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FALL 2021 ON MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT AND SERVICES VOL. 9 NO. 2

Addressing the Workforce Crisis During the COVID-19 Pandemic

Help Wanted! Now More Than Ever

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

A 2016 report of the Health Resources and Services Administration (HRSA) offered a bleak depiction of the current and future state of the nation's behavioral health services workforce. Nearly half the American population resides in a designated Mental Health Professional Shortage Area (HPSA), and its plight is expected to worsen in coming decades. A majority of individuals with behavioral health conditions is currently unable to access appropriate care, and by 2025 a projected shortage of approximately 250,000 health professionals will relegate behavioral healthcare to the realm of luxury (Health Resources and Services Administration, 2016). Tragically, it is poised to become a rare commodity to be consumed only by the privileged few.

The HRSA report and its discouraging predictions were issued long before the Coronavirus visited our shores and wrought unspeakable havoc on the economy. Our national workforce is in disarray to a degree unseen in decades, and the behavioral health sector is more vulnerable to the vicissitudes of the job market than many others. In short, the COVID-19 pandemic produced a confluence of exceptional challenges that compounded existing trends. A precipitous rise in the incidence of serious mental health and substance use issues during the past 18 months threatens to unravel what is left of a strained safety net. Between November of 2020 and May of 2021, the proportion of adult New Yorkers who experienced symptoms of anxiety or depression and reported they were unable to access specialized mental health treatment steadily increased (New York State Health Foundation, 2021). An epidemic of adolescent suicidality, especially among girls, has assailed emergency departments and hospitals as their personnel struggle to contain the causalities of the Coronavirus (Centers for Disease Control and Prevention, 2021). In addition, a

see Help Wanted on page 18

An Interview with the New York State OASAS, OMH, and OPWDD Commissioners to Address Critical Healthcare Issues

By David Minot, Executive Director
and Ira Minot, Founder
Mental Health News Education (MHNE)

In a rare opportunity, Mental Health News Education, publisher of Behavioral Health News and Autism Spectrum News, has brought together the Commissioners of the NYS Office of Mental Health (OMH), The NYS Office of Addiction Services and Supports (OASAS), and The NYS Office for People with Developmental Disabilities (OPWDD) to address critical healthcare issues currently affecting the New York State community. Topics addressed in this interview-style article include: COVID-19 and vaccinations; the workforce crisis; federal funding; diversity, equity, and inclusion; and the collaboration between the three state offices. We are delighted to present to you the following responses from OASAS Commissioner Arlene González-Sánchez, LMSW, OMH Commissioner Ann Sullivan, MD, and OPWDD Commissioner Theodore Kastner, MD.

COVID-19 and Vaccinations

Can you comment on your department's current thoughts on vaccination and mask mandates? How can we further protect staff (whose vaccinations are seriously lagging) and clients?

Arlene González-Sánchez
Commissioner, NYS OASAS

Ann Sullivan, MD
Commissioner, NYS OMH

Theodore Kastner, MD
Commissioner, NYS OPWDD

NYS OASAS
The New York State Office of Addiction Services and Supports (OASAS) conforms with the CDC and NYS DOH COVID-19 guidance with respect to masking. Vaccination acceptance by the OASAS-regulated system staff and clients is slightly lower than the vaccination acceptance numbers for NYS residents in general. However, many clients may receive their vaccinations outside of the OASAS system, so these vaccinations are not monitored by OASAS.

The agency is also addressing vaccine hesitancy with weekly webinars for OASAS staff and clients and will also be hosting a webinar with a panel with OASAS provider staff who have overcome their vaccine hesitancy to share their experiences in doing so.

NYS OMH
The pandemic is not over, and now, as we experience the effects of the Delta and other variants, we must do everything possible to keep our patients, staff, and clients safe. NYS Governor Kathy Hochul recently implemented a series of universal mask requirements that apply to all

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Deadline: September 16, 2022

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New York State Office of Mental Health Enhances Recruitment Efforts to Address Workforce Shortages

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

As New York State faces another wave of COVID-19, the need for access to mental health care in our communities has never been more urgent. Unfortunately, health-care delivery systems across the nation are overwhelmed and understaffed.

And while this workforce shortage presents many challenges, it also presents opportunities for dedicated, qualified, and caring individuals to make a difference in people's lives while furthering their own career goals.

A common response among mental health professionals, when asked why they went into the field, is: "I wanted to help people." Working in this field is extremely rewarding and fulfilling; and helping others can dramatically increase employee motivation and overall job satisfaction.

Certainly, a career in mental health can be challenging. There are some difficult days. But few professions offer the ability to literally transform lives for the better. There's no greater feeling of accomplishment for a mental health professional than seeing a patient or client reach a goal or overcome a significant challenge. We do truly share in their joy.

With a workforce of more than 13,000 people statewide, the New York State Office of Mental Health (OMH) operates the largest state mental health system in the nation, with 22 psychiatric centers, two world-class research insti-tutes, one secure treatment and rehabilitation center, and 90 clinics. Our agency also oversees community-based mental health services throughout the state.

OMH offers career opportunities in many diverse occupational areas. We have a continuing need for psychiatrists and other medical doctors, nurse practitioners, registered nurses, psychologists, social workers, and direct care staff to work with adults, children and youth, and forensic populations in a variety of inpatient and community settings.

OMH is addressing the national workforce shortage by expanding our recruitment efforts and implementing both long and short term strategies. In the short term, OMH is using funding from the Mental Health Block Grant (MHBG) and

Ann Sullivan, MD

Federal Medical Assistance Percentages (FMAP) to enhance, expand and sustain these services by providing a combination of targeted rate increases to eligible programs and flexible workforce recruitment and retention funds to support a wide range of activities to build capacity.

Federal funds from the enhanced FMAP enable OMH to invest in strengthening and expanding capacity to address increases in demand, adjust to the realities of post-pandemic service delivery, and build workforce capacity for long-term sustainability of the community mental health system.

As part of system transformation, OMH has prioritized the development of a comprehensive array of rehabilitation services to promote access to prevention and recovery-oriented supports for adults and children. While the enhanced FMAP resources are one-time, OMH will be advancing strategies to use the funds to enhance, expand and sustain these services by increasing rates, providing workforce recruitment and retention funds to allow providers to build capacity, and targeting funds for infrastructure investments including training in evidence-based practices and resources to improve the quality and efficiency of services in the more immediate term. The rate increases for rehabilitative services will be continued with support from reinvestment savings.

Long-range planning includes recruitment strategies such as working with schools on behavioral health curriculums and formalizing and enhancing the vocation of community mental health workers. We have partnered with university schools and departments of Social Work across the state on the Schools of Social Work Project for Evidence Based Practice (SSW EBP Project). Through the project, second-year master's in social work (MSW) students receive training and education in recovery oriented, evidence-based practices for adults living with mental illness. This collaboration began with five Schools of Social Work but has since expanded to include fourteen universities and colleges in NYS.

We are also working to enhance the housing workforce through the development of a training curriculum for all housing types that can be implemented statewide. Recruiting residential staff from the community in which they live and providing them with training and a potential career ladder is a step towards strengthening and building a more diverse and sustainable workforce.

OMH has worked with the NYS Department of Civil Service to establish a new Licensed Mental Health Counselor (LMHC) title in state service. LMHCs provide clinical mental health counseling and psychotherapeutic services to individuals in State facilities, programs, and community settings. They apply professional counseling theory, principles, and methods to assess, evaluate, identify, and treat individuals with mental, emotional, and behavioral disorders, including addiction and problem gambling, and prevent, alleviate, or eliminate symptomatic, maladaptive, and undesired behavior.

Another critical element of strengthening the workforce is investing in peers. One of our workforce priorities is to expand certified and credentialed peer workforce (inclusive of adult, youth and family) including resources for recruitment, retention, education/training and career pipeline investments.

Establishing competitive salaries and benefits is also an important recruitment tool. OMH recently received approval of new, enhanced Geographic Pay Differentials (GPDs) for a wide variety of Registered Nurse (RNs) titles. RNs at all downstate facilities now receive a GPD of $18,000 (replacing the longstanding $12,871) and RNs at all upstate facilities now receive a GPD of $12,000 (previous amounts vary).

To encourage psychiatrists to join the OMH team, OMH administers a Psychiatrist Loan Repayment Program that provides awards of up to $150,000 for newly recruited psychiatrists who meet eligibility requirements and commit to working at OMH facilities for five years.

In addition to competitive salaries, OMH offers many other benefits as well, including:

• Generous medical, dental, and vision insurance options with competitive employee contribution rates;

• Defined-benefit pension and deferred-compensation (457b) retirement plans;

• Paid vacations, holidays, personal days, and sick leave;

• Flexible scheduling;

• Access to tuition assistance programs;

• Full- and Part-Time positions – full benefits available for those working 20 hours or more per week;

• Flexible Spending Accounts for health-care and depen-dent care;

• Supplemental income through the physicians' extra service program;

• OMH-sponsored Continuing Medical Education (CME) Pro-gram;

• Professional leave for additional learning activities;

• Academic affiliations with a number of prestigious institutions;

• First-time Certification and Licensure Exam Fee Reimburse-ment;

• Additional compensation for board certification in Child and Ado-lescent or Forensic Psychiatry;

For information on applying or to learn more about these career opportunities, please visit the OMH website at: Careers with New York State Office of Mental Health (OMH) (ny.gov)

Serious Mental Illness Recovery: The Basics

By Larry Davidson, PhD, and Katherine Ponte, BA, JD, MBA, CPRP

Larry Davidson, PhD

Katherine Ponte, JD, MBA, CPRP

When managing serious mental illness (SMI), the recovery journey can be long and challenging. It often requires creative and prolonged efforts to build and maintain a full life, but many people do reach recovery. In fact, up to 65% of people living with SMI experience partial to full recovery over time.

The term "recovery" refers to the process of learning how to minimize the symptoms associated with SMI. Note that recovery does not mean symptoms stop entirely or that deficits disappear. Ultimately, recovery is not synonymous with "cured." Rather, it means reaching a place where you are able to pursue a safe, dignified and meaningful life.

The cornerstones of recovery are self-determination, treatment, engagement with family and friends, work and hope. Loved ones play a critical role in a person's recovery, especially when well-intentioned caregivers listen to and respect their loved one's goals. Additionally, the guidance of competent, experienced and compassionate mental health practitioners can also be invaluable.

While recovery may look different for different people, there are several basic strategies that can serve anyone looking to manage their illness. These basics may help you reach recovery more quickly and easily.

Maintaining Hope

Recovery is rarely achieved in the absence of hope. Its power cannot be overestimated. You must always try to maintain hope despite the challenges (including loss, stigma, discrimination) you face. Hope doesn't have to come solely from internal strength; it can come from caregivers, friends, peers, people outside of a mental health context, and even animals or faith. Feeling supported, accepted and loved as a person of value and worth can foster and nurture hope.

Practicing Self-Determination

Recovery has to be pursued; it does not simply occur in response to medication or other treatments. That is why it is so important to make your own decisions and actively use treatment, services, supports or other resources. For example, preparing a Psychiatric Advance Directive, which states your treatment preferences in the event of a mental health crisis, can allow you to retain control over care even if you become impaired. As with any illness, you may have to self-advocate to ensure everyone in your care team respects your right to have a say in your care.

Do not give up on your dreams. Identifying your life pursuits, such as living, working, learning and participating fully in the community, is an important recovery goal. After establishing these objectives, you can work with your providers and caregivers to make those goals a part of your care plan.

Starting Now

You should not delay the pursuit of recovery in the hopes that your symptoms will go away on their own. Progress typically occurs through a series of small steps, which may involve considerable effort, patience and persistence over time. These accomplishments become possible

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Digital Transformation, Virtual Learning, and the Resilient Organization

By Jordan Baker
Content Marketing Manager
Relias

Jordan Baker

With onset of the COVID-19 pandemic in 2020, human services organizations across the United States had their worlds turned upside down. For many, the effects of the pandemic only exacerbated the community issues their organizations were founded to fight. The increased risk of infection, the effects of quarantine on individuals' mental health, and staff turnover due to new budgetary constrictions have caused the industry to seek new answers.

When a given industry is disrupted to this degree, innovating how it provides its services is the only way forward. For human services organizations, this includes digital transformation. A widely adopted concept in traditional for-profit businesses, human services lags behind in its adoption of technology. As we continue to navigate the new industry landscape brought on by COVID-19, a shift to technological innovation is necessary to ensure proper training of staff and continued care of clients.

The Importance of Organizational Resilience

Within the human services and behavioral health world, the term 'resilience' gets used a lot, but typically in the context of individual resilience. Human services do, however, have a growing need for organizational resilience. So, what makes an organization resilient? According to Deloitte:

"Resilient organizations plan and invest for disruption, and can adapt, endure, and rebound quickly in a way that enables them to not only succeed in its aftermath, but also to lead the way to a 'better normal.'"

To put this in the context of human services, a resilient organization is one that can plan for and respond to disaster in ways that allow for a continuous and high-quality level of care for their clients. Though there was no planning for the level of disruption caused by the COVID-19 pandemic, taking steps that can mitigate, at least partially, the effects of future disasters can go a long way.

While there are many ways to achieve this end, one of the most important is digital transformation.

Digital Transformation and Human Services

According to Salesforce, digital transformation "is the process of using digital technologies to create new – or modify existing – business processes, culture, and customer experiences to meet changing business and market requirements."

What does this mean for human services?

While there are only so many ways human services organizations can digitize the provider-client experience (telehealth being a major one), there's a lot organizations can do to digitally transform the staff experience. Some options include holding online meetings to ensure proper social distancing, giving staff easier and more holistic access to client information, and the ability to create better communications between programs and officers.

Here, however, we'd like to focus on the ability to provide better, more flexible training.

The Intersections of Technology, Training, and Resilience

One constant need in human services is proper training. To both ensure that staff meet government required compliance policies and have the skills they need to provide high quality care to your clients, your organization must offer robust training practices. As the world has had to go virtual, this has become harder.

To create a digitally transformed learning experience for your staff, consider a learning management system (LMS). Through an LMS platform, administrators can assign trainings to staff, track completion rates, and track required compliance data. These capabilities can make it easier to spot where roadblocks around meeting compliance requirements come up, how training is affecting the care your organization provides, and more. Plus, a more robust tracking system means you'll save time by not having to comb through spreadsheets, emails, or Word docs to ensure your organization has met its compliance requirements.

What's more, an LMS makes for a more convenient learning option for staff. Organizations can provide flexible, customized training that doesn't require their staff to take time off work to complete. This is important, as you can address the compliance needs of your organization

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Lessons of COVID-19: Staff Dedication and Skill Key to Success

By David Woodlock, CEO
and Pamela Mattel, COO
Institute for Community Living (ICL)

Our Culture is the Wind Beneath Our Wings

At ICL, there were countless examples of staff at every level going beyond expectations to be there for clients and for each other. Here are reflections from two senior staff from our housing divisions.

"Our staff showed up, day after day, during the height of the pandemic -- providing support and reassurance, sharing updates as government guidance changed daily. Whatever people needed, staff provided -- food for clients afraid to shop or medications they weren't able to get. Our frontline staff supported each other as well -- covering shifts when other staff were out sick or quarantined. We really did get through it all together."
Sharon Sorrentino, VP, Child, Family and Young Adult Services

"Our staff teamed up and delivered food, PPEs, and monthly checks to clients. Garbed in PPEs they checked in on high-risk clients with medical challenges, secured wrap-around services as needed. Staff checked in on each other; reached out through regular phone calls to make sure they were okay, asked what they needed and how their families were doing. We did everything we could to stay connected and provide support when other staff needed it."
Soniar Clarke, VP, Supportive Housing

The ICL compass shines brightly on our North Star: "People get better with us." This simple yet profound message has given us meaning and purpose during unprecedented social upheaval. We know, empirically, that what matters most and keeps people in their job is meaning and purpose. In its ranking of employment qualities, for example, the Society of Human Resource Management put "respectful treatment of employees" first, with opportunities "to use their skills and abilities to make a difference" third. Interestingly, compensation came in fifth.

In more common disasters, there is an overwhelming all-hands-on-deck and "rush to cure" response. What has been unbelievably unique about the pandemic is its' length and persistence, demanding protracted efforts and calling into action sustained resiliency and resources. While most organizations can respond in the short term, it has been the strength of the ICL culture that has maintained a heightened response over the long haul.

Because of the steps ICL has taken over the years to emphasize the meaning and purpose of our work, these winning attributes have become embedded in our organizational fabric. One important dimension of our "people get better with us" culture, is that all of us – regardless of our roles -- prioritized safety while keeping all of our programs open during the pandemic.

We know it will take years for our country – and the world - to adequately heal and adapt to life post-pandemic. It was clear from the earliest days of COVID-19 that physical health challenges would extend far into the future. What was unexpected to most of the world -- though not to the behavioral health provider community – was the extent of the toll on emotional and psychological health, and the subsequent pressure this places on an already overwhelmed care system. So what can we do to address this dilemma?

What helped ICL respond effectively to the onslaught of challenges in the worst days of the pandemic is at the heart of our success. Staff began every day filled with purpose knowing they were essential, that their efforts, compassion, and self-sacrifice contributed to literally saving lives and sustaining wellness and recovery. They buoyed each other with inspiring stories and unconditional support.

Backed by an organizational culture that encourages staff to look beyond programmatic boundaries and gives them the skills to do so, their understanding of the multi-level impact on clients, families and communities helped strategize where care would be most needed. And then, how to deliver that care in the face of the pandemic's myriad of obstacles.

Home visits are a lifeline for our clients, and staff knew they were more important than ever. Always with full PPE, staff made frequent home visits to make sure the most fragile and isolated clients had nutritious food, medications, and a feeling that they mattered, that we cared about them, and that they were not alone.

We recognized that working in the pandemic is a second "full time job" requiring all of us to re-prioritize what matters most to staff and clients. The well-being of our staff is always important, and was heightened from the outset. The depth of our staff's commitment is so ingrained that, in the beginning, we had to actually discourage staff from visiting clients for everyone's safety.

Organizational culture endures with consistent, transparent messaging. We used every means of communication as often as possible, offering coping tips and strategies as well as guidance on new ways to serve clients. We designed our leadership weekly huddles to be our central hub of information and highly responsive to staff. We established frequent virtual and in person staff check-ins, facilitated numerous virtual town halls for all shifts including our overnight staff, consistently shared stress management and work/life balance tips, and increased supervision. We translated and synthesized governmental guidance into easy to follow action steps. And our safety action steps included distributing over 1 million pieces of PPE, frequent hyper-vigilant cleaning of facilities and offices, and social distancing reinforced with posters -- some designed by clients. Since the vaccine became available, we have embarked on informational campaigns, partnered with Community HealthCare Network for onsite vaccine drives, and fully support people to get tested.

Our staff know that they make a difference, not just because we say so, but because we measure and share clients' outcomes and clients' views about their own care. Staff know that they are part of something larger than themselves. Routinely, we celebrate client success stories at small and large gatherings so everyone knows that people are getting better. We keep our promise by asking staff and clients "how are we doing?" One employee recently said, "ICL has made it possible for a guy like me to do this type of work and make a difference." Another remarked, "Our team has more power to help people than is normally given to staff".

For many years, everything we have done has been in service of an integrated whole health, whole person approach. It's about getting people better, not in some ways, but in all ways. And everyone is part of – and recognize their role in – bringing to life our promise that "People Get Better with Us". Or as one staff member put it, "It's like a Make a Wish Foundation for our clients!"

A Shared Culture At the Heart of What We Do

Throughout these difficult months, we've used the ever deepening strength of our organizational culture and mission to offset the pandemic's serious burden on clients and staff. "People Get Better with Us" is an all-encompassing promise – to staff, clients, and volunteers. More than a tagline, these words inspire and fulfill our work every day. And ALL of our staff – whether in payroll, maintenance or a supportive housing program – are an integral part of caring for people. We believe that the values of our organization guide not only how we relate to and work with clients, but create a place where staff feel that sense of shared purpose; we work hard to build community and human connection. "I'm integrated into all of the programs at ICL, so we are pulling together", one employee told us recently. "And together we have more relationships and resources to help our clients."

We're especially proud that this shared culture has grown organically. In the end, what most bonds people together at ICL is knowing we are all part of "getting people better".

Responding to the Next Wave of Mental Health Needs

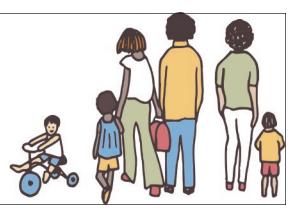
We applaud the nation's overdue recognition of the driving force of emotional well-being and mental illness. But this hopeful development is clouded by the current state of the behavioral health services system, particularly its workforce, which has always deserved adequate compensation, respect, and appreciation for essential life-saving work.

According to a report issued earlier this year by SAMHSA (federal Substance Abuse and Mental Health Services Administration), national behavioral health needs require a workforce of at least 4.5 million; yet there are only some 700,000 individuals working in behavioral health, including substance use disorder services. This leaves a 4-million-person shortage for behavioral health services.

The SAMHSA report offers a number of recommendations for filling this gap, including a national public education campaign about the need for behavioral health providers; encouraging students to pursue this career; and increasing loan forgiveness programs in behavioral health specialties to encourage entry to the field and increase the peer professional workforce.

On a more local level, there are many ways providers are addressing the workforce crisis. At ICL, we've focused significant resources over the past decade to reward staff for the critical work they are doing - in tangible ways like raising salaries or giving bonuses when we are able; offering a matching pension plan; and absorbing skyrocketing insurance premiums (in the millions of dollars each year) so our staff does not have to. Our strategic plan includes increasing investment in leadership, administrative and clinical competencies, elevating our employee wellness, actively support work-life balance, advancing overall whole person health, and preventing burn-out.

While the workforce shortage is unnerving and we are all waiting for the federal and state initiatives to take hold, where are those 700,000 people going to choose to work?



A THANK YOU TO OUR EXTRAORDINARY STAFF

Many factors allowed us to keep our more than 100 programs open during the pandemic.
The single most important factor? ICL staff.
With safety protocols always in place, staff did what they had to do
to ensure continuity of service so that no ICL client would ever feel alone.

While we appreciate all of our more than 1,200 staff,
once again this year, 25 individuals were recognized for going above and beyond.

Congratulations ICL Employee Excellence Award Recipients 2021

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Tushna Bhumgar External Relations
Esther Cherubin Department of Quality
Tajh Lambert Finance
Norvarene Thompson Entitlements
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Fred McCorkle Joselow
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We are proud to announce the opening of a SAMHSA-supported Community Behavioral Health Center with a special focus on Latinx communities in our East New York Health Hub. Many job opportunities — Spanish-speaking staff preferred.

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Staffing Shortages Halt Progress

By Marcus
A Client Served by S:US

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 author is 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.

I'm a 40-year-old man of American and Caribbean descent. I have been receiving support from Services for the UnderServed (S:US) since I was released from incarceration in 2014. I currently live at an S:US shelter that supports men with mental health and substance use disorders. I'm not a boisterous person, but I do like to have my voice heard—especially if I have something that can contribute to my well-being while I'm at the shelter and working on my OCD (Obsessive-Compulsive Disorder) and mental health. And for that reason, I'm pleased to share my story.

My Experience with Staffing Shortages

In the time I've received services from S:US, I've worked with six caseworkers. To be honest, at one point I got very frustrated with staff shortages. I had to slow down and take a moment for myself. In this field things do change at a fast pace and there's a lot of staff turnover due to stress, burnout, the pandemic, etc. It has been frustrating because I grow a bond with each caseworker and then, as the ball gets rolling, they suddenly switch. So, I have to go back to first base, introduce myself, and start over with a new caseworker, which is really hard. At times it felt like I was taking each new caseworker on as a client because I had to catch them up on what the last caseworker was doing and let them know where things stood. Each caseworker would ask the same questions and it was frustrating to have to tell my story over and over again. It's hard to make progress when it keeps getting interrupted.

Staff Stretched Thin

My current caseworker is doing the best she can but she is overloaded. I know we're in a time of crisis but people need a break. I would appreciate it if they said "your caseworker is on vacation." I would do cartwheels because she deserves that. But I don't think she's able to take a break because of workforce shortages. I believe working too much causes mental illness because you overstress people. Nobody is Clark Kent (Superman).

I know we can't go to certain places because of the pandemic, so I'm working with my caseworker to plan more shelter activities and additional therapeutic groups to help support my progress.

I also know there's only so much one staff person can do to try to make things a little better. And it's hard when the staff is stretched thin. I have learned that S:US is doing what they can to solve staffing issues and is considering flexible work hours, incentives, competitive salaries, and other creative solutions to address these challenges. There just aren't enough caseworkers and peer specialists right now and the pandemic creates additional challenges.

Seeing the staff overwhelmed makes me feel sad because this is a field I like. I want to become a caseworker for young people who are having a hard time. I know it's difficult but I want to help people like me.

Pandemic Silver Linings

The pandemic has been hard but there have also been some unexpected benefits during this time. As various providers moved to virtual appointments, I was able to get in touch with people who were hard to reach before the pandemic. My mental health counselor has been more available

see Progress on page 35

When Staff Burnout Prevents Progress

By Dr. April Naturale, Dr. Mona Masood, and Amy Carol Dominguez

Dr. April Naturale

Dr. Mona Masood

Amy Carol Dominguez

After nearly two years of facing COVID-19 waves and realities, healthcare workers are facing unprecedented levels of burnout. Providing important support, resources and space for staff can help prevent this and other acute stress responses from turning into longer term behavioral health challenges.

The Covid 19 pandemic has amplified long-standing staffing concerns within the healthcare industry, affecting every role from physicians to nurses, aides and support staff. While the media have labeled the distress of staff in the healthcare industry broadly as experiencing mental health problems, this is not the core issue. The initial problems in the COVID response centered on the inability to provide critical PPE, staffing, as well as other resources to adequately address the needs of excessive numbers of seriously ill patients in the various settings. This lack of preparing for and immediately responding to the COVID 19 pandemic falls on leadership at all levels. This includes government, business and manufacturing as well as service providers. The lack of preparedness and adequate response to the pandemic coupled with these incompetencies have imposed burnout on healthcare workers who consistently have to stay focused on the health of their patients. And as the pandemic continues, wrought with political and social division, healthcare workers are facing increasing patient distrust, jeopardizing the foundation of the doctor-patient relationship.

Let us be clear. Burnout is not a mental illness. Rather, it is a response to problems with the structure, proper implementation (or lack thereof) of policies and procedures by the organizations, agencies and businesses designated to support the healthcare of our country. Preparedness has not been a priority, but worse not even recognized as a need and this has resulted in the unacceptable situation our healthcare workers are facing today.

This does not invalidate the fact that our healthcare workers are suffering from severe stress, exhaustion, and grief, as well as the fear and anxiety that COVID has brought to all of us. But healthcare workers experience high levels of work stress, exposure to gruesome situations,

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Federal and State Vaccine Mandates and the Behavioral Health Workforce

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

The COVID-19 public health emergency has contributed to workforce crises across almost all industries, fields and professions. The behavioral health field has not been immune. Even worse, behavioral health has historically been impacted by workforce challenges, stemming from "chronic underfunding of the behavioral health safety net, historically low wages, and high case load."[1] According to a 2016 study by the federal Health Resources and Services Administration, worker shortages present a key challenge in ensuring widespread access to behavioral health programs and services.[2]

In addition, a HRSA resource document on the behavioral health workforce offers a rather gloomy prognosis:

Between 2017 and 2030, the total supply of all psychiatrists is projected to decline as retirements exceed new entrants. Rapid growth in supply of psychiatric nurse practitioners and psychiatric physician assistants may help blunt the shortfall of psychiatrists, but not fully offset it. In 2030, the supply of these three types of providers will not be sufficient to provide any higher level of care than the national average in 2017, which does not fully meet need.[3]

A new potential wrinkle in the workforce battle is vaccine mandates – on both the federal and state level. In late August, former New York Governor Andrew Cuomo mandated COVID-19 vaccines for all workers in hospitals and other health care facilities. Then, in early September, President Biden announced new federal vaccine mandates for workers across the country. Both leaders were clearly motivated by the desire to curb new COVID-19 infections and to continue to stimulate and grow the struggling economy.

Rachel A. Fernbach, Esq.

According to the Mayo Clinic, as of September 15, 2021, only 54.3% of eligible Americans had received both doses of the COVID-19 vaccine.[4] It remains to be seen whether the new vaccine requirements will have an adverse impact on the already suffering behavioral health workforce numbers. Some behavioral health employers may be concerned that vaccine mandates will drive workers to leave their jobs rather than be vaccinated.

Summary of
Federal Vaccine Requirements

A. *Private Employers with 100 or more employees:* The federal Occupational Safety and Health Administration will be promulgating emergency standards that apply to all employers with 100 or more employees. Covered employers must ensure that their workforce is either fully vaccinated or require any workers who remain unvaccinated to produce a negative COVID-19 test result once a week. Employers must provide paid time off for vaccination appointments. A specific effective date has not yet been determined, but violations can result in fines for the employer of up to $14,000 per offense.

B. *Federal Workers:* On September 10, 2021, President Biden signed an Executive Order requiring all federal executive branch workers to be vaccinated no later than November 22, 2021. There will be no test-out option, but workers will be able to receive a reasonable accommodation for limited medical and religious reasons. The same rule will apply to all contractors that do business with the federal government. The Safer Federal Workforce Task Force, comprised of the White House COVID-19 Response Team, the Office of Personnel Management and General Services Administration, is expected to issue additional guidance in the short term.

C. *Workers at Health Care Facilities that receive Medicare and Medicaid Funding*: Over the summer, the federal Centers for Medicare and Medicaid Services (CMS) mandated COVID-19 vaccines for workers in nursing homes funded by Medicare and Medicaid, the federal health care programs. CMS will now be expanding that mandate to all federally-funded health care facilities, including hospitals and other ambulatory care settings, with no test-out option. Here in New York, this federal mandate will apply to all Medicaid funded programs under the auspice of the NYS Office of Mental Health (OMH) and the NYS Office of Addiction Services and Supports (OASAS), e.g., Article 31 and Article 32 outpatient clinics, and behavioral health services furnished by hospital outpatient departments that receive Medicare and Medicaid reimbursement. The mandate will apply to both clinical and non-clinical staff and volunteers. CMS has announced that it is developing regulations to implement this new requirement, expected in October 2021.

Summary of
New York State Vaccine Mandates

In his last few weeks in office, former New York Governor Andrew Cuomo mandated COVID-19 vaccines for the state's healthcare workforce, including staff at hospitals, nursing homes, adult care facilities, and other congregate care settings. Following the former Governor's directive, the Public Health and Health Planning Council issued emergency regulations on August 26, 2021 to implement the new requirements, with no option for weekly testing. For personnel working in general hospitals and nursing homes, the first dose of the vaccine must be received by September 27, 2021. For personnel working in other covered facilities, such as dialysis centers, adult care facilities, hospice and home care service providers, the first dose of the vaccine must be received by October 7, 2021. The emergency regulations provide for a limited exemption based on pre-existing medical conditions, but no exemption on religious grounds.

Legal Challenges

Following President Biden's announcement on September 9th, some Republican governors publicly condemned the mandates as overreaching and promised to challenge them in court. On September 14th, Arizona became the first state to formally oppose the federal mandates. The Attorney General of the State of Arizona announced that his office has filed a lawsuit against President Biden and his administration to challenge the vaccine mandate imposed on federal employees, federal contractors and private employers with more than 100 workers.

In addition, as reported by Reuters.com, a statement issued by the Republican National Committee indicated it "will sue the administration to protect Americans and their liberties."[5] Florida Governor Ron DeSantis has also indicated that his office will oppose the vaccine mandate to be imposed on private businesses.[6]

In New York, also on September 14th, a federal District Court Judge issued a temporary restraining order barring the State from enforcing its mandate against

see Mandates on page 34

Lessons Learned from Senior Executives of Human Service Agencies Over the Past 20 Months

By Arthur Y. Webb
With Italicized Quotes From Members of NYIN*

Who is in charge? Over the last 20 months, chief executives of human service agencies were faced with unprecedented crisis. The twin epidemics of the tragic consequences of COVID-19, with the resultant massive disruption in services and financial instability, tested these executives in untold ways.

Seldom do we have a chance to peer into the thinking of chief executives, but using lessons learned we get an inside view of how chief executives of NYIN* managed during the pandemic and the problems it wrought. While these providers head multi-service agencies serving multiple constituents, the focus for this article is related to the field of intellectual and developmental disabilities (I/DD).

Leaders were confronted with an unprecedented situation, with no easy answers in the leadership playbook. There was little room or time to think; this was a clarion call for action. CEOs knew the calamity would get worse before getting better.

An interesting lesson surfaced, one hardly ever in the forefront: The value of peer-leader support. Several executives

Arthur Y. Webb

agreed that: *Thankfully, we have peers at NYIN who are like-minded and care deeply for the mission, the people we serve and the staff who provide the supports and oversight.*

Existential threat: There is no question that human services faced an existential threat in which basic order was thrown into uncertainty, and the safety of both the individuals receiving services and their staff was undermined.

Who we serve: In this article the focus is on people who are intellectually and developmentally disabled, which includes a wide range of conditions including intellectual disability, cerebral palsy, epilepsy, neurological impairment, and autism. These individuals are highly dependent on daily services that sustain their participation and engagement in society and maximizes their opportunities to achieve independence.

We are in charge: As one executive made clear: *The CEO needed to set the tone and the staff needed to know that the CEO would fight for what was right.* It would be an understatement that these executives were faced with a situation that quickly could have gone out control, but they stressed that they were in charge. An illuminating phrase, *maintaining a clarity of purpose*, captures their core thinking. The words that were frequently used in the lessons learned are *nimble and flexible*. As one executive explained: *Be prepared for multiple scenarios; be prepared to change strategies; and move quickly when the situation demands a quick response.*

A different perspective was stated by one executive: *Ensure that everyone on the front line had what they needed to keep people safe, and then get out of the way.*

Through weekly calls, there was considerable sharing of information, including how to access PPE and other equipment. These exchanges were vital because government had not made such access a priority for the I/DD field.

Another leader affirms the declaration that chief executives were in charge: *While society and government were in chaos, we needed to show that we were in control of the situation as best as we could. We made the hard decisions as soon as we knew the situation was dire and urgent. Being upfront and making hard decisions immediately allowed us to get control of a very uncertain and scary situation.* This lesson was wholeheartedly accepted by all the executives.

The following wise words go right to the core of occupying the position of chief executive: *We were balancing business decisions with personnel decisions. We understood that we needed to survive as a business, but we also knew that staff, families, and people we served were all panicking. We needed to make hard decisions and make them fast.* All these leaders agree with what one executive stated: *Celebrate successes big and small. Let people know about an achievement or payment or milestone and cheer loudly.*

see Lessons on page 35

Let's Celebrate Our Workforce

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

Michael B. Friedman, LMSW

Every day when he left home to serve as the attending psychiatrist at an inpatient unit at a general hospital, he wondered whether he would contract COVID at work that day and bring it home to his wife and two small children. Maybe he had already brought it home. Had stripping in the garage and taking a shower before entering the house been enough to protect them? Would it continue to be enough? He doubted it. But he had job that had to be done despite his fear of COVID for himself and his family.

This story or one like it played out 100s of thousands of times every day when COVID was at its height and there were no vaccinations. Doctors, nurses, social workers, direct care workers in hospitals, nursing homes, assisted living, and residential treatment, risked their lives and the lives of their families everyday because there was a job to be done.

This issue of *Behavioral Health News* is about the workforce crisis during the pandemic. And no doubt problems were revealed, especially in residential settings. But what was also revealed was the heroism and inventiveness of the health care workforce including the behavioral health workforce.

The sheer courage of doing their jobs every day astounds me. I suppose if I weren't retired, I would have done the same thing because those of us who work in this field have obligations that we generally live up to. Still, I was very happy to be sheltering-in-place, and I have great admiration for the professionals and paraprofessionals and peers and volunteers who did their jobs while fearing for their lives and the lives of their families.

I also have great admiration for the inventiveness that emerged during desperate times. What gets the most attention is the use of telehealth to replace in-person contact, and it is amazing that this happened so quickly, amazing that psychotherapists and others adapted so quickly. Even more amazing, I think, that telehealth was used for not just one-to-one psychotherapy but also for group therapy, for rehabilitation, for mutual support groups, for morning meditation groups, and more.

And hats off to the elected officials and bureaucrats who declared an emergency and changed reimbursement rules virtually overnight. I've been working to get improved funding mechanisms in place for over 40 years—with slow incremental gains. Overnight, the people who have to slug through the complexities of modern bureaucratic regulation did it.

Our professions also rose to the occasion with efforts to educate people who were experiencing considerable fear and sadness (almost everyone) how to cope with their distress. Tip sheets and other tools emerged also overnight. An amazing response.

I confess that I am not enamored of these tip sheets. I don't think they speak to many of the people who where most devastated by the economic consequences of the pandemic or to people who are not well educated or to people just too overwhelmed by taking care of their families to have time to take a break, make a plan, or breathe deeply. And getting a good night's sleep is much easier to advise than to do, even in the best of times.

But the people who got these tips out were very well-intended, very rapid in their response, and probably helped some people who needed it.

I was also enormously impressed with efforts that were quickly put in place to use volunteers (for the most part) to combat social isolation among people who had to shelter-in-place because of their high vulnerability. Telephone callers reached out to many of them with offers of help—most commonly they needed food and access to their medications—as well as offers of simple companionship. Several of these efforts built in mental health back up services for people whose distress in response to the pandemic suggested mental and/or substance use disorders.

Senior centers, houses of worship, and other community groups also tried with some success to reach out to their members who were now cut off and lonely.

These humane efforts were a wonderful example of preventive interventions that hopefully will continue after the crisis is over.

In a sense, the pandemic revealed what had already become a growing concern—that there are powerful social determinants of behavioral health. The pandemic itself is a social determinant, but so are rises in racism, struggles to survive economic catastrophe, the loss of access to spiritual support, and more.

And despite the vituperative political divide in our nation today, which I believe contributes to the apparent rise in psychological distress in the United States—despite that divide, the country rose to the occasion and provided economic supports and concrete services that made it possible for people to survive and to weather the emotional storm.

So, there is much to praise about the courage and inventiveness of our nation and fields of practice. But there is also reason for concern going forward. The hopefulness that emerged with vaccines has been partially dashed by the recent resurgence of the pandemic due to the large number of people who refuse to take

see Celebrate on page 31

Jody Rudin Named CEO of the Institute for Community Living (ICL)

By Staff Writer
Behavioral Health News

Jody Rudin

The Institute for Community Living (ICL), a premier nonprofit innovator of whole health care that serves more than 15,000 New Yorkers each year, is pleased to announce that Jody Rudin has been named President and Chief Executive Officer. Rudin has over two decades of experience in the social services sector, working with nonprofits and in government.

"I have long admired and respected ICL as a leader in the field. I'm excited to join the organization and work with its incredible staff and Board to build on ICL's strengths and continue to be a model of best practices in integrated care. I can think of no more important work now than ensuring people get better, and that's what ICL does day in and day out," said Rudin.

Most recently, Rudin served as Executive Vice President and Chief Operating Officer at Project Renewal, where she led over 1,000 employees and administered a $120M budget. While at Project Renewal, she oversaw a 15 percent increase in revenue and stewarded significant programmatic growth -- the organization's housing and shelter capacity is on track to grow more than 50 percent over the next five years. Prior to her work at Project Renewal, Rudin was Executive Vice President and COO at Damian Family Health Centers, where she led day-to-day operations for a multi-site health center network with 15 locations across the five boroughs. In both these positions, Rudin nurtured positive and inclusive cultures for clients and staff.

Rudin also worked as a Deputy Commissioner at the New York City Department of Homeless Services (DHS) where she directed 500 employees and 150 contracted DHS programs. In her 12 years with DHS, she was promoted five times, a testament to her record of delivering results for the agency and its clients. Her creative approach to addressing street homelessness, which was based on significant input of people with lived experience, resulted in a 40 percent reduction over the course of five years. Through her inclusive approach, the agency was able to help place more than 4,000 chronically homeless people into permanent housing, redesign the city's homeless outreach services, and place 500 veterans into housing over a two-month period, resulting in the effective end of chronic veteran homelessness in the City of New York.

Rudin began her career in public service as a legislative aide to Council Member Christine Quinn, then worked for Housing Works, an HIV and housing services organization. She is a graduate of Emory University in Atlanta and has a Master's in Public Administration from NYU's Robert F. Wagner School of Public Service.

"We are incredibly excited to welcome Jody to ICL," said Mary Harrison, chair of ICL's board. "Jody's career has been fueled by holistic care for people who have experienced trauma. Her personal relationships with individuals who have faced the challenges of HIV, housing insecurity, and incarceration have taught her that service that does not centralize the needs of the client can actually create additional harm. We are looking forward to having such an accomplished, compassionate leader at the helm of ICL."

Rudin assumes the top leadership post of an organization renowned for its success in meeting the needs of our most at-risk community members. In recent years, ICL has secured millions in federal grant dollars from the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration to attack disparities in mental and physical health outcomes in East New York and surrounding neighborhoods.

see Rudin on page 33

Attracting and Retaining Employees During the Workforce Crisis of 2021

By Kenise Etwaru, SPHR
Vice President and Chief Human Resources Officer, New York Psychotherapy and Counseling Center

The COVID-19 pandemic is beyond unpredictable. No one can really say with certainty how and/or when this situation will be under control to the point where behavioral health organizations can go back to normal or know what the new normal would look like. With lockdowns, social distancing, and a variety of safety recommendations, many employers have been forced to hurriedly make drastic changes in a matter of weeks just to keep going. This uncertainty further contributes to new challenges for organizations to maintain employees.

During this workforce crisis which has forced employees to change the way they work almost overnight, organizations had to focus on business continuity. A business continuity plan provides protection, a safeguard to ensure the operations are still going. A huge part of a business continuity plan is the challenge of attracting and retaining employees.

As employers work feverishly to address these challenges for the remainder of 2021 into 2022, here are 8 tips that would help your organization thrive during and after this workforce crisis:

1. Company Brand - With all the personal life changes brought about by the pandemic, we will see that many candidates, post pandemic, are going to be looking for more than just a job, and more than just any organization. How can you make your company brand stand out above the rest to attract the best candidates? Begin by having strategic planning sessions with your team to build and implement your company brand that will attract top candidates.

Kenise Etwaru, SPHR

2. Seamless Recruiting - Your recruiting efforts should be optimized from the top down to ensure that the candidate has a flawless, efficient, and quick turnaround from screening the candidate to making an offer and getting them onboarded. In such a hot job market, you want a process that has no bottlenecks.

3. Training and Development - Begin by looking at your current onboarding process. A great onboarding process provides the building blocks that will help develop employees for the right roles from the time they enter your door. Create and streamline additional training plans that will allow employees to be successful in their roles. When an employee is not properly trained, they can get frustrated and leave causing a high level of turnover. The organization's ROI when it comes to training and development is creating future leaders. A well thought out training and development program will not only keep employees happy, but also help to reduce turnover. It's a win-win situation. When employees feel like they are growing in a company, they want to continue working there.

4. Benefits, Benefits, Benefits - Unfortunately, traditional benefits such as medical, dental and vision plans will no longer cut it during this crisis. It's imperative for employers to begin thinking outside of the box and begin promoting benefits geared towards better physical and wellness in addition to lifestyle flexibility.

5. Pay Equity - Specifically in behavioral health, there has been a tremendous increase in demand for services. Therefore, having a competitive employee compensation plan and/or bonuses can improve employee morale and make attracting top talent in the industry less challenging. Keep in mind, it's helpful to ensure that your compensation provides equal pay for equal work regardless of gender and race.

6. Employee Recognition - Recognize your top performers and reward them. Trust me, your top performers know they are good at what they do, but most times they don't really know if the company sees their hard work. Now is the time to rethink succession planning by engaging and motivating your top A plus players. You definitely do not want to lose them to a competitor. The best way to keep them is by frequently engaging and recognizing their hard work.

7. Constant and Open Communication - Many employees may be working remotely for the first time, and still adjusting to the lack of in-person communication. Make sure they feel connected to the team through various communication channels through regular phone, video, and check-in meetings. Remember, not all check-in conversations should be work related. It is okay for a manager to check-in on team members just to find out how they are feeling. This kind gesture is priceless and greatly appreciated by employees.

8. Employee Wellness is Key - Showing employees that you care about their health and wellness is essential for employers today. More than ever, employees do not want to stay at an organization if they feel their health is at risk or do not have a work/life balance. Employers who make employee wellness a focus are scoring big points with employees during the pandemic. From enforcing safety guidelines in the workplace, such as wearing a mask, social distancing, and limiting capacity to sponsoring wellness events such as virtual Zumba, Laughter Yoga etc.

This pandemic has brought about many unique challenges for employers and has essentially upended the employee experience as we know it. For organizations to work towards ending the workforce crisis post pandemic, employers must be forward-thinking, creative, and working daily towards making adjustments. A more employee-centered approach and focus will create a positive environment and a more loyal workforce during and post pandemic.

Read the MHNE Founder's Inspiring Story: "From the Depths of Despair to a Mission of Advocacy"

Help Wanted from page 1

well-documented rise in drug overdose deaths, attributed largely to widespread opioid misuse and abuse, peaked in 2020 with more than 93,000 fatalities. This is 30% more than were reported in 2019 (Chatterjee, 2021). All of this occurs as behavioral health providers face unprecedented challenges in retaining what is left of an enervated workforce and prospective recipients encounter innumerable obstacles to accessing what few opportunities for care remain. (Many individuals have found themselves newly unemployed during the pandemic and without employer-sponsored health insurance coverage needed to access care.)

The imbalance between the supply of behavioral healthcare and growing demand for it is surely stark, and nothing less than a seismic shift in political will is needed to address it. Nevertheless, there have been some auspicious developments, if only on the margins. The American Rescue Plan Act (ARPA) and Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA), two federal laws enacted in 2021 to address economic and public health exigencies associated with the pandemic, recognized the role of the health and behavioral health workforce in responding to the public health emergency and provided supplemental funding to the Community Mental Health Services Block Grant (MHBG) on which states rely to bolster their behavioral health services infrastructures. The federal government is also offering additional support through enhanced Federal

Ashley Brody, MPA, CPRP

Medical Assistance Percentage (FMAP) funding (i.e., increases to the federal share of Medicaid funding available for certain reimbursable services). The means through which these funds will be expended is described in a report the New York State Office of Mental Health (OMH) recently prepared for the State Legislature pursuant to its regulatory authority, overarching goals of MHBG funding, and specific purposes of these one-time enhancements. Supplemental appropriations for the state's share of MHBG funding include approximately $46 million and $80 million under the CRRSAA and ARPA, respectively, and the OMH report identifies workforce investment and the associated expansion of the behavioral health system's capacity as priorities to which newly awarded funds should be committed (New York State Office of Mental Health, 2021). Such investments might rectify longstanding deficiencies in the state's behavioral health workforce, some of which have been compounded by the pandemic, but they are unlikely to achieve their intended goals absent other measures that would enhance the system's capacity to prevent and to proactively respond to emergent needs, thereby diverting individuals from more costly and extended care our system is ill-equipped to provide. "Upstream" interventions such as crisis prevention and response services and First Episode Psychosis (FEP) programs (e.g., OnTrackNY) promise to reduce long-term demand for behavioral healthcare and to alleviate the strain on our service infrastructure. Both are priorities for investment as described in the OMH spending plan. Service delivery via telephone and videoconference (i.e., telemental health) has become a mainstay during the pandemic, and it has received considerable approbation from providers and recipients alike for its role in ensuring public health and safety. It has also effectively served as a "staff extender" by enabling providers to meet recipients' needs more efficiently than is generally possible through conventional methods of service delivery. Expansion of providers' telemental health capacity is another priority identified in the spending plan.

Another state-sponsored initiative was recently announced that promises to build on the successes of the Delivery System Reform Incentive Payment (DSRIP) program and to strengthen the health and human services workforce. The DSRIP program was an ambitious undertaking that authorized the state to invest approximately $8 million in savings realized through Medicaid payment reforms into transformative initiatives intended to reduce service recipients' reliance on costly (and often suboptimal) emergency department and institutional care services. It was largely successful in achieving its overarching goals, and the state Department of Health (DOH) recently signaled its intention to pursue a comparable initiative in a concept paper submitted to the Centers for Medicare & Medicaid Services (CMS). Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services (HHS) to approve pilot or demonstration projects that would promote the objectives of the Medicaid program. Known as "1115 Waiver" projects (inasmuch as they are exempt from certain requirements customarily applicable to Medicaid-funded programs), these have figured prominently in the advancement of various innovations designed to improve the health or welfare of Medicaid recipients and the service delivery system on which they depend. The DOH Concept Paper enumerates several goals to be accomplished through an 1115 Waiver request, some of which would address deficiencies in the health and social welfare infrastructure that have been exposed or worsened during the pandemic. This includes a commitment to augment the state's healthcare workforce through investments that would enhance the existing Workforce Investment Organization (WIO) infrastructure. (WIOs were authorized in a previous 1115 Waiver and promoted the retraining, recruitment, and retention of direct service personnel in select capacities.) It also includes commitments to address Social Determinants of Health (SDoH) and racial inequities that continue to abound in our society, of which our health and social welfare system (and its workforce) is a prominent component (Scott, 2021).

Should the foregoing initiatives achieve their intended aims, the dedicated and compassionate individuals who commit themselves to serving the most vulnerable among us might finally find some of the support they need to sustain themselves and their careers at an extraordinarily challenging time. They deserve nothing less.

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From Crisis to Connection: Meeting the Workforce Shortage Head On

By Stacey Roberts, LCSW, and
Dr. Dottie Ann Stevenson, EdD, sHRBP
MHA Westchester

The workforce shortage has been felt keenly in the behavioral health field (BHECON, 2018). To effectively address this shortage, we must identify its root causes, understand dynamics that result in staff resignation decisions and connect the perceived impact on business sustainability while continually improving our culture and practices to recruit and retain staff.

The COVID-19 pandemic, along with its variants, was and still is a crisis (Abdool Karim, de Oliveira & Loots, 2021). When the COVID-19 pandemic first penetrated the United States in March 2020, health, employment, education, child care, elder care, and basically every function of human life was disrupted (Godinic, Obrenovic & Khudaykulov, 2020). Employers had to pivot to establish remote access and distribute equipment to staff so they could continue to work, but remained optimistic that this crisis would be over in a matter of few short weeks (Kniffin, Narayanan, et Al 2021; Fragala, Goldberg & Goldberg, 2021; Zompa & Bompiedi, 2021). The weeks became months, and the strain on employers and staff grew. As if the nation thought it could not get worse, racial injustice, and the murder of George Floyd in Minneapolis on May 25, 2020, took its toll on employers and staff (Thelwall & Thelwall, 2021). Racial injustice, coupled with COVID-19, challenged the mental health and human needs of our nation almost minute by minute (Weine, Kohrt, et Al, 2020; Thelwall & Thelwall, 2021).

Employers struggled with the effects of business operations (Fragala, Goldberg & Goldberg, 2021; Thelwall & Thelwall, 2021). There was a shared strain on employers and employees; each attempting to assure the other that we were going to get through this but silently concerned about uncertainties (Zompa & Bompiedi, 2021).

Employers, especially in local healthcare and social services settings, had to adapt to new or different ways of conducting business. The new normal of Zoom and Teams became the way to connect not only about business matters but as a daily check in on staff – to feel the pulse of staff and ensure they were okay during this crisis (Zompa & Bompiedi, 2021). As working in the office every day became a thing of the past, so did traditional work settings and schedules (Sander, 2014; Beno, 2021). But what does this mean now for employers and workforce going forward? Workforce behavior is changed (Beno, 2021; Eifling, 2021).

The workforce crises have a particular impact on service organizations, including behavioral health service providers such as MHA. Staff retention is an ongoing challenge that pre-dates the pandemic, given the emotional demands of our work, salaries that are historically less than in the private sector, and more than often, the "need to do more with less."

MHA manages these challenges in multiple ways. We had applied for permanent waivers at all of our clinic sites prior to the pandemic and due to pandemic restrictions, then applied for additional waivers for many other services to continue providing care. With these emergency waivers, we addressed our own staff shortages by recruiting geographically more widely to fill program needs.

During the pandemic, staff shared that the multiple challenges they faced left them feeling overwhelmed, anxious about personal commitments, unsure if they could remain working in their current position without accommodations and, for some, contemplating retirement. Like many organizations, we experienced multiple resignations that forced us to assess critical needs of our programs, re-deploy staff, and innovate ways to attract and sustain new staff, especially during this time of increased demand for services.

Supporting worker wellness has been a long-time priority at MHA. For example, staff may work a flexible schedule that meets program and client needs, while enabling the staff to maintain a sustainable work-life balance. MHA offers tuition reimbursement, robust staff training opportunities, a designated space in the offices as a "wellness room" that staff can use for a quiet place as needed, and a flexible summer schedule, which emphasizes staff emotional and physical wellness.

Also prior to the pandemic, MHA created an enhanced staff support team to provide targeted support in response to difficult staff experiences at work. The team is trained in a peer model that provides short-term assistance to a colleague. Staff grieve the deaths of their clients and during COVID, these losses multiplied. MHA engaged the Bereavement Center to provide support to those staff members. Several of our programs organized program-wide memorial services following the death of a client, moments that were essential in helping staff honor the individual and address their own grief.

Other components of our worker wellness initiatives are MHA's softball team, and, at the time of writing, we are completing a good-natured competitive fitness challenge, where staff can safely participate and engage in physical activities, track progress and more.

Last year, we set up a series of "drop-in" virtual meetings for staff, creating space for discussion about isolation, pandemic-related challenges, and racial injustice. Staff also participated in weekly family/pet remote calls to stay connected.

Our Executive leadership team has invested a significant amount of time analyzing staff needs, identifying ways to retain staff based on feedback and industry research. This practice has become embedded into our agency culture as it is critical in addressing current challenges, but also investing in the workforce of the future. We have been able to provide sign-on bonuses for hard-to-fill positions and provide hero pay for some positions.

MHA is an organization that is thoughtful and intentional about the needs of the staff. We routinely survey staff satisfaction and utilize the responses to inform practices and policies. During the pandemic, we enhanced our survey to add items that pertained to COVID. Of equal importance is communicating how administration plans on addressing the needs and the changes that have been made based on recommendations and feedback. The questions on the survey were intended to cover a diverse array of areas including, but not limited to: staff enjoyment of agency culture, tools needed to be successful, meaningful ways to stay connected, communications and identifying areas that are important in career advancement.

During the height of the pandemic, we hired new staff who had not seen the physical locations of the site they would be affiliated with or the main administrative offices. Our new hire orientation was fully remote. The personal nature of orientation was greatly impacted. But as always, we adapted and adjusted. It was important for administration to assess the quality of this new process. Our human resources department devised the new 31-day new staff survey. It was given to all

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National Council for Mental Wellbeing Selects CBC President and CEO Dr. Jorge Petit for Medical Director Institute

By Staff Writer
Behavioral Health News

Coordinated Behavioral Care (CBC) today announced that the National Council for Mental Wellbeing has selected CBC President and Chief Executive Officer Jorge Petit, MD, to join the Medical Director Institute. Dr. Petit is the newest member of this nationally renowned group of medical leaders. The National Council's Medical Director Institute (MDI) leverages its breadth of diverse knowledge and experience to advise National Council members on best clinical practices and develops policy and initiatives that serve organizations focused on mental health and recovery from substance use challenges.

"It is an honor to join the National Council for Mental Wellbeing's Medical Director Institute and the amazing group of physicians and expertise they've assembled," says Dr. Petit. "I have been impressed over the years by the MDI's important role advocating and promoting best practices to improve equitable access to needed mental wellbeing services. Their work aligns squarely with my own professional efforts and core values."

Jorge Petit, MD

The National Council established the MDI in 2015 to tackle complex issues impacting the delivery of psychiatric and substance use services nationwide. Its statements and publications—most recently "Resilience-Oriented COVID-19 Navigation," published in May 2021—identify and create concrete calls to action to ensure that all people in the U.S. have access to a comprehensive, integrated continuum of care with the expectation of recovery for mental health and substance use challenges.

"We're thrilled that Dr. Petit is joining the MDI. He has dedicated his career to complex issues that impact the health and wellbeing of everyone in the United States, such as the quality of care for Medicaid beneficiaries living with and seeking treatment for mental health and substance use challenges. His expertise, compassion and drive make him ideal for the MDI," said MDI Co-Chair Joe Parks, MD.

As the leader of a not-for-profit organization that represents over 70 community-based health and human service agencies through a lead Medicaid Health Home and citywide Independent Practice Association (IPA), Dr. Petit will provide insights on integrated behavioral health delivery systems and efforts at contract/payment reform. He joins a roster of more than 30 Medical Directors.

For more on the National Council's Medical Director Institute, visit the National Council's website.

Founded in 2012, Coordinated Behavioral Care (CBC) is a provider-owned and -led organization consisting of a Medicaid Health Home (HH), an Independent Practice Association (IPA), a Training Institute (TI) and an Innovations Hub which incubates new program models, such as Pathway Home™, and emerging technologies-assisted care solutions. CBC leverages community partnerships to coordinate integrated medical and behavioral health interventions that, coupled with a specialized emphasis on social determinants of health, promote a healthier New York. CBC brings together over seventy community-based health and human services organizations which provide access to quality treatment, housing, employment and other needed services.

Founded in 1969, the National Council for Mental Wellbeing is a membership organization that drives policy and social change on behalf of nearly 3,500 mental health and substance use treatment organizations and the more than 10 million children, adults and families they serve. The National Council advocates for policies to ensure equitable access to high- quality services, builds the capacity of mental health and substance use treatment organizations and promotes greater understanding of mental wellbeing as a core component of comprehensive health and health care. Through its Mental Health First Aid (MHFA) program, National Council has trained more than 2.5 million people in the U.S. to identify, understand and respond to signs and symptoms of mental health and substance use challenges.

Telehealth, Burnout, and the New Normal

By Kelly Daly, PhD
and Elana G. Spira, PhD
WJCS

No amount of education, training, or clinical experience could have prepared us, as therapists, for the reality of collective trauma on a global scale. As clinicians at the largest provider of community-based outpatient mental health services for our county, Westchester Jewish Community Services (WJCS), we did what everyone else did in March of 2020. The vast majority of us dutifully left our clinics, barricaded ourselves in our homes, and booted up our laptops for working remotely, while others continued to work in the field and do what was needed to keep our clinics open and operational. What we became aware of, what we witnessed — what we treated— over the subsequent 18 months was often devastating.

Our clientele constitutes a racially and ethnically diverse group of individuals, the largest contingent of whom are underserved—effectively a microcosm of those most negatively impacted by the pandemic on a national scale. Indeed, only 6 months into the pandemic we surveyed a small sample of our clients (N = 128) and found that 45% had undergone a change in household income, 15% were living with someone who had contracted COVID, and 25% had experienced the death of someone close to them from the virus.

As an agency and as therapists, we attempted to navigate not merely effectively transitioning to telehealth, but effectively transitioning to telehealth in the context of our clients' stark pandemic-related adversities. We embraced flexibility and creativity, we improvised, and we had numerous ongoing discussions about the process of therapy under these circumstances. We talked a lot about how: how to do ADHD interventions that facilitated remote learning with children whose families couldn't afford laptops; how to tackle depression arising in response to the confluence of job loss, mounting debt, and necessary social isolation; and, how to counsel someone who was deprived of the opportunity to say goodbye to a loved one and subsequently prohibited from arranging a funeral—how to sit with someone in their grief when the conduit of your presence was a 5-inch mobile screen.

Like everyone else, we adapted. In accordance with WJCS' commitment to programmatic research and self-evaluation, after the agency had been providing remote services for a full year, we surveyed our clinicians regarding their experiences with telehealth. In addition, we assessed the ways our clinicians had been personally impacted by the pandemic, and their current burnout. Resulting from prolonged interpersonal stress in the context of one's job, burnout is a syndrome characterized by debilitating exhaustion, feelings of profound ineffectiveness, as well as cynicism and disconnection (Maslach & Leitner, 2016). The phenomenon of burnout is familiar to all mental health professionals. The term itself is often invoked as a caution, presented as the culmination of a therapist's failures to engage in self-care, set appropriate boundaries, and maintain work-life balance—provisions rendered near-impossible at various points during the pandemic. Related, we wondered about the blurring of personal and professional roles for our clinicians and the multitude of responsibilities many were now juggling from home, an inevitability of lockdowns and pandemic restrictions.

We targeted all clinicians who were providing individual mental health treatment remotely, achieving a participation rate of just under 70% (N = 61). The vast majority of our clinicians (85%) identified as female and most (80%) were working full-time for the agency. On average, our clinicians were responsible for treating 29 individual clients (SD = 13) per week and had 14 years (SD = 11.9) of experience in mental health. Among the small subset of participants who completed the personal impacts section of the survey (n = 38) more than one year into the pandemic, 29% of our clinicians reported having had COVID, 34% lived with someone who had COVID, and 29% had someone close to them pass away from the virus. We are unsure how representative this is of our clinicians at large, as we cannot extrapolate from this data. It is plausible, for example, that clinicians who elected not to complete this portion of the survey did so because they didn't deem it relevant to them. With regard to personal roles and responsibilities, just over half of participating clinicians had children living at home (n = 31), the majority of whom were either too young for school or attending school remotely. A number of parent clinicians endorsed difficulties scheduling clients due to their children's pandemic needs. Moreover, 65% of parents described an increase in childcare since the onset of the pandemic with 20% of them devoting more than 10 additional hours to childcare each week! Further, 16% of our clinicians identified as the caretaker for an older adult or individual with disabilities living in their homes.

As a function of increased time and obligations at home, many therapists reported that lines demarcating their personal and professional lives had blurred. Sixty-nine percent agreed that this was an overt difficulty for them, while additional evidence of boundary blurring was apparent in clinicians' behavior. The vast majority (77%) reported forgoing sick leave they would have otherwise taken to continue working from home while ill, and two thirds took substantially less vacation time than they generally would. In addition, therapists coped with an increase in behavioral health challenges among their clients. Relative to pre-COVID, 90% of clinicians endorsed that their clients had more severe symptom presentations (to a varying degree). Given that clinicians are being impacted by the pandemic both directly (e.g., becoming sick, losing a loved one) and indirectly (e.g., loss of childcare, less in-person contact with social supports), while simultaneously counseling clients through it, it is hard to imagine them not being burnt out. And indeed, on the abbreviated version of the Maslach Burnout Inventory (MBI-9; Maslach, 1993), the most widely used and well-validated measure of burnout, 71% of our clinicians scored as experiencing high burnout in at least one of the three independent dimensions of burnout (depersonalization, emotional exhaustion, and lack of accomplishment).

Unfortunately, the findings of our survey contribute to a recent litany of articles implying that burnout is the current reality for the vast majority of mental health practitioners in the U.S. While addressing a problem of this scale warrants more than trite aphorisms about not filling from an empty cup, empirical evidence does suggest that therapists tend to be bad at self-care. So rather than espouse the need for such, perhaps, at the present moment, it is more appropriate to recommend that we, as therapists, give ourselves grace. Indeed, I suspect that some of the factors that have made this transition so difficult for us are the same ones that have enabled us, as providers, to survive it. Included among them is some degradation of

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A Virtual Peer DBT Consultation Group

By Liza Pincus, PsyD,
Kelly Daly, PhD,
and Elana G. Spira, PhD
WJCS

Dialectical Behavior Therapy (DBT), an evidence-based treatment developed for individuals meeting criteria for Borderline Personality Disorder, is one of the primary interventions delivered at Westchester Jewish Community Services (WJCS). In an effort to supplement existing training and practice in DBT and provide peer support during the pandemic, we developed a remote DBT Peer Consultation Group. The 30-week group provided a weekly opportunity to practice DBT strategies in an informal, supportive setting. Given increased needs in a post-pandemic world for remote learning and practice, the opportunity to explore the feasibility of virtual peer consultation groups was especially valuable.

Our research study about the DBT Peer Consultation Group aimed to determine the effect of remote peer consultation on clinician perceptions of self-efficacy in delivering DBT-informed treatment, as well as self-assessment of adherence to the DBT model. The group focused on various topics essential for comprehension of, and adherence to, a DBT treatment model. Specific interventions for augmenting participants' knowledge and confidence included didactics/discussion of readings, case discussion, and role-playing. The study measured changes in clinicians' perceptions of self-efficacy related to delivering DBT-informed treatment as a function of involvement in peer consultation group, clinicians' attitudes toward incorporating DBT into their future practices at the conclusion of peer consultation group, and the feasibility of peer consultation via virtual consultation sessions.

Measurement tools included a pre-group survey of group participants, as well as a 6-month and post-group follow-up. We also administered a weekly survey measuring usage of DBT strategies in clinical work. Clinician confidence was measured by such questions as: "I am confident in my ability to work with clients who experience suicidal behaviors" and "I am confident in my ability to effectively use DBT chain analysis in individual therapy." There were 13 confidence questions in total, and the responses were measured according to a Likert scale.

Starting at Week 10, clinicians were asked each week to report if they had used various DBT interventions covered in group. Several strategies were coded as "key" strategies because they were newer skills for participants: use of a DBT commitment strategy, creation of a new target hierarchy, reference to a previously created target hierarchy, utilization of a DBT diary card, or completion of a DBT chain analysis.

The research sample included 10 clinicians at WJCS, six of whom were masters-level clinicians, and four of whom were psychology doctoral students. Six had prior DBT experience (defined by attending at least one intensive DBT training, receiving training in an externship or internship setting, and/or providing significant DBT-informed individual treatment), and four did not. On average, participants carried a weekly caseload of four DBT-informed cases (range 2-8).

On average, each participant in the group used 3.3 DBT strategies per week attended. Across the first 3 sessions after measuring, 72% of participants reported using key strategies that week. Across the last 3 sessions, 93% reported using key strategies each of those 3 weeks. There was a trend toward a correlation between

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Weathering the Workforce Storm

By Christal Montague, MSW, LMHC, CASAC, CARC, and Maryclare Scerbo, MSW, Outreach

Over the past year, the behavioral health and health field has endured a wave of voluntary employee departures and mounting challenges in its ability to recruit highly qualified staff. Turnover brings considerable costs to organizations, time - and resource-wise - in recruiting and training new employees. There is also a significant loss of institutional knowledge and reduction in productivity while positions remain vacant.

To help retain staff and to weather this storm we are currently experiencing within the field, it is important for organizations to analyze the data available to them to help identify employees who are likely to leave. The following are some early warning signs that indicate your employees may be on their way out the door:

• Major life changes- Keep an eye on staff who are graduating or who are starting a family. Big life changes often indicate potential turnover. This information may be hard to ascertain, which is why maintaining a good relationship and trust with staff can help.

• Missed promotions- Staff who are disappointed about being passed over for promotions might begin to look elsewhere for opportunities to advance. It is beneficial to keep a list of staff who applied for promotions and check in with those who weren't selected to ensure they feel appreciated and to help them better prepare for the next opportunity.

Christal Montague, MSW

Maryclare Scerbo, MSW

• High department turnover- Look at turnover data by department/division and manager to pinpoint where higher turnover rates exist. The staff in those departments/divisions are at risk of leaving if you don't quickly identify and address the concerns of the unit.

• Reduced communication- Staff who are normally responsive in their emails or calls who exhibit a change in pattern might be considering leaving.

• Absenteeism- Taking time off in the middle of the day can potentially point to the possibility that staff may be doing interviews. Staff who are complaining, being less productive or job hunting online while at work may be considering a job change. If you want to retain staff, it will be important to put in preventive measures before `they quit.

To help reduce predictive voluntary departures, organizations can take the following steps:

• Identify your top performers. Empower managers to sit down with staff to conduct "stay interviews" designed to make sure workers are satisfied. If you wait until the employee makes the decision to leave and start looking and applying for jobs, your chance of keeping them is much lower.

• Address staff concerns. Listen to your staff challenges and have staff assist in finding the solutions. Flexibility and empathy are key.

• Communicate frequently. The best way to reduce turnover is to understand why staff stay and why they leave. With the uncertainty caused by the COVID-19 pandemic, staff need to trust that leaders and their organizations are there for them. Leadership needs to be open and flexible with a strong line of communication between the staff and leadership, so staff feel comfortable acknowledging when they need extra support.

• Be accessible. Make it easy for staff to communicate how they are feeling.

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How Autistic Individuals Taught Us to Teach

By Donald M. Fitch, MS
Founder
Center for Career Freedom

About ten years ago, one of our NYS ED/BPSS licensed instructors for Microsoft Excel Certification came to me. She was frustrated that more and more of her students weren't paying attention; they didn't look at her, fidgeted, kept turning their backs to her to play with their computers, etc. Nothing she did would hold their attention. Whatever was the cause, our stand-up lecture teaching model was .not working. We needed a new method of instruction. We tried different instructors, frequent breaks, snacks, money, awards, positive reinforcement, nothing worked. We stopped teaching. When I was a business consultant, and we wanted to get to the bottom of a problem - we asked people. So, we asked our students.

What's the best way for you to learn? How do you want the instructors to teach? What should we do? They told us to "Stop lecturing us," "I can't remember what you're telling me," "You talk to fast," "I can't relate your words to the computer program." "I'm bored."

Students were demanding to be in charge of their instruction, to be hands-on and at their pace. They would tell us when they had a question. Stand by.

Donald M. Fitch, MS

One of our Instructors balked at the idea of a "flipped" classroom: "I have a Master's in Special Education, and ten years teaching experience at a public high school in the Bronx. I can't teach until all the students are quiet and attentive. I'm in charge of the class. "We need discipline and Ritalin." We realized what we had was a battle for power and we were losing.

We surrendered to the students. We had them face the computers and gave them a series of tasks to complete at their pace. We were available to help them when they were stuck. Class times dropped to half for an average of twenty-five (25) weeks, passing rates increased from fifty to ninety-five percent (95%), Then in March of 2020, Covid came, and the Center closed. After a few weeks; all our instruction went online. ZOOM, first as a test, then, permanently. We were able to offer one-two hour sessions, any day and time convenient to the student; Monday–Saturday; 9 am- 2pm.

Because we were training on the computer, the switch from onsite to online instruction was minimal. We only had to loan out five (5) computers. What was new was the one-on-one instruction and the class time. With a class size of ten, each student received an average of six minutes of 1:1 instruction. Online, the student received all sixty minutes and at their pace.

Again, class times dropped, and certification rates improved. We couldn't wait to ask the students which instructional methods, onsite or online, they preferred and why? Online was preferred by over 80% because:

• It was live, not prerecorded.

• It was private; they felt free to ask "dumb" questions and not feel embarrassed.

• It was at their pace; they didn't feel lost.

• It was sufficient: the time was more than enough to grasp the full lesson and to review the material.

• They could stay up to 1am, play video games and still make their 12 noon class.

• No more getting dressed and having to take the bus, especially in poor weather, and it was cheaper.
• Their teacher was like a friend they could share stuff with.

Following Microsoft Certification, the next step is a six-month Internship to familiarize them with the world of work – first at home. The Internship concentrates on strengthening their "hard skills," data entry, peer instruction, job shadowing. It is paid (about $15.00/hr. for about 400 hrs.). Thanks to ACCESS-VR or OPWDD – self direction – the supporters of our training program.

With the support of Mike Spano, Mayor of the City of Yonkers, and School Superintendent Dr. Quezada, several public high schools in Yonkers have partnered with the Center to adopt our instructional model to their 11th and12th grade students in Special Education.

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Honoring David Woodlock's Service to the Mental Health Community

By Staff Writer
Behavioral Health News

David Woodlock, President and CEO of the Institute for Community Living (ICL), recently announced his retirement after a career in the mental health field spanning nearly five decades. Woodlock, who served as Deputy Commissioner for Children and Families at the New York State Office of Mental Health, is a leading national advocate for whole-person health, an approach to care that addresses an individual's full range of emotional, social and physical health needs. Over the course of his career with the State and ICL, he introduced innovative behavioral health programs and developed projects that led to meaningful improvements in care for adults and children facing serious mental health challenges. ICL's Board of Directors has conducted a national search for a new CEO.

"Since I began my career almost 50 years ago, working to move people suffering with mental illness out of psychiatric hospitals, we've made great strides to help people facing serious challenges live healthier, happier, more independent lives," said David Woodlock, President and CEO of the Institute for Community Living. "While we still have a long way to go, I am incredibly grateful to have had the opportunity to serve the people of New York State, and lead an organization

David Woodlock

like ICL that provides essential, life-changing services to 10,000 New Yorkers every year. I want to thank the ICL board for the opportunity to lead this organization over the past nine years and our wonderful staff for their dedication to our clients."

Woodlock joined ICL, a premier innovator of whole health care, as CEO in 2012. He has led ICL in pioneering the use of person-centered, integrated care that leads to improved health outcomes and reduced health care costs. In 2018, this work culminated in the opening of one of the country's largest and most comprehensive whole health centers, the East New York Health Hub. Today, the Hub serves 5,600 people annually with 19 different programs. Under his leadership, the agency has become one of the country's leading innovators in helping people with serious mental illness and substance use issues.

"For over almost five decades, David Woodlock has been a tireless advocate for adults and children facing serious challenges, and an innovative leader in behavioral health," said Mary Harrison, Board Chair of the Institute for Community Living. "Since joining ICL, David has taken our organization to another level, expanding the scope and reach of our programs. David's leadership has improved the lives of our clients, the communities we serve, and his forward-thinking advocacy has had a profound impact in New York and throughout the country. We thank David for his service, and wish him and his wonderful family all the best in retirement."

During his three decades at the New York State Office of Mental Health (NYS OMH), including four years as Deputy Commissioner for Children and Families, Woodlock was responsible for securing the largest annual appropriation for children's mental health services in New York State history. At NYS OMH he spearheaded an early intervention strategy that focused on schools and primary care, and led in the development of the first-ever statewide Children's Plan, a multi-agency effort to help kids in health care and other settings such as schools and the juvenile justice system.

In addition to his work in government and the nonprofit sector, Woodlock served as CEO of Four Winds Hospital/ Saratoga, a private psychiatric system in upstate New York. He is the author of the 2017 book, *The Emotional Dimensions of Healthcare*, and is the recipient of numerous awards, including the Visionary Leadership Award from the National Council on Behavioral Health, Extraordinary Leadership Award from New York State Coalition of Children's Mental Health Services, Special Congressional Recognition Award, and the Social Justice Award from Syracuse University.

New York State Office of Mental Health Commissioner Dr. Ann Sullivan said, "David's remarkable career is distinguished by the number of people he has helped over the last 50 years. Thousands of individuals and families have received the support and assistance they desperately needed, thanks to David's efforts. As a deputy commissioner here at the NYS Office of Mental Health, as CEO at Four Winds Hospital, and as President and CEO of the Institute for Community Living, David's focus has always been on improving health outcomes for people

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Telehealth: An Unexpected Silver Lining During a Pandemic

By Janelle Westfall, LPC, LBA, BCBA, and Molly Stubbs, LPC
Devereux Advanced Behavioral Health

Cozy up in your home's coveted armchair, paired with a blanket, headphones and your smart phone. Click on your telehealth link. Begin your remote outpatient therapy session from the comfort of your own home. But wait … are we referring to individuals served, therapists, or perhaps both?

March 2020 changed the way many mental health therapists conduct their sessions. In an effort to reduce the spread of COVID-19 and ensure the health and safety of employees and families, many community mental health agencies -- including Devereux Advanced Behavioral Health – transitioned to providing telehealth sessions.

Telehealth sessions enabled people to continue receiving the care they needed and wanted, while adhering to the guidelines set in place by the Centers for Disease Control and Prevention.

Navigating telehealth obstacles: Providing services via telehealth was not a new concept in 2020. In fact, tele-mental health was a service used often with clinicians in private practice. However, many community-based providers spent years trying to navigate the licensing, credentialing and financial regulatory landscape

to offer these services. The pandemic served as an impetus – propelling behavioral health providers into a new and exciting frontier. This new service delivery method allowed all behavioral health providers the ability to become efficient, timely and responsive to their clients' needs – in real time.

However, telehealth also brought with it a series of challenges and obstacles. Providers had to be nimble and create protocols and procedures to offer services and support quickly, efficiently, and ethically. At Devereux, we needed to navigate which telehealth platform would be best for our teams and families; locate and purchase the necessary technology equipment to go remote within days; develop training tools on how to deliver telehealth services; and revise our policies and procedures to ensure compliant delivery. In addition, challenges related to Wi-Fi connections for clinicians and families were rampant in those first few months because platforms experienced outages as a result of the significant volume of usage.

Keeping individuals and families at the forefront: The children and families who needed regular connection, care and support were always at top of mind. Devereux was an amazing place to work during the pandemic – we saw some of the best clinical minds gathering on Zoom calls, across time zones, strategizing about what worked best. Within five days, Devereux Arizona and Pennsylvania converted all of its outpatient therapy services to telehealth. Clinicians and supervisors from different states came together to develop additional training tools, share ideas around how to engage individuals and families via telehealth, create standards of best practice when using telehealth, and reduce the spread of COVID-19 by staying safe at home.

"At the beginning of the transition, we experienced some anxiety about adjusting to a new service delivery platform, questioning whether or not it would be effective to engage our individuals in treatment. Through the course of the pandemic, I've come to the realization that telehealth is convenient and effective, and it has increased my individuals' attendance," said Charlley Labik, LPC, Devereux Pennsylvania Children's Behavioral Health Services clinician.

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Grand Opening of Liberty Station
A New Housing Development in Port Jefferson Station

By Staff Writer
Behavioral Health News

Concern Housing, Inc.—a Medford-based non-profit agency committed to helping individuals live with dignity and enhanced opportunities—celebrated the grand opening of Liberty Station in Port Jefferson Station, New York. Liberty Station, a 77-unit rental community, provides workforce and accommodating housing options to persons in the community, including veterans.

"We are thrilled to join the Port Jefferson community and provide a housing option that is in desperate need for so many in our region," said, Ralph Fasano, Executive Director of Concern Housing. "Liberty Station offers veterans who have fought for our country quality, affordable housing as everyone deserves to live with dignity and respect. We a proud of our team and the numerous partners that made this much-needed project come to fruition."

Standing beside its various partners and elected officials, Concern cut the

Ralph Fasano

celebratory ribbon welcoming six, two-story apartment buildings comprising 77 affordable homes. 75 of the 77 apartment homes are one-bedroom units, with the remaining units being two-bedroom units. 25 of the apartments are reserved for veterans, 20 additional units are given preference for veterans and the remaining units are for individuals making less than 50 percent of the Area Median Income.

To ensure the quality living of residents, the community also provides residents with access to private parking lots and amenities such as a fitness center, a library and a computer room.

Additionally, staff offices are on-site so staff members are available to help resolve any issues or needs. Residents also benefit from being in close proximity to major bus routes as well as the Port Jefferson LIRR station.

Liberty Station would not have been possible without the help and support from the following partners: New York State; Suffolk County; The Home Depot Foundation; Capital One; The Community Preservation Corporation; National Equity Fund and LISC.

"I am in an apartment on my own at a great location. I could never afford an apartment like this on my income and also, live on my own. I am living 150% better than I was. I love my own space, the sense of community and appreciate all that Concern does for housing Vets, like me." stated Harold Mains - Sergeant, U.S. Army .

For more information about the property, please contact Christine Velia at cvelia@concernhousing.org or visit us at https://www.concernhousing.org.

More About Concern Housing

For almost 50 years, Concern Housing has been helping low income and disabled persons achieve their goals of greater independence, housing stability, and increased pride in their accomplishments. Our programs have made it possible for individuals and families to transition out of homelessness and have reunited parents with children from whom they have been separated. We are one of the largest housing agencies of this kind in New York State. Concern offers a variety of housing options with individualized support services designed to support personal growth and independence.

Concern is currently serving over 2,000 individuals and families in over 240 locations.

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while giving your staff access to courses and training that allow them to grow their skills on their time. By doing so, you can ensure higher quality care for your clients, which, in turn, could lead to greater financial resilience.

Easy access to training can also help increase staff happiness, thus boosting retention rates. We at Relias have found that true organizational resilience stems from having a consistent, well-trained, and passionate staff base. In our *2021 State of Healthcare Training and Staff Development Report*, 48% of human services organizations (including behavioral health organizations) reported that training efforts had a positive impact on staff retention. By leveraging digital solutions to provide training opportunities to your staff members, organizations can create an environment in which they feel appreciated and see growth opportunities. Both of these factors lead to great staff retention, which is a core principle of organizational resilience.

Wrapping Up

Embracing digital transformation holds the key for the future of human services. By making it easier for staff to learn and grow, organizations can create higher quality outcomes for persons served within their community. This happens because digital transformation promotes increased organizational resilience. More resilient organizations have higher levels of staff retention, as they both promote staff wellness and can navigate the murky waters of disruption. By creating a more stable and skilled workforce, you'll be better able to deliver care to persons served.

Embrace the change and become a more resilient organization.

About Relias

For more than 10,000 healthcare organizations and 4.5 million caregivers, Relias continues to help its clients deliver better clinical and financial outcomes by reducing variation in care. Our platform employs performance metrics and assessments to reveal specific gaps in clinical knowledge and addresses them with personalized, engaging learning.

We help healthcare organizations, their staff and those under their care, get better: get better at identifying issues, get better at addressing them, get better outcomes for all. Let us help you get better.

We invite you to visit Relias online for more information.

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• Innovate and incentivize. Consider new and creative ideas to recruit and retain staff. Chief examples include staff referral programs, where incentives are offered to staff who refer qualified candidates who end up getting hired.

By taking thoughtful, proactive steps, organizations may be able to retain staff for a longer period of time. These above listed tips, while especially helpful now, are useful all year round, even during "normal times."

Christal Montague, MSW, LMHC, CASAC, CARC, is Chief Strategy Officer, and and Maryclare Scerbo, MSW. SPHR, is Director of Human Resources, at Outreach. To learn more about Outreach please visit us at www.opiny.org.

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with mental illness, substance abuse issues or developmental disabilities. It has been an honor and a pleasure to partner with him and I wish him the best on this next phase of his life."

"It's been my pleasure to know and work with David Woodlock over my career. In addition to serving as the CEO of ICL, David is the Vice Chair of The Coalition's Board. I have deeply appreciated David's leadership, strategic thinking, and extraordinary counsel on a variety of issues. I congratulate David on his retirement and wish him the best in his next chapter," said Amy Dorin, President and CEO of the Coalition for Behavioral Health.

"David's been a source of inspiration for me personally and professionally. His tireless work on behalf of physical and mental wellbeing has significantly improved millions of lives in New York and beyond. Congratulations on your retirement and a job well done, David!" said National Council for Mental Wellbeing President and CEO Chuck Ingoglia.

About ICL

ICL provides trauma-informed, recovery-oriented, integrated, and person-centered care through supportive and transitional housing, counseling, and rehabilitation services for adults, children, veterans and families with mental health challenges and those living with developmental disabilities. We serve 10,000 people each year; every night 2,500 New Yorkers call ICL home. Our goal is to help people achieve better health and the most fulfilling life possible.

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Our Microsoft Certified students have been able to teach their fellow students Word, Excel, PowerPoint, Outlook, etc. and strengthen their resumes and job prospects using our Microsoft Certified students as volunteer instructors. This enables the school to re-create the Center's instructional model with minimal disruption and at no cost – that's one hurdle.

A second hurdle for folks on SSI is to raise the earning cap. Currently, SSA holds back one-half (1/2) of all gross earned income over $85/mo. It doesn't pay for folks on SSI to go to work.

There's hope. Senators Warren and Schumer included a bill that just passed the House that raises the earnings cap from $85/mo. to $700/mo. This would remove a second hurdle to achieving self-sufficiency.

It's wonderful to realize folks on the autism spectrum are leading the innovation in education and employment.

Training the Workforce in Non-Traditional Modalities of Self-Care: A COVID-19 Silver-Lining

By Emily Grossman, MA, CPRP, and Amanda Semidey, LCSW
Coordinated Behavioral Care (CBC)

Over the past 18 months, the pandemic and the many associated societal stressors, have caused great suffering, and the behavioral health (BH) workforce has been no exception. The novel coronavirus and ongoing pandemic have wrought tremendous personal loss, job and/or income insecurity, and forced isolation from family and other social supports on nearly all of us, and the BH workforce has had to grapple with these life stressors in tandem with their ongoing commitment to continue serving clients. Even in less historic and unprecedented times, the BH sector has had to reckon with compassion fatigue, burn-out, vicarious trauma and high employment turnover. The pandemic's compounding effect on the BH workforce has presented a stark need to help those that make up the "helping" professions, and to do so via non-traditional workplace training modalities that focused primarily on individual self-care.

From its unique vantage as a network organization serving over sixty community based BH provider agencies in NYC, Coordinated Behavioral Care (CBC), Inc. and its Training Institute (TI) saw an opportunity and sensed an obligation to pilot a new self-care training series that could broadly reach NYS's mental health professionals. In January 2021, CBC and its partner CBHS, received a Substance Abuse and Mental Health Services Administration (SAMHSA) COVID-19 Emergency Grant, through OMH, with funding that would support a new array of self-care trainings for NYS frontline BH workforce impacted by COVID-19. As demand and attendance soared, CBC TI sought and secured further funding from the New York State Health Foundation (NYSHealth) to broaden this work to serve Peers/Peer Specialists and staff in congregate settings that may work less traditional hours.

CBC TI leveraged these funds to build partnerships with self-care experts that haven't historically had tremendous visibility within the BH sector. For instance, CBC TI partnered with the Kripalu Center in Massachusetts—an internationally renowned yoga and meditation retreat center—to bring their mindfulness and holistic wellness offerings to the NYS BH workforce, free of charge. Kripalu's RISE program is a six-week, evidence-based mindfulness and meditation skill building training designed to meet the needs of healthcare providers by fostering greater clarity and resilience, improved situational awareness and work/life integration that can promote superior long-term performance for individuals and organizations.

The RISE sessions ultimately served over 300 staff from 87 unique BH agencies between February and June 2021. Attendee feedback was overwhelmingly positive. One participant commented, "I was able to make room in my schedule to attend the 6-week Kripalu Rise Series and have to say that it was one of the best virtual trainings I've attended in a very long time. It sadly ended today but I wanted to share my gratitude for offering this to the CBC network as part of the SAMSHA funds. If given the opportunity, I hope this is offered again as I'd love to see my fellow staff and colleagues, who are the helpers and healers of the communities we service, take advantage of the training." Another participant stated, "phenomenal experience—exceptional facilitation and exercises."

In addition, CBC TI set out to

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Psychiatric Consultation: A Method to Expand the Workforce

By Marc Avery, MD
Principal Consultant
Health Management Associates

Marc Avery, MD

I remember, almost to the day, when my psychiatric practice changed for the better by moving towards a psychiatric consultation model of care. Prior to this day, I was working as a medical director at a community mental health center where almost all my patients each were assigned to face-to-face services with a case manager and a psychiatric medication provider, with additional services provided as needed. We constantly dealt with the limits to how many patients we could serve using this model of care, and always felt we needed more psychiatrists and other mental health care clinicians in order to meet our client's needs. Each day the staff at our center worked diligently to address the barriers to achieving better outcomes with our patients. However, we didn't systematically track outcomes, and thus lost track of patients who may be dropping out of care or simply not improving as we had hoped. We had limited abilities to coordinate our care with one another as well as with the primary care providers who were also treating our patients. And finally, our care often wasn't standardized from clinician to clinician. Our result, too often, was fragmented, uneven access to quality care, and with uncertain and likely reduced clinical outcomes.

So, I jumped at the opportunity about 15 years ago to participate in an early example of the Collaborative Care Model (CoCM) by participating in the Mental Health Integration Project, or MHIP, sponsored in part by the AIMS center at the University of Washington School of Medicine. Though the MHIP program was initially just a pilot project, I quickly came to realize that our whole mental health center would benefit from incorporating many of the principles that were core to the CoCM model.

My experience with the CoCM model taught me that psychiatrists can play a key role in improving clinical outcomes via the use of psychiatric consultation models of care. A psychiatrists' training and experience affords the opportunity to provide leadership around the core principles of the CoCM model; namely, promoting integrated team-based care, using population health approaches, and incorporating measurement-based care practices. Though each of these components can be discussed separately, in my experience each one fits together with the other in a kind of jigsaw puzzle – with each potentiating the other. Of course, other models of consultation exist, many with similar features to the CoCM model. However, the CoCM model remains one of the most researched and validated models for primary care integration.

Implementing team-based care has been promoted as one of the potential solutions to addressing our country's shortage of psychiatrists and other behavioral health providers. We simply can't 'fix' the shortage by working longer hours or waiting for more psychiatrists to graduate (though this would certainly help!). No, we need to take another approach – one where we partner with primary care teams to create a team-based approach to care. By working in our separate environments, we are working ineffectively and inefficiently. But, by joining together as a team, we can share tasks more efficiently by reducing gaps, clarifying roles, and eliminating redundancies. By working as part of a CoCM team, I quickly noted that I was overseeing many times the number of patients in my CoCM work as compared to my usual clinical work, but in the same amount of time. It was obvious from the start that the CoCM model allowed me the possibility to extend my reach as a psychiatric provider to help many more patients.

And, by working together as a team we could add more providers to the team itself, such as care coordinators, community health workers, nurses, or others – with each person working with a clear blueprint for their role and each person practicing at top of scope and skill level. The psychiatrist serves as a consultant on these teams – providing guidance around evidence-based treatments and care pathways and in identifying which patients might need more attention or a change in treatment.

The second central principle of the CoCM model is a switch to incorporate population-health practices. For me this was revitalizing to take on broader accountability for all the patients in my practice – not just those that were showing up for services or those that were improving as expected. For so many of us,

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facilities and programs licensed, certified, or funded by The New York State Office of Mental Health (OMH) as well as those programs overseen by the Office of Addiction Services and Supports (OASAS), the Office for People With Developmental Disabilities (OPWDD), Office of Children and Family Services (OCFS), and the Office of Temporary and Disability Assistance (OTDA). This requirement will protect healthcare workers as well as our patients and clients and our communities.

OMH has promoted the safety and effectiveness of the COVID-19 vaccine through a series of videos featuring union leaders as well as OMH executives and staff. We have also produced posters, fact sheets, and other educational materials on the vaccine and on the importance of other infection mitigation protocols that we know to be effective - such as wearing masks, maintaining distance, and frequent hand washing.

These initiatives have helped us to educate individuals and address misinformation, fear, and mistrust. Focusing on actions that individuals can take to reduce the risk of infection also helps to alleviate anxiety which has become more prevalent in the past 18 months.

Now that the vaccine is available to all New Yorkers aged 12 and over, we encourage all who are eligible to get vaccinated to protect themselves, their families, and communities. OMH has administered vaccines through our O-Agency Link-Outreach-Vaccinate program (O-LOV). OMH-operated and O-LOV sites have administered over 77,000 vaccines since December 23, 2020. In addition, OMH Psychiatric Centers have provided more than 400 mobile clinic and pop-up events throughout New York State since January - allowing us to reach some underserved communities. We have been very successful in our efforts with more than 70 percent of our staff and inpatients receiving the vaccine to date.

NYS OPWDD

The New York State Office for People With Developmental Disabilities (OPWDD) is committed to ensuring the safety and security of the people we support and the workforce who support them. We have worked closely with the NYS Department of Health throughout the pandemic to ensure that our guidance is in line with masking, vaccination, infection control and social distancing requirements at the state and federal level.

The majority of people we support within residential settings have received their vaccination. While our staff vaccination numbers lag behind, we continue to work on ways to incentivize the workforce to get vaccinated and are waiting on final federal approval of New York's American Rescue Plan proposal to provide bonus pay to those workers who receive the vaccination. In addition, NYS has recently mandated vaccinations or testing for all state workers beginning September 27th, 2021.

The Workforce Crisis

Many providers have reported critical staff shortages due to the pandemic, in part due to salary disparity, fatigue and burnout. What is your department's strategy to address the workforce crisis that the field is experiencing?

NYS OASAS

OASAS is rolling out grant programs to our providers to assist them with a host of workforce agendas, including staff recruitment and retention. We plan on using a portion of a Federal Substance Abuse Prevention & Treatment Block Grant Supplemental award and additional funds received for Medicaid services to help with these efforts at our prevention, treatment, and recovery providers.

OASAS also offers resources on our website to assist providers with training, credentialing, and clinical support for their staff, including helping staff who are facing mental health issues such as fatigue or burnout.

NYS OMH

First, it is important to recognize the incredible dedication and commitment of our mental health workforce throughout this pandemic. They have been terrific.

But there is a serious workforce crisis in many areas of the labor market– health care and mental health being one of them. OMH is planning a wide range of recruitment and retention initiatives to increase community- based capacity and create a mental health career pipeline. Another goal is to target recruitment and retention efforts to diverse and multilingual individuals to expand culturally competent mental health services in underserved communities.

This requires an approach that includes both short and long-range solutions. In the short term, OMH is using funding from the Mental Health Block Grant (MHBG) and Federal Medical Assistance Percentages (FMAP) to enhance, expand and sustain these services by providing a combination of targeted rate increases to eligible programs and flexible workforce recruitment and retention funds to support a wide range of activities to build capacity.

Long-range planning includes recruitment strategies such as working with schools on behavioral health curriculums and formalizing and enhancing the vocation of community mental health workers. One possibility is strengthening the housing workforce through the development of a training curriculum for all housing types that can be implemented statewide. Also developing a workforce from the community where our clients live and providing them with training and a potential career ladder is a step towards strengthening and building a more diverse and sustainable workforce.

Another critical element of strengthening the workforce is investing in peers. One of our workforce priorities is to expand certified and credentialed peer workforce (inclusive of adult, youth, and family) including resources for recruitment, retention, education/training, and career pipeline investments.

The pandemic has brought on stress and focused a spotlight on the importance of physical and mental wellness. Despite our training and understanding of the importance of wellness, we sometimes forget to address our own needs and should be sure to help our workforce remember that their wellness is vital. Simple self-help practices can be effective such as practicing mindfulness, stress relieving desk exercises, and reaching out for additional support when needed. OMH has provided wellness trainings and coping tips and resources to State and community partners throughout this challenging time. Additionally, NY Project Hope has provided crisis counseling in communities and the Emotional Support Helpline available statewide to anyone needing support.

NYS OPWDD

As with all human services fields nationwide, COVID-19 has had a significant impact on an already shrinking field of available direct support workers and OPWDD is taking an active role along with our providers of services on finding solutions to the workforce issues faced by our field. We recognize that our direct care workforce is the backbone of a strong service delivery system, which is why New York State has made substantial and ongoing investments in wage increases for our direct care workforce over the past several years, including three targeted initiatives to increase compensation to staff of service providers: two 2% increases in 2015, two 3.25% increases in 2018 and another round of two 2% increases in January and April of 2020. In addition, not-for-profit service providers also received a 1% COLA increase as part of the 2021-2022 Budget.

OPWDD has an additional opportunity to make investments in our workforce through the one-time American Rescue Plan funding and are currently awaiting approval from the federal Centers for Medicare and Medicaid Services on our proposed spending plan.

In addition to funding wage increases, OPWDD has worked with our provider partners by funding the Regional Centers for Workforce Transformation, which is a network of workforce champions who provide training, curriculum development, technical assistance, and recruitment and retention support. OPWDD is also approved by the Veterans Administration to take part in their financial benefits program which enables veterans to leverage military benefits for direct support training. Additional efforts are underway to expand recruitment to high school students interested in the field of direct support through partnerships with BOCES and SUNY.

Federal Funding

How can enhanced Federal Medical Assistance Percentage (FMAP) be used, not just as a one-shot influx of support that temporarily props up systems that are already in crisis, but instead is as a down payment towards a longer-term investment in the overall system of care and support? Specifically, how will the federal funding be used for infrastructure support, enhancing technology, provider rate increases, salary support, and program enhancements?

NYS OASAS

We plan to use this funding to make a significant investment in workforce development initiatives including tuition support, loan forgiveness, and training, which we are hopeful will have positive long-term effects even after this temporary funding runs out. We are also investing in our residential system to ensure these providers have the support they need to address longer term substance abuse treatment.

It is our hope that we can establish a strong foundation to support continued strengthening of the entire prevention, treatment, and recovery service continuum throughout New York State in the coming years.

NYS OMH

The federal funds enable OMH to invest in strengthening and expanding capacity to address increases in demand, adjust to the realities of post-pandemic service delivery, and build workforce capacity for long-term sustainability of the community mental health system.

As part of system transformation, OMH has prioritized the development of a comprehensive array of rehabilitation services to promote access to prevention and recovery-oriented supports for adults and children. While the eFMAP resources are one-time, OMH will be advancing strategies to use the funds to enhance, expand and sustain these services by increasing rates, providing workforce recruitment and retention funds to allow providers to build capacity, and targeting funds for infrastructure investments including training in evidence-based practices and resources to improve the quality and efficiency of services in the more immediate term. The rate increases for rehabilitative services will be continued with support from reinvestment savings.

With extensive input from stakeholders, OMH's plan prioritizes the following investments:

Strengthen Rehabilitation Programming: OMH will implement permanent rate increases for Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), and rehabilitation services in Community Residences which will be continued in the out-years supported by reinvestment savings.

Workforce Investments: OMH will include temporary rate increases for federally eligible programs to support a wide range of provider workforce recruitment and retention strategies including recruitment and retention incentives.

System Capacity Building: OMH will provide one-time resources to significantly expand certified peer and family support capacity, support training and implementation of evidence-based practices (EBP), and the implementation of alternative payment methodologies to drive outcome based, quality-of-care oversight, and incentivize value based payment.

Expanded Access to Children's Services: The State will be advancing temporary rate increases to grow and expand the new Children and Family Treatment Supports and Services (CFTSS) and Home and Community Based Services (HCBS) as well as infrastructure and workforce funds to build capacity.

There is also a significant increase in Federal Block Grant Funding that will help make possible the development of a truly robust and effective crisis system across NY state. This is part of the exciting implementation of the 988 mental health crisis number that will make it easy for anyone to receive the help they need in a crisis.

NYS OPWDD

OPWDD's FMAP initial plan initiatives targeted more than 76% of the anticipated

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funding to workforce initiatives ($554 million) including 70% to payments to increase the wages of direct support professionals (DSPs) and supervisors (more than $514 million). Other workforce funding is targeted towards increasing the quality of DSPs through advanced training and credentialing programs and recruitment and retention strategies to help retain and recruit DSPs.

Additional initiatives planned for the remaining 24% ($173.8 million) of anticipated eFMAP funding is targeted to the following: $120 million to increase, expand or strengthen HCBS services; $11.4 million to expand and strengthen crisis supports; and $42.4 million to strengthen the OPWDD information technology infrastructure.

Diversity, Equity, and Inclusion

We need more professionals of color in our systems: social workers, physicians, nurses, nurse practitioners, etc. In addition, critical improvements are needed in access to care and workforce diversity. What is your department's strategy to address persistent racial disparities in the care and support systems?

NYS OASAS

Among CASACs (Credentialed Alcoholism and Substance Abuse Counselors) in New York State, which make up approximately 97% of professionals certified by OASAS, racial demographics are comparable to the overall population of the state.

We are always working with our providers to increase opportunities for all New Yorkers, regardless of their background, to find employment in the substance use disorder (SUD) field. We are in the process of establishing initiatives to assist with workforce diversification, which we hope to roll out in the near future.

NYS OMH

OMH has publicly declared racism a public mental health crisis and is implementing policies to reduce disparities in access, quality, and treatment outcomes for marginalized populations. We are utilizing a multi-faceted strategy to address and reduce disparities, grounded on the concept that organizational change and self-reflection are key to creating and sustaining long-term success. We are doing this, in part, by implementing the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards).

We are currently pilot testing a "Vital Signs Dashboard" to depict racial, ethnic, and gender-based disparities in NY's mental health system. It's currently in OMH clinics, and the full system release is expected in early 2022. The dashboard will contain 10-15 metrics in four domains and will be used to identify and implement strategies to mitigate disparities in access, quality, and treatment outcomes for marginalized populations. We also recently included equity components into all Requests For Proposals released by the Agency.

We are also working with the Center for Research on Cultural and Structural Equity in Behavioral Health to do a multi-level assessment of policies and practices at the Agency, both internal and external - for structural racism.

To address long-standing issues involving the lack of a culturally diverse workforce in the public mental health system, OMH's Bureau of Inspection and Certification, in close collaboration with the Office of Diversity and Inclusion, will be reviewing organization's diversity, inclusion, equity, cultural and linguistic competence plan more rigorously than before. Any organization seeking OMH license or operating OMH licensed programs is expected to demonstrate efforts to ensure data-informed diversity recruitment in initial and ongoing inspection and certification activities.

OMH has also created a number of resources and tip-sheets to increase information sharing and educate individuals on vital topics impacting our communities. These topics include:

• African American's Mental Health

• The Impact of Racism on Mental Health

Our Office of Diversity and Inclusion has hosted a number of "Race Dialogues", which involved difficult but necessary conversations around the importance of recognizing biases, celebrating diversity, and working to be a more inclusive environment for all individuals. These are important action-based discussions that allow for a safe-space to share and discuss personal experiences and promote agency -wide changes in the way we interact and engage with one another.

We have also experienced through our work with NY Project Hope the need to actively engage individuals within their communities. Our Emotional Support Helpline was not as effective at providing services to people of color, but when our workers began conducting grass roots outreach into communities, we found that we were much more successful.

Additionally, OMH will look to expand workforce training opportunities, including the training of law enforcement in diversion techniques, to best support underserved and emerging populations, such as justice-involved individuals and older adults with mental illness, as well as our current service population, to ensure the workforce is adequately equipped to provide effective mental health services to all New Yorkers.

NYS OPWDD

OPWDD is committed to creating an environment that values diversity, promotes an inclusive culture, and provides equitable services to the public and people with developmental disabilities. In 2021, OPWDD launched the agency's Diversity, Equity, and Inclusion Strategic Plan to advance our mission of a diverse workforce that promotes equity and inclusion for all. The plan includes a four-year timeline and measurable outcomes for the agency and the larger developmental disabilities service system. OPWDD is committed to further advancing our mission with the establishment of a new Chief Diversity Officer executive-level position. The Chief Diversity Officer will drive change through the examination of current OPWDD policies, workforce, and equity practices as well as overseeing the Diversity, Equity, and Inclusion (DEI) program.

Some proposed examples of practical and impactful system DEI projects OPWDD will initiate include: developing workforce strategies that address cultural competence guidelines for staff, including care managers; compensating staff for bilingual or tri-lingual ability; developing outreach strategies to diverse groups for policy development; and, creating a family-centered, culturally competent approach in developing truly person-centered supports.

As a participant in the federally funded National Community of Practice (CoP) on Cultural and Linguistic Competence, OPWDD is also identifying systemic, regional, and local needs to address multiple dimensions of equity and access concerns. Initial efforts indicate the need for further work with an equity lens to include data analysis, policy review and impact studies, stakeholder engagement and service delivery. To this end, OPWDD has committed to providing FMAP funded grants to non-profit service providers, local government authorities, and/or institutions of higher education with demonstrated expertise in addressing the needs of underserved and historically marginalized populations.

NYS O-Agency Collaboration

So many service recipients have multiple conditions that span your three Offices. How can the Offices enhance your collaborative efforts to address this issue?

NYS OASAS

OASAS works collaboratively with other agencies on a regular basis. We have multiple ongoing projects with OMH, and in all OASAS-certified settings, individuals are screened for mental health risks and directed to services if needed. We have worked closely with OMH in expanding services for both SUD and mental health through Certified Community Behavioral Health Clinics (CCBHCs), a federal demonstration program that offers a full spectrum of care to anyone who qualifies. This care includes a full range of SUD and MH clinic services, case management, crisis, and psychiatric rehabilitation services.

Our agencies also collaborate with the Department of Health (DOH) on regulation and oversight of Integrated Outpatient Services, as well as issues related to pregnant and parenting persons with substance use disorder, and with the DOH's Office of Drug User Health (ODUH) on overdose prevention. We are also working with OMH on crisis stabilization centers which are intended to provide an alternative to ERs and incarceration for those experiencing a behavioral health crisis. We are in discussion with OPWDD to determine how to meet the needs of individuals with developmental disabilities that may seek services in these settings. Other joint projects include efforts to improve parity for payors of SUD and mental health services, such as regulations and enforcement. Many of our integration efforts have faced challenges due to statutory barriers, reimbursement shortfalls, reporting requirements, contracting, and funding issues.

As we move forward, OASAS is fully committed to working with our sister agencies to enable our providers to deliver integrated services that bypass these pitfalls and allow them to support people with both substance use disorders and mental health challenges.

NYS OMH

OMH is committed to integrated care across the lifespan, including individuals with co-occurring mental health issues and substance use challenges, intellectual and developmental disabilities, physical health needs, and justice involvement. We are working with public and private partners to create programs and services for these vulnerable populations to ensure they do not continue to fall through the cracks of bureaucracy and end up requiring more costly and restrictive inpatient services.

One of our priorities has been to expand beds and services for children who are dually-diagnosed with a developmental disability as well as behavioral health needs. We recently announced a collaboration with OPWDD and SUNY Upstate Medical University to develop a specialized inpatient unit for children and youth from 12 to 17 years old who are dually-diagnosed and at risk of being separated from their families because the treatment they need is only available far from home, often out-of-state.

We have also worked with OPWDD to develop a dually-diagnosed residential treatment program with Baker Victory Services at Erie County Medical Center in Buffalo, as well as an acute care unit at Kings County Hospital for adults living with a mental illness and a developmental disability.

We also frequently collaborate with OASAS, including on the development of regulations for Crisis Stabilization Centers prepared to serve all New Yorkers regardless of disability. By improving crisis services and expanding programs such as Certified Community Behavioral Health Clinics (CCBHCs) and Integrated Outpatient Services (IOS), we can work together to reduce unnecessary hospitalizations and enable individuals to recover and thrive in services in their community.

And, together with the NYS Department of Financial Services, OASAS and OMH initiated the Community Health Access to Addiction and Mental Healthcare Project (CHAMP) which is helping to ensure parity by educating individuals, families, and health care providers on their legal rights to coverage and helping them to access treatment and services. CHAMP will investigate and resolve complaints regarding denial of health insurance coverage.

Another important collaboration with OASAS is enhancing the capacity of the public mental health system to identify and treat opioid use disorders. Together we have launched several large-scale initiatives through the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) including:

• PSYCKES Opioid Use Disorder Quality Measures and Alerts were added to PSYCKES (launched 2018-2019) to support quality improvement by providers, counties, and managed care plans, and to increase clinician awareness of individuals at risk for overdose.

• Building Capacity for Best Practice Treatment of OUD within Mental Health Clinics which was mandated for all 485 OMH licensed mental health clinics statewide and was launched in early 2019. All clinics are required to implement best

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and noticeable if you set and achieve realistic and short-term, if not immediate, personal goals. Small, incremental steps can build on each other, positioning you to address more ambitious goals further down the line. Celebrating achievements, no matter how seemingly mundane, is an important part of the recovery process.

Finding the Right Care

Finding caring, trusting, supportive relationships with a practitioner is critical for recovery. Practitioners should encourage and support your hopes, interests, assets, talents, energies, efforts and goals. To achieve these, you should discuss calculated risk-taking with your practitioner. A calculated risk is a carefully considered decision that could be beneficial but includes some degree of risk. For example, making the decision to change your treatment plan or medication regimen.

Care should be person-centered and you should hold an active role in your care. Accordingly, practitioners should engage your participation using a strengths-based approach. This approach, known as shared decision-making, is evidence-based and has been shown to improve outcomes.

Care should also be grounded in your "life-context," which acknowledges, builds on and appreciates your unique history, experiences, situations, developmental trajectory and aspirations. Care plans should be based on individualized, culturally sensitive, holistic and multidisciplinary considerations and developed in collaboration with you and your supporters each step of the way. Your care should focus on helping you live the life you want and choose.

Gathering Information on Community Factors

Practitioners should have adequate knowledge of community factors that may impact care, including opportunities, resources and potential barriers. These may relate to access to employment opportunities as well as employment disincentives that are built into programs for access to affordable housing and medical care. If practitioners cannot offer you guidance on these subjects, they should at least be able to share resources and provide referrals to people who can.

Coping with Stigma

Stigma is widespread, even among friends and family and within the mental health care system, including from practitioners themselves. The detrimental impact of stigma can be greater than that of the illness itself. Thus, you may need to develop coping strategies to manage stigma, particularly if you are experiencing self-stigma.

You might consider discussing how you are impacted by insensitive statements with those who use them. You could also consider limiting interaction, if possible, with people who may continue to stigmatize you. Talking to peers can also be helpful to process the way stigma affects you.

Engaging with Peer Support

Peer support can be invaluable. People living with a similar condition can help you normalize SMI, address loneliness and isolation, and offer acceptance and support. They also can provide insights based on their own struggles and achievements, and they can help take away some of the uncertainty of living with SMI by helping you understand what to expect. They can offer hope as a mentor who is a living example of the reality of recovery.

The recovery journey is never easy, but it is always worth it. When a person with SMI reaches recovery, they often regain their self-love, self-worth and self-esteem. Recovery can then free a person from stigma, shame and embarrassment. Perhaps most importantly, it can stop them from defining themselves merely by their illness.

Some people with SMI have to recognize that the greatest barrier to reaching recovery may be their own mindset. People who refuse to take back control of their lives (including their care) and refuse to take responsibility for their illness will find it more difficult to reach recovery. It is a great tragedy that so many never reach recovery because it is possible for so many more.

Ultimately, we all need more visible and promoted examples of everyday people living in recovery. The promise of eliminating stigma does offer hope, but recovery offers so much more.

Note: An extremely helpful recovery resource is: A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care.

Larry Davidson, Ph.D., is a Professor of Psychiatry and Director of the Program for Recovery and Community Health at Yale University's School of Medicine. He is the author and co-author of more than 450 publications on the processes of recovery and the development of innovative policies and programs to promote the recovery and community inclusion of individuals with serious mental illnesses and addictions.

Katherine Ponte, B.A., J.D., MBA, CPRP, is a mental health advocate, writer, entrepreneur and lawyer. She has been living with severe bipolar I disorder with psychosis and extended periods of suicidal depression for 20 years and is now happily in recovery. Katherine is the Founder of ForLikeMinds, an online mental illness peer support community. She is a Faculty Member of the Program for Recovery and Community Health in the Department of Psychiatry at Yale University's School of Medicine. Katherine is also the Founder of BipolarThriving, which provides bipolar recovery coaching, and the Creator of Psych Ward Greeting Cards, which visits and distributes greeting cards to patients in psychiatric units. She is a member of the Board of NAMI New York City and Fountain House. Katherine is the author of ForLikeMinds: Mental Illness Recovery Insights.

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introduce the BH workforce to other modalities of non-traditional healing, including "Reiki," a therapeutic energy practice that originated in Japan. According to the International Center for Reiki Training, the practice is based on the idea that we all have an unseen "life force energy" flowing through our bodies and is practiced to promote relaxation, reduce anxiety, manage pain and dislodge depression. CBC TI partnered with two Reiki masters, each of whom introduced the practice and guided participants through techniques on how to use their own hands to self-administer Reiki. Many participants found these groups quite supportive and were thankful for the opportunity to become familiar with this technique.

CBC TI is currently offering beginner yoga sessions and has partnered with NYC's Integral Yoga Institute (IYI) to provide healthy cooking and sound healing courses in the coming months. Without access to healthful foods, people living in "food deserts" may be at higher risk of diet-related conditions—such as obesity, Type 2 diabetes, and cardiovascular disease. The healthy cooking course is intended to present participants with information on how to cook nutritious and appetizing meals for themselves and their families. Meanwhile, the sound healing course will introduce participants to Tibetan singing bowls, which produce sounds that are thought to promote relaxation, and promote healing, and are regularly used in meditation practices and yoga. IYI will also be offering yoga sessions for individuals suffering from long- term COVID symptoms or insomnia and a course on visualization. CBC is thrilled to bring IYI's expertise to NYS BH providers.

CBC was proud to usher in a roster of trainings on modalities of self-care that would not have been otherwise readily available for NYS BH providers due to cost and availability in their communities. It was our mission to bring non-traditional practices such as yoga and meditation to our workforce so that they could begin implementing lifelong practices to support their wellbeing, with the hope that the benefits of such practices would trickle down to the participants that they serve. When BH providers are practicing good self-care, they are better equipped to help people on their caseloads. CBC TI knows that together, we can foster a community of self-invested learners to help reduce feelings of isolation and burnout that many providers are enduring in these extraordinary times. In so doing, CBC TI is building its own legacy of a COVID-19 "silver lining."

Emily Grossman, MA, CPRP, is Training Director, at the CBC Training Institute. Amanda Semidey, LCSW, is Vice President, Care Coordination Services at CBC. Please email us at CBCTrainingInstitute@cbcare.org for more information and also check out our website.

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personal and professional boundaries. Many of us have found ourselves in telehealth interactions that belie the professional doctor patient relationship structure. And that may be a good thing. Perhaps allowing clients a small window into the reality that despite our experience and our credentials, we, too, are just trying to figure out how to endure this—often messily—is therapeutic. Undoubtedly the pandemic has humanized us all.

Despite the myriad ways their lives have been altered by the pandemic and their current degree of burnout, WJCS clinicians assessed telehealth quite positively. Among our clinicians, 75% reported they made the transition to telehealth with ease, and 94% described the technology as easy to use. As an avenue for treatment, 92% felt that telehealth made therapy more accessible to clients, 96% reported no difficulties in adapting the way they typically conduct adult therapy to telehealth, and 76% agreed that telehealth is as helpful as face-to-face sessions for adults. In fact, 66% of clinicians reported enjoying telehealth as much as conducting sessions in person.

Although many of us anticipated an urgent demand from patients and practitioners alike to be back in our offices for face-to-face treatment, the survey responses showed that both clinicians and clients truly like telehealth. In fact, when asked about future treatment preferences, 75% of our clinicians indicated a desire to pursue a hybrid model of care, including some days in the clinic and others administering telehealth from home. Should this positivity be reflected across therapists and practices, telehealth is likely to endure long past the conclusion of the pandemic, serving as a mainstay in the provision of accessible mental health treatment. In the meantime, we will all continue to navigate this new normal.

Kelly Daly, Ph.D. was a psychology fellow at Westchester Jewish Community Services (WJCS) from 2020-2021. Elana Spira, Ph.D. is Director of Research at WJCS. To learn more about WJCS, please go to wjcs.com.

A Lesson in Resiliency

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

The Pandemic has and continues to challenge everyone in many similar and different ways. The profound loss of lives and continuing vigilance and preparation/ adjustment on part of everyone has tested the limits of many individuals, families, businesses and organizations. Increased stress and unresolved grief and loss for those affected has significantly challenged everyone's ability to cope and adjust life styles for one's safety and that of others. Clearly all these changes required and demanded much from everyone in terms of patience, tolerance and adaptability. With the Pandemic came a significant rise in need for behavioral services in general and in particular for those dependent on not for profit agencies.

Maintaining a Dedicated Workforce

The challenges for the not for profits were great and perhaps greater in some respects depending on public funds and not having deep pockets to weather such profound and drastic events and changes that ensued. Perhaps there was an expectation on part of some that many would

Max Banilivy, PhD

fold and many needy individuals would be left in the cold. Yet, the picture ended up being very different. Thanks to support at all levels, but most notably of the leadership of those responsible for these agencies, their senior administration, and those direct service providers maintained their commitment/dedication and presence in their positions. This dedication clearly speaks to inherent and some acquired resiliency on the part many in all sectors of the society that did their best to work with the tragedies and the unexpected to come up feeling good about what we learned and overcame.

COVID-19 Did Not Reduce Us

I was fortunate enough have the opportunity to learn from number of Chief Executive Officers at agencies in NYC and on Long Island who shared their time and wisdom to answer a number questions posed to them.

To my pleasant surprise the conversations were far from being negative or pessimistic. It was more about everyone rolling up their sleeves and doing the tough job of taking care of the individuals we serve and the staff who stayed the course of providing the services. We learned to be creative and developing other or novel ways of taking care of the business of the not-for-profit behavioral health field. Changes were necessary and required many adjustments needed to be made. The extent of what was done and continues to be a focus going forward is impressive. The mission and the vision always being on the individuals who depend on the services that behavioral health and other organizations provide.

A very informative article published by the Coalition for Behavioral Health entitled: Lessons Learned: Challenges and Successes of Behavioral Health Providers During the Pandemic (Feb. 2021) Is a must read for those interested in the topic.

Many things were learned going forward and others were highlighted as focus of work to attend to by different entities. We examined and focused on what matters the most, people's health and lives. But something else seems to have happened. We asked questions about our personal and professional life. Do we need to live and work as before. Were we forced to try other options and choices unfamiliar and lived and continue to live a life with some or a lot of FEAR. It is said that with every crisis comes opportunities for us as individuals and collectively to improve the life we live and the work we do. Many individuals and families are doing this already. Likewise, many agencies are looking at not just the immediate future but also planning for the future in the distance. This is a process that will continue for some time. With mindful attention to a newer reality that, for example Telehealth, can provide effective or even more effective treatment for some. There is also already an impact on the workforce presenting challenges in terms of availability and turnover. We are afforded more flexibility and perhaps choices about how we choose to live our personal and work life.

I believe through tragedy we are offered the opportunity to grow, become more adaptable, flexible and realizing more choices.

Thank you again to all of those administrators who shared their time and experiences with me.

Celebrate from page 16

the vaccine. It's clear that this is terribly disheartening to the people who have had the courage to carry the nation through the darkest days of the pandemic. For many it is also infuriating.

Will they burn out? We'd better hope that the sense of duty that kept health and behavioral health care personnel going throughout the pandemic does not get overwhelmed by anger and disappointment about the people who refuse to take care of themselves and their families and who risk the health of their communities in the process.

Sustaining a sense of duty, the courage to face death, and the energy to persevere are, it seems to me, the primary workforce "crises" at this time of COVID. I say this while hoping that by the time you read this, my fear for the future will be totally out of date, that what will be left is just a need to celebrate what the workforce achieved.

Michael B. Friedman, LMSW is a retired social worker who continues to teach at Columbia School of Social work—via Zoom—and who has become the volunteer chair of The Cognitive and Behavioral Health Advocacy Team of AARP Maryland.

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practices including screening for OUD, providing naloxone to all individuals at risk, improving referral practices, and initiating medication assisted treatment for OUD.

• High Behavioral Health Risk Quality Collaborative for Emergency Departments has engaged 94 Emergency Department services statewide to implement best practices in screening, assessment, treatment, and referral and follow-up for individuals with emergent behavioral health crises.

Overdose Prevention Quality Improvement Collaborative, launched April 2021, has engaged 130 mental health clinics in a quality improvement project to accelerate best practices in the treatment of OUD, including screening, therapy, and medication assisted treatment.

NYS OPWDD
OPWDD works with several state agencies to collaborate on service provision, workforce issues and building awareness. Currently, OPWDD collaborates with OMH and OASAS specifically on high needs cases in which people being supported have dual diagnoses and need a range of supports provided by our respective agencies. OPWDD is also currently working with OMH to expand the availability of children's crisis services and expand the use of specialized treatment facilities and specialized inpatient psychiatric units for the dually diagnosed. In addition, multiple agencies are involved in the Employment First Commission, Most Integrated Settings Coordinating Council (MISCC), and other multi-agency initiatives related to workforce and raising awareness for people with disabilities. We are continuously looking for ways to support people across systems to ensure people have access to the best supports to meet their individual needs.

Collaboration with MHNE Publications

So many service recipients have multiple conditions that span your three Offices. How can the Offices enhance your collaborative efforts to address this issue?

NYS OASAS
We always appreciate the opportunities offered by Behavioral Health News to publicize our ongoing initiatives at OASAS and assist with outreach to people who are in need of our services. We look forward to continuing to work with the publication to support our goal of reaching all New Yorkers with help and resources for substance use disorders, whether they themselves are personally impacted, or are the family member or friend of an individual in need of assistance.

NYS OMH
Behavioral Health News has already been extremely helpful in promoting and encouraging access to mental health services and we look forward to continuing and enhancing our partnership.

An ongoing focus of our media and community relations work has been the promotion of anti-stigma messaging. We always seek new methods and new messengers to spread the word that mental health is as important as physical health and that they should be viewed in the same way. Most people wouldn't hesitate to see a dentist if they had a toothache, and they certainly wouldn't have to think twice about seeing a doctor if they fell and broke their arm.

We want people to think the same way about their mental health. If anyone has concerns about anxiety, depression, or any aspect of their mental health, we want them to be comfortable talking to their doctor or to a behavioral health specialist. That's the message we are working to spread through social media, public service campaigns, and through partnerships with agencies and organizations across the state.

We are also seeking to engage minority and culturally diverse communities, which, as we saw during the rise of COVID-19, are often underserved and have less access to physical and behavioral health services.

Behavioral Health News can be a tremendous help with both those efforts. Your work to address and reduce stigma is commendable, and we would be happy to discuss helping you to create partnerships with organizations in different communities that could help share your publication with people who need to hear our message!

NYS OPWDD
OPWDD and our providers are continuously hiring to fill direct support roles all across New York State. Given the current workforce crisis, shining a spotlight on the role of Direct Support Professionals and the amazing work that they do would be incredibly helpful in not only elevating the role of this selfless workforce, but also driving interest in this career path.

Burnout from page 12

and the discomfort of working in personal protective equipment. They have managed interpersonal violence, firearms injuries, stabbings, mass violence and other epidemics from Ebola to AIDS. And with the right support, we can help them to move through this pandemic without burning them out or losing them in the profession altogether.

The Reality

Healthcare leaders will continue to be under the stress of limited resources, staffing concerns, patient mistrust and difficulty managing the numbers of seriously ill patients as a result of the COVID pandemic. These long-standing problems are not solved easily or without a significant amount of political and social will. Thus, we can expect a continuation of extreme stressors imposed on our healthcare workers. Actions to support them need to be implemented now.

Additionally, whereas previous disasters and viral epidemics have been short-lived, a pandemic, and in this case, as we see multiple COVID variants developing, we are experiencing a level of chronicity not seen in our lifetime. Thus, typically acute distress - responses that would normally resolve over a reasonable period of time (approximately 30-90 days) - stress, fear, anxiety and grief, remain constant (CMHS 2001; Norris et al. 2002; Myers and Wee 2005). Healthcare workers not only bear the weight of caring for their patients, but also have concerns for themselves, their family members and other loved ones as COVID ravages the globe. Grief suffered from the loss of patients, loved ones and our communities as a whole, is painful and exhausting. It can last for extended periods of time and may become a complex problem if we are unable to allow ourselves the time needed to experience and express it through ritual and connection to others.

At the Physicians Support Line, a 24/7 peer support line for doctors, manned by psychiatrists, reports of compassion fatigue and despair have been a recurring theme in the calls. What started off at the beginning of the pandemic to be a joint mission between doctors and patients to partner together in preventing infection and staying safe, has slowly deteriorated where now doctors feel very much that they are not only alone in fighting this pandemic, but that they are being blamed for any bad outcomes. Their patients don't trust their advice or their treatment plans. And, patients accuse doctors of not giving them the medication they demand, even though it is not evidence based. Doctors find it very difficult to have empathy for people who do not have empathy in return. There is no meaning and purpose in the work when there is a breakdown of the doctor-patient relationship (NCPTSD, 20160). This is one of the more serious problems that can lead to physicians leaving the profession.

Furthermore, there is ongoing stigma within medicine for seeking mental health care (Wang et al. 2007; CMHS 2001). Currently, several state medical licensing applications ask physicians to disclose their mental health, especially if they had sought treatment for it. There is so much time, energy and financial investment that goes into becoming a physician that it feels the stakes are too high to risk losing it all because of mental health. This perpetuates the false narrative that doctors are well and well-adjusted and sends the message to other physicians that if they are struggling, then it must be an individual problem rather than a systemic one.

Chronic stress in professionals who are helpers or caregivers need proactive support to impose self-care and create space for proper wellness practice and support. This becomes the task of the healthcare leaders. It is up to them to establish the structure and implement policies so that self-care, wellness and emotional care are integrated into all aspects of the workplace. When leadership models and supports wellness by providing education and training, as well as the structure and tools that allow workers to take care of themselves, the likelihood of achieving wellness successfully is much higher.

Interventions that Make a Difference

As mentioned earlier, leadership must support the efforts to ensure staff wellness, most especially at times of extreme distress, but ideally on a routine basis. And again, modeling this sends the message that not only is wellness encouraged, but that everyone is expected to participate equally. Interventions can range from very simple activities such as providing water coolers and healthy snacks to more extensive efforts like engaging EAP programs in full-scale wellness offerings continuously throughout the year. When leadership can be seen taking a walk, using a meditation room, participating in a short stretching session, and sitting in the cafeteria talking to others during lunch breaks, staff are essentially given permission to do the same.

Feedback from staff satisfaction surveys consistently indicate that everyone wants to be acknowledged. "Management by walking around," a model of support developed several decades ago still holds as an effective means of supporting staff. When leadership takes the time to get to know their staff and the work they do, acknowledging their efforts as well as listening to the concerns that staff verbalize, and then respond by prioritizing staff's needs, they can influence an increase staff satisfaction and a decrease in burnout.

Engaging healthcare EAP and in house wellness programs to provide self-care education and training activities that can be implemented in the workplace (breathing, stretching, walking, yoga, hydration, music, mindfulness, use of quiet rooms for guided imagery, meditation and prayer) in addition to social events like team challenges, environmental decorations, art and imagery, food preparation/sharing are ways leadership can set the stage. These events can help lead the way towards employee and workplace wellness, even in the midst of a pandemic.

Conclusion

Healthcare workers across the varied sectors of the industry are some of the hardiest, grittiest workers our country knows. They more than rise to meet the needs of patients and family members even as they expect crowded waiting rooms, commonly abusive foul mouthed or foul-smelling patients, many of whom act out their drunkenness or substance abusing disinhibitions, exposure to human caused violence, staff shortages and long shifts, less than adequate pay, minimal to no COLA raises, and some experiences we cannot imagine. Can we at least take the responsibility of setting a culture of selfcare within the structure of the workplace that highlights our appreciation for these essential, hard workers? They are our mothers and fathers, our wives and husbands, partners and children, our siblings and cousins, our neighbors and colleagues - whom we would - quite literally - not survive without, should burnout overtake them.

About the Authors

Dr. Naturale is a traumatic stress specialist with a 35-year history as a health/mental health care administrator and clinician specializing in responses to traumatic events. After 9/11/01, Dr. Naturale led Project Liberty, the NY mental health response to the World Trade Center disaster and over the past 20 years Dr. Naturale has provided disaster and traumatic stress response training and consultation throughout the U.S. and internationally. Dr. Naturale served as the U.S. Substance Abuse and Mental Health Services Administration Disaster Technical Assistance Center Project Director, led one of the World Trade Center Health Program's outreach and education programs and she was the architect of the Boston Marathon bombing behavioral health response.

In 2004, she helped launch the National Suicide Prevention Lifeline, in 2008, an international not for profit called Psychology Beyond Borders and in 2011, the Disaster Distress Helpline. She then worked with the Dept of Justice/Office for Victims of crime as a program and needs assessment consultant for the San Bernardino terror attack, the Las Vegas Harvest Festival, Pulse Nightclub, Parkland, Thousand Oaks, Pittsburgh Tree of Life, Virginia Beach, El Paso and Highland Ranch shooting incidents and the TN Christmas Day bombing. She has trained Psychologists in the Ukraine Military Service, Humanitarian Aid workers for the European Union and recently helped launch the new European Centre of Expertise for Victims of Terrorism.

Currently, Dr. Naturale is the Assistant Vice President of National Programs for Vibrant Emotional Health, where she oversees the Veterans Crisis Line, the National Disaster Distress Helpline and the Crisis Emotional Care Team and the Lifeline Cares Team - a wellness program dedicated to supporting the call center staff who respond to the National Suicide Prevention Lifeline calls. She continues to provide training and support to humanitarian aid workers across the globe. Her dissertation focused on Secondary Traumatic Stress in disaster responders, a subject she continues to study.

Board Certified in general adult psychiatry, Dr. Mona Masood is an outpatient psychiatrist in the greater Philadelphia area and a Board Member of a non-profit community mental health organization, Muslim Wellness Foundation, which provides mental health educational services to the community. Dr. Masood is the Founder and Chief Organizer of the Physician Support Line.

Amy Carol Dominguez serves as the Program Director for the Crisis Emotional Care Team at Vibrant. She has been working Disaster Mental Health since 2007. Amy's career has taken her around the world to countries like Ethiopia, Liberia, Colombia, Argentina, Canada, and Mexico. Amy has coordinated international disaster mental health responses in Haiti, Nepal, Puerto Rico and across the United States as Managing Director of Disaster Psychiatry Outreach. She holds her Masters in Public Affairs from Indiana University and splits her time between Mexico and Connecticut with her husband, Adiel and daughter, Sofia.

References

Center for Mental Health Services. (2001). Emergency mental health and traumatic stress: An overview of the Crisis Counseling Assistance and Training Program. Retrieved June 11, 2004, from http://www.mentalhealth.samhsa.gov/cmhs/Emergency Services/ ccp_pg01.a

Myers, D., & Wee, D. (2005). Disaster mental health services: a primer for practitioners. New York: Routledge Psychosocial Stress Series.

National Center for Post Traumatic Stress Disorder (NCPTSD). (2016). Disasters and Terrorism. https://www.ptsd.va.gov/professional/trauma/disaster-terrorism/index.asp.

Norris, F. H., Friedman, M. J., & Watson, P. J. (2002). 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. Psychiatry: Interpersonal and Biological Processes, 65(3), 240–260.

Wang, P. S., Gruber, M. J., Powers, R. E., Schoenbaum, M., Speier, A. H., Wells, K. B., et al. (2007). Mental health service use among Hurricane Katrina survivors in the eight months after the disaster. Psychiatric Services, 58, 1403–1411.

Behavioral Health News Winter Issue: "Volunteers and the Vital Role They Play"

Article and Advertising Deadline: December 14, 2021

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new staff hired during the pandemic and asked questions related to the quality of new hire orientation, including: Were your questions answered? Do you have sufficient information to do your job? Did you receive enough information on COVID guidelines? Are you receiving individuals /group supervision? What is your overall impression of MHA and your job? Currently, we are practicing a hybrid model of care. Once staff came back to physical sites, all new staff were given a "re-introduction" to agency practices and physical tours. Something as little as knowing where the supply closet is or where do I go to pick up my laptop was not insignificant in nature.

Ongoing informative communication with staff about the agency's mission, values, direction, and challenges is essential, but became more critical during COVID. We continually strive to improve

Stacey Roberts, LCSW

Dottie Ann Stevenson, EdD, sHRBP

communication to staff. There are several mechanisms through which we aim to do this: quarterly town halls with the CEO at which she addresses current issues, agency updates and invites questions; Weekly Wrap Up Newsletter, a digital newsletter that highlights essential news, upcoming internal trainings, and other agency recaps; quarterly staff newsletter that offers a deeper dive into agency news celebrating staff honors and achievements and spotlighting agency programs including all back office departments; and creation of an agency pandemic response team, which included administrative staff from human resources, innovation and facilities department. Communication from this team included frequent updates about rapidly changing regulations related to COVID or agency changes needed. Staff could access this team to answer any questions related to physical space, PPE, technology, health screening practices, etc.

MHA is not alone in our determination to provide the best possible services despite the challenges of staff recruitment and retention. We continue to learn from our own successes and challenges, from the input of staff and colleagues, as we strive to be a "best place to work."

Stacey Roberts, LCSW, is Chief Operating Officer, and Dr. Dottie Ann Stevenson, Ed.D, sHRBP, is Chief of Human Resources at MHA Westchester.

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increased number of DBT clients and more frequent use of DBT strategies. There was no difference in frequency of DBT strategy usage between participants with prior DBT experience and participants without prior DBT experience, which could point to willingness of participants without prior experience to try new strategies for the first time.

We specifically examined the use of chain analysis because it is considered one of the more difficult DBT strategies to implement, and something many group participants were nervous about implementing. Exactly half of the final total sample (n = 8) did chains more than 50% of weeks that they attended group. By Week 25 and each week after that, every attendee (100%) reported doing a chain every week. On average, participants with no previous DBT training completed chains during the weeks of 57% of the peer group sessions they attended. In contrast, participants with previous DBT training completed chains during the weeks of 49% of the peer group sessions they attended. Again, this could point to willingness of participants without prior experience to try new strategies for the first time.

Attitudes toward DBT demonstrated a positive trend from pre-group to post-group. At pre-group, 25% of participants somewhat agreed that they would like to incorporate DBT into their future practice, while 50% agreed and 25% very much agreed. At post-group, 42.9% agreed that they would like to incorporate DBT into their future practice, and 57.1% very much agreed. At pre-group, 20% of participants somewhat agreed that DBT can be adapted to fit the needs of a community mental health setting, while 60% agreed and 20% very much agreed. At post-group, that trend was reversed; 60% agreed that DBT can be adapted to fit the needs of a community mental health setting, while 40% very much agreed.

At baseline, there was a significant difference in DBT confidence scores between clinicians who did and did not have previous experience $t(8) = -2.535$, $p < .035$. At pre-group, clinicians with prior DBT experience scored an average confidence value of 39 (out of a total possible confidence value of 65), and clinicians without prior DBT experience scored an average confidence value of 30. Overall, clinician confidence in delivering DBT increased an average of 11 points from pre-group to last recorded measure (6-month or post-group follow-up), $t(7) = -2.808$, $p = .026$.

Qualitative themes, as measured by open-ended questions on the follow-up surveys, indicated that post-intervention, participants:

- were more comfortable adapting DBT in community mental health (i.e. "The concepts are universal and the skills are adaptable")

- found it less overwhelming to deliver DBT-informed treatment with more training and practice (i.e. "I feel more confident about delivering DBT informed treatment than I did prior to the group")

- had plans to incorporate DBT into their future practices (i.e. "DBT is now one of the main therapies that I identify using as a therapist, which it was not prior to this group")

- saw value in remote consultation groups (i.e. "I feel that they are at least as effective as in-person, and personally I feel more comfortable speaking up in an online setting than I usually do in person; The experiment this year has worked and it relieves me of having to travel")

- found the peer group supportive (i.e. "I find it easier to talk candidly in this group because it truly feels like a supportive group of peers without the hierarchy of supervisors, clinic directors etc.; This group was an essential part of my feeling less professionally isolated while working remotely during the pandemic")

There are several key implications of our research findings. First, the findings point to the value of peer consultation groups in terms of increasing clinician confidence and competence. In addition to increased confidence scores and a reported increase in usage of key DBT strategies throughout the course of the group, participants appeared to value its nature as a peer-, rather than supervisor-led group. Participants also noted that the remote group provided greater opportunity for cross-clinic relationships, and the ability to connect with and get support from other therapists doing similar work. These findings point to the value of remote, peer-led consultation groups in terms of skill and confidence-building for clinicians, as well as the value of offering such groups remotely, both during and after the COVID-19 pandemic.

Liza Pincus, Ph.D. and Kelly Daly, Ph.D. conducted this research as Psychology Fellows at Westchester Jewish Community Services. Elana G. Spira, Ph.D. is Director of Research at WJCS, one of the largest human service agencies in Westchester County. To learn more about WJCS mental health services, please go to https://www.wjcs.com/services/mental-health/.

Rudin from page 16

ICL's groundbreaking East NY Health Hub, opened in 2018, provides comprehensive and integrated health, housing and employment services in that same area, one of the most underserved in the city. According to ICL's Healthy Living Survey, 96% of client's report feeling better about their prospects for improving mental and physical health thanks to ICL's programs, and ICL clients saw an 83% reduction in hospitalizations for mental health reasons after being in the organization's care.

Rudin succeeds David Woodlock, who is retiring after a nearly 50-year-career in mental health services. Woodlock joined ICL in 2013 and has been a pioneer in innovating impactful strategies in the mental health field. Under Woodlock's leadership, ICL has seen both improved healthcare outcomes for clients and reduced healthcare costs as well as an expansion of available resources for those that need them the most.

About ICL

ICL provides trauma-informed, recovery-oriented, integrated, and person-centered care through supportive and transitional housing, counseling, and rehabilitation services for adults, children, veterans, and families with mental health challenges and those living with developmental disabilities. We serve more than 15,000 people each year; every night 3,200 New Yorkers call ICL home. Our goal is to help people achieve better health and the most fulfilling life possible. Referrals can be made by calling 844-ICL-HOPE.

see Silver Lining on page 25

Telehealth works for me: A variety of telehealth technology platforms have been adapted to meet the needs of individuals during the pandemic in an easily accessible way. Mental health therapists have found that conducting therapy sessions from their clients' homes has even allowed for a more in-depth understanding of their clients' environments, living space, access to privacy, and safety.

Agencies and private practitioners are seeing an increase in referrals requesting mental health services. In many cases, individuals who might have completed therapy after six to 12 months are requesting to continue services due to dealing with additional stress related to social anxieties and returning to in-person learning, among others.

"Telehealth works for me. If I didn't have the ability to do Zoom sessions with my therapist, I don't think I would be able to make it to therapy because of transportation issues with my mom working more hours," said one Devereux Pennsylvania client. Parents are also seeking additional support from mental health therapists in how to parent their child who has been affected by the pandemic.

With FDA approval of the Pfizer vaccine granted and continued emergency approval of the Moderna and Johnson and Johnson vaccines, mental health therapists will continue to use telehealth as an option for therapy sessions.

"I prefer telehealth for many of my cases. It's user friendly, and I've found I can deliver great clinical services to the individuals and families I serve every day," said Labik. "I also have a better work-life balance and I don't have a commute."

The ability to pivot and quickly adapt to the needs of our individuals, families and team members has been Devereux's greatest asset during COVID-19. The use of tele-mental health services has allowed us to reach those who are often forgotten or under-utilizing mental health services, including minority groups.

As the pandemic continues, Devereux is ready and able to offer clinical therapy that meets its individuals where they are – either in an office or virtually. Because, ultimately, offering telehealth to those who may not have access in-person services, can literally save lives.

Janelle Westfall, LPC, LBA, BCBA, is Devereux Advanced Behavioral Health Arizona Clinical Director, and Molly Stubbs, LPC, is Devereux Advanced Behavioral Health Pennsylvania Clinical Supervisor. For more information about this article, please contact Janelle Westfall at jwestfal@devereux.org or Molly Stubbs at mstubbs@devereux.org.

About Devereux
Advanced Behavioral Health

Devereux Advanced Behavioral Health is one of the nation's largest nonprofit organizations providing services, insight and leadership in the evolving field of behavioral healthcare. Founded in 1912 by special education pioneer Helena Devereux, the organization operates a comprehensive network of clinical, therapeutic, educational, and employment programs and services that positively impact the lives of tens of thousands of children, adults – and their families – every year. Focused on clinical advances emerging from a new understanding of the brain, its unique approach combines evidence-based interventions with compassionate family engagement.

Devereux is a recognized partner for families, schools and communities, serving many of our country's most vulnerable populations in the areas of autism, intellectual and developmental disabilities, specialty mental health, education and child welfare. For more than a century, Devereux Advanced Behavioral Health has been guided by a simple and enduring mission: To change lives by unlocking and nurturing human potential for people living with emotional, behavioral or cognitive differences. Learn more: www.devereux.org.

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healthcare workers who claim an exemption due to their religious beliefs. The case was filed by a conservative legal organization on behalf of 17 healthcare workers who object to the vaccine on religious grounds. The State has until September 22, 2021, to oppose the plaintiff's motion for injunctive relief.

Affected employers who generally oppose OSHA regulation may also seek to challenge the emergency standards in court, as reported by Reuters.

What Comes Next?

The high rates of vaccine hesitancy across the country make clear that more public education and outreach is needed regarding the proven efficacy and safety of the currently available COVID-19 vaccines. OMH and OASAS programs and hospital administrators may have legitimate concerns about the loss of valuable clinical and support staff in an already short-staffed and overworked workforce. Public sector behavioral health has traditionally been an underfunded field. A state and federal commitment to provide funding for more competitive wages for those working in the sector will go a long way towards staff retention and recruitment.

If the federal mandates stand up to legal challenge, every single OMH and OASAS program and hospital outpatient program in New York will be required to comply because they receive Medicare and Medicaid funding (and most likely employ more than 100 individuals). As the vaccine deadlines approach, we do not yet know if the new mandates will send health care workers looking for new opportunities in better paying industries. There is one thing we know for sure – that the need for behavioral health care and treatment is at an all-time high and ensuring access to quality mental health care and treatment remains a number one priority.

Ms. Fernbach is Deputy Director and Assistant General Counsel of the New York State Psychiatric Association and a Partner in the law firm Moritt Hock Hamroff LLP, located in Garden City, New York.

Footnotes

1. Behavioral Health + Economics Network, Behavioral Health Workforce Fact Sheet. https://www.bhecon.org/wp-content/uploads/2016/09/BHECON-Behavioral-Health-Workforce-Fact-Sheet-2018.pdf

2. Id.

3. HRSA Fact Sheet: Behavioral Health Workforce Projections: 2017-2030. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf

4. https://www.mayoclinic.org/coronavirus-covid-19/vaccine-tracker

5. https://www.reuters.com/world/us/bidens-covid-vaccine-mandate-angers-republicans-libertarians-2021-09-10/

6. Id.

Consultation from page 27

we have to deal with busy clinical schedules moving from patient to patient, answering calls between appointments, and scrambling to keep up with documentation. It's tough and heroic work, to be sure. But it also was too easy to focus our attention only on those patients who are coming into the clinic each day, and to lose track of those patients who do not. As I learned more about the CoCM model, I began to be more comfortable with regularly asking myself a series of population-health style questions:

• Who are all the patients my team is responsible for serving?

• Have we worked to engage each of them into care?

• Who isn't coming in for services?

• How do we know if people are getting better?

• Who isn't getting better as we all expected?

To address these questions – we used a shared electronic list of all of our team's patients that tracked last appointment dates and clinical outcomes scores. A CoCM team periodically reviews all patients on the caseload in a meeting using just such a roster of patients. In many ways these meetings feel like virtual clinical rounds. A key feature of these discussions includes highlighting patients that need a change in care strategy. These changes are often quite simple – perhaps a different approach to engaging the client, a change in medication, or even just making a telephone call. But if it weren't for these virtual clinical rounds – this opportunity was too often missed. These meetings also disciplined us all to adopt a more population-health approach that focused on outcomes rather than on appointments or processes.

A third principle of the CoCM model that transformed my work was the shift toward use of measurement-based practices, for example by using the PHQ-9 screener tool. Each member of the CoCM team learns how to administer and interpret this tool. No rating scale is perfect, and there is not a single tool that applies to every patient – but I found that the PHQ-9 and other rating scales gave me several new abilities in my consultation work. First – they gave me and my patients a means to quantify clinical improvement. This, in turn, allows me to track improvement over time. They also gave me the ability to communicate more effectively with one another on the CoCM team. For instance, nearly all of our CoCM patients struggle to a certain degree with some amount of depression even if it is not their primary diagnosis. The PHQ-9 and other rating scales serves as a shorthand and structured means of discussing these patients efficiently.

Over the years I have heard countless testimonials from psychiatrists, primary care providers, patients, and other behavioral clinicians about how integrated psychiatric consultation models like the CoCM can improve care experience and outcomes. These psychiatric consultation models do not replace specialty mental health care for those patients who really need those higher levels of care. However, it wasn't long before I was incorporating many of the principles of the CoCM model into my specialty mental health work with as well. Many patients were able to be treated just a effectively, or better, with an integrated model of care – and with more convenience and improved access for the patient. In addition, consulting practices allow me to extend my reach and thus my impact as a clinical psychiatrist to improve the overall health of more patients.

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References:

Integrated care: Working at the interface of primary care and behavioral health. Raney, L. E. (Ed.). American Psychiatric Publishing, Inc. (2015).

Core principles and values of effective team-based health care. IOM: Mitchell, et. Al., (2012) http://www.iom.edu/tbc

A Tipping Point for Measurement-Based Care. John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D. Published Online https://doi.org/10.1176/appi.ps.201500439 (Sept 2016)

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Broad challenges: In addition to the impact on direct services, one executive stated that *many, if not all of the societal conflicts that were foregrounded during the pandemic played out in our settings.* Issues of equity, social justice, access to health care and housing were relevant and pressing for every leader.

Moral grounding: One executive said: *I truly believe that at all times a higher power gives each leader the vision and strength needed to make the right decisions.* The prevailing lesson among these executives was the importance of core values to guide decisions and communications. One CEO shared this: *[He] believes being guided by core values not only helps ensure quality service delivery but also allows for a cohesive workforce with common goals and helps build trust and confidence within a team.* Another expressed a sentiment that leaders throughout history understood: *Do what you know is right and don't question your decisions – this will only confuse your staff and everyone else.*

Safety first: The implications and impact of each decision pervaded all that was being done. The overwhelming focus was on "safety first" for the people being served and the frontline staff. As one executive observed: Management heard that *[it] must be hypervigilant in its response to COVID and put into place control protocols above and beyond those of other service providers or mandated through Administrative Memoranda and Executive Orders.*

Do It Yourself: Early in 2020, it was dramatically and immediately apparent that DIY was required. We realized government was not going to be helpful, so CEOs had to rally.

In relation to the DIY modus operandi, one executive expressed the following: *We are very good at improvising. Another one said: We had to think out of the box.* Many CEOs came up with innovative response, such as creating, almost overnight, specialized residential units (called recovery units) to receive individuals being discharged from hospitals who were without adequate medical treatments and needed to be quarantined. They didn't wait for government to give them permission. One executive put it well: *It is better to ask for forgiveness than permission in these situations.* This exceptional statement could apply to any number of moral issues.

Taking care of staff: This was another prevailing and overwhelming demand. One lesson was particularly insightful: *The way we managed our staff pre-crisis helped reduce any wholesale loss of personnel. We put our money where our mouth was.* Another executive was emphatic in saying: *Big change requires staff buy-in; it's important to bring staff representing different parts of the organization into the process discussion as early as possible. This will ensure processes run more smoothly in future.* Another valuable opinion was offered: *It was critical to bring people together to engage in dialogue; listen and respond to concerns.* Another statement makes it clear about the importance of staff members: *They needed to understand that the CEO was in the fight with them…. every day.* One executive characterized payments to staff as *hazard pay* for people working with those who were infected or suspected of being infected.

Communication a must: Maintaining clear, consistent, and timely communication was another critical lesson learned. Messaging had to be current and honest, even if it was bad news. Transparency was a premium. One leader put it this way: *At the beginning of the pandemic information and guidance came from many sources and needed to be culled in order to separate fact from fiction, reasonable responses from unreasonable, and the feasible from the unfeasible.*

Ongoing communication with families was essential. As one executive said: *Staying in contact with families was critical to help reduce anxiety and uncertainty. We also used a lot of face time.*

Grieving: Grieving is typically a private or personal emotion but given the depth of conditions, an executive expressed the following: *Understand that people must grieve and then support them in their efforts to do it. Understand and support people who are going through it and let them express their sadness about it.* One executive made clear that *there was a sense of loss all around us, and we had to find ways to support our individuals, families, and staff.*

Where is government?: The levels of emotion during the pandemic ranged from deep anger and resentment to a total disregard for the usefulness of government advice. One observation: *The real leaders during the pandemic have been execs throughout the state and their respective leaders within their organizations.* Another executive made it explicit that *[Our] regulators don't have a clue (or don't care) about how we operate nor how the pandemic challenged us, which they were buffered from. Those of us that are in multiple service sectors experienced such dissonance across the regulators/funders.* Most executives were decidedly blunt about the lack of government support or leadership for persons with I/DD, other than the bureaucratic requesting of more reports and issuing administrative directives.

The crisis is far from over. As a befitting summary, one executive made clear that: *As a result (of poor or lacking government support), Agency X remains committed to its contention that being guided by its core values was, and will continue to be, the best approach.* He continued: We also learned from another executive *that a crisis could propel us to accomplish goals much sooner than expected when forced to by circumstances.*

The future: Generally, most executives indicated that the future is evolving but a return to the pre-COVID era is extremely unlikely.

Enormous respect is due to I/DD leaders for their accomplishments in the ongoing COVID pandemic, and certainly as well to the heads of every human service agency.

Note: All the phrases in italics are direct quotes from the NYIN members.

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and I've been able to have one-on-one conversations with her. This has helped me make progress and achieve some of my goals.

I've also been able to develop a deeper relationship with my current caseworker. I've seen a whole other side of her and we have been able to connect in an appropriate and meaningful way. It's a good thing to be able to talk to her and I'm glad our relationship has grown.

Staying Safe

Wearing a mask and maintaining social distance while in the shelter hasn't affected my relationship with staff. I know it's an important safety precaution and something that needs to be done on a regular basis so we can get done with this "hootenanny." I like to walk with a little speed and get exercise every day. Wearing a mask complicates my breathing a little bit but that's ok. Once you find a better understanding about what the COVID virus is and how to fight it (by getting vaccinated), personally it's better. I'm thankful that I got vaccinated.

Learning Patience

I had to teach myself to be patient since I got to the shelter and am waiting for a more permanent place to live. I've been working on my OCD, along with my patience and meditation, which is hard to do in a shelter environment. It's taught me how to accept change—that's the process of life. Not everything remains the same. Some people expect instant gratification and want things right away, but there are lots of people who need help. I had to train myself to be patient and work with my caseworker.

It's important to stay positive. S:US has allowed me to plan for my future and start working on my goals. I also picked up some good hobbies while at S:US—I'm a puzzle fanatic. That's one of my therapeutic things I do, along with meditation.

I understand that S:US has a plan to retain staff and recruit new staff, but I'm hoping that I won't be switched to a new caseworker. The work that they do is vital to people like me. And I'm thankful for their care and support.

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