clients and therapists are facing multiple layers of confusion and crisis. It is an inter-connected mesh of emotions arising from the following triggers: financial insecurity, health complications, loss of familiar support, fear of the unknown and fear of death. Let us understand the crisis from a low income, legally documented South Asian immigrant perspective.

Financial Insecurity: Talking about NYC, most of the low-income group South Asian community members do odd jobs at various stores and restaurants. A big number of South Asian men are usually the yellow and green cab and/or the TLC cab drivers. Model minority is a myth as all South Asians are not in IT or are not doctors or scientists. Most of the females from these households are often the care givers of seniors with MLTC services, since the South Asian communities have senior family members living together. Due to COVID-19, men are unable to drive cabs, the women are earning through MLTC services to the seniors at home. I am focusing on only those families that are enrolled in these services. However, many are opting to quit the care giving jobs to file for unemployment with an expectation to get some more financial help. This kind of insecurity has led many families in major food crisis. Many such families facing major financial crisis are not used to online shopping hence these families are relying on community resources. Potential risk about the economic crisis is a stress that can lead to unimaginable behavioral outbursts and patterns for this community where we still find mental health issues as a taboo.

Health Complications: Community members with an underlying health conditions are at risk of getting COVD-19. Many low income South Asian families live in lower income group housing or small apartments where maintaining social distancing is difficult. Often large families are in a small apartment or multiple families live together. Most of the South Asian seniors have high diabetes, cardio-respiratory problems and asthma. A carrier of COVID-19 in such a household can bring in additional stress, blame for the carrier and unwanted trips to the ER or urgent care. As a Care Manager, I observe patients often describe that until

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Surviving the COVID-19 Pandemic: The Behavioral Health Effects of Social Distancing and the Social Safety Net

By Jason Lippman
Founder & Principal
Jason Lippman Solutions, LLC

In communities across the United States, social distancing measures are in place to slow the spread of the COVID-19 virus. This is necessary to flatten the curve for coronavirus infection rates and not overburden our healthcare system as there is no effective treatment or a vaccine on the horizon. Yet, staying at home for the foreseeable future with limited social contact can have profound effects on our mental health and wellbeing. Human beings are social animals by nature. When social distancing leads to social isolation, feelings like loneliness, fear, anger, anxiety, or depression can surface.

For the 1 in 20 Americans already living with mental illness, COVID-19 and social distancing can bring on further bouts of symptoms such as anxiety and depression. A recent study published in JAMA Psychiatry found that social distancing had potential adverse outcomes on suicide risk. Additionally, people in recovery from substance use disorders can experience increased cravings, relapse or rising use of substances to cope with the social effects of the COVID-19 pandemic, as chronicled in USA Today. Because of crisis-induced stressors from social distancing or concerns about one's health and economic standing, anyone can suddenly find themselves in need of treatment despite preexisting behavioral health conditions. Moreover, exposure to 24/7 media coverage of the pandemic can intensify thoughts of fear and anxiety. It is therefore recommended to limit exposure to media, particularly social media, to manage anxiety about COVID-19. Instead, designating time to get information from reliable sources like the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO).

Often, if behavioral health issues worsen, physical health effects follow, including a more compromised immune system, changes in rates of metabolism and sleep and awake cycles. People living with behavioral health conditions may also find it more difficult to fill their prescription medications and access the community supports that they are familiar with, due to program closures from social distancing. This can exacerbate risk factors for individuals living with mental illness and substance use disorders. In addition, people living in unsafe conditions can become more vulnerable during times of distress and where social distancing leads to less oversight, including victims of domestic violence, seniors at nursing homes, and runaway homeless youth in congregate shelters.

Long after we, as a collective, survive the COVID-19 pandemic, the behavioral health effects from the immediate health crisis and social distancing will be perpetually profound. Think of how other public crises, like 9/11 (19 years ago) or the Great Recession (13 years ago) forever changed our society, our outlook, how we live, and the pervasiveness of post-traumatic stress left in their wake. People who worked at office buildings near Ground Zero had higher rates of absenteeism after 9/11, as mentioned in the World Economic Forum. Suicide rates rose sharply in the aftermath of the 2007 recession, as reported by NPR. In many senses, the psychological fallout from COVID-19 will be ubiquitously long standing. Nonetheless, there are strategies that might help to alleviate the behavioral health effects of social distancing as we live through trying times once again.

Jason Lippman

Maintain and/or Seek Professional Help as Needed

To ensure that treatment and services continue through the COVID-19 pandemic for the behavioral health effects brought on by the COVID-19, telehealth services are increasingly available through video chats and phone conversations, apps and texting. New York State has setup an emotional support hotline at 1-844-863-9314, staffed by 6,100 mental health professional volunteers. Within New York City, NYC Well is available to connect to behavioral health supports at 1-888-NYC-WELL.

Stay Socially Connected While Physically Distant

Social distancing is actually physical distancing, so we need not socially isolate during the crisis. It is especially vital to have someone else to speak with and regularly contact for mutual support. Many are now using technological platforms like Zoom, Google Meet, or Skype to host virtual meetups while in their own homes. You can also stay in touch with family, friends, colleagues and peers through email, texting, and phone calls.

Prioritize Self Care

Staying healthy in times of mental distress can provide for a stronger foundation to stand on. You can stay physically active with fitness, dance, or yoga classes online. Additionally, there are a variety of ways to practice mindfulness and help bring more balance back into your life, including meditation (see A NY state of mind), deep breathing exercises or going on walks outdoors in fresh air (while maintaining social distancing guidelines of course). Cooking healthier foods at home and getting a full night of rest can help support mental wellness too.

Establish Daily Routines

You may find it helpful to keep an at-home routine of daily activities, such as mealtimes, exercise, work, educational activities and bedtime, for example. Creating a daily schedule, even a rough outline of one, might help preserve some sense of order during this time of tremendous uncertainty. You may also finally have time to delve into new hobbies or indulge old ones through arts and crafts, puzzles, board games with family or roommates, cooking and baking, reading books, writing or journaling, playing music, as well as many other creative ideas and activities that you think of.

Be Grateful for Social Safety Net Providers

We are fortunate that behavioral health and other essential providers are working tirelessly to help keep us safe, well and socially connected. In addition to essential services, community-based providers are assisting people in need with accessing food, personal care and household items, during social distancing and COVID-19.

Holes in the social safety net system fall on nonprofits. Yet the sector is already operating community-based programs on diminished funding and increasing service demand. Now, during COVID -19 and social distancing, nonprofits must manage remote workforces and keep essential workers out on the front lines saving lives and preventing vulnerable people from needing emergency care.

As each week goes by, nonprofits are bleeding through resources. Furthermore, they are at risk of being inadequately reimbursed and additional funding cuts are likely on the horizon as states and localities grapple with their own budget deficits in response to the crisis. Just how long can community providers (particularly smaller ones) continue at this rate?

In assisting community-based providers to figure out different ways of achieving their missions during COVID-19, some key points to consider have comprised of:

• Innovating with new approaches to serving consumers while adhering to social distancing.

• Adapting quickly with technology to reenergize fundraising initiatives electronically.

• Communicating with donors and funders, so they know that their support is having an impact.

• Providing support to the community in general through outreach on social media and websites.

• Developing COVID-19 recovery plans to execute when social distancing relents, and the economy fully reopens again.

If Medicaid redesign and the introduction of value-based payments did not provide for enough change, COVID-19 will accelerate new and better ways of conducting business. COVID-19 is already changing how we work, provide services and access supports.

When all is said and done, what will we as a sector have learned from this experience? What has worked well and what has not during this crisis? Where can we improve? Many might see that remote options perform well and no longer need the same amount of office space. I look forward to hearing about your unique insights and lessons learned as we get there.

Finally, I am inspired by the many dedicated people and providers rising to the occasion to meet the challenges

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Adapting to Respond to COVID-19

By Deeana Dobrer,
Director of SI Programs
Coordinated Behavioral Care

Since 2016, Coordinated Behavioral Care (CBC), a city-wide Behavioral Health IPA and a lead Health Home, has overseen an incredibly successful preventive case management program, funded by the Staten Island PPS, and in collaboration with Staten Island (SI) community-based behavioral health agencies (SIMHS, Project Hospitality, CHASI). The program, Staten Island Community At Risk Engagement Services (SICARES) was developed to bridge gaps in care by connecting community members to necessary support services so that they could be empowered to manage their own health care while being connected to the broader health and wellness community. This successful, brief intervention model of care, using community Health Coaches, ensured that over 7,000 Staten Islanders were meaningfully connected to community-based health care services, offered annual check-ins and addressed social determinant of care needs.

SICARES, because of DSRIP funding, was set to sunset at the end of March, but as the first cases of COVID-19 emerged in NYC, CBC recognized that dismantling the current care coordination infrastructure would have disastrous effects on the most vulnerable population on SI. CBC proactively worked with the SI agencies and self-funded the program for an additional 6 months as a response to the emerging pandemic devastating NYC residents. Based on some preliminary data analytics of the program's outcomes, especially with the population over 55 years old and medically frail, CBC worked on changing some critical aspects of the program to meet the new demands of managing care during COVID-19. With Health Coaches already in place, the SICARES program was uniquely positioned to provide immediate telephonic support and advice through tele-care management to those at highest-risk from COVID-19. The Health Coaches have been able to connect with and reach people with underlying health conditions who, by following the Governor's stay at home order, are isolated, stressed and have heightened levels of anxiety. While social distancing minimizes the risk of exposure it does create additional stress through financial burdens and isolation that can negatively impact people, particularly their mental health.

Deeana Dobrer

The SICARES Health Coaches have been working hard to provide telephonic support (using Zoom), referrals to services, and advocacy for their client with the goal of creating a mental health response rooted in concrete interventions while also addressing the underlying social care needs of this vulnerable population. Health Coaches are also working closely with medical care providers to ensure that members continue to attend necessary appointment and that prescriptions are filled and delivered. In addition, they have found that they can play a valuable role in providing education and support on the symptoms and treatment of COVID-19. The core elements of SICARES's telephonic care management include ensuring that physical health and mental health concerns are addressed as well as inquiring about and assisting in connections to services and resources re: finances and social determinant of health needs.

CBC's response to the current healthcare crisis—adapting an established, light-touch, preventive case management program into a seamless access point for community members that would otherwise not be eligible for care coordination—was a critically needed public health strategy. Through a response focused on check-ins, coordination, and addressing concrete social factors that inhibit health care access, SICARES Health Coaches are addressing the unmet needs of the most vulnerable and at-risk at this unprecedented time. Additional workflows that bring together Health Coaches to address needs through the lens of collective impact strategies also creates culture shifts in how front-line staff

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texters began reporting a mounting sense of unease and a need for information related to Covid-19, particularly among people with underlying health concerns.

Impact

During the impact phase of most disasters, when the crisis is happening and threatening lives or property, the DDH typically isn't receiving contacts from affected areas, since the priorities in that moment would be stabilization and safety. Those calls are going to 911. Calls and texts may start to come in from outside of the affected areas, from loved ones or others experiencing vicarious distress related to what they're seeing and hearing in the media, or from people nearby who aren't in immediate danger, but who are searching for information and resources because they're feeling overwhelmed about a rapidly changing situation.

There is a common saying in disaster mental health "when a disaster occurs, no one is untouched by it," though usually disasters are confined to a specific geographic area – a neighborhood, city, state, or region, such as with hurricanes. The first-level "circle of impact" includes people directly impacted by the event. They may have suffered losses or had some other high degree of exposure, resulting in an increased risk for distress or mental health concerns. The circle then expands outward from there to include people who were at or near the disaster, but weren't directly impacted, and beyond.

Covid-19 is different. Every single person in the U.S. has been touched in some way by the pandemic, making the circle of impact quite large and at higher risk for distress: people who have been diagnosed with the disease, loved ones of people who are seriously ill or who have died, those who have become unemployed, people who are quarantined and socially isolated, "essential" front-line workers such as in healthcare, grocery/food retail, utilities, emergency responders, behavioral health workers, etc.

While infections are still occurring and distancing measures are still in effect, the vast majority of people in the U.S. are still experiencing the 'impact' phase of Covid-19.Contacts to the DDH during this period of time continue to be marked by fear and uncertainty, as well as distress related to financial strain, grappling with losses, interpersonal conflicts or rising tensions within households, isolation from limited access to social supports, stress from parenting or other caregiving responsibilities, and from essential workers worried about their physical and emotional health.

Heroic and Honeymoon

During the heroic phase, people from across the country have pulled together to support those most impacted by the pandemic via fundraisers, sewing masks, cheering healthcare and other frontline workers, and many more examples. This happens within cities with higher rates of infections and in areas that have seen zero infections. Concurrently, it's common for the DDH to receive calls and texts during this phase from people searching for ways they can help -- including volunteering directly with the DDH.

People who have been or are currently impacted are also compelled to engage in heroic behaviors, which can help them move forward on the path of recovery, mitigating against the distress they're simultaneously experiencing. For them, engaging in helping can be a form of coping in and of itself.

The heroism behind these constructive actions builds toward the honeymoon stage, the peak at which people may individually and collectively feel optimistic and unified in the face of trauma and tragedy.

Disillusionment

Eventually and inevitably for most people affected by disaster, the impact of the heroism and honeymoon stage starts to lose its power to lift moods and cushion against distress. Resiliency is further tested and strained as financial support winds down or runs out, mental health and other services that were operationalized in the immediate aftermath of the event may start to wind down, and the media may shift attention to other newsworthy events. This can leave people still struggling emotionally to feel left behind.

DDH calls and texts see disillusionment after a disaster manifested as feelings of isolation, anger, frustration, hopelessness. Persistent or more serious mental health concerns, like depression, substance abuse, or anxiety, begin to surface as people start to grapple with losses and perhaps feel as if recovery isn't possible.

Disillusionment often occurs several months after the initial impact of a disaster. Many people who have been personally affected by Covid-19 may be in the disillusionment phase now. Financial support may be limited or already used up and necessary physical distancing measures are starting to try people's resolve and, in some places, community cohesion is starting to fray.

Following trends from past disasters, volume to the DDH typically starts to trend downward at some point during the disillusionment phase. Temporary distress reactions experienced from the impact stage through the initial stages of disillusionment start to diminish. At the same time, the surges in contacts from people seeking information and resources declines. as Communities "settle in" for long term recovery or reconstruction.

Reconstruction

For many people reconstruction after a disaster involves coming to terms with losses, adapting to a new normal, and overall working towards a new beginning or 'reconstruction'. As with other disaster phases, there is no timeline for this stage of recovery. For some it might be a short period of time, while for others recovery may occur over months or even years. Long-term recovery can also be marked by setbacks, such as the occurrence of a new disaster or other traumatic event that can impede rebuilding. There are usually fewer remaining support services available specific to the disaster experienced, which can exacerbate a sense of loneliness for people still struggling.

Through the process of reconstruction,

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RIP Medical Debt Shifting Focus During the Pandemic

By Allison Sesso
Executive Director
RIP Medical Debt

Allison Sesso

At RIP Medical Debt we have one focus – buying up and abolishing the crushing medical debts of families across the United States. Our method is simple. We raise funds from generous donors in large and small amounts, combine them and purchase large portfolios of medical debt for pennies on the dollar; $100 of donated funds can abolish $10,000 of medical debt.

At this time of extreme uncertainty, the RIP team was determined to leverage our mission for this moment. So, we launched the Helping COVID Heroes Fund, a medical debt relief fund focusing on healthcare workers and emergency responders first.

You have read stories from the front lines: Doctors and nurses working long shifts with little personal protection from the deadly virus they are treating; social workers and home health aides continuing to make long drives for poor wages in order to provide care and support for our elderly and infirm. All of this is physically demanding work that cannot conform to social distancing recommendations, resulting in substantial personal risk.

We are all indebted to this heroic workforce and wanted to find a concrete way to show them we have their back. We have already identified more than $80 million in unpaid, unpayable medical debt belonging to individuals with professional licenses or union memberships tied to healthcare and emergency responder roles and we are on our way to eliminating it.

While healthcare workers are exposing their health and well-being daily as critical care providers, they aren't the only ones making profound personal sacrifices in our global fight against this novel coronavirus. All of us are staying home to contain the spread which has had devastating economic impacts, with distinctively severe results in the United States stemming from our employer-sponsored system of health insurance. Families in the U.S. lose their income and health insurance when they lose their jobs. The economy is shedding jobs at a nauseating rate, leaving many without health insurance or income, while a highly contagious and deadly virus is spreading through our communities. That is why RIP Medical Debt is helping the workers from the service tier of our economy as well.

For families with no income or insurance, paying medical debt is not only impossible – it would be irresponsible – with so many other survival needs to cover. That is why our Helping COVID Heroes Fund will also provide debt relief for families dealing with the effects of unemployment and reduced income with the greatest focus on those areas hit hardest.

While we can't buy and relieve COVID-19 related healthcare debt yet, it is critically important to remove all medical debt from the backs, and credit reports, of those with the most exposure to this virus (healthcare workers, emergency responders) and those who've lost their economic stability. RIP Medical Debt will, of course, gladly purchase and relieve COVID specific debt when it becomes available. For now, however, we are focused on removing the pre-COVID debt burdens of those sacrificing the most at this moment.

In fact, we encourage hospitals and other health care providers to sell us their uncollectable medical debts. We are actively seeking to obtain additional debt and welcome provider inquiries regarding the sale of their debt to us for the purpose of abolishment.

RIP Medical Debt is proud to have adapted our work in response to this unprecedented global pandemic. We are determined to relieve the debts belonging to the heroes of this moment and to remove the debt burdens of those hardest hit. While the world has changed dramatically, it has not fundamentally changed us. Our sense of community and goodwill continues and has only become stronger.

Telehealth: The Solution for Getting Help During COVID-19

By Anthony DiFabio, PsyD
President and CEO
Acenda Integrated Health

Anthony DiFabio, PsyD

We are facing truly unprecedented circumstances with the COVID-19 pandemic. It is affecting our families, our communities, and our way of life. No generation is left untouched. Families are juggling new working from home dynamics, older adults are cut off from visitors at senior living communities, and students are finding themselves missing out on important milestones and activities.

We must all concern ourselves with not only the spread of COVID-19, but also the mental health impacts that arise as a result of prolonged isolation and anxiety. For those of us in the behavioral health realm, the primary focus is providing uninterrupted care for those who depend on mental health professionals for guidance and support. This is especially important for those patients who may also have comorbid risk factors, or family members who may be at high risk from COVID-19, where the dangers to health must be balanced with the need for behavioral health care services.

Mental Health Concerns Increase During Crises

Approximately one third of Americans report that the coronavirus has caused mental wellness concerns, according to a survey released recently by the Kaiser Family Foundation. Of those, 14% say worrying about the virus has had a "major negative impact" on their mental well-being. During times of social distancing and isolation, we also see an increase in psychological traumas such as domestic violence, child abuse, addiction, and neglect.

For those already receiving behavioral health services, maintaining regular counseling appointments may suffice. There may also be a significant increase in individuals needing your help given these stressful circumstances.

Telehealth Technology: A Lifeline

Physical illness that goes undetected and untreated can become debilitating. Similarly, ignored psychological issues can become equally crippling. Physicians across the country are emphasizing the importance of telemedicine to help the homebound diagnose everything from a simple cold to potential coronavirus symptoms. Telemedicine for mental health issues is just as vital.

Maintaining a connection to our routines, loved ones, and health resources is paramount as we continue to be physically separated from our communities, careers, and families. Not being able to "find someone to talk to" should never be a barrier to obtaining mental health care.

When in-person sessions are no longer an option, telehealth is an effective and safe way to receive counseling support. Unlike a phone call, videoconferencing allows a face-to-face connection where clients can speak candidly about their feelings and stressors. This option provides continuity of care for those receiving therapy, treatment, and support for mental illness or behavioral health issues prior to the pandemic. It also allows us to respond to the influx of individuals seeking support from COVID-19 related stressors to receive help and guidance.

Let's Make Virtual Care the New Norm

While the gold standard for the provision of services has always been an in-person model, the COVID-19 pandemic has demonstrated that tele and virtual health care services are both necessary and effective. During this pandemic, we are finding innovative ways to meet the physical, socioemotional, and behavioral health needs of our community. Yet, even in a post-COVID-19 world, individuals will continue to experience barriers to accessing care. We should both anticipate and advocate for telehealth as a viable option for providing behavioral and mental health services, both today and in the years to come.

During these tenuous times, it is our duty as mental health professionals to provide support and resources to individuals, families, and the community. I'm hopeful that insurance companies along with state and federal governments will understand the need for telehealth even after this pandemic ends. As we navigate these unchartered waters, we will do whatever it takes to keep our clients safe and healthy, not only for today, but for the tomorrows yet to come.

Dr. Anthony DiFabio is the President and CEO of Acenda Integrated Health, a leading nonprofit organization dedicated to world-class prevention, treatment, and wellness services. His vision for innovative care and strategic development has elevated him as a leader within health and social services. Acenda is at the forefront of community-based services by offering more than 100 innovative programs that support children, adults, families, veterans, caregivers and the community at large.

Maintaining Clinician Wellness During the COVID-19 Pandemic

By Richard Juman, PsyD
National Director of Psychological Services
TeamHealth

Richard Juman, PsyD

The COVID-19 pandemic has almost instantly raised the stakes on our perception of stress in our lives. Think about the things that until very recently kept you up at night- the prosaic stressors of "normal life" in the professional, financial, community and familial realms- and you will likely find them dwarfed by the stressors of the pandemic and the "new normal". You may be worried about whether you and all of your loved ones, particularly your older relations, will simply survive the Coronavirus pandemic. Or you may be preoccupied by the virus's impact on the U.S. economy and our societal structure. It's impossible to predict what the world will look like post-pandemic, and that uncertainty may be the most stressful aspect of the situation for many.

For most of us, the need to remain aware of stress has been replaced by an urgent need to manage a level of stress that is obvious and may be overwhelming. Stress is a natural part of the human condition, and while it has positive elements, chronic stress that is not addressed can have a significantly negative impact on one's quality of life and physical health. For better or worse, right now we have no difficulty identifying the myriad sources of stress in our lives; so the question immediately becomes: "How can clinicians respond to the obvious increase in our stress levels in a way that is positive and protective?"

We're all shocked by the pandemic's already-massive cost in terms of human life, as well as by the its extraordinary, and extraordinarily rapid, ramifications. Look back in your calendar to about two months ago, and you'll likely see that, although you were aware of the virus, you were still going about your business in a fairly normal manner. Now, just a couple of months later, everything has changed. We follow the global and national calculations about the quickly rising number of COVID cases, and we see the strain on our health care system. Schools are closed, most people are isolating at home, businesses have closed, major corporations are on the ropes, millions have lost their jobs. The coronavirus pandemic is clearly the defining challenge of our generation- it's really more like several major challenges at once. It's a medical crisis, a social crisis, an economic crisis, a political crisis and a mental health crisis. The way that we respond to these simultaneous challenges will have long-lasting ramifications for the world, for our country and for each of us. We truly can't see what things will be like when the pandemic subsides, and it's that very uncertainty that many find so disconcerting. Anxiety about the pandemic can be as contagious as the virus itself.

We are all likely aware of the idea that the Chinese character for "Crisis" is actually composed of two characters- representing both "Danger" and "Opportunity". I think that's a good metaphor for the situation that we find ourselves in. People who study historical crises tell us that a crisis creates change, and that the changes that come out of crises are frequently positive. We can already see, in ways large and small, some ways that the world has reshaped itself. One of the primary roles of government is to protect its citizens, and we are now seeing that happen in ways that were unimaginable just a few weeks ago. Our government has quickly spent trillions of dollars to ensure that individuals and small businesses have the resources they need to survive. Companies are quickly reinventing themselves, whether by starting to produce ventilators or PPE, or by drastically changing the relationships they have with their customers. Health care workers, like us, are reminding the world of the dedication we feel towards our roles. People are rising to the challenge of social distancing, and at the same time finding new and creative ways to support each other.

So while these are undeniably scary, uncertain times, all things must pass, and the pandemic will be no exception. As they say, "tough times don't last, but tough people do". The world will be different when the dust settles on the pandemic, and so will we. We can't control the pandemic, obviously, but we can, and we must, control the way that we react to it for as long as this crazy time lasts. First and foremost, we need to monitor and maintain our personal equilibrium so that we can rise to the occasion of what is expected of us now, and what will be

see Wellness on page 37

Care Management Responses to COVID-19: Lessons from CBC Health Home's ADAPT Series

By Amanda Semidey, LCSW
VP, Care Coordination Services, and
Melissa Martinez, MS,
Director, Health Home,
Coordinated Behavioral Care, Inc. (CBC)

Amanda Semidey, LCSW

Melissa Martinez, MS

Coordinated Behavioral Care (CBC) Health Home (HH), in recognition of the diligent work continuously done by CBC's citywide Care Management Agencies (CMAs) and in response to the COVID-19 pandemic launched the **ADAPT Series**, allowing CMAs to document their best practices in **Applying Dynamic Approaches and Practices Telephonically.**

COVID-19 has posed serious challenges to the healthcare sector, with CMAs grappling with issues related to workforce and client safety, transitioning to telephonic care and remote supervision of Care Managers, all the while making both medical and behavioral health supports available to vulnerable members while under a NYS stay-at-home order. CMAs needed to nimbly adapt their models of community-based Care Management and Care Coordination services for CBC's nearly 18,000 Adult Health Home members and over 3,000 Health Home Servicing Children to be more dynamic, flexible, person-centered and primarily telephonic.

CBC's CMAs also had to quickly transition primary and meaningful engagement interventions away from face-to-face contact to telephonic, electronic, and video services, as well as contend with connecting to HH members with no phone service. It became clear early on in the pandemic that HH members were reporting limited cell phone data and minutes with the need to make tough choices about wanting to preserve those minutes for their natural supports versus using them for their care coordination and other social service needs/supports. CMAs were uncovering and addressing growing food insecurity, gaps in care, and the need for connections to recovery and rehabilitation services; all those added to the pressing need for COVID-19 psychoeducation and support.

In light of all the transition and challenges being posed and met by the CMAs, CBC HH launched the ADAPT Series in March 2020 to create an opportunity to share and highlight interventions and innovations applied and utilized during these unprecedented and challenging times by the CMAs and spread lessons learned. The CBC CMA Network embraced the value(s) of the ADAPT Series, as it created a forum for CMAs to contribute to the Network's collective learning during this public health crisis, identify and highlighting best practices with our network's Care Management leadership and staff on the frontlines. The ADAPT Series showcases the nimbleness of our CMAs to identify and swiftly address technological barriers and the rapid shift to managing a remote workforce, inclusive of creating new workflows, new norms for Care Management team communication, all while ensuring that member safety and immediate needs for medication, food and shelter were addressed.

CBC Network CMAs, such as Federations of Organizations, understood that it was imperative to arrange weekly group supervision and Care Management staff text messaging for additional support. NADAP, has been addressing Care Management morale by acknowledging staff birthdays and anniversaries via Zoom and recently implemented virtual meditation to support the well-being of their workforce.

CMAs have also been seeking opportunities to re-engage potential Health

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Current Telehealth Expansion in the Behavioral Health Sector

By Elise Kohl-Grant, MBA and Jorge R. Petit, MD

Elise Kohl-Grant, MBA

Jorge R. Petit, MD

Technology permeates almost every facet of our lives, personally and professionally, making communication easier and faster. With seemingly limitless avenues for connection, technology increases the number of touchpoints between people. Now in the middle of an unprecedented heath crisis, many clinicians and service providers have had to move rapidly to adopt new technologies in order to respond and manage continuity of care for the most vulnerable populations.

Telehealth and other technology assisted care solutions have been growing as an adjunct service option in the behavioral health (BH) sector, becoming more desirable as consumers culturally shift their communication preferences to text and video chat. Strict telehealth regulations has made it hard for agencies to adopt this innovative approach within their care settings. The increased availability of reliable broadband Internet, combined with consumer comfort with applications like FaceTime, WhatsApp and other social entertainment apps, has accelerated the willingness of individuals to accept non clinic-based treatment modalities. In the 2019 Behavioral Health and Emerging Technologies Whitepaper, a survey conducted by CBC, with over 400 consumers receiving mental health and substance use disorder treatment services in the Bronx, showed that over 70% of consumers had access to a smart phone with Internet and 70% of these accessed the Internet multiple times a day. Participants were asked which technology features they would use before, after, or between appointments to communicate with program staff. Text messaging, phone call reminders, and calendar appointments were the most common features requested by consumers as a way to communicate with staff.

Recent events have opened the door for telehealth to be widely used across the entire sector as a means of adapting to social distancing requirements. Individuals dealing with behavioral health conditions and/or impacted by social determinants of health factors are now at higher risk for stress and anxiety, potentially worsening health conditions and facing economic hardship. The opportunity to speak with therapists and doctors, even if through these technology assisted care solutions, offer solace and encouragement in these challenging times as well as needed information and treatment interventions. Regulatory requirements around the use of telehealth have been substantially relaxed due to COVID-19 to allow for continuity of care via phone and video telehealth options. We recognize the potential benefits of leveraging technology to connect with and treat consumers, both in this current COVID-19 environment as well as post-pandemic.

Through this health crisis, telehealth's growth was accelerated. The Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS) have had to quickly develop and distribute guidelines and waiver processes to allow providers to add telehealth to their service delivery options. Additionally, telehealth vendors have substantially scaled up production and increased service functionality, as a response to the growing demands.

REIFY (formally known as Innovative Management Solutions NY (IMSNY), celebrates its new branding while being a joint venture of two large Behavioral Health IPAs, Coordinated Behavioral Care and Coordinated Behavioral Health Services, together make up a network of nearly 100 behavioral health (BH) provider agencies. REIFY conducted an evaluation

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CBC's Pathway Home Response to COVID-19 and Future Implications

By Barry Granek, LMHC
Senior Director, Pathway Home™
Coordinated Behavioral Care

Barry Granek, LMHC

As we enter the third month of social distancing and in an evolving healthcare landscape with COVID-19, community-based care management teams are adapting and testing innovative operational approaches to ensure the needs of the people they serve are being met. This adaptation is taking place in real time, meaning years of cultivated technique and experience are yielding entirely different approaches to care management. Care management staff have needed to navigate all this while often dealing with their own challenging and anxiety provoking personal situations.

Accessing care management and healthcare services in this pandemic, while maintaining a safe physical distance is vital, and in many instances lifesaving. Yet, it is not just in-person care management services that require adjustments. Many coping resources used successfully before the pandemic are no longer available, due to closures of gyms, places of worship, entertainment establishments, schools, and workplaces. Consideration is needed to ensure continuity of care in providing mutual support, linkages to services and activities, and troubleshooting barriers.

CBC's Pathway Home™ (PH) is an award-winning care transition intervention for individuals returning to their community after an institutional stay. PH recognizes that uncertain times like these require novel practices to meet the needs of individuals receiving community-based behavioral healthcare. Care transitions from psychiatric inpatient units back to the community continue to occur, currently at a faster rate, as hospitals are expanding capacity for COVID-19 patients. Under these conditions, PH teams continue to accept referrals, operate with quality care, and attend to the individual's served daily needs.

These are some of strategies that PH Teams have implemented to keep individuals in their care safe and ensure they are following the recommendations enacted by government and healthcare organizations:

Telehealth Services: With the inability to conduct in-person visits, open and frequent communication between members and providers is more important now than ever. Therefore, PH services have shifted to primarily telephonic and video-based services. Although many providers and members believe in-person visits are more effective than telephonic interventions, many are now realizing that telehealth services are necessary and useful. PH was fortunately well prepared to move to telehealth services, as PH has been practicing and utilizing these technologies, such as texting and smart phones treatment applications to connect with members for several years (Petit and Granek, Behavioral Health Care, 5(4), pp. 22, 2018).

For the numerous PH members without phones, PH is supplying smartphones and shipping them directly to members to ensure ongoing contact with the PH team and their support network. Members are being taught how to attend their appointments and recovery groups virtually. PH has also outreached former members to extend emotional support and offer enhanced linkages to community resources.

Mindful Recreation: During these times of self-isolation, PH teams have prepared individualized care packages and have had them delivered with personalized letters to help overcome feelings of loneliness. Items sent have included home audio players, art supplies, books, board and video games, TV and streaming services, and literature on coping strategies. PH peers have also led virtual yoga and cooking classes, workshops on making comics, and social-distancing bike rides.

Basic Needs: To address the factors influencing social determinants of health and enable members to remain home and avoid contracting and potentially spreading the virus, PH is helping those with limited access to resources. Food, toiletries, and clothing provisions are being shipped directly to members utilizing online resources such as PeaPod, Instacart, and Seamless. PH nurses are delivering safety kits containing gloves, masks, hand sanitizer, and other precautionary items. Transportation assistance is provided through ridesharing (e.g. Uber Health), so members can avoid public transportation and continue to attend appointments with their outpatient providers.

Supporting Staff: Even though PH is familiar with using technology to supplement in-person engagement, the effort to

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Censor ruminating.

Self-soothe Through Your Senses: Be mindful of one soothing sensation as you experience it. Vision: Look at nature (flowers, rain, sky), a flickering candle; go to a virtual museum. Hearing: Listen to nature; music; go to a virtual concert; sing. Smell: Use nice smelling lotion; light a scented candle; bake; smell the air and flowers outdoors. Touch: Bathe/shower; surround yourself with a soft blanket; put a cool washcloth on your forehead; feel the breeze or sun on your face.

Experience Opposite Emotions: Create opposite emotions to your negative emotions with books, movies, music.

Encourage Yourself: Repeat: "I can stand it", "This will end", "I will make it out of this", "I'm doing the best I can do."

Connect With Others: You may have the impulse to detach and become less emotionally available and communicative with others. You will need time on your own to process your experiences but do not walk alone with these burdens. Social connection and a sense of community efficacy, when living through traumatic situations, are essential to resilience (Taylor, 2011). However, this is difficult during a pandemic. Physical distancing keeps us apart. Health care workers fear bringing the virus to their families. Others fear contact with those treating patients with COVID-19. Traumatic events are surreal and so far outside the norm that healthcare workers develop changes in their worldview, which family may not understand. All of this impedes the necessary feelings of connection. We need to be creative. At work: Emphasize partnership and teamwork; Seek consultation with peers; Seek supervision; Avoid working alone for lengthy periods. At home: Make it a priority to reconnect with your core social group each day, to have a conversation, share an activity, or just be around each other; Plan activities with family and friends, both those in your home and those elsewhere. Be creative (Remote movies, trivia, painting, cocktail parties); Deepen your relationships with those you love. Try new activities (e.g., each family member or friend chooses an activity they enjoy, and everyone tries it). Connect in a way that is most comfortable, without judgment.

Communicate Emotions and Experiences: Resilience is associated with the ability to communicate feelings, thoughts, and experiences openly. It is relatively common for healthcare workers to prioritize the needs of others over their own and to feel there is a stigma associated with expressing emotions to others. Engaging with feelings rather than pushing them down is the only way to cope with them. Journal to record and process your experiences. You may be concerned that your friends or family would be uncomfortable or afraid if you talked to them about your experiences in the hospital or that they would not understand. Of course, use your best judgment but maybe try them. They may not fully understand but may be a good support and even be helped by the sense of agency they gain by supporting you. Remember, there is great value in communicating about other emotions and experiences, too. Talk to and share your experiences and emotions with your coworkers. Focus on describing your feelings without judging them. Avoiding or suppressing negative emotions only strengthens them. If you push them down they will pop out in another way at another time. Engage humor, "another of the soul's weapons in the fight for self-preservation" (Frankl, 2006).

Evaluate Thoughts: The core premise of Cognitive Behavioral Therapy teaches that the way we react to a situation is more related to how we think about the situation than to the situation itself. Our thoughts drive our feelings and often our behaviors. Unrealistic thoughts can produce greater distress.

Ask yourself: Am I thinking rationally or is my thinking driven by emotion rather than evidence? Am I balancing emotion (anxiety/vigilance, compassion) with rational thought?

It is common to wonder "Am I doing everything I possibly can do for my patient? Am I doing enough? Am I doing the right thing and making the right choices? How vulnerable am I and will I infect my family?"

In answering these questions try not to engage in irrational or destructive thinking such as, "My contribution should be to work all the time. Taking care of patients is more important than my needs and it would be selfish to rest. I am the only one who can do this. There is danger to my family and me and there is nothing I can do about it."

Engage in positive self-talk such as, "I have done everything that is reasonably possible. There are situations I cannot change. I can focus my anxiety on what I know to be actual threats and not over generalize my fear. I can invest my efforts in what is within my power."

Know that your feelings and concerns are valid while understanding what you can control and ways you can contribute 1) to your patients' health without feeling unrealistically responsible for the lives of patients and 2) to protecting the health of your family and yourself.

Find Meaning: In times of crisis it is possible to find a new appreciation for life. Where concerns about our physical and economic survival consume us we can also find an opportunity to evaluate priorities. Reflect on what has importance and is of value to you. Practice gratitude for the blessings in your life. Engage in meaningful activities. Adversity can be an opportunity for personal and social growth. Focus on what it means to you to be human. Consider activities which emphasize creativity, humor, ingenuity, the arts, physical exercise, emotional insights, family, religion, whatever gives your life meaning.

Look Forward: The ability to make future plans and to be goal-directed in carrying them out is linked to hope and resilience. Make plans for the short-term future. What are you looking forward to that's happening soon? (an online exercise class? - family game night? - reading a good book? - a short walk at the end of the day? – learning a new skill?). Although we do not know when, this crisis will pass. Imagine the future when it does.

Reach Out for Professional Help When You Need It: If your feelings become overwhelming or you feel that you need someone else with whom you can express and process your emotions and experiences, reach out for professional support.

COVID-EMOTIONAL SUPPORT

HELPLINE – NYS Office of Mental Health 1-844-863-9314

SAMHSA's National Helpline 1-800-662-HELP (4357)

Correspondence concerning this article should be addressed to Michelle A. Dunn, Montefiore Einstein Center for Autism and Communication Disorders, 6 Executive Plaza Suite 297, Yonkers, New York 10701, 914-375-4898, MDunn@montefiore.org.

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associated with the COVID-19. So many are helping people in need, while launching their own emergency and contingency plans into action. When you give thanks tonight at 7pm to the essential workers, remember to give gratitude to the behavioral health care workers helping people endure the behavioral health effects from social distancing and the COVID-19 pandemic.

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designation, resources, emergency funding or quite frankly the same respect as our hospital-based colleagues. This article is not meant to blame or admonish our primary system, again, they are absolutely doing amazing and selfless things during this crisis. All I ask is that the term "Hero" should not be reserved for only part of the healthcare system. Let's recognize our residential SUD healthcare workforce, and advocate for the necessary resources, PPEs and other tools they need to make sure we eliminate BOTH epidemics (COVID-19 and the Opioid Crisis), that are simultaneously costing us the lives of our loved ones.

Robert Anderson currently serves as the Executive Director for the Educational Alliance and its Center for Recovery and Wellness located in New York City; which provides integrated Substance Use Disorder, Mental Health and recovery-oriented services all in a dynamic new open and inclusive community center approach.

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they have a life-threatening situation they will not got to ER or urgent care. I agree to tell patients to wait until they think that they should call 911 when they think that they cannot handle things anymore. Most of these patients are limited English proficient and cannot even describe their concerns when without a family member around. ER and urgent cares have become the hotspots for COVID-19 exposure, and patients cannot trust their providers anymore as non-carriers of COVID-19. Hospitalized patients cannot be with their families and the worse of all, many have died or will die alone and breath their last without being with their loved ones, but only virtually.

Loss of support: Most immigrant families have had the initial loss of support when they decided to get displaced and move or settle in another country. These immigrant families find support in the community among neighbors, peers and the biggest support being their

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We Are All Essential: Surviving the COVID-19 Pandemic in a Supportive Housing Agency

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

In early March, NYC was on the cusp of true panic mode related to the coronavirus, with calls for mass isolation and social distancing, a rush to buy vast quantities of toilet paper and supplies of hand sanitizer and masks rapidly exhausted. Very little guidance was in the public domain outside of hand washing recommendations, and government agencies were still figuring out suitable emergency policies and procedures for health providers and community based agencies. At Concern for Independent Living, a 48-year old supportive and affordable housing provider serving 1500 adults and 250 children in Brooklyn, the Bronx and on Long Island in a variety of residential settings, we had already learned of the death of three of our tenants from COVID-19 complications and quickly realized that local inpatient and emergency room systems could no longer be relied upon as a readily available resource to care for our tenants and staff who may get sick. In essence, we needed to prepare our existing

Jim Mutton, LMSW

housing stock to become de-facto healthcare settings for likely treatment and quarantine.

With fear and trepidation in our hearts and on our minds, Concern looked to develop an emergency housing and healthcare model that would protect our community and sustain us with hope and compassion for the long haul. To bolster the planning of our journey, we turned to several universal principles of mindfulness and compassion learned from work retreats at the Garrison Institute in upstate New York along with our common mission and purpose, notably:

• Loving Kindness – we tolerate uncertainty by helping others, gain resilience and grow from our self-reflection as a community

• Mindfulness – by living in the moment, we genuinely embrace our fears and concerns. We try to be present with our thoughts and feelings

• Self-Kindness – we cannot take care of others unless we support, nurture and encourage ourselves

• Common Humanity – we are all in this together and as an agency, we rise to the challenges together, leaving no one without a voice

Our model is still evolving as we learn more about the virus and ways to flatten the curve of the pandemic, but centers around five main points of intervention:

• Safety and Security – we have focused on widespread PPE acquisition for staff and tenants, working with local pharmacies, vendors, trade associations, government partners and other providers to acquire masks, gloves, sanitizers, wipes, sprays, disposable thermometers and finger pulse oximeters wherever available, in both small and large quantities, through bulk buying and single purchasing (allowing for enough PPE to last several months). We purchased infrared thermometers for every site so that temperatures of staff and tenants can be taken without a need to touch the skin. Direction was sent that all staff are to take their temperatures at home in the hours before reporting for a shift and again when they arrive on site. Anyone with a temperature in keeping with current guidance is to be sent home. Staffing across sites and multiple shifts has been reduced to limit exposure. All single site common areas, such as libraries, fitness rooms and recreational spaces have been temporarily closed. Plexi-glass barriers and safeguards have been erected at in lobby and reception desks. All non- essential guest privileges have been suspended. The best medicine has been prevention.

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Primary Health Care Worker who often is one who speaks the language these immigrant families prefer. So is the case with South Asian community. However, over the lockdown the community has lost a lot of healthcare providers and doctors leaving their patients in shock, in immense anxiety and stress. South Asian community members often ask for help as they do not know who to contact to get a medication refill, sign a prescription for a much-needed medical supply or as simple as getting a follow up consultation from a doctor who could speak their language and understand their concern in their own way. South Asians treat doctors as representatives of God who can cure everything and make someone perfect again. With doctors falling sick and dying, the community stands shaken in disbelief.

Fear of the unknown and death: It is by default that we want to die amongst our loved ones. We all want to be held tight, smiled at, prayed for and loved when we are breathing our last. Sadly, for many, COVID-19 has brought the exact opposite experience. People across the political boundaries in the world have died alone, away from their loved one and buried during mass burial. For many bodies are waiting to be claimed and many more awaiting. Families have not received the closure they need, there has been no bereavement process for those who lost their loved ones due to COVID-19. This is even more devastating to imagine for immigrant families as they are often split between their country of origin and the country they moved to. Many are left alone here as their immediate families have not returned due to the travel ban. Fear and anxiety has grasped the community to the extent that even after multiple falls, potential injuries and with symptoms of stroke, a patient would refuse to go to the ER fearing that he/she can contact COVID-19, a kiss of death! People fear that if hospitalized, they will be isolated and eventually die alone. Especially for South Asians, death is marked with spiritual and cultural practices that directly connect with faith. Bereavement and closure are more of a spiritual process. For South Asians lack of this process is very depressing and scary. Unfortunately, these concerns are often the unspoken and unmet needs that trigger behavioral concerns but are never addressed appropriately.

It has been awfully hard to come to terms with this pandemic and associated self-quarantine because we never imagined that we would face a lock down for so long. I have observed that the multilayered issues leading to the current behavioral changes and individual traumatic outcome is not just due to the virus. It is the ripple effect this pandemic has created in our daily lives that has not only changed our behavior towards ourselves and our family and friend, but also shaken us up to understand that certain adjustments are possible. This trauma will stay for a long time. It will take months before we regain the trust to shake hands, exchange items, sit beside one another without being concerned about contacting COVID-19.

Along with clients, South Asian therapists are in a similar crisis with a need for support groups. The author is involved in created such support groups for professionals and can be reached at resolveera@gmail.com.

Reimagining the New Normal for Addiction Services

By Norwig Debye-Saxinger
Executive Director of the Therapeutic Community Association of NYS

Although eclipsed by the COVID -19 pandemic, our opiate epidemic persists in the penumbra of that plague. In some places more people continue to diefrom overdoses and addiction related suicides, than from coronavirus infections.

Some of the isolation strategies implemented to flatten the COVID-19 infection curve may have had the unintended consequence of raising the death toll of substance use disordered people and those mentally challenged. That would be the dark side of the campaign to quell that novel coronavirus pandemic.

On the bright side, many "emergency" adjustments made to rules and regulations governing service delivery and billing have opened the door to best practices that should be made permanent in the addiction prevention and treatment field.

Foremost are the delivery of services by tele-practice; public assistance and medical assistance eligibilities accomplished by telephone and/or audio-visually; telephonic reviews by courts of clients diverted to treatment in lieu of incarceration.

Tele-practices made permanent would create access to treatment that should exist in the 21st century, and save an enormous amount of money previously spent on transporting people for face-to-face interviews.

Other Lessons to Be Learned.

It might be wise for the addiction services provider field to identify facilities that would be equipped to handle, quarantine, referrals with infectious diseases - should the normal hospitalization resources not be available. COVID-19 might well be followed by COVID-20.

I'm sure providers could provide many recommendations of what "emergency" guidances might best be made permanent; and which ones should not.

The easiest and best way for the federal government to provide a funding stimulus to dealing with the opiate epidemic would be to quadruple the Block Grant.

The formula for distribution of Block Grant funds to the states is in place. States have flexibility on how/where to allocate additional funding. It's all discretionary; not "entitlement." Allocations to service providers could be quick and cost-effective.

Given the immense stimuli funding packages already in place and being considered, a quadrupling of Block Grants (an addition of $3billion to the $1billion already out there) would be peanuts!

I recommend peanuts over no nuts!

Providers from page 1

population with guided profiling of weighted risk, based on known chronic diseases, general population health indicators, and communities at risk geographically.

Communication — development of internal and external messaging on how the organization is addressing COVID-19. Messaging is important, as it speaks to awareness, leadership, knowledge, and support. Developing action plans on messaging and identifying internal key personnel are also essential. The messaging must be consistent and come from members in the leadership group, as well as possibly from the service community. A key internal statement must be developed for this messaging. A key external statement must be developed as well.

The internal messaging must prioritize:

• improving staff competency to give them the skills to meet health, security, and training challenges;

• providing structure and daily goals;

• organizing tele-huddles to give support, supervision and decrease sense of isolation while working; and

• giving continued updates on how leadership is addressing risk and security for staff and the organization, etc.

Internal messaging has to be determined in terms of pathways of communication and scheduling. It is important to offer emotional support and develop messaging on coping and self-care for staff, particularly with the organization's Employee Assistance Program (EAP).

The external messaging includes continuation of services to clients, other providers, the state/county, and any potential collaborations. This must be developed in alignment with existing vision and presence in the community of service.

The client population must be messaged consistently about new service activities, risk characteristics, and coping skills. They should also be notified of wraparound services and/or offerings of new platform services (such as nutrition while in isolation, refresher on first aid at home, guided mediation/relaxation for biofeedback, narrative journaling, etc.). Coaching may include giving guidance on the use of current media, identifying goals for each activity, and using new media with assistance on procurement issues.

Education and Training — assist in identifying and/or developing responsive training for new services/activities (decontamination and safety hygiene, implementing teleservices in secured environment, care coordination of COVID-19 recovering patients, symptom assessment of COVID-19 risk, referral procedure for suspected COVID-19 infection, documentation of services, risks in data breach with hacking or ransomware, etc.). Identify and ensure training rollout of Evidence-Based Practices (stress reduction using CBT, reducing risk for self-harm with EMDR, sleep hygiene assessment, etc.) and federal guidance on services (state-specific implementation of the 1135 waiver) during the pandemic. Identify appropriate separate training rollouts for different levels of contact and duties to each organizational staff member (supervisors, clinical staff, peers, support clerical/ administrative staff, IT, etc.). Tracking and management reports for training should be developed for quality oversight and risk mitigation.

Data Integration and Security with New Technology Launch — with new or responsive services identified for COVID-19, assist providers to develop a roadmap for new tech-supported functions (patient portals for direct messaging and journaling, teleservice products, cloud storage and secure VPN access, group chat capabilities for staff in-checks and supervisions and huddles, etc.) to track, implement, report, and safely store data with existing or new products. Align organizational IT capabilities with state-specific requirements (store and forward function for teleservices, data integration and CMS billing updated for COVID-19, user security and authentication for remote access to data/cloud server, etc.) and a roadmap for implementation to lessen user burden, in addition to ensuring management oversight and data security.

SAE recognizes that these outlined tasks can certainly appear daunting to providers facing the challenge of providing behavioral health services to individuals and families coping with this illness. The spectrum of issues to address include the impact of anxiety and depression, dread and uncertainty, and the need to ensure the integration of behavioral health and medical care. Given the horrendous and terrifying symptoms that many COVID-19 patients endure during their treatment and recovery from this illness, we can expect the emergence of PTSD symptoms, often occurring beyond the patient's 30-day recovery period when still experiencing brief bouts of COVID-19 symptoms, such as shortness of breath and chest pains. Unfortunately, based on previous experience from Hurricanes Sandy and Katrina, we may see concurrent increases in domestic violence, child abuse, substance abuse, depression, and suicidality, to mention just a few potential outcomes from environmental trauma. Therefore, immediately identifying clients at greatest risk and developing safety plans is a natural first step.

SAE understands that many providers faced with the impact of this pandemic on their administrative, clinical, and financial operations need help now to get them through this crisis; to gain organizational stability; to access new resources; to identify and implement new technologies such as telemedicine; and to train staff to implement these new technologies effectively. SAE's COVID-19 Behavioral Health Response Team has the capacity to help your organization access new funding from SAMHSA, primarily through the CCBHC Funding Opportunity Announcement where SAE's grant writing team helped six behavioral health providers each receive 4 million dollars to expand their services in 2019-2020. We anticipate that the 2021 SAMHSA Funding Opportunity Announcements will focus on providing behavioral health agencies with the resources to expand the use of innovative technologies to engage and maintain in treatment the most disadvantaged populations of focus impacted by the coronavirus pandemic.

SAE's COVID-19 Behavioral Health Response Team has the skillsets and experience to help agencies implement the six critical steps noted earlier that you need to take to effectively implement changes required to gain agency control over its destiny and to begin the process of its recovery and eventual growth. SAE provides training, guidance, research, updates, and solution tools to help address the needs of agencies during this pandemic. Visit http://saeandassociates.com/ to view our array of resources, such as our Issue Briefs and Podcasts. To explore how we can assist your agency during this pandemic, email info@saeassociates.com to connect with our team.

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health issues: One night I snuck out because of my anxiety. I felt like the walls were caving in on me. I couldn't take it any longer. I put on a mask and gloves and went downstairs at 4am because I didn't think anyone would be around. I felt like I couldn't go on like this. I packed up a bag and was almost ready to leave — but something said "don't leave, stay." So, I stayed. That was the best thing I did.

Finding a test in the Bronx is challenging: I finally started feeling better and no longer had a high temperature, so my doctor recommended I get tested for COVID-19. I was worried about spreading the virus and wanted a test to confirm I was no longer ill. An S:US case manager who had been helping me tried to track down a test. In the Bronx tests are very hard to find. He went beyond the call of duty—he started calling people, going through all his contacts, and finally found a place that said "if you come in half an hour, we'll test you." Eventually my test came back negative, which meant I no longer had the virus.

When I heard that I was negative, I dropped on the floor and started praying and crying. It's hard being alone for 30 days. I've been on lockdown in prison, where I was put in the hole for 50-60 days but you always have time to talk to somebody. It's funny that now I'm in a 12-story building and I didn't have anybody to talk to.

Based on Barry's experience, he reached out to help others: There's a man on my floor who was going through the same thing I went through. I could hear him crying at night when I emptied my garbage. I knocked on his door and asked him how he's doing. I told him, "I know what you're going through. You need someone to talk to while this is going on. I wanted you to meet the people from S:US—they can help you get through this."

I am doing better now, though I'm wary of being put in rooms by myself and I carry around the paperwork to show my negative test result. I'm still going to my methadone program and I talk to my psychiatrist regularly.

S:US Cares: Isolation and illness can be scary. Many people feel alone right now. Though we may be apart, we stand together. We're thankful to S:US for their support, heroism and compassion during this pandemic. As we all adjust to the reality and uncertainties associated with COVID-19, we know that S:US remains committed to serving people like us.

Living Room from page 16

transportation options. On top of these conditions, COVID-19 has caused many to have an increase in symptoms, increase in substance use and increase in unhealthy behaviors.

Significant stress and panic are keeping people at home, so HDSW is checking on people more regularly. However, due to COVID-19, some who need HDSW's services are fearful to leave their home or the shelter and are not reaching out. We have provided outreach to all previous Guests. Many appreciated the connection and some were able to reconnect to other community supports using linkages offered by staff. Many needed assistance accessing food resources.

Referrals: Help Doesn't Stop During COVID-19

A significant component of The Living Room program is its extensive referral network. Our COVID-19-era Network remains as robust as ever, we know our region and our partners well. As Guests have needs we are providing linkages to address the services our guests need. In addition to screening for COVID-19 symptoms we have made referrals for COVID-19 tests and other medical conditions that require evaluation or monitoring like diabetes, asthma, high blood pressure, etc. HDSW has helped with technology to connect guests with their providers via telehealth and use their computers or smartphones with recovery oriented apps and websites. Guests report these new ways help them to feel connected and less isolated are helpful. Safety assessments and referrals are made for guests who are at increased risk and present with suicidal ideation and state they feel unsafe at home. The Living Room also has a small on-site food pantry, so guests can go home with food, even dog food, since pets are so important to stability. HDSW established an additional emergency food pantry to address food insecurity during the pandemic for clients we serve.

Living Room 2.0:
Near-Term and Post-COVID-19

For HDSW, the only certainty in this COVID-19 period is that the Living Room will stay open and will continue to innovate as needs present. Guests are our priority, and it's in our mission to listen to their needs and help. Once we made the decision not to close, we understood that we were going to be transforming how we provide service both now and into the future of The Living Room, essentially creating Living Room 2.0. In our new-normal or a post-COVID-19 world, Living Room 2.0 will support guests for an episode of care, knowing that although it may be a trauma experienced long ago, it may have been triggered or exacerbated by the pandemic and being socially isolated for extended periods. Staff will receive continued training for addressing loss and bereavement and other issues that may arise. We will continue to explore new ways to provide services, delivery of services online, by phone, and in -person as The Living Room evolves to meet the needs of our guests. What Matters To Our Guests, Matters To Us!

Outcomes from page 15

conversations, behavior skills trainings within residences, access to video and written task analyses on the organization's intranet and a COVID-19 website, and regular emails. In addition, families and board members were also kept informed via phone calls, video sessions and emails.

Changes to Organizational Structure and Operations

Melmark's senior leadership team enacted many layers of change to support health and safety protocols.

1. *Limitation of visitors and symptom monitoring:* As soon as the Governors from three states issues stay at home orders, all Melmark programs were closed to all visitors. All staff and individuals had their temperatures taken every two hours to ensure continuous symptom monitoring. Any individual showing COVID-19 related symptoms was immediately isolated, in their own residence if possible. Some went to specially designated homes, set up as isolation units. All staff showing symptoms were tested and sent home immediately. An increased focus on and training in effective hand washing procedures was also initiated.

2. *Reduction in numbers of people on site and in each location:* Schedules were examined to assign fewer numbers of individuals to each site, where possible, limiting the movement of staff between residences and reducing the numbers of staff working in more than one location. Some administrative staff were designated to work remotely, in full or part-time capacities, to reduce the number of people on site.

3. *PPE provision and training:* Full PPE was provided for all staff with COVID-19 cases in isolation. This included N-95 masks, gowns, gloves, and goggles or a face shield. The organization's health care and professional development teams led virtual instruction and in-person trainings on how to properly wear, don and doff PPE.

4. *Availability and access to on-site testing:* Test kits were purchased and were administered by healthcare professionals within the organization. This on-site testing ensured limited exposure by decreasing trips to external medical facilities, and rapidly provided guidance for intervention moving forward.

5. *Adherence to CDC and local Boards of Health for all aspects of care:* Social and physical distancing guidelines were enforced, including in clinical care (as appropriate) and in training contexts. Many trainings were moved to an online format while those occurring face-to-face were modified to reduce contact.

Summary

COVID-19 arrived abruptly and challenged all aspects of our lives, including the care of the most vulnerable. The need to care for those with developmental disabilities with co-occurring medical frailty and/or behavioral challenges in a safe environment necessitated an immediate, structured, and thoughtful organizational response. The multi-tiered action plan considered the best interests of the individuals and kept the responsibility of the organization to both staff and clients top of mind. Alterations in scheduling, equipment allocation, and the designation of space were important plan components. In addition, vigilant attention to new staff training protocols, prevention, detection and treatment ensured cases could be contained and reduced. While I hope we never again face such an unpredictable and unprecedented medical challenge, the lessons of COVID-19 have served us well to prepare for the continuation of care during public health threats and during other crisis situations.

Rita M. Gardner, M.P.H., LABA, BCBA is the President and CEO of Melmark, a multi-state human service provider with premiere private special education schools, professional development, training and research centers. Ms. Gardner leads with a mission-first focus on providing exceptional evidence -based and applied behavior analytic services to every individual, every day. Through her robust background in public health, as well as her business acumen, Ms. Gardner has guided Melmark's entire team on a clear, mission-focused path to ensuring the health and safety of the individuals served and staff employed by the organization.

Helping from page 19

and closure. Clients seek to close the hole in their heart their loved one has left, but instead realize over time that hole remains. The person has died, but the love, the memories and the relationship lives on. Grief is in fact about holding on and letting go. As clinicians we can help the client navigate holding both these feelings of loss and renewal. What will be the continuing bond that allows the client to carry their loved one with them? Will they wear an item of their clothing? Will they visit their grave or talk to them daily? Will they create legacy as they share stories with the next generation? Much of the work in mourning can be about how the person wants to construct this ongoing relationship, but not everyone will want to, as these continuing bonds are both comforting and painful. If grief is not about closure it is about finding and maintaining these continuing bonds.

During the quarantine it is particularly difficult to help clients "move forward" as forward motion has literally stopped across the globe. Clients describe now feeling alone in their grief, stuck at home with nothing but their photographs and memories, feeling disconnected from the support they need. As clinicians we can help clients add something to their grief so they can begin to hold both the loss and renewal. Can a client access what brings them peace and comfort? Is it talking to a friend who understands, listening to comforting music, doing something artistic or athletic, taking a long hot bath, watching a favorite TV show? As clinicians we need to stress self-care for clients as well as guard them against self-judgment. Some clients will think if they let go of a little pain they are letting go of the person; nothing is farther from the truth.

As our client's personal grief has been swallowed up by the collective grief the world is feeling, we can support our clients in their quest to create meaning and attain connection. If unable to go to their house of worship can they tune in virtually? Can they hold on-line gatherings with friends and relatives to share stories of loved ones? Is there a daily ritual that would connect them to their loved one? Can they create an online memorial book where people post their memories? Will they consider joining an online bereavement group to get peer support and share universal themes of grief? Would a gratitude exercise help clients to both express what they have lost and look at what they have retained as well? In the weeks, months, and years to come we will need not only to bear witness to our clients' stories, but also hold the hope for them that life beyond tragedy is possible.

Gillian Rittmaster, LCSW, is Bereavement Coordinator for WJCS, one of the largest human service organizations in Westchester county. WJCS offers individual and group bereavement support for Westchester County residents via telehealth for those who have suffered a loss of any kind.

Remote from page 12

CMS has clarified that a patient must verbally consent to receive Virtual Check-In services. In most cases, this service will be initiated by the patient, but providers may need to educate beneficiaries on the availability of the service prior to patient initiation. The following CPT code may be used in connection with Virtual Check-In services for Medicare beneficiaries:

HCPCS code G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

Electronic Prescribing of Controlled Substances via Telemedicine

The federal Ryan Haight Act requires a provider to conduct an initial, in-person examination of a patient before prescribing a controlled substance electronically. Effective March 17, 2020, the U.S. Drug Enforcement Administration has announced that this requirement has been suspended for the duration of the public health emergency.

OMH Emotional Support Helpline (1-844-863-9314)

In March of this year, Governor Cuomo announced the creation of a state-wide hotline to provide free mental health services to individuals at home who may be experiencing stress and anxiety due to the COVID-19 crisis. The New York State Office of Mental Health Emotional Support Helpline "provides free and confidential support, helping callers experiencing increased anxiety due to the coronavirus emergency. The Help Line is staffed by volunteers, including mental health professionals, who have received training in crisis counseling." In order to staff the Helpline, the Governor called upon mental health professionals to volunteer to provide telephone and/or telehealth counseling for individuals in need. To volunteer, professionals are asked to complete a survey at health.ny.gov/assistance and click on the tab for health, mental health and related professionals. Mental health providers interested in volunteering should indicate on the form that they are available for telephone and telehealth counseling services.

One concern among professionals interested in volunteering may be whether participation in volunteer psychiatric and mental health counseling services will subject psychiatrists or other professionals to potential malpractice liability. Executive Order 202.10, signed by Governor Cuomo on March 7, 2020, expands New York's Good Samaritan law to ensure immunity from civil liability for any injury or death arising out of medical services provided in support of the State's response to the COVID-19 outbreak. This protection from liability extends to volunteer mental health counseling services provided during the current public health crisis, unless such injury or death is caused by gross negligence. Further, some psychiatry malpractice insurance carriers have confirmed that their policies will cover psychiatric services provided on a volunteer basis in the state where a psychiatrist is licensed to practice medicine. For additional information, professionals should contact their individual carriers.

Telemedicine and other telehealth services are a key component in ensuring continuity of care for individuals with mental illness during the ongoing COVID-19 crisis. In addition, the OMH Helpline uses remote access to assist those experiencing increased anxiety, stress and fear. The use of remote technology plays a vital role in our efforts to address the mental health needs and emotional well-being of all individuals impacted by this crisis.

Rachel Fernbach is the Deputy Director and Assistant General Counsel of the New York State Psychiatric Association, a division of the American Psychiatric Association and the medical specialty society of psychiatrists practicing in New York State. Ms. Fernbach is also a Partner at Moritt Hock & Hamroff LLP, where she concentrates her practice in not-for-profit and mental health law.

SUD Community from page 24

where he and others assemble food boxes and set up temporary housing for doctors, nurses and first responders who can't go home and need a safe environment to stay before they return to work on the front lines. He also dedicates all weekend, every weekend volunteering either for the Red Cross or FEMA where he fills other critical roles including distributing much needed PPE to medical facilities and even transporting the recently deceased due to COVID-19 from hospitals to the city's public cemetery on Hart island where they are prayed for before they are interred. Christopher's inspiring story reminds us all the goodness and grace within people who are dedicated to pursuing a life of recovery and helping others.

Point 5: By the time this gets published I pray that the curve on the pandemic has not only been flattened but rather shattered to smithereens. However, if things are as they are, we need to do the following:

• make more protective gear available to our frontline workers and clients

• provide differential pay to those who put themselves in harm's way

• additional funding for take home doses for clients in medically assisted treatment

• funding for loss in revenue for fee for service providers who can't see clients

• residential programs to be funded, staffed and equipped like the hospital units they are now called to be

• mobile testing that can be done at residential sites so that providers can better triage their population

• **support one another like never before!**

Roy Kearse is a dedicated public servant, who has spent the last 40 years serving the needs of some of the most vulnerable new Yorkers, through his various roles as peer counselor, clinician, manager, administrator, various healthcare services board member , NASW NYC past vice president, past ASAP board president, board member MHNE, served on governor's advisory council on behavioral health, board member exponents, board member of TCANY, Current VP of SDV recovery services and community partnerships, chair of ASAP veterans committee, Chair of NYS credentialing board, and grateful recovering addict of 40 years. You may contact Roy Kearse at Roy.kearse@samartanvillage.org or (718) 206-2000 x1269.

Lessons from page 28

Home members. For example, Samaritan Daytop Village (SDV), initiated an outreach campaign to individuals they were unable to engage in February 2020 who were now accessible and receptive to services, obtaining verbal consent to enroll and beginning the assessment and care planning process.

Servicing high risk members in the community often calls for persistent and highly coordinated efforts to maintain safety and wellness. WellLife Network CMA demonstrated how they worked with transitioning an Adult Home Plus Member from an Adult Home Residence to an independent community setting thanks to the tenacious efforts of the Care Manager to ensure that the member receive all necessary supports to remain safe and stable in the community

Oftentimes, we forget to take stock of the incredible work that our frontline care managers do on a daily basis to fortify social supports, convene service providers, elicit the strengths of those they serve, and mitigate the barriers that all too often exist for marginalized and vulnerable communities. The ADAPT Series, has allowed CBC HH to draw a spotlight on these successes and not only share them across our Network but disseminate lessons learned and emerging best practices. At a time when we are all coping with personal as well as professional anxiety and uncertainty, CBC HH has developed a process whereby we could showcase our CMA Network's responses and expertise in adapting, connecting and intervening during this unprecedented crisis.

For more information about CBC HH and HHSC program, please visit our website at www.cbcare.org.

During and After from page 1

• Much effort has gone into preventing contagion in residential settings, in the hopes of protecting both clients/patients and the staff bravely providing care for them. Sadly, these efforts have not been entirely effective. Nursing homes have high rates of illness and death as, to a lesser extent, do psychiatric hospitals, shelters, jails and prisons, etc. To some extent this reflects failures to provide adequate testing, screening, and protective equipment.

• Governments have intervened to some extent to support the financial survival of providers with loans and changes in reimbursement criteria. Providers continue to struggle nevertheless.

• Training initiatives have been developed by professional organizations, trade associations, , professional schools, and continuing education programs to help providers learn how to use tele-mental health, to make use of emergency financing, to understand new regulations, and more.

• Providers have developed mutual aid groups to figure out how to deliver services when programs are closed, staff is in short supply, funding is problematic, etc.

• Governments, providers, professional organizations, and more have provided public information about how to cope with increased emotional distress.

• Helplines and hot lines have been beefed up for people seeking compassionate interaction, professional health, or immediate crisis intervention.

• Some professionals have come out of retirement to provide clinical services in volunteer corps that help to address the limited capacity of the behavioral health system in the best times and the more limited capacity now that some providers are out sick or with family responsibilities.

• Volunteers have been organized in neighborhoods, states, and even nationally to provide social connections and assistance to people who are isolated. In some of these initiatives, clinicians train the volunteers and provide backup when they connect with people who need professional help.

• Workplace programs, such as employee assistance programs (EAP's), have provided work site interventions ranging from yoga groups to enhanced treatment services to help workers survive the stresses of their jobs.

Continuing Challenges

As remarkable as these responses have been, there is still much that needs to be done to meet behavioral health needs during the pandemic. This includes:

• Vigilance and modifications of laws and regulations are necessary to make sure that relief promised for individuals and families and loans for businesses that are on the edge of bankruptcy (including behavioral health agencies) actually are delivered.

• New efforts are necessary to address racial and ethnic health disparities that have become increasingly apparent in the rates of sickness and death due to the pandemic.

Michael B. Friedman, LMSW

• Regulators and accrediting bodies need to set and enforce standards and provide adequate resources to avoid contagion in congregate care settings such as nursing homes, inpatient psychiatric units of general hospitals, state hospitals, adult homes, community residences, supportive housing, etc. Standards should include routine testing/screening of workers and clients/patients, adequate protective gear, and more. Efforts should be redoubled to get tests and protective equipment, and failures to provide them due to cost avoidance should not be tolerated.

• Tele-mental health has unquestionably been a savior for many people. But it has limitations, not the least of which is lack of universal access to computers or even smart phones.

• It is important to identify and continue to remove regulatory and fiscal barriers to behavioral health service provision. For example, there continue to be problems paying for service for people with both Medicare and Medicaid (dual-eligibles) as well as problems funding outreach, psychiatric rehabilitation, and non-medical model services.

• Behavioral health services are now threatened by cuts in funding because states have had tremendous losses of income. It is critical for the federal government to provide additional emergency funding to fill the emerging gaps.

• It is also important to address workforce shortages. This ongoing problem has been compounded by the cancelation of licensing exams due to the pandemic. As a result, newly graduated social workers, for example, cannot enter the workforce at a time when they are desperately needed. In addition, immigrants who have professional credentials in their home countries but are not licensed here could be available for service if licensing rules were changed.

• Appropriate utilization of psychiatric inpatient services has become a critical issue. If admissions are reduced in order to be able to maintain safe environments vis a vis COVID, what will happen to people who otherwise would be hospitalized, especially those who are homeless, potentially suicidal, etc.?

• Frontline healthcare staff are under tremendous psychological stress as they face severe illness and death daily, work long shifts, and manage anxiety about their own health and the health of their families. In addition, other essential workers, who risk their health daily, also experience great emotional distress. All of these heroic workers need special attention and care.

• People with physical, developmental, psychiatric, or cognitive disabilities who need predictable routines are also at increased risk during this time of sheltering-in-place.

• Their caregivers need supports to avoid burnout and to continue to provide care in the home.

• Alcohol and perhaps other substance abuse is on the rise. For example, alcohol sales in liquor stores—regarded as an essential business—are up over 50% and on -line sales are up over 250%. It is important to monitor and address rising risks of substance abuse, especially of deaths from overdoses and alcohol-related disease.

• Generally, suicide rates rise as the economy declines. The disastrous near collapse of the American economy, the associated job loss and struggle to survive contribute to what has been called "a perfect storm" for suicide. This will need to be monitored carefully, and if rates rise as many expect, extra efforts will need to be devoted to suicide prevention.

• As noted previously, tremendous efforts have been made to provide public information including remarkably good advice about how to weather anxiety and stress. However, there are important questions about who the tip sheets and public service announcements reach. Is it only the educated population? Do there need to be different approaches to reach poor, disadvantaged, socially estranged populations, who are particularly hard hit by the pandemic? And does the good advice being offered need to be more tailored to particular populations taking into account different developmental stages, lifestyles, levels of education, regular sources of information, etc.?

• It has become entirely clear during the pandemic that the closures of schools, houses of worship, senior centers, social service provider organizations and more create mental health challenges. Joint efforts between the behavioral health system and other services systems are needed to identify cooperative ways to contain the psychological and spiritual fallout of the pandemic.

• It is particularly important to find ways to help people deal with death and/or in grief without traditional ceremonies—bedside vigils, funerals, graveside gatherings, comforting social events, and the like. Are mental health professionals prepared to provide help? Enhanced partnerships with spiritual leaders would probably be beneficial.

• This unique pandemic and the responses to it create a broad range of research needs and opportunities. How much relapse takes place? Do the prevalence and incidence of mental and substance use disorders increase? How much and what forms of emotional distress do people experience? How extensive is resilience and adaptability? Do the programmatic initiatives work? What are the benefits and shortcomings of tele-mental health services? Are there implications regarding the integration of behavioral and physical health? Do alternative reimbursement models created for this emergency contribute to continued service and the survival of service providers?

Getting Ready for the New Normal

Hopefully, the stringent public mental health measures that are designed to contain COVID will phase down in the next few months. What then?

The pandemic has revealed—once again—the social fault lines and the consequences of economic, racial, and health disparities in America. An enormous proportion of the American population—most of whom are not officially poor--lives from paycheck to paycheck; they do not have enough in savings to cover necessities for even a couple of weeks. Many live on the edge of homelessness. And a very large number of Americans do not have adequate health insurance and have no coverage at all if they lose their jobs. Obviously, this makes their lives difficult. It also affects their behavioral health negatively and may contribute to rising suicide rates, drug overdoses, alcohol-related deaths (the so-called "deaths of despair").

Unquestionably, a major social task of the recovery from the pandemic will be to tackle disparities and the social determinants of behavioral health in a serious way.

With regard to behavioral health specifically, we can expect that the psychological fallout of the pandemic will not suddenly come to an end when sheltering-in-place stops. Some psychological effects will linger, and some will emerge when people are able to shift from the struggle to survive to an effort to re-establish normal lives. There may well be increased need, and demand, for behavioral health services.

Will behavioral health providers be able to meet the demand? Lack of capacity in America's mental health system and shortages of qualified behavioral health personnel are longstanding problems. They may get worse.

Funding of behavioral health services will certainly be a problem going forward. Behavioral health providers rely heavily on Medicaid—a political football before the pandemic that is likely to be so again especially with a presidential election coming up. They also rely heavily on funding from the states, which are all going to move to cut their expenditures as the pandemic slows down, if not before. Cuts in funding to providers that are already at risk of bankruptcy will put the entire system in jeopardy.

There have been some remarkable changes made to the behavioral health system so as to preserve services that have been perceived as exceedingly important.

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Supportive Housing from page 31

• Flexibility & Support – staffing schedules have been revised to reduce exposure and offer some relief with a combination of both on site and remote work, as well as a change of shifts to fit staffing needs at home and in the workplace. As has been discussed citywide, we see the major risk of infections coming from staff members who are contagious and come to work. As such we have focused on educating staff and setting clear policy to discourage anyone from coming to work while potentially contagious. We have provided guidance to all staff that no one need feel that they have to choose between working and being paid if they are ill or showing symptoms of illness. The agency is making sure that everyone who is ill or potentially ill is paid. In addition, persons who wish to remain at home because they have a compromising medical situation and/or are simply wishing to avoid exposure are being allowed to use their time - and even to go into negative time banks - so that they can feel safe and comfortable. This flexible use of accrued time off and paid compensation for those without has relied on principles of agency support without judgement on requests to stay home (no fear or worry underplayed). Payroll bonuses for on-site work and those who went above and beyond have been valuable incentives for staff and will be evaluated on each payroll cycle. On Long Island we hired a Nurse Practitioner to be available two days a week to consult with staff and tenants and to help facilitate communication with medical providers, as needed. In New York City we hired a physician's assistant, a former US Airforce medic who has good experience with infection control and behavioral health, to triage tenants and provide vital healthcare engagement. A consulting psychiatrist through JANIAN Medical Group has been providing ongoing remote healthcare through video conferencing on Doxy.me one day per week.

• Communication and Contact – Concern has engaged in a broad sharing of information to all employees and tenants. Each department and region have engaged in regular ZOOM based support meetings to hear concerns and discuss problem solving on shared issues. In many ways, we are communicating better than before the crisis. In response to a lack of remote connectivity with some tenants, we have purchased pre-paid cell phones for weekly contact and provided widespread signage and tenant/ staff education materials. Remote contact can often seem distant and disconnected, so everyone at Concern has tried to approach each other with warmth and gratitude, recognizing tenants and staff as valuable members of our community. Online support groups and conference calls for tenants are also being developed to respond to emotional and healthcare needs.

• Teamwork and Support – we have witnessed a heightened collaboration between agency administration, human resources, accounting, property management, compliance, employment and housing sites, with regular communication around staff and tenant needs. For example, our property maintenance staff have modified their responsibilities all over the agency to spend their time at congregate sites cleaning and sanitizing daily. We have adapted procedures at all sites to make it possible for staff to reduce the amount of contact they have with tenants when supervising medications. We have encouraged program leadership to buy extra food, items to entertain and occupy tenants to help encourage them to stay at home. In our scattered site apartments we have been delivering food and other essential items. Any tenant who tests positive or is showing symptoms is instructed to quarantine in their apartment or room. In two of our supervised sites, tenants share bathrooms and kitchens. As a result, we have recently secured the rental of a RV in the event that a person residing in one of the residences has a positive test result and needs to self-quarantine. That way, they can remain close enough to the program for us to continue to support their needs but can be separated from the other tenants. With recent active COVID-19 cases, we have also brought in an outside cleaning contractor to sanitize apartments and work spaces.

• Collaboration and Funding – Concern has maintained active and ongoing collaboration with partners and stakeholders – government, trade associations, board members, other housing providers – to share ideas, learn from others and stay ahead of the resource curve. The measures described in our initiatives to date have been costly but we made a decision as an agency that we would do anything we can to safeguard our tenants and staff. We have been diligently applying for any emergency funding that is related to COVID 19, including a Paycheck Protection Plan with our primary bank, FEMA funding and foundation grants to help fund our expenses and offset current costs.

In summary, we hope that by sharing this model of intervention we can offer some insight and support to our colleagues in the housing industry, as we survive this pandemic together and learn from our experiences. Thankfully and likely as a result of our interventions, our numbers of those getting infected have remained low. The model is likely indicative of further health and housing collaboration during challenging times and we hopefully provide a blueprint for future design. It is perhaps best summed up by the words of one of our peer counselors, who emailed this message at the end of his work week, "I believe the job that I do and you do makes us special because of the danger you walk into and you just keep on walking. The heroes are everywhere, some can be seen and some that can't. Concern is the hero that also has a goal, to save the lives of the people they serve. True heroes often remain in the shadows but keep doing the job to the best of their ability. That is why I am proud to be a part of Concern. From the inside and the outside, that gives me a view of the goodness you do, and to share with the clients on a level they feel comfortable with sharing how they truly feel. So, for them and for myself, thank you."

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Will these changes be carried forward? Will there be a greater appreciation of the importance of behavioral health services? **Will changes in regulations—especially regarding telehealth and the assurance of financial viability—be carried forward** or will government revert to reluctance to pay for telemental health and to suspicion that behavioral health providers don't really need the funding they claim is vital?

The use of **volunteers to provide social connections** for people who are isolated has also been a very positive development. Hopefully, these initiatives will be sustained after the sense of urgency passes.

The private sector will also have an important role as people come back to work. Workplace behavioral health programs will probably be under increased pressure to **address mental and substance abuse issues that affect productivity** and personal life satisfaction.

Research about behavioral health during the pandemic has the potential to illuminate future developments as well as to provide the basis for preparing for the next pandemic. It should be used to guide the system forward.

Mental health advocates should begin now to **identify the changes that ought to be preserved and be prepared to advocate for the fiscal and regulatory leeway that is needed to move forward.**

Hopefully, after the pandemic ceases to be an emergency, the behavioral health community will be able to **join forces to advocate for the overall system and the needs of the people it serves**. Even in good times, behavioral health providers fight over the bones of governmental funding, each seeking to meet its own needs. And even in good times, mental health advocates have made themselves dysfunctional by engaging in ideological disputes that pit personal freedom against social protection. **Hopefully, these disputes can be set aside and united action can be taken** to progressively meet the behavioral health needs of the American population as goes on.

ABOVE ALL ELSE:
PREPARE FOR THE NEXT TIME!

Michael B. Friedman, LMSW was Founder and Director or the Center for Policy, Advocacy, and Education of MHA of NYC until he retired in 2010. He continued to teach at Columbia University School of Social Work until he moved to Baltimore to be closer to his very special grandchildren. Now he serves as a volunteer behavioral health advocate with AARP of Maryland. He can be reached at mbfriedman@aol.com.

Expansion from page 29

and compared eighteen telehealth vendors. The evaluation included; demos, provider insights, and review of available material. The vendors were scored based on four criteria items: Price, Accessibility, System Functionality and Security. The vendors were then categorized based on the complexity of their system. For example, a pure play video chat app like FaceTime is a relatively easy "plug and play" option. On the other end of the spectrum were vendors that provided substantial add-on features, including health monitoring and on-demand therapeutic interventions. After a concise evaluation process, two vendors were selected as preferred partners in which we negotiated pricing for the larger network of providers.

Through this process, we established 3 key takeaways:

1. *Telehealth capacity building:* While most telehealth companies had a roadmap and business scale-up plan, the pandemic required a drastic ramp-up and caused many to expand past their growth capacity. That included the need to quickly hire sales representatives with limited knowledge of the product, unable to meet the growing demand of customer support inquires, limited features and not having complete privacy and encryption systems in place. We collected feedback from the IPA network providers and identified use case scenarios to evaluate usage and security risks. We continue to follow updates related to feature enhancements. It is apparent that telehealth companies are rapidly improving by the minute. In fact, the cadence of system updates and enhancements are now almost daily for some solutions.

2. Strength in numbers: For many small- to medium-sized BH organizations, spending significant time viewing product demonstrations, trying to get a sales representative on the phone, analyzing product options, and negotiating price can be overwhelming. The CBC and CBHS Network, via REIFY, was able to:

• Conduct virtual round table discussions to gather agency (end-user feedback);

• Survey the network to hear about direct experience with potential vendors;

• Leverage network size to secure lower prices; and

• Leverage volume to negotiate rates and support for the network providers.

3. *Planning for post-COVID-19*: Organizations that embrace this new form of communication and treatment delivery option will need to build new workflows, adjust scheduling expectations, and enhance privacy protections. They will find new ways to maximize revenue opportunities and connect quickly to consumers. Meanwhile organizations who fail to invest and adapt may struggle to meet the new needs for a changed environment. Even if an organization wishes to revert

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expected of us when we come out the other side. And we will come out the other side.

Professional Challenges

While everyone in America is doing their best to navigate the stress and deprivation of the pandemic, that challenge is compounded for clinicians who will need to confront the same challenges as everyone else while simultaneously struggling with the added pressure of performing at high levels in difficult environments. COVID-19 is clearly going to place new and unexpected stress on the vast majority of clinicians, and we know that many clinicians were already experiencing stress issues and symptoms of burnout before any of this kicked in. A holistic view of burnout looks, of course, at stressors in the workplace, but also factors in the contributions made by stressors from our larger lives. Right now, the combination of these two sources of stress, the extraordinary demands of the pandemic on us as clinicians, plus the stress involved in managing our personal, home, family and financial lives, will be formidable.

So we have perfect storm recipe for burnout, and it's critical that we all create a survival plan that allows us to come through to the other side. The "calling" to become a clinician creates a mindset in which sacrifice is expected, "pushing through" extraordinary challenge is expected, and the notion that "the patient always comes first" is expected.

But bringing those expectations to an extended period of extraordinary challenge, is not a feasible strategy. This will be a marathon, not a sprint. And clinicians who disregard and "push through" their limits, who ignore the warning signs of stress and burnout, are less likely to find themselves on the other side of the pandemic with their mental health, their patients, their families and their careers in equilibrium.

That's the challenge that we as clinicians are now confronted by- shaping a strategy that allows us to function optimally- for as long as the pandemic calls us to- for our patients, our families and ourselves.

Mental Health Impacts

After the metaphoric earthquake of a crisis comes the tsunami of its mental health ramifications. The U.N. defines a disaster as "a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources". Clearly, the COVID-19 pandemic fits the bill, and based on what we know about the impact of prior events on population mental health we need to be prepared for significant increases in the prevalence and severity of mental health disorders.

Patients with a variety of existing psychiatric disorders are likely to experience symptom exacerbations, particularly those with anxiety disorders, depression, obsessive compulsive disorder, panic disorder, histories of paranoid ideation and chronic psychiatric disorders such as schizophrenia and bipolar disorder. Those with PTSD or histories of stress reactions from previous trauma will be challenged by both the pandemic and its multiple impacts on day-to-day life. We are already seeing spikes in calls to mental health hotlines, increases in psychotropic prescribing and many other mental health barometers, but the full force of the mental health impact may not be seen until the immediate crisis has abated but the longer -lasting repercussions on social and family structure sink in.

People with addictive disorders will be challenged by the pandemic and the social isolation that is now part of it. Maybe you've seen the reports of huge increases in the sales of alcohol? Then factor in the fact that those who use 12-Step programs as part of their recovery plans are no longer able to attend those meetings because of social distancing.

So we want to be on guard for exacerbations of symptoms in our patient populations as well as for new-onset diagnoses of psychiatric disorders. Let's make sure that we're asking all of our patients how they're feeling emotionally, and inquire about specific symptoms, particularly anxiety. And let's make sure that patients who need it get the psychological and psychiatric care that we can provide.

At the same time, we need to be equally vigilant about the mental health impacts on our selves and on our fellow clinicians. As noted by Rachel Naomi Remen, "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet." Personal protective equipment will hopefully keep us safe from the virus itself, but there is no corresponding protection from the emotional toll that the crisis may bring us.

The Individual Perspective

In Man's Search for Meaning, Victor Frankl's account of his experience in a Nazi concentration camp, he described the experience of the prisoners as "a provisional experience of unknown limit." The prisoners didn't know what might happen to them in the camp, and they didn't know if or when they would ever get out. He wrote that those prisoners who had a hoped-for goal were more likely to survive than those who had no particular goal other than mere survival.

One of Frankl's personal goals was to survive the camp so that he would be able to teach others what he learned about the human psyche in the camp, a goal that he was ultimately able to achieve through his book and in the creation of a form of psychotherapy called logotherapy.

To the extent that we are all now living a "provisional experience of unknown limit", albeit one that for most of us fortunately doesn't compare to the horror of a Nazi concentration camp, it falls to each of us to create for ourselves the future goals that inspire us to wake up each morning and do battle. In doing so, we stop being victims of circumstance but rather individuals in pursuit of a set of priorities and goals for ourselves, and that mindset can play a very protective role in helping us get through to the other side.

Your training and experience have prepared you for the clinical work ahead. Your history of overcoming personal crises along with your commitment to family and community have prepared you for the challenges you will confront at home and in your extended family.

So, this is a good time to be asking ourselves some important questions.

• What kind of clinician do I aspire to be, and how can what's happening during this crisis help me get there?

• What kind of co-worker do I aspire to be, and how will my behavior during this crisis move me in that direction?

• What kind of spouse, parent or child do I want to be remembered as, and how will my behavior during this crisis make it more likely that I reach that goal?

• What kind of impact do I hope to have on the world, and how can what I do now help me leave that legacy?

So it goes without saying that Netflix and comfort food, tempting and even necessary as they may be, in sensible doses, aren't going to help us achieve our new goals. Of course we need to make sure that we are taking good care of our physical bodies through good nutrition, adequate sleep and other healthy behaviors. Of course we need to stay emotionally connected to our families and friends, in safe ways. And of course we benefit from spending time outdoors, in nature, and from staying in touch with our spiritual beliefs.

Let's also make sure that we set meaningful goals for ourselves, as our pursuit of them will surely inform everything else that we do. The world will be a bit different after the pandemic, and so will you. Think about who you want to be when this is over, and make every day a path forward in that direction. When we make decisions based on those core values, we're much more likely to be able to handle whatever the world throws at us.

Keeping Emotional Equilibrium at Work

It bears repeating that the COVID-19 pandemic is unlike previous crises that we've experienced. Many clinicians have been on the front lines of mass shootings, hurricanes and other crises, but in those situations the precipitating event and the storm of patients was over in a matter of days. In contrast, Coronavirus surges and their extended impacts will last for months, or longer, so the "push through it" strategy that may have worked in the past won't prove helpful now. In running a marathon, we save strength that will be sorely needed in the final mile. We need to adopt strategies here that will help ourselves, and our teams, in the long haul. Burnout can be contagious in an organization- we want the opposite- a contagion of positive actions among people doing the most meaningful work possible. Here are some ideas that might help:

Have team meetings: Difficult as it may be, try to meet as a team as frequently as possible. Give clinicians an opportunity to discuss both patient-related clinical issues and compare notes on what's working and what's not. These meetings can also be used as forums that allow clinicians to talk about their experiences, both positive and negative, around the pandemic. These brief get-togethers will save time in the long run and will go a long way to improving overall team wellness and morale.

Celebrate every victory: In the midst of the pandemic's predominantly difficult, even tragic, moments, there will be many scenarios in which clinicians go the extra mile, find creative solutions to problems or connect with patients in profound ways. Make sure that these moments are recognized and celebrated, don't let them get lost in the shuffle of an otherwise busy and perhaps chaotic situation.

Focus on what you can control: As clinicians, we are often powerless to save a patient- in many cases, COVID (or something else) will prevail despite our best efforts. But no force on earth can prevent us from provide the best possible care. Appreciate the fact that you did everything possible to provide the best, and most comfortable, outcome for the patient and family. You can't do any more than that.

Keep an eye on your colleagues: When the normally cool, calm and collected become irritable, flat or tired, don't assume they're just having a bad day. Let them know that you're noticing a change, that you're concerned about them and want to know if there's anything you can do to help.

Take breaks: Somewhat paradoxically, we need more, rather than fewer, breaks during times of crisis, because we need to pace ourselves to stay strong. And be mindful that when you do take a break, it's really that. Downing a cup of vending machine coffee while you catch up on notes is not a break. Walking outside for 10 minutes or spending the time in a quiet place, breathing deeply, is better.

Finish your work at work: Spending all day taking care of patients and then going home to spend the night writing notes is no way to navigate the pandemic. Home should be a special place with its own people, practices and rituals. If at all possible, walk into your house with all of your work-related activities completed.

Decompress before you get home: Think about what you can do to create a buffer zone or perform a transitional activity before arriving home. This is a considered action that puts work into the rear view mirror and establishes a clear boundary between work and home. Go for a run or a nature walk, meditate, do some breathing exercises, whatever works for you. You may have heard that the meditation app Headspace is providing free access for all health care workers, and there are many other options.

Staying Strong at Home

In some ways, the nearly-national stay-at-home scenario we're in now is like an unplanned social psychology experiment: What would happen if everyone were forced to spend all of their time with their families at home, we became responsible for our kids' education and we eliminated televised sports? While this situation is likely going to produce some negative outcomes, our goal is to use this period to move forward in important ways.

So if you follow the suggestions I discussed in the previous paragraphs, when you return home from work you'll have put a boundary between yourself and work, you'll be ready to fully engage in your time at home. Think not of being "stuck at home" but rather of being "safe at home," and free to organize your time in the healthiest way possible. Many of us are spending more time at home than we're used to, and that extra time presents an opportunity to rethink our typical patterns of behavior in a positive way.

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Wellness from page 37

Optimally, when the dust settles, we'll be able to look back on this period not as something we "survived" but as a time that provided the opportunity to make positive changes that lasted. Remember, it's a crisis- but it's also an opportunity.

At a minimum, that means having a healthy schedule and engaging in behaviors will help us come out the other side better than we started. That means creating and sticking to a schedule, eating healthy, setting aside plenty of time for sleep, avoiding excessive alcohol consumption, etc.

But we want to go beyond the basics by seizing this opportunity to change some things in positive ways. Creating and meeting goals puts us in control and sets us up for a series of satisfying victories.

A good way to start would be by using this time to significantly improve your level of fitness, which can be easily done either inside the home or outdoors. Wind sprints, deep knee bend, push-ups and sit ups all require no equipment, but they're all you need to significantly improve your physical fitness. Keep in mind that exercise is a true mental health intervention that compares favorably, for example, with anti-depressants for mild-to-moderate depression.

On another level, this stay-at-home period is a great opportunity to focus on our relationships with those we live with. Are there new family traditions or rituals that can be initiated? A weekly "kids-make-dinner night" or family movie night? Are there new ways of communicating that can be tried? How about a regular "gratitude" practice in which everyone at home is encouraged to say one thing they are grateful for? The pandemic and the huge issues it brings up- death and dying, impacts on school, work and the economy- are all grist for the mill in terms of initiating more meaningful connecting about the things that really matter. I'd bet that many of us have had more crucial conversations with the people we care about in the last two weeks than we did in the preceding year.

Are there projects that you've been meaning to do for years but never seem to have the time to get started? Maybe you have the time now to re-organize your photo albums, which is a great form of life review and a good way to provide an oral history to your kids.

Do you have a bucket list? If you don't, here's your chance to create one. If you do, are there items on it that you can actually cross off during this isolation? You can't climb Everest right now, but you might be able to learn how to play chess. And you can book that trip to Everest for summer 2021, which gives you something exciting to plan and look forward to.

The goal of all of these ideas, again, is to change our mindset from that of a victim who is tolerating being shut in to that of someone who is going to mindfully take advantage of an unusual period of time so as to move forward. Here are some other suggestions:

• Connect with people you haven't been in touch with for a long time- you'll likely find them at home!

• Start a new hobby or re-energize an old one that you set aside when school, career and family obligations set in

• Spend as much time as possible outdoors

• Find a way to engage in your unique religious or spiritual practice

• Meditate, do breathing or guided visualization exercises, yoga or progressive muscle relaxation. Free videos and apps for all of these activities are widely available

• Don't overindulge in TV news consumption. It's a 24/7 news cycle and an admittedly fascinating moment in history, but you really don't need to know everything there is to know about the pandemic.

• Learn to cook if you don't cook now. It will come in handy right now, when many restaurants are closed, and may become a valuable skill that you enjoy

• Start a journal

• Help neighbors who need it with shopping, gardening or errands that they are unable to do on their own

• Finally clean out your garage

I hope that all of you use this time to deepen your connectedness to your loved ones. You can make this a time that your young children look back on as special, that your older kids look back on as the time they learned how to manage big challenges, and that you look back on as the time when you came to appreciate and connect with all of your significant others in profound and lasting ways.

For clinicians, this is one of those "put your oxygen mask on first, before assisting others" moments. Taking good care of our own emotional well-being is a prerequisite for taking good care of our patients.

Expansion from page 36

back to in-person interventions, building the capacity to safely and effectively incorporate telehealth, even on an as-needed basis, is a relatively inexpensive move that will keep consumers engaged and organizations viable and thriving.

Over time, the BH sector will need to consider the right mix of telehealth-delivered services versus in-person interventions. We will need to assess the impact of telehealth in the outcomes and effectiveness of the intervention versus care-as-usual. It will be very hard to go back to pre-COVID-19 status quo. The BH sector will need to evolve and change to meet the needs and demands of our consumers through more episodic and technology assisted care solutions. As all this unfolds, what is constant is that people need meaningful connections, and telehealth can assist in making that possible.

REIFY (formally known as Innovative Management Solutions NY (IMSNY)) is a collaborative partnership that focuses on leveraging shared skills and expertise in the Behavioral Health sector. We are focused on the integration of transformative technologies and innovative strategies within practice care settings in scalable and cost-effective ways. IMSNY coordinates information technology (IT), data analytics, telehealth initiatives, value-based payment strategies and management services for IPAs and other entities.

Coordinated Behavioral Care (CBC) is a member-led, mission-driven, organization dedicated to realizing the opportunities under Medicaid redesign to improve the quality of care for Medicaid beneficiaries with serious mental illness, chronic health conditions and/or substance use disorders.

Elise Kohl-Grant, MBA, is Chief Information Officer at REIFY and Jorge R. Petit, MD, is President & CEO of Coordinated Behavioral Care (CBC).

Implications from page 29

transition to distance-based services still posed challenges and entailed adjustment for frontline staff. Many staff had to train on often unfamiliar technology, requiring learning on new techniques for distance-based engagement. PH created a "Tips and Tricks for Distance-Based Care Management" manual with standards to assist PH staff in adjusting to telephone and video communication. A comprehensive resource guide was also created to centralize available resources and emailed weekly with updates. Categories in the resource guide include food, childcare, telehealth support, benefits assistance, phone and internet, crisis hotlines and online support groups, pharmacy delivery, and in-home wellness activities.

As we continue to responsibly physically distance, it is important to simultaneously attend to our own self-care and support our staff to help them perform their work and adjust to changes in their roles. Therefore, PH has been hosting virtual meetings for specific team roles (Peers, Supervisors, Clinicians, Nurses, and Care Managers) to share strategies, lend collegial support, and share experiences and resources. A Member At-Risk Committee meeting (following the principles of Project ECHO) is held twice monthly to brainstorm effective interventions and marshal resources for members having difficulty accessing services or display high risk behaviors. Pathway Home™ Training Institute transitioned trainings offered onto a virtual platform. The trainings are designed to address COVID-19 and provide guidance on ways to support members and PH staff during this time of heightened stress. For example, Coping Skills for Your Participants in the Age of the Coronavirus was tailored for interventions with members and Self-Care in the Age of the Coronavirus was geared toward care management staff. All these efforts help ease the stress or confusion of shifting roles and ensure staff feel confident and prepared.

Implications for the future: While there have been massive disruptions to the healthcare system and the behavioral health community, these shifts may help inform best practices after the pandemic. Agencies are learning that it is feasible for technology to be used to expand the availability and accessibility of behavioral healthcare services. Telehealth has become the dominant mode through which preventative and treatment services are currently being accessed. Many providers have begun reporting increased engagement and more regular appointment attendance since virtual options were provided. Overall feedback from members has been positive, many expressing a preference for telehealth. Post-pandemic, PH hopes to take these lessons learned during this time and incorporate some array of distance-based services into the program model.

As the behavioral healthcare community learns to navigate the new landscape brought forth by COVID-19, PH remains committed to service delivery innovations. PH teams will continue to provide distance-based services, monitor for needed in-person outpatient visits, and collaborate with local providers to assist those most in need throughout this pandemic. As one PH staff member said, "We know that this is a scary time in the world. However, we're also here to say that this too shall pass, and we will all be stronger as we come out of it."

For more information about Pathway Home: www.cbcare.org/innovative-programs/pathway-home/.

Zone from page 23

technology able to meet it?

Information: Create a Crisis Library

• What is a crisis library? A crisis "library" is the organized storage of material related to the crisis, as it unfolds. This might include external communications from state and local governments, related internal communications about the crisis, updated regulatory information and status reports, and more.

• Identify a "crisis information manager." The earliest days of a crisis can pass in a whirlwind. Information, at times contradictory, is coming from all directions and can change daily. Identifying a specific staff member or members to sort, review and maintain relevant data, can free other team members to concentrate efforts on designing crisis policies, protocols and guidance. The identified crisis information manager can collaborate with other leads, enabling providers to divide and conquer necessary tasks, while simultaneously building a type of management journal that can be easily referenced long after the crisis has resolved.

Communication: Develop a Strategy Aligned with your Crisis Mission

• Frequent, targeted, and transparent communication. The uncertainty of crisis requires frequent and targeted communication. COVID-19 is affecting all individuals, worldwide, in some way. Our current holding pattern, fraught with insecurity, personal worries, and financial and health worries, requires frequent communication from all levels of leadership, with an understanding of what agency staff may be experiencing. It can be helpful to assign

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responsibility for specific types or levels of communication, to different staff members. For example, executive leadership, as transparently as possible, will want to provide a macro sense of the larger environment and the agency's place in the new order. A program director, focusing on new workflows and coordination of staff, will channel the communication assuring its dissemination and intended purpose of uplifting morale. Key to a communication chain is that it is in line with the overall crisis mission.

• Building in a process for rapid feedback. Through continuous quality improvement, rapid feedback must be part of the communication strategy. Never is it more important for provider agencies, and the staff within, to be able to pivot and shift depending on updated information or new systems that aren't working as planned. Traditionally obtained data, tracked through the electronic medical record and client and staff surveys, can offer insight into the effectiveness of program elements. But, in crisis, it is helpful to employ less formal methods for feedback, as well. Regular team check-ins - "huddles" - throughout different "layers" of an agency, can serve as a rapid feedback loop. By their nature, huddles are brief and targeted "non-meetings" which serve to affirm the current situation, confirm which plans are already in place, and assess any need to change the plan (SAMHSA.gov, retrieved 2020, May1). Huddles communicate clinical information and are 20 minutes or less. in non-crisis times. Transferring the huddle concept to managing crisis can ensure that two-way communication is maintained.

• Daily change requires prompt communication, and sensitivity to staff fatigue. The reality of the COVID-19 situation is that change occurs daily, sometimes multiple times throughout the day. One change may necessitate multiple micro-adjustments that ripple through the service delivery chain. Balancing the need to ensure communication at regular intervals, while respecting the very real impact of change-fatigue among staff, requires being in-tuned with what they need to hear, and when.

In times of crisis, behavioral health and substance use disorder providers' experience in program development is a necessary foundation. Equally important is being cognizant of the process of change and its impact on individuals. Taking a proactive response to sudden, unfamiliar and transformational change, supports a smooth and (somewhat) seamless transition to the "new normal." Virtual services through telepractice is a modality that is likely to stay and will certainly benefit a cohort of our clients. An underlying theme of the COVID pandemic is that it requires that we create a balance between current and effective evidence-based care in clinical settings, and to consider how clients are or can be best served through telepractice. Structuring program development through the change process extends the benefit to staff and paves the way for lasting organizational success.

Adapting from page 26

collaborate. Lastly, by adopting new technologies in their support of the medically and economically vulnerable community, they are embedding education and telehealth opportunities in the fabric of their relationships with the clients served.

Teens from page 23

telehealth to continue family therapy during the shelter in place order. By contrast, teens outside of treatment programs are forced to stay home with their families way more than they are accustomed to. Where parents may be enjoying the increased time with their teenagers, the young person that would normally be negotiating the task of separating and individuating (Blos, P., 1967) have experienced this as stressful.

Early in the process of implementing shelter-in-place guidelines, treatment professionals were prepared that teens and/or their parents might choose to leave the program against clinical advice amid COVID-19. Residential programs serving young people have experienced quite the opposite, seeing very good retention. Parents have expressed comfort in knowing that their children are in a physically and psychologically safe space. At the same time, the teenagers are kept informed and current about COVID-19 by clinical and healthcare staff. To this point, they have become accountable and responsible to the charge of keeping their parents and grandparents safe by remaining safely in treatment. Clinicians report telehealth family sessions to be affirming of the commitment to safety that parents and children have signed onto in the face of COVID-19.

Messages of continuity - life will go on. An important message that residential staff continue to communicate to the teenagers is that, despite the unprecedented upheaval in life activities and norms, this situation is temporary. Life will go on, and attention to treatment and education goals must remain strong. Seemingly, this lead and pace message has manifested in these young people taking full advantage of their virtual classrooms and increased introspection in their individual sessions with clinicians. It is so important remind them of all the good times ahead in their young lives.

The opportunity in the crisis? From our perspective, residential treatment for teenagers has provided a safe and nurturing setting that has allowed them to face COVID-19 in a resourceful way beyond their years. Perhaps the takeaway here is a reminder that when a young person enters residential treatment, they are taking time away to invest in themselves. Long after COVID-19 passes, let's remember how effective this treatment approach was in helping young people navigate the crisis.

Behavioral Health News Upcoming Theme and Deadline Calendar

Fall 2020 Issue:
"The Suicide Crisis in America"
Deadline: September 16, 2020

Winter 2021 Issue:
"Social Determinants of Behavioral Health"
Deadline: December 23, 2020

Spring 2021 Issue:
"Trauma Informed Care and Policy"
Deadline: March 18, 2021

Summer 2021 Issue:
"The Behavioral Health Technology Field"
Deadline: June 17, 2021

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Emotional Reactions from page 26

the optimal result of any person's journey across these phases is post-traumatic growth, a process of integrating the "story" of one's experiences from the disaster into their personal narrative. This includes lessons learned and new ways to cope to face future adversity.

As a 24/7/365, "never dormant, always available" disaster crisis and emotional support service, the DDH hears from people in the reconstruction stage who continue to struggle with difficult emotions years later, on milestone memorial dates when media tends to revisit the disaster or when commemorative community events occur. These may bring back painful memories, while also offering others a chance to acknowledge and honor any growth or rebuilding.

The question now is when will reconstruction from Covid-19 happen? For some who were seriously ill or who lost loved ones, that process may have already started. For others, who may still be in the impact or disillusionment stage, when distress or other mental health concerns are at their strongest and reconstruction seems far off, it's important to keep looking forward. Friends, family and loved ones can help people look forward to this "final" stage, with the message that recovery is possible. Emotional health supports, like the DDH, are and will always be available. No matter what happens, you are not alone.

After any disaster, including the Covid -19 pandemic, we will find "strength after" together.

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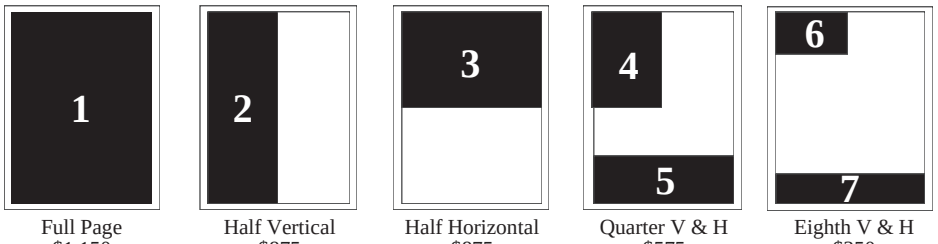

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