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EDUCATION, INFORMATION, ADVOCACY, AND COMMUNITY RESOURCES

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The Impact of Behavioral Health on Families

From Blame to Burden and Beyond: Changing Perspectives on the Family and Behavioral Health

By Michael B. Friedman, LMSW
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Over the past 40 years or so, there has been a dramatic shift in the views about dynamics of families with mentally ill family members, a shift from blaming them to sympathizing with them for the burden they have to bear.

50 years ago, when I was learning to be a clinician, I was taught that families were largely the cause of the mental illness of their children. Jason, for example, a teenager I treated at an excellent residential treatment center, often erupted in anger and cut his arms from time to time as self-punishment. His parents were divorced and re-married and, even though they tried to cooperate regarding Jason, the old angers between them frequently resurfaced. Conclusion: their dysfunctional relationship early in Jason's life was the primary reason for Jason's borderline personality disorder. Or Stephen, another teenager on my caseload, was diagnosed with childhood schizophrenia (a diagnostic category abandoned long ago and replaced with "pervasive developmental disability"). His



bizarre behavior began when he was about three. His mother was very anxious about him and very protective. His father was passive and distant. Conclusion: she was a schizophrenogenic mother.

At that time there were two dominant schools of thought about mental disorders: psychodynamic and family dynamic. According to most psychodynamic theories,

mental illness reflected a failure of child development due to inadequate parenting. I was taught that the earlier the parental failure was the more severe the mental illness would be. Failures in infancy would result in psychosis, just past infancy in borderline personality disorder, and failures between two and five would result in neurosis. The most extreme form of this view was Bruno

Bettleheim's theory that autism was caused by a cold mother's death wish for her child in infancy. Other theorists did not go nearly that far, but the finger was usually pointed at the mother, and the expectations that emerged for mothers were so extreme that Donald Winnicott, a British psychoanalyst who eschewed orthodoxy, felt it necessary to develop the compassionate concept of a "good enough mother." What a relief for mothers!

There is a similar psychodynamic theory about the origin of addiction in the relationship between mother and child in early life and failures of attachment.

Family dynamic theories of mental illness tended to see the family member with a mental illness not as an individual with mental illness but as the "identified patient" in a dysfunctional family. The family is ill, not the individual. There are many theoretical formulations along these lines. The family is [misstructured](#). The family suffers from [miscommunication](#). The family problems are multi-generational. At the extreme, Murray Bowen maintained that it took four generations of family dysfunction to create a schizophrenic.

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Fall 2023 Issue

Substance Use Disorder Prevention, Treatment, Recovery, and Harm Reduction

Deadline: September 14, 2023

Winter 2024 Issue

The Role of Housing and Employment in the Recovery Process

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Office of Mental Health

Supporting Families in the Recovery Process

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

At the New York State Office of Mental Health, our **Office of Advocacy and Peer Support Services (OAPSS)** – formerly the Office of Consumer Affairs – supports families to play a vital role in the recovery and resilience process. The office is staffed by individuals with expertise gained through their work and formal education, as well as the experience of being a current or former recipient of services or the family member of a recipient.

The focus of OAPSS is to better understand the people we serve and their families. The staff works across the State to increase the availability of self-help, self-advocacy, peer support to assist each person in the pursuit of their own individual recovery and resilience goals.

OMH Wants to hear from those individuals and families who've had experience with our services. OAPSS works to include recipients in all the decisions made about their services and supports and provides opportunities through collaboration for recipients and their families to effect change in OMH program and policies. OAPSS also tackles specific issues affecting various special populations and integral parts of the mental health system by providing advocacy, training, technical assistance, and leadership for the Peer Workforce and Peer Delivered Services. The office concentrates on all systemic issues regarding recipients of mental health services and speaks to the unique issues involving family members of individuals receiving services from the mental health system.

I hope you will also see that our name change reflects the growing role of Peer Advocates and Peer Support Specialists in OMH and a strong belief that Peers are a vital part of the mental healthcare system. In fact, New York was the first state to establish a Civil Service title for **Peer Support Specialists**. We're committed to ensuring that all families have access to peer services by making Family Peer Advocate Services reimbursable through Children and Family Treatment Supports



Ann Sullivan, MD

and Services and the Mental Health Outpatient Treatment and Rehabilitation Services program.

OMH has many exciting partnerships with outstanding family-centered community and advocacy groups. With **Families Together New York State and Youth Power**, OMH is supporting families in all regions of the state, including the availability of Family Peer Advocate staff at every OMH Regional Office. OMH also funds active and engaged Family Support programs throughout the state. Along with Families Together, **The Mental Health Association in New York State (MHANYS)**, and the **National Alliance on Mental Illness in NYS (NAMI-NYS)** are strong partners in whom OMH can always depend on to ensure that family support and engagement remain at the forefront of recovery.

Strengthening the OAPSS and Family Support programs is one way to ensure that the role of families is prioritized and built into the development of new programs and services. We also recognize the need to establish and strengthen community-based programs for children and adolescents where mental health treatment and support occur in a natural environment – whether that be home, school, or at a pri-

mary care office – where families are present and involved. Providing a continuum of community service options ranging from prevention to intensive treatment is our goal with the expectation that all programs partner with families. Some examples of these efforts are outlined below.

HealthySteps, an evidence-based program that offers universal access to services for young children ages birth to three and their families in a pediatric health care setting, provides early access and opportunities to integrate both mental health and physical well-being for the youngest children at a most critical time in brain development. HealthySteps integrates a child development expert, known as a HealthySteps Specialist, into the health-care team to promote the child's developmental, social-emotional, and behavioral health, and to support the entire family. The HealthySteps model offers the ability to instill preventative efforts through anticipatory guidance which may enhance positive outcomes and serve to alleviate future potential mental health challenges.

Project TEACH (Training and Education for the Advancement of Children's Health) supports maternal mental health and helps pediatric primary care practitioners (PCPs) deliver quality mental health care across the state. Project TEACH can provide a PCP with connections to key resources that patients and their families need in their communities, telephone consultations for mild-to-moderate mental health concerns, direct face-to-face consultations for selected pediatric patients, and CME-certified training on how to assess, treat and manage mental health concerns.

Pediatricians and family practice doctors are often the first-place families go to seek help or information if they have concerns about their children's emotional or behavioral health. Project TEACH connects pediatric primary care providers with psychiatrists and other behavioral healthcare experts for consultation, referrals to services and education, and training on children's social and emotional development.

OMH will be collaborating with top universities and hospitals in the state to enhance access. Partnering with OMH in the project is University Psychiatric Prac-

tice (UPP), a collaboration led by the University at Buffalo Department of Psychiatry, that includes faculty psychiatrists from the University of Rochester, Columbia University, New York State Psychiatric Institute, SUNY Upstate, Zucker School of Medicine/Northwell Health, Albany Medical Center, and Albert Einstein College of Medicine.

UPP will help expand and strengthen Project TEACH in a number of ways, such as by increasing training opportunities, tool kits, and educational materials for families in seven additional languages as well as expanding the availability of consultations for pediatric providers to include the specialized areas of infants and children ages 0 to 5; behavioral assessment and planning for autism spectrum disorders/intellectual developmental disorders; nonmedication intervention for substance use disorder; LGBTQ+ wellness and mental health concerns; and problematic sexual behavior assessment and treatment.

School-based mental health clinics provide a unique opportunity to engage children and families who might not seek mental health treatment elsewhere and strengthens the capacity for earlier recognition of mental health needs. Additionally, it provides opportunity for a collaborative, coordinated approach to mental health service delivery; an approach that can be holistic in nature and more easily foster the generalization of behavioral health skills to the academic setting. Most importantly, school-mental health clinics contribute toward the recognition of the interconnectedness between education and mental health, paving the way toward improved outcomes.

I'm especially proud that OMH is now the first state mental health agency in the nation to designate **Assertive Community Treatment (ACT)** teams specifically for youths.

Youth ACT teams provide mental health services to youth with serious emotional disturbance. They're made up of psychiatrists, nurse practitioners, mental health clinicians, and are required to include family peer advocates – a team approach that allows ACT teams to deliver intensive, highly coordinated,

see Recovery on page 10



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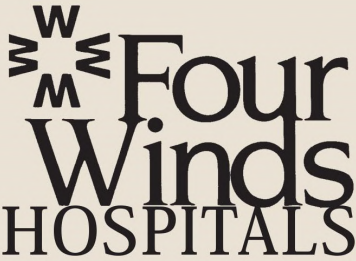
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Mental Health and Families: Working Together to Strengthen and Support Loved Ones

By Amy E. Schmelz, MS, NCC
and Shakima Hill, MPA
Institute for Community Living (ICL)

Having a family member diagnosed with a mental illness can cause great stress and a deep sense of isolation. Mental health challenges are difficult to open up about because of the fear of judgment, believing that no one will understand. Relationships with family and friends can be difficult to maintain; there's anxiety around bringing others into your home, not knowing how the individual with these challenges might act around others.

In spite of all the challenges, when learning about a mental health diagnosis in your family, it is critical that you gather as much information as possible about mental health and what is expected. Gaining this knowledge will arm you with the tools to maintain relationships with other family members and friends – and with the person struggling with this diagnosis.

It can be hard to know how to act around someone when you first find out that they are suffering mental health difficulties. People begin to treat the affected person differently – they feel sympathy towards the individual or fear making things worse. Try to be yourself. A professional can also help you deal most effectively with these new circumstances.

Knowledge is indeed power. These two examples provide a glimpse into the journey people embark on when they learn a family member is living with a serious mental health challenge.

Maria – Breaking Through Stigma: When symptoms of schizophrenia first began for Maria, she was living with her husband, Jim, in a community where people did not talk about mental illness. The associated stigma made it very difficult to seek and receive mental health care. Months in, the silence around Maria's situation and leaving it untreated had taken a great toll on the household and on their relationship. Jim was scared and ashamed; he was also unprepared to deal with the financial burden of his wife's illness. Left unattended, the challenges festered and grew.

Maria's granddaughter stepped in – to act as her grandmother's caregiver. It was only then that Maria received the professional care she so desperately needed. She began to thrive and was more able to manage her mental health. With family treatment, Jim was able to accept Maria's illness; the couple is now living happily, their granddaughter close by for continued support.

Amelia – Understanding a Child's Anxiety: Halfway through first grade, Amelia suddenly announced she didn't want to go to school anymore. Her reluctance led to daily crying and feeling sick, at bedtime, more tears and great worry. Amelia's mom said she was not aware that children as young as her daughter could develop anxiety, outside of a traumatic experience. For months, Amelia's caregivers reassured themselves that the child would grow out of this behavior and



get better. Instead, Amelia's symptoms grew worse.

The family finally came to accept that something was truly wrong and sought professional help. As a result of the support they found, Amelia and her family developed the skills needed to help her manage anxiety; today she is thriving, able to go to school and experience the happiness a young child should be able to feel.

mental illness may cause ripples within the family dynamic. Families already struggling financially will have greater challenges facing the additional costs of treatment. This should be addressed as a family and guided by professional advice. There are often affordable options for mental health care that can be found.

For couples, mental illness can have negative impact on intimacy and bonding

By using the family as a support system, practicing self-care, and recognizing that hope and mental health are inextricably linked, we can strengthen our ability to take small, daily actions that will help thrive as a family.

Finding the Tools for Meaningful Support: There are many questions a family member will face learning someone they love is diagnosed with a mental illness. How will it affect their life and the life of other family members? Will the loved one be okay? Could they have prevented this? How can they help? What will the future hold? What adjustments need to be made to daily life?

Whether it is your child, parent/caregiver, sibling, or partner, caring for someone struggling with a mental illness can take a toll on you and impact various aspects of your life. It affects everyone in the person's life so it is very important that everyone is involved in living with this new reality. If they can come together to process this new information, they can best plan for the future of the person diagnosed as well as everyone else involved in their life.

Not only do these kinds of mental health challenges affect family relationships, there are often significant financial burdens. Along with psychological difficulties, the financial burden associated with

the family may be the best-kept secret in the arsenal of healing. When a person is struggling with a mental illness, support from members of the family can make a big difference in their ability to get better, especially by being non-judgmental and actively involved in the healing process such as by attending family therapy.

Family members can encourage loved one to be more independent, to take medications as prescribed and to show up for appointments. At the same time, a family member needs to take care of his or her own needs to reduce feeling overwhelmed or resentful. They are the main support team and whoever they are – caregiver, sibling, child, or partner – they are no doubt stressed and tired and even grieving and deserve attention as well.

As a family, there are many things we can do to sustain hope and the strength to battle the challenges associated with mental illness:

- **Focus on strengths.** Remembering and using our personal strengths creates confidence that we can get through whatever comes our way.
- **Practice gratitude.** Research on gratitude shows that it is more effective than self-control, patience, or forgiveness in creating hope for the future. Families can do a gratitude practice together by going around and each sharing one thing they are thankful for.
- **Reframe negative thoughts.** When feeling afraid or hopeless, try focusing on what's scaring you and looking at it in a different way. For example, if you're thinking, "We will never overcome these challenges as a family," shift to "It might be more demanding to overcome these challenges, so we'll need to use our strengths as a family to work toward overcoming those difficulties."
- **Spend time with hopeful, optimistic people.** When we surround ourselves with people who are hopeful and positive, we are more likely to feel that way ourselves.

One of the biggest struggles involves feeling ashamed of the behaviors of the loved one who is struggling with a mental illness. And though mental health came to be more fully appreciated during the pandemic, there is still great stigma in our society around mental illness. As a result, people who need help are reluctant to try to get it. In frightening and uncertain times, it can be difficult to feel hopeful, but having hope for recovery within our family strengthens our ability to get through tough times. And hope can reduce anxiety, trauma, and depression.

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Tips on Becoming an Antiracist Leader

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

White institutional culture is most often invisible. It determines the norms and standards in your organization and is damaging to the antiracist journey. It requires training your eyes to see, your ears to hear, and your voice to become racially fluent. The first step for an antiracist leader is to learn to become a critical lover of your organization, which means identifying barriers to achieving your goals of a fully inclusive workspace.

Throughout my extensive career, I have held the roles of clinician, administrator, executive, coach and President & CEO of MPG Consulting, a company committed to eliminating bias and structural racism in the workspace. I have supported executives on the journey towards leading antiracist organizations create brave spaces for difficult conversations, an atmosphere of psychological safety, inclusiveness and belonging, and opportunities for systemic change.

Questions to Ask Yourself

- Are Black, Indigenous, and People of Color thriving in your institution?
- Are there Black, Indigenous, and People of Color in decision-making positions?
- What are the similarities/differences between those in decision-making positions and clients served?
- When there is a change in client demographics, are the decision makers actively seeking to be more closely aligned with and responsive to the change?

Barriers to Becoming An Antiracist Organization

“Check the Box” Mentality: These are shortcuts leaders sometimes make in their attempt to diversify the racial makeup of their organizations. Without the intent to make meaningful and long-lasting changes, there is an insufficient number of BIPOC in leadership roles who have the authority to make substantial changes to the organization. Under the guise of “progressive diversity work,” issues of bias, white-body privilege, and structural racism all remain invisible, free of scrutiny, and unexamined.

Favoritism: According to Dr. Nancy DiTomaso, the preferential treatment white leaders offer colleagues in their networks aggravates the racial inequality in our organizations (Cornell University, 2014). Their colleagues receive more opportunities and have more access to social and cultural capital. Due to the implicit nature of favoritism, many whites operate under the assumption that they made their way on their own, not acknowledging the advantage favoritism plays in their hires or promotions.

“Fit” (Cultural Similarities): “Fit” is code for cultural traits that match the



Mary Pender Greene, LCSW-R, CGP

dominant culture in body type, presentation style, and lived experience. Fit is a major barrier to advancing antiracist work within organizations as it is used as justification to exclude BIPOC from leadership positions.

Pipeline Problem: Discovering qualified BIPOC leaders and board members is as simple as developing cross-racial personal and professional relationships outside of your organization, asking BIPOC leaders, and seeking outstanding BIPOC currently on staff who may need some professional development and encouragement by their white leaders.

Lack of Psychological Safety: *Psychological safety* refers to “a shared belief that the team is safe for interpersonal risk taking” (Edmonson, 1999). BIPOC, specifically leaders, are discouraged from being their full selves or offer an authentic perspective to a situation due to underrepresentation, hypervisibility, and excessive scrutiny. Lack of psychological safety engenders conformity, a barrier to progressive decision-making, and meeting the organization’s antiracist goals.

Pockets of Resistance Against An Antiracist Organizational Change

According to Dolly Chugh in *The Person You Mean to Be: How Good People Fight Bias*, bias impacts:

- Hiring
- Promotions
- Potential leaders
- Who is heard and valued
- Who is trusted, supported, rewarded
- Who is favored and given the benefit of the doubt when a mistake is made
- Who is oppressed by over supervision and suspicion
- Who is burdened by conscious and unconscious racial biases, stereotypes, and judgments

When leaders allow pockets of resistance to go unchecked due to their personal biases, the antiracist work stalls and BIPOC staff are harmed. It is crucial for antiracist leaders to hold all staff accountable, no matter their tenure and level of authority in the organization.

Racial inequities are deeply baked into our systems. The most important tip for all antiracist leaders is to commit to the journey for the long haul, for yourself, your network, your organization, and your community. The antiracist journey is eternal.

Things to Do to Increase Racial Literacy

1) Develop authentic relationships with BIPOC outside and inside of your organization - Some ideas for building authentic relationships include:

- Walking Lunch with BIPOC colleagues
- Join professional groups where you are in the minority
- Develop or deepen a personal cross-racial friendship

2) Participate - Take the Undoing Racism™ Workshop: The Undoing Racism™ Workshop is a unique two-and-a-half-day workshop by The People’s Institute for Survival and Beyond, a national network from New Orleans, dedicated to ending racism and other forms of institutional oppression. (It changed my life and my practice). - www.pisab.org

3) Attend—What White People Can Do About Racism - The Center for the Study of White American Culture: contact@euroamerican.org

4) Take - Specialized Training in Anti-Racist Work for White People and White Helping Professionals. Irene Greene: www.irenegreene.com

5) Join - The Undoing Racism™ Executive Collective **Virtual** Gathering. This group is designed for people in senior leadership roles in their organizations, particularly executive directors and who have substantial decision-making authority and are invested in nurturing their organizations to become more equitable, just, and antiracist institutions. Others are also welcome. Learn from speakers, obtain resources, and gather with peers to grapple collectively and honestly with the challenges antiracist leaders frequently encounter. To be added to email list, contact: mpgconsultingnyc@gmail.com First Monday of Every Month, 9am-11am | Zoom Gathering (No Cost)

6) Read - *The Person You Mean to Be: How Good People Fight Bias* by Dolly Chugh: “[Becoming an Antiracist Leader: From the View of a Black Female Clinician and Consultant](#)” and *The Enduring, Invisible, and Ubiquitous Centrality of Whiteness* by Kenneth V. Hardy, PhD

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Eliminate Bias & Structural Racism In Your Workspace



We're MPG Consulting

MPG Consulting (MPGC) is a consultant group committed to eliminating bias and structural racism in the workspace. We support organizations and leaders in their pursuit of creating an inclusive, fair, and respectful work culture with the goal of removing barriers to success in the workplace.

Cross-Racial Teams

Our team comprises social workers, educators, psychologists, psychiatrists, business experts, researchers, social justice advocates, and community organizers with extensive experience providing training on cultural and racial competence for mental health and human service staff.

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Our work is informed by an understanding of the impact, constructs, and intersections of race and racism with gender (including gender fluidity), LGBTQIA+, class, religious (including anti-Semitism and Islamophobia), intellectual, emotional, and physical bias, as well as other systemic forms of oppression based on social identity.

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Supporting Families in Integrated Behavioral Health Care

By Shawna Marie Aarons-Cooke
SVP of Programs
The Guidance Center of Westchester

When someone you care about is struggling with alcoholism, substance use, mental health and well-being, finances, employment, or housing, I suspect you will feel compelled to get them support. You may even want to be involved and see them through to the other side of their challenges. As a professional working in the field of behavioral health or social services, you may already know of resources that can be of assistance. But what if you didn't? And the person struggling is a family member? What would be most helpful in this scenario? What would you want to know and how would you like to be considered in this loved one's care process?

As professionals in behavioral and social determinants of health care, we have a responsibility to create care pathways and access to care that meet the needs of those who seek services and supports. This responsibility extends to include best practices which lead to the intended outcomes of healing, recovery, and well-being of those we serve. Given the growing body of research noting relational approaches as beneficial to healthcare utilization, cost saving and treatment outcomes (Crane & Christensen, 2012), intentional integration of families in care is imperative.

A Relational Perspective

Helping professionals understand the importance of relationships in the change process. This understanding informs interactions with those served as well as efforts to strengthen relationships to pro-



mote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities (NASW, 2021.) Whether one directly draws on relational theories of Adler, Bowlby, Freud, Rogers, and Winnicott or has a cursory exposure to concepts of person-in-environment, the helping and treatment process can be strengthened or harmed based upon how relationships are considered and incorporated into care.

Chosen and biological families take many forms. From single individuals with a supportive chosen family of others, to couples, adoptive parents with children, and multiple generations of biological and blended families, our care pathways do well to consider how to support the full range of family constellations in care. When thinking about how to thoughtfully integrate the full range of potential family supports, one must be mindful of the full system of care. Do your website, social

media, and outreach materials reflect images of multiple family structures? Does your intake/assessment process explore the relationship supports who may be referred to as family by the individual seeking services? Can your process begin to engage and signal support for partners, chosen family, and other family members to be involved in care?

A Case Example

Jed (pseudonym) contacted The Guidance Center of Westchester (TGCW) centralized welcome and engagement center using the toll-free 888-TGCW-CAN hotline. During his call, the engagement specialist collected contact information and his inspiration for contacting TGCW. Jed disclosed that he struggles with anxiety and depression and has been using heroin. He was reportedly told by his parents that he

wouldn't be able to stay at home anymore unless he got help for his mental health and addiction. Jed was scheduled for intake the next morning at the dual OASAS and OMH licensed Opioid Treatment Program METRO and advised us that he had transportation via his mother.

At his initial appointment, Jed was asked by the psychotherapist about supportive individuals in his life who may be or be considered to be family. Jed talked about his parents, cousins, and a long-term friend who lived in Texas. His psychotherapist also asked if and how he may want to involve these individuals in his care. This prompted a thoughtful discussion by Jed and his psychotherapist as to the challenges he experiences with each of the named family members, his concerns about confidentiality, as well as their roles in his substance use. His psychotherapist assured Jed that any involvement with these individuals would be at his discretion and with his permission, which would be further discussed and evolve as part of his care. Although he described it as a "long shot," Jed shared that one day he would like to be able to visit his friend in Texas, work, and get his own apartment.

During the early phase of his treatment, Jed did not feel comfortable involving his parents to the level of their expectations. He wanted complete privacy in his care and did not want his parents involved. His parents frequently called attempting to get more information and involvement in his care. As his psychotherapist, psychiatrist, and treatment team continued to honor his process and support him in negotiating with his parents about their involvement, he felt empowered to make the decision to eventually

see Families on page 48

The Behavioral Health Community Has Many Vital Programs and Services to Help You During Times of Crisis - Visit Behavioral Health News

Recovery from page 4

individualized services, and skilled therapeutic interventions to ensure children and families have the level of treatment and services to support their recovery.

Teams are highly responsive and flexible to meet the individualized, changing needs of the child and family, and they offer support 24 hours a day, seven days a week. They're run by not-for-profit agencies that have experience in this field. The new Youth ACT program will help young people ages 10 to 21 who are at-risk of entering residential or inpatient psychiatric treatment to receive services while remaining with their families. The goal is to help youths and families recover by helping them to stay together, and to help youth remain in school and develop the skills they need to lead successful and independent lives.

Youth ACT teams are being established in the Capital, Finger Lakes, Mid-Hudson,

Mohawk Valley, Southern Tier, Western, and Central regions upstate and in Long Island and New York City.

Home Based Crisis Intervention (HBCI) is a family preservation program designed to address the significant needs of children and youth in crisis who are at risk of entering, or rapidly readmitting to, inpatient psychiatric treatment or residential treatment. HBCI provides short-term, intensive crisis intervention and skill building for children and families to help maintain the child in the home, school, and community. HBCI ensures that the child and their family have the support services and access to clinical professionals needed to sustain any gains made in the program.

For individuals who are returning to the community after being in an inpatient or correctional setting, focusing on the transitional time is very important. The **Mental Health Community Partners** project, operating under a two-year contract with

the Mental Health Association in New York State (MHANYS) is a 90-day program for youth ages 12 and older with serious emotional disturbances and adults with serious mental illness as they transition from any type of inpatient treatment or institutional setting to the community. With the support of these certified Mental Health Community Partners, individuals, and their chosen supporters, be it family, friends, or the Mental Health Community Partner, participate together in creating a comprehensive care planning strategy for a transition to successful community participation. For information, visit: <https://mhcommunitypartners.org/>.

OMH is particularly interested in enhancing treatment and support services for children with mental health needs, by helping to strengthen families through parenting education. This is why we partnered with other public and private agencies to establish the **New York State Parenting Education Partnership** (NYSPEP) a

statewide cross-systems initiative designed to prevent or reduce child abuse and neglect by enhancing parents' knowledge, skills, and behavior. NYSPEP is the only state-level organization representing those engaged in the field of parenting education.

Parenting education helps parents to be more effective in caring for their children, which of course is a major factor in a child's health, cognitive development, and ability to succeed in school and in life.

NYSPEP is working to expand access to parenting education. Their Parenting Educator Credential is a professional recognition for individuals, teams, or agencies and helps to ensure quality parenting education in New York State.

Love, empathy, and encouragement can work wonders for people living with mental illness and understanding that they are not alone can provide people with the strength they need to seek help. The support of family, friends, and peers can be a cornerstone of the recovery process.



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Family Mental Health: How Your Organization Programs and Services Are Helping

By Shaniqua Saxon, LCSW
and Marlene Morris, LMSW
Vibrant Emotional Health

For over 50 years, Vibrant Emotional Health (formerly known as The Mental Health Association of NYC) has been fulfilling its mission to help people achieve mental and emotional well-being with dignity and respect. The work of the organization has branched into comprehensive direct service programs with several that focus upon families living in some of the most economically disenfranchised areas in New York City. Our experience supporting families has informed our perspective upon collaborative care which centers families’ strengths and preferences for how they would like to receive services as we develop comprehensive plans to address their holistic needs.

When several stressors are impacting a family at once it is imperative that the services identified are both specific and coordinated to match the family’s needs. The starting point is one of compassionate inquiry as we set out to answer the question: How does one collaborate with other providers that will minimize the impact on a family repeatedly reliving their trauma? Below is a case example to demonstrate one way we answered the above inquiry with a family Vibrant has served over the years:

Ms. Smith was referred for services to address concerns of being overwhelmed with the care of her seven minor children, aged 3, 8, 9, 10, 13, 16, and 17. The referral source alleged that several of the chil-



dren, as well as Ms. Smith, had developmental delays. Ms. Smith was diagnosed with depression in the past and was not engaged in mental health services. Her 16-year-old experienced suicidal ideations at school on several occasions and was in the process of getting evaluated by the Committee of Special Education. To complicate matters, the family resided in a private house that was later determined to be un-inhabitable due to dangers related to the structure of the home. As a result, the family was subjected to moving to a family shelter located in a city hotel where they resided for several years.

The family was initially introduced to Vibrant’s Family Treatment and Rehabilitation program (FTR) to help address the

mental health concerns for the 16-year-old. The main goal of FTR is to reduce the likelihood of a child being placed in foster care. FTR works with families using a strength-based approach to help families reach their goals. One specific criterion which distinguishes FTR from other preventive models is that the program is designed to serve families where at least one family member is living with a mental health and/or substance abuse disorder. The services provided include advocacy, educational support, assistance with enhancing children’s well-being, treatment referrals, conducting assessments and screenings and support with resource navigation. As part of the first phase of coordinated care, the 16-year-old

was linked to mental health services, where the preventive team remained active partner’s that closely monitored development and engagement around treatment goals. The team also supported the family in making 311 complaints in regarding to the hazardous conditions in home.

Seeing the benefits of services, the family was open to hearing about how Vibrant’s other direct service providers could meet their needs. The FTR team connected the family to the Family and Youth Peer Support Services (FYPS) program to assist them in the management of child welfare concerns. At times, parents can often feel like they are struggling alone and that providers may not truly understand their challenges; however, and FYPS provided Ms. Smith with one-on-one peer support by connecting her to an individual who had their own direct experience navigating the child-serving system. As Ms. Smith gained confidence in herself, she continued to navigate the Board of Education’s system to address the IEP needs of her 8- and 13-year-old children. Simultaneously, the FYPS team provided group and teen nights for the youth lead by a youth peer advocate. With the assistance of FTR and FYPS, the family was linked with Bronx Legal Services, who stepped in with free legal support to ensure that the schools didn’t discriminate against Ms. Smith and her children as they sought appropriate evaluations and service implementation.

While the above progress was noteworthy regarding Ms. Smith and her

see *Helping on page 43*

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NYSPA Report: The Launch of 988 and Crisis Stabilization Centers Are Among New Efforts in NYS to Help Loved Ones and Family Members

By Jamie Papapetros
Communications Coordinator
Government Relations Office
New York State Psychiatric Association
(NYSPA)

New York State has undertaken significant new efforts in 2022 to continue building a comprehensive crisis response system to help meet the needs of New Yorkers living with a mental illness and their families, including launch of the 988 crisis line and establishment of supportive and intensive crisis stabilization centers.

The National Suicide Hotline Designation Act was enacted on October 17, 2020 and transformed the ten-digit National Suicide Prevention Lifeline/Veterans Crisis Line number 800-273-8255 administered by Vibrant Emotional Health, into the three-digit number, 988.¹ This law was enacted in response to an order from the Federal Communications Commission designating 988 as the National Suicide Prevention Lifeline and Veterans Crisis Line, which “required all telecommunications carriers, interconnected voice over Internet Protocol (VoIP) providers, and one-way VoIP providers to make any network changes necessary to ensure that users can dial 988 to reach the Lifeline by July 16, 2022.”²

New York passed enabling legislation in 2021 and 2022 requiring the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) to prepare an implementation plan outlining the resources that would be necessary to make sure the 988 hotline system would be “...available, operational and effective across New York State.” OMH and OASAS maintain oversight of the hotline in concert with the National Suicide Prevention Lifeline (NSPL). An implementation plan was released by the two agencies in February 2022 and the historic moment was noted as follows, “The implementation of 988 is a watershed moment in the history of crisis and



Jamie Papapetros

behavioral health care in the United States. It presents an opportunity to reach millions in emotional distress while destigmatizing help-seeking. New York State has an opportunity to be a national leader in coordinated crisis services during this pivotal point in time.”³ The report identified eight priority areas:

1. 24/7 statewide coverage by designated National Suicide Prevention Centers;
2. for identifying and supporting funding streams to meet the projected increase in volume;
3. mechanisms related to increasing and sustaining capacity for call, chat, text, and follow-up at the centers, including workforce capacity building and training;
4. operational, clinical and performance standards, including identifying reporting metrics on usage, services, and impact for all Lifeline Call Centers;
5. multi-stakeholder input through a 988

implementation coalition;

6. systems to maintain local resource and referral listings, as well as assure linkages to local community crisis services;
7. follow-up services for individuals who contact 988 through call, text and chat based on Lifeline best practices and guidelines; and
8. public messaging at the state level to distinguish from 911 and educate the public on the range of 988 services which shall include public messaging and underserved and high-risk populations.⁴

The launch of 988 in New York has been supported by a \$10 million one-time federal mental health block grant, a \$7.2 million two-year SAMHSA grant and \$35 million in the enacted in 2022-23 New York State budget annualized to \$60 million starting in fiscal year 2024.

When an individual dials or texts 988, they will be routed to a local lifeline crisis center based on the caller’s area code or IP address, if initiating contact via chat. Despite the method of contact, the individual will be connected with a trained crisis counselor who will listen, provide support, share resources and offer follow-up services. In the event the local crisis center is unable to receive the call, it will be rerouted to the national backup crisis center. As of February 2022, New York had established 12 NSPL centers which are accredited either through the American Association of Suicidology or the International Council for Helplines. The funding was used in part to launch NSPL centers in the 11 counties of New York State that did not already have in-state NSPL coverage through Vibrant Emotional Health and Mental Health Association of Essex for counties in the North Country. According to the August 988 Updates and Education Newsletter report, New York has achieved 24/7 in-state coverage for all 62 counties.

OMH recently released data from its

contact centers for August 2021 compared to August 2022. In August 2021, the call centers routed and received 11,565 calls with 7,629 answered in-state (66%) with 32 seconds as the average answering speed. In contrast, in August 2022, 16,964 calls were routed and 16,059 received with 13,230 answered in-state (82%) with 27 seconds as the average answering speed. New York’s crisis contact centers responded to 100% of chats and text during the months of July and August 2022. On a national level, SAMSHA reports that, based on 9,360 average daily contacts, approximately 98% of individuals who contact 988 are helped by a crisis counselor without the involvement of 911, 1% those who contact 988 agree to have a counselor call 911 because of serious risk to life and fewer than 1% require a call to 911 without consent because of serious risk to life.⁵ For more information visit: <https://omh.ny.gov/omhweb/crisis/988.html>.

The mission of the comprehensive crisis response system envisioned by OMH is summarized as “someone to call” (988), “someone to come” (crisis mobile teams) and “somewhere to go” (crisis residences and crisis stabilization centers). A September 2022 update from OMH noted mobile crisis services are in 50 of New York’s 62 counties with intent to expand to all counties so there is 24/7/365 coverage.⁶ The Crisis Stabilization Centers are being developed under the oversight and authority of OMH and OASAS under two models: (1) supportive crisis stabilization centers and (2) intensive crisis stabilization centers. These centers will provide observation, evaluation, care, and treatment on a 24/7 basis. Pursuant to agency guidance and regulations, supportive crisis stabilization centers are “services are for recipients experiencing challenges in daily life that do not pose the likelihood of serious harm to self or others. Such challenges may also create risk for an escalation of behavioral health symptoms that cannot reasonably be managed in the

see Efforts on page 49



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From the Desk of Dr. Max

Mansour (Max) Banilivy, PhD

Director of Clinical Training, Education and Internship Placements



Ask Dr. Max: Family Life Cycle and Mental Illness Challenges

By Mansour (Max) Banilivy, PhD
Director of Clinical Training,
Education and Internship Placements
WellLife Network

It is important to start with the understanding that everyone thinking about and desiring to have a family is not only with great expectations but with many hopes and aspirations. Unexpected events result in shocks and traumas impacting everyone and each family system based on many factors including individual and/or family system resiliency.

Couples and families go through stages in their own life cycle. These phases and stages are somewhat universal, but also unique to the characteristics of the individual, their support system, as well as their own resiliency and emotional fortitude. No two couples, like no two families, are exactly alike.

When there is realization and/or news of any kind of abnormality or unusual concern, it shakes the foundation of the family and extended system. Often on a short-term basis, this system halts to absorb the shock. Many times, it starts with a disbelief that something is not “NORMAL.” Difficulty accepting the emotional shock puts many things on hold and may even derail the regular course of development for the children as well as the couple and the extended family. The family needs to focus diligently and dedicate a great deal of effort and time to addressing and recognizing the situation and trying to cope. In at least some situations, they may have to make permanent adjustment to the irreversibility of the condition(s). Siblings, older and younger, if present, not only need to understand at their developmental level, but their course of development and emotional needs may be affected by the needs and demands of the family member who is not well. Many times, they are not



able to verbalize effectively how they feel about the changes in their family life.

Any change requires an appropriate explanation to the children at their level. Often the couple's and family's focus and time may unintentionally be solely focused on the care of one family member at the expense of some others. Trauma response, physical and emotional exhaustion could and does result in burn out.

There are many nuances to these dynamics. Behavioral and mental illnesses present their own unique challenges based on lack of understanding, stigma, myths and, in some cases, a “perfect” cure. Although some have their roots in childhood with a genetic and organic cause, others do not fully reveal themselves until sometime in childhood or adolescence. The expectation and need for a clear and real explanation (as well as a cure, if applicable) are quite understandable; however, this is not always available and more rarely on a short-term basis. Often, diagnoses are not clear, are provisional, or there is no agreement among professionals. Families

can have a different perception of the problem which results in different reactions and expectations.

Psychological and emotional challenges have similar and different impacts on the families compared to physical, medical, and developmental disabilities. There is a wide range of challenges and ongoing consequences that many must deal with and address. For some, unfortunately, it becomes unresolved grief, loss, and unfinished business indefinitely.

Some of the specific consequences can include despair, sadness, worries, anxiety, anger, shame, helplessness, guilt, frustration, disillusionment, compassion fatigue, and hopelessness. At times, it may include wanting to give up on life as the pain and the trauma become unbearable. The toll and the long-term consequences for the affected individual, and the rest of the family, can be unpredictable and often negatively affect the quality of life for many. This can result in unintentionally neglecting and overlooking other needs.

An older sibling once said to his parent,

“I will give my right arm if my sister could be normal again.” The parent answered, “Unfortunately, nothing can make her normal, but we still love each other and are a family”. We can all collectively help the one needing more assistance. There are many kinds of opportunities. Our reactions and adjustments to traumatic experiences are quite varied and a function of many factors. Many unpredictable negative events happen to a large portion of the population. Lifetime implications necessitate not only one adjustment, but many adjustments.

SCARS REMAIN BUT WOUNDS CAN HEAL. It is essential that collectively we maintain our focus on the fact many families are under emotional duress and that “MENTAL HEALTH MATTERS”. Family members may need to develop *new* ways of taking care of themselves, relating to others and incorporate lifestyle and standard of living changes. On the positive side, many families do adjust and become resilient as a result. It is essential that we learn from them to help others. Key factors that families need are readily available professional and supportive services and education that is compassionate and factual.

Mansour (Max) Banilivy, PhD, is Director of Clinical Training, Education and Internship Placements, at WellLife Network. You can reply to Max.banilivy@welllifenetwork.org.

Resources

Sederer, L.I. (2015). The Family Guide to Mental Health Care W.W. Norton & Company

Rosalyn, C. (2011) Helping Someone with Mental Illness: A compassionate guide for family, friends and caregivers. New York: Three Rivers Press

NAMI (National Alliance for Mentally Ill) local chapters: www.nami.org.

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VOTED TOP WORKPLACE ON LONG ISLAND

From the Shadow of COVID, a Bright Emergent Resource: Crisis Stabilization Center

By Jeffrey Friedman, MA, BS
Chief Executive Officer
CN Guidance & Counseling Services

One enduring effect of the COVID-19 pandemic is its intense illumination of the need for more accessible mental health and substance-use services in our community (a patchwork of towns east of New York City). During the pandemic, CN Guidance & Counseling Services—born in 1972 to fill a gap in mental healthcare—needed to further elevate its tradition of innovation and adaptability to keep all programs running and available. We pivoted almost instantly to deliver a nimble combination of face-to-face, online (telepsychiatry), and mobile services—meeting each client in a place comfortable and accessible to them. Many of our COVID-era innovations are now adopted as permanent improvements to the choices and effective modes of service we offer individuals and their families.

In July 2022, CN Guidance added another important resource and tool to our community’s arsenal in the fight to address mental illness and substance use, Long Island’s first Intensive Crisis Stabilization Center.

Built on a platform of expanding community partnership, CN Guidance’s Long



Island Intensive Crisis Stabilization Center, designated for launch at the end of 2023, will be a welcoming place for individuals and families from diverse backgrounds and neighborhoods on Long Island when they are experiencing mental health and/or substance use-related crises. The carefully tailored setting will embody 24/7-accessible help from trained/experienced, supportive, and empathetic clinical professionals and peer specialists. Our Crisis Center mission will be rooted

in providing the best crisis de-escalation and therapeutic care possible during the critical hours when a person/family needs help most, linking them to pivotal longer-term services, and following up methodically to support their progress. From the start, our partnership-enhanced approach has been culturally informed and customized to fit the needs of varied individuals/families in crisis, so each person (‘guest’) served by the new Crisis Center can get back to a life that is informed by their

values, goals, and individualized view of recovery.

The new Crisis Stabilization Center will target individuals from **marginalized** and **disproportionally underserved** communities across Long Island with the aim of reducing inpatient admissions, emergency room visits, and crisis-services usage, while uplifting personal wellness and family functioning (fostering stability).

All services to Crisis Center guests will be provided by an on-site **multi-disciplinary team**, using a strengths-based, recovery-oriented, trauma-informed, and evidence-based approach, so each guest and their family have enhanced capacity to sustain healthy interactions, healthy emotional attachments, and functional relationships.

The overall goals of the emerging Crisis Stabilization Center are to: (1) improve rapid access to crisis care; (2) stabilize individuals experiencing acute mental health/addiction crises (while supporting affected family members); and (3) provide short-term (up to 24-hour) intensive behavioral health intervention to individuals who are experiencing acute psychiatric or addiction crises but who do not require immediate inpatient services. Individuals served will be linked appropriately to the type and level of care they need

see COVID on page 43



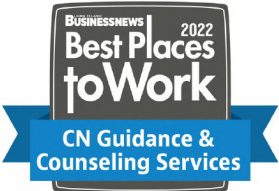
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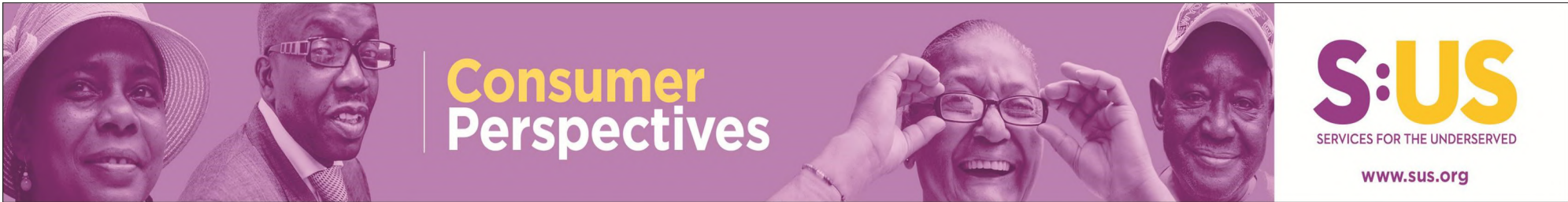


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Consumer Perspectives: Housing is Essential for Recovery

By Brittany, Rotiesha, and Sheila

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

We are New Yorkers in our 30s, 40s, and 60s, who have overcome a lot of obstacles in our lives and made progress in achieving stability, with help from S:US. We’ve each experienced challenges with homelessness, mental health, and substance use disorder. We’re all thankful for our families and grateful to have a roof over our heads.

Housing Saves Lives

Two of us experienced homelessness and lived in shelters or in our cars before



finding stable housing. We now live in supportive housing, which we really like.

“Living at a shelter for one year and three months was depressing and aggravating. It took a while to move into an apartment. It helps to have our own space now, with no curfew; my boys love having their own space. And the building management is great,” said Rotiesha. “S:US helped me

get an apartment, apply for Medicaid, SNAP, and SSI, plus they helped with finding food, getting bills paid, etc.”

“I was suicidal when I met my husband in a detox facility. We wanted to build a family and a better life. We moved into a homeless shelter when I was pregnant and lived there for two years. This is our first Christmas in a home. My daughter really

enjoys having her own space. S:US housing saved our lives and helps us feel like there is a future,” said Brittany.

“I really like my apartment and live with my son and sister. I have a lot of gratitude for S:US,” said Sheila.

We’ve Overcome Substance Use Disorder

Two of us received help to overcome our issues with substance use and now we help others. Peer support is important to us.

“I’ve been in treatment and recovery for eight years. The treatment is very good. I’ve never relapsed, though being bipolar presents unique challenges,” said Sheila.

“I’m originally from Long Island and I came to New York City to get help with my substance use. Growing up, where I was living wasn’t a ‘home.’ I feel lucky that I have an apartment for my family that is a home and it’s big and clean,” said Brittany. “Now I work as a Peer Intern and enjoy helping people make decisions

see Housing on [page 43](#)

Do you have a passion for helping others?

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Exploring the Use of Virtual Reality in Alleviating Loneliness Among Older Adults

By Heidi Billittier, LMSW
Director of Older Adult Services
Compeer of Greater Buffalo

Social isolation is a reality for many older adults, and in response, technology is proving a viable avenue worth serious exploration. Virtual reality (VR) may be a solution, as it can transport us to distant lands, expose individuals to novel experiences, and connect to others within a virtual environment. VR offers unique opportunities for older people to immerse themselves in multisensory experiences that promote engagement and feelings of well-being. The use of virtual reality in reducing feelings of loneliness among older adults is gaining the attention of researchers, social workers, and gerontologists, and although studies are limited, data demonstrates positive responses and outcomes.

Impact of Social Isolation on Wellbeing

Many older people experienced profound psychosocial responses due to social isolation and loneliness during the height of the COVID-19 pandemic. Particularly for individuals without strong support networks, socialization during the period of quarantine was limited at best,



which jeopardized mental and physiological well-being (Brown, 2019). A study by Gao and colleagues (2020) examined the impact of isolation on the physical health of older people. Lack of exercise and movement significantly impacts health in general and can intensify chronic health issues including obesity, heart disease, stroke and diabetes, all of which are controlled in part with consistent exercise.

The social and physical benefits of exercise which may include walking, dancing, swimming and other interactive experiences were significantly limited during the pandemic.

VR: Recreational Implications and Reduction of Loneliness

According to Hughes et al. (2017) it has

become increasingly apparent that the use of VR has potential to effectively mitigate negative effects associated with isolation and loneliness. Additionally, use of VR holds promise in supporting physical and cognitive health for people of all ages. Cheung K.L. et al. (2014) found a positive correlation between use of VR and changes in neuroplasticity. Neuroplasticity occurs when the brain creates new pathways; challenging imagination, inspiring curiosity and critical thinking all stimulate cognitive functioning. VR offers users opportunities to engage in activities that increase cognitive activity, inspire creativity, and thus, promote neuroplasticity.

The user accesses the metaverse using a VR headset together with hand controls. The company Rendeavor offers a VR platform by which a facilitator controls a collective shared experience from a tablet or device. This device offers participants a "hands-free" platform thereby providing a VR experience that mitigates challenges in navigating the metaverse on one's own. Participants can enjoy immersive virtual journeys back to their childhood neighborhoods, attend virtual concerts or they may join with others for an art gallery exhibit and lecture. Applications such as *Zenjo*, *Walkabout Golf*, *Liminal* and

see *Loneliness* on [page 45](#)



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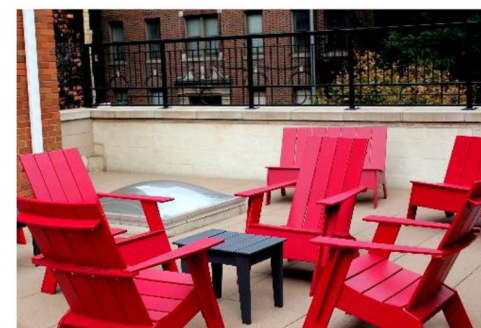
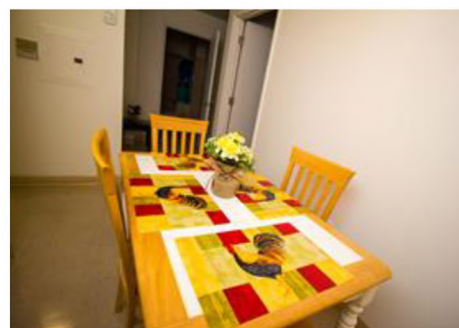
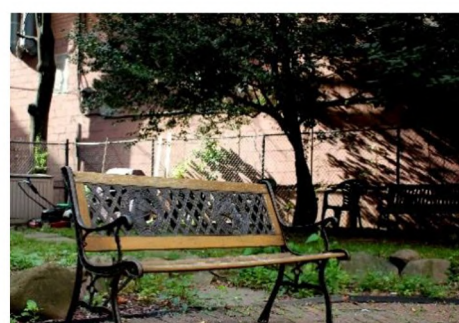
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You Don't Have to Do this Alone:

988 Lifeline Offers Support for Loved Ones Concerned About Suicide

By Angela Jacobs, LCSW
Coordinator of 988 Services
St. Vincent's Hospital Westchester
A Division of Saint Joseph's
Medical Center

At a recent fund-raising event I attended for St. Vincent's, CNN correspondent Randi Kaye was honored for her efforts to promote suicide prevention. In her acceptance remarks, she spoke about her family's shock, disbelief and unanswered questions when her father died by suicide.

She said: "I made a promise when he died that I would not bow to the stigma of suicide. I would talk about him, share his story. I want people to know that it's okay to talk about this and we should be talking about this, so other families don't have to go through what we went through."

Earlier that day, Kaye visited St. Vincent's and talked to the counselors who are handling Westchester County calls to the 988 Suicide and Crisis Lifeline. She spoke of her wish that her father had reached out to someone to ask for help.

The 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline) offers 24/7 call, text and chat access to trained crisis counse-



lors who can help people experiencing suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support.

When families reach out about a loved one, they fear is considering suicide, trained counselors assess the safety of the loved one; educate the caller on how to support and increase safety for their loved

one; take necessary, least-invasive action to increase safety for the person of concern; and provide support to the third party themselves, and assess for suicidal thoughts.

When a family member or friend reaches out, they may need support for themselves as well. Suicide impacts all of us: parents, children, siblings, friends, and partners. Our counselors provide support, empathy, and actively listen. We can pro-

vide resources for the family on how to support their loved one and how to get them help. There are times when someone is refusing help, when this occurs, we connect them with a local mobile crisis team who will go to the home and try to engage with them.

We have had families reach out on behalf of their adult child, after assessing for safety we connected them with their local crisis team who did a full mental health assessment and then referred them to a therapist.

If the individual in need will not reach out, we can call them together. When a loved one refuses help this can be very challenging for the family. Families often feel helpless, lost, guilty, and often frustrated as one person's stressors or mental illness becomes a primary focus. When a loved one begins to detach or have reduced feelings of empathy they may be experiencing what is called compassion fatigue. When this occurs, our trained counselors can take the time to help families reflect and work on self-care.

Some Common Myths About Suicide

Myth 1: Talking about suicide increases the chance a person will act on it.

see Lifeline on [page 44](#)

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The Behavioral Healthcare System's Response to Families: A Legacy of Unfulfilled Promises

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

Family members of those with serious behavioral health conditions often encounter innumerable obstacles in the pursuit of effective treatment and other essential services for their loved ones. Navigating a byzantine network of resources, many of which entail restrictive eligibility criteria and extensive waitlists, is exceptionally challenging for even the most resilient and steadfast among us. Individuals commonly assume this responsibility while coping with the emotional distress that follows the revelation a son, daughter, sibling, parent, or spouse has received a potentially grave diagnosis for which the course of treatment and prognosis are anything but certain. In short, our behavioral healthcare system imposes an onerous burden on individuals during periods of acute vulnerability. A wealth of research has validated families' experiences and suggests various improvements to the existing system of care are warranted. One comprehensive review of literature on the subject revealed common denominators that would resonate with many. It found family members frequently suffer from significant stresses, experience "moderately high levels of burden," and receive insufficient assistance from mental health professionals (Saunders, 2003). Another study found more than a third (35%) of individuals have been adversely affected by a family member's mental health condition, and it revealed significantly greater levels of distress among those who provide care for a family member with a mental illness (Pearson, 2015). Moreover, these findings are not unique or even limited to the United States. An analysis of family experiences in other Western nations revealed common themes irrespective of geographic, cultural, or sociopolitical considerations. For instance, multiple studies suggest behavioral healthcare providers and the institutions with which they are affiliated perpetuate family members' distress. One investigation found family members frequently cited their relatives' psychiatrists as a source of stigma that exacerbated their distress (Angermeyer, et al., 2003), and another found family members desired more collaboration and cooperation from their relatives' mental health professionals (Saunders & Byrne, 2002). A focus group with relatives of individuals diagnosed with schizophrenia or bipolar disorder revealed similar sentiments among participants, many of whom described their relatives' therapists as critical and unsupportive (Rose, 1998).

It would be uncharitable (and inaccurate) to conclude such experiences are universal, however. One study indicated family members benefit from alternative approaches that incorporate emerging evidenced-based and recovery-oriented care for individuals with mental health conditions. One of these approaches (i.e., the "Clubhouse Model") facilitates partic-



Ashley Brody, MPA, CPRP

ipants' involvement in "normalized" pursuits that include socialization and a variety of purposeful activities aligned with their goals and interests. Relatives of these participants frequently report positive experiences and derive considerable support from the broader Clubhouse community (Pernice-Duca, et al., 2015). Another exploration of family members' experiences suggests significant minorities are pleased with the support they received from their relatives' healthcare professionals. Approximately one-third (39%) of family members were satisfied with the support they received, and a similar percentage (38%) were satisfied with the quality of communication they maintained with their relatives' treatment providers (Vermeulen, et al., 2015).

These themes emerged through my recent dialogue with the parents of a young man who lived with a serious mental illness and substance use disorder for several years until he succumbed to the Coronavirus. "Sarah" and "Andrew" witnessed some of the best and worst our behavioral healthcare system had to offer to their son "Jason." They were kind enough to share insights borne of difficult experiences that culminated in the incalculable grief that attends the premature death of a child. I am deeply indebted to them for their candor and generosity. Their experiences are not unlike those of other families as described in the research literature, and the failings of our system coupled with the enduring pain of a grievous loss might have engendered considerable cynicism or animus. This did not occur. Sarah and Andrew maintain an exceptionally thoughtful and nuanced view of our system and its response to their son's illness. They remain cognizant of its deficiencies, appreciative for its strengths, and optimistic certain improvements might be realized in time. They are also grateful for the assistance their family received and how it lightened what could have been an unbearably heavy load.

Sarah believes Jason was fortunate to encounter a compassionate and knowledgeable treatment team following the onset of his illness whose members recognized he would require a comprehensive

array of services in order to manage his symptoms and to achieve progress in his recovery. This does not suggest she and her husband are fully satisfied with the behavioral healthcare system. They were left deeply dissatisfied and disappointed at times, and they readily identify innumerable areas for improvement. Nevertheless, they recognize Jason's initial encounter with well informed and responsive professionals operating under the auspices of a reputable behavioral healthcare institution was auspicious (if not downright lucky), and it rapidly led to his engagement with other services that mitigated the most troublesome manifestations of his condition. Jason was entrusted to the care of a local behavioral healthcare facility whose psychologist and discharge coordinator recognized the potential severity of his condition and need for long-term services and supports. Although Sarah and Andrew were understandably distraught by their son's illness and its implications, they found comfort in his treatment team's reassurance such services would be available to aid him in his recovery. They also received assistance in navigating the complexities of the system and the myriad tasks this entails. For instance, they were unfamiliar with the financial entitlement programs Jason must secure in order to access outpatient treatment, supportive housing, and other essential ser-

vices. They were gratified to receive guidance in this realm that led to his receipt of entitlements and subsequent placement in supportive housing and enrollment in other services supported by these entitlements. Sarah reported "nothing was spared in securing help for [Jason]" during the initial phase of his treatment.

The road to recovery from a serious behavioral health condition is seldom linear. It is often uneven, at best, and frequently fraught with false starts, pitfalls, and setbacks. Jason's journey followed a similarly circuitous trajectory, as did his parents' experience of the care and support afforded to them. Their initial optimism would soon be supplanted by disappointment and disillusionment. Jason was not unlike many others dually diagnosed with mental illness and substance use disorder for whom the behavioral health system is ill equipped. His initial supportive housing placement, promising as it seemed, could not address his complex needs. A subsequent placement was located in a neighborhood where prevalent drug abuse further compromised his recovery. A near fatal overdose followed, and, by Sarah's account, the response of his treatment team and local law enforcement authorities was unresponsive if not altogether negligent. Lingering effects of

see Legacy on page 46



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The Lens of Loss: Perspectives of Family Members Following Suicide Loss

By Jeanette Fairhurst, Sean Mayer, and Yvonne Tropp-Epstein
Members, Board of Directors
MHA Westchester

When we think about the suicide of a loved one, we think of profound loss, of grief, of finding a way to endure amid unyielding pain. But we gain something in the aftermath, one nearly as burdensome. It is a new perspective: Loss becomes a lens through which life is lived. And it can be difficult for many to see through the blur.

For three members of The Mental Health Association of Westchester's Board of Directors, much as with anyone who has suffered the loss of a loved one to suicide, that lens is ever-present. Their success in regaining clarity has been mixed.

The phone call 8½ years ago that changed Sean Mayer's life forever was not exactly unexpected. His brother, Ryan, had suffered from an array of mental health challenges for 20 years and had attempted suicide three times. The difference this time was that he had succeeded.

Mayer for years had told his wife that he thought his brother would die by suicide one day. He spent those years steeling himself for that seeming inevitability.

And yet, when the call came, Mayer, a



longtime editor who prides himself on attention to detail, realized that no amount of preparation could have readied him for that loss. Nor could it have prepared him for the reality that loss – and the potential for loss – would become such a focal point.

“My parents and their sanity became my singular focus,” he said. “I needed to get them through a pain that can't possibly go away to a reimagined existence where it is OK to live and even to laugh. I

didn't have the time or the energy to do my own grieving. But I didn't know any other way.”

Since his brother's death, Mayer alone has been responsible for helping his parents – a mother nearby with increasing and worsening health issues and a father leading an isolated existence 1,300 miles away in Florida – navigate the hurdles brought on by aging. “For someone plagued by his own depression and anxiety, it can be exhausting,” he said. “But what is truly draining is the fear that history can repeat itself.”

Mayer's oldest son, 16, suffers from anxiety and obsessive-compulsive disorder. He does very well in school despite his difficulty studying, and he has a girlfriend and close friends. But he is prone to bouts of exhaustion and moodiness. Mayer said he and his wife are rarely at ease.

Meanwhile, Mayer's identical twin sons, 13, excel in school – seemingly no grade below a 95 is acceptable despite their parents' protestations to the contrary – and they are talented musicians, with both already targeting Juilliard for college. There will be countless auditions, and the pressure and competition will be ratcheted up. Mayer fears they will burn out – and then what?

“That lens of loss, or potential loss, is like a cataract – it clouds all that I see and do. But a cataract can be removed; that lens will be with me forever. I ache for just one day of unimpeded vision.”

Jeanette Fairhurst's daughter, Ali, was 23 when she passed, with the only warning to family of expressed suicidal ideation coming once, five years earlier. Fairhurst, her husband and their son were together when they heard the news and bonded by getting Ali's pets from her apartment. Fairhurst's son led the way in being open about Ali's suicide on social media. They chose to celebrate her life at her funeral alongside speaking about her intermittent struggles with depression.

Fairhurst knew she had to continue to see joy amid her loss. “I will always be a mom to both my son and my deceased daughter,” she said. “To be effective, I create space for living and grieving.”

There is no right way to grieve, and the Fairhursts respected their differences while trying to help each other and con-

sulting professionals for help. Her husband and son were more inwardly focused, but being a scientist at heart, Fairhurst needed to learn and share her experience to prevent similar outcomes. Within a few months, she attended MHA Westchester's first-ever Community Conversation, where Mayer moderated a panel on suicide prevention.

“Hearing directly from those surviving the loss of family and those who had attempted suicide was painful but so helpful,” Fairhurst said. “There were recognizable elements that made me feel connected.”

Building an association with MHA Westchester has helped Fairhurst heal and uniquely honor her daughter while helping a vital organization. A Sock-It-To-Stigma raffle brought a fun twist while raising funds and suicide awareness, and Fairhurst brought suicide prevention classes from MHA Westchester to her workplace. The presentations sparked her founding of the Regeneron Resilience Is Essential (RisE) employee resource group. What started as sharing resilience strategies evolved to include sharing mental health challenges and fighting the stigma of those challenges at work. It has been a ground-breaking outlet for the group's 600 members to help each other and themselves.

Fairhurst shared that, to let joy and grief coexist, she views others with more empathy. Often, others feel ashamed for bringing up their “little problems” to her. But she believes all problems are valid and need to be addressed for healing to occur.

“The grief of a son or a grandmother is no less important than that of a mom,” she said. “We need to find ways to live life fully as families and yet let ourselves grieve individually or together to be our best selves for each other.”

Yvonne Tropp has faced many losses in her long life, including two husbands. But the loss of one of her grandsons, Nick, to suicide in 2018 has brought a different challenge: helping her daughter and Nick's brother with the lasting effects of Nick's loss while keeping her fond memories of him alive.

Nick grew up with Asperger's Syndrome. At the conclusion of his senior year at a private high school, he spoke from the stage of the school chapel, telling everyone about the ups and downs of his life for the first time. He had attended therapy sessions for many years. At the conclusion of his talk, many students praised and hugged him, then wished him well in college.

He was about to graduate from college in December 2018 when an unexpected situation overwhelmed him. He told his Reformed University Fellowship (RUF) friends that he planned to stay in his apartment after graduating, then enter graduate school that September. They told him that, as a college graduate, he would not be able to continue to participate in RUF events, as it is an undergraduate campus ministry.

“He did not call his mom to let her know this,” she said. “If he had done so, she would have told him to take two more



The Mental Health Association of Westchester's new Postvention Services provide support to individuals experiencing grief following the loss of a loved one due to suicide.

Offered at no cost, our short-term support also includes connection to various resources and education about grief reactions associated with suicide loss.

Postvention is an integral part of comprehensive suicide prevention efforts. Postvention services for affected individuals can facilitate healing from the grief and distress of suicide loss, as well as mitigate other negative effects of exposure to suicide.

For more information, please contact:
Nellana Flores, MSW, Postvention Specialist
floresn@mhawestchester.org or 845-745-0087



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see Loss on page 49

SPOP

SERVICE PROGRAM FOR OLDER PEOPLE

HEALTHY AGING



For Older Adults, The Pandemic is Far from Over

By Nancy Harvey, LMSW
Chief Executive Officer
Service Program for Older People (SPOP)

As we move into Year Three of the COVID-19 pandemic, older adults remain at high risk. Those over age 65 now account for 90% of COVID deaths – and many of those becoming ill are fully vaccinated and boosted. While many Americans feel confident to resume social activities and travel, our older friends, neighbors, and family members continue to experience isolation, anxiety, and despair associated with the pandemic.

At SPOP/Service Program for Older People, we are acutely aware of the pandemic's continued impact on mental health and well-being of older adults in our region. As the only agency in New York City exclusively focused on community-based behavioral healthcare for adults age 55 and older, SPOP provides a continuum of services including individual and group therapy, psychiatry, group-based rehabilitation support, bereavement support, linkages to other service providers, and training in the field. We serve over 2,000 adults each year and provide services at 23 locations in Manhattan, Brooklyn, and the Bronx, via telehealth, in the home for those who are disabled.

At this time last year, we were able to reflect on how our client population had managed during the pandemic – they had embraced telehealth and online learning or socialization opportunities, and many had demonstrated remarkable resilience as they adapted to a new way of living. Our clients were creating artwork, chatting with grandchildren on the computer, attending religious services online, and working to manage their fears and adjust to a new reality. Most important, we felt tremendous optimism that the high rates of vaccine compliance among older adults in New York City would provide a secure level of protection.

We now know that, while vaccinations definitely help, their effectiveness in an older population is reduced because the aging immune system is less robust. Older New Yorkers feel this first-hand. Our clients are aware of high rates of COVID transmission among their cohorts. Many have experienced the loss of a partner, spouse, friend, or loved one due to COVID, and many are fearful to venture into social settings. Referrals for behavioral healthcare at our Clinic remain abnormally high and client symptoms are severe.

SPOP is bracing for a challenging winter, and isolation among older adults is one of our leading concerns. Three years ago, isolation was a painful but adaptive way of living that everyone had to em-



Nancy Harvey, LMSW

brace. For many older adults, physical isolation was compounded by the deaths of friends and family members, leaving them emotionally isolated and bereft, without community support for mourning. Many of our clients continue to experience intense seclusion, unresolved grief, and despair – especially as they face a third winter alone.

Within the clinical setting, the challenges of isolation and loneliness are often manifested in severe depression, distressing symptoms of anxiety, insomnia, substance misuse, hoarding, increased suicide ideation, eating disorders, or unhealthy media consumption. At SPOP we see a worrisome increase in this trend. Some older adults try to self-manage anxiety-related insomnia by consuming alcohol or cannabis or by binge-watching television. Hoarding is serious problem for many in our client population, which is generally compounded by fear of eviction. Clients who are managing chronic pain or illness are often reluctant to enter a hospital – or they are frustrated by challenges in scheduling medical appointments. And the most marginalized among us – people of color, LGBTQ people, and those experiencing homelessness – are at risk for discrimination, hate crimes, and diminished access to healthcare.

In many ways Year Three of the pandemic is more challenging than the first two years. Every community-based behavioral healthcare I know is struggling to recruit and retain staff, address employee burnout and compassion fatigue, and manage a growing wait list for treatment. Among older adults, fatigue and hopelessness have replaced the resilience that we saw in 2020. There is general acknowledgement that we are facing a mental health epidemic.

At SPOP we have taken concrete steps to meet these challenges. We expanded our group therapy offerings so that clients have an opportunity to experience peer

support and social engagement as part of their treatment. We have forged new partnerships with community-based organizations and older adult centers that serve marginalized populations, including LGBTQ adults, people of color, and those most severely impacted by COVID-19. We created trainings in self-care to address trauma and compassion fatigue, which we have presented to our own staff and to those working in aging services or behavioral healthcare. We opened new clinic satellite sites in high-need neighborhoods of the city. We provided emergency food assistance for those who needed help purchasing groceries. And we have worked with each client to determine the safest and most beneficial balance of telehealth and in-person sessions.

Even with these stark truths, we remain focused on the value of therapy as a foundation of support and healing, as illustrated by this client's story:

Elizabeth is a 60-year-old Latinx transgender woman. She has a long histo-

ry of trauma and discrimination, which she feels worsened dramatically during the pandemic. She is routinely mocked, sexualized and harassed in the street, and she often feels afraid to leave her home. She is currently receiving treatment at a SPOP clinic satellite site co-located at an LGBTQ-supportive older adult center near her home. She appreciates the easy access to care and has recently started to take advantage of other resources at the center. She is making progress toward treatment goals and is building a supportive social network.

The past three years have also been a time to reflect on our work and our role in keeping older adults healthy and independent. We hear from many clients that the relationship with their therapist has been a lifeline during the pandemic. Our staff also report that this has been an especially rewarding experience, as they learn from their clients and are reminded why

see Pandemic on page 49

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The Behavioral Health Workforce Crisis and its Impact on Families

By Jordan Baker
Content Marketing Manager
Relias

The behavioral health field has been enduring a workforce shortage for some time. In 2021 alone, direct support organizations saw a turnover rate of 43%. On top of that, research has shown an increase in the demand for behavioral and mental health services since the beginning of the COVID-19 pandemic.

The increased workload with a short-handed workforce is putting the onus on behavioral healthcare providers to bear the brunt of the workforce crisis. This not only leads to greater stress on behavioral healthcare staff but may also lead to clients receiving inadequate care.

While the difficulties this has posed for human services organizations is well documented, the impact it has on families has yet to be widely discussed. In this article, we'll cover the effects of the workforce crisis on behavioral health clients and their families, as well as the homelife of the remaining behavioral workforce.

Impact on Clients and their Families

As the behavioral health workforce remains understaffed, clients may not get the care they need. Due to overworked staff and large staff-to-patient ratios, as well as the increased risk of absenteeism and turnover related to overwork, agencies run the risk of providing inadequate care for clients. One example of this



comes from a study conducted by the American Hospital Association, where researchers found that 100 million Americans live in areas that are experiencing a shortage of psychiatrists.

Additionally, behavioral health organizations have reported growing wait lists. In one recent study, the National Council for Mental Wellbeing found that 62% of their member organizations have experienced a growth in patient waitlists. As more individuals report symptoms of anxiety, depression, and other mental health issues, these growing waitlists will only compound the logistical complexity that staff shortages create for behavioral health agencies.

When agencies do not have the staff to provide adequate care to their existing clients or take on more clients, this can leave the families of these clients responsible for their mental well-being. As untrained family members attempt to provide this type of care, however, it can lead to burnout and compassion fatigue, as they will provide this care on top of their other responsibilities, such as work, child or elder care, etc. Additionally, untrained family members, while well meaning, may not understand why their loved one behaves in a certain way or the best means to help them cope with their mental or behavioral health issues. This could very well lead to strained familial relationships,

making the treatment or recovery persons served all the more difficult.

But clients and their families are not the only ones affected by the behavioral health workforce crisis. Staff members and their own families are now facing very real issues of their own.

The Family Life of Behavioral Healthcare Providers

As turnover and patient waitlists continue to increase, the behavioral health workforce will remain understaffed and overworked. Due to the stressful nature of their work, and the long hours and large patient caseloads they must now work with, many in the field run the risk of adverse mental health effects. The most common of these adverse effects is burnout.

While the implications of burnout at work (distancing from clients, weaker communication, etc.) are well documented, it's also important to note the impacts that burnout can have on one's familial life. Indeed, many of the physiological and psychological symptoms can cause providers to become distanced from their loved ones. These symptoms include ailments such as increased fatigue, headaches, anxiety, gastrointestinal issues, and depression.

All of these symptoms of burnout can cause one to withdrawal from friends and family, leading to accidentally strained relationships. In a BBC article, one therapist noted: "My energy levels get lower when I get home, and when that's happening more

see Workforce on page 30

The Hidden Effects of Combat-Related PTSD on Spouses

By Heidi Hillman PhD, BCBA-D, LMHC
Associate Professor
Eastern Washington University

The U.S. Department of Veteran Affairs (2014) reported that approximately 20% of service members who served in Iraq or Afghanistan developed combat-related PTSD. Mental health issues following combat tours are not exclusive to service members. de Burgh et al. (2011) stated that spouses of service members affected by combat-related PTSD display symptoms of anxiety, sadness, anger, displacement, and dissatisfaction in the relationship. Ahmadi et al. (2011) and de Burgh et al. (2011) referred to these symptoms as secondary traumatic stress (STS). Symptoms of STS are like PTSD symptoms; however, they develop due to a relationship with a traumatized individual, rather than experiencing a traumatic event (Ahmad et al., 2011).

While combat-related PTSD among service members have been studied extensively, studies exploring STS and general psychological stress among military spouses are sparse (Bjornestad, Schweinle, and Elhai, 2014; Nelson-Goff et al., 2016). We need to recognize that



military spouses can be negatively affected by their partner's PTSD symptoms. Hence, researchers are encouraged to focus on military spouses' daily challenges living with someone diagnosed with PTSD. Additionally, it is important to include military spouses during mental health assessments, since PTSD affects the entire family. Currently, mental health providers do not consider military spouses

during the PTSD treatment process.

The aim of this article is to raise awareness of military spouses' experiences, pinpointing common themes, and advocating for access to mental health resources, which currently is almost non-existent. Data were collected through in-person semi-structured interviews with 15 spouses (12 wives, 3 husbands) of service members who served in either Iraq or Afghanistan. I

identified five common themes from the interviews which I summarize next.

Lack of intimacy. All 15 spouses reported a lack of intimacy with their military partner after their return from a combat tour. The most common behaviors were reduced cuddling, hugging, holding hands, and significantly reduced communication regarding the relationship. The wives reported they thought the change was their fault. All the spouses noted they felt like they were walking on eggshells, never knowing what would set their military spouses off. All spouses reported they were a "nervous wreck, everything I did was wrong. I never knew the correct thing to do." One husband said when his wife (service member) left on an 18-month tour, they had a one-year-old. Since he was the primary caregiver for those 18 months, it was a difficult adjustment when his wife returned. His wife admitted she did not feel as strong of a connection with their daughter and would get angry at the close dad-daughter relationship.

Anxiety, depression, and anger. Of the 15 spouses, nine reported feelings of depression and six reported feelings of anxiety

see PTSD on page 41

Virtual Care and Mobile Response: A Must for Certified Community Behavioral Health Centers

By Javier Favela
VP, Solutions Behavioral Health
and Integrated Care
NextGen Healthcare

There are many factors contributing to the need for mobile technology applications among Certified Community Behavioral Health Centers (CCBHCs) and other behavioral health providers. First, and perhaps most important, is the vital role that Mobile Crisis Response Teams play in communities. This is a need that continues to grow in many areas of our country. Mobile Crisis Response Teams provide crucial services in many communities, particularly those with increasing unhoused populations and people with serious mental health concerns that are not receiving regular treatment or support. This is a common way for clients to get engaged in treatment and provides an opportunity to meet clients in their most vulnerable states—when they are receptive to help and beginning their recovery journey. Crisis services typically have 24/7 care teams available by telephone and out in the communities.

Mobile Crisis Response Teams need mobile applications that provide both online and offline access to clinical workflows since internet connectivity can be spotty or unavailable in rural areas, jails, schools, or even under both proverbial and literal bridges. Teams need solutions that allow them to review prior clinical notes and documentation for existing clients, review medications, and provide the ability to complete assessments and add new clients and clinical notes in the field. The application must then fully synchronize with the EHR when it is next connected to internet service.

A “Wrap-Around” for Success

Another common program that needs mobile support is intensive outpatient services for clients struggling with severe mental health concerns. These programs are commonly referred to as “wrap-around programs” or “intensive case management” and provide an interdisciplinary team, which can include a therapist, psychiatrist, nurse, case manager, and peer support specialist to “wrap” around the client with the right level of expertise and services. These programs also meet clients where they are—in this case in their homes. Sometimes, for example, clients



Javier Favela

need help adhering to their medication regimen and need medications dispensed on a daily or weekly basis. Other times clients need help developing social support and skills to stabilize.

These programs, much like crisis response teams, require a mobile solution that is easy to use and allows them to quickly access information and document services while in the community. Some states require a mobile solution that includes Electronic Visit Verification that includes a date, time, and geolocation stamp for providers to “prove” that they were providing a service in the community. This requirement is a method for reducing Medicaid fraud.

The pandemic accelerated the need for CCBHCs and other behavioral health providers to offer telehealth capabilities and begin virtualizing care delivery in many outpatient programs. Behavioral health services are some of the best suited for telehealth, as they can be less likely to require a physical examination by a practitioner or require laboratory tests that need specimen collection. Research shows that “telehealth is just as effective as in-person care for certain behavioral health conditions.”¹

The increasing need for CCBHCs to provide virtual care is also being driven by client demand for convenience. Many CCBHC clients experience challenges related to transportation, childcare, and work schedules that make it difficult to receive regular in-office care. Access to a provider via a mobile device from any location helps ensure more consistency of

care and reduces the rate of no-shows for appointments, which also improves the CCBHCs’ financial outlook. There are programs available that provide mobile phones and mobile services to people who might not otherwise be able to afford them, which also enables more virtual care. For clients to be active participants in their care remotely, it is critical for communication and engagement to be facilitated through technology. Mobile tools, including those for patient engagement, have become essential in engaging clients in their care—such as tools to help people manage their symptoms, communicate with their care team, fill out evidence-based assessments, etc.

Selecting the Right CCBHC Mobile Technology Applications and Capabilities

There are plenty of mobile applications available for CCBHCs and other behavioral health providers—and certain capabilities are critical to virtual care success. First, ensure that the mobile solution supports both individual sessions and group therapy. It must also include capabilities to engage clients including a portal that enables clients to:

- Complete new patient or other in-take paperwork, including consent forms
- Fill out outcome measures such as the Patient Health Questionnaire (PHQ-9)
- Receive a cost estimate for any out-of-pocket expenses the client will be responsible to pay
- Check-in for a virtual session
- Pay any co-pay
- Communicate with their care team
- Request a prescription refill

The technology must also support the full CCBHC workflow, including the collection of all data required for the organization to be reimbursed for the session.

In addition, the mobile application should include capabilities to host educational materials and tools such as how to better manage specific symptoms, conduct mood screening and journaling capabilities, and provide medication adherence reminders, among other important educational content and videos.

The Bottom Line

CCBHCs need technology that supports their client-centered approach to care and their goals of better outcomes for their clients. Value-based care initiatives also mean that CCBHCs must successfully help clients get and stay healthy faster, need fewer services over time, and reduce the incidence of relapse. The right mobile technology application aligns with these goals and enables them.

Mobile applications help CCBHCs meet clients where they are both in terms of their need for services and their physical location. As a result, clients can receive more consistent care. Some CCBHCs can even reduce their operating costs by needing less physical office space. CCBHCs and clients alike can benefit from the right mobile technology solutions. Clients can have better access to care and CCBHCs can have the tools they need to make a bigger impact on their communities.

About NextGen Healthcare, Inc.

NextGen Healthcare, Inc. (Nasdaq: NXGN) is a leading provider of innovative healthcare technology solutions. We are reimagining ambulatory healthcare with award-winning solutions that enable high-performing practices to create healthier communities. We partner with medical, behavioral and oral health providers in their journey toward whole person health and value-based care. Our highly integrated, intelligent and interoperable solutions go beyond EHR and Practice Management to increase clinical quality and productivity, enrich the patient experience and drive superior financial performance. We are on a quest to achieve better healthcare outcomes for all. Learn more at nextgen.com, and follow us on [Facebook](https://www.facebook.com/nextgen), [Twitter](https://twitter.com/nextgen), [LinkedIn](https://www.linkedin.com/company/nextgen), [YouTube](https://www.youtube.com/channel/UC8vXqYqYqYqYqYqYqYqYqYq) and [Instagram](https://www.instagram.com/nextgen).

Javier Favela is VP, Solutions Behavioral Health & Integrated Care at NextGen Healthcare. For more information, please visit www.nextgen.com/1-bh.

Footnote

1. Brittany Lazur, Lily Sobolik, Valerie King, “Telebehavioral Health: An Effective Alternative to In-Person Care”, *Milbank Memorial Fund Issue Brief*, October 15, 2020, accessed October 7, 2022.

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Federation of Organizations: A Family Affair

By **Barbara Faron**
Chief Executive Officer
Federation of Organizations

Families have been and continue to be instrumental in the development and implementation of treatment and support options for people with mental illness. Founded by family advocates, for the last 50 years Federation of Organizations (Federation) has been developing an array of community-based, recovery-oriented services incorporating peers in the professional team to deliver effective services to people with mental illness and their families. Mental illness is truly a family affair and interventions based on family support and education are critical to successful treatment outcomes.

In 1972, Federation was incorporated as an advocacy group to improve conditions in psychiatric hospitals and to develop resources in the community for people upon their release. At the time of its inception, families were considered part of the problem and lifetime institutional care was the dominant intervention. The advent of psychotropic drugs in the late 1960's and early 1970's and the various liberation movements of the time, together with the high cost of keeping 90,000 people in psychiatric hospitals throughout New York State, dramatically changed the



Barbara Faron

nexus of care to the community. At the time there were few community-based treatment resources, and two-thirds of the people released from hospitals in the first wave of deinstitutionalization were sent back to their families of origin, who were ill-prepared to provide the resources required for a successful transition to community living. This gave rise to increased efforts on the part of families to establish the necessary services in the community.

Since 1981, Federation has been employing peers who have a personal mental health and/or substance use history and can share their experiences regarding how families can support clients and navigate the mental health system. Federation's mental health and substance use programs incorporate family supports into treatment. Home and Community Based Services (HCBS), Community Oriented Recovery Empowerment Services (CORE), Children and Family Treatment Support Services (CFTSS), Assertive Community Treatment (ACT), Personalized Recovery-Oriented Services (PROS), Outpatient Clinic Treatment and Home BEST are all community-based services, which can be provided in the home and engage the entire family. CFTSS and Home BEST employ licensed family peer advocates who have lived experience as the parent or primary caregiver of a child/youth with a social, emotional, behavioral, mental health, or developmental disability. They foster effective parent-professional partnership and promote the practice of family-driven and youth-guided approaches. The Home BEST Program works with youth who are at risk for hospitalization or an out-of-home placement. Their goal is to reduce the rate of residential placement and to optimize the youth's functioning in the community.

Since 1972, Federation of Organizations has been a leader in advocating for community-based treatment and has developed a comprehensive array of services that support families challenged by mental illness and make recovery a reality for their loved ones. Inspired by the experience and advocacy of families seeking to improve the mental health system, in the last 50 years Federation has evolved into a multi-service, community-based agency and is a major provider of behavioral health and wellness services on Long Island and New York City. Federation operates innovative, successful programs that are designed to meet the needs of vulnerable populations. Federation believes that family involvement in a loved one's treatment is an integral part of the recovery process for individuals who are diagnosed with mental health and/or substance use disorders.

Barbara Faron has served as the Chief Executive Officer of Federation of Organizations since 1986. Under her steadfast leadership, Federation has grown from a small not-for-profit serving Suffolk County, to a multi-faceted social service agency serving Nassau, Suffolk, Queens, Brooklyn, and the Bronx providing care to thousands of individuals each year while employing over 500 people. Beginning her career with Federation as a direct service worker in Federation's Foster Grandparent program, Ms. Faron gained hands-on experience and a keen perspective on how to develop programs that truly help others succeed.

Throughout her tenure as CEO, Ms. Faron has been the catalyst for positive change within the agency and has helped Federation adapt and grow in an ever-changing healthcare system. Her memberships include the National Association of Social Workers and the National Alliance for the Mentally Ill. Since 1990, she has served as chairperson of the Islip-Babylon Service Area Council and in October 2000, she received the second annual "People in Recovery Choice Award" from the Mental Health Association of Suffolk County. Other achievements include: the 2004 Distinguished Alumni Award from the Stony Brook University School of Social Welfare and the 2008 Town of Brookhaven Outstanding Community Service Professionals award.

Most recently, Ms. Faron was recognized as a Top Female CEO by the Smart CEO Brava Awards, a Top CEO from Long Island Business News, and a Future 50 Award winner for Fastest Growing Company, all for 2016. Ms. Faron is a Licensed Master Social Worker and a Certified Psychiatric Rehabilitation Practitioner. She holds a Master's Degree in social work from the Stony Brook University School of Social Welfare and has extensive experience in criminal justice, community organizing, aging, and mental health.

For more information on family services please contact 631-782-6200 or visit www.fedoforg.org.



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Families and Suicide: How to Engage Your Child in Conversation

By Scott Bloom, LCSW, Director
Special Projects and Initiatives
New York Psychotherapy and
Counseling Center (NYPCC)

As parents, we must balance our feelings of anxiety and uncertainty, on top of our own emotions with those of our children. There are many aspects to the relationship between suicide and families, especially having conversations to find out if children are thinking about suicide. Many parents are ambivalent to finding out if their child is suicidal. As a parent, you may not want to say anything for fear of making the situation worse or because you don't know what to say if they confirm your concerns. While these conversations can be very difficult and anxiety producing for parents, there is a lot you can do. Talking about suicide with your child provides an opportunity to address the underlying issues, correct misinformation, show that you deeply care, and ultimately get help for your child. There are many reasons why teens lock parents out from their suicidal thought, foremost is a conviction that their parents will "freak out" (Freedenthal, 2022). While parents may have a myriad of reactions from anger or dismissal, impatience to blame – in the end, parents must overcome their own barriers so that their children know that they are safe and encouraged to share their innermost thoughts about this most important topic.

Myths and Facts

It's natural to find the issue of suicide averting and it can be difficult to start the conversation. You might be concerned that you will make the situation worse or that you will ask about suicide and be mistaken. There are many myths about suicide, the top three being:

Talking about suicide gives someone the idea to take their own life. You don't



give someone suicidal ideas by talking about suicide. Rather, the opposite is true. Talking openly and honestly about suicidal thoughts and feelings can help save your child's life. By talking openly and directly you are sending the message that you care about them. Having the conversation is often felt by the child as a relief, especially when someone has been alone with these thoughts. If your child is not thinking about suicide, it can still be an opportunity to discuss why you were concerned about them and let them know you're available if things get challenging.

People who talk about suicide won't really do it. Almost everyone who attempts suicide has given some clue or warning. Don't ignore even indirect references to death or suicide. Statements like "You'll be sorry when I'm gone," "I can't see any way out,"—no matter how casually or jokingly said—may indicate serious suicidal feelings.

Anyone who tries to kill themselves must be crazy. Most suicidal people are not psychotic or insane. They are upset,

grief-stricken, depressed, or despairing, but extreme distress and emotional pain are not necessarily signs of mental illness.

Observations and Warning Signs

Suicide is often not about wanting to die; it is about wanting to end severe emotional pain. It happens when pain exceeds resources for coping. It's a complicated problem and lots of distinct conditions can make someone feel suicidal or think about suicide. For most youth, suicide isn't a socially acceptable way to solve problems or get attention (Freedenthal, 2022). Some youth may "talk" about suicide indirectly, through their writing or artwork. Pay attention to these types of communications from your child and ask about anything that seems out of the ordinary. Not every question will need follow-up, but if you hear an answer that concerns you, keep your eyes open for other signs of suicide risk (see below). Avoid making assumptions about how often or how casually suicide threats are made. Every threat should be taken seriously. Reiterate that you are there to listen, to be

present, and not to judge, no matter what he or she has to say.

Possible Warning Signs for Suicidal Behavior Include:

- Previous suicide attempts
- Talking or writing about suicide or death, even jokingly
- Seeking access to something lethal
- Being moody, withdrawn or sad
- Saying goodbye or giving away possessions. For kids this may be their favorite video games, graphic novels, clothes or other prized possessions that you know would otherwise never leave their hands.
- Losing interest in things they previously enjoyed
- Taking less care of their appearance
- Anxiety or agitation, including difficulty concentrating or sleeping
- Engaging in self-destructive or risky behavior
- Increased use of alcohol or drugs
- New York State Office of Mental Health. Suicide Prevention Center

Starting The Conversation

Preparation is the best way to manage your anxiety when communicating your concern. Sometimes conversations will be unexpected, and you won't have time to prepare, but getting prepared can make you feel more comfortable. Usually, it's better to have the conversation in person, in private, and somewhere you will both feel more at ease and unlikely to be

see Suicide on page 50



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More Than an Acronym: How LGBTQ+ Health is Transforming Industry

By Jason Gibby
Copywriter
California State University, Northridge

It's a typical scenario: you walk into the doctor's office, possibly after several postponements, afraid of what they might find. Will your blood pressure be up? Or maybe your cholesterol, you think. A myriad of possible underlying conditions flash suddenly through your head.

But what if, instead of health worries, your fear was based on who you are.

That, for most of our history, has been the experience of LGBTQ+ populations – in health care and elsewhere.

Fortunately, however, that's changing.

In today's health care industry, the ideal is no longer one size fits all. Instead, providers nationwide are now embracing a much larger umbrella, with treatments tailored to the individual and based on compassion and respect. This transformative change is important to wide demographics, but none more so than the LGBTQ+ population.

This expansive group – also known as lesbian, gay, bisexual, transgender, queer or questioning, and other non-heteronormative identities (LGBTQ+) – exists at a unique cross-section of an ever-changing health care landscape.

With the publication of the Institute of



Medicine's "Report on the Health of LGBT People," and the National Academies' comprehensive follow-up report, "Understanding the Well Being of LGBTQI Populations," plus the inclusion of LGBTQ+ people as a population of focus in Healthy People 2030, the health concerns of this population have come to the forefront of medical, social and political thinking.

For many in the LGBTQ+ community, requesting care can be an uncomfortable experience – especially when lack of access, historical prejudices or gaps in knowledge can make pursuing care difficult. That's true of everything from rou-

tine checkups to HIV+ treatment to corrective surgery.

Even today, as most larger organizations, like HMOs, strive for more inclusive care, many LGBTQ+ patients still struggle to feel accepted, included or heard.

In fact, more than half (56%) of LGBTQ+ individuals, including 70% of transgender or gender non-conforming people, report experiencing some form of discrimination and/or harsh language from health care professionals (Caceres et al., 2020).

And because of this, specialized care – focused on humane and compassionate

treatment –is necessary. That's where CSUN's Graduate Certificate in LGBTQ+ Health comes in.

This program trains current and future health practitioners and community leaders to develop and apply best practices to reduce health disparities and improve health outcomes for LGBTQ+ populations.

Not only is this program delivered fully online, but it's only one year from start to finish. In that time, learners develop hands-on skills and strategies desired by some of the largest employers in health care – from Kaiser Permanente to Facey Medical Group. They also study the historical conditions, in both industry and society, which led to limited or inadequate care for this vulnerable population.

Unlike many similar programs, CSUN's certificate is not only more comprehensive, but it's centered on the LGBTQ+ experience. The difference, again, is one of intent. Some programs are designed to professionally train participants; others, meanwhile, focus on the community. CSUN does both.

This program is a major step toward ensuring millions of Americans receive fair and compassionate treatment in facilities across the country. It's also a significant opportunity for health care professionals to expand their skillsets and specialize in a high-demand field.

see LGBTQ+ on page 49

University Certificate in LGBTQ+ Health

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Workforce from page 26

consistently, I tend to isolate and not be emotionally available for my family.”

While burnout is certainly a major cause of withdrawal from family life, another is simply the hectic schedule that behavioral health professionals are now expected to keep. In a survey in Behavioral Health News, 77% of therapists reported forgoing sick leave they would have otherwise taken in order to work. Additionally, 66% of these respondents took “substantially less vacation time than they generally would.”

With more clients to see, and less staff with which to treat them, behavioral health organizations are having to lean heavily on their remaining employees. Unfortunately, this means that many staff members do not get to spend enough time with their families. As the workforce crisis continues, this separation from family will only serve to compound the effects of burnout on behavioral health staff.



Jordan Baker

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The Challenges of Family Caregiving

By Sarah A. Lieberman, LMSW
WJCS Pathways to Care Program

Melissa is in her early 30s and moved back into her parents' home six months ago when her father was diagnosed with terminal cancer. She and her mother and brother have taken on the loving and overwhelming task of caring for her father through to the end of his life at home. Melissa was building her career and chose to suddenly stop working in order to be at home and provide care. The family understood from the beginning that her father's prognosis was poor, but nobody expected the decline to be quite as precipitous. They have brought in some home health aides but cannot afford full-time care. Melissa previously had an active life, with her partner, her work, and her hobbies. Now she finds herself increasingly isolated and depressed at a time when she knows she needs the emotional support of others.

Kay and her husband, Jerry, are both 80-years-old and have been married for 58 years. Jerry was diagnosed with Alzheimer's disease several years ago. His memory is extremely poor, and he needs increasing assistance with many day-to-day tasks. Kay finds herself feeling very overwhelmed and wishes she did not get so testy with him when he repeats himself or cannot remember something from the recent past. Jerry reportedly did "everything" around the house and Kay admits that she withdrew money from the ATM, pumped her own gas and paid some bills all for the first time recently. She describes bearing witness to her husband's cognitive decline as brutal.

As Rosalynn Carter, former First Lady and founder of the Rosalynn Carter Institute for Caregivers, has said, "there are only four types of people in the world: those who have been caregivers, who are caregivers, who will be caregivers, and who will need caregivers." The prevalence of family caregiving is borne out in the statistics. According to the 2020 Caregiving in the U.S. report, published by the National Alliance for Caregiving and the AARP Public Policy Institute, 53 million Americans are providing unpaid care for relatives and friends. Most of those caregivers (41.8 million) are looking after parents or partners, age 50 or older. The New York State Department of Health has estimated that in New York State alone about 1 in 5 adults provide in total 2.68 billion hours of unpaid care.

At the Westchester Jewish Community Services (WJCS) Pathways to Care Program, we provide individual and group support to family caregivers. The need for emotional and practical support is critical. In 2021, the Centers for Disease Control and Prevention (CDC) reported that, among over 10,000 U.S. adults surveyed



during the pandemic, parents, unpaid caregivers of adults, and parent-caregivers had significantly worse mental health than adults not in these roles. Caregiving can be relentless and managing your own time when you are also providing care to someone else is challenging. Melissa used to exercise regularly and now feels as though she has no time to go to the gym. She is sleep deprived and finds it hard to make time for herself.

Family caregivers often remark, with equal parts humor and exasperation, about the varied roles they take on. One spouse "joked" that, after her many years of caring for her chronically ill husband--taking him to appointments, advocating for him during a hospital stay, or providing hands-on care at home--she was a doctor without ever having gone to medical school. Melissa has learned how to care for her father's wounds and Kay has taken on brand new financial responsibilities. The to-do list grows, and the physical toll of caregiving can leave caregivers feeling stressed and overwhelmed.

The financial strain of caregiving is real. Kay's husband, Jerry, has been showing signs of his dementia for many years and the cost of paying for a home health aide and his twice weekly adult day health program adds up. And the uncertainty that comes along with many diagnoses, especially Alzheimer's, can be unsettling. Jerry's doctors cannot predict the precise trajectory of his disease and Kay understands she may be "in it" for the long haul.

Caring for a family member can be an isolating experience. Clients often describe feeling lonely, unable to find time to care for themselves, and fearful of asking for help. The realization that one needs assistance can often be an "aha" moment. One caregiver talks about his wife with advanced dementia. For a couple of years his adult children begged him to hire aides and find support for himself.

He ignored their suggestions stating that he was a one-man show. He eventually recognized that it does "take a village" and reached out for support.

The tips we provide family caregivers

at the WJCS Pathways to Care Program are focused on helping them manage stress and stay healthy. We provide and direct clients to where they can gather information about their loved one's condition. Becoming educated and knowing how to tap into community resources are helpful from a practical perspective and empowering from an emotional one. Kay reached out early to the Alzheimer's Association and researched grants that could assist in paying for some homecare. Melissa and her family have shared what they are going through with friends and neighbors, all of whom have been remarkably generous with providing food and respite to the family.

We encourage caregivers to learn how to be an advocate for their loved ones and for themselves. Knowing how to ask for help when you need it is essential. Support groups provide caregivers with a sense of empowerment and improve coping skills. One caregiver reminded others in a group that she believes she can take care of her husband only

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"Stigma: How Can We Make a Difference" - Deadline March 16th

A Family's Recovery Journey: An Interview with Jorge R. Petit, MD

By Kristin Streznetcky
Advocacy and Research Associate
Services for the UnderServed (S:US)

Services for the UnderServed (S:US) is a nonprofit organization that plays a critical role in the health and wellbeing of more than 37,000 of New York City's most vulnerable individuals and families each year, helping them overcome complex and challenging life circumstances. At S:US, we understand that for there to be long-term social change, we must invest in people and communities. We work to eliminate the root causes of inequity and poverty, while addressing people's unique needs—needs that are compounded by the challenges people face due to a lack of opportunity. We give people hope, providing a path to a bright future for themselves, their families, and communities, a future that is not defined by challenges, but by opportunities for all.

S:US President & CEO Jorge R. Petit, MD conducted an interview with S:US Advocacy & Research Associate Kristin Streznetcky on the challenges her family faced as impacted by mental illness and substance use disorders. Kristin is also a person served by S:US, living in one of S:US' supportive housing apartments and receiving mental health supports and services.



Jorge R. Petit, MD

Jorge: Thanks, Kristin, for so openly sharing your personal and family story with us; by telling your journey of recovery, you are a powerful voice in eradicating the stigma and taboo that still exists around mental health and substance use issues. At S:US, we are committed to righting societal imbalances and creating opportunities for all. I truly believe that these core values are embodied in your recovery journey and what respect, caring, dignity and creating a life of purpose can



Kristin Streznetcky

do to help someone, like yourself, on their own path to recovery.

Kristin: Thanks Jorge and I am honored to share my story with you. This was originally going to be a mother/son interview, but my son regrettably declined at the last minute, as the subject had dredged up some emotions that he isn't ready to revisit. I decided to disclose this because I feel humbled by the man my older son is becoming. Sometimes we think people get

over things when they truly aren't. His feelings may have subsided, but the hurt and pain that I have caused my son, during my active addiction phase, has been a far deeper scar than I could've ever imagined. As you read my story, please remember, that it's possible to accomplish anything you want when you set your mind to it!

Jorge: Why don't you start by telling us about yourself and what you are currently doing?

Kristin: My name is Kristin, and I have been blessed to be in recovery for the past nine years after struggling with mental health and substance use illnesses for 36 years. I had my first taste of illicit substances when I was 8, at the hands of my cousin who babysat me regularly, and thought it was funny to watch an 8-year-old confused and disoriented from smoking marijuana in front of her friends. I didn't start regularly using other substances until I was 12, trying to deal with multiple traumas—like being molested by a “family friend” who was supposed to be like an uncle to me—but I didn't begin experimenting with hard drugs until I was 16, eventually noticing that harder drugs drowned out the hurt and pain so much

see Journey on page 47

Most Reported Substance Use Among Adolescents Held Steady in 2022

By National Institute
on Drug Abuse (NIDA)

The percentage of adolescents reporting substance use in 2022 largely held steady after [significantly declining](#) in 2021, according to the [latest results](#) from the [Monitoring the Future survey](#) of substance use behaviors and related attitudes among eighth, 10th, and 12th graders in the United States. Reported use for almost all substances decreased dramatically from 2020 to 2021 after the onset of the COVID-19 pandemic and related changes like school closures and social distancing. In 2022, reported use of any illicit drug within the past year remained at or significantly below pre-pandemic levels for all grades, with 11% of eighth graders, 21.5% of 10th graders, and 32.6% of 12th graders reporting any illicit drug use in the past year.

The Monitoring the Future survey is conducted each year by researchers at the University of Michigan, Ann Arbor, and funded by the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health.

“The Monitoring the Future Survey is one of the best and most timely tools we have to monitor and understand changes in substance use among young people over time, including through historic events such as the COVID-19 pandemic,”



said Nora Volkow, M.D., NIDA director. “It is encouraging that we did not observe a significant increase in substance use in 2022, even as young people largely returned to in-person school, extracurricular activities, and other social engagements.”

The Monitoring the Future survey is given annually to students in eighth, 10th, and 12th grades who self-report their substance use behaviors over various time periods, such as past 30 days, past 12 months, and lifetime. The survey also documents students' perception of harm,

disapproval of use, and perceived availability of drugs. Notably, the survey results are released the same year the data are collected.

From February through June 2022, the Monitoring the Future investigators collected 31,438 surveys from students enrolled across 308 public and private schools in the United States. The completed survey from 2022 is nationally representative and represents about 75% of the sample size of a typical year's data collection. The Monitoring the Future investiga-

tors noted that schools opt-in to participate in the survey, and some schools that normally participate opted-out this year as they continued to operationally recover from the pandemic. All participating students took the survey via the web – either on tablets or on a computer – with between 95-99% of respondents taking the survey in-person in school.

The survey found that adolescents most commonly reported use of alcohol, nicotine vaping, and cannabis in the past year, and levels generally held steady with those reported in 2021. For substances where reported past-year use did increase between 2021 and 2022, the vast majority of reported use remained at or below the pre-pandemic levels observed in 2020. Compared to levels observed in 2021, data reported in 2022 show:

- **Nicotine vaping** remained stable for all three grades surveyed, with 12% of eighth graders, 20.5% of 10th graders, and 27.3% of 12th graders reporting vaping nicotine in the past year.
- **Cannabis use** also remained stable for all three grades surveyed, with 8.3% of eighth graders, 19.5% of 10th graders, and 30.7% of 12th graders reporting cannabis use in the past year. Of note, 6.0% of eighth graders, 15.0% of 10th graders, and 20.6% of 12th graders reported **vaping**

see Substance Use on page 46

Behavioral Health News Spotlight on Excellence: An Interview with Mitchell Netburn, President and CEO of Samaritan Daytop Village

By Staff Writer
Behavioral Health News

David Minot, Executive Director of Mental Health News Education, the non-profit organization that publishes Behavioral Health News, interviewed Mitchell Netburn, President and CEO of Samaritan Daytop Village, a nonprofit organization that has been improving the quality of life for New Yorkers for over 60 years through addiction and mental health treatment and supportive housing.

David Minot: Hi and welcome to the Behavioral Health News Spotlight and Excellence series where we feature exceptional leaders in innovative healthcare solutions that are raising the standards of care in the behavioral health community. My name is David Minot and I am the executive director of Mental Health News Education, a nonprofit organization that publishes Behavioral Health News and Autism Spectrum News. Our mission is devoted to improving the lives and delivery of care for people living with mental illness, substance use disorder, and autism, while also supporting their families and the professional communities that serve them. By providing a trusted source of science-based education, information, advocacy, and quality resources, we aim



Watch the Interview with Mitchell Netburn, President and CEO of Samaritan Daytop Village

to improve the delivery of care for those in need. Today, we're speaking with Mitchell Netburn, the President and CEO of Samaritan Daytop Village, a nonprofit organization that has been improving the quality of life for New Yorkers for over 60 years through addiction and mental health treatment and supportive housing. Mitchell, thanks so much for being here with us today.

Mitchell Netburn: Thank you so much for having me and for focusing on Samaritan Daytop Village.

David: So how about we begin with talking about the mission of Samaritan Daytop Village and sharing an overview of the services provided and the people served.

Mitchell: Sure. Our mission is pretty simple: it's to help people help themselves. That's really what we're about, giving them the tools to overcome whatever challenges they have and doing it in a client-centered way, meaning asking our clients what their goals are and what is the best way for them to reach those goals.

We don't have a cookie-cutter approach; we provide a full range of services. We like to say we're from "crinkle to wrinkle," meaning we serve little kids and pregnant moms all the way to seniors. Our main area of focus is certainly substance use disorder, and we have a full range of substance use disorder services: residential treatment, outpatient clinics, recovery centers, and more. We've also added mental health services over the years, understanding the link between the two even before it became government policy. We operate a large number of shelters for single men, single women, and families. We have a Senior Center, we run a few proprietary schools for youth with behavioral health issues, and we have employment and education programs. So, we really like to say that we can offer people in need whatever services they need to help them live independent, fully productive lives.

David: You certainly keep busy! I've read that Samaritan has opened a few new facilities in the past year. Perhaps you can tell us about the Richard Pruss Wellness Center and why this is a transformative addition to an underserved community.

Mitchell: First of all, I'd like to provide a little bit of history. Richard Pruss was the

see Spotlight on page 51

An Overview of Seasonal Affective Disorder

By The National Institute of Mental Health (NIMH)

Many people go through short periods of time where they feel sad or not like their usual selves. Sometimes, these mood changes begin and end when the seasons change. People may start to feel “down” when the days get shorter in the fall and winter (also called “winter blues”) and begin to feel better in the spring, with longer daylight hours. In some cases, these mood changes are more serious and can affect how a person feels, thinks, and handles daily activities. If you have noticed significant changes in your mood and behavior whenever the seasons change, you may be suffering from seasonal affective disorder (SAD), a type of depression. In most cases, SAD symptoms start in

the late fall or early winter and go away during the spring and summer; this is known as winter-pattern SAD or winter depression. Some people may experience depressive episodes during the spring and summer months; this is called summer-pattern SAD or summer depression and is less common.

What Are the Signs and Symptoms of SAD?

SAD is not considered a separate disorder but is a type of depression characterized by its recurrent seasonal pattern, with symptoms lasting about 4 to 5 months per year. Therefore, the signs and symptoms of SAD include those associated with major depression, and some specific symptoms that differ for winter-pattern and summer-pattern SAD. Not every person with SAD will experience all of the symptoms listed below. Symptoms of major depression may include:

- Feeling depressed most of the day, nearly every day
 - Losing interest in activities you once enjoyed
 - Experiencing changes in appetite or weight
 - Having problems with sleep
 - Feeling sluggish or agitated
 - Having low energy
 - Feeling hopeless or worthless
 - Having difficulty concentrating
 - Having frequent thoughts of death or suicide
 - For winter-pattern SAD, additional specific symptoms may include:
 - Oversleeping (hypersomnia)
 - Overeating, particularly with a craving for carbohydrates, Weight gain
 - Social withdrawal
 - Trouble sleeping (insomnia)
 - Poor appetite, leading to weight loss
 - Restlessness and agitation - Anxiety
 - Episodes of violent behavior
- How is SAD Diagnosed?
- If you think you may be suffering from SAD, talk to your health care provider or a mental health specialist about your concerns. They may have you fill out specific questionnaires to determine if your symptoms meet the criteria for SAD.

see SAD on page 38

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Centering the Family: What It Means to Implement Family-Focused Practice (FFP) in Adult Mental Health Care

By Matt Kudish, CEO
National Alliance on Mental Illness
of New York City (NAMI-NYC)

Providers have an important role and responsibility to engage families when patients have a psychiatric hospitalization. HIPAA is often used to deny patients' families access to critical information. By educating and engaging families along the way, we can significantly reduce patient readmission and improve after-care.

In partnership with Manhattan Together, NAMI-NYC surveyed patients who have had a psychiatric ER visit in NYC. The ER experience improved when patients were able to stay with their families. With their families, patients found hospital staff provided them with support and that they were treated with dignity. When families are excluded during hospitalization, patients not only had a worse experience, but hospital staff are functioning without critical family knowledge. Our survey found that families often wanted to give hospital medical staff information about the patient's situation at home but were not allowed to do so during admission.

Family members have patient history and "real time" observations that practitioners do not have access to. Families



would also be aware of Psychiatric Advance Directives (PAD), which is a legal document outlining a person's preferences for future mental health treatment and names an individual to make decisions when the patient is in crisis. PADs are highly underutilized in clinical settings even though such documents can prevent coercive crisis interventions.

This recent psych ER survey and stories

from our community tell us that we need to center the family in adult mental health services. Family-Focused Practice (FFP) is a "whole family" approach to care, including family care planning and goals, a family and service liaison, individual and family focused support, individual and family-focused assessment, psychoeducation, and a coordinated system between families and services. ⁱⁱ It also emphasizes

the relational aspect of the recovery journey, as well as acknowledges intergenerational mental health needs. ⁱⁱⁱ

A study of 200 inpatients with serious mental illness at New York hospitals in 2019 found that family involvement was beneficial. Family involvement was defined as at least one interaction between family and inpatient staff, including discussion of services available to the family, the patient's health or mental health, discharge date, post discharge treatment plan, post discharge residence, warning signs of decompensation, ways to prevent readmission, or concerns about discharge or treatment. When there were family phone calls or visits, attendance at family therapy sessions, and communication with staff, patients were more likely to receive comprehensive discharge planning. Family engagement was also significantly associated with entry into follow-up care within 7 to 30 days of discharge, and adherence to post discharge medication.

The pandemic provided lessons on how to communicate with families too. One NYC study offers best practices for working with families, as well as supporting them. ⁱ The hospital teams – the palliative care and psychiatric departments -- created a new remote liaison role for

see Centering on page 52

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The Integral Role of Families in Promoting Mental Health and Managing Mental Illness

By Crystal Taylor-Dietz, PsyD
and Amy Kelly, MBA, MNM
Devereux Advanced Behavioral Health

When you think about those at the forefront of managing mental health concerns – psychiatrists, psychologists, therapists, counselors and other professionals may come to mind. However, former Surgeon General Dr. David Satcher released a mental health report in 2000 that declared “families are the primary source of care and support for the majority of adults and children with mental problems or disorders” (Satcher, D., 2000).

Prior to the COVID-19 pandemic, approximately 21% of Americans suffered from a mental illness (that number has since increased), and of those, only 40% sought mental health services. For youth and adults who seek services, the average amount of time that passes between the onset of initial symptoms and treatment is 11 years (NAMI).

Families play an integral role in an individual’s mental health journey, and family involvement has a significant impact on the ways in which someone thinks about their mental health, their willingness to seek services and their level of trust with mental health professionals.



Family involvement vs. family engagement: Family engagement is a term used to describe the active contribution of a family throughout treatment as an equal partner of the care team, while family involvement is less interactive and collaborative. Family engagement refers to ongoing, goal-directed relationships between families and providers that are mutually and culturally responsive. Family engagement plays a critical role in successful interventions and outcomes in behavioral

health treatment.

Collaborating with families in culturally responsive ways is particularly important when considering the impact of mental health stigma on the utilization of, and engagement with, mental health interventions. Stigma is the external (public) and internal (self) negative perceptions one has about mental health challenges (www.mcleanhospital.org). While stigma is universal, it is even more prominent in historically marginalized cultures and

communities. Often, culture-specific stigma is internalized by individuals and families, which impacts help-seeking behavior and contributes to mistrust of mental health professionals. Successful engagement with families, including extended family, has the potential to minimize stigma by helping providers better understand the specific historical and cultural perceptions a family holds regarding mental health issues and treatment, and allowing for the development of culturally responsive and sensitive approaches to rapport-building and interventions (Lindsey, Joe & Nebbitt, 2010).

In the field of mental and behavioral health treatment, the [National Building Bridges Initiative](#) and the [2018 Family First Prevention Services Act](#) have set high standards for the implementation of increased family engagement across provider services, particularly in residential treatment settings or out-of-home care. These initiatives have led to shortened lengths of stay, improved behavioral health outcomes, increased community connections and natural supports, and sustained success post-discharge. These programs have also demonstrated the importance of frequent and continual contact with the family so they can contribute to

see Promoting on page 53



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Ketamine for Mental Health Treatment: How Promising Is It?

By Caroline Emmitt, MSW
and Izabela Sadej, LSW
Partnered Evidence-based
Policy Resource Center (PEPRcC)

For centuries, we have sought cures for depression. Some discoveries, such as psychotherapy and medication treatment, are now widely accepted. But they don't work for everyone. More recently, an unorthodox drug has garnered attention as a new, possible intervention: ketamine.

Classified as a mental health disorder, depression can also affect physical health, negatively impacting most of the body's systems. Compared to pre-pandemic reporting, depressive symptoms among adults in the United States tripled during the COVID-19 pandemic.

Depression is often treated with pharmaceutical antidepressants, but they have their limitations. Most antidepressants, like Prozac, are selective serotonin reuptake inhibitors (SSRIs). About 30% of adults with depression don't respond to SSRIs. That's because SSRIs target less than 20% of the neurotransmitters in a person's brain, and the 80% that are left untreated are believed to be responsible for regulating most brain activity, including mood.

It's clear that new pharmaceutical treatments for depression are necessary. This is where ketamine emerges as a possible



candidate. While classified as a Schedule III non-narcotic substance and typically only used for anesthesia, there are now medical exemptions for ketamine use for mental health diagnoses, with new research showing promise in successful treatment of depression and suicidality, though not without notable risk.

How it Works

Some say ketamine is a "miracle drug." So, what makes it different from other treatments?

On a clinical level, ketamine works fast

and well. As a rapid acting antidepressant, users experience same-day relief after an infusion, with measurable effects three to four hours after treatment. Low-dose infusions can last five to seven days, with high-dose infusions lasting even longer. Repeated injections have shown to successfully decrease suicidal ideation by 69%, a groundbreaking discovery given that suicide remains a leading cause of death in the United States.

On a biological level, ketamine triggers glutamate production, allowing the brain to forge new neural pathways, including new positive thought patterns. Ketamine

is also believed to reduce inflammation and promote the regeneration of connections between brain cells damaged by stress, which has been linked to mood disorders.

There are two types of ketamine used for depression, often administered in conjunction with antidepressants. Ketamine can be administered by nasal spray, infusion, intramuscular shot, or sublingual lozenge. Except when in lozenge form (a much lower dose), ketamine can only be administered in monitored clinical settings.

Risks

Using ketamine to treat depression isn't risk-free. In fact, it can be quite risky for some. The potential side effects emphasize the importance of treatment being administered by a trained clinician.

Ketamine is a dissociative drug that can distort a user's sensations and increase feelings of detachment from the environment and self. Possible side effects range from nausea and vomiting to "out-of-body" catatonic experiences, often referred to as "k-holes," which can include hallucinations and the inability to speak or move. Some research suggests that regular ketamine use can lead to ongoing dissociative and psychotic symptoms. Further study is needed to determine the risks of frequent dissociative experiences, even

see Ketamine on page 54

Using the Partnership to End Addiction's Online Risk Assessment Tool to Assess and Combat Children's Risk of Developing Addiction

By Mithra Salmassi
Research and Outreach Coordinator,
Service Equity and Inclusion
Partnership to End Addiction

As a society, we're well versed in the factors that can increase our risk for diseases like cancer and diabetes. But what about risk factors for addiction?

Addiction, like diabetes and cancer, is a disease. And as a disease, it is caused by a combination of many different factors: behavioral, psychological, environmental, biological, and genetic. Depending on a child's combination of risk factors, some may be more likely to progress from initial use to problem use to a substance use disorder. The teen brain undergoes massive changes, only ending in one's mid-20s, and substance use can thus adversely impact development, especially for children with risk factors.

For a parent or caregiver, the idea of their loved one developing a substance use disorder is terrifying. But being aware of these risk factors and using available tools, such as those from the Partnership to End Addiction can help parents reduce their child's risk and get them necessary support.



Risk Factors for Addiction

There are several prominent risk factors that can make some individuals more vulnerable to developing a substance use disorder.

Genetic risk factors and a family history of addiction are of real concern, accounting for about half of the likelihood that an

individual will develop addiction. Environmental concerns, such as current substance use in the family or among friends, as well as exposure to trauma, also increase a child's likelihood of developing a substance use disorder.

Mental health concerns, such as depression or ADHD, can also increase a child's risk of substance use. Co-occurring disor-

ders are very prominent among youth, as 30% – 45% of adolescents and young adults with mental health disorders have a co-occurring substance use disorder, and 65% or more of youth with substance use disorders also have a mental health disorder. Youth with behavior and impulse control issues who may frequently take risks and flaunt rules are also at higher risk of developing a substance use disorder.

Finally, a key risk factor for substance use is one's age of initiation. Research shows that the earlier substance use is initiated, the more at risk they are of developing a substance use disorder. According to the Substance Abuse and Mental Health Administration (SAMHSA) to late adolescence – between the ages of 12 and 17 – are a critical period for youth when it comes to their risk of developing a substance use disorder. This means that preventing substance use in young people is essential.

It is important to note that these risk factors do not automatically determine that one will develop a substance use disorder. Rather, being aware of them can help gauge whether there is potential for an issue. This is where the Partnership's online risk assessment tool can come in handy.

see Addiction on page 40

Using the Seven Principles of Afrocentricity to Frame a Community-Based Organization's Programs and Services for Individuals, Families, and Communities

By Nadjete Natchaba, EdD, LCSW, MPA
Chief Operating Officer
Behavioral Health Services
Services for the UnderServed (S:US)

Services for the UnderServed (S:US) is one the largest community-based, health and human services organizations in New York State and intentionally works daily to "right" societal imbalances by providing comprehensive and culturally responsive programming. The need to fulfill its mission of driving scalable solutions and transforming lives and communities means approaching care for people served in a manner that not only acknowledges their multiple identities but also the critical role of blood or chosen families in the treatment process. Over 90% of the people served and employed by S:US identify as Black, Indigenous, People of Color (BIPOC). According to SAMSHA's 2018 National Survey of Drug and Health, 16 percent (4.8 million) of Black and African American people reported having a mental illness, and 22.4 percent of those (1.1 million people) reported a severe mental illness over the past year and (SMI) rose among people of all ages, Black and African American, between 2008 and 2018. It is also well established that Black and African American people living below the poverty level are twice as likely to report



severe psychological distress than those living over two times (2x) the poverty level. Adult Blacks and African Americans are more likely to experience sadness, hopelessness, and worthlessness than adult whites, but sadly, many believe that discussions about mental illness would not be appropriate even among families. To compound matters even further, coping mechanisms for African people consist of either assimilating, over-compensating, or internalizing messages

from western worldviews that are harmful to Black bodies.

As service providers, we are responsible for finding effective ways to take care of BIPOC people who are living with different abilities. Carlton-LaNey refers to implementing culturally relevant responses to meet the unique needs of Black communities as "race work" and emphasizes its roles in collectively advancing social justice and changing community services. S:US starts the process of righting societal

imbalances by acknowledging systems of power, knowledge, and culture that uphold coloniality which is the "long-standing patterns of power that emerged as a result of colonialism but that define culture, labor, intersubjective relations, and knowledge production well beyond the strict limits of colonial administrations." Afrocentricity is one framework for an organization to consider as they develop programs to serve BIPOC people in their communities. The three objectives of Afrocentricity, as outlined by Schiele, are (1) to promote an alternative social science concept more aligned with the cultural and political reality of African Americans, (2) to refute damaging misrepresentations about people of African ancestry via spreading a worldview rooted in whiteness but unfortunately ingrained in many people of African descent, (3) to advance a worldview that fully supports human and societal change toward spiritual, moral, and humanistic ends that will encourage people of different cultural and ethnic groups to connect over a mutual interest. Dr. Karenga also operationalized the concept of Afrocentricity by developing the "Nguzo Saba" which means seven principles in Swahili as the matrix and a minimum set of values people of African descent who are now Americans can use to reconstruct their lives to mirror

see Afrocentricity on page 42

NIH Launches Harm Reduction Research Network To Prevent Overdose Fatalities

By National Institutes of Health (NIH)

To address the overdose crisis in the United States, the National Institutes of Health has established a research network that will test harm reduction strategies in different community settings to inform efforts to help save lives. The harm reduction research network's efforts build on existing harm reduction research and represent the largest pool of funding from NIH to date to study harm reduction strategies to address overdose deaths.

More than 107,000 people in the United States died from a drug overdose in 2021, according to provisional data from the U.S. Centers for Disease Control and Prevention. These deaths are largely driven by the proliferation of cheap, potent synthetic drugs like fentanyl contaminating the drug supply, including in heroin, cocaine, methamphetamine, and counterfeit pills.

Harm reduction is an evidence-based, often life-saving approach that directly engages people who use drugs to prevent overdose, disease transmission and other harms. Researchers will test strategies to connect enrolled participants who use drugs with services and treatments and measure the effectiveness of these inter-



ventions in reducing overdose deaths and other outcomes.

"Getting people into treatment for substance use disorders is critical, but first, people need to survive to have that choice," said National Institute on Drug Abuse (NIDA) Director Nora D. Volkow, M.D. "Harm reduction services acknowledge this reality by aiming to meet people where they are to improve health, prevent overdoses, save lives and

provide treatment options to individuals. Research to better understand how different harm reduction models may work in communities across the country is therefore crucial to address the overdose crisis strategically and effectively."

Funded by the NIH Helping to End Addiction Long-term Initiative, or NIH HEAL Initiative, through NIDA, the awards are expected to total approximately \$36 million over five years, pending

the availability of funds. Studies will enroll participants to investigate a range of harm reduction approaches, such as distributing naloxone, a lifesaving medication to reverse overdose, and fentanyl test strips, which people can use to determine if drugs are contaminated with fentanyl.

The research network will also examine the efficacy of moving harm reduction services and tools into communities via mobile vans, peer support specialists, internet- and smartphone-based tools and other types of outreach. By offering these services, harm reduction may be a first step interaction that also helps people access treatment for addiction and other healthcare.

Novel forms of harm reduction services may prove helpful in rural areas of the country, where people may need to travel long distances to receive care and services. According to 2020 CDC data, rural counties experienced 26.2 overdose deaths per 100,000 people, which was only slightly lower than the rates in urban counties (28.6 deaths per 100,000 people); overdose deaths involving psychostimulants were higher in rural counties than in urban counties from 2012 through 2020. Additionally, several projects will be aimed at populations disproportionately

see Fatalities on page 41

Applied Behavior Analysis as a Treatment for Survivors of Trauma

By Jeridith Lord, MA, LCPC
Adjunct Professor, Clinical Counselor
Endicott College

Understanding trauma has become a major focus for many different fields of mental health, with each proposing a different strategy for addressing traumatic symptoms and core issues. This has not been an easy feat for several reasons. First, the current reports of trauma are only as accurate as the population making them; trauma is an immensely personal and painful experience for the individual, so many survivors decline to report. Second, there are a wide variety of traumas that may have an impact; while traditionally, trauma is spoken of as an “emotional response to a terrible event like an accident, rape, or natural disaster” (APA, 2019), there is now growing research to support the variable, subjective nature of trauma identified through adverse childhood experiences. Third, trauma is difficult to understand due to its two-fold nature: a traumatic incident must occur *and* there must be an associated emotional reaction. While an individual may have had a documented traumatic experience, they are not automatically going to have a traumatic response.

The complexities of trauma cannot be understated and require the clinician to have



intensive, specialized training to reduce the risk of retraumatization of the survivor. The two modules of therapy that have been traditionally used to reduce the symptoms of trauma have been cognitive behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR). While both have had success with survivors, the author would like to propose a third option for consideration: Applied Behavior Analysis (ABA). Although ABA has been traditionally applied towards individuals with devel-

opmental disabilities, its dedication to evidence-based interventions, data driven results, and contingency management makes it a viable option.

An Overview of Trauma

Current Reports on Trauma: As described above, accurate reports of trauma can be difficult to verify when it comes to analyzing national trends. This is directly related to the individual comfort of the

survivor and the accessibility of the resources. If the individual does not feel safe reporting, they won't. If the individual does not report, then those are not added to the statistics.

The current data suggests that over sixty percent of men and fifty percent of women have had a traumatic experience in their background (DVA, 2018). Men typically report traumatic responses as a result from accidents involving bodily harm, physical assault, military combat, national disaster, or from witnessing a traumatic incident. Women typically report traumatic responses as a result of sexual abuse as a child or rape (DVA, 2018). Finally, it is estimated that approximately six percent of the population are diagnosed with PTSD every year as a result of experiencing trauma (DVA, 2018).

Different Types of Trauma: While the American Psychiatric Association's definition of a traumatic event is limited to “a terrible event like an accident, rape, or natural disaster” (APA, 2019), there has been significant expansion to other experiences that may contribute to trauma responses. The most common indicators of future trauma responses are typically cited as adverse childhood experiences (ACEs) and include elements such as physical abuse, sexual abuse, emotional abuse,

see Trauma on page 55

SAD from page 33

To be diagnosed with SAD, a person must meet the following criteria:

- They must have symptoms of major depression or the more specific symptoms listed above.
- The depressive episodes must occur during specific seasons (i.e., only during the winter months or the summer months) for at least 2 consecutive years. However, not all people with SAD do experience symptoms every year.
- The episodes must be much more frequent than other depressive episodes that the person may have had at other times of the year during their lifetime.

Who Develops SAD?

Millions of American adults may suffer from SAD, although many may not know they have the condition. SAD occurs much more often in women than in men, and it is more common in those living farther north, where there are shorter daylight hours in the winter. For example, people living in Alaska or New England may be more likely to develop SAD than people living in Florida. In most cases, SAD begins in young adulthood.

SAD is more common in people with major depressive disorder or bipolar disorder, especially bipolar II disorder, which is associated with recurrent depressive and hypomanic episodes (less severe than the full-blown manic episodes typical of bipolar I disorder). Additionally, people with

SAD tend to have other mental disorders, such as attention-deficit/hyperactivity disorder, an eating disorder, an anxiety disorder, or panic disorder. Learn more about these disorders by visiting the [NIMH Mental Health Information](#) page.

SAD sometimes runs in families. SAD is more common in people who have relatives with other mental illnesses, such as major depression or schizophrenia.

What Causes SAD?

Scientists do not fully understand what causes SAD. Research indicates that people with SAD may have reduced activity of the brain chemical (neurotransmitter) serotonin, which helps regulate mood. Research also suggests that sunlight controls the levels of molecules that help maintain normal serotonin levels, but in people with SAD, this regulation does not function properly, resulting in decreased serotonin levels in the winter.

Other findings suggest that people with SAD produce too much melatonin—a hormone that is central for maintaining the normal sleep-wake cycle. Overproduction of melatonin can increase sleepiness.

Both serotonin and melatonin help maintain the body's daily rhythm that is tied to the seasonal night-day cycle. In people with SAD, the changes in serotonin and melatonin levels disrupt the normal daily rhythms. As a result, they can no longer adjust to the seasonal changes in day length, leading to sleep, mood, and behavior changes.

Deficits in vitamin D may exacerbate these problems because vitamin D is believed to promote serotonin activity. In

addition to vitamin D consumed with diet, the body produces vitamin D when exposed to sunlight on the skin. With less daylight in the winter, people with SAD may have lower vitamin D levels, which may further hinder serotonin activity.

Negative thoughts and feelings about the winter and its associated limitations and stresses are common among people with SAD (as well as others). It is unclear whether these are “causes” or “effects” of the mood disorder, but they can be a useful focus of treatment.

How is SAD Treated?

Treatments are available that can help many people with SAD. They fall into four main categories that may be used alone or in combination:

- Light therapy
- Psychotherapy
- Antidepressant medications
- Vitamin D

Talk to your health care provider about which treatment, or combination of treatments, is best for you. For tips for talking with your health care provider, refer to the NIMH fact sheet, [Taking Control of Your Mental Health: Tips for Talking With Your Health Care Provider](#).

Light Therapy

Since the 1980s, light therapy has been a mainstay for the treatment of SAD. It

aims to expose people with SAD to a bright light every day to make up for the diminished natural sunshine in the darker months.

For this treatment, the person sits in front of a very bright light box (10,000 lux) every day for about 30 to 45 minutes, usually first thing in the morning, from fall to spring. The light boxes, which are about 20 times brighter than ordinary indoor light, filter out the potentially damaging UV light, making this a safe treatment for most. However, people with certain eye diseases or people taking certain medications that increase sensitivity to sunlight may need to use alternative treatments or use light therapy under medical supervision.

Psychotherapy or “Talk Therapy”

Cognitive behavioral therapy (CBT) is a type of [talk therapy](#) aimed at helping people learn how to cope with difficult situations; CBT also has been adapted for people with SAD (CBT-SAD). It is typically conducted in two weekly group sessions for 6 weeks and focuses on replacing negative thoughts related to the winter season (e.g., about the darkness of winter) with more positive thoughts. CBT-SAD also uses a process called behavioral activation, which helps individuals identify and schedule pleasant, engaging indoor or outdoor activities to combat the loss of interest they typically experience in the winter.

When researchers directly compared CBT with light therapy, both treatments

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What Can Families Expect After Drug Rehab?

By Dr. Lea McMahon, LPC, EdD
Chief Clinical Officer
Symetria Recovery

The first step when a loved one leaves rehab is to determine if they are serious about sobriety. Worrying or constant monitoring doesn't help. But, pretending everything is OK, because you want it to be OK, is even more harmful. Walk the thin line of being supportive, yet aware and ready to speak up. A relapse doesn't mean failure, but it can't go unaddressed. Here are the five most common warning signs to look for.

1) Are they asking for money?

Part of the recovery process is stepping up to take responsibility. This includes maintaining a job or committing to school (or both). It's not uncommon for family members to be manipulated in additive addiction. Putting an end to manipulation is a huge part of their (and your) healing. Things like paying for the first few months of sober living can be helpful, but don't be afraid to verify where the money is going. You can ask for account passwords, call the company, get copies of the bill or pay directly without completely taking over their finances for them. Ultimately, giving your loved one money shouldn't be the norm.



2) Are they reverting back to their old schedule?

You'll almost always notice suspicious behaviors before you confirm a relapse. If they're staying out late, sleeping in, not coming home or avoiding family dinners, it's time to reach out. These types of behaviors show the person is letting their healthy lifestyle slip. They may even be back in addiction and

it's controlling their life and dictating their schedule.

3) Are they hanging around the same people and places?

Avoiding old drug-using networks and friends is one of the best strategies to prevent relapse. ("The Recovery from Dependent Drug Use: Addicts' Strategies for Reducing the Risk of Relapse," 2022) If someone is

hanging around the same people and going to the same places, they'll be constantly reminded and tempted. Life after rehab should include new friends, meetings, a sponsor and hobbies. If you don't see them changing where they spend their time, they may not be serious about recovery. And, you should act accordingly.

4) Do they change the subject when you ask about their recovery?

Addiction is often a source of shame, but recovery should come with pride and accomplishment. While recovery doesn't have to define them, they should be happy to tell you they're still on the right path. If they've slipped back into addiction, they won't want to talk. It's embarrassing, and they probably feel guilty. Most people would rather change the subject or walk away rather than lie. Don't stop asking just because they shut you down. In fact, address that specifically.

5) Have they stopped actively working on their recovery?

Recovery is a life-long commitment. Even people that are 10, 20, 40 years sober go to support meetings and see therapists. (That's why they're still sober). If your loved one isn't following the recommendations, it's a sign they're still stuck in

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The Silent Battlefield of Veteran Suicide and the Measures Being Taken to Help Them

By Claire Szewczyk
Digital Content Coordinator
Hill & Ponton, P.A.

On Friday, May 30th, 2014, I woke up to one of the most devastating phone calls I've ever received. My best friend for almost a decade, Joshua Drury, who was in his mid-thirties at the time, had taken his life. Joshua had served many years in the U.S. Army prior to our meeting. While he told us stories about his time in the military over the years, including many that involved him off-roading in tanks (his favorite ones to tell), there was a lot he stayed silent about. Many struggled wondering if we had known more, if we could have helped him in some way. Yet his pain would always remain a mystery to those who loved him. Unfortunately, my friend Joshua's story is not an uncommon one. Veterans comprise nearly a quarter of suicide deaths in the United States, every year. **The suicide rate is over 1.5 times higher** than that of the general population. To put this in better perspective, about 20 veterans commit suicide every single day. Not only that, but Veteran suicide-related deaths are increasing at a greater rate than that of the general U.S. population.



The Factors Behind Disproportionate Suicide Rates

There seems to be a wide number of factors that contribute to the risk of suicide among veterans. Military service can lead to a variety of mental health issues, the most common being Post-Traumatic Stress Disorder (PTSD), and depression, as well as other serious conditions like substance abuse disorders and chronic pain. To complicate matters, veterans often experience systemic barriers in their at-

tempts to access much-needed health care. The Department of Veterans Affairs (VA) has stated many times that **preventing suicides is a top concern** and clinical priority, and has made a variety of resources available to the community, including therapy, mobile apps, and other trainings. However, a wide number of bureaucratic hurdles, including availability of healthcare providers, long wait times, and financial qualifications and concerns, prove to be never-ending obstacles that discourage veterans from trying to obtain

the care that they need. It is interesting to note, that while access to healthcare services may be a hurdle for many veterans, in a 2020 report from the VA, a staggering 40% of those who received care from the Veterans Health Administration (VAHA), had an encounter with them at least once within the year leading up to their death. Other research indicated that **56% of male VHA patients** with substance abuse disorders who died by suicide had a VHA encounter within a month before their death, and 25% the week prior. These statistics make a very profound statement: how absolutely critical it is to be able to identify patients experiencing suicidality—including suicidal thoughts, plans, self-harm and suicide attempts—and to be able to connect them with evidence-based treatment options.

The VA's 10-Year Suicide Prevention Plan for Veterans

In 2018, the VA released a 10-year strategy to help prevent suicide among the veteran population. This plan included a wide variety of approaches, including better treatment plans and services for veterans identified as high risk, and

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Online Risk Assessment Tool

To help parents and caregivers understand if their child is at risk of developing a substance use disorder, Partnership to End Addiction and Kaiser Permanente have developed an [online substance use risk assessment tool](#). This tool provides parents with the essential ability to screen their own children and act if necessary.

The tool consists of 19 questions and takes between 5-6 minutes to complete. The questions asked throughout the tool concern risks related to mental health, well-being, personality, family history, and environment. Each question contains information on why it is a relevant ask, and parents can skip any question they would prefer not to answer. Parents are also advised that this is not a diagnostic tool and should get a professional evaluation if they believe their child has a substance use disorder.

The first questions in the tool are statements posed to parents that they are tasked to agree or disagree with, such as “As a parent, I have trouble enforcing rules for my teenage child.” To answer, they are provided with a scale of responses: “don’t know”; “disagree strongly”; “disagree somewhat”; “agree somewhat”; and “agree strongly.”

After these statements, parents are asked factual questions regarding their child’s environment, mental health, family history, and more, such as “At least one of my teenage child’s parents or current caregivers has seen a healthcare provider about a mental health problem.” They can then respond “yes,” “no,” or “I don’t know.”



Mithra Salmassi

The tool then asks whether parents are aware if their teenage child uses substances: tobacco/nicotine, alcohol, marijuana, and/or drugs such as cocaine and methamphetamine and non-prescribed prescription drugs. They can respond with “don’t know”; “never”; “used to”; “at times (monthly use)”; or “often (weekly use or more).” Finally, parents are asked how old they believe their child started using substances if they suspect their child is using substances. Age categories range from 11 or younger; 12-14; 15-17; and 18 or older.

Once the parent has filled out the risk assessment tool, they are directed to their results. The results page informs them on how many risk factors they’ve identified

and lists each one with relevant information and feedback on how to lessen their loved one’s likelihood of developing problems with substance use if they do have an increased risk. Parents are directed to relevant articles and resources on the Partnership website.

Playbooks for Parents of Teens and Tweens

Understanding a child’s potential risk factors is crucial, but the next step is knowing what to do about them. The Partnership has developed a playbook for parents of [teens](#) and one for [tweens](#), respectively, to protect their child’s wellbeing, handle challenges they may face, and preempt future problems.

These playbooks offer information and resources on how to deal with challenges such as mental health problems, behavioral issues, stress from social media, peers, difficult family circumstances, and substance use. The playbook for parents of teens focuses on the protective factors that can combat the risk factors in their child’s life. The playbook for parents of tweens is intended for parents of children aged 7-12 and centers on the importance of early intervention to minimize the impact of environmental, behavioral, and mental risk factors.

It can be overwhelming for parents to know exactly how to support their child, and scary to know that there are factors out of their control that can impact their child’s health. But these tools can help parents identify and resolve problems early.

For more information or to access support services, visit the [Partnership to End](#)

[Addiction’s website](#). To [connect with a specialist](#), text [CONNECT](#) to 55753.

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emphasizing suicide prevention initiatives.

One of the components of this initiative, included a universal screening. This screening briefly assessed patients for risk of suicide upon intake at a health care facility. It was conducted regardless of whether the patient was exhibiting signs of suicidality.

Over the past few years, [research on this screening](#) has indicated that it was effective in identifying suicidal risk from the entire population, verses just those seeking mental health care.

Even data outside of the VA medical system seems to indicate similar results. Looking at the general population, research has shown that [about half the people who die by suicide](#) visited a mental healthcare provider in the months before their deaths. Including a universal screening as a part of comprehensive suicide care, can greatly aid in the prevention of unnecessary deaths.

These screenings are so important, that between the screening and evidence-based interventions, the reduction in total sui-

cide attempts [was over 30% in one year](#) of data that was analyzed.

Charities That Support Veterans’ Mental Health

There are a wide number of charities that help support veterans and their mental health needs. This list encompasses some of the more well-known and larger ones, including: the Wounded Warrior Project, Headstrong Project, Combat Stress, and K9s For Warriors.

Wounded Warrior Project: Mental Health for Wounded Veterans: The [Wounded Warrior Project](#) was founded in 2003 by a group of veterans with the desire to help wounded servicemen and women. They offer a variety of vital services, including mental health services.

Headstrong Project: Evidence-Based, Trauma-Focused Treatment: The [Headstrong Project](#) was founded in 2012, to provide mental health services to military personnel and veterans. They provide these services free of charge, regardless of

discharge status or military branch.

Combat Stress: Mental Health Support for Veterans: Founded in 1919, [Combat Stress](#) was created by a group of philanthropists who wanted soldiers affected by “shell shock” (or what is more commonly referred to as Post-Traumatic Stress Disorder now), to be rehabilitated. The charity provides mental health services to all veterans after their involvement in conflict.

K9s For Warriors: Service Dogs for Veterans: [K9s For Warriors](#) was founded in 2011, by a mother who noticed how a dog helped her veteran son’s mental health, after he was diagnosed with PTSD. Today, they train shelter dogs to become service dogs for combat veterans returning from service with PTSD.

While the Future Looks Optimistic, There’s Still Need for Improvements

In the 2022 National Veteran Suicide Prevention Annual Report, data from 2001-2020 was analyzed. [The report findings](#) indicated that there was a drop in

suicides over the last few years, about 350 from 2019-2020. However, the statistics still hold true—one quarter of the nation’s suicides are veterans, and even with the improvement, there were still 6,146 veteran suicides in 2020.

In some studies and analysis’, the rate of suicide among veterans may be more than double with federal officials report, because of undercounting related to [drug overdose deaths](#) and service record deaths.

Although there is no simple solution to the devastating problems surrounding suicide within the veteran population, there is clearly hope for the future. With approaches like universal screenings and evidence-based therapies and interventions, we can continue to help save veterans lives.

For civilian help regarding suicide, contact emergency services or the [National Suicide Prevention Lifeline at 1-800-273-TALK](#).

If you are a veteran and are having suicidal thoughts, or you know someone who has served that might be, contact the [988 Veteran Suicide and Crisis Lifeline](#), by dialing or texting 988.

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were equally effective in improving SAD symptoms. Some symptoms seemed to get better a little faster with light therapy than with CBT. However, a long-term study that followed SAD patients for two winters found that the positive effects of CBT seemed to last longer over time.

Medications

Because SAD, like other types of depression, is associated with disturbances in serotonin activity, antidepressant medications called selective serotonin reuptake inhibitors (SSRIs) are also used to treat SAD when symptoms occur. These agents can significantly enhance patients’ moods. Commonly used SSRIs include fluoxe-

tine, citalopram, sertraline, paroxetine, and escitalopram.

The U.S. Food and Drug Administration (FDA) also has approved another type of antidepressant, bupropion, in an extended-release form, that can prevent recurrence of seasonal major depressive episodes when taken daily from the fall until the following early spring.

All medications can have side effects.

Talk to your doctor about the possible risk of using these medications for your condition. You may need to try several different antidepressant medications before finding one that improves your symptoms without causing problematic side effects. For basic information about SSRIs, bupropion, and other mental health medications, visit

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due to “having to watch over spouse constantly.” One husband stated, “My (military spouse) was like Jekyll and Hyde; one day happy and the next crying or mad. Then she would not want to talk, I felt so helpless! It took a toll on me since I did not know what to expect.” Seven wives reported they ceased talking about politics and felt they had to watch over their military spouses when they engaged with friends in case an argument ensued. All 12 wives reported feeling scared and anxious when their husbands started getting angry. One wife said she was on edge all the time. “The anger comes out of nowhere and with the smallest thing.” Another wife said, “He would get angry over the smallest things.” Five spouses reported their military spouses began playing first-person shooter computer games. All spouses attended military sponsored seminars on what to expect when service members return. However, they all agreed the seminars did not prepare them for the psychological toll. Majority of spouses said, “I felt all these behaviors were because of me. I just wanted my old life back. I just wanted my old relationship back. I wanted my spouse back.”

Caregiver burden. All interviewees reported difficulty coping with their military spouses’ isolation, and its effects on them. The interviewees reported that since their spouses refused to spend time outside of the house with friends and family, they too isolated from friends and family. “I would make up excuses to not meet up with friends, I was nervous to leave (military spouse) home alone.” One spouse reported, “My (military spouse) isolated in the bedroom for hours sleeping or reading a book. I did not know if I should join or leave him be. I would lay down, and he would ask what I wanted. It



Heidi Hillman PhD, BCBA-D, LMHC

was nervous and confusing!” All three husbands mentioned anxiety about leaving their military spouses at home; they worried about their military spouse and had difficulty concentrating at work. One husband went so far as to ask his mother to spend time at the house since he was anxious about leaving his military wife alone with their two-year old. The spouses reported difficulty in navigating the VA system for medical visits and the complicated process of securing a PTSD diagnosis for their military spouse. “God forbid my husband needed urgent care, I can’t make an appointment with the VA online or over the phone. I must leave a message and the clinic will call back—that is if they ever call me back—to set up an appointment.”

Secondary traumatic stress. All spouses reported hypervigilance and isolation in response to their military spouses’ behav-

iors. All spouses reported trouble sleeping since their military spouses were continually waking up at night. One spouse mentioned being careful not to argue with her husband at nighttime since he would become enraged and go for long walks in the middle of the night. All spouses reported being hypervigilant when it came to fireworks. “The sound of fireworks always takes my husband back to Iraq.” Out of the 15 spouses, 13 mentioned unease about going into public with their military spouses, the unknown about how their partner would react to people, to logos on t-shirts, to posted political signs, to looks from strangers.

Isolation. All spouses reported feeling alone and not supported. Although all spouses mentioned they could go to counseling groups for military spouses, it was not the same type of intensive support as mental health counseling their military spouses were entitled to. All spouses reported feeling misunderstood and not supported. Although none of the interviewees reported lack of support from family and friends, they all reported limited support from the military and had limited (if any) resources for mental health services. Most of the spouses talked about a military culture—you married into the military, you fix the problems, and support your military spouse. “There is a stigma to seeking out help for mental health issues.”

Military spouses carry a burden few understand; many do not recognize the increasing mental health issues that accompany being a military spouse. However, their support is vital in a service-member’s successful reintegration after a deployment. Spouses I interviewed reported lack of support preparing them for the psychological stress living with a service member with PTSD and lack of support in coping with the stressors. It is imperative researchers conduct research in

this area to promote change in the perception that military spouses are immune and don’t need mental health services. Military spouses are the backbone of service members. As one wife said, “Family and friends are so glad my [military] husband has me for support. But who supports me when I need it?”

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affected by the negative impacts of drug use, including Black and Latino/Latina communities, and women.

“The opioid and overdose crisis continues to evolve in dangerous and unpredictable ways, but scientific solutions that embrace innovative research and community connections offer the best hope for saving lives across America,” said NIH HEAL Initiative Director Rebecca G. Baker, Ph.D.

The new harm reduction research network will include nine research projects and one coordinating center. Grantees will investigate harm reduction strategies for their effectiveness in preventing drug overdoses and other adverse outcomes, sustainability and level of individual and community engagement. All projects will have a community advisory board and/or people with lived experience will have paid positions to support the research. Leading institutions and their projects include:

- **Johns Hopkins University, Baltimore:** Evaluating the impact of mobile van-delivered harm reduction services on overdoses among women in Baltimore who use drugs. Mobile vans will offer participants supplies like naloxone, fentanyl test strips and necessities

such as food and clothing, brief trauma-informed counseling, and referrals to drug treatment, medical care and social services.

- **New York University School of Medicine, New York City:** Investigating the effects of a harm reduction intervention delivered via mobile van to Black and Latino/Latina participants who use drugs in New Haven, Connecticut, and the borough of the Bronx, New York. A community-based care coordinator will assess the unique needs of each participant (such as housing, food assistance, and mental health treatment) and then link them to appropriate services.

- **Oregon Health and Science University, Portland:** Evaluating two interventions – contingency management, an evidence-based behavioral intervention for the treatment of a variety of substance use disorders, and the identification of personal harm reduction goals with the support of a peer with lived experience – at community-based organizations in rural Oregon to increase the availability and effectiveness of harm reduction services for people who use methamphetamine.

- **Research Triangle Institute, North Carolina:** Assessing the reach, effective-

ness, adoption, implementation, and maintenance of harm reduction services in San Francisco, with the goal of helping public health agencies, community-based organizations, and policy makers better understand how to tackle health-related harm among people who use drugs.

- **Research Triangle Institute, North Carolina:** Establishing a harm reduction research network coordination center that will provide support to the nine research studies in the harm reduction research network.

- **University of Chicago:** Measuring the use of harm reduction services and investigating how to successfully implement remote harm reduction strategies in rural Illinois communities. For instance, examining “secondary distribution” approaches, in which people who obtain harm reduction supplies (e.g., naloxone or fentanyl test strips) from harm reduction service providers share them with other people who use drugs who are currently without access to these providers.

- **University of Nevada-Reno:** Testing ways to identify and support “overdose responders” (people who use drugs who respond to overdoses in their peers), to better understand barriers to naloxone

use and increase long-term use of naloxone among people who use drugs.

- **University of Pittsburgh:** Developing and testing an intervention aimed at changing behaviors and reducing risks among Black people who use drugs who visit the emergency department in Pittsburgh. The intervention, which will be delivered to participants by peers with lived experience of drug use, bundles evidence-based harm reduction strategies including take home naloxone and fentanyl test strips.

- **University of Wisconsin Madison:** Developing and testing an intervention consisting of up to four internet- and smartphone-based tools designed to improve access to harm reduction services for hardly reached people, enrolling participants in both urban and rural regions of Wisconsin.

- **Weill Medical College of Cornell University, New York City:** Determining where and how to best provide mail-delivered harm reduction supplies by investigating the barriers to mail-delivery of harm reduction supplies, predictors of use and long-term engagement with mail-delivered harm

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Afrocentricity from page 37

Afrocentric families, communities, and culture. Here is how S:US is using the Nguzo principles as outlined by Dr. Karenga as our foundation to build programs that effectively address the needs of BI-POC people:

1. Umoja (Unity): to strive for and maintain unity in the family, community, nation, and race. S:US' work is centered around community building, helping persons served restore any desired link with their natural or chosen family. Our services encourage staff's collaboration with persons served's identified support unit and connecting persons served to larger affinity groups to explain the ramifications of systemic oppression for marginalized groups. The ultimate goal for S:US is to help foster in persons served, family, and community partners the spirit of becoming agents of change to disrupt systems of inequities.

2. Kujichagulia (Self-Determination): to define ourselves, name ourselves, create ourselves, and speak for ourselves. S:US demonstrates this value by intentionally seeking the voices of people served and encouraging them to be the subject in their journey to recovery. These voices are present in developing service/treatment plans and spaces where discussions are happening about programming, satisfaction with services, and advocacy. Sharing power with persons served is an effective way of disrupting systems of power which is one of the pillars of coloniality.

3. Ujima (Collective Work and Responsibility): to build and maintain our community together and make our brothers' and sisters' problems our problems and solve them together. S:US explores the concept of interdependency with families, persons served, staff, local partners, etc. One of our core values—having a supportive culture aligns with this Ujima principle and is illustrated by centering our diversity, equity, inclusion, and belonging efforts around resources for persons served and staff to experience growth through the established process of mutuality. One example is our community street outreach efforts to support our brothers and sisters struggling with substance use and mental health challenges but don't trust the system of care.

4. Ujamaa (Cooperative Economics): to



Nadjete Natchaba, EdD, LCSW, MPA

build and maintain our stores, shops, and other businesses and profit from them. S:US develops community programs to enhance the communities where we are located and offer services. One example is our **Urban Farms** that provide therapeutic horticulture, nutritional programming, and employment opportunities through workshops and hands-on experiences to people served living in various New York City communities. Persons served not only have the option to earn income but also provide healthier food for their loved ones and the community.

5. Nia (Purpose): to make our collective vocation the building and developing of our community to restore our people to their traditional greatness. S:US exemplifies "Nia" daily through the provision of rehabilitation services in our day habilitation programs, clubhouse, etc. Persons served are achieving personal milestones allowing them to elevate their sense of agency and fulfill life roles. Creating opportunities for all (persons served, their families, and our staff) is seen in the myriad of traditional and non-traditional services provided across S:US.

6. Kuumba (Creativity): to always do as much as we can, in the ways we can, to leave our community more beautiful and beneficial than we inherited it. S:US continues to replace empty neighborhood lots with beautifully designed and environmentally friendly buildings to house families with a history of home-

lessness. S:US' Housing Division consists of 120 buildings owned, managed, or leased in New York City; has developed 19 Low Income Housing Tax Credit (LIHTC) buildings with 1,139 units of supportive and low-income housing owned and operated by the organization, and currently has 1800+ units in development or under construction. S:US also recently added community fridges for people to help themselves to nutritious food in a dignified manner and lending libraries.

7. Imani (Faith): to believe with all our heart, our parents, our teachers, our leaders, and the righteousness and victory of our struggle. Despite operating within various systems of oppression, S:US envisions a city where everyone has a roof over their head, is healthy, productive and can enjoy the social connections that create a life of purpose. S:US' staff reports to work daily with the commitment, dedication, and conviction that they are righting societal imbalances through their actions.

Providing social services to honor the full agency of people served, families, and the community requires a commitment and a philosophy that motivates people to persist despite challenges. To succeed, organizations must ground their work in the principles of Nguzo Saba which honor the dignity of every human being and encourages mutual and respectful relationships that are centered on the interconnectedness of our humanity. S:US' core values—respect for all, integrity in all actions, maximizing individual potential, continuous quality improvement and supportive culture—and commitment to create opportunities for all, are the frameworks that guide our daily work of promoting interdependence and righting societal imbalances.

Dr. Nadjete Natchaba, Ed.D, LCSW, MPA, has been working with people living with mental illness, substance use disorder and homelessness for over 20 years as a clinician, administrator, and executive in Human Services. Dr. Natchaba currently works at Services for the UnderServed (S:US), a nonprofit organization with a staff of 1,800 that provides \$245 million in services. In her role as Chief Operating Officer, she leads a team of devoted clinicians and administrators managing Assertive Community Treatment teams, Certified Community Behavioral Health Clinics, Home and Community Based Services, Care

Coordination Services, shelters for single adults and families, and crisis respite residences.

Dr. Natchaba joined the Silberman School of Social Work at Hunter College as a faculty member teaching fundamental courses in the MSW program to expand her work of preparing our workforce to "show up" for people served. Dr. Natchaba is also a member of National Association of Black Social Workers and a graduate from the African Centered Academy.

Supporting the workforce at Services for the UnderServed and in the larger community is Dr. Natchaba's way of living up to her core value of interdependency.

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Fatalities from page 14

reduction services and preferences of study participants who use them.

NIH is not providing funds for the purchase of pipes, syringes or needles.

The new harm reduction research network joins other [ongoing harm reduction research](#) funded by NIDA and the NIH HEAL Initiative, which address drug overdoses, drug use, transmission of HIV and hepatitis C, and intersectional stigma. NIDA and the NIH HEAL Initiative also fund substantial research on drug use and addiction prevention, diagnosis, treatment, and [recovery support](#).

For more information on substance and mental health treatment programs in your area, call the free and confidential [National Helpline](#) 1-800-662-HELP (4357) or visit [www.FindTreatment.gov](#).

Helping to End Addiction Long-term and NIH HEAL Initiative are registered service marks of the U.S. Department of Health and Human Services.

About the National Institute on Drug Abuse (NIDA): NIDA is a component of the National Institutes of Health, U.S. Department of Health and Human Services. NIDA supports most of the world's

research on the health aspects of drug use and addiction. The Institute carries out a large variety of programs to inform policy, improve practice, and advance addiction science. For more information about NIDA and its programs, visit <https://www.nida.nih.gov/>.

About the NIH HEAL Initiative: The Helping to End Addiction Long-term® Initiative, or NIH HEAL Initiative®, is an aggressive, trans-NIH effort to speed scientific solutions to stem the national opioid public health crisis. Launched in April 2018, the initiative is focused on improving prevention and treatment strategies for

opioid misuse and addiction and enhancing pain management. For more information, visit: <https://heal.nih.gov>.

About the National Institutes of Health (NIH): NIH, the nation's medical research agency, includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical, and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.

Helping from page 12

16-year-old, several of her other children met the criteria for care coordination due to diagnosed co-morbid medical and behavioral health conditions. FTR provided referrals to a child-serving care coordination program that paired a care manager with the children who would support them in navigating through the multiple systems and service providers. The assigned Care Manager for the family provided additional support in facilitating team meetings with the family’s providers to ensure that there was no duplication of services and that there was a comprehensive plan for the family to address their mental health, housing, and academic concerns. One of Ms. Smith’s greatest concerns was how could she focus on her own mental health needs when all of her children also required multiple and ongoing services. The Care Manager took the lead in coordinating ongoing provider visits for each family member and became



Shaniqua Saxon, LCSW

Ms. Smith’s only point of contact – which she reported as helpful to her feeling less



Marlene Morris, LMSW

overwhelmed and more able to address her own well-being while ensuring that

her children’s needs were also supported. Programs at Vibrant continue to be innovative as we serve families and youth with an emphasis on family voice and choice. Staff continue to champion the agency’s mission to see families stay together and thrive together. Being able to provide collaborative care helps the communities we serve and supports the overall wellness of families. This case example is a good illustration of meeting complex needs as multiple services were engaged to address all the families’ concerns. By simplifying the process to collaborative care, the agency was able to positively support Ms. Smith and her children in addressing their mental health, academic and case management needs.

Shaniqua Saxon, LCSW, is Family Connections Program Director, and Marlene Morris, LMSW, is Assistant VP of Youth and Family Services, at [Vibrant Emotional Health](#).

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(and choose) toward their goal and vision of their long-term recovery. The results will be reduced Emergency Department visits, reduced inpatient hospitalizations, reduced incarceration, reduced re-arrests, and reduced involvement of persons with behavioral health crises in the criminal justice system.

This emergent Intensive Crisis Stabilization Center will comprise *part* of Long Island’s newly revamped crisis response system, including mobile crisis providers, crisis residences, law enforcement, EMS, and other community treatment and support services.

Any person on Long Island facing a behavioral health crisis will be able to walk into the new Crisis Stabilization Center – or be brought in voluntarily by family, friends, police, or mobile crisis unit any time of day or night – and receive instant, customized access to an array of **instantly accessible services**, including: triage,

screening, and assessment; peer support; psychiatric diagnostic evaluation and planning; psychosocial assessment; medication management; Medication for Addiction Treatment / Medication-Assisted Treatment (MAT); mild to moderate detoxification services; and discharge, aftercare planning, and follow-up. The center will operate 24 hours per day, seven days per week, and 365 days per year.

The *physical* features of the Crisis Stabilization Center will be both welcoming and functional. The space will include: A separate entrance and reception from the rest of the adjoining clinic at the same address; Comfortable reclining chairs in a large living-room type area; Warm decorations with live plants, soothing lighting, cheerful walls, and gentle music; Showers and personal laundry facilities for people in need; Comfortable rooms where families, clients, and therapists can meet; Cabinets and counters with snacks, coffee, and water; A nurses’ station (for physical/primary care screenings); A separate play

and/or therapy area for children/families (distinct from an adult area); and a separate entrance for police (to expedite screening while respecting clients).

We have found that **collaboration** is a key to progress when embarking on these initiatives. Dozens of providers across Long Island have pledged their support to this critical endeavor. In addition, four key regional providers will play a more central role in ensuring the center’s success. They are: (1) Northwell Health hospital system, (2) EPIC/South Shore Child Guidance Center, (3) EAC Network (a social service agency that Empowers, Assists, and Cares for people in need), and (4) Family & Children’s Association. Each will work toward amplification of vulnerable residents’ streamlined access to the Center and/or provision of needed supports corresponding to their respective domains of expertise and specialization, often addressing the social determinants of health.

In my 30-year career, this is the first

time I can remember such a meaningful, *multi-stakeholder* focus on behavioral health—backed by committed partnership and action. With new financial resources infused into the system, our government offices (federal, state, and local) are making long-term investments in ensuring that people in crisis have someplace (catalytic) to turn. As we co-create an imaginative solution that: (a) expands *accessible* mental health and substance-use services in our community; and (b) welcomes our community’s *most vulnerable residents*, helping to propel them from crisis to stability to recovery/thriving, CN Guidance is excited also to play a role in transforming a *larger system* that has been needing substantial attention. From the shadow of COVID, a **bright** new partnership-driven **resource** for our region is emerging.

To reach Mr. Friedman at Central Nassau Guidance and Counseling Center, jfriedman@centralnassau.org; website: cnguidance.org; 516-396-2834

Housing from page 19

about their health. I want to pursue a career in harm reduction.”

Support for Mental Health
Makes a Difference

We’ve all struggled with our mental health and appreciate the crucial support we’ve received to stabilize our lives.

“I meet with a therapist every week. S:US staff are also helpful, they set up tenants with care packages and offer emotional support. I know I can talk things out with them outside of therapy. My case manager is supportive, too. I meet with her frequently. This has all helped me get my life back on track,” said Rotiesha.

Messages for Others
Experiencing Similar Challenges

We’ve all experienced serious challenges that have kept us down. We would like to encourage others to keep going, don’t give up, and find support.

“Don’t give up on finding housing. Having housing and additional services helped my family get our lives together,” said Rotiesha.

“I believe that people with substance use issues need someone with the same experiences to tell them things will be OK, someone to set an example. Advocate for yourself and help others get on track,” said Sheila.

“Keep pushing forward and keep advocating for yourself. There is help out there,” said Brittany.

Challenges from page 31

“from a place of strength” and tries to get that strength from doing at least one small thing for herself daily. Participants often develop a clearer understanding of what to expect from the progression of a particular condition or disease. Perhaps, most important, a support group can give caregivers reassurance that they are not alone. Kay has participated in a support group and describes the benefits of speaking with others who “get it.”

Despite the many challenges, caregivers can often tap into some of the rewards, such as a deepening bond with their loved one, increased empathy, and a sense of purpose. As Rosalynn Carter states, “caregiving is hard, even on the good days when it brings joy and fulfillment. It requires dedication, determination, and time.”

Sarah A Lieberman, LMSW, has supported family caregivers in her work as a social worker for close to three decades, with the past eight years working at



Sarah A. Lieberman, LMSW

Westchester Jewish Community Services in the Pathways to Care program. She can be reached at slieberman@wjcs.com or 914-761-0600 x2141.

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For more information please visit www.marypendergreene.com, and by email at mary@mpgconsultingnyc.com, (212) 245-2510.

Designing from page 21

Multipurpose centers and therapy rooms where family and patient can meet should continue the comfortable, dignified theme. The key is to promote a feeling of community among staff, visiting family and fellow patients that drives the desire to participate in their care and achieve the goals of their treatment. Providing more gathering space for family encourages them to be a critical part of the patient’s treatment during their stay, and it can also help set the groundwork for their continuing journey and care afterwards.

Promote Recovery

Spaces that inspire a sense of normalcy – such as art studios, workout areas, dining rooms with healthy meals, and access to the outdoors, while maintaining security – can help offset the loss of control and autonomy that many behavioral health patients face. Offering open gathering areas with various seating groupings and quiet spaces with access to music selection for patients, allows for flexible choices between socializing and respite during in-patient care stays. These features and comforts promote opportunities for family and loved ones to contribute to the treatment process, surrounding patients with familiar faces and situations that can aid in recovery and improve outcomes.



Michelle Morgan

Ensure Safety

The overarching concern for any behavioral health facility design is ensuring the safety of patients, families, staff, and other visitors. Integrating the previously mentioned design elements safely requires creativity, research, and knowledge of the best materials, products and processes used in a behavioral health facility. Designers can’t just remove all barriers in the lobby to create a more open feel; some safety measures must remain. So instead

of having the reception desk behind full-height walls, a compromise of an open concept desk with partial height safety glass may be the answer. Other design considerations involve concealing safety features, such as securing patient beds to the floor, and selecting products that are safe, but that evoke a more familiar feel to patients and their families. Techniques such as this can improve patient wellbeing and aid in their healing.

Planners, architects, and interior designers must also specify products that are unlikely to cause stress or agitation in a behavioral health patient, while reducing the risk of harm. Artwork can be colorful, but typically should remain abstract to ease overstimulation. Floors and walls should limit patterning that can be disorienting to patients. The use of sound absorbing materials and elements can help reduce distracting noise and provide privacy. Glaring light can also have deleterious effects on patients. Selecting LED light fixtures with dimming and color-changing capabilities and carefully contemplating the placement of lighting in the space, can all have an influence on the patient’s healing and encourage choice. Thoughtful consideration must be made when selecting furniture based on the patients being served. Spaces should have only the furniture they need, and it should be incapable of being turned into a weapon,

such as by weighting the bottom of furniture or securing it to the floor. Other spaces may be more suited to have light, movable pieces.

A New Age for Behavioral Health Design

Much has changed in behavioral health treatment over the years. Facilities are no longer sterile, grim institutions, the stigma around mental illness is waning, and progressive providers emphasize recovery over restraint. This is a refreshing shift for the families and friends of behavioral health patients, who entrust to the facility’s staff the care of their loved one.

As more people confront their mental illness, addictions or other behavioral health concerns, the need for facilities to treat them will only grow. By keeping pace with the evolving state of treatment and care, design professionals can contribute significantly to the growth and advancement healing, recovery, and a way forward for patients and their families.

Michelle Morgan works in the San Diego office of Taylor Design, an architecture, interior design and strategic planning firm with five offices in California. To reach her write to mmorgan@wearetaylor.com. For more information, go to www.wearetaylor.com.

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Lifeline from page 22

Fact: Talking about suicide may reduce, rather than increase, suicidal ideation. It improves mental health-related outcomes and the likelihood that the person would seek treatment. Opening this conversation helps people find an alternative view of their existing circumstances. If someone is in crisis or depressed, asking if he or she is thinking about suicide can help, so don't hesitate to start the conversation.

Myth 2: People who talk about suicide are just seeking attention.

Fact: People who die from suicide have often told someone about not wanting to live anymore or they do not see the future. It's always important to take seriously anybody who talks about feeling suicidal. It's important to be kind and sensitive, and ask direct questions such as: "Are you thinking about hurting yourself?" "Are you thinking about suicide?" or "Do you have access to weapons or things that can be used as weapons to harm yourself?"

Myth 3: Suicide can't be prevented.

Fact: Suicide is preventable but unpredictable. Most people who contemplate suicide often experience intense emotional pain, hopelessness and have a negative view of life or their futures. Suicide is a product of genes, mental health illnesses and environmental risk factors. Interventions targeted to treat psychiatric, and



Angela Jacobs, LCSW

substance use illnesses could save lives.

Myth 4: People who take their own lives are selfish, cowards or weak.

Fact: People do not die of suicide by choice. Often, people who die of suicide experience significant emotional pain and find it difficult to consider different views or see a way out of their situation. Even though the reasons behind suicide are quite complex, frequently suicide is associated with psychiatric illnesses, such as depression, anxiety, bipolar disorder, schizophrenia and substance use.

Myth 5: Teenagers and college students are the most at risk for suicide.

Fact: The suicide rate for this age group is below the national average, and suicide risk increases with age. The age group with the highest suicide rate in the U.S is men and women between 45 and 64. Though particular groups may be at higher risk; suicide is a problem among all ages and groups.

Common Warning Signs

- Talking about suicide — making statements such as "I'm going to kill myself," "I wish I were dead" or "I wish I hadn't been born."
- Getting the means to take your own life, such as buying a gun or stockpiling pills.
- Withdrawing from social contact and wanting to be left alone.
- Having mood swings, such as being emotionally high one day and deeply discouraged the next.
- Being preoccupied with death, dying or violence.
- Feeling trapped or hopeless about a situation.
- Increasing use of alcohol or drugs.
- Changing normal routine, including

eating or sleeping patterns.

- Doing risky or self-destructive things, such as using drugs or driving recklessly.
- Giving away belongings or getting affairs in order when there is no other logical explanation for doing this.
- Saying goodbye to people as if they won't be seen again.
- Developing personality changes or being severely anxious or agitated, particularly when experiencing some of the warning signs listed above.

If a friend or loved one talks or behaves in a way that makes you believe he or she might attempt suicide, don't try to handle the situation alone. Get help from a trained professional as quickly as possible because the person may need to be hospitalized until the suicidal crisis has passed. Encourage the person to call 988 or, in the U.S., call the National Suicide Prevention Lifeline at 800-273-TALK (800-273-8255) to reach a trained counselor. Use that same number and press "1" to reach the Veterans Crisis Line. Service languages other than English are available.

You're not responsible for preventing someone from taking their own life, but your intervention may help them see that other options are available to stay safe and get treatment.

When in doubt, always call 988 to consult. You do not have to do this alone.

Loneliness from page 20

Brushworks for example, offer stimulating sensorial options, together with interactive artistic exploration. VR opens windows to the world and offers access to a variety of experiences that might otherwise be unattainable.

The risks associated with social isolation extend beyond physical, emotional, and cognitive decompensation. Older people who are isolated are at higher risk for experiencing financial and physical abuse including neglect (Thangavel, G. et al., 2022). Technology that tethers individuals to their communities and systems of care can significantly reduce risk factors; all people need to be connected in order to be safe. VR offers users the opportunity to interact in both an instructional and social capacity thereby connecting them to the community and promoting visibility within the VR realm and among facilitators.

Pilot VR Study

Clinical Associate Professor Louanne Bakk, PhD, MSW, and her team from State University of New York, University at Buffalo, piloted a study in 2021 to explore the use of VR with a cohort of nine older adults in partnership with a Program of All-Inclusive Care for the Elderly (PACE). Participants were 65 years and older and included both males and females. The participants experienced VR in group settings utilizing the Rendever VR platform. Participants explored a variety of virtual experiences including, but not limited to, traveling to various locations, exploring childhood neighborhoods, and attending a concert or cultural event. Focus groups were conducted to assess participants' perceptions of the VR intervention. Participants reported their VR experiences as stimulating, pleasurable and engaging. The most common themes suggested that VR programming is regarded as a highly immersive, positive experience that facilitates connections and elicits positive feelings. Moreover, participants felt empowered by the experience. Therefore, the findings were inconsistent with common misconceptions that assume older people reject or have little interest in engaging with technology. The researchers concluded that utilizing VR programming with community-dwelling older adults can provide interactive and engaging immersive experiences and has the



Heidi Billittier, LMSW

potential to reduce social isolation and improve well-being and connectedness (Bakk et al., 2021).

Limitations - Brown, J.A. (2019) examined the use of VR for older people to learn whether the experience holds value and additionally, whether the device (in this case was the Samsung Gear VR) was manageable for older people. Participant concerns included headset discomfort, hair caught in headset straps, and eyeglass adjustment challenges. The headset was noted by some to be heavy and awkward; others noted confusion using hand controllers. Dizziness was not reported as they were seated during the virtual experience. Brown advised that individuals with neck or head pain may find the headset less than comfortable and noted that accommodations for visually impaired may be necessary.

Findings - In 2019, Lin et al. studied the effects of the use of VR on a group of older adults' social and emotional well-being. Pre and post intervention surveys were administered to assisted living residents to gauge participants' attitudes toward, and feelings about the technology. After engaging with VR there was measurable improvement in several domains including an increase in perceived mental and physical wellbeing together with improved ability to manage depression and stress. Lin and colleagues concluded that

VR has the potential to become a valuable tool in improving overall well-being among older people.

Van Houwelingen-Snippe, J., and colleagues (2021) reviewed literature that explored the concept of virtual immersion in nature in eliciting feelings of physical, emotional, and social wellbeing. Immersive and static, nature scenes and experiences elicit a sense of connectedness and in a broader sense, access to heightened spirituality. While engaging in nature-based experiences, VR can provide a distraction from emotional and physical discomfort. For others who may or may not ascribe to organized religion, spirituality often exists in nature and nature becomes a source of religiosity made accessible through VR.

Implications - The studies and articles referenced in this article strongly suggest that the tides are shifting and the movement toward incorporating VR into formal and informal interventions for older people holds value and deserves serious consideration. Technology evolves rapidly and with change comes greater accessibility and ease of use. For older adults, the potential benefits of VR use appear to outweigh the challenges and as technology moves into our homes, long-term care facilities, and adult centers, people of all ages will enjoy connecting with and through VR. Cole AC et al., (2021) and colleagues maintained that it is important to involve older people in co-designing and implementing technology to ensure the best possible outcomes for users. Assuming that older people reject technology is a common misperception, it is short-sighted, stigmatizing, and serves no purpose other than to exclude older people from enjoying the range of benefits that technology has to offer.

Heidi Billittier is a social worker committed to reducing stigma around aging and mental health and is a current Doctor of Social Work student. You can reach her at Heidi@compeerbuffalo.org

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Behavioral Health News Editorial Calendar

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Deadline: March 16, 2023

Summer 2023 Issue

Serious Mental Illness: History and Challenges Ahead
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Winter 2024 Issue

The Role of Housing and Employment in the Recovery Process
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his overdose necessitated a nursing home placement that provided him with a safe space and essential primary care services but inadequate psychiatric treatment and no meaningful rehabilitative services. By Sarah’s account, Jason received little encouragement from this facility’s staff to secure a less restrictive living arrangement or to pursue his recovery. If not for his parents and their sustained advocacy, he would never have been interviewed for another supportive housing opportunity. He was on a waitlist and awaiting placement in a program for dually diagnosed individuals when he contracted and succumbed to the Coronavirus.

Sarah and Andrew have clearly reflected on the frailties of the behavioral healthcare system. When asked to identify prospective corrective measures, Sarah enumerated many that would surely resonate with others who have stood in her shoes. She was astonished by considerable variability in the quality of care Jason received throughout his journey. She cited an absence of “Standard Operating

Procedures” as a source of continual stress and consternation for her family. In her experience, even similarly licensed and situated programs employed vastly different policies, procedures, and practices that complicated or forestalled her son’s recovery. An enduring shortage of qualified and appropriately trained personnel compounded his plight. Too many providers sought simply to manage him and his condition and failed to apply the recovery-oriented standards we might (and should) expect. Some would dismiss or discharge him when he failed to adhere to treatment recommendations or seemingly arbitrary expectations. Inconsistent communication and fragmented coordination were the rules, punctuated by rare but cherished exceptions. Provider capacity invariably fell short of demand. Services and supports targeted specifically for family members were elusive or insufficiently responsive. “Phone answering is important,” Sarah said, as she described her attempt to elicit assistance from one of the many community-based family support providers to which she and Andrew were referred.

These lamentations are frighteningly

familiar to many. But they also point the way to potential improvements. Sarah concluded our interview with a question – one she wished providers would ask on behalf of each client entrusted to their care. “How can we make this client a ‘success story’?” We should ask the same of our behavioral healthcare system.

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Substance Use from page 32

cannabis within the past year, reflecting a stable trend at the pre-pandemic level among eighth and 12th graders, and a small increase in reported use among 10th graders, though reported use among 10th graders in 2022 is still significantly below pre-pandemic levels.

- **Alcohol use** remained stable for eighth and 10th graders (with 15.2% and 31.3% reporting use in the past year, respectively) but returned to pre-pandemic levels for 12th graders in 2022 (with 51.9% of 12th graders reporting alcohol use in the past year).
- **Any illicit drug use other than marijuana** also remained stable for all three grades surveyed, with 4.9% of eighth graders, 5.7% of 10th graders, and 8.0% of 12th graders reporting any illicit drug use other than marijuana in the past year. These data build on long-term trends documenting low and fairly steady use of illicit substances reported among teenagers – including past-year use of cocaine, heroin, amphetamines, and nonmedical use of prescription drugs, generally.
- **Use of narcotics other than heroin** (including Vicodin, OxyContin, Percocet, etc.) increased slightly among 12th graders between 2021 and 2022 (with 1.7% of 12th graders reporting use within the past year), consistent

with the pre-pandemic levels observed in 2019 and 2020 (2.7% and 2.1%, respectively).

When asked a range of questions about the perceived harmfulness of occasionally taking specific prescription medications (such as OxyContin and Vicodin), or the risk of “narcotics other than heroin” overall, the percentage of students who reported perceiving a “great risk” ranged from 22.9% among eighth graders to 52.9% among 12th graders. The percentage of respondents who reported perceiving a “great risk” associated with taking Adderall occasionally ranged from 28.1% among eighth graders to 39.6% among 12th graders.

Though the data have indicated stable or declining use of illicit drugs among young people over many years, other research has reported a recent [dramatic rise in overdose deaths](#) among young people ages 14-18. This increase is largely attributed to illicit fentanyl, a potent synthetic drug, contaminating the supply of counterfeit pills made to resemble prescription medications like benzodiazepines, ADHD medications, and opioids.

“The proliferation of fentanyl in the drug supply is of enormous concern. Though the data indicate that drug use is not becoming more common among young people than it has been in the past, the tragic increase in overdose deaths among this population suggest that drug use is becoming more dangerous than

ever before,” said Dr. Volkow. “It is absolutely crucial to educate young people that pills purchased via social media, given to someone by a friend, or obtained from an unknown source may contain deadly fentanyl.”

The results were gathered from a nationally representative sample, and the data were statistically weighted to provide national numbers. This year, 11% of the 12th grade students who took the survey identified as African American, 22% as Hispanic, 5% as Asian, 1% as American Indian or Alaska Native, 47% as white, 1% as Middle Eastern, and 14% as more than one of the preceding categories. The survey also asks respondents to identify as male, female, other, or prefer not to answer. For the 2022 survey, 48% of 12th grade students identified as male, 47% identified as female, 1% identified as other, and 4% selected the “prefer not to answer” option.

“We were curious to see whether the significant decreases in substance use we observed last year would continue into the future, and we now see that there may indeed be a longer lasting impact for some substances,” said Richard A. Miech, Ph.D., team lead of the Monitoring the Future study at the University of Michigan. “The fact that cannabis use and nicotine vaping did not appear to return to pre-pandemic levels in 2022 is a fascinating data point. Moving forward, it will be important to continue to monitor these trends to understand the impact on future drug use be-

havior and outcomes.”

The [2022 Monitoring the Future data tables](#) highlighting the survey results are available online from the University of Michigan.

For more information on substance and mental health treatment programs in your area, call the free and confidential National Helpline 1-800-662-HELP (4357) or visit www.FindTreatment.gov.

About the National Institute on Drug Abuse (NIDA): NIDA is a component of the National Institutes of Health, U.S. Department of Health and Human Services. NIDA supports most of the world’s research on the health aspects of drug use and addiction. The Institute carries out a large variety of programs to inform policy, improve practice, and advance addiction science. For more information about NIDA and its programs, visit <https://www.nida.nih.gov/>.

About the National Institutes of Health (NIH): NIH, the nation’s medical research agency, includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical, and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.

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better. It was also a bonus, that by self-medicating, the mental health challenges I was suffering from would also subside. After high school graduation, I went to beauty school and became an amazingly successful hairstylist, even working behind the scenes at NYC Fashion Week towards the end of the '90s. But soon I realized that functioning as an addict lasts for only so long before I had succumbed to the inner demons of my addiction, causing me to stop working for some time.

Eventually, I started to have severe mood swings and became emotionally unstable on a regular basis. But it wasn't until my fifth rehabilitation program, at age 21, when I was formally diagnosed as having Bipolar Disorder with Manic Depression and Extreme Anxiety. I knew nothing about these conditions but getting diagnosed help make a little more sense to me about why I was the person I was. The more I learned about my mental illness, the more I understood that my feelings of hopelessness, the insomnia, feeling worthless, with every part of my life falling apart, plus my constant, over the top irritability had all been part of a mental disorder I hadn't known I was suffering from.

Jorge: We all know about the high rates of mental health disorders, exacerbated by COVID-19, but we also have significant lag time between onset of symptoms and diagnosis/treatment as well as a challenging time accessing needed services. It seems like this was something that you experienced.

Kristin: Yes, even once I started getting help, over the next 10 years, I was put on one medication after another by a multitude of doctors through the many programs I'd entered, trying to balance my mental stability, unfortunately to no avail. It wasn't until I met my first husband and became pregnant in 2002 that I took my recovery seriously and began to regularly take my medication, that I found finally controlled all the symptoms that I had suffered with my entire life. Everything was great for the next 8 years, until November 27, 2011, when my husband unexpectedly died from a Grand Mal seizure at 30-years-old, and looking into my 7-year-old's crushed eyes, after telling him that daddy was gone forever, triggered an episode of depression. This led to a relapse not even a month later and regretfully abandoning my son when he needed me the most!

For the next three years, after hurting and disappointing myself and everyone that loved me, I had found myself homeless on the streets of NYC. In order to survive daily, I was sleeping on park benches throughout the East Village, or in subways, also stealing and having to pan-handle. I eventually made my way to a harm reduction center, joining the daily groups to get MetroCards, eating lunch and getting a dinner bag when needed. Plus, it was the only place a homeless addict could take a shower and wash clothes once a week.

Jorge: That sounds really challenging. We are currently seeing and hearing a lot about the growing homelessness crisis. How did you manage that period in your life?

Kristin: After many months of this rut, I was in, I finally met my current partner and the father of our younger son. But I was homeless and became pregnant, which made me feel even more hopeless and stuck than ever before. I didn't want to disappoint another child and I didn't realize what "rock bottom" was until I was faced with having to be responsible for another human being again. I already saw myself a failure as a mother and there were moments when I thought I'd be better off dead, which I sometimes felt might be a better alternative than going through life the way I currently was. At that point, we decided to get help by moving into a NYC Department of Homeless Services (DHS) Family Shelter, with hopes of living a better life for us and our new child. I decided to go back to that harm reduction center every day to stay out of trouble and was asked to participate in a 12-week, women's empowerment program, which unknowingly became the long but rewarding journey that I will be on for the rest of my life.

Jorge: So, it sounds like at that point in your life you felt the need to change and found a program that helped you start the process of recovery. Can you tell us more about the program and how it helped you?

Kristin: By working through the curriculum in this program, I was able to learn how to face the causes of the pain I felt inside, how to not feel ashamed for things that happened to me that were not my fault, how to talk about my issues honestly and without judging myself, and so many more great things. But most importantly, that program taught me how to love myself unconditionally! It wasn't until then, that I could look in the mirror again and didn't hate who was looking back. Without those breakthroughs, I know I wouldn't be anywhere near where I am in my life now. The confidence and determination that I found within was pushing me to fight back. I decided that my children and I would never be ok with settling for less than what we are worth, and since I could never put a value to that, I will never stop fighting to accomplish the goals I have set to accomplish in life.

Jorge: Can you tell us a bit more about your recovery journey?

Kristin: My recovery journey was difficult; after 27 years of substance use, I had been in 14 detoxes, 7 different 30-45-day rehabilitation centers, and 1 long-term program that I ran away from only 6 months in. I began attending these programs from the young age of 17, and now at age 48, it's been a total of 36 years of a fight that I've been lucky enough to have survived, even after overdosing from heroin use 5 times. The last nine of those years have been the best years of my life thus far. From addiction support groups to homeopathic remedies, my family has tried to "heal" me with every kind of help, but nothing worked until I was ready to stop using. Sad to say that neither my son nor my career was enough to make me stop getting high and I couldn't understand why, because I loved my son more than anything in this world. But even that love couldn't drown out the emotions I didn't want to feel, leading to relapsing many times throughout the years. No matter what type of program I was put in,

none of them helped me face the root causes of my problems, which were made worse due to my Bipolar Disorder and would stay with me forever, unless I figured out how to get past the guilt that I felt from the traumas I had experienced. The boredom of talking to different therapists, counselors, and medical staff over and over again, throughout the numerous programs I attended was inevitable, and I "fool" the caretakers that would believe everything I told them, especially because I knew exactly what they wanted to hear, after becoming a career patient in the dual diagnosis world.

Jorge: What do you think changed?

Kristin: There would never be enough programs or groups that were going to help me stop, unless I was finally done, which I wasn't for 27 long years. But I finally found the strength and courage I needed while participating in that women's empowerment program I spoke about earlier. There, I had the realization of what my "rock bottom" was, finally realizing that desire and need to drown out the feelings I wasn't comfortable dealing with. I had been reminded that I, too, deserved happiness in life and that I was punishing myself for things that had happened to me that weren't my fault at all. Between this empowerment program and relating to professionals that actually had lived experiences similar to mine, has helped to change my way of thinking, which finally ignited a fire within that has since burned brighter with each passing day. We were still living in the shelter when I graduated the 12-week program and was offered a peer educator position at that same harm reduction center but I felt I could do more and help others, so I started to seriously think on becoming a lawyer. A goal that caused many family members and friends to laugh at, but as soon as I heard my older son tell me he believed in me, this was all I needed to hear to become determined to make that dream come true. Proudly, I am currently halfway through my 10-year success plan.

Jorge: How do you think your mental health, substance use, and homelessness impacted you directly and how did it impact your child and his development?

Kristin: I came close to dying multiple times because of my mental health and substance use issues. Sadly, not one of those times scared me enough to stop getting high because the drugs were making me feel normal, it led me to believe I could never live without using drugs. To say that every aspect of my life was impacted would be an understatement. Untreated mental illnesses are horrible to deal with but when adding substances in the mix, it's even more impactful. I was always surrounded by people that loved me, but still I always felt alone. No one could figure out why I couldn't deal with life on life's terms, supposedly like every non-addict did, and the ups and downs of my personality would give everyone around me whiplash to say the least. Once I was diagnosed properly, it became easier to understand why self-medicating had been so successful in my eyes, but still couldn't explain why I suffer through addiction rather than getting help.

Surprisingly, being homeless on the streets was a blessing in disguise. I ended up in a place where I needed to be to fi-

nally realize that I was destroying my life and slowly killing myself, all for nothing! I lost everything I had ever worked for in life, from the house my first husband bought me, to our beautiful Bayliner boat, cars, and clothes, all which are replaceable. But most importantly, I lost the rest of my soul when I lost my first-born son. I was on my way to being a world-renowned hairstylist, my husband then was a firefighter, but when I had the chance to be a great mom to an amazing son, I let the mental illness and addiction turn my heart cold, in order to pull me back in its grasps after my first husband's death. Looking back now, I can say that I am stronger for all the pain and anguish I went through and that I am a survivor with the drive to persevere through anything that comes my way.

Today, I can admit that my oldest son has been impacted the most by the issues I suffered with my entire life, and I have been fortunate that my youngest has avoided the same heartache I had caused his big brother. The impact on my oldest was nothing short of cruel. No 8-year-old child deserves to lose a parent, let alone be deserted by their mother less than a month after their father died. And that's exactly what I did without batting an eye. Everything from his behavior to his schoolwork was impacted negatively. Although I am lucky enough to have a great family that always took care of him, no one can replace a parent.

Jorge: Do you recall when you had your first conversation with your son about the impact of your challenges on him? What was that like? How did he respond? How did you process what you heard?

Kristin: The very first time I told my older son that I was an addict, he was 8, and I think that was a harder conversation to have than telling him his dad had died, but he was still too young to understand the gravity of what I was telling him. It wasn't until I started my recovery in 2014, when he was 11, that we actually sat down to talk about how my mental illness and substance use affected his life. I can still remember the pain I saw in his eyes when he told me about some of the things that he saw and experienced when he was with me during my active addiction. We cried together and bonded like we had never bonded before. But no matter how apologetic I was or how remorseful I felt for the hurt I caused him--I could never give him back those precious childhood years that I had robbed him of. No amount of time could give him better memories to share with his own children that will call me grandma one day. He never turned his back on me and still wanted me to be a part of his life. His love was unconditional, and he was there to accept me back into his life with open arms.

Jorge: How would you describe your relationship today? How much work/effort did it take to get you two to this point?

Kristin: I don't think it took long or much effort to regain that special relationship that we have today. I couldn't fathom why he still wanted to be my son, but he did. No matter how much I hated myself for what I put him through, my son would constantly reassure me that he didn't

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invite his mother to a family session after dosing hours (to ensure privacy for other program participants.) Over time, both of his parents became increasingly involved in Jed's care and their own supports.

Family sessions with Jed and collateral family sessions with just his parents enabled them to learn about opioid addiction and resources, medication assisted treatment, the complex co-occurring conditions Jed experienced, and how to engage Jed without exacerbating emotional dysregulation or further substance use. Jed's parents became informed advocates for his recovery process and care. With the full support of his care team, parents, and out-of-state friend, who also attended some of his sessions virtually, Jed qualified for a care-team-authorized, out-of-state trip with take-home bottle privileges to visit his close friend in Texas.

Now in the maintenance phase of his



Shawna Marie Aarons-Cooke

care, Jed is working with the vocational services team of TGCW to prepare for further progress in achieving his life goals of employment and independent housing.

Strengthened by the experience of working together during previous phases of Jed's recovery process, his parents now serve as supports for his continued healing and recovery process.

A Path Forward

As behavioral and social determinants of health care continue to evolve and operate with stretched resources, empowering and engaging family becomes even more critical to the care process. The greatest opportunity for integrating family in care is in the minds and hearts of those of us in the behavioral and social determinants of health care field. From restoring fractured relationships to cultivating a larger system of support involving families, valuing the importance of human relationships includes those individuals who most interact with those we serve.

The Guidance Center of Westchester is part of the Access Network – a group of agencies led by [Access: Supports for Liv-](#)

ing. Together, the nearly 2,200 staff of the Access Network provide support to more than 17,000 adults and children with mental health and substance use needs, developmental disabilities, children, and families facing challenges, and those who need support with housing and employment across New York's Hudson Valley, the five boroughs of New York City, and Long Island.

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Journey from page 47

blame me for anything and promised to stay by my side, whether it be good or bad, throughout my recovery process. When I opened up to him about my issues, this was the moment I knew our relationship would be the envy of almost every mother and son in the world. I also knew I had to stop beating myself up for the horrible mother I used to be or I would never become the mother he needed and deserved. From that day, nine years ago to now, he calls me twice a day and is my best friend, which I am truly grateful for. We have no secrets from each other because we talk about everything, even things I don't want to know, but I am delighted that he confides in me anyway. I can't tell you how many people tell me they wish they could have a relationship with their kids like I have with mine, if they only knew. He is an amazing son, both of my kids are, and thankfully, my older son did not follow in my footsteps, unlike so many children of substance users usually do. My son goes to school, works full-time, stays out of trouble, and I couldn't ask for a better role model for his younger brother.

Jorge: What advice do you have to other parents with children who are struggling with mental health, substance use, and/or homelessness that you wish you had received?

Kristin: After overcoming substance use, I was able to get help with my mental health issues and eventually homelessness, with the help of S:US. So, I decided to go to college in the fall of 2018 in order to give myself and my sons the kind of life we deserve to live. Currently, I'm on track to graduate college with a bachelor's degree in criminology, a minor in psy-

chology, and a dispute resolution certificate. I will start law school in the fall of 2023. I am also employed by S:US in a new unique role as their Advocacy and Research Associate, which helps to bridge the gap between S:US and the people we serve. Today, I'm proud to say that not only am I sober, but I have become the mother my two amazing sons, Skyler and Robert, deserve to have.

The advice that I would give other parents struggling with mental health and substance use issues, including homelessness, is to truly take care of yourselves, and not to be afraid of letting people help you! Visit your doctor frequently, follow their orders, and take any medications they may prescribe on a regular basis, not sporadically like I used to. Another big mistake I've made in the past has been thinking I don't need to take my prescriptions anymore because I felt so good that I thought I was cured. Ridiculously not realizing that it is the prescription medications that are working to help keep me feeling good. Look in a mirror, even if it's hard, look deep within yourselves to find the real reason you keep using and find a way to either forgive yourself or work through the issues you're having. Look back at yourself in that mirror and tell yourself that you love yourself. It's so much easier to move forward with your life when you can accept that no one is perfect, and it's ok to make mistakes as long as we catch ourselves right away. I could say so many things, but the most important is to set goals, small ones first, because they're easier to obtain. Once you've completed those goals, it becomes easier to accomplish the bigger goals you set. Also, don't ever get discouraged by someone else's words, as misery loves company and miserable people will always try to bring you down. Recovery is a bumpy road and sometimes you may fall,

but when you remember to pick yourself up right away and continue to move forward, it's easy to restart your day at any time. Lastly, we are not alone, so don't be so hard on yourself. There are millions of people that struggle with the same issues daily, so remember you're never the only one. Finally, life is a journey of learning experiences. We all fall but not everyone gets back up to try again. Always remember that anything that's worth having in life is worth fighting for!

Jorge R. Petit, MD, is a community psychiatrist and the President and CEO for Services for the UnderServed (S:US). S:US drives scalable solutions to transform the lives of people with disabilities, people in poverty, and people facing homelessness: solutions that contribute to righting societal imbalances. Founded in 1978, S:US works with more than 37,000 individuals and their families every year to create pathways to rich and productive lives by offering housing, employment, skills-building, treatment and recovery services.

Prior to joining S:US, Dr. Petit was the President and CEO for Coordinated Behavioral Care (CBC), a not-for-profit organization dedicated to improving the quality of care for individuals with serious mental illness, chronic health conditions and/or substance use disorders, through a Health Home, an Independent Practice Association (IPA) and an Innovations Hub.

Dr. Petit was the Regional Senior Vice President for New York State for Beacon Health Options and before that was the Founder and President of Quality Healthcare Solutions, a consulting firm that provided training and consulting services for healthcare systems including community-based behavioral health agencies, hospital systems, and local and

state regulatory entities. He was the former Associate Commissioner for the Division of Mental Hygiene in the New York City Department of Health and Mental Hygiene.

Dr. Petit has been the primary lead on several large-scale grant-funded implementation projects including Integrated Care Models to Improve Health Outcomes and Reduce Poverty funded by the Robin Hood Foundation; the Depression Care Management in Primary Care funded by Forest Laboratories; the Behavioral Health Care Collaborative (BHCC) funded by NYS OMH and the BHCC expansion grant funded by NYS OASAS.

Dr. Petit sits on the board of Primary Care Development Corporation (PCDC) and Mental Health News Education (MHNE); is a Distinguished Fellow in the American Psychiatric Association (APA) and a member of the Committee on Psychiatric Administration & Leadership in the Group for the Advancement of Psychiatry (GAP) as well as a member of the National Council for Mental Wellbeing's Medical Director Institute.

Dr. Petit is the author of Handbook of Emergency Psychiatry and The Seven Beliefs: A Step-by-Step Guide to Help Latinas Recognize and Overcome Depression and the recipient of the Schiff Community Impact Award from The Jewish Board, the 2017 Greater Good Honoree, Corporate Social Responsibility Award, 2018 Heritage Healthcare Organizational Leadership Award and the Community Partnerships Award, Virtual Community Partners Award from Federation of Organizations (FOO), Crain's New York Business 2022 Notable LGBTQ Leader, City & State New York 2022 Nonprofit Power 100, and City & State New York 2022 Responsible 100.

Loss from page 24

courses and graduate the following June.” Instead, without communicating with her, he died by suicide on campus.

Tropp remembers that the college staff was supportive and got her daughter and son-in-law to smile a little. During the memorial service on campus, many students attended and talked about Nick fondly. A few years later, a wonderful memorial space overlooking the water was built with Nick’s name engraved, and there were fond remembrances from his RUF friends.

Tropp sees the effects on the family. She knows her daughter will never get over Nick’s loss despite having a supportive therapist. They still go places Tropp

loves, places where they were previously very social. But her daughter doesn’t feel like socializing much now, and this limits their interaction with others. Meanwhile, Nick’s brother was very close with him and won’t talk about his loss. Tropp said he is hugely upset and misses his brother enormously.

Still, Tropp relishes the time with her daughter and grandson. She tries to keep them smiling more than crying.

Tropp knows her grandson is smiling down, while she is smiling up at him. She chose to share what Helen Keller once wrote about creating memories: “What we have once enjoyed and deeply loved we can never lose, for all that we love deeply becomes a part of us.”

LGBTQ+ from page 30

Indeed, in the coming years, the need for such specialized care will only grow.

Why?

For one, LGBTQ+ health now represents billions of dollars in annual revenue. And that, in large part, is the result of changing social norms. But the industry is still catching up.

Unsurprisingly, companies intend to capitalize on this emerging market, which is why they’re aggressively recruiting graduates of programs such as CSUN’s Graduate Certificate in LGBTQ+ Health.

But more importantly, beyond any financial reasons, this transformation in health care is a human one.



Jason Gibby

Efforts from page 14

recipient’s home and/or community environment without on-site supports.” On the other hand, intensive crisis stabilization centers provide “urgent response and/or treatment services to recipients experiencing an acute mental health and/or substance use crisis . . . including rapid access to services for acute symptoms, assisting in diversion from a higher level of care, and prescribing or administering medications to manage substance use and mental health symptoms.”⁷

Supported by up to \$75 million in funding, OMH and OASAS announced awards this summer to create nine intense crisis stabilization centers in the following regions: New York City, Long Island, Mid-Hudson, Finger Lakes, Western, NY, Southern Tier, Central NY, North Country and Mohawk Valley. OMH and OASAS have issued RFPs to create three additional centers, two in New York City and one in the Capital Region.⁸ The development of the supportive crisis stabilization centers is currently in the procurement phase.

Another program that continues to be key for individuals and families is the Community Health Access to Addiction and Mental Healthcare Project (CHAMP), which provides ombudsman services to help to individuals and providers with health insurance coverage rights, issues, concerns, and complaints. CHAMP is administered by the Community Services Society in partnership with the Legal Ac-

tion Center, NYS Council for Community Behavioral Healthcare, and Medicare Rights Center. The ombudsman helpline is available Monday-Friday from 9 am to 4 pm at (888) 614-5400. The program is supported by annual funding in the NYS budget. Legislation enacted this year will require the ombudsman to submit an annual report by each October 31st to the Governor and Legislature that summarizes work of the program “and make recommendations to address systemic issues identified during the previous year.” Stakeholders are currently awaiting release of such a report.

2022 has been a consequential year for the advancement of public health policies aimed to help individuals living with a mental health and substance use disorder and their families. In one Canadian study, 35% of respondents said their lives had been affected by their family member’s mental health and 71% who stated their lives were affected provided care to their family member.⁹ The rates were similar in an October 2022 survey by CNN and Kaiser Family Foundation which found that among those whose family member experience a severe mental health crisis, four in ten said it impacted their own mental health or family relationship, with one in five saying it also impacted the family’s financial situation.¹⁰ This national survey also found that 90% of respondents believe there is a mental health crisis in the U.S. with half of adults indicating that they or a family member have experienced

a severe mental health crisis, and, furthermore, found 56% had not heard about new 988 hotline. New York has not been immune as DOH’s spring 2022 quarterly Opioid Report found that drug-overdose related deaths increased by 37% between 2019 and 2020 -- “an increase in overdose deaths to the highest amount recorded in 2020.”¹¹ 988 and crisis stabilization efforts will be an important component in meeting the needs of New Yorkers and reducing or reversing these alarming trends compounded by the effects of the COVID-19 pandemic with a ripple effect for immediate and extended family members.

Jamie Papapetros is Research and Communications Coordinator at New York State Psychiatric Association’s Government Relations Office, in conjunction with Karin Carreau of Carreau Consulting. Mr. Papapetros has a decade of experience in government relations, identifying, tracking and analyzing pertinent legislation, providing legislative and electoral research, memo preparation and in depth legislative and regulatory reports.

Footnotes

¹ <https://www.samhsa.gov/blog/groundbreaking-developments-suicide-prevention-mental-health-crisis-service-provision>

² <https://www.fcc.gov/document/designating-988-national-suicide-prevention-lifeline-0>

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⁵ https://omh.ny.gov/omhweb/bh_services_council/omh-updates-09222022.pdf

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¹⁰ <https://www.kff.org/report-section/kff-cnn-mental-health-in-america-survey-findings/>

¹¹ https://www.health.ny.gov/press/releases/2022/2022-04-04_qtr_opioid_report.htm

Pandemic from page 25

they chose this profession. We expect a challenging winter ahead, but we feel confident that we have learned how to adapt to the changing environment to meet the needs of our clients. This work has never been needed more urgently.

Launched in 1972 and independently incorporated in 1979, SPOP is one of the largest and longest-standing agencies entirely focused on community-based behavioral healthcare for adults age 55 and older. Learn more at www.spop.org.

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Suicide from page 29

interrupted (avoid public spaces) and allow for plenty of time so you don't feel rushed. You know your child's moods and behaviors better than anyone else – be direct. Starters can include: "I have been worried about you lately." "I've noticed some differences in you lately." "Are you having thoughts about suicide?" or "Are you thinking about killing yourself?" Use open-ended questions so that you get a better understanding of their situation, thoughts and feelings. Avoid phrases like: "You don't want to kill yourself, do you?" "You're not thinking of suicide, are you?" As you ease into the conversation, the questions will come more naturally, but make sure you ask without judgment and in a way that allows them to be open and honest.

With younger children, one of the best ways to address suicide in conversation comes from Dr. Pamela Morris (P. Morris, personal communication, February 22, 2022). Think about how you would talk to your child about other health conditions (e.g., headache or a fall): *How much does it hurt? How long have you felt this way? What happened right before you felt this way? What happened right after you felt this way?* This allows for you to get a full picture of your child's current emotional makeup.

Listen Without Judgment

It is a natural response to want to talk your child out of suicide, to react with fear and anguish, to do anything to keep your child safe. What youth need to know is that they are safe, even welcome, to share their innermost thoughts about this emotionally charged topic. You want to support your child's feelings without interruption, with nonjudgmental listening and exploration of their pain (Freedenthal, 2022). Children need an opportunity to talk about how they are feeling and may be relieved to be able to do so. You want to make statements that express empathy for their distress: "It sounds like that was really difficult." "I know how painful that



Scott Bloom, LCSW

can be." "I know what that's like. I've felt that way." Telling them not to feel that way, to *pull it together*, isn't as helpful as letting them know what it is that you're concerned about, and how you can help (Kaslow, 2022).

Risk Factors

If your child confirms they are thinking about suicide, it is important to try and find out if they are in immediate danger. People are usually at higher risk of suicide when they have a specific way in mind and the ability to carry it out. The more detailed the plan is, generally the higher the risk will be. Other factors (Suicide Prevention Center, 2022) include a family history of suicide, being diagnosed with some type of mental illness, having made a previous attempt, and, being exposed to the death of a peer who dies under any circumstance not just suicide. For teens and young adults who are struggling to find their own identities and place in life, being confronted with mortality can be very unsettling emotionally and some

teens who are already emotionally vulnerable may think about dying themselves (NYSOMH, 2022).

In Summary

- Pick a good time and ask your kids what they think/feel about suicide
- Be conversational, honest and direct
- LISTEN to the answer
- Don't disagree with them or minimize what they tell you
- If you hear anything that concerns you, simply say: TELL ME MORE
- Be prepared to take action
- Be kind to yourself. It can be draining talking to someone about suicide and supporting them.

Immediate Resources and Supports

- 988 – National Suicide and Crisis Hotline
- Trevor Project – LGBTQ Crisis Hotline 1-866-488-7386
- 1-888-NYCWELL or text "WELL" to 65173*
- Apps:
 - Suicide Safe by SAMHSA
 - Suicide Safety Plan

To contact Scott Bloom, LCSW, email to SBloom@nypcc.org and visit the New York Psychotherapy and Counseling Center at www.nypcc.org, (347) 352-1518.

Citations and Resources

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de facto founder of Samaritan Daytop Village and was our first and very long-term CEO. He was a visionary and understood early on that you couldn't just treat substance use disorder; it was closely linked with mental health issues in many cases and needed full wrap-around services. He expanded our portfolio to include those other areas. The building is named after him; it's in honor of his legacy and is a physical embodiment of his philosophy. The building was purpose-built for us, with a very large number of services under one roof, and it's a beautiful building. It's a place where clients come in and immediately feel a sense of respect and dignity. It's very appealing, very client-centered, and friendly.

Regarding the range of programs at the Wellness Center, we have an outpatient mental health clinic, an outpatient substance use disorder clinic, a methadone clinic, and soon we'll have a licensed Article 28 medical clinic for physical health issues. We have a recovery center for people who have been through treatment where we make sure that we are giving them the tools they need to continue their path to recovery. We also have a central admissions office - the idea is that there is no wrong door; someone comes in, we can find the best place for them and help arrange transportation. We also have a health home case management program there. It's really one-stop shopping. So, clients can receive all of these services from Samaritan Daytop Village in one building where we can coordinate these services with warm handoffs, resulting in better outcomes and an improved "customer service" experience. It's been tremendously embraced by clients and staff, and there's more interaction between staff, so there's better teamwork.

David: Congratulations on that! Another opportunity where you got to break out the big scissors for a ribbon-cutting was the recently opened Bronx Support and Connection Center. What services are being provided there and what impact will this have on community members with mental health and/or substance use disorders?

Mitchell: There are a tremendous number of services in that facility as well, but it's a smaller program and it's one of two pilots funded by the City of New York. The idea is that the people brought to the Support and Connection Center would initially be brought there by New York City police officers if they encounter someone on the street or receive a call and the person is exhibiting some behavioral health issue, whether it's related to mental health and/or substance use disorder. This wouldn't include things that would require an arrest or rise to the level of needing to go to the emergency room. Some examples for what would bring a person into the Bronx Support and Connection Center include: public nuisance, urinating on the street, walking in traffic, harassing people, etc. It is a very rich service model so that the issues people who are brought there are exhibiting can be treated.

We can do detox on site, provide mental health services, do a full physical examination - many of the people we see will have chronic health conditions in addition to mental health concerns and/or substance use disorder. They can also stay

there for up to five days, with the possibility of an additional five beyond that. It's not a shelter or a residential program, but rather a short-term solution to address the person exhibiting that behavior, stabilize them, and get them what they need immediately (not making a referral because they may never get to that other place, and if they do make it to an emergency room for example, they may get lost with people who might be exhibiting more severe conditions). A critical component is for us to then link them to whatever services they may need beyond those five or ten days to ensure that they are continuing with whatever program is best suited to them. We also have an open-door policy, so they can always come back, recognizing that issues of mental health and substance use disorder, like any other health issue, can have ups and downs and relapses. We never view those as failures, and the doors are always open for them to come back to that support and connection. The impact on the community will be positive over time, as we expand our geographic catchment area. The community initially had some concerns, but once they understood the program, they started asking if they could make referrals. The city is not quite there yet, but I think it will have a positive impact on not just the local community but broader as we expand our geographic catchment area.

David: With so many services in one place, for both of these facilities, it must be a bit of a staffing challenge. Are you having issues with the workforce shortages?

Mitchell: Yes, we are facing a problem that not just everyone in our industry is facing, but it's truly a worldwide phenomenon in all industries. Telephonic and telehealth services have had a big impact on that. Having multiple programs in one facility helps us shift resources more freely and eliminates transportation issues, but it is still a challenge. It's not the first and only challenge we've faced, and we have to deal with it creatively. The burden falls on the staff, who I have to commend. They are true heroes and heroines who have been working through the pandemic and are working in a situation where we are not fully staffed, which adds additional burden. However, they have risen to that challenge.

David: Speaking of the pandemic, how did the most difficult parts of the COVID pandemic shape the way you guys are now operating?

Mitchell: Well, the pivot to telehealth and telephonic services was dramatic overnight, and I have to applaud state government who made quick rule changes that might have taken 10 years happen in just 10 days. This has resulted in a more efficient use of some professionals' time as they no longer have to spend time traveling. Also, because of the workforce shortage, this makes more efficient use of the staff that we do have. In general, clients have generally responded well. We still offer and have gone back to in-person services, but we can now give people a choice between in-person and remote services.

The pandemic has also led to a shift towards a less paternalistic view of clients. That's how the system was structured in the past. I'll use methadone clinics as an example. Many people have to

come every day to get their methadone. For certain people, we would always give them a supply for several days - on rare occasions up to 28 days. Well, at the beginning of the pandemic, we didn't want people coming in every day, so we have to make judgement calls about giving many of our clients longer-term doses for multiple days. We've gone back a little to requiring people to come in a bit more, but not all the way. Clients prefer this, and it has also instilled a sense of trust that they can manage their own life and be more independent. We saw that, in our shelters during the height of the pandemic, the city moved many of the clients from congregate shelters with 10-20 people sleeping in one room to hotels with two people sleeping in one room. To be honest, we were concerned about that. Many of our clients have serious mental health issues and/or are active substance users, and now all of a sudden, they are behind a closed door, and you can't see them. The good news was that we had very few issues - there was a sense from clients that they now had their own room, so they wanted to keep it up to a certain standard and stay in this better situation. Overall, it really empowered our clients more and allowed our staff to be a bit more efficient.

So, we pivoted a bit to remote work but not for all staff, as many of the jobs require you to be there 24-7. In those ways, it has made a profound but positive impact.

David: Switching gears for a moment, we are all well aware of the recent migrant crisis in New York City and I know Samaritan Daytop Village does a lot with supportive housing. What role has the organization played in supporting the asylum seekers who have recently been arriving from Latin America?

Mitchell: Our major response so far to the influx of asylum seekers and migrants has been to open three hotels in Brooklyn, Queens, and Manhattan for asylum-seeking families. In just a few weeks, we opened those programs and are serving 400 families; well over 1,000 people. We have a lot on our plate, but despite staffing shortages, Samaritan Daytop Village has always been there to meet the needs of anyone in New York City and views asylum seekers as New Yorkers. We are a sanctuary city and are responsive to government. We have also converted two single hotels to house approximately 160 men specifically for asylum seekers. We were fortunate to receive funding from a small hedge fund to provide employment skills, job placements, and English as a second language courses for asylum seekers to get better-paying jobs and become productive members of the workforce. We are proud that we have been able to do this and we are currently housing around 1,500 asylum seekers every day.

David: That's such a huge impact really, and the lasting impact that you are having on these people's lives in this difficult situation is really wonderful. So, harm reduction is something that is being embraced at the federal level and the New York State level. How is Samaritan embracing this harm reduction approach to substance use disorder treatment to prevent overdose deaths, save lives, and engage clients?

Mitchell: We have fully embraced harm reduction in many different ways. It has been a bit of a culture change for Samaritan Daytop Village, though my predecessor Tino Hernandez really took the agency far in embracing it; I give him a lot of credit for that. However, many of our staff are in recovery, which is something that we are proud of, and did not come through harm reduction programs, so they have their own mindsets. To address this, we are providing agency-wide training on harm reduction and stressing that this is about saving lives. The unprecedented number of overdose deaths is a preventable tragedy that has claimed over 100,000 lives in any 12-month period recently. As we say, "Its lives over philosophy." You can't help someone deal with their substance use disorder if they are not alive. It is a matter of life and death. Saving lives is our overriding principle.

In addition to training our staff, we also did some training with our Board. Instead of simply asking our Board if we wanted to run a harm reduction program, we provided educational material and reached out to Joe Turner from [Exponents](#), a leading agency in harm reduction, to present to our Board. We have some staff at Samaritan who are experts that collaborated in the presentation. So, we acknowledged that we are not the experts on this subject and working with Joe was a great experience. From the presentation, we then have to put what we have learned in place.

We are also working on a pilot program at one of our shelters, which was initially designated for people with substance use disorder but has now been expanded to include behavioral health issues. We are partnering with [Exponents](#) and [Housing Works](#) to provide harm reduction services, including fentanyl testing strips and clean needles, in the parking lot of the shelter. Some of our staff have raised questions and concerns. For example, "I have some clients who don't want to use but are we condoning this?" You encourage people to express their feelings and then you talk them through it. A lot of it is a change in mindset, education, and just focusing on saving lives. We have also implemented Narcan training and received special funding to address the opioid crisis in three boroughs of New York City. Those people are out on the street doing fentanyl testing and education. It's about engaging people - there is no caveat that "We are going to do this and you've got to go into treatment." It's just engaging someone. If you are going to use, be safer and don't do it alone, regardless of what drug you are using as fentanyl these days is pretty much laced into everything. We have a standing harm reduction committee that meets to discuss ways to integrate harm reduction into our programs. We believe that harm reduction is crucial to saving lives, as the number of overdose deaths is preventable with the right resources and approaches. It is an ongoing process, but we are committed to making a positive impact and saving lives.

David: We've touched on a lot of the challenges that come with your work, but what are some of the highlights and positive things that come with your work as President and CEO of Samaritan Daytop Village?

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psychiatric residents. When receiving the case, the resident would call the family to explain their role and call to follow up 2-3 times weekly. The psychiatric residents provided supportive counseling to the family, normalized their grief and anxiety, listened to their fears and hopes, as well as learned more about the patient. The residents also shared healthy coping mechanisms with families and connected them to social benefits and programs from food and unemployment to mental health services. Interpretation services were available, and all calls were documented in the patient’s chart. The hospital also offered post-hospitalization care for families.

There is still a great deal of uncertainty around how FFP is implemented. Family-Focused Practice is more often implemented when a child is involved, but can be incredibly effective in adult mental health services, as well.^{vi} Practitioners play a key role as an intermediary among service providers, families, and organizations, but often find that they don’t have the adequate resources to prioritize the practice.^{iv} There’s often a lack in confidence, skills, and knowledge in the real-world practice of FFP.

Not enough government and organizational policies authorize and promote family-focused practices either.^{vii} Innovative approaches include the Effective Family Program in Finland, the Think Family initiative in the U.K., Children of Parents with a Mental Illness and Families where a Parent Has a Mental Illness in Australia. In Scandanavia, legal amendments have been passed requiring practitioners in adult mental health services to identify and assist with needs of children whose parents are using services.

If you’re a provider looking to implement FFP in adult mental health services, research recommends six action points:

- 1.Health care providers must identify



Matt Kudish

practitioner and family readiness for the “therapeutic alliance.” Readiness is just as important on both sides.

2. Practitioners need both the flexibility to implement as well as monitor their own family focused practice. They need to understand how patient mental illness impacts family members, and practice how to hold a dual perspective.
- 3.FFP must be a part of an organization’s identity and built into policy. FFP will be a part of core competencies recruitment, as well as practitioner training, support, and monitoring systems. Outcome measures will include family well-being.
- 4.Leadership at various levels of the organization must support FFP, including communicating family-focused practice as a priority, developing training, and creating reporting systems. Managers will facilitate family-inclusive mental health practice in daily work.

- 5.An internal implementer can ensure sustainability. The implementer can support leadership and build practitioners’ skills and confidence.
- 6.Both the implementation and practice of FFP can transform larger funding and political context of the organization. If the provider measures parent, children, and family outcomes, the lens will shift from individuals to family resilience and wellbeing.

Family-Focused Practice demonstrates that “family matters” and can have positive, long-lasting impact on individuals living with serious mental illness.^v We hope that our healthcare leaders will make families a priority in mental health care – for the wellbeing of patients, families, and our communities.

Matt Kudish is the CEO of the National Alliance on Mental Illness of New York City (NAMI-NYC), which has centered families and individuals affected by mental illness and their families for 40 years. Learn more about our family classes, support groups, mentoring, Helpline, and more at www.naminyc.org.

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VI. (PDF) [A Sustainability Model for Family-Focused Practice in Adult Mental Health Services](#) (researchgate.net)

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Mitchell: I try to get out of the office and many clients will come up to me and figure out who I am. What I hear a lot is not just that we offer great services, but “You’ve saved my life.” I hear that a lot and it just warms my heart. And that is not a rare thing people say. It’s not just clients, but staff will ask to speak with me, and they will reveal to me that they were a client of Samaritan and they are in recovery. Usually, they will say the same thing: “I probably wouldn’t be alive if it weren’t for Samaritan Daytop Village. The staff are incredibly dedicated. They let me know that they get job offers from other places, but they stay because they want to give back.

The Samaritan buildings that used to

run the programs that are now included at the Richard Pruss Wellness Center were all scattered throughout that neighborhood and were below our standards. It makes me feel good to see the new building with client artwork on the walls. Clients come in and don’t expect to be receiving services in such a nice place like that.

The asylum seekers have had traumatic experiences leaving their home countries, getting to the border, and ending up in New York City where they may not have planned on coming. We are able to give them something they haven’t experienced – letting them know they are welcomed and supported. Giving someone permanent housing is certainly rewarding. It is a wonderful thing to be able to provide someone with a key to their own apartment, potentially for the first time in their

life and see their joy. The same thing when they get employment.

These are the things that “recharge my battery.” Getting out and about helps me see the fruits of our incredible staff’s labor. Those are the things that really make me feel good.

David: The impact that you and your staff at Samaritan Daytop Village are having on people’s lives is immeasurable.

Mitchell: Yeah, we serve about 33,000 people a year. Every single night, we house about 7,000 people, including 2,200 kids. That’s a lot of people and I know they’re in a safe place. We held a big toy drive for the holidays so that every kid can have a toy. Each one of those 2,200 kids at least will get one toy for sure. Par-

ticularly, for people in our shelters of limited means, it just brings joy for the holidays. We try to do that each and every day of the year.

David: Well, I know I speak for many when I say thank you for what you do and to all your staff and I want to also thank you for your time today. It’s been such a pleasure to speak with you!

Mitchell: And thank you! Your publications are great and really help the fields in many different ways. We’re all stronger and better for all the work that you do. For more information about Samaritan Daytop Village, please visit SamaritanVillage.org and stay tuned for our next installment of the [Behavioral Health News Spotlight on Excellence Series](#).

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the progress of their loved one. Opportunities for family participation include phone and video connections, active contributions in treatment team meetings and family therapy, and full engagement in home visits for community integration, as well as the individual's eventual completion of the program. Without this kind of true family engagement, optimal outcomes can be minimized, prolonged, or even halted.

Devereux's prioritization of family engagement: Devereux Advanced Behavioral Health practices a family engagement model that is grounded in the Building Bridges Initiative. Devereux understands there is no one definition for the term "family," and "embracing families" means something different to everyone. Staff are required to participate in trainings that discuss the family perspective, and how to fully honor it while providing mental and behavioral health services for their loved ones.

"Meeting the family where they are, not where you expect them to be" is an important motto for Devereux's family engagement and partnership work. This requires a thorough understanding of the family, their strengths, needs, life's circumstances, priorities, barriers, and culture. Special attention to these factors is at the core of Devereux's admissions process.

As a trauma-informed care (TIC) organization, Devereux keeps TIC principles, including historical, cultural and gender issues, at the forefront of its framework for all interventions, including family engagement. Staff are trained in topics related to diversity, equity, inclusion and belonging (DEIB), and begin addressing cultural factors and perception of treatment with families in initial stages of engagement, including outreach and admissions. This framework is utilized throughout treatment and during the discharge process.

Future considerations for family engagement: While research supports the need for family engagement, and the benefit of family engagement initiatives on outcomes, there is significant diversity in the behavioral health field regarding the



Crystal Taylor-Dietz, PsyD

systems and interventions utilized for family engagement. Innovation and continued integration of culturally responsive interventions, with a focus on destigmatization, are essential to an organization's ability to support a wider population of families who are the primary supports for individuals with behavioral health needs.

Future considerations for best practice in family engagement across the mental and behavioral health industry should include:

- A **family peer support model** (also known as a family navigator), where family members with previous or ongoing lived experiences of a similar behavioral health situation are offered as a resource to support the incoming family from the moment of referral through discharge and beyond. A family peer will guide the family through their journey, moving from guidance in a "doing for" to a "doing with" model. Note: Employing family navigators from varied cultural and ethnic backgrounds also is essential to helping decrease mistrust and stigma for families from marginalized backgrounds.
- An **online family portal**, where families can electronically access their loved



Amy Kelly, MBA, MNM

one's information, including their daily schedule, medications, recreational activities, and direct care staff, at any point in time. Cultural sensitivity to internet and electronic access should be part of the assessment and interventions with families.

- **Translated documentation** across multiple languages and communication means (e.g., website, letters, emails, family portal language), and access to interpreters for phone calls, team meetings or assistance with center interactions.
- **Prioritizing communication** of their loved one's strengths on an ongoing and regular basis, not just the challenges.
- **Discharge planning** should begin at the time of admission; consider realistic and manageable options; and consider creating a family "transition preparation" training for transitions that is available to the whole family prior to their loved one ending services with the organization.

Crystal Taylor-Dietz, Psy.D., is National Director of Behavioral Health Services, and Amy Kelly, MBA, MNM, National Director of Family Engagement, at Devereux Advanced Behavioral Health

About Devereux Advanced Behavioral Health: Devereux Advanced Behavioral Health is one of the nation's largest non-profit 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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[The Impact of Stigma on Mental Health | McLean Hospital](#)

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the [NIMH Mental Health Medications](#) page. Also, visit the [FDA website](#) for the most up-to-date information on medications, side effects, and warnings.

Vitamin D

Because many people with SAD often have vitamin D deficiency, nutritional supplements of vitamin D may help improve their symptoms. However, studies testing whether vitamin D is effective in SAD treatment have produced mixed findings, with some results indicating that it is as effective as light therapy but others detecting no effect.

Can Sad Be Prevented?

Because the timing of the onset of winter pattern-SAD is so predictable, people with a history of SAD might benefit from starting the treatments mentioned above before the fall to help prevent or reduce the depression. To date, very few studies have investigated this question, and existing studies have found no convincing evidence that starting light therapy or psychotherapy ahead of time could prevent the onset of depression. Only preventive treatment with the antidepressant bupropion prevented SAD in study participants, but it also had a higher risk of side effects. Therefore, people with SAD should discuss with their health care providers if

they want to initiate treatment early to prevent depressive episodes.

NIMH supports a wide range of research, including clinical trials that look at new ways to prevent, detect, or treat diseases and conditions—including SAD. Although individuals may benefit from being part of a clinical trial, participants should be aware that the primary purpose of a clinical trial is to gain new scientific knowledge so that others may be better helped in the future.

Researchers at NIMH and around the country conduct clinical trials with patients and healthy volunteers. Talk to your health care provider about clinical trials, their benefits and risks, and whether one is right for you. For more information about

clinical research and how to find clinical trials being conducted around the country, visit the [NIMH Clinical Trials](#) page.

If you are thinking about harming yourself or attempting suicide, tell someone who can help right away. Call 911 for emergency services. Go to the nearest hospital emergency room. Call or text 988 to connect with the 988 Suicide & Crisis Lifeline. The Lifeline provides 24-hour, confidential support to anyone in suicidal crisis or emotional distress. Support is also available via [live chat](#). Para ayuda en español, llame al 988. This article was originally published by The National Institute of Mental Health. You can view the original source [here](#).

Perspectives from page 1

Bowen and other family therapists viewed addictions in much the same way—as reflections of dysfunctional families.

Looking back, I am stunned and a bit ashamed that I and many, many others believed this sort of thing. I guess we were convinced that psychotherapy and family therapy helped—as they often did—and that therefore the underlying theories must be correct. But we also believed that medication therapy helped. Shouldn't we have wondered a bit more about the organic roots of mental illness than many of us did at the time.

Towards the end of the 1970s and into the 1980s families began to revolt against the idea that they were to blame for their children's mental illness. Parents of autistic children, who were deeply offended by Bettelheim's accusation that they were as cold as refrigerators and that they wished their children dead, insisted that autism is not a mental illness at all, that it is a developmental disability, no more caused by the parents than is limited intelligence. At around the same time, families of people with schizophrenia, largely through NAMI, insisted that schizophrenia was a genetic brain disease that they did not cause. They focused on the burden that they had to bear as caregivers to family members who were profoundly dysfunctional and needed considerable family support just to survive.

Some professionals began to see it the same way. They were struck by the clear organic component of schizophrenia. Studies, for example, of [twins separated at birth](#) showed that if one identical twin developed schizophrenia it was likely the other did too, despite being raised by different par-



Michael B. Friedman, LMSW

ents in different living environments.

Some professionals were also struck by how difficult it is to be the parent of a person with schizophrenia—the emotional cost, the financial cost, the disruption of careers, the fragmentation of families.

In addition, it began to become clear that relating to families as if they were to blame created a tremendous barrier to an effective relationship between families and therapists. This was noted, for example, in [a brilliant paper](#) that Ken Terkelsen wrote in 1983, in which he called for a new approach to working with families—a compassionate, collegial approach instead of an approach that reinforced their guilt and shame about having a severely mentally ill child.

Similar lines of thought began to emerge regarding emotionally disturbed children and their families. Family

groups, such as Family Ties in New York, formed around the country, and parents fought against the accusation that they are to blame for their child's suffering. They insisted that they be treated as allies in the treatment of their children and argued for a change in mental health policy emphasizing family support.

This compassionate view of families, of the burden that they bear, and of their need for support is now widespread, though, of course, not universal among mental health professionals.

But there is another perspective that has emerged that once again points the finger, at least partially, at the family contribution to emotional disturbance, mental illness, and addiction. That is the perspective that emerges from the studies of adverse childhood events (ACES).

According to that perspective, children who live in troubled families—families that are violent or in which there is substance abuse or in which there is severe mental illness—are more likely to develop mental disorders, addictions, and even physical illnesses in later childhood and in adulthood.

This perspective is at the heart of the modern hope for the prevention of mental and substance use disorders. Reduce the risks to children by diminishing adverse parental behavior.

Of course, this is not at all the same as saying that all or even most mental problems are caused by parents. But it does call for recognition of the toxic trauma that children may experience in their families and its impact on their later life.

It's also important, I think, that even though there has been increasing acceptance of the idea that addiction is a brain disease and recognition of the burden addiction places on families who love

and want to help their children, siblings, lovers, and spouses, there has also been an elaboration of views about addiction as a condition that involves entire families. Many [addiction recovery organizations](#) talk about six family roles: (1) the person who is addicted, (2) enabler, (3) the scapegoat, (4) the hero, (5) the mascot, and (6) the lost child. The essence of this is that addiction is seen as a family problem.

Where do we stand now? In general, we have made a transition from a toxic view of families to a compassionate view. In general, there is recognition of the tremendous burden that families bear if there are people with severe and persistent mental illnesses and/or substance use disorders within them. In general, we recognize that families need substantial support to bear their burden. And in general, we accept the harsh unavoidable fact that families do sometimes contribute to the mental illness or addictions of their family members.

In this, as in all things human, life is complex and ultimately mysterious. It calls, I think, for humility among the professionals who accept a responsibility to help people with behavioral health conditions and their families.

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Ketamine from page 36

with clinically appropriate dosages.

There is also risk of [addiction](#) and [abuse](#), especially when administered outside a clinical setting. Fortunately, there is a limit to how much ketamine an individual can [absorb sublingually](#), making it [nearly impossible to overdose](#) when taken in lozenge form.

Demand

In light of the promising benefits – and despite the potential risks – demand for ketamine treatment for depression has boomed. When a new ketamine nasal spray went on the market in 2019, over [6,000 Americans](#) used it within the first year. The demand has also resulted in the emergence of hundreds of new [ketamine wellness centers](#) across the country.

Some patients even have [pre-measured doses](#) of ketamine shipped directly to their homes. [Mindbloom](#), a company at the forefront of at-home services, recently conducted (and sponsored) the largest [evaluation](#) to date on the safety and effectiveness of at-home ketamine kits for depression and anxiety, with over 1,200 participants. Participants benefited from the same rapid and significant positive effects at rates consistent with clinically administered ketamine treatment. At the same time, there is [little oversight](#) for at-home treatment kits, which introduces warranted concerns considering ketamine's potential risks.



Caroline Emmitt, MSW

Using ketamine to treat depression and other mental health conditions is still in its early stages. While the benefits of ketamine look promising and have successfully treated some, the associated risks are significant and need to be better understood. Ketamine itself is not a cure and should always be a part of a [comprehensive treatment plan](#) aimed at developing resiliency against symptoms. Nonetheless, this new approach provides hope to those who struggle with depression and feel left behind by conventional treatments.

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For the complete list of references, [click here](#).

Trauma from page 38

physical neglect, emotional neglect, exposure to significant mental illness, exposure to contemptuous divorce, substance abuse, domestic violence, and separation from family due to crime (Oral et al., 2016). There is no finitely defined set of ACEs, but these are generally considered the most commonly cited.

Different Responses to Trauma: As described above, trauma is difficult to understand due to its two-fold nature: a traumatic incident must occur *and* there must be an associated emotional reaction. It is possible for individuals to have experienced trauma and not develop traumatic responses, evidenced by a survey of survivors of the September 11th attacks. This survey indicated that fifteen years post-attack, approximately fifteen percent of pedestrians, eleven percent of area residents, and thirteen percent of local workers suffered from posttraumatic stress (Hamwey, 2020). Of course, the author is not suggesting the absence of a PTSD diagnosis indicates a lack of trauma response, but rather as a means to highlight that different people experience and internalize trauma differently. This element makes it especially difficult to be proactive in treating trauma, resulting in what often feels like reactionary measures.

Popular Treatments for Trauma: Trauma informed practices and specializing in trauma are two separate ideologies. Trauma informed practice refers to the general



Jeridith Lord, MA, LCPC

understanding of trauma and commitment to guide everyday practice (regardless of the field) with the intent to avoid revictimization and provide consistent information, humility, and compassion. Having a specialty in trauma implies that a mental health clinician has had specific training in order to guide a trauma survivor through various interventions with the intention to reduce suffering and also avoid revictimization. Every interaction should be considerate of a person's potential trauma.

The two modules of therapy that have been traditionally used to reduce the symptoms of trauma have been CBT and EMDR. CBT in application towards trauma involves identifying the thoughts associated with maladaptive behaviors, with

the goal of increasing positive thinking and emotional regulations (APA, 2017). These sessions typically span twelve to sixteen sessions (APA, 2017).

EMDR is an extremely structured approach to trauma therapy, with six to twelve sessions being conducted approximately twice per week (APA, 2017). The goal is to identify "unprocessed memories" that result from distressing past experiences which are thought to contain the emotions and sensations associated with the trauma (APA, 2017). In EMDR, the focus is on the memory and how to reduce/eliminate the intrusiveness of that memory. The procedures of this therapy utilize "rhythmic left-right stimulation" and associated eye movements, with the goal of reducing the impact of the emotion associated with the memory (APA, 2017).

How Can ABA Help: Although CBT and EMDR have demonstrated efficacy, there is still room for growth. With this in mind, the author would like to propose a third option for consideration: Applied Behavior Analysis (ABA). ABA would be most beneficial in addressing the contingencies that are maintaining the maladaptive behaviors, specifically in states of crisis. Using a four-term contingency, ABA examines a behavior with consideration for the motivations that contribute to the behavior, immediate antecedents that occur before the behavior, and ultimately the consequences that result. For example, consider a woman who has left a violent relationship and is experiencing hypervigilance; she jumps when she sees

someone step out from around a corner. Her motivation is to stay safe, random stimuli are viewed as potentially dangerous, and the consequence is the affirmation that she is actually safe. By understanding these contingencies, a behavior therapist can implement an intervention to teach alternative behaviors with the goal to reduce this hypervigilance and return the woman's sense of control over her life. This is obviously just one example, but there is significant potential for the application of ABA towards survivors of trauma.

Conclusion

Trauma is a complicated and intricate collection of symptoms resulting from adverse experiences. This article has analyzed several barriers to addressing these symptoms, including the hesitation by many survivors to report, the variety of incidents that may be considered traumatic, and the difficulty in conceptually understanding trauma. There are currently two major approaches to treating trauma: CBT and EMDR. The author proposes the consideration of ABA as a third option. Perhaps best used in collaboration with psychotherapeutic, ABA offers evidence-based interventions, data driven results, and contingency management. With this in mind, it would be a beneficial option to explore for future use with survivors of trauma.

For further information on this topic, Jeridith Lord can be reached at JLord@mail.endicott.edu.

Rehab from page 39

denial. A general recommendation is:

- 30 support meetings in the first 30 day
- A sponsor by day 45
- Outpatient treatment for at least 3 months
- Sober living for at least 1 month, ideally 6-12 months
- Continuing all medications until stopped by a professional

These aren't hard rules, but they are good goals. You should see your loved one actively working on their recovery after rehab.

Why is More Treatment Needed After Rehab?

The positive reinforcement of regular therapy allows them to learn to voluntarily abstain from drug or alcohol use without constant supervision - until the risk of relapse decreases.

Try to hold your loved one accountable for outpatient treatment at least weekly, starting immediately after they leave.

Meeting regularly with a therapist is the best way for anyone to remain in a good place mentally and think clearer about their life and issues.



Dr. Lea McMahon, LPC, EdD

When emotional situations come up - such as a death in the family or marital struggles - they should look to resume outpatient treatment right away.

Therapy can be like going to the gym. It's something they can do regularly (weekly or bi-weekly) forever as a safety net.

What Should I Do If I Notice a Relapse?

Address any warning signs you see as early as possible but be sure you're addressing specific behaviors rather than general fears about them relapsing.

- Allow them to open up to you.

- Help them be honest with themselves
- Encourage them to contact their support network.
- Don't come at them with anger and judgment. They already feel depressed and embarrassed about slipping.

Relapse means gaps exist in your loved one's recovery that need to be addressed. More treatment is always required - no exceptions or excuses.

However, this doesn't have to mean going back to inpatient rehab. It could involve things like seeing a therapist weekly or getting back on antidepressants. There are anti-craving medication options like Vivitrol that may help too.

Don't let them brush off the topic. Continue to push past denial or excuses even though it's easier not to.

A relapse can be a temporary setback and learning experience. But, if they refuse further treatment, go back to setting boundaries and require them to take sobriety seriously.

The earlier you can intervene the more likely they will get back on track. Though, your involvement should feel like a loving ally that is also pursuing a healthy lifestyle like going to family support groups and your own therapy sessions when needed.

What Should I Do if They Are Doing Well?

If they are active in their recovery, great! You can work on forgiveness and start re-defining your relationship.

Be willing to participate in family therapy sessions to work on healing and support their efforts. But also find activities to do together unrelated to their addiction story. Maybe you can read the same book, join a softball team or start Friday dinners.

You also should help celebrate their recovery. One month sober might not seem impressive to you, but it's probably a big deal to them.

Your love and support (without enabling) can continue to play a major part of their recovery journey ongoing.

Symetria Recovery has 12 outpatient clinics across Illinois and Texas. To learn more about their MAT and IOP treatment options, visit: <https://www.symetriarecovery.com/about-us/> or call (866) 719-3813. To read more articles by Dr. Lea McMahon LPC, EdD, visit: <https://www.symetriarecovery.com/blog/>

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