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Stigma: How We Can Make a Difference

Addressing Stigma: The Importance of Cultural Relevance and Early Intervention

By Ann Sullivan, MD
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The stigma surrounding mental illness can take a huge toll on children, youth, adults, and families with mental health concerns. Addressing stigma not only helps the individual, but the entire community. Eliminating discrimination that is caused by stigma can lead to improved opportunities for housing, education, and employment among others. Eliminating the negative repercussions that stigma has on policy development, access to care, and insurance reimbursement is a primary goal for the Office of Mental Health.

Ann Sullivan, MD

The COVID-19 pandemic has had a great impact on mental health. Not only have we seen an increase in the number of individuals who are experiencing mental health concerns, but also an expanded awareness of mental illness and the resulting challenges. During the pandemic 40% of individuals reported having an adverse mental health condition – many experiencing symptoms of depression or anxiety. While this increase has required us to focus on ensuring access to services for those affected, it has also provided the opportunity to have an honest conversation about mental health. This is one of the most effective ways of addressing stigma. Changing the culture of schools, colleges, and workplaces by encouraging discussions on mental wellness and self-care - as well as taking action and making accommodations when individuals need to address mental health concerns - is vital to ensuring the best opportunity for everyone to be healthy and successful.

Many studies report that over half of individuals with mental health concerns do not seek treatment. Many times, it is to avoid being labeled with a mental illness. That avoidance can have a negative impact on family relationships, the ability to sustain romantic relationships, as well as all other areas of life – reinforcing feelings of sadness and low self-esteem that can accompany mental health issues. We must change this narrative on mental health by incorporating mental health education into school curriculums, locating services within schools for early access, and addressing the need for culturally appropriate care that reaches into all our communities.

Teach the Children

Perhaps the most effective way to dispel the stereotypes and decrease the stigma of mental health and illness is to reach children and young people before they have been inundated with misleading, inaccurate, and negative messages.

Many of us grew up learning these stigmas from an early age and accepting them as reality. Trying to alter that reality for adults is difficult and often met with resistance. But having positive conversations about mental health with children will allow them to better understand that their psychological well-being is an important part of their overall health, and that sharing their worries, feelings, and fears, and seeking out help is not a sign of weakness.

In 2018, New York State passed a law requiring that all public schools include mental health education as a fundamental part of their school curriculum. These affirmative, age-appropriate lessons give us the opportunity to dispel the myths, break down the stigma, and provide a positive impact on the overall health of children by enhancing their understanding of mental health. Many schools are also incorporating a deep culture of social emotional wellness that actively promotes a supportive learning environment that enables mental wellness, prevents bullying, and fosters positive social connections.

Last year, the State invested $2.5 million to create and support a Mental Health Resource and Training Technical Assistance Center for Schools. The center supports all New York State public and private schools and helps them to provide mental health education and social emotional wellness as part of the K-12 health curricula. This is another very positive step toward reducing the stigma surrounding mental health and illness.

I believe the current generation of school-aged children is the most knowledgeable about the importance of mental health, especially here in New York State, thanks to the innovative programs we've implemented. Children today are more open, and more willing to discuss their

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The Ways That Stigma Hurts People Who Use Substances and How to Help

By Patricia Lincourt, LCSW, and Kelly S. Ramsey, MD, MPH, MA, FACP, DFASAM, NYS Office of Addiction Services and Supports (OASAS)

Stigma hurts, when stigmatizing language is used against those with substance use disorders. In a study by the Recovery Research Institute,[1] 314 survey respondents were asked to answer questions about two individuals who were using substances. The only difference in the way that the individuals were described was how they were labelled. The first individual was described as a "substance abuser" and the second individual was described as "a person with a substance use disorder." The person described as a "substance abuser" was perceived by the study respondents to be:

- less likely to benefit from treatment,
- more likely to benefit from punishment,
- more likely to be socially threatening,
- more likely to be blamed for their substance use, and
- more likely to be able to control their substance use without help.

This study highlights the power of language to influence the perception of people who use substances or have a substance use disorder. This perception has consequences for relationships, interactions with authorities and systems (e.g., health care, child welfare, criminal justice, law enforcement), and policy development. If the language we use confers blame on or belittlement of the individual for substance use or a substance use disorder, we are less likely to have empathy for them or want to assist them in accessing harm reduction services, treatment, other social services, and community supports.

Social Isolation

One of the consequences of stigma is social isolation. In her blog on the National Institute on Drug Abuse (NIDA) website, Nora Volkow[2], Director of NIDA, discusses how stigma and societal judgment discourage people from participating in social contact. You can imagine that every interaction in which an individual experiences judgment or disapproval discourages future interaction. Dr. Volkow describes how stigmatizing interactions work like an electric shock or punishment and individuals learn to avoid contacts that cause them pain.

In a recent article in the journal Nature, Venniro[3] demonstrated how social interaction serves as a deterrent to substance use in rats. Venniro's research builds on research done in the 1970s by Bruce Alexander[4]. He challenged some of the studies done at the time showing the power of opioids to take over the brains of rats in experimental conditions. Alexander questioned the results of the previous studies because the rats in these studies were isolated and kept in small cages away from stimulation and other rats. Knowing that rats are social animals, he created what came to be known as the rat park experiments. He showed that these social animals, opted for socialization, and had less opioid use compared with the rats in previous studies who existed in isolation.

Patricia Lincourt, LCSW

Kelly S. Ramsey, MD, MPH

Perpetuating Shame and the Internalized Negative View of the Self

The sum of these stigmatizing interactions can lead individuals to internalize the views of others and feel shame about themselves and their substance use. This causes a self-perpetuated loop of increased substance use as the person avoids social interaction and self-medicates the feelings associated with that isolation. This can lead to additional internalized stigma and can result in more use of substances, supporting a cycle of use, stigma, and shame. Historically, there was a lot of focus on "tough love" or allowing a person to "hit bottom" and a belief that individuals needed to face the consequences of their substance use. This thinking justified the use of stigmatizing and disparaging language.

Many people trained to work with people with substance use disorders will learn not to believe what someone who uses substances says about their use or their motivation. This learning occurs in formal classrooms, workshops, and through others working in the field. It also occurs in popular media as people who use drugs are depicted as dishonest. They may have learned that people with substance use disorders lie to protect their use and cannot be trusted. Seeing a person as distrustful, in denial, and as an unreliable reporter about their own life and circumstances can affect the relationship and make it difficult to form trust. These unjustified beliefs can result in internalized stigma for the person who uses substances.

Ways to Help:
Use Person First Language

Language about substance use, substance use disorder, and people who use substances has changed over time as we understand more about the causes of and effective interventions and treatments for substance use disorders. What doesn't change is that a person's health condition does not define them. A person is not a cancer, a person has a type of cancer. A person is not an "addict" or "substance abuser", a person has a substance use disorder. Regardless of how language evolves to discuss substance use disorder, the person first language should remain. Substance use disorder is just one of many aspects of an individual's life; they may also be a sister, father, aunt, cousin, son, carpenter, student, nurse, mechanic, painter, and teacher. The impact of this small change in language signifies that they are a person first and conveys dignity and respect for the individual which, in turn, changes how they are seen and how they see themselves.

Avoid Placing Blame

People who have substance use disorders often are blamed for continued use. They frequently have heard things like, "I don't understand why you don't just stop." It is difficult to understand why a loved one or an employee or a patient just doesn't stop using. To an outside observer, it seems like a person who is using substances makes other conscious decisions and they can conclude that continued use is a choice as well. With respect to substance use disorder, the diagnostic criteria include the inability to stop using despite negative consequences in multiple spheres of their lives. It isn't that an individual doesn't want to stop, but rather that the brain undergoes physiological and anatomical changes with chronic use that reinforce the use itself.

Agency, or the ability to have control over one's behaviors, is a complex concept in all chronic health conditions. All chronic health conditions are a complex combination of genetic, social, environmental, and individual behavioral factors. For health conditions where stigma is low, such as high blood pressure, there is less blame directed towards the individual for having the condition with more emphasis on support for choosing behaviors (following a heart healthy diet, regular exercise) that can improve the condition and less blame for choosing behaviors (unhealthy eating, lack of exercise) that may exacerbate them.

Stigma associated with people who use substances can be contradictory. People can be seen as either passively controlled by an external force, the substance, or as fully in control of their behavior. Both viewpoints are stigmatizing and inaccurate. They fail to take the whole person into account. A more accurate, holistic view of the person includes the biological impact of the substance that drives continued substance use and acknowledges their ability to make decisions that can impact their use of substances.

Providing support for choices that reduce substance use can encourage the person to continue choosing healthier alternatives. For example, Community Reinforcement[5] is an evidence-based model that helps family members support positive behaviors that have been shown to be effective at reducing substance use. It is a way to help without stigmatizing the person who is using.

Acceptance and Inclusion

If judgment and shaming increase social isolation, acceptance of the person and inclusion in social activity encourage connectivity. It has been said that connection is the opposite of addiction[3], and Venniro's research supports that statement. People, like the rats in Venniro's study, seek out social connections, acceptance, and inclusion. Acceptance can lead to a self-perpetuating cycle that involves less substance use and more opportunity for inclusion. Believing a person can solve problems in their life and report accurately about their experiences can support trust in the relationship and support a positive internalized view of self.

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Footnotes

1. www.recoveryanswers.org/research-post/the-real-stigma-of-substance-use-disorders/

2. Addressing the Stigma that Surrounds Addiction | National Institute on Drug Abuse (NIDA) (nih.gov)

3. Venniro, M., Zhang, M., Caprioli, D. *et al.* Volitional social interaction prevents drug addiction in rat models. *Nat Neurosci* 21, 1520–1529 (2018).

4. Addiction: The View from Rat Park (2010) (brucekalexander.com)

5. Smith, J. E., Milford, J. L., & Meyers, R. J. (2004). CRA and CRAFT: Behavioral approaches to treating substance-abusing individuals. *The Behavior Analyst Today, 5*(4), 391–403.

Art: A Tool for Breaking Stigma

By Mindy Liss
VP for Communications
Institute for Community Living

While the reasons for stigma around mental illness are complex and vary by community – we know its prevalence prevents many from seeking treatment – from finding help and building a better life.

At the Institute for Community Living (ICL), we offer an array of support services for people living with mental illness. Since its founding in 1986, ICL has helped thousands break the isolation and go on to feel more connected to community and able to overcome their struggles.

Services provided at our more than 100 programs across New York City are grounded in a whole health approach and the integral relationship between physical and mental health. This approach takes us beyond traditional counseling and supportive services, incorporating a variety of interventions and tools that aid in healing and recovery. One very effective tool for addressing mental health challenges are programs that nurture creative expression by people with mental illness.

Today at ICL, there are a range of art initiatives at many of our transitional shelters and supportive residences. In addition to aiding in recovery and improved mental health, an unexpected but promising result of the encouragement of artistic expression is how it is helping to break the stigma of mental illness. This stigma is often the result of misunderstanding – even by family and friends – what mental illness is and who the people living with mental illness are. As we often say, people are not their diagnoses. When you view the art being created throughout ICL, you begin to understand just how true that statement is.

Painting by Olga L. at the ICL Exhibit at the Brooklyn Museum

The connection between art and stigma is becoming more and more central to the discussion about mental illness. In an article, "The Art of Ending Stigma" in *Champions of Science*, Dr. Eric Kandel, a renowned neurologist explains, "Creating a dialogue surrounding mental illnesses through works of art and creative expression can destigmatize mental illnesses and cultivate empathy."

Why de-stigmatization happens when art comes into play is less clear. One explanation is simple – viewing this art shows the viewer someone who is an artist -- not just someone with a mental illness often only otherwise seen as someone to fear and shun and wish to be hidden away.

At ICL, we see this breaking of stigma happen every day. When you walk into the ICL East New York Health Hub, one of the first rooms you see is a light-filled art studio with people are hard at work on a piece, on a canvas set on an easel or on a sketch pad trying out a new idea.

For many artists at the Hub, the seeds for their passion for drawing and painting were sown in a special collaboration between ICL and the Brooklyn Museum that first began 15 years ago. Every month, ICL artists visit the Museum where a specially trained docent provides in-depth tours of special exhibits. Each year the program culminates in an exhibition by ICL artists in a Museum gallery of works often inspired by what they viewed on their Museum visits. Having this show at one of the world's most respected museums is an incredible honor. There's an exciting opening of the show, where guests are struck by the extraordinary talent they're witnessing, listening intently as the artists explain the works they've created.

Art as a Lifeline

Art proved to be an especially important lifeline during the 2+ years of the pandemic for the people served at ICL – for whom loneliness and disconnection were particularly acute. When it was safe, many of the artists came to use the Hub art room they had become comfortable working in. They worked on their art socially distanced, wearing masks. Being there with their fellow artists helped break the isolation and allowed them to give expression to all the emotions the pandemic had brought on.

In spite of the pandemic forcing the closure or shift to remote operation of their ICL programs -- and the shut-down of much of the world -- these individuals showed a prolific dedication to their artistic process.

Once the Brooklyn Museum reopened, plans were made for an exhibit of this work created during the pandemic as well as new work done since Museum visits had been re-started. Teaching Artist Dylan Stanfield, who leads the Hub art studio as well as a program at ICL residences for developmentally disabled, helped the artists regroup to get the visits up and running again. One exhibit they had the chance to view was *A Crack in the Hourglass: An Ongoing COVID 19 Memorial* by artist Rafael Lozano – Hemmer. Viewing this work inspired a collaborative piece in memory of a fellow artist from ICL who passed away from COVID-19 early in the pandemic. Trying to make sense of the world, the artists used their creativity and imagination to craft a visual poem about these times. Many found this process to be a lifeline in a time of great uncertainty.

An opening reception was held last June for the newest show *Creating a Lifeline*; still-masked artists and friends gathered to celebrate the unlikely production of work. This dedication to making art under these circumstances demonstrates how important the artists feel about their creative expression, and the role it plays in their ability to live a spiritually, mentally and physically healthy life.

All who had the chance to view the work over the course of the exhibit's four-month run likely came away with a new understand of what it means to live with a mental illness and to struggle to lead a full and productive life.

ICL helps New Yorkers of all backgrounds and ages living with serious mental illness, substance use disorder, and developmental disabilities achieve greater health and independence. From housing to care coordination to office- and school-based support, our innovative whole health approach addresses behavioral and physical health as well as the social determinants of health such as housing and food security.

ICL artists working in the studio at their East New York Health Hub

Finding Peace: A Journey to Positive Mental Mindset

By Sue Zbikowski, PhD,
inZights Consulting, LLC,
and Shelley Schoenfeld,
GoMo Health

Like many people who struggle with mental illness, Helise withdraws and isolates herself when she feels overwhelmed. While alone and shut in, she found herself ruminating about her thoughts and feelings, this pattern only made her feel worse. Feeling isolated and uncertain about what to do, Helise needed help. She was fortunate to find it with Bridgeway Behavioral Health Services, but many individuals with mental illness aren't so lucky.

Poor mental health and diagnosed mental health illness affect millions of US adults: approximately one in five Americans (53 million) experience a mental illness (Center for Disease Control and Prevention (CDC)). (see Fig. 1 on page 46)

While there is no single cause for mental illness, the root cause varies from traumatic experiences, an imbalance in brain chemistry, and significant struggles associated with other medical/health conditions and life in general (CDC, World Health Organization). Mental illness can be debilitating—interfering with quality of life, leading to loneliness and isolation, and tragically, can even result in death (National Alliance on Mental Illness (NAMI), California). People do not always get care when needed; in fact, less than half (46%) of individuals with mental health concerns are currently receiving care (NAMI-A). When people do seek professional help, they often have to wait several months to see a professional, resulting in additional suffering and increased daily challenges.

There are many proven and effective behavioral and pharmacological treatments for mental illness; however, access to timely care is often hindered. In recent years, mental health concerns and the need for mental health care have been outpacing the availability of mental care professionals and behavioral health specialists. To further complicate matters, primary care providers lack the training, expertise, and time to properly treat mental health conditions.

One in five adults enrolled in mental health treatment programs drop out before completing their recommended course of Treatment (Olfson et al., 2009).

Behavioral treatment options typically range from one-on-one or group care delivered through outpatient or residential programs. While these programs can be incredibly effective, the type and amount of care delivered is typically limited to the time in-session and rarely includes out-of-session support. Thus, the structure of behavioral therapy may leave patients feeling lost or unclear about how to implement treatment recommendations outside of the in-person care delivery setting. Fortunately, there are many innovative solutions, such as those designed and offered by GoMo Health, addressing these care gaps and improving adherence to treatment and treatment outcomes.

Every Day Matters: A Combined In-Person and Remote Care Coordination Program

A little more about Helise, who was first introduced at the beginning of this article: Helise was diagnosed with borderline personality disorder and struggled to leave her house. This, of course, presented challenges with attending her partial-day treatment program. Her condition became so prohibitive that her most frequent personal interaction was with the pizza delivery person, who eventually began bringing her cat food and litter so she could properly care for her pet.

To view Helise's full story, visit: https://youtu.be/r_--qy5xEHg.

The Every Day Matters program was created as an added support solution for Bridgeway's Partial Care participants, using an interactive combination of on and off-site methodology that optimizes human activation and resiliency by focusing on three key components:

- Individual: In the Moment Support
- Relational: A feeling of community, membership, and reciprocity
- Continuous and Ongoing: Available whenever it is needed

Bridgeway, a New Jersey-based psychiatric rehabilitation services provider, recognized a pattern with Helise and other members, who would show up initially for their in-person group sessions and then taper off their regular attendance. Patients shared a variety of reasons for the drop off—they began to feel better and didn't think additional care was needed; the pending sessions were overwhelming to consider attending even the night before, let alone the day of; or they gave in to lack of confidence and simply didn't show. For many patients who didn't show, they didn't recognize the impact it had on the other members of the group. They gave in to their lack of self-confidence which made it difficult to engage in treatment.

The Bridgeway leadership and staff knew that patients could only improve if they came to group sessions and followed treatment recommendations—in person and at home. The team at Bridgeway was certain that if they could address the hesitation to come to program in the moment, they'd have a higher likelihood of people regularly attending in person.

So was born the Bridgeway Every Day Matters program. This program, created and operated by GoMo Health, was designed to leverage the membership concept, empowering Bridgeway patients to be healthy, positive members of society and maintain that mindset. The goal was to create a sense of community, to motivate patients to show up, engage in, and follow their treatment plan and recommendations, and to transform the Bridgeway Day Program into a 'Lifestyle Program.' This was achieved by using technology-enabled messaging to provide intervention content at the right time, reinforce target behaviors, and help patients cognitively connect a desired action with an existing everyday action.

On the morning of in-person treatment, members receive messages motivating them to come in for their session and to start the day positively. Later in the day, after returning home, members receive additional messaging to encourage them to act on therapeutic principles they learn during their sessions, as well as take other healthy steps in their daily life. Helise said, "When I would get my message every morning, it just reminded me that I was connected to something bigger. It reminded me of the good things here. They talk about being needed and wanted and expected. When I get those messages, I just feel connected to Bridgeway."

According to Bob Gold, GoMo Health Founder and Chief Behavioral Technologist, "Bridgeway experienced a 17% increase in weekly attendance and an astonishing increase in patient retention from 60% to nearly 90%; both of which resulted in greater annual revenue for the center." (see Fig. 2 on page 46)

The Road to Recovery: Recovery Pathways

There is a ripple effect associated with mental health. It can impact other aspects of health and well-being as well as relationships with family and friends. People with mental health conditions are at risk for other medical conditions, including substance use disorders (NAMI-B):

- One in 15 US adults experience both a substance use disorder and mental illness (NAMI-A).
- Nearly one out of three people with mental illness experience substance use disorder (NAMI-A).

Thus, it is vitally important that services exist to address both conditions concurrently. That is the case for the programs offered by the Rimrock Foundation.

Rimrock offers intensive outpatient and residential treatment programs for individuals struggling with addiction, mental health conditions, or court-ordered treatment related to drug felonies. The largest treatment center for adults with substance use and co-occurring disorders in Montana, Rimrock views addiction as a whole person illness, affecting an individual's emotional, physical, spiritual, and social wellbeing. (see Fig. 3 on page 46)

In 2020, Rimrock identified an opportunity to improve outcomes by extending care and support outside of the traditional treatment setting. This resulted in the creation and launch of the Recovery Pathways digital health management program in partnership with GoMo Health.

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GoMo Health leveraged its proprietary emerging science, BehavioralRx, to build the program and determine the engagement strategy, approach and content delivered. (see Fig. 4 on page 46)

Original on-site programming consisted of months of addiction treatment, training, education, and life skills development, individual and group therapy, case management, and peer support. The Recovery Pathways program enhances patients' experiences by adding text messages delivered several times per week, bolstered with videos and other content designed to reinforce lessons and skills taught in the program and principles covered in therapy. Throughout the program, assessments are delivered to check in on how a patient is doing and escalate to additional care and support available from Rimrock if needed.

The program includes content on preparing patients for required events such as court appearances, maintaining employment, transitioning between phases in the program, promoting self-care, healthy living, behavior change and resiliency, easing re-entry concerns for those who may have served time, and engaging, informing, and supporting caregivers. The program support continues (for six months) even after patients graduate from onsite programs.

The program has been hugely successful, receiving recognition throughout the state as a new gold standard for treating addiction recovery. To see the program's achievements, see Fig, 5 on page 46.

According to Montana Governor, Greg Gianforte, "Recovery Pathways is the

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Developing a Culture of Accountability and Belonging

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

Creating a psychologically safe and inclusive work culture of Accountability and Belonging is central to the role of a developing anti-racist leader. The culture of any organization is shaped by the worst behavior that leaders are willing to tolerate. An effective culture shift requires the engagement of the entire leadership team. This means demonstrating a clear commitment and meaningful awareness that everyone can articulate about an organization's anti-racist values and clarity about what it means to have an anti-racist, equitable and inclusive culture of Accountability and Belonging. Remember that valuing anti-racist work is both an attitude and a mindset, and that fear, apathy, and discomfort are expected reactions to any change that disrupts the status quo.

Mary Pender Greene, LCSW-R, CGP

A Culture of Belonging

Our society privileges whiteness, a message deeply rooted in—and amplified across—the media, social systems, and **all** institutions. Keep in mind that physical exclusion isn't the only way to prevent access. There are subtle and not so subtle interactions and microaggressions that can cause Black Indigenous People of Color (BIPOC) to feel devalued, such as exclusion from meaningful work, slights, marginalized input, invalidation, insults, having their voices ignored or interrupted, and being treated as if they are invisible even though they are physically present. Individuals thrive at work when they can connect their ideas to those of the organization and experience positive regard from team members. Belonging goes beyond the initial concepts of DEI—it's a feeling of being fully welcomed and accepted. It's essential that Belonging be added as a vital part of DEI initiatives so that it becomes Diversity, Equity, Inclusion, and Belonging (DEIB).

Psychology tells us that self-esteem derives from a need to belong. Naomi Attaway, founder of I am Triangle, describes three signs of Belonging: vulnerability, shared experiences, and nurturing bonds. She notes that "We need others. For completing the patchwork of our identities, with our singular traits and those that we share with kindred and friends" ("On Belonging," Psychology Today). According to Greatplacetowork.com, relational trust is the glue in building a culture of Belonging. "Belonging in the workplace is an employee's sense that their uniqueness is accepted and even treasured by their organization and colleagues. It is an accumulation of day-to-day experiences that enables a person to feel safe and bring their full, unique self to work. The pandemic and the Great Resignation have also made creating a culture of Belonging more critical than ever – not just for employee well-being but for business success." If BIPOC do not see anyone who looks like them in leadership roles, it is harder for them to develop a sense of trust or Belonging.

BIPOC often suppress their authentic thoughts and feelings to survive in white spaces. While a diverse workforce can be created through deliberate hiring practices, when BIPOC are hired, frequently they do not have a feeling of Belonging due to a lack of authentic relationships within the organization. BIPOC leaders often bemoan how so few white coworkers have cross-racial relationships that support, mentor, or sponsor BIPOC staff members. This places a heavy toll of "unpaid emotional labor" on the organization's few BIPOC leaders who recognize the importance of Belonging and the need to support BIPOC staff.

It is vital to intentionally promote a culture of Belonging and Accountability by moving beyond white allyship and encouraging the development of White co-conspirators, who play an important role in the support and success of BIPOC leaders. According to Black Lives Matter Co-Founder, Alicia Garza, co-conspirators "are people who are actively fighting against the system of white supremacy and in particular the benefits they receive from it." As a co-conspirator, you are conscious of your privilege, and you voluntarily use it to help navigate barriers that BIPOC face. In other words, it's important to have skin in the game. BIPOC seek meaningful co-conspirator relationships where they are actively supported, respected, and treasured.

Act outside of the box and request walking meetings with select BIPOC staff and board to learn about their experience at the organization and ask if their BIPOC colleagues are thriving. Walking meetings can strengthen interpersonal relationships and a sense of Belonging since walking side by side tends to lead to conversations that is more peer-to-peer. They can reduce hierarchical status distinctions and tension during discussions. You must be patient with this process because it will take time to build trust in these relationships.

Being Accountable

As a developing antiracist leader, set the tone from the top by evaluating where you are as an organization. Don't pretend to have a diverse leadership team or Board when you only have a few BIPOC. Also, assigning all race-related matters to the one or two BIPOC board/leadership team members free the rest of the team from the accountability of anti-racist work and increases their racial emotional labor. Since these roles are often given without proper authority, sufficient resources, or extra compensation, it signals to those inside and outside that the organization lacks commitment to their stated anti-racist goals and displays a devaluing of BIPOC. Be aware of who is hired, who gets the plum assignments, who is promoted, who is opting out, who is turning a blind eye, and where the pockets of resistance are. Are you developing co-conspirators? Are white leaders embracing the anti-racist values and mission? Are there unnamed white roles and/or BIPOC roles? Are some people being treated poorly? Do people feel disconnected? Are people frequently resigning or quiet quitting? Do BIPOC feel psychologically safe enough to display their best selves at work? Would staff say that this is a great place to work?

It is the anti-racist leader's role to ensure that anti-racist work is not elective. Include every single person working within your organization (including board, consultants, students, volunteers, EVERYONE). Staff with positional power who resist the antiracist goals especially must be held accountable. When staff are allowed to opt out of the anti-racist work, it is another form of favoritism. A leader's silence will be viewed as a lack of dedication to anti-racist goals. This inaction is the #1 threat to an organization's anti-racist mission because people will distrust the commitment of leadership.

Pockets of resistance by staff with positional power are the greatest threat to an organization's anti-racist work. Everyone in the organization knows who they are—they hold the power to define what and who is good and valued, and yet they are often permitted to opt out of the anti-racist work. When these individuals are not held accountable, it allows for unchecked white-body privilege, bias, and structural racism. You must publicly and privately have zero tolerance for racist or oppressive behavior. Holding everyone accountable is key to the success of your anti-racist initiatives.

Repeated microaggressions, subtle insults, witnessing white favoritism, and feeling unvalued can consume considerable energy. The amount of time that BIPOC are forced to spend on addressing these issues, fighting for job survival, and proving themselves repeatedly causes racial trauma and destroys aspirations. This leads to less-than-optimal performance and retention, as well as low morale, quiet quitting and burnout. All evaluations by executives, managers, and supervisors should stress their ability to recruit, develop, and maintain a diverse team. Supervisory sessions must include conversations about the status of the team, especially cross-racial relationships. The more employees feel that they can discuss race relations and share their experiences of bias in the world and at work, the more they will feel heard, acknowledged, valued, and connected to the organization. You can also track the hiring, retention, and promotions of BIPOC staff and check for departmental or supervisory patterns regarding transfers, turnover, and grievances.

Success lies in holding yourself and the entire organization accountable for the anti-racist goals and mission, seeing the value of each team member, and eliminating barriers to the contributions of BIPOC staff. You must become racially literate and upskilled to be able to see, discuss, and interrupt bias and structural racism. Becoming an anti-racist leader means being a critical lover of your institution and learning how racial inequities are embedded into our systems and investing time in anti-racist education and culture shift. Remember that the work is messy and external, with no finish line, and with the purpose of bringing balance, fairness, and equity while creating an environment of Accountability and Belonging.

Moving Forward

- Clarify what Accountability and Belonging mean within your organization.
- Focus on ways to ensure anti-racism work is known, felt, and invested in by all staff, leaders, and Board.
- Support all leaders and board members in continuously learning and reflecting on how the organization will address institutional racism and uphold a culture of Belonging and Accountability.
- Upskill all staff, so they can confidently handle complaints relating to racism and microaggressions.
- Identify what managers and supervisors need to contribute to a culture of Belonging and Accountability.
- Place special focus on team building and community building.
- Constantly identify and address barriers to the retention and development of BIPOC staff across all levels.
- Embed mentorship and professional/career development into the ongoing supervisory process.
- Place relationships at the center of your work.
- Ask "How are we working together as a team?"

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Countering Stigma Through Education and Outreach

By Rola Aamar, PhD
Senior Clinical Effectiveness Consultant
Relias

Stigma around mental illness remains an all-too-common occurrence, despite the increased availability of information about mental illnesses and the national discourse on prioritizing mental well-being. While we have made great strides in understanding mental illness, false perceptions of weakness, violent behavior, or personal failings still remain. Fortunately, educating individuals on mental illness has proven a viable means of combatting stigma.

A study conducted in Scotland (Committee on the Science of Changing Behavioral Health Social Norms, 2016) examining a two-year campaign aimed at normalizing mental health to the public garnered interesting results. After the campaign's conclusion, researchers found a 17% decrease in the perception that individuals with mental illnesses are dangers and an 11% decrease in individuals who felt the public needed protection from those with mental illnesses.

Clearly, education can help decrease stigma. In this article, we'll discuss certain types of content that research has shown to be effective in these educational campaigns.

Words Matter

The language we use when discussing mental illness and substance abuse disorders (SUDs) has a profound impact on the levels of stigma within a society. Stigma itself is a negative view of people based upon certain characteristics or criteria. And stigmatizing language only serves to reinforce these negative views, causing psychological harm to those being stigmatized. For instance, studies (Volkow et al, 2021) have found that when individuals with alcohol use disorder (AUD) perceive large amounts of public stigma around their condition, they are 50% less likely to seek treatment. And, unfortunately, researchers have observed very similar results across populations with SUDs and mental illness.

In order to counteract these outcomes, behavioral health professionals must avoid using terms with negative connotations when discussing mental illness or addiction. More and more, research is illuminating just how impactful language can be. A study published in Neuropsychopharmcology (Volkow et al, 2021) showed that the use of non-stigmatizing and inclusive language can lead to a decrease in feelings of stigmatization.

To get started using non-stigmatizing language, focus on person-centered language. This type of language reflects that an individual's health condition is only one part of their life, not a defining characteristic. For example, rather than calling someone an "alcoholic," providers should use the term, "a person with AUD." Another example would be replacing the word "schizophrenic" with "a person with schizophrenia."

Rola Aamar, PhD

When trying to decide what language to use to describe a mental health condition, don't be afraid to ask individuals living with that condition what terminology they prefer you use. Using inclusive language means understanding that different people talk about their mental health in different ways and adjusting the language you use to fit their needs.

As this type of person-centered language has proven to be less stigmatizing, it allows behavioral health organizations to not only provide treatment to persons served, but also craft more effective community outreach and education programs.

Shifting the Narrative
Away from Biogenesis

It has been a common practice for some time to discuss biogenetic explanations for mental illness and SUDs as a means of removing blame from those living with these conditions. The original thought behind this type of discussion in educational settings was to demonstrate that mental illness was not a result of weakness or some sort of moral failing, but, rather, a medical condition.

Recent research (Kvaale et al, 2013), however, suggests that educational campaigns around mental illness and SUD should limit the information provided that highlights the genetic components of these conditions. While limited use of this type of information may be helpful in-patient education during treatment within specific settings, research has shown that its use in widespread community education campaigns has had the opposite of its intended effect.

Language that highlights genetic markers and other medically relevant information that pertains to an individual's likelihood of developing mental illness may lead to several unintended and negative consequences. For one, this type of discussion can lead individuals without a diagnosed mental illness to see those with a diagnosed mental illness as different or even less than, which may inadvertently distract from the message of recovery. Additionally, discussion of biogenesis may cause those with a mental illness to feel as if their condition is biologically predetermined and, thus, recovery and healing are impossible tasks.

It's time to shift the narrative to biopsychosocial components, rather than purely biomedical components. Patient education focused on the biopsychosocial components of a condition is an important part of understanding and addressing mental health needs. Biopsychosocial patient education can be a powerful tool because it helps individuals understand that while a condition may be complex, there are resources available in each domain of health that will help them navigate it.

Putting it All Together

Overcoming stigma is not an impossible task, but it will take time and effort. Through effective community outreach and education, behavioral health organizations can effectively reduce the instances of stigma in their areas.

As research has shown time and again, educating ourselves and others about mental health stigma is one of the most effective means of working toward a de-stigmatized world. To create effective education programs and outreach, however, it's important that your organization understands the unique challenges of the populations that you serve and that you adhere to current literature and best practices on patient education and community outreach, some of which are shared here.

First, ensure that all your communications, both internal and external, include person-centered language. This language puts people at the center of the discussion, rather than mental health conditions, and thus allows organizations to educate the public on these conditions without implying there is something inherently wrong with those who live with these conditions. Additionally, by using person-centered language in your internal communications, your organization can practice effective self-education and create a culture of inclusivity.

Next, as research suggests, it may be time to move away from discussion of biogenetic explanations for mental illness; remove this language from your educational materials. This goes hand-in-hand with person-centered language. Just as organizations strive to focus on the whole person at the center of care, they should place the whole person at the center of their educational campaigns, rather than one domain of the conditions with which they live. One way to achieve this is by making sure that educational campaigns promote an understanding of the biopsychosocial model of health and provide resources and treatment options that address all three domains of health.

Finally, understand how the populations you serve are learning about mental health conditions, specifically from which social media outlets they receive their information about mental health. Be prepared to provide patient education that counters any misinformation they may receive through social media. Also, vet social media sources that are reliable and accurate and share their accounts with the individuals you serve. Directing them to specific posts or videos with information that may be relevant for them can help your patients understand that you support their use of social media to be more informed about mental health, and that you will be a partner in guiding them to accurate and helpful information.

Rola Aamar, PhD, is currently the senior clinical effectiveness consultant at Relias for behavioral health, bringing her clinical and operational knowledge of integrated care, data analytics, and behavioral healthcare to support client use of analytics to improve clinical performance and patient health. In this role, she provides clinically-informed, data-driven consulting to clients to promote performance improvement. Rola began her career as a behavioral health clinician in integrated care working with multidisciplinary healthcare teams to develop comprehensive treatment programs for comorbid chronic health and mental health conditions. Rola completed her PhD at Texas Tech University, where she focused her clinical research on the importance of treatment alliance between patients and healthcare providers to address treatment attrition and treatment adherence. Prior to Relias, she developed and managed integrated care programs in primary care clinics, specialty clinics, community health centers, schools, and hospitals.

For more than 11,000 healthcare organizations and 4.5 million caregivers, Relias continues to help clients improve clinical and financial outcomes by reducing variation in care. We help healthcare organizations, their people, and those under their care, get better. Better at identifying problems, addressing them with better knowledge and skills, and better outcomes for all. Learn more at www.relias.com.

References

Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington (DC): National Academies Press (US); 2016 Aug 3. 4, Approaches to Reducing Stigma. Available from: https://www.ncbi.nlm.nih.gov/books/NBK384914/

Volkow, N.D., Gordon, J.A. & Koob, G.F. Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. Neuropsychopharmacol. 46, 2230–2232 (2021). https://doi.org/10.1038/s41386-021-01069-4

Volkow, N.D., Gordon, J.A. & Koob, G.F. Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. Neuropsychopharmacol. 46, 2230–2232 (2021). https://doi.org/10.1038/s41386-021-01069-4

Kvaale EP, Gottdiener WH, Haslam N. Biogenetic explanations and stigma: a meta-analytic review of associations among laypeople. Soc Sci Med. 2013 Nov;96:95-103. doi: 10.1016/j.socscimed.2013.07.017. Epub 2013 Jul 31. PMID: 24034956.

The NYSPA Report - Insurance Circular Letter No. 1 (2023): A New Tool in the Fight Against Stigma

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

In 2022, the United States Departments of Labor, Treasury and Health and Human Services issued a joint report entitled "2022 MHPAEA Report to Congress - Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage." The Report notes:

For far too long, people with MH/SUD conditions and their loved ones have faced stigma, discrimination, and other barriers inside and outside of the health care system. These biases and discriminatory practices can often operate as an impediment to even seeking MH/SUD treatment in the first place. And once individuals attempt to seek care, they often find that treatment for their mental health condition or substance use disorder operates in a separate, and often very disparate, system than treatment for medical and surgical care, even under the same health coverage.[1]

The Report's recommendations for strengthening the consumer protections already available under our federal parity laws include civil money penalties for federal parity violations, recovery of amounts lost by plan participants and beneficiaries in connection with wrongfully denied claims, and expansion of telehealth and remote health care services, among other initiatives. These recommendations make clear that the fight for full implementation and enforcement of our federal and state parity laws is still underway and that we continue to battle institutional stigma against those with mental health and substance use disorders.

Here in New York, our fight against stigma and its dangers is well underway. Earlier this year, the New York State Department of Financial Services (the "Department") issued Insurance Circular Letter No. 1 (2023).[2] A Circular Letter is a written communication issued to insurers doing business in the state to provide instructions, guidance and clarification on topics of importance to the insurance industry. The publication of Circular Letter No. 1 (2023) represents the culmination of significant efforts by NYSPA Central Office and Government Relations staff over the past 18 months.

Rachel A. Fernbach, Esq.

Circular Letter No. 1 (2023) reminds New York insurers that they must accept and initiate processing of all health care claims submitted by psychiatrists pursuant to, and consistent with, the current version of CPT codes, reporting guidelines and conventions, including evaluation and management (E/M) claims.

NYSPA advocacy efforts leading to the issuance of this circular letter resulted from a significant uptick in utilization review efforts by New York carriers starting in 2021. It appears that the newly invigorated utilization review activities may have been related to the implementation of recent changes to documentation requirements for office and outpatient evaluation and management (E/M) codes. Effective January 1, 2021, CPT documentation requirements for office and outpatient E/M claims were significantly updated, establishing an entirely new framework for code selection and documentation. Following these changes, psychiatrists and their patients noted a significant increase in claim denials and down coding of claims, requests for documentation, pre-payment reviews and post-payment audits, which result in reduced reimbursement for psychiatrists and/or cost-shifting to patients where claims are submitted on an out of network basis.

In order to assist members who were experiencing significant claims processing issues, NYSPA staff began to contact the insurance carriers in question to challenge denials, records requests and other ongoing review activities. NYSPA also reached out to the Department for further assistance in ensuring that carriers comply with CPT and to address aggressive utilization review activities that appeared to be focused solely on psychiatry services. NYSPA staff met several times with Department representatives to provide specific data regarding the number of psychiatrists (and their patients) who have been impacted by these issues, including regular and ongoing claim denials, pre-payment review and post-payment audits.

If an insurer's claim processing and payment procedures fail to comport with the codes, guidelines and conventions of CPT, this may violate both the federal HIPAA statute and the federal parity law, the Mental Health Parity and Addiction Equity Act ("MHPAEA"). First, HIPAA and its implementing regulations require that all covered entities adopt HIPAA-compliant code sets, including CPT. Second, if utilization review is being imposed solely on claims submitted by behavioral health providers, this also may be a violation of MHPAEA, which requires that any nonquantitative treatment limitation (NQTL) imposed on behavioral health benefits be comparable to and applied no more stringently than an NQTL imposed on non-behavioral benefits under the same plan.

The following are examples of ongoing claims-related challenges reported by New York psychiatrists:

- Denials in connection with documentation of time spent providing psychotherapy
- Denials for failure to identify the mode of transmission by which telehealth was rendered
- Denials for failure to document "patient progress and response to treatment" even when clearly documented in several sections of the note. There is no requirement that patient progress or response to treatment be listed under a separate heading.
- Denials claiming that only one CPT code should be used (i.e., non-medical psychotherapy codes such as 90832, 90834 and 90837) and refusing to recognize "medication-management" codes
- Consistent and routine denials, with no specific feedback or information, other than:

1. "Insufficient documentation"
2. "The documentation does not support the service billed"
3. "Benefits for this service are denied. The documentation we requested from you was received, however we have been unable to confirm the service was rendered as billed."

Circular Letter No. 1 (2023) provides a summary of the new office and outpatient E/M documentation requirements and how they are to be implemented in connection with claims for psychiatry services. The Circular letter clearly states that "when processing office and other outpatient E/M codes, issuers must do so consistently, with the criteria that became effective January 1, 2021." Finally, Circular Letter

see New Tool on page 40

Co-Creating an Equitable Crisis Care Continuum to Reduce Stigma

By Sa'uda K. Dunlap, LCSW
and Johnell Lawrence
Vibrant Emotional Health

People are in pain. We are experiencing an onslaught of public health crises that is affecting our overall functioning. The fierce urgency of now to collectively move us to a space of wellness is imperative to our quality of life. The current crisis care continuum is not designed to meet the needs of those in behavioral health crisis. First responders are not sufficiently trained to intervene. This lack of training leads to negative outcomes particularly for those communities who experience the most inequities and trauma: people who identify as Black, Indigenous, people of color, LGBTQIA+, people with disabilities, non-English speaking people, rural communities, older adults, houseless people, returning citizens from a carceral state, immigrants and youth. This is further compounded by the health crisis of mental health stigma in historically harmed communities. Evidence shows that mental illness stigma is higher among ethnic minorities than majorities. An important clinical implication of these findings would be to tailor anti-stigma strategies related with mental illnesses according to specific racial and/or ethnic backgrounds with the intention to improve mental health outreach (Eylem, et.al 2020).

Sa'uda K. Dunlap, LCSW

Johnell Lawrence

Barriers in Mental Health Care for Harmed Communities

Racism is a public health crisis (APHA, 2021). Racism is a system—consisting of structures, policies, practices, and norms—that assigns value and determines opportunity based on the way people look or the color of their skin. This results in conditions that unfairly advantage some and disadvantage others throughout society.

According the Center for Disease Control, a growing body of research shows that centuries of racism in this country has had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These conditions—often referred to as social determinants of health—are key drivers of health inequities within communities of color, placing those within these populations at greater risk for poor health outcomes.

As a result of inequitable social determinants of health, communities of color are caught in a perpetual state of mitigating layers of compounded trauma which includes the ongoing impact of COVID 19, the pillaging of histories via book bans, harmful policies, state sanctioned brutality and financial losses. Most racial/ethnic minority groups overall have similar—or in some cases, fewer—mental disorders than whites. However, the consequences of mental illness in historically harmed groups may be long lasting (American Psychiatric Association, 2017).

Historically harmed communities have a healthy paranoia with the mental health systems. They have been either under and over diagnosed, complaints ignored or dismissed. Or they have not been properly assessed but prescribed medications that may not address their underlying causes of presenting problems. To add, lack of insurance, underinsurance, mental illness stigma, lack of diversity among mental health care providers, lack of providers who practice cultural humility and language barriers contribute to underutilization of mental health services.

The 988 Suicide & Crisis Lifeline

On July 16, 2022, the National Suicide Prevention Lifeline transitioned to the three-digit access code 988 and a new name – the 988 Suicide & Crisis Lifeline (988 Lifeline). Funded by the U.S. Department of Health and Human Services

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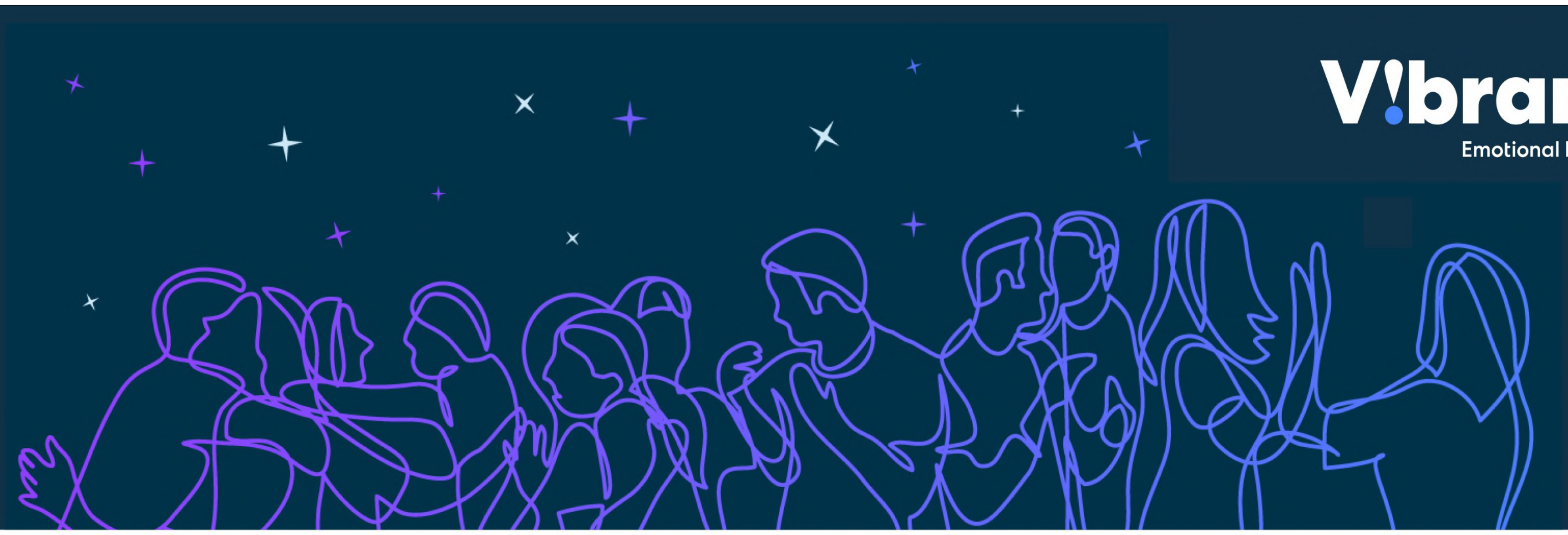

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Stigma: How Vocabulary and Language Can Make a Difference

By Dioanne "JoJo" Adsuara, MSN, PMHNP-BC, and Dave Ofori, MSN, RN, NP-P, PMHNP-BC
Phoenix Houses - NY | LI

Compassionate language can improve care and change the stigma associated with substance use disorder. The terms or phrases healthcare providers use to discuss substance use are often imbued with negative connotations that create bias. Research shows harm reduction-based vocabulary and education can help change this stigma and in turn provide benefits to patients in treatment. Current, evidence-based education of the illness of addiction as well as addressing the vocabulary and language of substance use disorders will help change the stigma of addiction.

Over the course of our work with the substance use disorder community, we've noticed a culture exists that views substance use disorders in a negative light. Patients and team members alike used terminology such as "addict" or "abuser," even though those words do not accurately reflect most patients' cases.

While exploring harm reduction approaches, we've discovered that this population would not solely benefit from programs such as needle-exchange and free Narcan distribution. In fact, we learned that providing current evidence- based education of the illness of addiction as well as addressing the vocabulary and language of substance use disorders will help change the stigma of addiction and in return provide a supportive and empathetic approach when helping this population.

Although there are 40.3 million American adults dealing with substance use disorder, only an estimated 14.3 percent seek treatment (SAMHSA, 2020). One of the reasons this population does not seek treatment or care is the stigma associated with their disease (SAMHSA, 2020). For those in treatment, there is an opportunity to mitigate the harm of substance use disorders by providing up-to-date evidence-based education regarding the disease and providing empathetic care through mitigation of vocabulary and language stigma.

Stigma surrounding people with substance use disorder results in this community being labeled as dangerous, incapable of managing treatment, or at fault for their condition (Hadland et al., 2018). Some of the negative words used to describe individuals with substance use disorder include "addict," "user," "junkie," and "alcoholic" to name a few. These words personify the illness and reduce the scope of an individual's humanity to the disease they are suffering from. Other negatively associated vocabulary includes "clean," "dirty," and "abuse."

Applying these words to an individual struggling with substance use may reduce motivation towards change as one may feel that they are their illness – self-identifying with an illness removes hope towards change and recovery. Similarly, terminology such as "clean" in the context of maintaining sobriety suggests negative tones regarding an individual that relapses – "dirty." These negative ideologies reduce the willingness of individuals with substance use disorder to seek treatment. They also can lead others to feel pity, fear, anger, and a desire for social distance from people with substance use disorders.

Health care providers are not immune from the effects of stigmatizing language. Stigmatizing language can negatively influence health care providers' perception of substance use disorder, which can impact the care they provide. Educating licensed independent practitioners, counselors, and the community can diminish the prevalence of antiquated, inaccurate

see Language on page 43

How Modeling Compassion Can Help Reduce Stigma in Mental Health

**By Vickie Mishoulam, MA, MSW,
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NYCPS, and Enmanuel Gonzalez-Pantoja, CASAC-T, CRPA, NYCPS,
ACMH, Inc.**

From left to right: Vickie, Vanessa, John, Marisol, and Enmanuel

In recent years, as our understanding of mental illness has continued to develop, we have seen many positive changes that have impacted behavioral health care and the lives of consumers. Nevertheless, public and personal misconceptions about mental illness continue to be of concern as it creates and promotes stigma in how we perceive individuals who are diagnosed with mental illness as well as how they perceive themselves. This leads to millions of individuals with mental illness not receiving the proper support they may need. Mental health stigma is a long-standing public and human rights problem that causes a complex social process that results in labeling, separation, diminution of status and discrimination, which systemically creates disadvantage and limits life chances to people diagnosed with mental illness (Stuart et.al., 2012). As a result of the adverse impact of mental health stigma, a large number of people with mental illness do not seek critically needed care/treatment/services available to them due to feelings of shame and fear of being perceived as inadequate, incompetent or dangerous (Corrigan & Shapiro, 2010).

Peer Counselors at the ACMH Residential Crisis Support Program agree that mental health stigma may transform into self-stigma, preventing individuals from realizing their strengths, value and capabilities; thus, feeling unable to believe that they would ever be able to thrive and grow beyond their stigmatization labels. "You feel locked out, like nobody is going to want you"- John Kvarnstrom, Peer Counselor. ACMH Peer Counselors shared that overcoming feelings of entrapment, due to mental health stigma, is extremely challenging. It can take an extended period of time before considering the possibility of joining the work force and, our peer staff agree that even once they did, they felt that at any given moment, they would be dismissed from their jobs.

There are various methods and interventions that have been implemented in mental health settings and community arenas to increase public awareness of mental health stigma and ultimately work to reduce it. One of the most valuable interventions used to reduce mental health stigma is the modeling of compassion. Research on the value of compassion has been found to be extremely effective in supporting mental health recovery for those individuals who have experienced it. Modeling compassion has been shown to reduce low self-esteem and self-denigration in those with Major Depressive Disorder (Avest et al., 2021). Furthermore, modeling compassion promotes self-compassion which is defined as the ability to treat oneself with warmth, kindness and non-judgmental understanding when suffering (Ka Shing Chan, 2018).

One tool often used to model compassion towards oneself and others is mindfulness. Research suggests that mindfulness may help individuals respond to stressful experiences with psychological flexibility, which is defined as the ability to be in the present moment with all of the thoughts and feelings it contains without the need to emotionally defend oneself; but stay focused on goals and values; thereby, alleviating psychological distress (Ka Shing Chan, 2018). The body of literature suggests that utilizing mindfulness to model compassion at a community level promotes empathy, compassion for humanity, acceptance and inclusion for individuals with mental illness. Peer Counselor, Emmanuel Pantoja-Gonzalez, shared the importance of understanding the range of emotions that an individual with mental illness can go through based on their experiences and situation at a certain moment in time. "Someone with a mental illness who may be facing homelessness and lack of support, may be showing anger and frustration, but all this comes from fear and uncertainty. As someone with lived experience, I understand this and it allows me to model compassion under challenging circumstances.

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Consumer Perspectives: Food Security is a Social Justice Issue

By Anna, Francisco, Glen, Jackie, Sherese, Steve, and Wiley

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, 50s, 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 experienced challenges with homelessness, mental and physical illness, unemployment, and food insecurity.

New York City is experiencing unprecedented levels of food insecurity, with hunger impacting an estimated 1.5 million New Yorkers in 2021. Visits to New York City food pantries and soup kitchens were up 69% in 2022 compared to 2019 - and up 14% just since January 2022 when inflation costs began sending food prices soaring. The pandemic, combined with inflation, labor shortages, global supply chain issues, and the war in Ukraine has made it challenging for many people to afford enough food. And food scarcity increases anxiety and depression.

Like many people in low-income communities, many people S:US serves (like us) experienced food insecurity throughout the COVID-19 crisis. In the 2022 Annual Survey of individuals who are served by S:US, 43% of survey respondents (1512 individuals) reported that they would like support accessing a food bank, meal delivery, or grocery delivery. More than half of respondents are either marginally food secure or food insecure. 22% of respondents (784 individuals) reported that in the last 12 months they cut the size of a meal or skipped a meal because there wasn't enough money for food. More than one third of those 784 respondents reported that they did this almost every month in the past year.

The S:US Community Food Security Program has grown and adapted to meet the needs of the people they serve (like us) and the larger community throughout the pandemic. S:US is also hosting a Summit to Serve New York on April 19 that will focus on Food Security. This half-day gathering will feature community leaders in the NYC-region food justice movement, diverse speakers from multiple sectors, and organizations serving New Yorkers in the food security and food justice space showcasing their work.

Overcoming Challenges

We've all overcome challenges in our lives. Most of us live in S:US supportive housing, some of us receive different behavioral health services, and some of us are getting help finding jobs.

"I lived in the shelter for three years when I was in Brooklyn. I was working, I came home one day, and my building was

see Food Security on page 53

People helping themselves to free fresh produce and pantry items at the S:US Community Fridge in Brooklyn, New York

Working with Newly Arrived Asylum Seekers: A Firsthand Look

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

New York Psychotherapy and Counseling Center (NYPCC) has been working with newly arrived immigrants since inception in 1974. With the majority of our clinicians bi-lingual, we pride ourselves in meeting the mental health needs of our Latinx population through a culture lens. It's one thing to work with such clients, it's another to see how their journey begins. NYPCC has been in partnership with the National Latino and Hispanic Mental Health Technical Transfer Center (NHLMHTTC) for webinars and trainings over the last few years. I recently went to McAllen Texas for the NHLMHTTC annual meeting and had the opportunity to take two field trips: to an immigrant respite center in McAllen and to an immigrant camp in Reynosa Mexico to learn about their journeys and mental health concerns. The Center partners with the University of Texas Rio Grande Valley whose psychology department staff and students are doing research and interventions at both sites.

The Catholic Charities Humanitarian Respite Center located in downtown McAllen, helps families with their transition to a new, uncertain world. The respite center provides support to recent asylum seekers families that have been processed by U.S. immigration officials and assist with food, clothing, shelter and needed medical services. The center welcomes up to 300 individuals a day serving over 100,000 immigrants as they prepare for their final journey to friends or relatives in the United States.

Before they can get to the Respite Center, migrants both deported and nationals (and foreigners) seeking to cross into the United States must wait in an immigrant camp in Reynosa, Mexico. It was here that we crossed over the Rio Grande via the Hidalgo Bridge and met up with Universidad Autonoma de Tamaulipas, Aztlan Campus of Reynosa with both faculty and students who work with migrant populations to discuss their work and the mental health challenges of the communities they serve.

We visited *Casa del Migrante Reynosa*, a camp that offers a safe place for migrants passing through the city of Reynosa, providing them with information on their rights and duties, free basic services during their stay, such as: food, clothing, personal hygiene items, phone calls, medical care, psychological care, procedures for some personal documents, etc., promoting their family reunification.

It was during these trips that I was able to speak with the volunteer staff about the mental health challenges and trauma families experience daily. I saw families huddled together, witnessing the blighted quarters, lack of privacy, and children of all ages with nothing to do all day, that gave me a perspective you don't get by watching news reports or reading articles. It was an experience that put me intimately in touch with the challenges and hardships that many of our NYPCC immigrant clients and families must endure before getting into the US.

Initial Steps Working with Newly Arrived Asylum Seekers

While there are *push-pull* motivating factors that cause people to migrate, each newly asylum seeker has his or her own set of characteristics that, in interaction with the environment, may place them in varying positions of resilience or vulnerability resulting in acculturative stress (Berry, 1997). The phases of the migration process: premigration, during migration, and postmigration, have specific risks and exposures that may differentially impact youth mental health outcomes including trauma. This information should be compiled and used to inform interventions, including effects of migration, experiences of racism and discrimination, language and educational barriers, and access to services and resources.

As clinicians we need to key in on how clients' migration undertaking is perceived, expressed and how they make meaning of the experience to help them heal from trauma. Making meaning is influenced by many factors related to culture, in understanding why something happened, spiritual rituals associated with meaning and closure, level of social connection and support, and help-seeking practices. This includes norms for where to seek support, whether from family, friends, community leaders, religious or spiritual leaders, or mental health professionals. Making meaning of trauma is also influenced by the broader impact of any generational or historical trauma, which influences cultural identity and how families and communities understand current experiences of trauma. EX: Espiritismo (Wilson, 2007; Kirmayer, 2003).

At NYPCC we work with many newly arrived asylum seekers who face trauma reminders over an ordinary day - the whole world seems dangerous, and no adult seems deserving of trust. Keeping that in mind, here are some best practices:

- Engagement should be helpful, voluntary (at their own pace) based on trust with all family members; not only to increase the benefits of treatment, but also to ensure the family will accept your recommendations and referrals.

- Tune into culture specifics and norms and be able to identify behaviors that may be a trauma response. Listen to the family's concerns, acknowledge the importance of their expressed primary problems, and address first the basic or most urgent needs.

- Don't assume you know the answers – ask and state your reason for asking – many who have not established trust will be wondering about the information they share and if you will use it against them.

see Asylum Seekers on page 44

An Antidote to Stigma

By Ashley Brody, MPA, CPRP
Chief Executive Officer
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Ashley Brody, MPA, CPRP

Stigma against persons with mental illness has waned in recent years, as affirmed by a Harris Poll administered on behalf of the American Psychological Association. This poll found a significant majority of Americans (87%) believed there is no shame in having a mental health diagnosis, and a comparable proportion of respondents (86%) said they believed individuals with mental illness may recover (American Psychological Association, 2019). As promising as these findings are, however, they belie a disconcerting undercurrent that suggests stigma is still prevalent, particularly among individuals who have neither experienced mental illness nor been exposed to others with a mental health diagnosis. Less than one-third of respondents who had a mental health diagnosis or were acquainted with others who did agree with the statement, “People with mental health disorders scare me,” whereas nearly half (47%) of those who lacked personal experience with mental illness endorsed this statement (American Psychological Association, 2019). To bastardize a quotation commonly attributed to Geoffrey Chaucer, *unfamiliarity* appears to breed contempt, at least when the targets of the contemptuous have a mental illness.

This phenomenon may be interpreted as a manifestation of the “fundamental attribution error,” a construct proposed by social psychologists nearly 50 years ago that suggests individuals are inclined to attribute others’ behaviors to personality or dispositional factors and to ascribe their own behaviors to circumstantial or situational elements beyond their control (Explore Psychology, 2023). Individuals are most susceptible to this error when the target of their attribution is unknown or unfamiliar to them. That is, we commit the fundamental attribution error when we lack information concerning the internal states of other people and must draw inferences about their behavior based on assumptions, stereotypes, and prejudices. In doing so, we employ what the social science literature describes as “heuristics.” Put simply, these are conceptual models or mental shortcuts through which we interpret the world in a generalized manner that obscures the subtleties and nuances underpinning behavior (Cherry, 2022).

Some data suggest the fundamental attribution error is predominant in certain (primarily Western) cultures that promote an ethos of individualism and corresponding belief that individual characteristics (e.g., motives, personality, general disposition, etc.) govern our behavior (Corrigan & Watson, 2002). By contrast, it is less prevalent in societies with collectivist orientations that readily acknowledge the influence of group dynamics on human affairs, as affirmed by research that suggests attributional errors and stigma against persons with mental illness are less widespread among certain Eastern and Asian cultures reputed for their advancement of communal values (Fabrega, 1991).

The fundamental attribution error may amplify prevailing stereotypes applicable to marginalized populations that include persons with mental illness. For instance, an (erroneous) belief that persons with mental illness are incompetent or dangerous reflects an enduring stereotype that may be strengthened by the fundamental attribution error. One who subscribes to this stereotype is likely to embrace it with even greater fervor when presented with a negative depiction of mental illness (i.e., a person yelling or gesticulating on a street corner), particularly when this depiction fails to include contextual information that would produce a more nuanced understanding. Regrettably, depictions of mental illness in the news media and popular culture writ large are seldom positive, and they rarely include information that encourages their audiences to look beyond dispositional factors to situational variables implicated in idiosyncratic or dysfunctional behavior. Chronic underfunding of behavioral healthcare and community-based services and a dearth of affordable housing and employment opportunities signal a corrosion of the social safety net that has had predictably adverse effects on the most vulnerable among us. Nevertheless, the intricacies of public policy cannot be captured in soundbites or the fleeting (and often unflattering) images of mental illness commonly fed to the general public. We are therefore left to rely on conceptual shortcuts that reinforce and perpetuate stigma.

To effectively challenge prevailing attitudes toward persons with mental illness we must employ strategies that illuminate the particulars behind the people. “Corrective information” may exert a countervailing effect on stereotypes, as affirmed by a body of research that has explored this and related strategies designed to combat stigma. In one study, investigators supplied research subjects with information that corrected misconceptions concerning mental illness and subsequently shared a stigmatizing newspaper article concerning an individual with schizophrenia. Subjects who received corrective information were less inclined to embrace the stigma conveyed in this article when compared to subjects who did not receive this information (Penn, Kommana, Mansfield, & Link, 1999). This study, administered more than 20 years ago, has been followed by an extensive body of research that affirms its central findings and suggests similar interventions. A comprehensive review of research on strategies to combat stigma has validated the role persons with lived experience in recovery may play in dispelling common myths and misconceptions. An editorial published in *The Lancet* in 2016 summarized the research literature, and it highlighted the promise of educational campaigns that feature persons with mental illness whose progress in recovery has enabled them to participate fully in the fabric of community life (“The Health Crisis of Mental Health Stigma,” 2016). Such campaigns have become commonplace, and some now receive financial support from the NYS Office of Mental Health (OMH) via voluntary contributions from state taxpayers.

Interventions that increase the visibility of persons with mental illness, particularly ones that include sufficiently nuanced depictions of their lives and circumstances, are poised to dispel longstanding myths that continue to undermine progress and to perpetuate stigma. For these interventions to succeed, however, they must achieve sufficient depth and breadth to counter a deeply entrenched public discourse that eschews nuance in favor of simplicity.

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References

American Psychological Association, 2019. Mental Health Survey.

Cherry, K. (2002). What are heuristics? These mental shortcuts can help people make decisions more efficiently.

Corrigan, P.W. & Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness. World Psychiatry, 1(1), 16-20.

Explore Psychology, 2023. Fundamental Attribution Error.

Fabrega, H. (1991). Psychiatric stigma in non-Western societies. Comprehensive Psychiatry, 32(6), 534-551.

Penn, D.L., Kommana, S., Mansfield, M., & Link, B.G. (1999). Dispelling the stigma of schizophrenia: II. The impact of information on dangerousness. Schizophrenia Bulletin, 25(3), 437-446.

The Lancet. (2016, March 12). The Health Crisis of Mental Health Stigma.

Countering Stigma: Speaking as if Our Words Matter

By Kevin Wadalavage, LMHC, CASAC 2, MAC, Training and Quality Consultant
Outreach

There are now several identified strategies that can help address stigma toward populations with behavioral health challenges. Some involve providing public education. Some involve the addition of addiction and mental health-related curricula to educational institutions and training programs for all service providers who frequently come in contact with these populations, such as in medicine, social services, criminal justice, etc. Another is to shine a light on people who are in recovery and, in doing so, expose the all-too-often hidden reality that people can stabilize, recover, and more-successfully manage their life and that individuals with behavioral health disorders can be every bit as moral, productive, intelligent, talented and humanly complex as the next person. We can also create venues for advocating pro-recovery messages, policies and programs as well as promote community spaces where recovery can flourish and serve as a beacon of hope to others.

Kevin Wadalavage, LMHC, CASAC 2

While these efforts might require initiative on the level of policy, resources, and coordination, others can be in our individual hands. One of these involves the skillful use of our language to reduce stigma. George Orwell wrote in Politics and the English Language, "But if thought corrupts language, language can also corrupt thought." If we are trying to address how people think about those with behavioral health disorders, we need to cultivate an awareness and discipline around our choice of words. This is obviously not a new idea and the professional and general culture use of certain "acceptable words" can shift over time. We used to commonly refer to people with an Opioid Use Disorder as "junkies" and individuals with schizophrenia are less-often called "schizophrenic" in order to avoid defining them solely by the symptoms of their disease just as we would unlikely call someone with arthritis an "arthritic."

The use of "person first" language sees the person before we see what condition they might have. While some are more obvious, such as referring to people with no further use of problematic drugs and/or negative toxicology results as "clean," versus someone who tests positive as "dirty," or having "failed" the test, other words, and phrases - especially those pertaining to addictive disorders - might be harder to translate into more neutral language.

To help with this, the National Institute on Drug Abuse (NIDA) released a set of guidelines on how to avoid stigmatizing language, entitled "Words Matter: Preferred Language for Talking About Addiction." For instance, the guidelines state that saying someone "abuses" drugs open that person up to negative judgment and suggests "uses" instead, regardless of their legal standing or functionality consequences. Prescription drugs might be "misused" if they are consumed outside of how they were intended. Stating someone is on "Medication-Assisted Treatment" is discouraged as the phrase implies that solely using a medication such as methadone or buprenorphine to address an Opioid Use Disorder is not a treatment on its own, just as antidepressants might be a stand-alone therapy for some.

Changing our language use will be difficult in some cases. It might require retraining responses and word usage we have been using a long time as both participants in the general culture and in our professional roles. In addition, some of our patients will find it difficult to go along with these changes. People in some Twelve Step groups often refer to themselves as "alcoholic" or "addict" as an anchoring phrase to remind themselves of who they are or to be consistent with the language of their fellowship, even though the NIDA guidelines discourage this usage, instead preferring phrases such as "Person with a Substance (or Alcohol) Use Disorder." Some people who identify as a proud and special part of a neurodiverse community might not see why we should not call someone "Autistic." The harm reduction community has asked us to consider whether labeling someone who has failed at an attempt to change their behavior as having a "relapse," which implies a discouraging failure as opposed to a learning opportunity which can be part of the journey towards recovery.

The invitation and challenge for us as individuals and/or organizational service providers will be to make thoughtful decisions around using language that can serve to reduce stigma while also continuing to be effective communicators as we conduct our day-to-day interactions and interventions. This can start by considering our own current language choices and which ones have the potential to contribute - even subtly and without any antagonistic intention - toward negative judgments, blame, inaccuracies, etc. which can feed into the very stigma which we and those we serve might encounter. This can be hard, as it will involve changing sometimes long-held and calcified patterns of thought and communication. Some patients will laugh at my referring to them as a person in recovery from an alcohol use disorder instead of their own self-reference as a "former drunk." That's okay. Just as a physician might refer to a patient's self-identified "stomachache" as gastritis, they can still work together towards the patient getting better regardless of whether that "teachable moment" around less-stigmatizing language becomes available.

Likewise, organizations are invited to consider a "language audit" and think about whether their promotional, patient, and professional messaging, forms, handouts, etc. can be considered to have potentially negative and damaging meanings. Sometimes even hearing staff using different word choices with the same meaning, such as one saying "he's been clean for two weeks" versus another's "he's not been using for the past two weeks" can invite a discussion during a supervisory or staff meeting, as can just a general discussion on thoughts and feelings around use of non-stigmatizing language, with examples.

In the spirit of "progress, not perfection," even those who mindfully work towards changing their personal, professional and/or organizational language choices can expect such shifts to occur only over time, as this includes a deculturation process. Even some of our lead government agencies, such as NIDA, National Institute on Alcohol Abuse and Alcoholism (NIAAA), and Substance Abuse and Mental Health Services Administration (SAMHSA) continue to use the term "substance abuse" in their own titles even though that is considered a less-than-neutral term and does not follow the recommendation that the Office of National Drug Control Policy issued in 2017. There are efforts currently underway to change some of these names.

As with other language shifts that might be occurring in our culture, let us be gentle and understanding of ourselves and others while still actively working towards choosing those words which can advance compassion and proper care for those we serve.

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References

Orwell, G. (2013). Politics and the English language. Penguin Classics.

"Words Matter: Preferred Language for Talking About Addiction" NIDA Addiction Science Series, June 23, 2021

Office of National Drug Control Policy, "Changing Federal Terminology Regarding Substance Use and Substance Use Disorders." January 9, 2017. Available online at: obamawhitehouse.archives.gov/blog/2017/01/13/changing-language-addiction.

The Importance of Equity for All: Accessing Preventative Affordable Behavioral Health Care

By Allashia Smith-Harris, MHC, CASAC-T
Vice President of Community Programs
The Mental Health Association
of Westchester

The Office of Behavioral Health Equity (OBHE) coordinates with SAMHSA's efforts to reduce disparities in mental and/or substance use disorders across populations. These efforts are focused on the promotion of behavioral health equity for underserved racial and ethnic minority, as well as lesbian, gay, bisexual and transgender (LGBT) populations. The OBHE utilizes several key strategies to impact policy and initiatives, such as sharing data-informed quality improvement approaches to assist in addressing racial and ethnic disparities in SAMHSA programs and ensuring that SAMHSA policy, funding initiatives and collaborations include emphasis on decreasing disparities. As a result of said efforts, grant opportunities are made available to community mental health providers, to assist in addressing disparities. The Mental Health Association of Westchester (MHA) has been privileged to be awarded a SAMHSA grant which supports our innovative approach to the aforementioned populations, making available equitable, easily accessible preventative behavioral health care within their communities.

Allashia Smith-Harris, MHC, CASAC-T

The mission of The Mental Health Association of Westchester (MHA) is to promote mental health through advocacy, community education and direct services. MHA facilitates recovery by providing services that reflect our deeply held values that include the recognition of individual rights of self-determination, choice, shared decision-making and collaborative work. Our highly trained staff utilize evidence-based practices throughout our comprehensive array of trauma-informed and recovery-oriented services. Through our robust services, as well as our advocacy programs and community events, MHA is able to meet the needs of thousands of men, women, children and families each year, helping them live independent lives in the community.

MHA provides neighborhood-based, in-home and in-community services for underserved individuals in Rockland and Westchester counties in New York through Driving Towards Resilience, a new and innovative service that features two customized behavioral health mobile units. Utilizing two completely renovated RVs (one in Westchester and the only in Rockland), we aim to serve at least 500 unduplicated individuals per year, including enrolling 400 individuals into care through our behavioral health mobile units and providing Functional Family Therapy in the community for an additional 100 individuals per year. Within four months of award, we deployed our vehicles in both counties and continue to expand our community partnerships.

The mobile units are equipped with two therapy rooms and a modified living room concept for de-escalation of crises or pre-contemplative services. The mobile units are staffed by licensed and/or credentialed specialists, Peer Specialists and Care Managers, all who have the capability to also use telehealth technology to access psychiatry or other services for the population being served.

Our population of focus includes individuals adversely impacted by the COVID-19 pandemic and specifically targets economically disadvantaged neighborhoods and communities impacted by racial bias and social injustice, where there is little access to care. Our population of focus includes adults, children, adolescents, transitional aged youth, and families, the LGBTQ+ population, and racial and ethnic minorities, which often experience higher levels of stigma within their communities. We aid individuals who are often left underserved because they either lack access to insurance, have limited means of transportation, speak a language other than English, or are unable to reliably access telehealth services due to a lack of internet or cellular service. We provide in-person family and individual therapy using strategies such as Functional Family Therapy (FFT), Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), and Seeking Safety (SS) for suicide prevention. Services provided in the mobile units include family and individual therapy, substance use disorder treatment, and telehealth services. In-home FFT services are also provided. We intend to serve individuals who have not yet been screened for behavioral health needs due to a lack of access;

see Equity on page 53

Organizational Strategies for Anti-Stigma Work Within Our Four Walls

By Ruth Colón-Wagner, LMSW
CEO and Executive Director
VCS Inc.

Mental health stigma affects all of us. It is so ingrained in our society, that we have to consciously choose to share or not to share our experiences or connections to mental health challenges. This conscious level decision-making brings a processing we engage in asking ourselves either, "Am I willing to deal with the consequences?" or "I am willing to deal with the consequences." It's strikingly simple yet equally impactful, the question or the statement… the question mark or the period. It's nuanced, but both very emblematic of the weight it places on each of us.

I present stigma through the lens of conscious and unconscious bias. Over our lifespan and the lifespans of those who raised us and those who raised them, back through generations, we are exposed to accumulated biases so compacted and deep-rooted in our lives that they become our facts, reducing the definition of what is a "fact" as much as it has eroded in our general society today.

Ruth Colón-Wagner, LMSW

There are very active campaigns to normalize mental health challenges as part of the human experience; to remove the isolation and pain, increase understanding and to bring recovery, hope and healing to our lives for today and for our children. And yet, mental illness has also never been more vilified. People are committing crimes and atrocities, gaining momentum in our society, making each of us scared and on edge, not knowing when this will personally affect us. Critically, these acts of violence are immediately connected to mental illness, by the media and general society, all asserting that the person must have a mental illness. Fighting mental health stigma is like pushing a boulder uphill. Alone, by myself, I cannot do this but as a community, we can do anything.

For as long as I've been an administrator, I've known the value of organizational culture and have taught other administrators how to cultivate it, sometimes in the face of massive opposition often pushing towards some form of agency-transformation. Regarding Anti-Stigma work, I propose that this work is as complex, even amongst those of us who work in the mental health field. That is how pervasive and deep the stigma lives.

When we think of mental health stigma, we may think of our communities, friends and family. As mental health providers we attend to how mental health stigma impacts our staff and our organizational culture. We are all representative of our society and equally exposed and impacted by prejudicial beliefs. So, knowing this, how does stigma present itself within our four walls? Even we well-meaning mental health providers can unintentionally express bias against those whom we proclaim to help. This is more likely expressed in judgements, stereotypes, and expectations or in our lack of expectations. With the prevalence of mental illness measured at 26% of people in our society, we can comfortably assume that our workforce is impacted by employees included in those numbers. We are society and society is us. This is nothing that should shame us. Instead, let's focus on our resiliency and how, despite any challenges, we are living life in a manner in which helps and supports others on their own journey.

Within our workforce, there is only one discipline that requires a staff person to be in recovery from a mental health challenge and to disclose it. Our Peers have an amazing position where they get to support and to be supported. But we know that stigma remains. Over a decade ago, I observed a social worker say very mean things to a Peer staff. Experiencing this and dealing with the aftermath, placed me in the unique position to learn from those mistakes. It taught me to share my expectations with staff. I need to communicate that each person is needed, and each discipline is equally part of the team for our work to flourish. We are to work together with respect. I thought that it wasn't necessary to discuss this as it should be the natural course of professionalism. However, when a new discipline is introduced, precision care must be taken to introduce the who, the why, the benefit and the impact we can all have through everyone's specialty.

To do this anti-stigma work, it's easier to work with what is within our span of control. I may not be able to change the whole of society, but I can move my place of business in the right direction, and it begins with me. We can be brave and say, "I am willing to deal with the consequences" and to work steadily until safety and acceptance will be nurtured among the staff. Although my role is not that of a Peer, that does not mean I am without mental health challenges. I am professionally a social worker and that does not mean I am without mental health challenges. We must learn to work inclusively. To do this, lets:

1. Create safety by adding the following to advertisements and job descriptions, "people with lived experience are encouraged to apply" for every discipline as well as other positions within the organization.

2. Create safety by NOT requiring people to disclose but instead set an example for your team by normalizing some behaviors they see in the people they work with. Not everything is pathological. By sharing your experiences, over time, they will share theirs. This is gentle guiding and leading by example.

3. Share news of people in positions of influence and or power as they disclose their mental health challenges. Self-disclosure is on the rise and the more we are exposed to it, the more we support and encourage it.

4. Ensure your management team and supervisors engage in Mindful Leadership so that they are in tune with their internal emotional landscape before responding to a situation. We may get angry or disappointed but as leaders, we don't gain respect through strong emotions.

5. Keep close ties with your team, especially your Peers, as they historically have experienced stigma in our line of work.

Transparency is Healing

I am CEO of VCS Inc. and I've experienced anxiety and depression. I am resilient, responsible, caring professional and effective in leading my organization and in my relationships with family and friends. I am transparent because I believe that when each of us normalizes our experiences, then we are truly practicing anti-stigma work. I believe in "Counseling for All" and through this simple declaration, I am breaking down stigma. I encourage you to join me.

About VCS

Since 1970, VCS Inc., a non-profit organization located in Rockland County, New York, has provided continuous service and programs throughout Rockland County and in other areas as determined by the needs of the community. VCS Inc. was formally known as Volunteer Counseling Service of Rockland County Inc. The name was changed after the agency saw many years of growth and the development of a vast array of services that were beyond the scope of the original model. The VCS mission is to provide hope and promote social justice for individuals, families and communities through mental health counseling and community change. VCS employs a unique combination of professional staff, trained volunteers and collaborative partnerships to create innovative responses to pressing social needs and issues.

Ruth Colón-Wagner, LMSW, is CEO and Executive Director of VCS Inc. For more information, email rcwagner@vcs-inc.org.

SPOP
SERVICE PROGRAM FOR OLDER PEOPLE

HEALTHY AGING

When Stigma is the Greatest Barrier: Strategies to Connect Older Adults to Treatment

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

When Client R, age 68, was referred to SPOP ten months ago she described symptoms of depression and anxiety – and she stated emphatically that therapy was for "rich white people" and not for her. She identified herself as an older Black Puerto Rican lesbian and said that when she had tried therapy before she always felt shamed and alienated as she told her story. Fortunately, the bilingual intake coordinator kept her on the line and listened with a trained ear.

R grew up in a home where sexuality and mental health were taboo subjects. She was rejected by her parents when she came out, and she has had no family contact or support for over 30 years. She has struggled to form authentic intimate connections with either peers or romantic partners. After retirement from a 30-years career in the food service industry she found her "dream job" of working in a record store – only to quit after she felt harassed for her age and appearance.

R had tried psychotherapy a few times, but she resented having to educate her therapist about her life experience; she kept repeating that therapy was not for someone of her background. She described her sense that the therapist could only focus on one or two of her identities and couldn't absorb her in totality.

The intake navigator encouraged her to talk and assured her that SPOP could connect her to a treatment team that understands the complex layers of identity that an older person may experience. She encouraged R to complete the intake process – with the result that R now meets each week with a SPOP therapist and is grateful that she feels seen and heard.

Here was an individual who was suffering deeply after decades of trauma, isolation, and discrimination relating to her sexual identity, gender expression, race, and ethnicity and yet was afraid that therapy would re-traumatize rather than help her. Stigma and shame associated with mental health and sexuality were deeply ingrained in her – and had, in fact, been reinforced by her previous experiences.

We often hear that the pandemic and telehealth have helped to remove stigma as an issue, but for many older adults it remains a barrier to treatment – a barrier that can play out in unique ways, as R's story indicates. Our agency, Service Program for Older People (SPOP), is dedicated to providing community-based behavioral healthcare for older adults in New York City, and we have developed programs and services to address such barriers as economic hardship, physical disability, language, transportation, or fear. Stigma, however, is often the most complicated and challenging barrier that we encounter.

Nancy Harvey, LMSW

Founded in 1979, SPOP is one of the largest and longest-standing agencies of its kind in the U.S. We serve 2,000 individuals each year through an outpatient clinic, a day program for adults with serious mental illness, bereavement support for adults of all ages, and training at the intersection of aging and behavioral health. Our client population reflects the racial and ethnic diversity of New York City and is overwhelmingly low-income, medically frail, and socially isolated.

We learned early on that our success would depend on three essential factors: (1) assembling a staff trained in the diverse and complex needs of older adults; (2) making treatment more accessible by offering services at neighborhood locations; and (3) connecting to hard-to-reach older adults by working in partnership with other community-based organizations. That strategy has enabled us to reach out to the most isolated and vulnerable older adults and acknowledge the full life experience of each client without judgment.

Our approach with Client R reflects that strategy. R was initially referred to SPOP by SAGE, the first and largest organization in the country to provide services and advocacy for older LGBTQ+ adults. SPOP has a long-standing partnership with SAGE, and we operate clinic satellite offices at two SAGE older adult centers where we offer individual and group therapy, psychiatric services, outreach workshops, and cross-training with SAGE staff. This partnership has enabled SPOP to offer treatment that is LGBTQ+ affirming and that prioritizes cultural humility and sensitivity through trainings and workshops.

When R had her first conversation with SPOP, she was following guidance from a trusted source at SAGE, which helped to support a degree of openness from the outset. During that initial call, she spoke with a bilingual intake navigator who is trained in anti-racist clinical practices, LGBTQ+ affirming treatment, and how to listen without judgment. We were able to gather essential information, flag her for fast-track assessment, and assure her that SPOP had the resources she needed. We addressed stigma and established trust within the first 30 minutes of the relationship, and we moved quickly to schedule her next appointment.

This approach requires a considerable investment in staff. SPOP offers ongoing training for direct service staff in cultural competency, LGBTQ+ competency, diversity and inclusion, and best practices for communication, data collection, and intake services. The result is a team of professionals who use consistent language, are prepared to connect individuals to other resources as needed and understand that an older person is far more complex than just their chronological age.

R is now working with her therapist to understand and process the trauma she has experienced. She is working on strategies to build self-esteem, develop skills to support trusting relationships, understand her depression and anxiety, and allow for anger. She has joined a support group at the Edie Windsor SAGE Center in New York City and is working a few days a week at an LGBTQ+ thrift store where she feels accepted and appreciated.

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 in New York City. Learn more at www.spop.org.

Early Mental Health Screening and Intervention Could Halt Addiction Epidemic

By Dr. David Hans
Chief Clinical Officer
American Addiction Centers

The epidemic of substance use disorder (SUD) has become a plague on our society, resulting in countless deaths, overwhelming our health care and justice systems, and taking a terrible toll on the families of those suffering from this disease.

While billions of dollars have been poured into drug and alcohol prevention campaigns and interventions designed to help those with SUD get treatment, none have been terribly effective. Despite this massive investment, in 2021 the U.S. still saw a record number of overdose deaths[1] and sharp increases in drug and alcohol consumption[2] over the last two years.

Perhaps the problem isn't that we're not doing enough to treat addiction - it's that we're not sufficiently addressing the root cause.

There is a clear, undeniable connection between mental health disorders and SUD. In fact, roughly 50% of those with an SUD have a co-occurring mental health disorder[3] (or about 1 in 15 U.S. adults[4]). These issues play a direct, predictable role in driving SUD development: research indicates that those with a mental health disorder are 5X to 18X more likely to develop an SUD[5] - and those are just the ones we know about. Likely millions more suffer with undiagnosed and untreated mental illnesses, many turning to self-medicating their symptoms with alcohol, opioids or other illicit substances.

Dr. David Hans

By focusing on early screenings and treatment for mental health disorders, we could prevent millions of people from developing SUDs and save countless lives. Here are six strategies that could stop SUD in its tracks by addressing the underlying cause before it becomes a deadly addiction:

1. **Train Primary Care Providers (PCP) To Screen for Mental Health and Addiction Risk.** While PCPs might ask patients about mental health and substance use during an annual well visit, many providers may be ill-equipped to respond appropriately if a patient admits to abusing drugs or alcohol. Training PCPs to ask the right questions about mental health and substance use and to respond appropriately to an affirmative response could provide a powerful first-line of defense in preventing a full-blown addiction from developing. Additionally, by becoming well-versed on holistic health, PCPs could screen for underlying mental health issues as part of their diagnostic workup and refer to appropriate providers immediately.

2. **Raise Public Awareness of the Risks of SUD Genetic Predispositions.** Evidence shows that those with a parent who's abused alcohol or drugs have a 40-60% risk[6] of developing an SUD themselves. By raising awareness of the genetic risk of SUD, we could encourage more people to seek treatment for their mental health disorders before they turn to drugs and alcohol.

   Mental health is having "a moment" right now with increased awareness combating the stigma and emphasizing the importance of self-care. We should leverage this attention to encourage seeking treatment and expose the risks of substance use.

3. **Provide Tools to Build Coping Skills and Mental Resilience.** Stress levels continue to be at an all-time high[7] for millions of Americans with social and political unrest, layoffs and economic uncertainty. It's no wonder substance use has increased dramatically,[8] putting so many people at risk for developing SUD.

   Developing mental resilience is critical for effectively managing stress without substances. Health care providers, employers and health insurers should take an all-hands-on-deck approach to providing resources and tools to help us learn such coping skills as focusing on exercise, practicing mindful yoga, self-care, positivity and gratefulness. By cultivating a stronger foundation, grounded in firm mental and emotional fortitude, we could reduce the need for people to turn to substances to cope with stress.

4. **Build Integrated Health Hubs.** Integrated health hubs that co-locate PCPs and mental/behavioral health providers in the same building, or at least nearby, would allow providers to refer patients to a specialist right down the hall where they could be seen much faster and with greater certainty. This also provides a mechanism for follow-up and closed-loop feedback. Currently, if a

see Epidemic on page 38

Black Men and Mental Health: Practical Solutions

By Nashira Funn Kayode, PhD, LCSW
Mental Health Expert
Kayode Psychotherapy & Consultation

It's no secret that black men face a unique set of circumstances in our world; economic, healthcare, and educational disparities, systemic racism, and social injustice. These factors create a world where it seems Black men's lives are rarely valued, much less their thoughts and feelings. This has resulted in Black men being less likely to seek treatment for mental health services and when they do, they are more likely to receive less adequate care.

The ultimate consequences have been detrimental for the Black community. Suicide is the 3rd leading cause of death for black or African American men ages 15-24. According to the US surgeon general from 1980 - 1995, the suicide rate among African Americans ages 10 to 14 increased 233 percentage, as compared to 120 percent for non-Hispanic whites. In 2018, the suicide rate for Black or African American men was 4 times greater than for African American women.

There is significant research and statistical data documenting the problems that lead to disparities with Black and African American men accessing sufficient mental health services. However there remains minimal practical solutions other than broad terms such as cultural diversity and cultural sensitivity. But what do those concepts actually look like in practice?

Nashira Funn Kayode, PhD, LCSW

Solutions

There are many specific tasks and skills clinical providers can implement to increase Black and African American's successful participation in mental health services. The following factors should be considered:

- **Personal Biases:** Clinicians should accept that everyone has personal biases and take steps to recognize and identify such biases. This needs to be done in a more specific manner than just self-introspection. Utilizing tools such as such as the Implicit Association Test (IAT) from Project Implicit, that assesses biases such as "skin tone" and "race" should be used to identify areas of concern. Once identified, individual practitioners and agencies should take steps to specifically address the identified concerns on an ongoing basis including follow up assessments.

- **Culturally Sensitive Assessment and Diagnosis:** Black and African Americans are often over diagnosed with more severe mental illnesses such as Schizophrenia and are underdiagnosed for mood related disorders such as Depression and Anxiety. They are also less likely to be offered medication for their diagnosis, even when appropriate and covered by healthcare.

  Implementing evidence-based screening and assessment tools that follow a biopsychosocial spiritual model such as the Cultural Formulation Interview (CFI) from the American Psychiatric Association (APA) will increase the efficacy of culturally sensitive diagnosis and treatment. These types of tools assist by focusing clinical attention on the patient's perspective and social context" and should be used in conjunction with the DSM-V.

- **Treatment Modalities, Techniques, and Skills:** Active listening is important to all successful treatment but even more crucial when working with Black African American clients in order to build rapport. Treatment interventions should utilize paradigms that validate and empower the client while normalizing their feelings and empathizing with the unique struggles they face with racism and discrimination. Clinicians must understand and accept the impact these factors have on the presenting problems and symptoms that have led them to your care.

  Implementing specific interventions such as talk therapy, narrative therapy, and talking and healing circles that have also shown to have more successful treatment outcomes should be considered.

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How Faith Communities Can Help Reduce Mental Health Stigma

By Rabbi Simcha Weinstein
Diversity, Equity & Inclusion Coordinator
Families Together in New York State

Rabbi Simcha Weinstein

Reducing the stigma around mental health requires a multifaceted approach in which individuals, communities, and society at large all have a role to play. But for many people who are seeking help for a mental health or substance use problem, their first point of contact isn't a doctor or a therapist.

It's Their Faith Leaders - People Like Me

I don't have a degree in medicine or counseling, and there are no letters following my name. As a rabbi, though I've been involved in the mental health space for quite a long time - not in spite but *perhaps* because of my lack of letters. I've seen firsthand how clergy can play a critical role in reducing mental health stigma, using our unique positions within faith communities to support those who are struggling and to promote awareness and influence the attitudes and behaviors of others.

But We Can Only Do It if We Know How

I love my Jewish community and our tradition (I'm a rabbi - of course I do!), and I know what joy it brings to people's lives. Yet the social dynamics within tight-knit religious communities can sometimes be double-edged. On one hand, they provide a sense of belonging, purpose, and communal resources; on the other, their insular nature can foster guilt and shame in members who are unable to conform to group expectations. The result is often a bevy of misconceptions about mental health, including the incorrect view that mental illness and even neurodiversity are the result of spiritual weakness or a lack of faith, rather than what they really are - science.

In the past, many faith leaders were raised in a generation that largely kept mum about mental health; some even learned to "pray away" the symptoms of mental illness rather than seeking professional guidance. To their credit, many religious communities and individuals, including clergy, have taken great strides away from these dangerously misguided notions of mental health. But as long as any trace of such beliefs persists, more work remains to be done.

In some religious communities today, for example, the revelation of past or present mental health challenges can impact potential marriage prospects. And sometimes, seeking mental health treatment is seen as crossing a social boundary, even requiring the permission of faith leaders. These outdated cultural mores are deeply damaging to faith communities on the whole - and especially to individuals who are struggling in silence with their mental health.

Understandably, such beliefs perpetuate a stigma that can lead individuals to view their mental health as a source of shame to be hidden away and ignored. And when people conceal their conditions, they're unlikely to seek therapies that could help. The result is silent suffering within our communities, left unaddressed, untreated, and unrelenting.

My family has lived experience with the fear of stigma. When my son was first diagnosed with autism, my immediate reaction was denial and defensiveness, born not of shame but of fear of what his diagnosis might mean for his future. I was afraid of how stigma would follow him throughout his life - yet I kept these fears and the pain they caused me to myself. As a rabbi, I felt obligated to maintain the façade that I was okay. I felt compelled to put on my game face and solve everybody else's problems; I couldn't burden them with mine. I wondered how my community could trust me with their issues if they knew I had my own.

Only years later can I see the way that stigma kept me silent and prevented me from seeking the support that my family and I needed.

What will it take for our faith communities to become a part of the solution? Experience has taught me when clergy speak openly, seek deeper understanding and engage in advocacy, our communities respond positively.

As a veteran community and campus rabbi, hospital chaplain, and family peer advocate, I have real-world experience in a variety of medical system settings. Through my campus ministry work, I've served as a go-between of sorts between students and the health and counseling department. And as the father of a child on the autism spectrum who has high-support needs, I also founded the Jewish Autism Network, a grassroots-led network of self-advocates, parents and caregivers. For me, advocacy, like religion, is a calling, and I am deeply committed to shining light on the complex, intersectional needs of the dual-diagnosed neurodivergent population.

see Faith on page 42

Insights From Four Stigma-Reducing Roundtables Organized by the New York State Office of Mental Health and Behavioral Health News

By Suzanne B. Feeney, MBA,
Helen-Maria (Marilena) Lekas, PhD,
David Minot,
James Plastiras,
James Rodriguez, LCSW, PhD,
Karin A. Wagner, PhD,
Philip T. Yanos, PhD,
and Jessica Zahn


2023 Mental Health Stigma Roundtable Discussion Series

A Four-Part Roundtable Discussion Series Featuring People with Lived Experience, Advocates, Policy Makers, Mental Health Providers, Community Leaders, Researchers, and Media Figures

The New York State Office of Mental Health (OMH) in partnership with Behavioral Health News (BHN) organized four roundtable discussions as part of a larger strategic plan to reduce the stigma of mental illness. The roundtable panels consisted of experts working in community-based agencies, most also with lived experience of a mental health condition and one roundtable consisted of representatives from the media. The audience was broad and consisted of persons with lived experience and families, Peer Specialists and community advocates, staff working in behavioral health community-based and government agencies, and clinicians, including social workers, psychologists, and physicians. In this essay, the team of organizers (the roundtables' facilitator, Office of Mental Health (OMH) leadership, BHN directors, and two stigma researchers), synthesized the insights and suggestions that emerged from this effort to contribute to the discussion of how to reduce stigma and promote the behavioral health and wellbeing of persons in New York State.

The panelists discussed how the different types of stigmas manifest as *internalized*, *anticipated*, *experienced*, and stigma *inflicted* upon others. They shared how some persons with lived experience of mental health conditions and their families can *internalize*, that is, absorb the negative stereotypes that the public often associates with mental health challenges, and how some *anticipate*, that is, expect to be stigmatized by others. How these two types of stigmas prevent accessing and staying in mental health services was also discussed. Internalizing and anticipating stigma can also manifest as self-blame and shame and undermine self-care. Therefore, even persons who are not exposed to stigmatizing actions or behavior by others (e.g., being discredited and made to feel as lesser than or being excluded from opportunities such as, a job or a social event) can still be harmed by internalized and anticipated stigma. Experiencing stigma was defined as being personally exposed to stereotypes and excluded from opportunities and as witnessing the stigmatization of peers, friends, and family, a form of *vicarious stigmatization*. Family members of persons with mental health conditions and especially parents, brought up their exposure to *courtesy stigma* or *stigma by affiliation* and discussed the deleterious impact of this form of stigma. The mental health workforce can also experience this type of stigma by affiliation. The panelists also highlighted that health care and social service settings and other places where people access services and support are not free from stigma and that care providers' stigmatizing behaviors can jeopardizes recipients' continuity of care, progress in recovery and wellbeing. The insight that some providers *inflict or enact stigma* on service recipients, despite being knowledgeable about mental health conditions and routinely interacting with service recipients, suggests the limitations of *educational and contact interventions*.

Bravely recognizing the presence of stigma in health care and social services

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Talk therapy provides the client an opportunity to discuss feelings and emotions. This is especially vital to African American men who often do not feel they have the opportunity to do so.

Narrative therapy provides both the client and clinician the opportunity to separate the client from the problem. This is especially important for this population who fears being seen as only a mental health problem (stigma).

Healing Circles are cost effective and have been shown to have timely results in reduction of symptomatology. Healing circles provide clients with an opportunity to share their lived experience in a nonjudgmental environment. Allowing clients to share their lived experience provides validation and creates a sense of community which has been shown to be a factor that is more important to African Americans as opposed to other groups.

- **Spirituality:** Incorporate patients' spiritual and/or religious values into treatment as appropriate. Although research indicates that younger generations (Millennials and Gen Z) are less religious than older generations, Black and African Americans continue to place a higher importance on spirituality as compared to other groups. Additionally, evidence suggests that spirituality is often a protective factor for Black and African Americans fostering hope and resiliency.

Dr. Nashira Kayode is an expert with the State of California Board of Behavioral Sciences, therapist, consultant, and author. Dr. Kayode has practiced mental health for over 17 years throughout the state. She has several publications on mental health. To learn more about Dr. Kayode or mental health visit Kayode Psychotherapy.

References

American Psychiatric Association. Working with African American/Black Patients, Prepared by Steven Starks, M.D. Psychiatry.org - Working with African American/Black Patients

American Psychiatric Association. Stress and Trauma Toolkit for Treating African Americans in a Changing Political and Social Environment Psychiatry.org - African Americans

CDC. National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). www.cdc.gov/injury/wisqars/index.html

G. Eric Jarvis, M.D., Laurence J. Kirmayer, M.D., [...], and Roberto Lewis-Fernández, M.D., M.T.S. Focus: the journal of lifelong learning in psychiatry. Update on the Cultural Formulation Interview.

NAMI; Mental Health by the Numbers. Mental Health By the Numbers | NAMI: National Alliance on Mental Illness

U.S. Surgeon General, 2001. http://www.ncbi.nlm.nih.gov/books/NBK44251

Ward EC, Wiltshire JC, Detry MA, Brown RL. African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. Nurs Res. 2013 May-Jun;62(3):185-94. doi: 10.1097/NNR.0b013e31827bf533. PMID: 23328705; PMCID: PMC4279858.

Addressing Stigma Among High School Students Using NAMI's Ending the Silence

By Joseph S. DeLuca, PhD
and Philip T. Yanos, PhD

Middle adolescence, corresponding to ages 14-18, when youth typically attend high school, is a potentially critical period for both the development of mental health conditions and targeting mental health stigma. Approximately 50% of all diagnosable mental health conditions develop in middle adolescence, and there is evidence that it is a crucial period for the crystallization of stigmatizing attitudes that can affect interactions with peers and discourage future help-seeking (see DeLuca, 2020, for a review). As a result, the past 5 years have seen increased interest in the importance of providing "mental health education" in schools to address stigma. In fact, following advocacy from the Mental Health Association in New York State, in 2018 the New York State Board of Regents mandated "school mental health education" in New York State schools to "help young people and their families and communities feel more comfortable seeking help" (www.nysed.gov/curriculum-instruction/mental-health).

Despite the growth of interest in addressing mental health literacy and stigma in middle adolescence, there is currently no standardized approach to addressing stigma in educational settings. As a result, it is possible that many schools will not offer any specific information that directly addresses negative stereotypes about mental illness and ways to be supportive toward peers who have been diagnosed. Further, it is unlikely that schools will incorporate the most consistently "evidence-based" approach to addressing stigma: contact with a person with lived experience of mental illness who is a both "local" (i.e., is reflective of the characteristics of the community being targeted) and "credible" (i.e., shares a relatable story about their experience with mental health conditions) (Corrigan, 2018). Identifying methods of bringing in "local" and "credible" contact experiences as part of mental health education is therefore essential. Ending the Silence (ETS), developed by the National Alliance on Mental Illness (NAMI), is freely available approach that shows promise as a stigma reduction initiative that is specifically targeted toward high school students (NAMI, 2015) and may therefore be considered as a viable option for New York State's Mental Health Education initiative. ETS includes a 1-day, classroom-based presentation that lasts approximately 50 minutes, and includes an informational presentation and personal story from a trained presenter who is a young person with lived experience of mental illness, as well as time for discussion (see the NAMI website for more information on ETS).

Our own research aimed to determine if ETS showed evidence for addressing stigma in its many dimensions using the "gold standard" randomized controlled trial design. Prior to our research, Wahl, Rothman, Brister, and Thompson (2019) had conducted a study of ETS in five U.S. states, using a pre/post/follow-up (4 – 6 weeks) nonrandomized design, including a no intervention control group. They used an ETS survey rather than standardized measures of stigma. Their results indicated positive changes at the immediate follow-up for ETS, especially in being able to

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Shame and Hunger: Breaking the Stigma Through Lived Experiences

By Corissa Raymond, MPH
and Alexandra Rouzier
U.S. Hunger

Corissa Raymond, MPH

Alexandra Rouzier

In the United States, the U.S. Department of Agriculture reports that 33.8 million Americans are food insecure. These individuals do not have access to enough food to meet the needs of their household; thus, they must employ various coping strategies to stretch the food they can acquire. Yet, hunger is not the issue. It is merely the symptom of a combination of root causes- social inequities that vary from economic hardship to inadequate access to transportation, poor physical and mental health, as well as other barriers related to the social determinants of health. When examining the relationship between food insecurity and mental well-being, specifically, there is a bidirectional association. An individual who is food insecure is more likely to experience poor emotional health, including depression, anxiety, and stress. The converse is also true. A person who experiences poor mental health is also at a heightened risk of facing food insecurity. This relationship epitomizes the intersectionality of food insecurity and mental health. As low-income families struggle to feed themselves and their loved ones, they also often face the stigma surrounding the utilization of food assistance programs. They report negative emotions, like shame, anger, and isolation when considering waiting in line at food pantries or while being bounced around to various social services. To ensure that those who are eligible are accessing the resources that are available to them, we must employ strategies that combat the stigmatization of people who use assistance programs, whether it be for food or other social services.

The cyclical relationship between mental health and food insecurity is well documented and highlights how stigma can place additional burdens on people who are going through a difficult time in their lives. To better understand how food insecurity affects emotional health, U.S. Hunger polled a focus group, asking the following: "How do you feel when you are experiencing food insecurity?" Responses were received from 1,367 individuals who had previously applied for food assistance via the Full Cart online application. The respondents could select multiple responses with the majority (73.4%) reporting that they felt stressed. Participants additionally reported feeling anxious (54.9%), depressed (52.8%), angry (22.6%), isolated (19.3%), overwhelmed (<1%), and embarrassed (<1%). In line with these findings, Fang and colleagues (2021) found that food-insecure individuals were 257% more likely to report anxiety and 253% more likely to report depression during the COVID-19 pandemic. This risk of heightened mental illness related to food insecurity was significantly higher than that reported by those who became unemployed during the pandemic. Utilization of economic assistance programs (e.g., unemployment benefits, stimulus payments), also did not lower the risk of anxiety and depression. These findings suggest that economic burdens experienced by low-income families are not the sole source of heightened feelings of anxiety and depression. Alternatively, other factors related to shame and stigma surrounding food assistance evoke negative emotions. Thus, when applying for and receiving food assistance, it is essential that individuals in need are treated with dignity and discretion.

To destigmatize the use of food assistance programs we must first recognize food insecurity as a social equity issue and then seek to understand the people who experience it. We can educate

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PSA Addresses Mental Health Stigma in the Latino Community

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

NAMI-NYC, which has been providing support to families and individuals affected by mental illness for over 40 years, has developed culturally responsive programs to help address the mental health needs of the Latino community. Our Helpline provides information, education and support in Spanish and 180 other languages. We've also developed our classes in Spanish, including *Bases* (Basics) and *De Familia a Familia* (Family-to-Family), as well as our *Familiares y Amistades* support group.

The PSA video was created after talking to friends and neighbors in the community and is aimed at reaching New Yorkers who are not familiar with NAMI-NYC or its programs. Our Video Producer and production interns went to various neighborhoods throughout the city, including Bushwick in Brooklyn, the Oculus in lower Manhattan, and Harlem in upper Manhattan to learn more. We tested several of our proposed focus group questions like, "In your opinion, what is mental health?" and "Do you know anyone struggling with their mental health?" Younger respondents felt comfortable talking to their closest friends and peers about their feelings. Many care for their physical health, like going to the gym, to improve mental well-being. Older respondents were more reticent to talk about mental health challenges.

Matt Kudish

From these field observations and interviews, we crafted the story for the PSA. The video features a mother and daughter who were once close but have grown apart due to the daughter's mental health challenges. The mother, like many caregivers, has tried everything to reach out to her daughter but has become exhausted and resigned. The video shows that by realizing that she needs help, the mother can take the first step towards recovery for herself and her family. We also created a toolkit offering various ways for individuals and organizations to engage with the PSA and spread the word, such as sending an email to your network, hosting a community discussion, or sharing the video on social media. To date, the video has aired locally on CUNY TV, BRIC TV, and Manhattan Neighborhood Network. You can view the video and toolkit here: www.naminyc.org/psa.

Thus far, we've hosted one focus group via Zoom to measure the impact of our efforts - and hope to capture responses of at least 100 participants. We recruited 25 participants who identify as Latino for a 45-minute community conversation. We incentivized the group with a $25 Visa gift card. We explained the project, administered the pre- and post-surveys after screening the PSA, and facilitated a brief discussion. Preliminary results suggest there is a positive correlation between viewing the PSA and shifting mental health attitudes. Participants may have learned that people with SMI do indeed face stereotypes in their everyday lives and that anyone can be affected by mental illness. Participants were also eager to learn more about NAMI-NYC's free mental health programs.

Mental health should not be a taboo subject, and it's time to start having more candid conversations about it. At NAMI-NYC, we aim to reduce the stigma surrounding mental illness in the Latino community and encourage more people to seek help when they need it. We hope you join the conversation.

Matt Kudish is the CEO of the National Alliance on Mental Illness of New York City (NAMI-NYC), helping families and individuals affected by mental health challenges for 40 years. Learn more about our mental health programs in Spanish: www.naminyc.org/espanol.

Simple Tools to Overcome Everyday Mental Illness Discrimination

By Dan Berstein, MHS
Mediator
MH Mediate

When does stigma turn into discrimination? Mental illness stigmas are negative attitudes and assumptions about people living with mental health problems, including the damaging and inappropriate stereotypes that we are dangerous, incapable, or socially undesirable. As someone living openly with bipolar disorder, I encounter these painful beliefs all of the time. Research shows that people living with mental illnesses face many different kinds of microaggressions - subtle comments or gestures that target people with hurtful, stigmatizing messages. For instance, when I first told a colleague about my mental disorder he responded in a sing-song voice saying, "Oh wow, you're doing so well!" Though he meant it as a compliment, this remark implied that the typical expectation was that someone with my condition would not be doing well. That makes this a microaggression because it reinforced negative ideas about my mental illness. These kinds of demeaning incidents, by themselves, hurt but they do not necessarily amount to discrimination. Discrimination happens when someone is treated differently in a damaging way because of their mental health impairment.

The Americans with Disabilities Act (ADA) makes it illegal for organizations to turn someone away or provide them disparate treatment on the basis of them having a mental impairment, even if it turns out the person did not actually have a mental health problem. This is because discrimination is based on what is in a person's mind when they are treating you differently, so it is their beliefs about you that matter even if they were wrong about whether you really had a disabling mental health need. Unfortunately, mental illness discrimination is common. Because people often do not understand it is wrong to treat someone differently based on their mental illness, there are sometimes even written policies that inadvertently recommend treating people improperly.

Dan Berstein, MHS

How Can You Notice if Someone Is Treating You Differently Based on a Mental Health Problem?

There are a few key ways that mental illness discrimination tends to happen, including privacy violations, disparate treatment, screening, and problems providing requested reasonable accommodations.

A. Recognizing Inappropriate Questions That Violate Your Privacy

The first type of mental illness discrimination may occur when someone violates your privacy protections by asking questions that are not legal or appropriate to ask, such as if an employer starts seeking details of a possible psychiatric disability as part of their hiring conversations. The Equal Employment Opportunity Commission (EEOC) has a list of questions that are not okay to ask employees, including asking someone whether they have a disability, asking about their medications, and asking more generally what their impairments are. You can view the EEOC's here.

It can be helpful to be mindful of protecting your personal health information. For example, I have consulted with some people who took medical leaves at their workplaces without realizing they did not have to share the full details of their mental health conditions. Their human resources contacts facilitating the leave offered to help file the paperwork for the disability insurance company, without disclosing that the employer had no legal right to access this information. Had these people sent the forms to their human resources department instead of directly to the insurance company, some folks at their workplace would have seen their doctor's full description of their psychiatric symptoms. There are many institutional processes that seem supportive, and often are meant to be, but also can result in your sharing more information than an organization is legally entitled to receive. Therefore it can help to be careful and aware when sharing your private mental health information to make sure any disclosure remains your choice. You have every right to tell people you would like to keep your information private as much as possible, and to ask why it is necessary to share with them.

B. Noticing Different Treatment Based on Mental Health Problems

Another way people may treat you differently is if they secretly try to change their normal way of doing things because they have heard you have a mental illness, or because they have guessed you are showing related symptoms. Any kind of different treatment that puts you at a disadvantage or different tier of service relative to other people may be discrimination. I work as a mediator, and some practitioners follow guidance to try to notice if parties show signs of personality disorders so they can provide those individuals with a different, more limited conflict resolution process. In this model, parties suspected of showing personality disorder traits are offered less opportunities for discussions of insight, feelings, or the past - all done secretly, with the mediators being advised to never reveal they have profiled the parties as showing symptoms of "high conflict" mental impairments. Because professionals may make these kinds of changes without disclosing them, it is important to stay aware of times you may be treated differently from normal procedures. You can access the Mental Health Safe Project's guide to noticing and responding to

see Discrimination on page 39

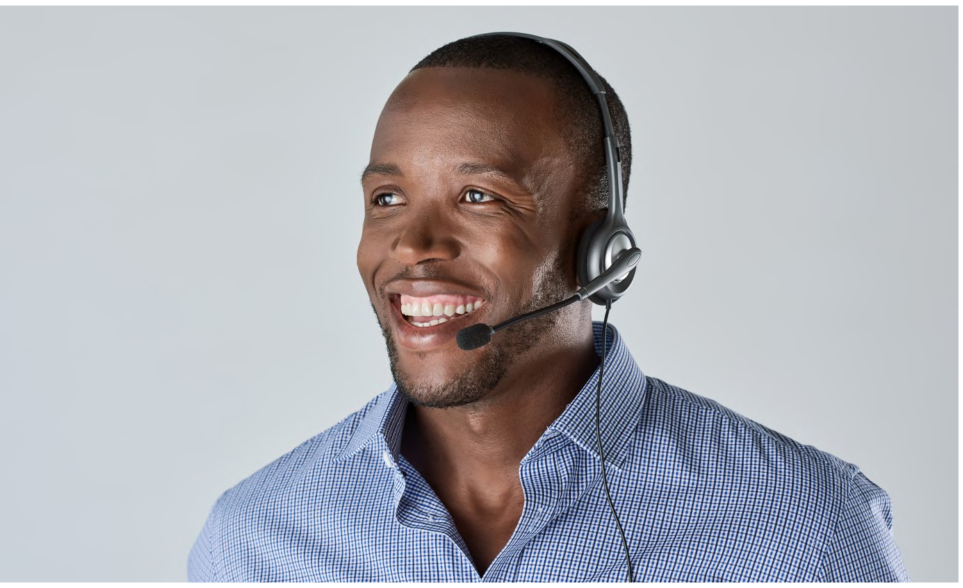
From Crisis to Recovery: The Role of Peer Support Specialists at NYC Well

By Carl Alan Blumenthal, MS, NYCPS
Peer Counselor
Sunset Terrace Family Health Center
NYU Langone Health

In her foreword to *Intimations*, written on May 31, 2020, novelist Zadie Smith states that as a result of reading Stoic philosopher Marcus Aurelius' *Meditations*, she discovered "two invaluable intimations. Talking to yourself can be useful. And writing means being overheard."

That she needed to transform her private thoughts into public discourse about life in New York City during the first peak of the COVID-19 pandemic suggests fear that she too might sicken and die, and, like Marcus Aurelius, need to leave a legacy. Likewise, who among us didn't fear for our lives then and feel unprepared for death!

I have lived with bipolar disorder for 50 years and have been a peer specialist since 2002 (first certified by New York State in 2015). For 25 years prior, I was an urban planner, with a public health degree, who learned how socio-economic challenges contribute to trauma.



As a peer support specialist for Vibrant Emotional Health's behavioral health crisis line, NYC Well, from July 2020 to November 2022, I interacted with thousands of people during the pandemic who were overwhelmed because they had only themselves to talk to, and needed to be (over)heard and thus validated. Through "reflective listening" and "motivational interviewing," I supported their self-care.

Smith quotes novelist Ottesa Moshfegh, who wrote, also during the pandemic, "Without love, life is just doing time.'" Many people who contacted us from New York City, the rest of the U.S., and across the world understood this sentiment too well due to the stress of relationships and a lack of self-esteem.

Callers, chatters, and texters to 1-888-NYC-WELL and nycwell.cityofnewyork.us can choose between a licensed crisis counselor and a certified peer specialist as well as the language to converse in.

Counselors assess risk in depth for suicide, homicide, and self-harm as well as for child and elder abuse, and domestic violence. They determine mental health status, provide brief counseling, and transfer clients to mobile crisis teams, EMS, police, or other authorities when safety planning is not possible.

Peers react to such crises using our lived experience and training to offer support more informally and, when additional clinical backup is needed, transfer callers to counselors.

Both counselors and peers respond to such major concerns as disruptions in life events, depression, anxiety, and other mental health challenges, substance use, functional, and social difficulties, and, especially during the Covid pandemic, the dangers of isolation.

We solve problems collaboratively, including coping skills derived from Cognitive Behavioral Therapy (positive thinking, thought stopping, motivational interviewing) and Dialectical Behavior Therapy (distress tolerance, emotional regulation, interpersonal effectiveness, mindfulness), as well as deep breathing, progressive muscle relaxation, and engaging in pleasant activities.

And we make referrals along the continuum of care for behavioral health and social services, summarize interactions for our callers and visitors (chatters and texters), and outline next steps, including natural supports and therapy.

Finally, we remind them of the 24/7/365 availability of NYC Well, offer a consumer survey, and write progress notes. If a crisis counselor determines their risk is high enough, other counselors follow-up.

see Peers on page 42

Modeling Compassion to Reduce Mental Health Stigma

By David L. Putney, MS, CRC, LMHC
Executive Director
Elmira Psychiatric Center
NY State Office of Mental Health (OMH)

I grew up believing that I lived in a perfect family, including my grandparents' generation. In a way, this provided a sense of safety and positivity in my world. As I grew older, I came to know about relatives who struggled with depression and anxiety. I also learned of individual and family trauma, including a great aunt about whom I had never heard until I was in my 50s. It was believed that she had suffered trauma at the hands of a relative. She died by suicide at the age of 15 while at a relative's home. My grandmother's bipolar illness wasn't referred to by a diagnostic name. My grandfather often referred to her condition as "a case of the nerves" or "psychosomatic" problems. Later on, as I furthered my studies in the fields of psychology and clinical mental health counseling, I came to understand how stigma played a role in preserving painful family secrets through endorsing an unspoken belief system in which things were "perfect."

"Unexpected kindness is the most powerful, least costly, and most underrated agent of human change." - Bob Kerrey

David L. Putney, MS, CRC, LMHC

When I experienced some emotional struggles as a very young child as well as during my teen years, I sometimes talked about them with my father. He was not a trained clinical professional; however, he exuded kindness and truly listened to people. He listened to me. When I was unsure about what to make of some of my thoughts or feelings, instead of dismissing my concerns, he reflected on them, and he provided encouragement. He also shared with me about some of his struggles in life, which let me know that I was not alone and that he was there for me. A powerful comment that my father once said to me has stuck with me and has been helpful in growing compassion that leads to action. He said, "We all have a little something." I knew what he meant. I felt what he was extending to me: compassion. Underlying this compassion were his understanding and empathy. As professionals working in behavioral health services, we are more likely to focus on and practice empathy. Although compassion and empathy are distinct concepts, compassion that is built on and compatible with empathy can be woven into our interactions and relationships with others in ways that can facilitate reducing mental health stigma.

"A kind gesture can reach a wound that only compassion can heal." - Steve Maraboli

Informed compassion should lead us to action - Developing and living out compassion in our daily lives can facilitate a way of life—a way of life which is lived out regardless of any circumstance in which we find ourselves. Compassion can be instrumental in most life circumstances. Practicing compassion (including with ourselves) can reduce mental health stigma by creating safe, trusting environments of care where people can develop resilience, moving toward healing and recovery through exercising their strengths, rather than through a primary focus on trying to overcome mental illness.

So, what is compassion? Various dictionary definitions include the word "empathy", but compassion is a much older word than empathy. Per Meriam-Webster, compassion has… "been part of the language since the 14th century, and comes ultimately from Latin *com*-and *pati*, meaning "to bear, suffer." I like this one the best: "Compassion is a sympathetic consciousness of others' distress together with a desire to alleviate it."

So, how do we become better informed in our compassion? How can we develop and sustain a compassion-filled work environment where people want to engage, live out their best ideals and contribute to the betterment of recipients' lives? My suggestions below are not scientifically derived, though research endorses some of them. They are principles which I have learned through management coaching and development, trainings and reflectively lived personal and professional experience.

Develop a safe, trusting environment - The environments we build with ourselves and our colleagues tend to become a way of life that extends to recipients of care. It is impossible to offer a trusting environment of care when we are not in synch with our organizational and personal goals for building trusting environments. When people know that they are accepted for who they are and can be assured of a safe, nurturing environment, they are more likely to engage in healing and recovery.

see Modeling Compassion on page 40

Destigmatizing Mental Illness: Music Therapy in the Clinical Outpatient Realm

By Ariel Avissar, MA, MT-BC, LCAT
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South Beach Psychiatric Center

Destigmatizing mental illness through the power of music in clinical mental health treatment therapy combined with peer support can be beneficial to achieving transformation within the current paradigm in mental health. The effects of stigma are felt most by disregarded communities who tend to be among the first to be affected by societal changes (Canen et al., 2020; Hogenaar, 2022). Destigmatizing mental illness by means of music therapy supports a collective shift in how mental health issues are addressed. Music therapy effectively reduces the stigma of mental illness by fostering inclusion and sense of belonging among clients and therapists. The goal is reducing the sole focus on mental illness and increasing the focus on music to consider the user perspective (Tuastad et al., 2022).

At Elm Place clinic in Brooklyn, NY, an outpatient clinic operated by South Beach Psychiatric Center, a facility of the New York State Office of Mental Health, integrating music therapy with mental health outpatient treatment is a tradition that first started at Baltic Street OPD in the mid-1990s. The clinic merged with the Heights Hill site in April of 2022 thereby increasing the amount of access to a larger pool of clients with a range of mental health and psychosocial needs. Clients who have participated in the music therapy group and individual experiences offered at Elm place clinic have contributed much to addressing the challenge of stigma.

One such individual is a 55-year-old black American man originally from Brooklyn, New York who writes songs, plays the bass guitar in the music performance therapy group accompanying himself singing, and performs his poetry. His participation in the music therapy programs has played an integral role in his long-term psychiatric stability and in maintaining remission of the symptoms of schizophrenia that he has experienced since late adolescence. This individual's increasing involvement with the music therapy services at the clinic, has provided him with the opportunity to reconnect with his core identity as a musician which was disrupted by mental illness and other related challenges earlier in his life. He discovered an opportunity to move away from the stigmatized label of viewing himself as a disenfranchised patient in a mental hospital to becoming a member of the community who simply needs help. This client developed into an empowered individual who possesses healthy ways to cope with challenges within the context of a life worth living. He actively supports and encourages his peers especially when they are working through difficulties, and models transformation and recovery using music therapy that he experienced as a viable therapeutic modality.

The Baltic Street Band Collective is a music performance therapy group that consists of clients who have a range of musical interests and experience and who consistently participate in rehearsing selected material and regular performances. This specialized performance therapy group has been playing in the community since the 1990s. Clients, students, peers, and therapists have all shared in the experiences of being accepted and hired in venues to perform without any reference to mental health, or request for special consideration. In 2010, the group played its first show at a well-known music venue in the East Village in Manhattan. All participants were chosen to share their artistic expression with no mention or relevance to their serious mental illness status. Therefore, the group's accomplishments

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Overcoming Stigma Through Education and Capacity Building in Communities

By Helena Maguire, MS, LABA,
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Social Stigma, according to Wikipedia, is the disapproval of, or is discrimination against, an individual or identifiable group of people based on perceived characteristics that serve to distinguish them from other members of a society. Stigma can negatively affect the emotional, mental, and physical health of affected individuals often resulting in isolation or feelings of depression, anxiety, and shame. At times, we see that social stigma often leads to discriminatory acts by others. Such discrimination can be intentional or an unconscious bias. Regardless of the motivation, individuals may have experiences of rejection by other groups, verbal abuse, and physical abuse or denied access to basic needs such as education, healthcare, and employment.

In 1972, Dr. Wolf Wolfensberger wrote the seminal article, "The Principle of Normalization in Human Services." This article highlighted the primary philosophy that all people with disabilities should be supported in leading their lives like others in their community and of their similar age. It emphasized that people with disabilities should be offered the same opportunities and environmental conditions to have a normal course of life. Dr. Wolfensberger offered a few guiding principles that included:

- Supporting the development of personal behaviors and characteristics that are culturally normative (note that this can change over time, and has been altered by an explicit value on individual difference and disability identity)

- Supporting individuals to look and behave in ways that are considered culturally appropriate and similar to that culture relative to age and sex (this can also change over time and should be flexible based on personal preferences, and has also been altered by explicit values on individual differences and identities)

- Supporting individuals to interact with others at an individual level, family level, peer group, school and education systems, neighborhoods, vocational / work settings, and navigating social justice systems.

Since the writing of this 1972 article, several advances have been made in providing individuals with disabilities with equal opportunities. Laws have been passed prohibiting discrimination in schools and employment sectors (Rehabilitation Act of 1973; ADA of

see Education on page 47

Reducing Stigma Through Harm Reduction Interventions

**By Nadjete Natchaba, EdD, LCSW, MPA,
and Rebecca Linn-Walton, PhD, LCSW
Services for the UnderServed**

Services for the UnderServed (S:US) is one the largest community-based health and human services organizations in New York State that works intentionally daily to right societal imbalances by providing comprehensive and culturally responsive services.

The pandemic has deepened many of the wounds already affecting the world. It is known that the pandemic hit those hardest who were most likely to experience barriers to medical care, housing, employment (especially the ability to work safely during the beginning of the pandemic), and other protective factors against problematic drug use.[1] Due to the fact that over 90% of the people served and employed by S:US identify as Black, Indigenous, and People of Color (BIPOC), it is essential to highlight the drastic increase in racial and ethnic disparities during this period. One of the areas of concern for S:US, like the rest of the state, is that the overdose crisis has worsened in the past three years in New York City yet challenges to accessing care remain. A commonly discussed barrier to accessing care is stigma. While much of the literature around stigma and access to care focuses on perceptions of those served, stigma held by those in the system of care can have a deadly impact on those we serve.[2]

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Rebecca Linn-Walton, PhD, LCSW

In this context, we understand stigma as "an attribute that links a person to an undesirable stereotype leading individuals to reduce the bearer from a whole and usual person to a tainted discounted one."[3] Aside from dealing with the stigma of race, poverty, and mental illness, people struggling with substance misuse are also highly stigmatized as untrustworthy, blameworthy, and dangerous,[4,5] hindering their help-seeking behaviors.[6,7] Another barrier to accessing behavioral health care for underserved communities is the perception (often accurate) that the medical field has a long history of racist and disparate practices based on socioeconomic status. This phenomenon plays out in providers who are less likely to offer medication for addiction to people of color and women, and counselors whose experience pre-dates harm reduction are more likely to promote abstinence-only models, despite the evidence demonstrating these punitive methods of care to be less effective.[8] In the field of substance use care, stigma can have deadly effects. This outcome is evident in the escalation in overdose fatalities, overcoming practitioner stigma through a culture shift in training, supervision, and approach that has never been more critical. For a service provider in New York City, the intersection between diversity, equity, inclusion (DEI), anti-stigma, and harm reduction means saving lives. S:US has intentionally adopted interventions that honor the full agency of persons served.

In the past five years, S:US has embarked on an agency-wide effort to shift toward harm reduction and holistic care. We believe that harm reduction interventions foster the idea of complete acceptance of persons served and their journey. The basic tenet of harm reduction at S:US reminds all staff that even when people use substances that can cause harm to them, their lives are just as important as any other lives and that we must demonstrate our belief via our care and services. Staff are trained during new hire orientation to administer Narcan, which is medication to treat any known or suspected

see Interventions on page 54

Overcoming the Stigma of Mental Illness: Changing Minds and Creating Opportunities

By Michael B. Friedman, LMSW
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What can be done to overcome the stigma of mental illness? Because stigma is generally understood as a concatenation of negative attitudes and beliefs, community mental health education designed to change people’s minds seems to be what is needed. But there is another way to think about stigma—in terms of its consequences. Stigma results in a number of troubling problems including housing and job discrimination, lack of welcome in the mainstream community, social isolation, difficulty getting good medical care, and even difficulty participating in religious life, not to mention low self-esteem and reluctance to ask for help. If the problem of stigma is understood in terms of these kinds of barriers to well-being, barriers that come in the wake of stigma, then overcoming stigma can be thought of not just as changing attitudes and beliefs but also as opening and creating opportunities that are largely closed to people with serious mental illness.

There are two different approaches to "overcoming" stigma: (1) Changing attitudes and beliefs mostly through broad-based community mental health education; and (2) changes designed to bring about increased community access for people with mental illness in specific ways such as rights to housing, anti-discrimination measures, programs that create opportunities for people with mental illness such as employment programs, Housing First, psychosocial clubs, etc.

Changing Minds

“The stigma of mental illness” refers to the common perception in our society, and in most human societies, that it is shameful to be mentally ill. This attitude links to a number of common myths about mental illness - that people with mental illness are dangerous, that mental illness reflects a failure of moral character, that people with mental illness need supervision and protection, and so forth.

Stigma also links to a variety of troubling images of people with mental illness:

- of a mentally ill man pushing a woman to her death in front of a subway,
- of a bedraggled homeless person sleeping on a heating grate in the cold of winter,
- of a person cut off from reality and lost listening to inner voices,
- of a person immobilized by depression,
- of a person pursuing impossibly grandiose visions.

Images of this kind have hung over people with serious mental illness for all of human history. In modern times they have been frequently reinforced by the media - in lurid headlines, in films about deranged killers, in TV shows in which people you’d never guess are the villains kill for bizarre reasons. Even movies and TV shows that are sympathetic to the plight of people with mental illness tend to exaggerate their suffering and their inability to lead satisfying lives.

What to do? The answer seems clear. Develop broad-based community education efforts that focus on dispelling the myths about mental illness. This includes working with the media to present more realistic images of mental illness. They need to understand that yes, some people with mental illness are dangerous, but very few. They are more likely to be

see Opportunities on page 55

Simple Self-Care Methods to Reduce Anxiety, Stress, and Depression

By Dr. Gene Ira Katz, DMCJ, DABS,
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Positive Pathways Counseling

Anxiety is generally characterized as feelings of tension, worried thoughts, increased blood pressure, sweating, trembling, dizziness, and a rapid heartbeat. Anxiety disorders include recurring intrusive thoughts and fears about unspecified threats. While some degree of anxiety is common, it’s considered a disorder if it lasts longer than six months. Serious medical problems can result from long-term anxiety, such as diabetes and heart irregularities (American Psychological Assn [APA], 2021). Over 40 million American adults have ongoing anxiety, with 30% experiencing clinical anxiety disorders, along with 10% of children under the age of 17 years (American Psychiatric Assn [APA], 2021); NIMH, 2022; NAMI, 2023).

Like anxiety, stress is a common biological response that can cause physical, emotional, or psychological strain, often due to circumstances requiring extreme concentration and arduous activity, or by present and perceived threats. Everyone experiences such pressures occasionally; however, persistent stress can impact one’s well-being. Trying to ignore stress often leads to significant mental and physical issues (WHO, 2021). In 2022, 76% of U.S. adults reported various ongoing impacts from stress, including headaches, fatigue, nervousness, and sadness. (APA, 2022). Both anxiety and stress are also related to chronic conditions, such as GI issues, heart disease, migraines, and sleep problems (Pathways Psychology Services, n.d.).

Dr. Gene Ira Katz, DMCJ, DABS

Everyone gets sad, but persistent depression, with constant feelings of melancholy and detachment, can develop into a major depressive disorder, negatively affecting every feeling, thought, and behavior. 21 million Americans had at least one major depressive episode last year, and of those, a severe condition developed for 2/3 of adults and 3/4 of adolescents. (NIMH, 2017, 2022). Depression often leads to sleep disruptions, heart disease, weight gain/loss, a weakened immune system, and physical pain (Mayo Clinic, 2023).

Several simple evidence-based practices have long been recognized as beneficial for addressing anxiety, stress, and depression (Ellison, et al. 2009). Some of the most accessible and simple approaches are presented here, each is easily doable, and scientifically substantiated. Through regular practice, improvements are highly likely (Riopel, 2019).

In the 1930s, educator Kurt Hahn proved that simply being in nature is beneficial to our physical, mental, and emotional health. This has since been upheld by numerous scientific studies and led to the creation of Outward Bound (Ming, 2022; NYS DEC. n.d.).

Some 2500 years before Hahn, ancient Southern Asians developed the deep relaxation and mindfulness techniques of yoga, and their beneficial health effects have been well established. Prehistoric Africans and Indigenous Americans practiced chanting and group drumming even earlier, which have also been proven to elevate disposition, and health (Fancourt, 2015). Now in the 21st Century, mental, behavioral, and physical health practitioners-- worldwide routinely prescribe similar activities, and other experiential techniques, to treat anxiety, stress, and depression (Riopel, 2019).

Arguably the easiest, most accessible experiential exercise for addressing anxiety is brisk walking, faster than a stroll, with an energetic stride and some exertion, but not quite running. Especially effective when done in a heavily wooded area -- as explained further on –but even in urban environments without trees, the benefits of brisk walking for about 40 minutes daily include stress relief, increased energy and stamina, improved sleep and mood, weight loss, and better heart health. Walking increases blood flow and circulation throughout the brain and body which literally calms tense nerves (WebMD, 2021).

About being in nature, the Japanese practice called Shinrin-yoku (Forest Bathing) includes hugging trees, listening to birds singing, and kicking through leaves, all proven to boost mental health. Trees also emit phytoncides, chemicals that can help boost our immune system. Regularly practiced by over five million Japanese, forest therapy is also becoming a recognized remedy throughout the world, supported by a number of scientific studies that confirm its beneficial effects,

see Self-Care on page 54

The Impact of Stigmatizing Language From Family and Clinical Perspectives

By Amy Kelly, MBA, MNM
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Amy Kelly, MBA, MNM

Emily Garten, LCSW

Mental health challenges can impact everyone. Even if you have not been personally affected, you likely know someone who has – whether it is a family member, friend, or an individual you support as a behavioral healthcare provider. Mental illness is defined as mental, behavioral, and emotional disorders, and can vary in range from no impairment to mild, moderate, and severe mental illness.[1] According to the National Institute of Mental Health (NIMH), in 2020, nearly one in five adults (approximately 52.9 million people) in the U.S. was living with a mental illness. For children ages 3 to 17, anxiety grew by 27% and depression increased to 29%.[2]

Stigma and stigmatizing language are often associated with these conditions and can have a significant impact on the short- and long-term success of an individual in overcoming a mental health challenge. Stigmatizing language assigns negative labels, stereotypes, and judgment to certain groups of people. This, in turn, can contribute to negative outcomes, such as social isolation and reduced self-esteem, as well as a decreased likelihood to seek medical help.[3]

To overcome stigmatizing language, family members, friends and treating providers who are supporting the child or adult with the mental health condition, need to model appropriate, strength-based language when referring to the condition or the individual.

"No one would ever say that someone with a broken arm or a broken leg is less than a whole person, but people say that or imply that all the time about people with mental illness." – Elyn R. Saks, professor, lawyer, and psychiatrist[4]

Accepting a Loved One's Condition

Since 2020, there have been additional stressors contributing to mental health challenges, including the COVID-19 pandemic, social isolation, caregiver burden, virtual school, economic and housing instability, healthcare workforce shortages and political unrest. This has resulted in an increased demand for mental and psychological healthcare, requiring an even greater need for family members, friends and treating providers to speak in a destigmatizing way.

Acknowledging and accepting your loved one's mental health condition may be challenging, depending on your cultural values, predisposed opinions and biases about mental illness. From a family perspective, it is critical to demonstrate love, acceptance and non-judgement when speaking with, or about, your child or adult. Small adjustments, such as removing the word "crazy" from your everyday vocabulary, can make a difference. Speak in a strength-based, person-centered way. Rather than saying, "Joey is crazy" or "Joey is bipolar," it is preferred to say, "Joey has bipolar disorder." Understanding and discussing a mental health diagnosis, as you would a physical health diagnosis, is vital to normalizing the condition and preventing feelings of shame and self-doubt. Learn how to empathize with your family member who is affected. Use words or phrases to help them feel heard and understood, such as, "I can understand why you feel that way," or "I'm sorry this has been so painful for you." Avoid words and phrases that can reduce a person's identity or imply the inability to recover or make improvements in their life, such as "drug addict" or "drug abuser."

Destigmatizing Mental Health Counseling

Clinicians and other providers who offer

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Overcoming Self-Stigma in Bipolar Disorder: A Targeted Intervention for an Urgent Problem

By Andrea B. Vassilev, BA
Doctoral Student, Clinical Psychology

For many with bipolar disorder, as well as other mental health conditions, stigma remains a real and regular burden in everyday life. In addition to the stressors and difficulties of the condition, the experience of stigma can lead to a host of deleterious outcomes including lower self-esteem, reduced quality of life, and worse physical and mental health (Au et al., 2019; Alonso et al., 2009; Livingston & Boyd, 2010).

Fortunately, stigma has made its way into the public eye in recent years with increased dedication to education and reduction. After all, people with bipolar disorder deserve the same rights, respect, and opportunities as everyone else. There should be no barriers simply due to false preconceived notions about what bipolar disorder is or how it manifests.

Self-stigma, in comparison, is often under-examined.

Self-stigma is what happens when people take the public's negative, stigmatized beliefs about those with bipolar disorder (or another mental health condition) and turn them inwards. They internalize these false statements until the statements become core beliefs. It's extremely common; in a survey conducted by Dubreucq et al. (2021), 1 in 3 people with bipolar disorder were found to experience high levels of self-stigma. If someone continuously hears that people with bipolar disorder are dangerous/unreliable/lazy, they will likely at some point begin to internalize these false beliefs. "I have bipolar disorder - I guess I am dangerous/unreliable/lazy, too. After all, I'm one of *those* people."

Self-stigma may also occur when people take truths about their experiences with bipolar disorder and distort or exaggerate them beyond recognition. For example, Rosa et al. (2008) showed that occupational functioning is often impaired in bipolar disorder. An individual may have experienced times of intense symptoms during which they were less productive in the workplace. This experience may be distorted into a statement such as "I'm useless at work" or "I'm unemployable." These self-stigmatizing thoughts are not true and it's clear how they could be harmful to someone's wellbeing.

There is a plethora of negative consequences of self-stigma in bipolar disorder. Jenhani et al. (2022) demonstrated that self-stigma frequently leads to feelings of lower self-esteem. Additionally, Özdamar Ünal et al. (2022) showed that self-stigma can lead to a worse experience of the condition with more depressive episodes while Perich et al. (2022) showed that self-stigma is correlated with poorer functioning. Bipolar disorder, with its unpredictable and often devastating outcomes, is hard enough to live with: self-stigma just adds insult to injury.

Given the mental health crisis in our world, self-stigma is one problem those with bipolar disorder shouldn't have to add to their list of troubles. It is imperative that real, immediate, and targeted measures be taken to address the issue.

One solution to the problem is the new intervention Overcoming Self-Stigma in Bipolar Disorder (OSSiBD). OSSiBD is an eight-session small group program designed for individuals with bipolar disorder who are experiencing self-stigma, shame, and embarrassment due to their diagnosis. The program, which is fully manualized, can be run by any mental health professional. The materials,

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Primary Care Practices Should Embrace Value-Based Care

By Dr. Nele Jessel
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athenahealth

The COVID-19 pandemic left a lasting impact on our society and institutions, and few industries felt – and continue to feel – its effects more than healthcare. Among the many lingering issues, either driven or revealed by the pandemic, is the rising demand for behavioral health services – and a system that is struggling to meet it.

Because of existing mental health accessibility issues, patients are increasingly relying on their primary care clinicians to recognize and manage their behavioral health issues. In many instances, providers may be the only people who observe a patient's need for help.

While primary care clinicians regularly address and manage behavioral health conditions, they are ill-equipped to provide the support needed for a growing population of patients, some of whom may have more complex conditions that would benefit from specialized care.

Additionally, behavioral healthcare can be prohibitively expensive for many patients – quality behavioral healthcare treatment plans may include ongoing therapy and require multiple visits. Due to the demand for behavioral health services, many providers are able to choose not to accept insurance and require patients to pay out of pocket.

The result: For many patients, behavioral healthcare remains inaccessible.

On-Premises Support

One promising solution for increased access to behavioral healthcare would be for primary care practices to include a behavioral health specialist as part of the practice. Though currently rare, embedding behavioral health services in primary care practices offers significant advantages for patients and providers.

First, it removes the stigma of a behavioral health condition. Many still do not view behavioral health problems as medical problems. But a behavioral health diagnosis is a medical issue, just like asthma, heart disease, or diabetes, and it needs consistent treatment and management like any other medical condition.

Second, too often even when a provider recommends that a patient reach out to a psychiatrist or counselor, the patient does not follow through to seek help once they leave the primary care practice. This presents even more issues for the patient, as mental health diagnoses can have a significant effect on a patient's ability to manage other co-existing medical problems. Not to mention that once a patient leaves an office, waitlists and costs associated with seeking additional medical treatment remain obstacles.

With a behavioral health provider as part of the primary care facility, we can remove the stigma of behavioral health treatment and ensure the patient immediately receives the care they need. The primary care practice is where patients receive treatment for all their other health issues, and the patient is much more likely to agree to the care if barriers to access are removed.

Leveraging Value-Based Care for Better Patient Outcomes

While embedded behavioral health services may address patient accessibility issues, they still do not address the financial challenges for access to behavioral healthcare or the relative shortage of behavioral health clinicians, especially in more rural areas.

One potential solution to solving access to behavioral health clinicians lies in the provision of their services virtually via telehealth, which allows access for more patients. These virtual consultations can be conducted from an exam room within the primary care or even medical specialist office. Virtual group therapy sessions are also an opportunity to improve access.

The answer to clinicians receiving

see Care on page 46

Disasters: The Importance of Fighting Mental Health Stigma

By April Naturale, PhD
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Vibrant Emotional Health

April Naturale, PhD

Lindsay Mixer, MA, ABD

The last few decades have seen a steady increase in disasters around the world. Whether caused by humans or nature, for many communities disasters occur with such frequency that they overlap each other. The traditional Phases of Disaster model–anticipation, impact, adaptation, and recovery (Raphael, 1986)–no longer make sense in all situations, as communities are often unable to reach the recovery phase of one disaster before they are anticipating or impacted by another disaster or major crisis.

The new model of disaster, the Chronic Cyclical Disaster Model, directly addresses the reality of overlapping disasters and also engages with how a community's stress threshold affects their resilience in the face of those disasters. Developed by a group of psychiatrists, psychologists, and social workers, the model provides a new blueprint for communities, individuals, behavioral health and other disaster responders, to better understand the physio psychological impact after experiencing multiple or ongoing disasters.

Disasters also don't happen in a vacuum. For every community that experiences a disaster, there are people whose experience will be complicated by everyday stressors they face. These stressors range from foundational issues like systemic racism and intergenerational trauma to chronic stressors like housing instability and community or interpersonal violence (Beckie, 2012; Chen et al., 2007; Guidi et al., 2021). Additionally, for the last few years every community around the globe has been coping with the overarching fear and grief related to the ongoing COVID-19 pandemic.

These stressors affect community resilience–people's ability to "bounce back" to a pre-disaster state–in the face of a single disaster, let alone when multiple disasters strike at the same time. The theory behind this, known as allostatic load, gives us an understanding of the different resilience capabilities not only between communities but within communities. Simply put, the more stressors a group of people experience, the quicker they reach their stress threshold when hit with disaster(s), and the lower their resilience–their "bounce back" factor–becomes.

In many cases, these stress thresholds aren't the same throughout a community. Sub-communities often have different experiences of the world due to uneven access to resources such as food, safe housing, and healthcare, along with different stressors from racism, sexism, ableism, ageism, homophobia, transphobia, xenophobia, and more (Chandra et al., 2021). These impact how the sub-community is able to respond to the disaster and can result in a portion of a community being unable to bounce back physically or psychologically.

Imagine living paycheck to paycheck while experiencing violence every time you try to use a public bathroom. That's stressful enough. Imagine all that while also trying to recover from a hurricane that destroyed your home, only to have a mass shooting occur at the elementary school your child goes to, all during a global pandemic. It wouldn't be easy for anyone to recover.

Post-traumatic stress disorder (PTSD) and its newer associate complex PTSD (cPTSD) are both caused by experiencing traumatic events and include symptoms such as re-experiencing the trauma (flashbacks and nightmares), avoidance of reminders, dissociation, and a constant vigilance for any threats. For cPTSD, one must also display symptoms of Disturbance in Self-Organization, which is noted by continuing interruptions to daily life due to ongoing traumatic events (Kairyte et al., 2022; Rossi et al., 2022).

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Mental Health in BIPOC Communities: Reducing Stigma and Barriers

By Rakel Beall-Wilkins, MD, MPH
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Magellan Health

Much of the stigma around mental health stems from crisis situations. We fear people who seem out of control, especially when we don't know how to support them. For Black, Indigenous, and People of Color (BIPOC), social disparities can compound that fear.

During my career, I've worked in addiction medicine, served people with psychiatric problems caused by HIV/AIDS, and served in a psychiatric emergency department (ED). I've seen plenty of people become aggressive or combative during mental health crises. But I still remember one day in the ED when a mother came to me crying.

She was so thankful that I, another Black woman, was caring for her son during his acute episode. She explained that her family was terrified by her son's behavior—but they were even more afraid to call 911 or the police. They feared he would be criminalized because of his aggression. Or worse, killed.

Research supports the family's apprehension. One study, for example, indicates that unarmed Black men showing signs of mental illness are at higher risk of being killed by police than unarmed White men with similar signs (Thomas et al., 2021). However, community advocacy can go a long way toward removing stigmas and easing the fears that too often lead to crisis escalation rather than treatment.

Rakel Beall-Wilkins, MD, MPH

Here in Houston, for instance, community advocates recently pushed to create a crisis intervention team. Now, when someone suffers an acute mental health crisis, social workers and other people specifically trained to deal with such situations can respond. Through similar programs, we can better address the mental health needs of BIPOC communities.

By the Numbers

Mental health affects us all. More than 20% of adults and 16% of children in the U.S. have a mental health disorder, but less than half receive treatment (MHA, 2023).

According to the National Alliance on Mental Illness (NAMI), almost half of White Americans with mental illnesses receive therapy or counseling. Only 33% of the Hispanic and Latinx community, 31% of the Black community, and 25% of the Asian American and Pacific Islander communities receive needed therapy. Research (Perzichilli, 2020) also indicates that BIPOC are:

- Less likely to have access to mental health services
- Less likely to seek treatment
- More likely to receive low-quality care
- More likely to stop treatment early

To support mental wellness, especially in BIPOC communities, we must recognize and overcome barriers to care, including social stigmas and disparities, financial challenges, and accessibility.

Overcome Social Stigmas and Disparities

Unique stressors like racism and discrimination increase mental health vulnerability for BIPOC individuals. Within some Black communities, for example, a longstanding emphasis on physical, mental, and spiritual strength stems from generations of slavery and struggle. Therefore, having depression, anxiety, or other mental health concerns is sometimes viewed as weakness.

Our cultural beliefs and attitudes also influence how we express anxiety, sadness, and other emotions. Some people learn to focus on "physical" problems, such as pain or trouble sleeping, rather than underlying mental distress. Moreover, implicit bias may affect how expressions of need are perceived and treated.

During my residency, I presented about how BIPOC individuals with severe depression were more likely to be misdiagnosed with schizophrenia. Interestingly, the studies I showed indicated that implicit bias exists not just in White providers but in BIPOC providers, too. Research on this topic continues to show similar findings (Londono Tobon et al., 2021).

Thus, opportunities to reduce social disparities and stigmas can be found in both the civic and provider communities.

Community Opportunities

Communities have done a good job promoting the 988 Suicide & Crisis Lifeline. Why not apply a similar strategy to *any* acute mental health crisis? Community leaders should be encouraged to:

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Overcoming Stigma to Create More Inclusive Communities

By Dr. Doreen Samelson, EdD, MSCP
and Dr. Lindsey Sneed, PhD, BCBA-D
Catalight Research Institute

April is Autism Awareness Month and World Autism Day was April 2, 2023. These observances create important opportunities to break down existing biases and build more inclusive communities where all people are valued for their unique abilities.

While greater awareness is needed to foster understanding and support, shouldn't we set our sights a little higher? Now is the time to aim beyond mere awareness and acceptance and embrace the advances that are enabling people with autism to choose their own path.

Innovations in Autism Care

Changes to public policies and to the autism spectrum disorder (ASD) diagnosis itself, along with increased general awareness of autism, have contributed to a dramatic increase in ASD diagnoses. According to the most recent CDC data, 1 in 44 children in the U.S. has been identified with ASD – up from 1 in 150 children in the year 2000. In California, where public policies have made ASD care more accessible, the figures are even higher – 1 in 26 children has been diagnosed with autism.

Dr. Doreen Samelson, EdD, MSCP

Dr. Lindsey Sneed, PhD, BCBA-D

Nevertheless, stigma persists – a fact that families of people with ASD understand all too well. An ASD diagnosis can elicit unconscious bias on the part of doctors, teachers, neighbors, and even friends. Just as tragically, these biases also rob the broader community of the many contributions that autistic people can bring.

Stigma is based largely on inexperience, misunderstanding, and fear. For much of recent history, behavioral health services for people with ASD were the responsibility of schools, which were chronically under-resourced and produced very few stories about successful treatment outcomes. As a result, many people have an outdated understanding of ASD or of the potential of autistic people to benefit from innovative behavioral health treatment modalities and choose their own path in life.

In fact, care options for autistic people have changed markedly in recent years, spurred in part by mental health parity legislation. For example, California law SB 946, enacted in 2012, mandated meaningful coverage for behavioral health, including autism, under state-regulated plans. This was a major milestone for ASD awareness, care and for behavioral health treatment more broadly, inspiring similar laws in states across the country.

This, in turn, led to an escalation in demand for behavioral health care resources, along with important research and the development of innovative treatment modalities designed to meet the need for high-quality, affordable care. One result of this is the trend toward parent-led applied behavior analysis (ABA) treatment, which our research has found yields comparable or in some cases better outcomes compared with practitioner-mediated ABA, in which most of the direct treatment is provided by a paraprofessional.

In addition to reducing the cost of care for both families and payers, parent-led ABA significantly increases parental self-efficacy, meaning parents feel more confident in their own abilities to parent their child(ren) (Sneed & Samelson, 2021). This only makes sense: when parents of children with ASD have access to resources and training, they're less stressed, have more time for other members of the family and for themselves, and are better able to facilitate positive outcomes for their child, placing them on a path toward greater independence and self-sufficiency. Additionally, empowering families to participate actively in their loved one's treatment has the added benefit of inspiring greater confidence to advocate for their child's needs with teachers, physicians and other caregivers.

Early and Equitable Treatment

Besides being a valuable first step in overcoming stigma, awareness is

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Mental Health Stigmas in the Black Community

By Meghann Simpson, BA
Peer Advocate

In 2019, the Center of Disease Control and Prevention reported that 47,500 US citizens committed suicide (Suicide, 2022). Of this 47,500, over half identified as Black. This is an estimate of 4 out of 6 suicides committed by People of Color (POC) and 2 out of 6 being Caucasian, Hispanic, and other ethnicities. The collective data indicates that POC may experience mental health difficulties at a higher rate than other ethnic groups. M.D. Phillip Murry suggests that POC are 20% more likely to be diagnosed with a mental illness compared to their Caucasian counterparts (Murray, 2017). Despite POC reporting higher rates of mental health disorders in comparison to Caucasians, this same study concluded that only 25% of Black people seek professional treatment for their mental health whereas 40% of Caucasians (Murry, 2017). A primary reason for this disparity is stigma relating to mental health in the Black community.

These stigmas include being labeled as crazy and associated with signs of personal weakness. In her book *Our Own Voices*, Vanessa Jackson presents personal accounts demonstrating a belief that those who are experiencing mental health disorders are crazy (Jackson, 2002). Ph.D. Monnica Williams discusses how concerns of being viewed as weak or "crazy" is one obstacle that POC experience toward pursuing professional mental health care (Williams, 2011). A survey regarding POC's beliefs about mental illness showed that of two hundred and seventy-two participants, 63% reported they felt a mental illness is a sign of personal weakness (Ward, 2013). Alvidrez interviews showed the majority of Black women interviewed supported mental illness as a sign of personal weakness. By examining several reports regarding stigma, one can conclude that there is great concern of personal deficits being associated with mental illness in the Black community.

Literature Review

There are multiple qualitative and quantitative studies that indicate that being labels as "crazy" is a common mental illness stigmatic view. Jackson's book shares personal accounts of oppression, survival, and recovery in the mental health system. During the development and utilization of Insane Asylums in the United States from the 1800s and 1900s, many POC were institutionalized for criminal acts, disorderly social conduct, physical disability or impairment, and mental health disorders. In these asylums, POC were often misdiagnosed with "insanity" and received treatment that is considered cruel and unethical (Jackson, 2002). The labels perpetuated by white doctors are a leading contributor in the racial stigmatization of Black mental health being labeled as insane or crazy. PsyD. Monica Williams discusses the stigma of being labeled insane or crazy. She elaborates on how the fear of being labeled as crazy causes people of color to avoid acknowledging symptoms of mental illness (Williams, 2011).

Another common stigma that is mental illness as a sign of weakness. A survey of two hundred and seventy-two participants to determine stigmas associated with mental illness in this community (Ward, 2013). The results demonstrate that many participants were not comfortable with acknowledging signs or symptoms of mental illness. Alvidrez also found that Black communities report that stigma as a significant barrier in their pursuit for professional mental health treatment and that Black women are more likely to associate causes or symptoms of mental illness with other explanations.

Community Indicators

In the United States, 13.4% of the population identify as Black or African American. Of this 13.4%, 16% of them reported having a mental health disorder. To put this in perspective of individuals, this means that over seven million POC struggle with mental illness. Of this estimated seven million, 22.4% or one million people reported a severe mental health disorder (Mental Health America). In comparison to the 6.8% of their Caucasian counterparts, 12.3% of POC reported challenges receiving mental health services (Rockville, 2018). This percentage of the population demonstrates the disparities in Black communities receiving care.

Further addressing the disparities in mental health difficulties and diagnosis in the Black community, as a collective, POC report a higher rate of depression, anxiety, Post Traumatic Stress Disorder (PTSD), and schizophrenia compared to Caucasians (Murry, 2017). POC living below the poverty line are three times more likely to experience severe mental illness in comparison to those living above the poverty line. POC are also more likely to experience a traumatic event

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Epidemic from page 26

PCP does refer a patient to a mental health specialist, they have no way of knowing if the patient even made the appointment. With an integrated health hub, PCPs could track whether patients attend their appointments and incorporate specialists' feedback into patient charts and assessments.

5. **Demonstrate Early Intervention Value to Payers.** We know that early intervention drives better patient outcomes, but let's face it: when it comes to insurance, money talks. Mental health crises and overdoses frequently send people to the hospital for emergency care, which is extremely expensive. Often the same patient will present for repeat incidents, racking up huge medical expenses and straining a system that's **already stretched thin.**

   As providers, we must demonstrate how investing in mental health treatment can avert these expensive health care encounters, thereby saving insurance providers money. By quantifying the ROI on early intervention, perhaps we can convince payers to invest more in preventative services. Right now, there isn't even a mandate for small- to medium-sized insurers to provide mental health coverage, which is absurd. We certainly wouldn't tolerate an insurer refusing to cover cardiac catheterization to reduce the risk of a heart attack. Why should mental health treatment to reduce the risk of an SUD be any different?

6. **Incentivize Aspiring Providers.** One of the biggest challenges in providing mental health services to prevent addiction is the availability of care. The behavioral health industry is suffering a severe shortage of qualified providers,[9] especially in rural areas.

   To get these vital, life-saving services into the communities that need them most, we must develop programs for encouraging young people to choose behavioral health as a career and incentivizing providers to work in underserved, high-risk communities. Tuition reimbursement, student loan forgiveness or perhaps a stipend to supplement compensation would make these careers more attractive and increase access to treatment.

Without a doubt, mental health screenings and access to early treatment are essential for turning the tide on the addiction crisis. However, doing so requires a collaborative response that includes government support, policy changes and participation from payers and providers. By taking a more holistic approach and mounting a comprehensive response, we can prevent SUD before it starts and save thousands of lives.

Dr. David Hans is the Chief Clinical Officer of American Addiction Centers (AAC), the nation's leading addiction treatment provider. As CCO, Dr. Hans believes it is his duty to ensure AAC continues to consistently provide empirically based clinical services that effectively address the underlying factors and patterns of behavioral health issues. Dr. Hans brings his wide breadth of experience and skill set to expanding AAC's clinical services, overall clinical excellence across programs, and maintaining a safe environment for patients to heal and grow.

Footnotes

1. www.ama-assn.org/system/files/issue-brief-increases-in-opioid-related-overdose.pdf

2. nida.nih.gov/research-topics/comorbidity/covid-19-substance-use

3. americanaddictioncenters.org/co-occurring-disorders/assessment

4. samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

5. americanaddictioncenters.org/blog/risk-substance-abuse-mental-illness

6. nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

7. studyfinds.org/stress-americans-loneliness-mental-health/

8. cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

9. aamc.org/news-insights/growing-psychiatrist-shortage-enormous-demand-mental-health-services

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comprised of a Facilitator's Manual and Participant's Workbook, are intended for use in and are available for free to hospitals, clinics, inpatient/outpatient programs, and private practices.

The OSSiBD program employs a number of evidence-based techniques and activities to directly address self-stigma. It begins with psychoeducation on bipolar disorder including a resilience-based continuum model of wellness and recovery. Following that, techniques of Narrative Enhancement and Cognitive Therapy are employed. These ask participants to consider other parts of their identity aside from bipolar disorder as well as to celebrate their strengths. This is proceeded by information on the formation of stigma and self-stigma. The following two sessions teach Cognitive Behavioral Therapy tenets and skills that are then used to reframe self-stigmatizing thoughts. A discussion of disclosure tips and techniques comes next followed by an examination of the impact of relationships and culture on self-stigma. The program culminates in participants drafting brief strengths-based autobiographies that also utilize their new reframing skills and social insights. Since these activities are all presented in a graphically designed hard copy workbook, participants end the program with a meaningful journal-like keepsake of their growth.

The experience takes place in a small group of approximately 10 participants. This exposure to peers living through similar struggles is intentional and crucial: Maunder & White (2021) showed that peer contact may help reduce self-stigma in various mental health conditions.

Andrea B. Vassilev, BA

The aforementioned settings of inpatient, outpatient, clinic, and private practice, which are often the cornerstone of treatment, provide the perfect opportunity to address self-stigma where it begins. However, those who have been living with bipolar disorder for some time may be even more seriously entrenched in the experience of self-stigma. Therefore, it is equally important that they have access to this opportunity to learn, grow, and heal. OSSiBD groups are ongoing and available for free to individuals through the Depression and Bipolar Support Alliance of California.

OSSiBD was developed as part of the doctoral dissertation of A.B. Vassilev (Vassilev, 2022) and was reviewed by a worldwide team of experts in the fields of bipolar disorder and stigma before publication. Its activities and theoretical foundations are rooted in evidence-based practices for the treatment of self-stigma in various conditions. It is the first comprehensive program to specifically focus on the self-stigma experience in bipolar disorder.

Given the treacherous nature of bipolar disorder, with its lifelong, often worsening, trajectory and serious impact on quality of life, the last thing patients need is to live in shame about a condition they didn't choose to have. While interventions to reduce stigma in the general population may lead to an eventual reduction in self-stigma, the crisis of self-stigma in bipolar disorder warrants the attention of clinicians and hospitals across the nation and globe. Only through direct intervention and the cooperative support of patients can we help them reclaim their self-esteem and self-worth in the face of such a difficult condition.

Andrea B. Vassilev is a fifth-year doctoral student in clinical psychology, speaker, author, member of the advisory board of the Depression and Bipolar Support Alliance of California, and active member of the International Society of Bipolar Disorders. To contact Ms. Vassilev, please email andrea@ossibd.com. Please visit www.ossibd.com for full information.

References

Au, C. H., Wong, C. S. M., Law, C. W., Wong, M. C., & Chung, K. F. (2019). Self-stigma, stigma coping and functioning in remitted bipolar disorder. General Hospital Psychiatry, 57, 7-12. https://doi.org/10.1016/j.genhosppsych.2018.12.007

Alonso, J., Buron, A., Rojas-Farreras, S., de Graaf, R., Haro, J. M., de Girolamo, G., Bruffaerts, R., Kovess, V.,Matschinger, H., & Vilagut, G. (2009). Perceived stigma among individuals with common mental disorders. *Journal of Affective Disorders*, *118*(1–3), 180–186. https://doi.org/10.1016/j.jad.2009.02.006

Dubreucq, J., Plasse, J., & Franck, N. (2021). Self-stigma in serious mental illness: A systematic review of frequency, correlates, and consequences. *Schizophrenia Bulletin*, *47*(5), 1261-1287. https://doi.org/10.1093/schbul/sbaa181

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71* (12), 2150–2161. https://doi.org/10.1016/j.socscimed.2010.09.030

Maunder, R. D., & White, F. A. (2021). The relationship between contact with peers and self-stigma in people with mental illness. *Counseling Psychology Quarterly*, 1-17. https://doi.org/10.1080/09515070.2021.1970514

Özdamar Ünal, G., Bektaş, Ö. N. A. L., İşcan, G., & İnci, A. T. A. Y. (2022). The Relationship between internalized stigma, perceived social support and self-efficacy in bipolar disorder. *Genel Tıp Dergisi*, *32*(3), 350-357. https://doi.org/10.54005/geneltip.1104022

Perich, T., Mitchell, P. B., & Vilus, B. (2022). Stigma in bipolar disorder: A current review of the literature. *Australian & New Zealand Journal of Psychiatry*, *56*(9). https://doi.org/10.1177/00048674221080708

Rosa, A. R., Franco, C., Martínez-Aran, A., Sánchez-Moreno, J., Reinares, M., Salamero, M., Arango, C., Ayuso-Mateos, J. L., Kapczinski, F., & Vieta, E. (2008). Functional impairment in patients with remitted bipolar disorder. *Psychotherapy and Psychosomatics*, *77*(6), 390-392. https://doi.org/10.1159/000151520

Vassilev, A. B. (2022) Overcoming self-stigma in bipolar disorder: an intervention. [Doctoral dissertation, Alliant International University].

Discrimination from page 30

this kind of discrimination from mediators here. You can also find more general resources about noticing when people may be discriminating against folks with mental health problems by labeling them “difficult,” “high conflict,” or “toxic” by visiting www.mhsafe.org/toxic.

C. Seeking Help After Being Turned Away Due to Mental Illness.

Beyond times that someone is asking you invasive questions, or providing disparate treatment, there are also times they may actually decline service based on their assessment that you have a mental health problem. While it is often legal for clinicians to refer you to specialists for treatment, and therefore decline to treat you based on your specific diagnosis or situation, it is not okay for most businesses to ever turn someone away based on their mental illness diagnosis. Yet sometimes there are published policies that do advise professionals to turn folks away for this reason. Many professionals who turn someone away know better than to say it is for a reason that violates civil rights laws - so they could make excuses rather than say it is because of your mental health problem, or your race, or your gender. It can therefore be helpful, if you are wondering about why someone declined to offer you services, to ask to review the organization’s policies or to seek legal help. If you believe that your mental health problem is a reason you have been turned away from service, then you can also learn about filing ADA Complaints or access other resources at https://mhsafe.org/discrimination/

D. Speaking Up When Reasonable Accommodation Requests Are Mishandled

People can also discriminate against individuals with psychiatric disabilities by not providing reasonable adjustments to their normal procedures. If you have a psychiatric disability, the ADA generally makes it illegal for organizations to refuse your reasonable accommodation requests unless they can credibly claim it is an undue hardship, fundamental alteration, or direct threat or they have provided a suitable alternative to your request. I seek some reasonable accommodations under the ADA as part of my work. When I travel as a speaker, I ask hotels to help me identify and block off their quietest room for me to help me manage the sleep needs from my mental illness. I also generally ask that people let me know when they have received my e-mail messages and if they plan to reply so I do not end up having obsessive, intrusive thoughts about whether to follow up. These two requests cost nothing for someone to provide, yet it can still be difficult for me to receive them. The following are some ways a reasonable accommodation request might be mishandled:

- The organization takes an inordinately long time processing the request
- The organization requests more information about your disability than they are legally allowed to ask for
- The organization agrees to provide the requested accommodation, or a suitable alternative, but underdelivers once they actually implement it
- Employees, managers, classmates, or teachers observe the accommodation and respond with retaliation, hostility, or other backlashes

Reasonable accommodations are a legal right and not a favor, perk, or gift. To learn more about them, and how to ask for them in the workplace, visit the US Department of Labor’s Job Accommodation Network at www.askjan.org.

Staying Aware Without Being Judgmental

Mental illness discrimination can sadly be common, but the perpetrators often do not know what they are doing. Stigma can be so embedded that people may be acting routinely, or they may believe, paternalistically, that they are helping. Some research suggests that people often cannot realize they are discriminating against people based on mental illness, as compared to other marginalized groups. That means that it is safe to assume that folks are not acting deliberately or maliciously, even though their conduct can be burdensome and hurtful. Therefore, it might be helpful to approach them with a friendly tone when informing them of problems. It may also be possible to try mediation if there is a significant conflict.

Of course, whether it happens intentionally or not, there is no excusing stigma and discrimination. Hopefully, the tools from this article can help you notice and respond when it happens.

Dan Berstein founded MH Mediate to help people use dispute resolution skills to improve how they talk about mental health and resolve conflicts. MH Mediate’s Mental Health Safe Project provides free resources to address everyday mental illness discrimination. Visit www.mhsafe.org to learn more or e-mail Dan at dan@mhmediate.com with questions and feedback.

Modeling Compassion from page 31

Commit to active listening - Listen more than speaking. Actively consider what others are telling us through their words and nonverbal indicators. Listening with a compassionate ear offers non-judgmental understanding and as we offer support, people will believe that we are available to them again in the future. Even just letting someone know that you're available to talk can have a positive impact on their mental health.

"Dis-ease" vs. Disease - We have learned over the past two decades that becoming trauma-informed is essential to compassionate environments of care, and especially in the healing and growth processes. At the same time, let's challenge ourselves to be equally focused on how to lessen "dis-ease" through meaningful human connectedness. So much of our field has for years been overly focused on the disease aspects of mental illness. While these are important, essential components of the treatment process, competent, compassionate caring allows us to better understand other people, including the "dis-ease" that often accompanies mental health challenges. When people begin to understand misalignments in their lives from all angles—including psychological, physiological, existential and spiritual—they can begin to develop a sense of belonging and connectedness.

Avoid getting stuck on perfection - We've all heard the truistic exhortation, "Don't let perfect be the enemy of good." While we must address and improve deficits in care, let's also build on our individual and collective strengths, learning from recipients and each other on what allows us all to connect and grow. Let's recognize progress and improvements on which we can build more compassionate workplace relationships. As a colleague recently reminded me, "It's about profession, not perfection."

Know your life's purpose - When we examine our overall values and commitments in order to clarify our life's purpose, we can best live out who we are designed to be. This leads to an intentional way of living, including at work, which in turn can reinforce our authenticity. Living authentically allows us to demonstrate greater compassion as we strive to understand our colleagues, family and friends who might be struggling with mental health challenges.

Reducing mental health stigma requires more than good intentions. It requires a continual rededication to growing our compassion for others and putting it into action. Modeling compassion can bring much joy to others and ourselves as we focus less on what is "wrong" with someone and instead lift others up through compassionate caring that empowers others through a mutual focus on wellbeing.

Let's create environments where empathic, compassionate understanding is the norm rather than the exception! Let's get to know our colleagues beyond only a "workplace self" or style. While we need to create and maintain healthy boundaries, sharing even small personal aspects of ourselves helps to create a fuller sense of who we are, which in turn allows us to be more approachable and reciprocal in mutual support as we destigmatize mental health challenges. Let's build stronger bonds and resilience as we find new ways to be compassionate toward each other and ourselves within our healthcare settings!

"There is no small act of kindness. Every compassionate act makes large the world." - Mary Anne Radmacher

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New Tool from page 13

No. 1 (2023) confirms that insurers must utilize the most recent version of CPT when reviewing, processing and approving payment for all claims, including claims submitted by psychiatrists.

It is clear that the issuance of Circular Letter No. 1 (2023) was urgently needed to ensure that insurers and health plans adopt the new E/M documentation standards and immediately cease any disparate evaluation of claims submitted by psychiatrists.

During this budget season, Governor Kathy Hochul and the New York Legislature are also considering additional tools in the FY 2024 state budget that would expand access to care for those with mental health and substance use disorders, establish important network adequacy standards for insurers and health plans and create a private right of action under the state parity laws. If enacted, the ability for individuals to file a parity action would establish an important level of accountability mirroring the federal private right of action that already exists under MHPAEA.

The focus on mental health has never been greater as New York State and the nation contend with a mental health crisis compounded by the effects of the COVID-19 pandemic. We hope that Circular Letter No. 1 (2023), along with the current budget proposals, will serve as powerful new tools to push back on aggressive utilization review activities by insurers and to improve the lives of patients and others impacted stigma.

Rachel A. Fernbach is the Executive Director and General Counsel of the New York State Psychiatric Association.

Footnotes

1. 2022 Mental Health Parity and Addiction Equity Act Report to Congress

2. Insurance Circular Letter No. 1 (2023)

Hunger from page 29

ourselves and better understand the human experience of food insecurity by listening to first-hand accounts and testimonials provided by those who seek food assistance. U.S. Hunger has found that this can be accomplished through the employment of an online food assistance application as it allows people to share their personal accounts in a private, judgment-free space. This process eliminates the shame that is frequently reported by those who seek food assistance in-person at local food pantries and other charitable organizations while providing insight into the challenges being faced within our communities. For example, one Full Cart Applicant shared:

"The first time I needed help with food, I was terrified and embarrassed. Now many years later, needing help again that hasn't gone away, and it stops me in my tracks from accessing a pantry around the corner. It doesn't help that you have to wait in a line on a busy neighborhood street and they yell your name out when it's your turn."

An online application is a viable option to reduce the stigmatization of food assistance. It provides relief to those who need it while transparently revealing that food insecurity is intertwined with many social issues and is a reality for many people of various backgrounds and abilities. When people are treated with dignity and respect, they feel hopeful in spite of their circumstances.

"This last year has been one of the most defeating, and heartbreaking years. We have had a traumatic injury steal my mother's mental state and put her into early dementia, we've gone through foreclosure on our home, for the first time in my life having utilities turned off.. as a single mother to three, two of which have special needs on top of being a caregiver for my mother. This year has broken me in more ways I ever imagined and every day has been a struggle to push forward. Food insecurity has recently become a reality for us, also a first for me in my life to go through. I just want to thank the donors who take the time to think of others who aren't in the best spots in life and help without judgment. We are grateful beyond words thanks to your generosity and kindness."

The application of human-centric Artificial Intelligence (AI) and Machine learning serves as another way to leverage technology to combat stigma. AI offers an objective method of evaluating people's lived experiences. This process removes the influence of negative emotions, like shame and guilt, allowing the system to produce objective recommendations for services based on data-driven input. By collecting personal accounts, we can gain an accurate understanding of the prevalence and scale of the issue. Machine learning algorithms can then be used to impartially process the data to identify applicants most at risk of low or very low food insecurity and tailor support accordingly. Compassionate use of technology, therefore, can help us gain insight into the reality of food insecurity while providing more caring and compassionate support to those who need it.

"I lost everything. Despite the struggle and fight to remain stable, I was one day away from living on the street. It was the first and only time I faced hardship and was thoroughly defeated. The weight of it all crushed me. If not for a few friends and many strangers who got me back to where I needed to be, I wouldn't be here today. The first time I really needed food I was referred to a pantry. It was one of the hardest things I had ever done. I felt guilty, embarrassed, and that I was a failure. ...Words of thanks can be flat and meaningless, [but] a personal story brings those words to life. You've done a good deed, and it's based in action."

Corissa Raymond, MPH, is Data & Research Writer; and Alexandra Rouzier, is Client Experience Manager at U.S. Hunger. For more information about U.S. Hunger and how we use technology to unite families to a healthier tomorrow, please contact us at data@ushunger.org.

References

Bruening, M., Dinour, L., & Chavez, J. (2017). Food insecurity and emotional health in the USA: A systematic narrative review of longitudinal research. Public Health Nutrition, 20(17), 3200-3208. doi:10.1017/S1368980017002221

Fang, D., Thomsen, M.R. & Nayga, R.M. (2021) The association between food insecurity and mental health during the COVID-19 pandemic. BMC Public Health, 21(607). https://doi.org/10.1186/s12889-021-10631-0

Leung, C.W., Laraia, B.A., Feiner, C., Solis, K., Stewart, A.L., Adler, N.E., & Epel, E.S. (2022). The Psychological Distress of Food Insecurity: A Qualitative Study of the Experiences of Low-Income Parents and Their Coping Strategies. Current Developments in Nutrition, 4 (Supplement_2), 224.

Read the Compelling Story of Ira Minot, Founder and Publisher of Behavioral Health News

"A Personal Journey From a Survivor of Suicide:
From the Depths of Despair to A Mission of Advocacy"

Addressing Stigma from page 1

mental health concerns than past generations. Children are leading adults to think about mental health and wellness in new ways. This gives me great hope that we can decrease and even eliminate the stigma of mental illness; but only if we continue to provide our children, and all residents of New York State, with honest, accurate and positive messages about the importance of mental health and ensure that help is there when needed.

To increase access to mental health services and provide children and youth with positive messages about their mental health, OMH has licensed more than 1,000 mental health clinics in schools across the state. These clinics are especially important now, in the wake of the COVID-19 pandemic. A new study from the Centers for Disease Control and Prevention (CDC) indicates that more than one-third of high school students reported that they experienced poor mental health during the pandemic, and nearly half (44%) said they persistently felt sad or hopeless during the past year.

Governor Kathy Hochul last year announced $50 million in funding for school districts to improve student access to mental health resources and assist students who have experienced trauma that has impacted their education. And in her recently announced 2023-24 Executive Budget, Governor Hochul proposed an additional $20 million to expand school based mental health clinics.

School-based clinics have been shown to have a positive impact on grades, attendance, and student self-esteem. They also enable parents and teachers to be more aware of students' behavioral health issues and have easy access to the help they need.

Culturally Relevant Outreach

The work of addressing and decreasing stigma is challenging. Public awareness campaigns that use ineffectual or culturally incompetent messaging are often ignored, and some well-meaning public service announcements can actually reinforce negative stereotypes and increase the stigma associated with behavioral health issues.

In a diverse state like New York, there is no "one size fits all" anti-stigma message that will resonate with every community. New York has the benefit of being home to people from many different countries and cultural experiences. Along with the valuable contributions to society, there are challenges in the varied beliefs about mental health and viewpoints pertaining to mental illness. People in marginalized communities who face systemic discrimination often do not trust our systems and avoid seeking care. In many communities, seeking mental health treatment may be viewed as a sign of weakness, which brings shame and dishonor to an individual's family. Families may also be understandably reluctant to seek mental health care because of a long history of racism and mistreatment at the hands of providers in the U.S, as well as currently existing biases and inequitable treatment.

OMH's Office of Diversity and Inclusion (ODI) is a national leader in implementing strategies to improve equity, diversity, and inclusion for mental health treatment and services. One of the most effective ways to reach and engage people is to learn from individual communities and respond to their needs with culturally appropriate care, ensuring that it is delivered by a diverse workforce which is reflective of the community being served. Encouraging the practice of cultural humility in which there is an openness, and awareness of various experiences and biases is also important. The ODI offers written resources, educational opportunities, and individualized consulting to help health care providers build a workforce that is diverse and inclusive, with the ability to reach underserved communities and help reduce health care disparities.

OMH has also partnered with the State University of New York and the City University of New York to provide scholarships aimed at expanding the diversity and cultural competence of the clinical workforce in mental health programs. The program, funded through federal dollars, provides students with direct financial assistance to help support their degree completion.

OMH is committed to ensuring that the services we fund, and our practice and policies all work to reduce disparities and stigma. The ODI is working to strengthen the internal and external structures responsible for the reduction of disparities in New York's public mental health system by implementing a number of initiatives designed to ensure that entities funded by the OMH adhere to certain standards. And they also partner with local providers to conduct culturally relevant and appropriate education and outreach. The office recently helped determine award recipients for OMH's 2022 grants from the Mental Illness Anti-Stigma Tax Check-Off Fund, which were targeted to agencies recognized for their work serving underserved and under-represented minority and immigrant communities. The awardees were selected by proposing innovative, culturally relevant approaches to reducing stigma in underserved populations.

OMH receives valuable input from the Statewide Multicultural Advisory Committee (MAC) which is made up of mental healthcare recipients, policy makers, researchers, and experts in the field. The MAC provides input and advice to OMH on policy, programs, procedures, and activities addressing disparities in access, quality, and outcomes for members of historically underserved, disadvantaged, and marginalized populations. Culturally relevant outreach and engagement is absolutely essential if we are to overcome the stigma of mental health in all our communities.

Normalizing Mental Healthcare

Finally, incorporating mental healthcare into routine medical care is a critical way to normalize mental health and reduce stigma. HealthySteps is an evidence-based program that is being expanded in this year's budget and provides mental health services for youth and their families in a pediatric health care setting offering universal access. In addition, the NYS Collaborative Care Medicaid Program has been a leader in bringing much needed behavioral health services to primary care practices across the state by administering depression screenings and treatment as a routine part of care. Practitioners are increasingly screening and often treating depression, anxiety and substance use in their practices, just as they treat hypertension and diabetes.

An example of health care policy that perpetuates stigma is the lack of parity in financing mental health services. Mental health must have equal importance to physical health in our systems of care and how we pay for services. Parity reforms and recent insurance reimbursement provisions within Governor Hochul's proposed budget are aimed at guaranteeing payment by all insurers for mental health care in school-based services, crisis services, and intensive outpatient mental health services.

In summary, OMH continues to develop new approaches to address the many forms of mental health stigma that influence the lives and health of New Yorkers. We are committed to building on the increased awareness and interest in mental health since the COVID pandemic by teaching children from a very young age through culturally appropriate education and messaging that mental health is important in a way that will hopefully make a lasting impression and create generational change. We are working to ensure that throughout all our diverse communities we are able to effectively reduce stigma and enable access to needed care. And finally, we are always working to normalize mental health in our healthcare delivery system, provide parity for mental health services and change policies that have for too long perpetuated stigma.

Ann Sullivan, MD, is Commissioner of the New York State Office of Mental Health (OMH). For more information, visit https://omh.ny.gov/.

Peers from page 31

Working for NYC Well was more than a job for me. No longer able to care for my brother, who was quarantined in a nursing home, ironically freed me from that stress to come out of retirement and serve my fellow New Yorkers during their time of need.

This gave me a new lease on life, and, what we members of the Religious Society of Friends (Quakers), call "a leading." Without proselytizing, I emphasis the mind-body-spirit connection and the other dimensions of wellness according to Drs. Peggy Swarbrick and Michelle Zechner.

Working from home during my noon to 8 PM shifts, I would occasionally be triggered by callers and visitors who reminded me of my brother with his diagnosis of serious mental illness. (May he rest in peace after his death on May 18, 2022.)

But, during the height of the pandemic, I, a survivor of multiple suicide attempts, would successfully support a couple of teenagers every day in the midst of their suicidal crises. Often estranged from family and friends, they found comfort talking to a survivor, who, at the age of 70, reminded them of the wise counsel they had received from grandparents, some of whom had died due to Covid.

These and the other peers I connected with viscerally in virtual time and space reinforced the belief that none of us can sustain ourselves without the milk of human kindness. Some were frequent callers/visitors who depended on us for their daily doses of warmth and reassurance.

Carl Alan Blumenthal, MS, NYCPS

And the beauty of the interactions with peers is that we learn from each other not only about our trials and tribulations but also our coping strategies. In particular, while not a hearer of voices, seer of visions, nor an empath myself, I listened without judgement to the different wavelengths on which some peers vibrate.

Our staff is as diverse as our callers and visitors according to race, class, sex, and gender. With the age distribution of peer specialists, counselors, and clients represented by a bell curve weighted toward youth rather than older age, I was everyone's senior by 15 years. That my elder peers hardly called—they never chatted nor texted—is undoubtedly a reflection of not only our lack of media savvy but also the stigma of mental illness and substance abuse among us.

However, don't take my word for what working on a hotline is like. (Wound up like the Energizer Bunny after a shift, I would often unplug by listening to syndicated talk radio host Delilah's advice for the loved and lovelorn or Christian rock radio, K-LOVE.) Here are words of wisdom from Assistant Program Director of NYC Well, Gail Bower, peer specialist Mantasha Sharif (a member of my training class), and my peer supervisor, Daesia Jameslouis:

Carl Blumenthal: What's the history of NYC Well?

Gail Bower: In 1995 Lifenet was launched by the Mental Health Association of NYC (now Vibrant Emotional Health). Lifenet provided support, information and referral, and crisis services via phone 24/7/365, and linked individuals to NYC's behavioral health resources. Chat and text were added later to reach out to Lifenet counselors.

Following 9/11, Lifenet's number served as the primary starting point for NYC residents seeking support through Project Liberty, a program administered by the NYS Office of Mental Health to provide crisis counseling for individuals experiencing psychological distress due to the events of September 11th.

In April 2016, Vibrant Emotional Health (Vibrant) was awarded NYC Well under Mayor Bill DiBlasio's ThriveNYC initiative. NYC Well expanded the services already offered by Lifenet with the addition of peer support, warm transfers to resources, and follow up. Thus, NYC Well connects New Yorkers and others day and night for free to confidential, high-quality behavioral health care.

The inclusion of peer support staff was a significant and positive complement to the services already offered by counselors. Over the last six years, the demand to speak with peer staff has grown and now accounts for approximately 20% of the approximately 500,000 calls, chats, and texts received annually.

In addition to NYC Well, Vibrant's Here2Help Connect crisis contact center manages a variety of contracts, including after-hours lines for managed care companies, a bullying hotline, and a line for NFL players and family members, plus one for disaster response. It also serves as a 988 chat and text center.

In 2001, the U.S. Substance Abuse and Mental Health Service Administration (SAMHSA) awarded a grant to Vibrant Emotional Health to establish a network of local crisis centers and administer the National Suicide Prevention Lifeline (NSPL), which transitioned to the 988 Suicide & Crisis Lifeline (988 Lifeline) in July 2022.

Carl: How did the Covid pandemic affect operations:

Gail: Since 2006 the H2H contact center has had an established team of remote counselors and peer support specialists, recognizing the need to have staff available during a disaster or weather event.

When the pandemic required staff to work remotely, having the infrastructure

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As such, I've gleaned a powerful patchwork of evidence-based mental health literacy that has helped me provide much-needed pastoral care and counseling to countless individuals. In this domain, though, I find that am still in the minority.

Despite the fact that faith leaders are frequently consulted for help with mental health issues, many clergy remain unequipped to handle such challenges. Conversely, many professional mental health services are equally inept at working with faith communities in ways that are authentic and helpful.

When professional mental health services and faith communities work together, we can broaden our impact and strengthen support systems for people with mental health issues, ensuring that individuals have access to the full range of mental health resources. So, what do we need to do to make this happen?

1. Forge partnerships between faith-based communities and professional mental health services.

Faith-based organizations (and the clergy who lead them) are often a major part of individuals' natural support networks. But when our religious institutions don't coordinate with and learn from professional mental health services, the result is inadequate professional care for the community members who need it. The reverse is true, as well: When ethnic and religious minority groups are active partners in mental health spaces, their communities' engagement, experiences, and outcomes generally improve.

For example, a 2021 study found that when refugee and immigrant communities were engaged as partners in mental health services, the result was an increase in access to care, quality of care, and patient satisfaction, along with improved cultural responsiveness and an overall reduction in stigma (Derr, 2016).

The same held true for a systematic review that found that involving African American churches in the delivery of mental health services led to increased engagement, reduced stigma, and improved mental health outcomes for participants. Partnering with churches was shown to help address cultural barriers to accessing mental health care (Hays & Aranda, 2016).

It's clear that we need more formal efforts to train clergy in evidence-based mental health and substance use disorder (SUD) interventions. This faith-based initiative uses members to disseminate health messages.

2. Engage mental health providers in real, nuanced education about cultural differences.

Community engagement is critical, but too often, mental health professionals' existing community engagement practices assume religious communities to be homogenous entities. That's far from the reality, and it's not helpful to the overall goals of the cause. In fact, it's sometimes harmful and reinforcing to religious individuals that their providers can't understand what they're going through.

My Hasidic community, for example, may dress in black and white, but its adherents are anything but — to say nothing of the many differences between Jewish communities. Each faction of Judaism, while united under the same overarching umbrella of "Jewish," has its own culture, and values, oftentimes so distinct and unique that what resonates with one may confuse or even alienate another.

In other words, shared otherness does not equal homogeneity. Culture, so often reduced to tangible and obvious differences like music, food, and clothing, is complex and nuanced. Yet the current model for cultural competency is typically, at best, one in which providers watch a simple, straightforward training video (sometimes at double speed) about communities that are "other." In doing so, they cross off an item on a training list that, once completed, frees them of the responsibility to grow in their understanding of specific, multifaceted cultural differences - to the detriment of those communities.

Only by moving from cultural competency to cultural humility can we change the dialogue and ultimately the dynamic of community engagement. Recruiting mental health workers from specific communities is also a good start, as they have an innate understanding that cannot be easily learned. This intrinsic knowledge, and the empathy that accompanies it, can make their clients feel more fully understood. (That said, variety and choice are essential. Some patients may prefer to avoid waiting room encounters with others in the community or name recognition in billing services.)

Organizations like Families Together in New York State, where I work, also play a crucial role in contributing to this paradigm shift. They endeavor to reframe conversations around mental health and community engagement by acting as a resource for professionals and policymakers, training peer advocates and striving to establish a unified voice for youth in need.

3. Encourage clergy to speak openly about mental health in their communities.

Faith leaders can serve as strong role models by prioritizing their own mental health and wellbeing and sharing those experiences with their communities. When clergy speak with authenticity and vulnerability, our communities listen — and often, they respond in kind.

One such trailblazer is Pastor Michael Walrond Jr. from First Corinthian Baptist Church in Harlem, who frequently discusses his mental health journey in his sermons. Pastor Walrond has spoken extensively about the negative stigma of seeking therapy within his church community. In doing so, he and others like him inspired me to discuss my own experience with mental health and neurodivergence, including parenting an autistic child and being diagnosed with ADHD at age 45.

When clergy sermonize about mental health and acknowledge the prevalence of mental health issues, they help to debunk misconceptions, challenge stereotypes, and normalize the idea of seeking care. This individual openness from respected community leaders helps reduce the shame and stigma that often prevents others from getting help. Plus, sermons about mental health issues present the opportunity to share information about available resources to those who need them but may not have previously felt comfortable seeking support.

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beliefs of addiction to the current evidence-based definition of a chronic, treatable disease from which patients can recover and continue to live healthy lives.

Harm reduction is a multifactorial, multifaceted, multicultural, and multidisciplinary approach. The hope from the multiple studies researched and through evidence-based practice that as providers we can help mitigate future drug problems and promote a healthy environment for the population to seek help for their substance disorders.

How Stigma Arises, According to the Literature

In the United States, there are evidence-based treatments for substance use disorders, however, there are far more individuals dealing with substance use disorder than those who receive treatment (Saha et al., 2016). This is true of not only the United States but is a prevalent trend in other countries as well.

Substance-related stigma occurs due to the strong correlation between crime and other serious harms that extend more than the individual using substances (Room et al., 2001). Another reason for stigma is perceived controllability (Hegarty et al., 2008). For example, causes that are seen as to be uncontrollable tend to elicit pity and sympathy, while perceived controllability tends to elicit anger, hostility, and blame, as well as a low desire to help (Hegarty et al., 2008).

As an observer we may view SUD individuals as people who are unable to control their behavior. However, even as observers we view that substance use is an individual's choice; this may be inconsistent if there is a functional dysregulation and structural alterations have developed in the brain functions and systems that regular impulses (Erickson, et., al, 2008). From the dysregulation of the brain this can impair an individual's decision making and even cause them to harm themselves (Erickson, et., al, 2008). Further, there is a lack of evidence in addiction regarding their control over their disease process in the United States.

Furthermore, for years addiction to opiates has been disproportionately impacting marginalized communities (Carliner et., al, 2016). However, addiction treatment has not been a priority for most policymakers until recently when addiction to opiates had spread among white population subgroups (Martins et., al, 2017). Addressing this barrier and intersectionality regarding the SUD among all ethnicities can help decrease the barrier of access to care. Also, stigma can decrease the allocation of resources to the specialized population (SUD) when the financial resources are much needed. It showed that in 2017 SUD emergency room visit for alcohol use disorder was an average cost $5,616 million (Santo et al., 2021). Today the U.S. The Affordable Care Act (ACA) has helped decrease the stigma among SUD by providing coverage for SUD treatment, which also helped clients have access to care.

Dioanne "JoJo" Adsuara

Dave Ofori

Addiction is a difficult and temperamental topic to health care providers, community, and counselors managing the specialized community. The media even portray addicted individuals negatively, which can lead the individuals to not seek care, out of fear of judgment (Bartlett et., al, 2013). A study in the United Kingdom investigated the perception of nurses regarding intravenous substance users showed negative views regarding the population and believed that the addictive behavior is the cause of their health conditions (Monks et., al, 2013). The negative perception from providers does not promote better outcomes, in fact, it causes cynicism and burnout (Szalavitz, 2022).

Language stigma is a modifiable influence on perception and awareness of us providers regarding substance-related conditions that may help improve the stigma in healthcare. Kelly et al. 2010 concluded in their study that referring to an individual "having a substance use disorder (SUD)" opposed to "a substance abuser (SA)" were more engaged in treatment, had less misconduct, less social threat, and less deserving of punishment.

The population of SUD is seen to be dangerous, less autonomous regarding their medical care, and blamed for their conditions. The stereotyping can lead the population to not seek care due to the negative emotional reaction from stigma. As a community, improving the stigma through language can decrease the negative relation within the SUD community. Individuals struggling with addiction need nonjudgmental care from their providers to decrease the harm of substance use and hope to improve access of care (Psychiatric Mental Health Substance Abuse Essential Competencies Task Force, 2012.) However, more evidence and research need to be implemented to fill the gap in our knowledge regarding substance use disorders.

The prevalence of substance use disorder has increased especially with the pandemic. Thus, as clinicians we are tasked to change the stigma of substance addiction within the SUD community, whether from language modification or policy changes. Decreasing stigma may help improve and encourage individuals with SUD to acquire treatment. There are evidence-based behavioral and pharmacologic treatments that exist and can help individuals alleviate distress from substance use. Focusing on language stigma for harm reduction necessarily means caring about the lives of people who use drugs. This can also provide a nonjudgmental approach to the individuals while giving kindness and compassion.

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For over 50 years, Phoenix House has helped thousands of people overcome addiction in order to lead healthy, productive, and rewarding lives. In 1967, six heroin addicts came together at a detoxification program in a New York hospital. They moved into a brownstone in Manhattan and lived as a community; encouraging one another to stay sober. Phoenix House was born and become a model for a citywide treatment network. We are committed to supporting individuals and families by providing a wide range of services, including treatment for substance users with mental health challenges, Outpatient and intensive outpatient services as well as residential treatment. We have a specialized focus on providing services for military personnel, veterans, and their families. We offer medication assisted treatment at all our locations. Learn more about Phoenix Houses NY| LI here: https://phoenixhouseny.org. For media inquiries, contact claire@pythiapublic.com.

References

Bartlett, R., Brown, L., Shattell, M., Wright, T., & Lewallen, L. (2013). Harm reduction: compassionate care of persons with addictions. Medsurg nursing : official journal of the Academy of Medical-Surgical Nurses, 22(6), 349–358.

Carliner H, Delker E, Fink DS, et al. Racial discrimination, socioeconomic position, and illicit drug use among US Blacks. Soc Psychiatry Psychiatr Epidemiol. 2016; 51:551–60. [PubMed: 26810670]

Erickson, C.K. 2008 In defense of "dependence". Alcoholism: Clinical and Experimental Research, 32, 1–3.

Hadland, S. E., Park, T. W., & Bagley, S. M. (2018). Stigma associated with medication treatment for young adults with opioid use disorder: A case series. *Addiction Science & Clinical Practice*, *13*(1). https://doi.org/10.1186/s13722-018-0116-2

Hegarty, P., & Golden, A. M. 2008 Attributional beliefs about the controllability of stigmatized traits: Antecedents and justifications of prejudice? Journal of Applied Social Psychology, 38(4), 1023–1044.

Highlights for the 2020 National Survey on Drug Use and health. Substance Abuse and Mental Health Services Administration (SAMSHA). (2020).

Martins SS, Sarvet A, Santaella-Tenorio J, et al. Changes in US Lifetime Heroin Use and Heroin Use Disorder: Prevalence From the 2001-2002 to 2012-2013 National Epidemiology

Monks R, Topping A, Newell R. The dissonant care management of illicit drug users in medical wards, the views of nurses and patients: A grounded theory study. *Journal of Advanced Nursing*. 2013;69(4):935–946. doi: 10.1111/j.1365-2648.2012.06088.x.

Psychiatric Mental Health Substance Abuse Essential Competencies Task Force; American Academy of Nursing Psychiatric Mental Health Substance Abuse Expert Panel. Essential psychiatric, mental health, and substance use competencies for the Registered Nurse. Archives of Psychiatric Nursing. 2012;26(2):80–110.

Room, R., Rehm, J., Trotter, R. T., Paglia, A., & Üstün, T. B. 2001 Cross-cultural views on stigma valuation parity and societal attitudes towards disability. In Ü. T. Bedirhan et al. (Eds.), Disability and culture: Universalism and diversity (pp. 247–91). Seattle, WA: Hofgrebe & Huber.

Saha TD, Kerridge BT, Goldstein RB, et al. Nonmedical Prescription Opioid Use and DSM-5 Nonmedical Prescription Opioid Use Disorder in the United States. *J Clin Psychiatry.* 2016;77:772–80.

Santo, L., Peters, Z., & DeFrances, C. (2021). Emergency department visits for adults with mental health disorders: United States, 2017–2019. https://doi.org/10.15620/cdc:112081

Szalavitz, M.A.I.A. (2022). *Undoing drugs: The untold story of harm reduction and the future of addiction*. Hatchette Go.

Asylum Seekers from page 20

- Ask about their journey – we all have stories we can learn from; this may be the first time they have ever told it to someone outside of their circle.

- Focus on aspects of the mental health services that relate to the family's expressed values, such as supporting a child's academic success.

- Cultural differences between the individual and the clinician may also impact the level of communication. Misunderstandings of these expectations and the expression of values may lead to difficulties for the clinician in soliciting symptoms, difficulties in developing needed therapeutic rapport, and a misunderstanding of the significance of symptoms.

For more resources and strategies when working with asylum seekers and recently arrived immigrants, please click here.

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Resources

Berry, John. Immigration, Acculturation, and Adaptation. Applied Psychology. Volume 46, Issue 1. January 1997.

Cleary, S. D., Snead, R., Dietz-Chavez, D., Rivera, I., & Edberg, M. C. (2018). Immigrant Trauma and Mental Health Outcomes Among Latino Youth. Journal of immigrant and minority health, 20(5), 1053–1059.

Scott Bloom, LCSW

Kirmayer, L. J., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. Canadian Journal of Psychiatry, 48(3), 145–153.

Wilson, J. P., & So-Kum Tang, C. C. (Eds.). (2007). Cross-cultural assessment of psychological trauma and PTSD (pp. 3–30). New York, NY: Springer US.

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It's important to give people time and support them without judgement."

The implementation of peer support groups, where individuals living with mental illness can show compassion to one another and share their concerns and experiences with stigma, have been known to help build positive alliances and empower them to reduce self-stigma (Ka Shing Chan, 2018). In 2012, SAMSHA produced the What a Difference a Friend Makes campaign designed to encourage individuals to step up and support friends who are living with mental health illness. Marisol Cruz, Peer Counselor, recalls the moment when a friend and fellow peer acknowledged her talent for visual arts and strongly suggested that she pursue it at the Howie The Harp peer advocacy and training center. It was here that Marisol found the inspiration to discover her sense of self. "Having someone modeling compassion to me was very helpful in learning to model it for others and for my own healing. I learned to realize that I'm not defined by a label."

What does modeling compassion actually look like when actualized in tangible human experience? Peer Counselors working at ACMH's Residential Crisis Support program find that the most valuable way to model compassion is by active listening. Individuals diagnosed with a mental illness often feel dismissed by others and Peer Counselors have heard the phrase "I hate to bother you" too often during their work with guests going through emotional distress. Peer Counselors provide support and model compassion by listening to the guests and showing them that their concerns are valid. They support individuals in developing Wellness Action Recovery Plans (WRAP), personalized plans for individuals to achieve their recovery goals, and engaging in socialization and community activities. Peer Counselors agreed that taking the time to do these activities with someone in crisis can go a long way. Moreover, in the same way that someone modeled compassion for them by believing in them and shining a light on their strengths and abilities, they strive to do the same with others through their work. "Letting guests know where I've been and how I slowly got better, instills hope in them and that's the biggest thing. They look at what you are doing and they think maybe they can do it too."- John Kvarnstrom, Peer Counselor. Reducing self-stigma is a work in progress for many individuals diagnosed with mental illness. ACMH Peer Counselors have experienced that modeling compassion works both ways, as they strengthened their own self-compassion while providing support to guests at the Crisis Support program.

Interventions such as modeling compassion have proven to reduce self-stigma. But so much more work needs to be done, at both the individual level and in society at large, in order to combat the debilitating effects of mental health stigma.

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References

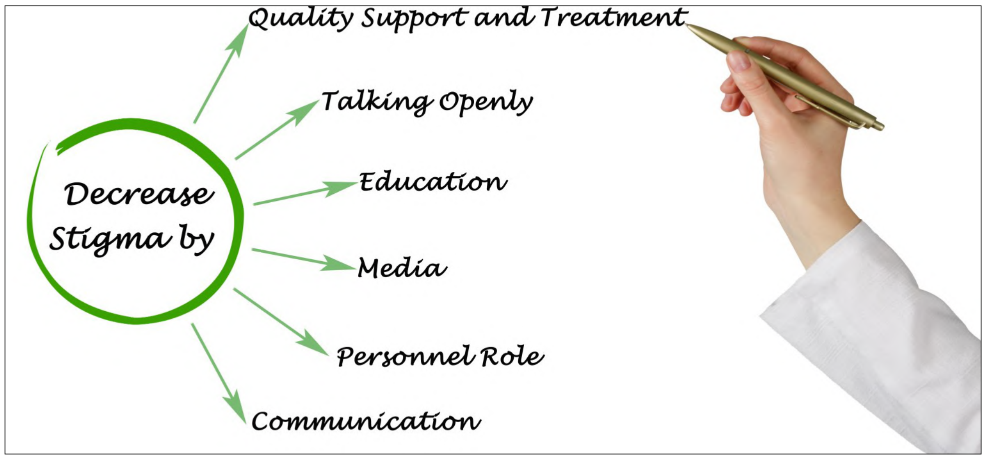
Avest M.J., Schuling R., Greven C.U., Huijbers M.J., Wilderjans T.F., Spinhoven P., Speckens A.E.M. (2021). Interplay between self-compassion and affect during Mindfulness-Based Compassionate Living for recurrent depression: An Autoregressive Latent Trajectory analysis. *Journal of Behavior Research and Therapy, 145.*

Corrigan P.W., & Shapiro J.R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review, 30* (8), 907-922.

Garfield R.L., Zuvekas S.H., Lave J.R., Donohue J.M. (2011). The impact of national health care reform on adults with severe mental disorders. *American Journal of Psychiatry, 168,* 486-494.

Ka Shing Chan K., Lee C.W.L., Mak W.W.S. (2018). Mindfulness Model of Stigma Resistance Among Individuals with Psychiatric Disorders. *Mindfulness, 9;* 1433-1442.

Stuart H. (2012) The stigmatization of mental illnesses. *Canadian Journal of Psychiatry, 57*(8) 455-456.



Faith from page 42

Faith leaders have the power (and, I would argue, the responsibility) to take intentional steps to help reduce the shame and stigma that still plagues conversations about mental health. As first responders to our congregants' spiritual and emotional needs, we can play a vital role in perpetuating the belief that asking for help isn't a sign of strength but a sign of weakness - and the first step toward healing.

But collaboration is critical. Faith leaders who are educated and open about mental health are better equipped to provide pastoral care to community members in need. And when professional mental health services endeavor to truly learn about and partner with faith communities, they increase the likelihood that people of faith will feel heard, supported and understood in their pursuit of treatment.

By working in tandem, professional mental health services and faith communities can create an environment that encourages open and honest conversations about mental health — an environment that ultimately dispels myths, misconceptions and stigma surrounding mental health once and for all.

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References

Derr, A. S. (2016). Mental Health Service Use Among Immigrants in the United States: A Systematic Review. Psychiatric Services, 67(3), 265–274.

Hays, K., & Aranda, M. P. (2016). Faith-Based Mental Health Interventions With African Americans. Research on Social Work Practice, 26(7), 777–789. https://doi.org/10.1177/1049731515569356

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(HHS) through Substance Abuse and Mental Health Services Administration (SAMHSA) and with Vibrant Emotional Health (Vibrant) as the nonprofit administrator, the 988 Lifeline network includes over 200 locally-operated centers offering free and confidential emotional support to people in suicidal crisis or emotional distress, available 24 hours a day, seven days a week.

With this transition, everyone in the United States and territories can call, text 988 or visit 988lifeline.org to chat, and reach a trained crisis counselor. This move to 988 Lifeline can shift how we care for people who are in need of behavioral health supports. In order for the service to be truly impactful, it requires a collective approach that is inclusive of all experiences across of the lifespan.

Vibrant recognizes that embracing diversity, equity, inclusion and belonging is a form of suicide prevention, and that by addressing systems of oppression that create disadvantages, centering this will only expand perspectives, frameworks and approaches to survivorship and well-being for all.

Vibrant has operationalized this commitment by hiring a dedicated Equity and Belonging Department to ensure that the values of equity and belonging are embedded throughout all areas and services within 988. This will be accomplished through collaboration, training, relationship building, advocacy and capacity building. This happens by bringing barriers and experiences of persistently harmed populations to the center while utilizing their feedback as a guiding force in all our work. Equity and Belonging seeks to imagine 988 as a system of action, accessibility and accountability. The goal is to continue to task ourselves with upholding our own values by striving towards the reality that each caller experiences a sense of support, affirmation and belonging, no matter their race, gender, culture, language, location or ability.

Why Commit to the Approach of Co-Creating the Crisis Care Continuum?

The last three years have taught us that when one person or community is in crisis, it collectively impacts us all. We have the opportunity to create a system of care that can address the needs of all people. The idea of the most harmed communities co-creating a system of care is powerful and can shift the power dynamics of systems of care. Engaging with impacted communities is a critical component of suicide prevention, as it allows for the development of community-led solutions and increases participation in prevention programs and initiatives; which ultimately mitigates harm, enhances trust and reduces mental health stigma.

Equity and Belonging will engage in a robust community listening sessions and surveys. The audiences will include those with lived experience, rural populations, LGBTQIA+ communities, older adults, unhoused, AAPI, Black communities and other persistently excluded populations. This will make sure that efforts to prevent suicide and provide care are centered in the most culturally appropriate and affirming ways. Once suicide data and community feedback have been analyzed, the results will be utilized to inform resource allocation, training needs, and accessibility gaps to ensure the most impactful suicide prevention efforts.

Normalizing Conversations About Mental Health

The ongoing pandemic has increased conversations about mental health and is playing a role in reducing stigma. We are moving towards prioritizing mental health as part and parcel to our physical health. It is creating the space for us to better advocate for better policies and resources to ensure a positive environment. Targeted mental health messaging can also be effective in reducing stigma. When people see themselves represented, it disrupts the narrative that mental health support is limited to the majority population and not those who have the most need.

The National Alliance on Mental Illness offers 9 ways to Fight Mental Health Stigma, they include:

1. Talk Openly About Mental Health
2. Educate Yourself and Others
3. Be Conscious of Language
4. Encourage Equality Between Physical and Mental Illness
5. Show Compassion for Those with Mental Illness
6. Choose Empowerment Over Shame
7. Be Honest About Treatment
8. Let the Media Know When They're Being Stigmatizing
9. Don't Harbor Self-Stigma

Dr. Vivek Murthy, US Surgeon General, says the mental health crisis is the biggest concern facing the country because it impacts so many people and different facets of life. Co-creating an equitable crisis care continuum that provides culturally responsive and affirming care is vital to our quality of life. We are all interconnected by the social contract of humanity that relies on us all to care for one another. Everyone deserves to have access to the resources they need to thrive. If we center the most harmed, all will get what they need.

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References

Eylem, O., de Wit, L., van Straten, A. et al. Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. BMC Public Health 20, 879 (2020).

Racism is a public health crisis. Available at: https://www.apa.org/topics-and-issues/health-equity/racism-and-health/racism-declarations (Accessed: March 9, 2023).

Racism and health (2021) Centers for Disease Control and Prevention. Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/minorityhealth/racism-disparities/index.html (Accessed: March 9, 2023).

Mental health disparities: Diverse populations (2017) Psychiatry.org - Mental Health Disparities: Diverse Populations. Available at: https://www.psychiatry.org/psychiatrists/diversity/education/mental-health-facts (Accessed: March 9, 2023).

9 ways to Fight Mental Health Stigma (2017) NAMI. Available at: https://www.nami.org/blogs/nami-blog/october-2017/9-ways-to-fight-mental-health-stigma (Accessed: March 9, 2023).

Mental health is biggest health concern in US says surgeon general (2022) Bloomberg.com. Bloomberg. Available at: https://www.bloomberg.com/news/videos/2022-11-02/mental-health-is-biggest-health-concern-in-us-says-surgeon-general (Accessed: March 9, 2023).

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which increases the risk of developing mental health disorders such as Depression, Anxiety, and PTSD. It has also been shown that POC are four times more likely than Caucasians to be misdiagnosed with a psychotic-disorder such as Schizophrenia, Psychosis, and Bipolar Disorder with Psychotic features (Schwartz, 2014).

Barriers to Care

Considering the statistical evidence, POC are less likely to pursue and receive mental health care compared to Caucasians. This is due to a variety of reasons including but not limited to stereotypes and stigma, mistrust of the health care system, lack of representation, and poor quality of care. As previously discussed, historical records show that POC have been labelled as "insane" or "crazy" when experiencing a mental health challenge. This label has developed into stigma in the current Black community, perpetuating the belief that those who are experiencing mental health disorders are "crazy" (Jackson, 2002). Asurvey regarding POC's beliefs about mental illness showed that of two hundred and seventy-two participants 63% reported they felt a mental health condition is a sign of personal weakness (Ward, 2013).

Meghann Simpson, BA

Mistrust in the health care system is evident in the Black community due to the variety of disparities and mistreatment by medical providers (Murry, 2017). Misdiagnoses of a mental health concern can lead to inaccurate treatment provided by professionals. When receiving a diagnosis including psychosis symptoms, individuals may fear they might be involuntarily hospitalized (Williams, 2011). On top of these misdiagnoses, it has been shown that POC are offered medication and/or therapy at lower rates than the rest of the US population (Murry, 2017). This lack of quality care can lead to POC to avoid seeking mental health treatment.

A lack of representation and inadequate cultural competency also creates mistrust in the health care system. Individuals receiving medical care are more likely to feel comfortable with a provider they can identify with. According to the American Psychiatric Association, it was concluded that only 4% of psychologists are POC (Lin, 2018). This lack of representation not only impacts Black client's comfort levels with a mental health professional, but also reinforces a lack of cultural competency in the mental health field due to POC having unique experiences that differ from Caucasians.

Conclusion

Despite the Black community reporting higher rates of mental illness than other ethnic identities, they are less likely to pursue professional care (Murray, 2017). By examining the culture, we can understand how historical events, socioeconomic status, and social role dynamics have perpetuated mental health stigmas in the Black community. One intervention to resolve the issue of stigmas is further community education and services for youth and adults.

Throughout her career, Meghann Simpson has provided professional support to youth, adults, and older adults for mental, emotional, and behavioral health needs. She graduated with her Associates in Social Science at Suny Erie Community College with a certification in Human Services. She will be graduating this year from University at Buffalo with a Bachelors in Interdisciplinary Social Science and a Minor in African American Studies. Meghann has pursued several certifications including Mental Health First Aid and Peer Advocacy. Her work experience includes youth peer advocacy, residential youth support, group facilitation, crisis intervention, Clubhouse program supervisor, and other voluntary community services.

References

2018 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; September 2019. AHRQ Pub. No. 19-0070-EF.

Alvidrez, J., Snowden, L. R., & Kaiser, D. M. (2010). Involving Consumers in the

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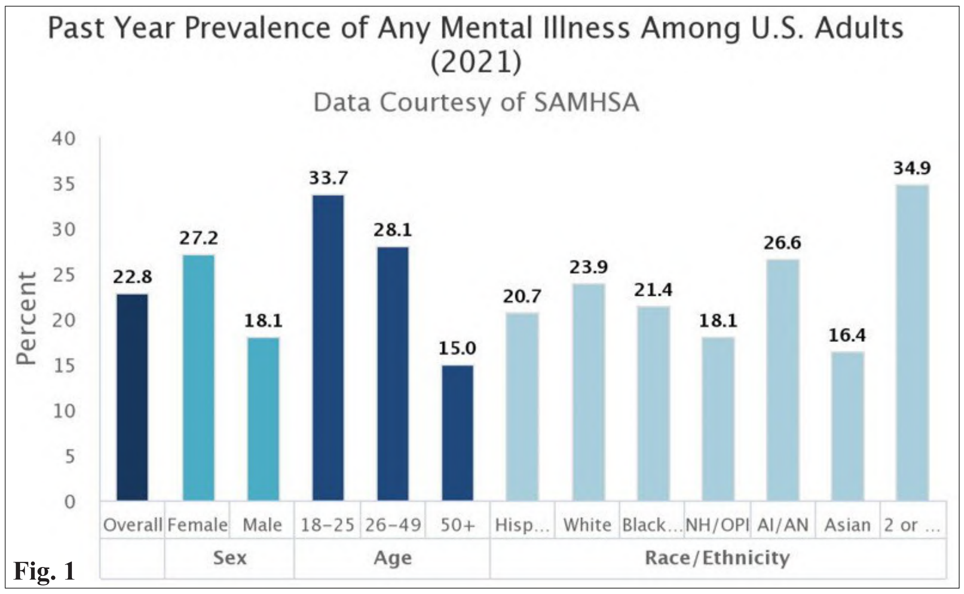


Fig. 1

Source: www.nimh.nih.gov/health/statistics/mental-illness

Fig. 2

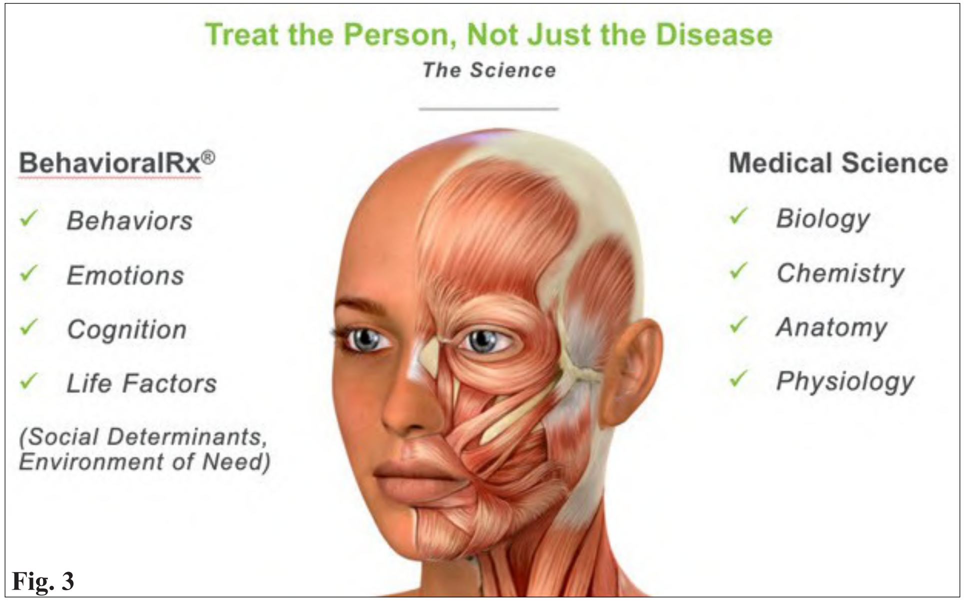
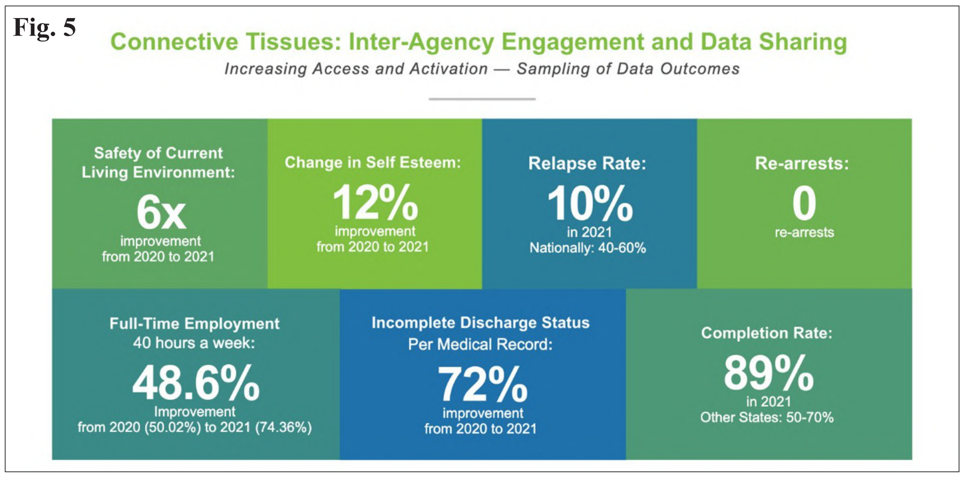


Fig. 3

Fig. 4

BehavioralRx Engagement Approach

Fig. 5



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appropriate payment for their work? Moving away from fee-for-service models and embracing value-based care.

Value-based care models allow physicians to focus on a holistic view of the patient. Through value-based care, physicians look at the entirety of what each patient needs, rather than billing for each individual service. This model connects payment to outcomes, rather than volume. Moreover, integrating behavioral health into primary care can lower the total cost of care for payers by improving outcomes of chronic medical conditions, giving providers more flexibility to treat mental health conditions, and allowing patients more access to treatment.

Through value-based care arrangements, the primary care practice can increase its focus on the patient's care. Value-based care payment models align incentives between payers, providers, and patients: everyone benefits from improved care delivery, more holistic care, and better patient outcomes.

Clearly, solving our national behavioral health crisis won't be easy. With increasing demand, limited professional resources, and a complicated reimbursement process, behavioral health issues represent one of many challenges facing our healthcare system. Yet by embracing alternative care delivery and payment models, we could help clinicians provide more support for those in need and drive better overall health outcomes for the populations they serve.

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particularly important for encouraging early evaluation and treatment of ASD. Multiple research studies and our own clinical experience demonstrate that early treatment results in better outcomes in critical areas like language development (Ben-Itzchak & Zachor, 2007; Tiura et al., 2017).

To bring about meaningful change, it's important that we not ignore the real needs of all autistic people and their families. While some autistic people may be able to advocate for themselves and leverage talents related to their autism (e.g., having an eye for detail), others, particularly those with co-occurring intellectual disabilities, will likely always have substantial needs for support. For efforts to eliminate stigma to matter, they must work for all the people who are subject to it today.

Toward Acceptance and Appreciation

The topic of stigma naturally leads to a discussion about the need for acceptance and appreciation. Acceptance includes not only the person's strengths and way of being in the world, but also an understanding of any disability they might have and the support they need. Just as important as acceptance is appreciation of the path that a person wishes to take and the contributions they're capable of making.

Acceptance and appreciation also extend to family members and others in an autistic person's life. These people are living with autism, too, and deserve support in a way that fits the whole family's needs.

This April, we can all make a difference in overcoming the stigma associated with autism. For many, this begins with reconsidering when and how to talk about autism. For others, it might mean extending an offer of employment to an autistic person. For still others, it means meeting the needs for support of an autistic person and their family. For all of us, it means moving closer to a world that reflects and celebrates everyone and enables all people to choose their own path.

Dr. Doreen Samelson, EdD, MSCP, is Chief Clinical Officer and Dr. Lindsey Sneed, PhD, BCBA-D, is Vice President, Clinical Excellence for Catalight Foundation.

Finding Peace from page 8

result of all three branches of government working together with the best private sector treatment providers and cutting-edge technology to treat addiction as it should be treated, as a disease."

GoMo Health is advancing the standard of care for mental illness and addiction treatment, leveraging its BehavioralRx® cognitive and behaviorally-based science of patient engagement to provide flexible and adaptive programs that enhance current treatment programs while improving reach, access, and engagement for the populations most at-risk and underserved.

Sue Zbikowski, PhD, is the founder and CEO of inZights Consulting and an Advisory Board Member at GoMo Health. Shelley R. Schoenfeld is Chief Strategist at GoMo Health. For more information about the GoMo Health Behavioral Health Personal Concierge Program and other digital health management programs, please visit https://gomohealth.com/campaigns/dei-in-healthcare/ or text DEI to 43386.

References

Centers for Disease Control and Prevention. About Mental Health. What Causes Mental Illness.

National Alliance on Mental Illness (NAMI), California. What is Mental illness.

National Alliance on Mental Illness (NAMI-A). Mental Health By The Numbers.

National Alliance on Mental Illness (NAMI-B). Chronic Illness and Mental Health: Recognizing and Treating Depression.

National Institute of Mental Health. Mental Illness. Past year prevalence of Any Mental Illness.

Olfson M, Mojtabai R, Sampson NA, Hwang I, Druss B, Wang PS, Wells KB, Pincus HA, Kessler RC. Dropout from outpatient mental health care in the United States. Psychiatry Serv. 2009 Jul;60(7):898-907. doi: 10.1176/ps.2009.60.7.898.

World Health Organization. Mental Health. Determinants of Mental Health.

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- develop crisis intervention teams,
- and create public education campaigns about the best resources to help those in a mental health crisis.

Mental health advocates should educate BIPOC communities about non-acute mental health conditions. Conducting outreach in places where people traditionally relax and feel comfortable might help normalize the conversation. Social media could also be used to promote accurate mental health information.

However, it's essential that we also engage social media companies to include "trigger warnings" - as well as links to mental health resources - on potentially traumatizing content. We know that repeated exposure to brutality through social media, such as the recent videos of Tyre Nichols, can negatively impact mental health.

Healthcare Provider Opportunities

Another way to lower barriers to care is to reduce bias and stigma within *provider* communities. To start, all providers should be offered implicit bias training to strengthen mental health diagnosis and treatment in BIPOC communities.

In addition, we should encourage more holistic training in medical school; stop separating the brain from the body. As psychiatrists, we're taught how medical problems throughout the body can ultimately impact the brain and behavior. That kind of holistic thinking should be an element of *all* patient care.

The U.S. Preventive Services Task Force is in the process of recommending that primary care providers (PCPs) screen adults for anxiety and depression, which could help bridge the divide between "physical" and "mental" care. As PCPs make mental health a routine part of care, their increasing comfort with mental health conversations should trickle down to their patients.

Overcome Financial Challenges

Economic well-being has historically been a struggle for BIPOC communities for many reasons, including institutionalized racism. Almost all BIPOC communities suffer from a generational wealth deficit.

Although there aren't many ways to rectify this fact alone, people can recognize the unique financial disparities that exist within BIPOC communities and acknowledge there is progress to be made. Then, with greater awareness, they can support laws and policies that ease financial barriers to care. This could take the form of promoting increased funding for community mental health centers, for instance, or expanded insurance coverage for low-income individuals.

Increase Access to Care

Even when people overcome social and financial barriers to care, the nationwide shortage of mental health professionals makes it difficult to receive treatment. It's even harder for BIPOC individuals who prefer to see providers who share their culture. Only about 2% of psychiatrists and 4% of therapists identify as Black, for example (O'Malley, 2021).

Still, there are resources designed to increase access to care, such as:

- Therapy for Black Girls, a website that helps Black girls and women find BIPOC therapists by location, virtual offering, clinical specialty, etc.
- Rapper Megan Thee Stallion's website, which links to numerous mental health resources, including the StrongHearts Native Helpline, The Steve Fund, and the LGBTQ Psychotherapist of Color directory.
- The Psychology Today website, with listings for BIPOC and non-BIPOC mental health professionals - including psychiatrists, LCSWs, etc. It also helps people find online therapy and video counseling.

Empower Yourself,
Empower BIPOC Communities

Mental health is no different than physical health; it impacts all people across cultures and communities. Consequently, everyone can play a role in reducing stigmas and overcoming barriers to mental wellness in BIPOC communities. It starts with educating yourself. Then, you can advocate for others.

If you notice someone struggling, take the time to talk with them without distractions. Tell them about your concern and ask how you can help. Be aware that their lived experience might differ from yours, but start the conversation. You don't have to be a mental health expert, just someone willing and able to point them in the right direction.

Above all, everyone should know that help is available. Nobody should have to struggle, fearful and alone, like the mother I talked with in the ED. Professionals work hard every day to create safe spaces where everyone can take care of their mental health.

Dr. Rakel Beall-Wilkins, MD, MPH, serves as a Medical Director at Magellan Healthcare. You can contact her at beallwilkinsr@magellanhealth.com. Additional resources from Dr. Beall-Wilkins can be found at https://www.magellanhealthinsights.com/author/rbeall-wilkins/.

References

Thomas MD, Jewell NP, Allen AM. *Black and unarmed: statistical interaction between age, perceived mental illness, and geographic region among males fatally shot by police using case-only design*. Annals of Epidemiology, Volume 53, 2021, Pages 42-49.e3.

Mental Health America. *The State Of Mental Health In America*.

National Alliance on Mental Illness. *Mental Health Care Matters*.

Perzichilli T. *The historical roots of racial disparities in the mental health system*. Counseling Today. 07 May 2020.

Londono Tobon, Amalia, et al. "Racial Implicit Associations in Psychiatric Diagnosis, Treatment, and Compliance Expectations." Academic Psychiatry : the Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, U.S. National Library of Medicine, Feb. 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7933096/

O'Malley L. *Addressing the Lack of Black Mental Health Professionals*. Insight Into Diversity. 17 November 2021.

https://therapyforblackgirls.com/

https://www.badbitcheshavebaddaystoo.com/

https://www.psychologytoday.com/us/therapists

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1990, 2008). For example, special education laws, teacher training, and training and specialization in healthcare fields to promote comprehensive care has been emphasized in residency programs. In addition, disabilities awareness and specialty training for law enforcement personnel have been implemented nationwide. These advances are significant, and they should be noted given the impact they have had thus far in attempting to equalize the opportunities for all individuals with disabilities. While we have certainly come a long way in reducing stigma, perseverance is still needed in finding ways to support people with disabilities. A major element of this movement involves having the community at large widen their definition of acceptable. Social acceptance of difference is key to improved outcomes.

Since some cultural norms change over time, we need to continually ask how we are helping overcome stigma. At the individual level, do we see the person we are supporting as able to dream and design a life by which they feel fulfilled? Or do we feel we "know better" and design a lifestyle for them with little regard to their desires? As a support system, we need to make sure we have educated ourselves about disabilities to be better positioned to support people with disabilities. Being supportive means treating people with dignity and respect and working together to figure out what they find meaningful. Establishing a better understanding of their personality and personal attributes can help us support their goals. In addition, helping family members in the process of supporting their loved one's needs and desires allows that person to continue to thrive in loving environments and communities they live in. (CDC)

Helping people with disabilities overcome stigma and discrimination includes educating other members of the community who can also help support their needs in a natural way (Unicef). A person's community includes neighbors, schools, first responders, physicians, businesses, prospective employers, and any other location in the community that is important to that person (Parenti, 2017). We need to help support people with disabilities to be fully integrated community members by ensuring they receive the appropriate access to education, healthcare, goods and services, and have the opportunity to have access to competitive employment, which can involve specific skills training. Disability advocates continually point out the ways in which marginalization continues to occur; we need to include those voices in all elements of planning and service provision.

In addition to continuing to educate others on the abilities of people with disabilities, it is crucial to be careful with our words given that the language we use can significantly impact stigma reduction. Our words and conversations need to be supportive and positive in order to impact stereotypes that may still exist within the community. Remaining positive and highlighting the contributions of a person with a disability helps support them and assists other community or family members to value the person's contributions. Ensuring that we see and name the "person" instead of referring to them as clients or patients helps others see the person too.

Case Study

The following Case Study illustrates an example of how one person was supported in ways that overcame stigma in their community.

William is a 38-year-old male diagnosed with an intellectual disability who resides in a home in the community. William receives 24-hour support from direct support professionals (DSPs) who work in his home as well as the program he attends during the day. William also receives behavior services to help support him in learning how to communicate his needs instead of engaging in behaviors that may be considered dangerous or disruptive, such as aggressive behaviors towards others, destruction of property, or yelling at others. William has great communication skills and is able to engage in conversations with others. He loves to help and will jump right in when he sees someone start to take the trash out or wipe down a table. He has strong gross motor skills and enjoys participating in a variety of vocational activities. William expressed a desire to be competitively employed, and the aforementioned skills helped his support team to work with him identifying possible jobs of interest. Competitive employment involves working in the community while earning a competitive wage (i.e., earning what someone else working the same job without a disability makes, at minimum wage or higher), with the ultimate goal being to have natural community supports. Natural supports in an employment setting include coworkers, managers, and any other person who will be naturally in the environment, as opposed to a paid caregiver.

In order to help make William's community involvement a success, preparation occurred for him, the community, and the DSPs providing support. To prepare William for success, his preferences were evaluated and community jobs/locations meeting those preferences were identified. William has full autonomy when he accesses the community and what activities are completed. To prepare the natural supports at the job location, the DSP demonstrates for coworkers and community members that all interactions should be with William, and not with the DSP. They also demonstrate and teach how to build a relationship and how to respond if William starts to become agitated. They also demonstrate the best way to teach William any new skills.

Initially, William attended work once a week for 30 minutes and would complete

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From Left to Right: Helen-Maria (Marilena) Lekas, PhD, Karin A. Wagner PhD, Jessica Zahn, James Rodriguez, LCSW, PhD, and Philip Yanos, PhD

settings ignited a discussion about differential access to care, quality of care and behavioral health inequities. The panelists discussed how the different social identities or statuses of service recipients including race, ethnicity, gender, age, sexual orientation, place of residence, religious affiliation, documentation status, and involvement with the criminal justice system and/or with substance use, intersect with the stigma of mental health conditions and result in differential exposure to stigmatization. For instance, when applying for a job or housing or interacting with health care providers, a Black man with a history of involvement in the criminal justice system and a mental health diagnosis will be exposed to greater stigma compared to a White non-Latinx woman without a forensic history despite having the same diagnosis. Sharing their lived experiences, the panelists from diverse racial and ethnic backgrounds and other statuses explained that *the stigma* of mental illness manifests differently when it interfaces with racism, gendering,, classism, and other forms of -isms that also negatively stereotype and exclude persons from life opportunities. Adopting *the lens of intersectionality* to understand the more profound and catastrophic impacts of stigma experienced by racially and otherwise minoritized persons with mental health conditions was deemed essential and urgent if we are committed to reducing health inequities in our society. To encourage adoption of an intersectional lens, one recommendation is to always use the term *intersectional stigma* of mental illness.

Health inequities were also the context in which panelists discussed the need to revisit what we consider to be effective mental health treatment and services, including stigma-reducing interventions and programs for diverse recipients, especially those from racially and ethnically minoritized communities. Increasing language access and availability of *culturally humble providers* were among the panelists' suggestions for expanding equity. The recognition of how historical trauma in minoritized communities can contribute to mental health challenges and the need to examine and integrate stigma-reducing interventions, programs and treatment modalities developed by minoritized communities were the strategies panelists proposed. We were encouraged to implement "our communities' ways" as one panelist stated. Going beyond provider *cultural competence* that refers to knowledge towards *cultural humility* that refers to embracing a respectful, open-to lifelong-learning approach to providing care was a recommendation. Prioritizing person-centered approaches to care and shifting away from *cultural adaptations* of "evidence-based" treatments (developed for White non-Latinx service recipients) to community-based treatments (developed by members of the community) was a novel and radical insight that emerged.

In the context of health inequities and intersecting stigmas, the profound stigmatization of substance use was a core theme. The public's tendency to blame persons who use substances, to misunderstand the impact of addiction in their lives, and the stubborn association of substance use with dangerousness and violence has generated and reproduced a highly negative stereotype of persons who use substances. This effectively undermines their treatment and chances for recovery. Moreover, when the public stigmatizes substance use it fails to recognize that this is one strategy for alleviating the symptoms and suffering among persons who lack access to mental health care, mostly from racially minoritized and resource-poor communities. This is another primary pathway leading to health inequity. As a suggestion, we should consider mental health and substance use challenges to both be behavioral health challenges, and design effective stigma-reducing interventions, programs, and treatment modalities that address both.

The intractable stigma of mental health conditions also stems from to the stereotypical association of mental illness with violence and unpredictable dangerous behavior. Despite robust research evidence that only a small percent of violent acts (3-5%) can be attributed to persons with serious mental illness, the public tends to equate mental illness with dangerousness. The media frequently fuels this harmful misunderstanding by producing and disseminating sensationalized stories to attract a larger audience. However, the media roundtable panelists were the exception to this trend and provided recommendations on how the media can be an ally in the fight against stigma. The journalists on the panel discussed the need to produce affirming, strengths-based stories that reveal the human complexity of persons with mental health conditions and highlight their capabilities instead of focusing exclusively on their diagnosis. To sever the by-default association of mental illness and violence, the recommendation was to not mention a person's mental health condition, unless it is clearly relevant to the violent event in the story. The media can also serve as an effective source of education, contact, and advocacy/protest interventions by providing accurate information on mental health conditions, how to access effective treatments and services, and present humanizing stories of challenges and recovery to counteract the negative mental illness stereotypes. The role of language in normalizing mental health statuses and the need to refrain from medicalizing different statuses and experiences emerged across all four roundtables and especially in the media panel. It was encouraging that in their stories, journalists recognized the importance of providing equitable access to mental health care through placing services in non-traditional mental health care and non-stigmatizing settings such as, schools and the workplace. To these settings, we add faith-based organizations such as, churches, synagogues, and mosques, and community-based organizations that are not focused on mental health but that attend to the social determinants of health such as, housing, food insecurity, or education and training.

Saving the most significant theme for last, all panels emphasized that if we are to reduce the stigma of behavioral health and health inequities, we must intervene on many different levels: the individual, interpersonal, organizational/institutional, and the societal. Designing interventions on the individual level to decrease internalization and anticipation of stigma among persons with mental health conditions and their families, or even interventions on the interpersonal level to enhance providers' cultural humility and establish person-centered non-stigmatizing services will not suffice. We must attend to the organizational/institutional level by integrating the expertise of persons with lived experience, peers, and community advocates as equal to the expertise of clinicians and researcher partners. The policies and practices of mental health institutions would greatly benefit from following the disability movement principle of, "Nothing about us without us," as a primary strategy to providing non-stigmatizing and effective services. Going beyond integrating peers into mental health services, we propose the development of a mental health movement that will mobilize the expertise of lived experience and through organizational coalition building and other community-based strategies work towards social change and true mental health equity. Such a movement would advocate, protest, but also lobby for policies and laws that operate on the societal level to protect and promote the wellbeing of persons with mental health conditions and their families.

Suzanne B. Feeney, MBA

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Disasters from page 36

The increase of chronic, compounding disasters around the world means that more people are being exposed to overlapping traumatic events and therefore more people are at risk of developing PTSD and cPTSD in the aftermath–especially those who are not provided the proper crisis supports, psychological first aid, and behavioral health resources that can help them work through their experiences (Alessi et al., 2021; Chen et al., 2007). For communities that experience systemic inequalities and uneven distribution of resources–things that worsen their community's ability to bounce back–the risk for developing PTSD and cPTSD is even higher. For example, a look into the literature shows that 16-38% of refugees and asylum seekers exhibit cPTSD symptoms (de Silva, 2021; Maercker et al., 2022). In contrast, a German study of cPTSD among the general population showed a prevalence of just 1% (Maercker et al., 2022).

While thankfully most people who experience traumatic events will *not* develop PTSD or cPTSD, those who do develop one or the other can face stigma and negative assumptions within their community. Those who do not develop long-lasting mental health issues sometimes view those who have as being overly dramatic or needing to suck it up (Healthwise, 2022; Jacobs et al., 2019; Lowe et al., 2019; Revelant, 2018). People do not always understand how experiencing multiple disasters and crises increases the risk of developing PTSD or cPTSD. We do not always allow for how living through adverse social conditions such as systemic racism affects our ability to bounce back after a major disaster.

The best way to protect against PTSD developing is increased resilience. For an individual person, this means increased access to post-disaster supports including: Social services, housing, physical health, and mental well-being. Getting behavioral health professionals who specialize in disaster psychology on-site can be a major game changer for survivors. The practical application of Stress First Aid, Psychological First Aid, and Skills for Psychological Recovery can make all the difference for individuals and families in the direct aftermath.

For communities, increasing resilience looks different. A community's resilience is directly tied to its broader social supports, community wealth, and experience of marginalization. Access to psychosocial support, health services, financial assistance, and childcare can do a lot to buffer a community's allostatic load by addressing those foundational and chronic stressors. Further, educating community members on disaster planning and recovery allows communities to best figure out how to help themselves in times of crisis. This provides greater community self-reliance and allows the people to make the best decisions for themselves.

It is more important than ever that we, as a society, realize that the incidents of conditions like PTSD and cPTSD may increase due to multi and chronic-disasters, especially if there is a lack of disaster specific behavioral health response activities. PTSD and cPTSD are not diagnoses limited to people who have gone to war, nor are they conditions that a person can just "get over" without proper care and treatment. Like any mental health condition, PTSD and cPTSD change how our bodies react to and process the world around us, causing people to "overreact" to seemingly minor stressors or inconveniences.

A person with PTSD or cPTSD cannot help the ways in which they automatically react to triggers, but there are ways that they can manage their responses, especially with the help of their community and professional intervention. These conditions can be debilitating, isolating, and terrifying, causing people to relive the worst moments of their lives with the slightest reminder or other stressor. The National Center for PTSD is one of the leading arms for PTSD care and has recommendations for determining signs of good PTSD care along with helpful descriptions of the types of PTSD now available that can be effective and bring hope to those who experience this disorder (Signs of Good PTSD Care - PTSD: National Center for PTSD (va.gov)).

Understanding how we, in big and small ways, can help lower foundational and chronic stressors is critical. We need to anticipate and prepare for the likelihood that our communities will experience more than one disaster at a time. Each of us must know our role as survivors, community leaders, and/or first responders so that our work is effective in decreasing the negative mental health impacts of these events. We can start by recognizing that not all of us will have the same response to disasters and advocating so that everyone impacted has access to the support and resources needed to address the impact of disasters on our community members' mental health.

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References

Alessi, E. J., Hutchison, C., & Kahn, S. (2022). Understanding covid-19 through a complex trauma lens: Implications for effective psychosocial responses. *Social Work, 67*(1), 79-87.

Beckie, T. M. (2012). A systematic review of allostatic load, health, and health disparities. *Biological Research for Nursing, 14*(4), 311-346.

Casas, J. B., & Benuto, L. T. (2022). Breaking the silence: A qualitative analysis of trauma narratives submitted online by first responders. *Psychological Trauma: Theory, Research, Practice, and Policy, 14*(2), 190.

Chandra, A., Acosta, J., Howard, S., Uscher-Pines, L., Williams, M., Yeung, D., ... & Meredith, L. S. (2011). Building community resilience to disasters: A way forward to enhance national health security. *RAND Health Quarterly, 1*(1).

Chen A.C.-C., Keith V.M., Leong K.J., Airriess C., LI W., Chung K.-Y., & Lee C.-C. (2007) Hurricane Katrina: prior trauma, poverty and health among Vietnamese-American survivors. *International Nursing Review, 54*, 324–331

de Silva, U., Glover, N., & Katona, C. (2021). Prevalence of complex post-traumatic stress disorder in refugees and asylum seekers: systematic review. *BJPsych Open, 7*(6), e194.

Guidi, J., Lucente, M., Sonino, N., & Fava, G. A. (2021). Allostatic load and its impact on health: a systematic review. *Psychotherapy and Psychosomatics, 90*(1), 11-27.

Healthwise Staff. (2022, February 9). *PTSD Myths*. MyHealth Alberta. https://myhealth.alberta.ca/health/pages/conditions.aspx?hwid=ug4379&

Kairyte, A., Kvedaraite, M., Kazlauskas, E., & Gelezelyte, O. (2022). Exploring the links between various traumatic experiences and ICD-11 PTSD and Complex PTSD: A cross-sectional study. *Frontiers in Psychology, 13*:896981. doi: 10.3389/fpsyg.2022.896981

Krzemieniecki, A., & Gabriel, K. I. (2021). Stigmatization of posttraumatic stress disorder is altered by PTSD Knowledge and the precipitating trauma of the sufferer. *Journal of Mental Health, 30*(4), 447-453.

Maercker, A., Cloitre, M., Bachem, R., Schlumpf, Y. R., Khoury, B., Hitchcock, C., & Bohus, M. (2022). Complex post-traumatic stress disorder. *The Lancet, 400*(10345), 60-72.

Raphael, B. (1986). *When disaster strikes: How individuals and communities cope with catastrophe*. Basic Books.

Revelant, J. (2018, April 17). *Understanding the stigma around PTSD and how to overcome barriers to care*. Everyday Health. https://www.everydayhealth.com/ptsd/ptsd-stigma/

Roscoe, R. A. (2021). The battle against mental health stigma: Examining how veterans with PTSD communicatively manage stigma. *Health Communication, 36*(11), 1378-1387.

Rossi, R., Socci, V., Pacitti, F., Carmassi, C., Rossi, A., Di Lorenzo, G., & Hyland, P. (2022). The Italian version of the International Trauma Questionnaire: Symptom and network structure of post-traumatic stress disorder and complex post-traumatic stress disorder in a sample of late adolescents exposed to a natural disaster. *Frontiers in Psychiatry, 13*, 859877. https://doi.org/10.3389/fpsyt.2022.859877

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a highly preferred job duty (taking out the trash). The length of time William attended, and the number of days were slowly increased, with his preferences and choices closely monitored. This gradual increase allows the co-workers to get to know William and build relationships. Once those relationships were built, the DSP was able to step back, and natural supports took over. William's DSP plays close attention to his verbal and physical cues, and if William becomes agitated or overwhelmed, he is reminded of his ability to take a break, or even to leave work early. Because the relationship has developed over time with careful attention to relationship building, the place of employment understands the need for flexibility and William is permitted to leave early, come in late, switch days, and so forth, based on his needs. William has also developed relationships with community members who frequent the convenience store and will notice if he's been out for a few days. They too help to provide the natural supports needed to secure successful community involvement.

By educating the natural supports in William's community about his needs and how best to support him, stigma around any perceived differences has been minimized and replaced with genuine care and concern for him as a person.

Though much progress has been made both legally and culturally related to discriminatory practices, there is still work to be done to create inclusive environments in all sectors of life. Modeling how to be inclusive in our everyday lives is crucial.

We must also continue to listen to the disability community about their needs and the best way to support a person with a disability in achieving the goals they set for themselves. While there are general guidelines for providing this support, specifics are determined by the person receiving supports, and this will look different for each person. What's most important is ensuring that the person receiving supports is actively involved in all aspects of planning to the greatest degree possible. Additionally, we must listen and heed the words of advocates who are also disabled, learn from their feedback, and involve them in our work.

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References

CDC, Disability and Health Inclusion Strategies, September 15, 2020 (webpage)

Parenti, K. (2017). Clinical Corner: First responder education in autism. Science in Autism Treatment, 19(7).

Patient Protection and Affordable Care Act of 2010

Section 504 of the Rehabilitation Act of 1973

The American Disabilities Act of 1990, ADA Amendment Act of 2008

Unicef, Reducing Stigma and discrimination against children with disabilities.

Wikipedia, Social Stigma definition

Wolfensberger, Wolf P.; Nirje, Bengt; Olshansky, Simon; Perske, Robert; and Roos, Philip, "The Principle of Normalization In Human Services" (1972). *Books: Wolfensberger Collection*. 1.

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in place meant IT did not have to start from scratch. However, the task of transitioning the majority of Vibrant's employees, not just the contact center, was still tremendous. Vibrant's IT team and H2H's operations staff, with the support of management, worked tirelessly so the contact center staff could quickly transition to working from home. When thinking back to that time about everything staff did on short notice, it really is nothing short of amazing.

A completely 100% remote workforce has enabled us to expand our pool of candidates for employment outside the metro area. This helped not only with recruitment efforts in general but also, with people on the West coast being three hours behind, it became easier to fill shifts starting later in the day.

Carl: Mantasha Sharif and Daesia Jameslouis (DJ), why did you become peer support specialists and what was your experience before you joined NYC Well?

Mantasha: I've had anxiety most of my life, but I didn't know what it was until I had therapy at age 21. I was a server in a restaurant before this job, so I had to learn how to manage my anxiety and not judge myself. I had no formal training as a peer specialist, although I provided peer-to-peer support with a young family member before that. Not everyone can speak up in a crisis, especially when there are cultural barriers and stigma about being called "crazy." Having a mental illness is not wrong.

DJ: Before becoming a peer specialist, I worked as a crisis counselor, paralegal, and sexual assault advocate, and was in the United States Navy. I became a peer specialist to share my recovery story and knowledge in the field of mental health. I believe the biggest takeaway from my journey was gaining a complete understanding both psychologically and emotionally. When recovering, I felt sharing that experience with others could provide hope and also coping skills to better face their mental health challenges.

Carl: What were your expectations when you started and have they changed over time?

Mantasha: When I first started, I expected to talk to people in various stages of their personal journeys, and I certainly have. Connecting with a visitor over shared experiences, common interests, or coping skills is always great. I also expected to be in a supportive work environment, and the team has certainly lived up to those expectations. The peer supervisors, the peer team, and all other staff are always helpful, kind, and supportive.

DJ: As a future licensed clinical mental health counselor, I was helped by the Vibrant team with hands-on training to piece together psychological knowledge, a sense of competence when counseling clients, and the ability to support them through crises. Vibrant has continually allowed peers to provide psychoeducation and model recovery.

Carl: What was your training prior to NYC Well and what on the job?

Mantasha: The training at NYC Well before starting the job carried a lot of weight. And I've learned a lot on the job. But there's always room for improvement. I was better on chats than on calls to start. And learning how to use our resource database took time. Now I'm learning a lot from the courses that the Academy of Peer Services requires for certification.

DJ: Training has provided much information regarding crisis counseling, intervention methods, supportive communication, and psychological knowledge. Before joining NYC Well, I obtained a degree in psychology and worked as a crisis counselor. When comparing both, Vibrant provided much more detailed hands-on training compared to other mental health positions.

Carl: What is the nature of your interactions with callers/visitors?

Mantasha: During the height of the pandemic, there was a lot of school stuff on the minds of chatters and texters. Over the semester, anxiety and depression went up with a lot of suicidal thoughts and self-harm. If you're naturally empathetic and want to help people, then this is the place for you. We can support people because it's awful to go through these things alone.

DJ: Peer specialists engage peers where they are, build trust through selective self-disclosure, actively listen without judging, validate their concerns, and affirm their strengths. Some callers simply want to vent, talk about a triggering moment, or cope through their ongoing mental health challenges. All want to be heard. Especially for callers who are new to their mental health diagnoses, peer specialists help them understand what it was like when we were first diagnosed and how we coped. We also assist individuals who are further along in their recovery and need a sense of hope by reinforcing the coping skills they have learned along the way.

Carl: How has your position or role changed since you began working there?

Mantasha: Being here for almost three years, I have learned how to better engage with struggling visitors and to not take things personally. Sometimes a listening ear and talking about how to get through the day go a long way. Calls and chats can be triggering, especially when they concern sexual assault and other trauma. But supervisors are always there to support us and there's time to take breaks, including for self-care when needed. I didn't practice self-care before because I'm an introvert who likes to be by myself. But now I don't feel guilty taking the time for music, walking, writing, and reading.

DJ: When beginning with Vibrant, I was originally offered a crisis counselor position but soon changed to the peer specialist role. After working the job for six months, I moved to peer supervisor, which requires technical multi-tasking while supporting peer specialists on and off calls. Although the stress can be negative, knowing you have provided that listening ear and constructive feedback is an extremely rewarding benefit.

Carl: What are the greatest rewards and challenges of the job?

Mantasha: It feels very rewarding to make someone's day or even just help them feel a little better than they were feeling before the interaction. Sometimes people need a space to be heard and be listened to. Most of the time, visitors have the tools within themselves to cope. It just takes a listening ear to remind them and help them reconnect to their own tools. One of the challenges of any helping profession is being prone to experiencing burnout.

DJ: Sharing your recovery story and psychological knowledge plays a big part in an individual's recovery. Knowing you made that slight difference is extremely satisfying. The biggest challenge is disconnecting from clients. Support goes a long way when done collaboratively but can go even further when clients choose to utilize these skills on their own.

Carl Blumenthal is a peer counselor for the SAMHSA-funded Enhanced Treatment and Recovery (EnTRy) program of NYU Langone's Sunset Terrace Family Health Center in Brooklyn, New York. He supports peers who have experienced psychosis. Carl has published more than 100 articles on behavioral health and a memoir, "Saved by Imagination: How Reading and Writing Restored My Mental Health." For more information, email carlblumnthl@gmail.com or call (929) 283-2562.

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treatment to those experiencing a mental health challenge also need to be aware of stigmatizing language. The most important action a provider can take to destigmatize mental health counseling in their role is to begin the conversation. Talk about mental health challenges, as well as grief, loss, trauma and addiction. Discuss with the individual how you can help them work through these challenges.[5]

Language is essential to framing an issue. The issue of mental illness must be labeled by providers in a way that is supportive and humanizing. The care and treatment they offer is critical to an individual's success, and language should be modeled for caregivers, family members and all related support systems. By eliminating stigmatizing language from the dialogue, providers promote the idea that the individual needs and deserves treatment.

When clinicians and other providers utilize destigmatizing, strength-based language, it ensures a more accurate representation of the mental health issues and the reality of the individual's experience. In addition, it creates a common language to facilitate a comprehensive and realistic treatment plan. When initiating treatment, assess the person's belief about seeking help. Provide a realistic view of the full treatment process, while acknowledging that counseling, therapy and/or treatment can be an intimidating concept.[6]

Use language that accurately reflects the experiences of the individual, as well as the greater social context that allows for the treatment necessary for leading a meaningful life[7]. As providers, we can continue to alleviate the stigma of seeking support by offering education, supplying factual information with the goal of correcting misinformation, and challenging negative attitudes and beliefs.[8]

Eliminating stigmatizing language associated with mental health conditions among family, friends and behavioral health care providers can help ensure individuals receive the care and support they need, and take the first steps toward healing.

About Devereux Advanced Behavioral Health

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

Devereux is a recognized partner for families, schools and communities, serving many of our country's most vulnerable populations in the areas of autism, intellectual and developmental disabilities, specialty mental health, education and foster care. 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.

Amy Kelly, MBA, MNM, is National Director of Family Engagement, Devereux Advanced Behavioral Health, and Emily Garten, LCSW, is Clinical Director at Devereux Advanced Behavioral Health Florida.

Footnotes

1. www.nimh.nih.gov/health/statistics/mental-illness#part_2555
2. www.hhs.gov/about/news/2022/03/14/new-hhs-study-jama-pediatrics-shows-significant-increases-children-diagnosed-mental-health-conditions-2016-2020.html
3. www.in.gov/recovery/files/Stigma-AddictionLanguageGuide-v3.pdf, n.d.
4. positivepsychology.com/mental-health-quotes/
5. 7. www.insightnorthwest.com/blog/destigmatizing-mental-health-counseling#:~:text=The%20most%20important%20thing%20we,heal%20through%20mental%20health%20counseling
6. www.goodtherapy.org/for-professionals/marketing/customer-experience/article/best-way-therapists-can-decrease-stigma-of-being-in-therapy
8. https://nap.nationalacademies.org/read/23442/chapter/6#73

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recognize the warning signs of mental health conditions, and knowledge of what to do to seek help if experiencing a mental health condition.

In our own research, we incorporated greater rigor by using a "cluster randomized controlled trial design" in which classrooms were assigned to ETS or an active control presentation on careers in psychology. We recruited a culturally diverse sample of 206 high school students in New York City. Students completed 4 surveys including validated measures of mental health stigma throughout the study (pre, immediate post-presentation, 4 weeks post, 8 weeks post). Prospective results (over 2 months) and qualitative feedback were analyzed. Analyses indicated significant effects in favor of the ETS group for reduced negative stereotypes, improved mental health knowledge, and less anticipated risk for disclosing to a counselor immediately following the intervention (these improvements decreased to some extent two months after the intervention, although they still remained superior to the control condition). There were also trends in favor of the ETS group for reductions in intended social distancing and negative affect, and improvements in help-seeking intentions. Qualitative feedback indicated positive impressions of ETS overall, but suggestions for more interactive activities and discussion.

Our study indicated that a relatively brief program such as ETS can be an effective way of reducing stigma among high school students, although there were some caveats. Although ETS participants showed clear reductions in negative stereotypes and mental health knowledge after the intervention, the fact that effects had dissipated 2 months later indicates that the intervention would benefit from a "booster" component, especially if formally incorporated into discussions with a teacher designated to facilitate mental health discussions. Regarding future work, NAMI has continued to expand the ETS program and now also offers ETS presentations specifically for *parents and caregivers* (e.g., https://namisouthdakota.org/support-and-education/presentations/nami-ending-the-silence) and *school staff* (e.g., https://naminycmetro.org/request-a-speaker/ending-the-silence/). Targeting individuals within a young person's network is particularly important, given the high prevalence of mental health stigma among the general public and the influence that close adults can have on youth.

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Furthermore, NAMI also now offers an online, self-paced version of ETS (https://ets.nami.org/), which is identical to the in-person talk in terms of lived experience videos and educational information. Based on prior research demonstrating the unique impact of in-person stigma reduction (e.g., Corrigan et al., 2012), it is likely that in-person ETS presentations are most powerful in reducing stigma and should be a "first-line" approach. However, the online version of ETS should certainly still be implemented if in-person presentations are not available or feasible. Going forward, collaborations with diverse groups to design and implement culturally-sensitive programming will also be imperative.

In sum, adolescent mental health is a pressing issue and stigma remains common. Rates of mental health problems among youth were already on the rise pre-pandemic, and the pandemic has only exacerbated this trend. Programs such as NAMI's ETS can help to start important conversations around mental health, reduce stigma, encourage help-seeking, and subsequently improve community inclusion and quality of life among young people living with mental health concerns. Complementary approaches to sustain such work—and foster adolescents' autonomy and inclusion in such work—may include *NAMI on Campus* clubs in high schools and colleges (e.g., https://namica.org/nchs/), groups that typically provide outreach and host events. Overall, stigma, at its root, is a social problem and continued, multipronged efforts will be needed to tackle it.

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References

Corrigan, P. W. (2018). *The stigma effect: Unintended consequences of mental health campaigns.* New York: Columbia University Press.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatric Services*, *63*(10), 963-973.

DeLuca, J. S. (2020). Conceptualizing adolescent mental illness stigma: Youth stigma development and stigma reduction programs. *Adolescent Research Review, 5,* 153–171.

DeLuca, J. S., Tang, J., Zoubaa, S., Dial, B., & Yanos, P. T. (2021). Reducing stigma in high school students: A cluster randomized controlled trial of the National Alliance on Mental Illness' *Ending the Silence* intervention. *Stigma and Health, 6,* 228-242.

Wahl, O., Rothman, J., Brister, T., & Thompson, C. (2019). Changing student attitudes about mental health conditions: NAMI ending the silence. *Stigma and Health, 4,* 188 –195.

Note: NAMI offers an adult version of ETS, "In Our Own Voice," which can be shown on college campuses, etc. (https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-In-Our-Own-Voice)

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were made solely on the merit of the artistry and musical message. For example, a significant achievement was that after a couple of well-attended and positively received performances the group was offered a residency at Sidewalk Café, in Manhattan in 2014. Several key experiences from memorable performances have been captured in images, video, and audio material that clients continue to reflect upon and cherish. Furthermore, the events and media preserved remain as a testament to their experience of moving beyond stigma.

Music therapy services offered at Elm Place Clinic include performance and community drumming groups, as well as individual music psychotherapy sessions. The music therapy treatment programs are led by on-staff clinicians, qualified peers, and graduate music therapy interns. A treatment experience that begins with meeting the client where they are is integral to eliminating stigma. Meeting a client in a relatable way involves debunking the traditional clinician-client way of relating in which the clinician is perceived to have all the authority and knowledge, and the client is expected to listen to and follow the direction of the clinician (J. Layton, personal communication, December 2, 2019). In an interview with outpatient clinic peer specialist Joel Layton (2019), the music therapy program at Elm Place clinic was described as an experience that is based on showing up to the music therapy group with fellow musicians who are also clients and having staff members who are both clinicians and musicians facilitate the groups. This kind of collaboration between clients and clinical staff can bring a meaningful performance to an audience and can be transformative for clients living with mental health issues.

Within the naturally collaborative process that is music making, there is a transformative experience that occurs as both client and staff work together towards the same goal through a music-based interaction which breaks down barriers by allowing for a shared experience to take place. From a peer specialist perspective, the stigma of mental illness is removed because "we are all there as musicians" as the group works together on a project and there is no focus on diagnosis, mental health identification, and being "sick" (J. Layton, personal communication, December 2, 2019). In music, all human beings in the room are working together towards the goal of regulating and managing emotions, because all who are engaged are navigating the same unified struggle. The group members endeavor to bring out the best in one another, accessing inner potentials by working together to bring out the "best possible performance."

The existing literature supports that music therapy is an effective service as adjunctive to traditional mental health treatment models. For example, Tseng et al. (2016) concluded that standard therapy treatment was more effective when combined with music therapy and that patients who received music therapy showed significant improvement in mood symptoms, positive symptoms, and negative symptoms compared to patients who did not receive music therapy. Also, Geretsegger et al. (2017) reviewed the effects of music therapy by adding music therapy to standard care for people with schizophrenia and schizophrenia-like disorders. The study examined treatment dosage varying from seven to forty sessions and found a positive effect on mental health for music therapy compared to standard care. Along the same vein, McCaffery and Edwards (2016) explored the utility of music therapy in the treatment of mental illness with qualitative case studies of several clients, showing that cognitions were reinforced and effectively reshaped in music therapy, while the "ability replaced disability in music therapy" (p. 137). Music therapy for many mental health patients presented a new, more empowered, and often far more forgiving view of the self that promoted cognitive awareness of ones' self-worth that was "distinctive and positive and contrasted with the self-image outside the sessions" (McCaffery & Edwards, 2019, p. 140). In summary, research indicates that music therapy consists of a joint effort between clients and clinicians, which strengthens the therapeutic alliance by working together towards a common goal and transformative purpose. Moreover, the shared vulnerable experiences with interactive music-making involves risk taking and navigating tension and uncertainty (Wimpenny & Meadows, 2017) can be helpful to breaking down barriers, allowing for greater equity and agency. Ansdell (1995) explains that the power of music-based relationships is that they "connect two minds together in the same experience" (p. 103), reinforcing the point that the space held together between people sets the foundation for soul-making experiences and transcending labels. Songwriting allows the client's imaginal realm to come to life because creative self-expression can lead to changes that are person-centered. There are situations where the client is directing the therapist, thereby affording them increased agency over the flow of a session. For example, in songwriting the client and therapist can envision their collective message to manifest through the music as a vehicle for a deeper kind of communication that surpasses spoken language. Thus, the effect of music psychotherapy can be destigmatizing as it allows for a more equalized form of interaction, rather than the conventional scenario where the therapist is the guide and thereby has more of a controlling influence in the therapy process.

Music therapy is a creative arts modality which focuses on the subjective experiences of clients in treatment by stimulating one's inner emotional life and echoes the collective lived experiences which are relatable to all human beings. Jung (1933) wrote that "what is essential in a work of art is that it should rise far above the realm of personal life and speak from the spirit and heart of the poet as man to the spirit and heart of mankind" (p. 172). In service to destigmatizing mental illness, transcending the labeling of people through their illness can be redirected through reflection and raising consciousness on language, collaboration with participants, increasing solidarity through enhancing communal awareness, and promoting social justice (Tuastad et al., 2022). The overall music therapy treatment experience focuses on clients as equal participants.

Collaborating with professional music therapists and qualified peers through interactive music making allows for collective, integrative, and holistic experiences that supports ones' individual message that reflects triumphs as well as struggles. Furthermore, clients are afforded an opportunity for personal growth that are consistent with cultural norms, and free from stigma and social ostracization. The creation of music for all involved can be deeply reflective and emphasizes healing and recovery.

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References

Ansdell, G. (1995). *Music for life: aspects of creative music therapy with adult clients*. Jessica Kingsley.

Canen, N., Kendall, C., & Trebbi, F. (2021). *Political parties as drivers of U.S. polarization: 1927-2018*. National Bureau of Economic Research.

Geretsegger, M., Mössler, K.A., Bieleninik, L., Chen, X.J., Heldal, T.O., & Gold, C. (2017). Music therapy for people with schizophrenia and schizophrenia-like disorders. *Cochrane Database of Systematic Reviews*, Issue 5

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.

Hogenaar, Timon. (2022). *A societal shift, a community split: mental health challenges in a polarized society*. Duquesne University.

Jung, C.G. (1933). *Modern man in search of a soul*. Keegan Paul, Trench, Trubner & Co.

McCaffery, J., & Edwards, J. (2016). Music therapy helped me get back doing: perspectives of music therapy participants in mental health services. *Journal of Music Therapy*, 53(2), 2016, 121–148

Tseng, P., Chen, Y., Lin, P., Tu, K., Wang, H., Cheng, Y., Chang, Y., Chang, C., Chung. W., & Wu., W. (2016). Significant treatment effect of adjunct music therapy to standard treatment on the positive, negative, and mood symptoms of schizophrenic patients: a meta-analysis. *BMC Psychiatry*. 16:16

Tuastad, L., Johansen B., Østerholt A.L., Nielsen, I., & D.S.H., McIvor (2022): Being a person who plays in a band rather than being a person with a mental illness playing in a band: A qualitative study of stigma in the context of music therapy in mental health aftercare, *Nordic Journal of Music Therapy*

Wimpenny, K. & Meadows, A. (2017). Core themes in music therapy clinical improvisation: an arts-informed qualitative research synthesis. *Journal of Music Therapy*, *54*(2), 161-195

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Development of a Psychoeducational Booklet About Stigma for Black Mental Health Clients. Health Promotion Practice, 11(2), 249–258.

Black and African American communities and Mental Health. Mental Health America. (n.d.). Black Emotional and Mental Health Collective. BEAM. (2022, February 17).

Chan, Mak, W. W. ., & Law, L. S. . (2009). Combining education and video-based contact to reduce stigma of mental illness: "The Same or Not the Same" anti-stigma program for secondary schools in Hong Kong. Social Science & Medicine (1982), 68(8), 1521–1526.

Brådvik L. (2018). Suicide Risk and Mental Disorders. International journal of environmental research and public health, 15(9), 2028.

Jackson, V. (2002). In Our Own Voice African-American stories of oppression, survival and recovery in mental health systems. The International Journal of Narrative Therapy and Community Work, 2002, 11.

Kahle, E. M., Veliz, P., Esteban McCabe, S., & Boyd, C. J. (2021). Psychiatric disorders mediates the association between sexual orientation discrimination and substance use disorders among sexual minority adults. *Annals of LGBTQ Public and Population Health*, *2*(4), 236–255.

Lin, L., Stamm, K., & Christidis, P. (2018, February). How diverse is the psychology workforce? Monitor on Psychology, 49

Murray, P. (2017). Mental Health Disparities: African Americans.

Quick Facts United States. (2020, April 1st). Census.gov.

Rose, T., Joe, S., & Lindsey, M. (2011). Perceived stigma and depression among Black Adolescents in outpatient treatment. *Children and Youth Services Review*, *33*(1), 161–166.

Rovai, A. P., & Gallien, L. B. (2005). Learning and Sense of Community: A Comparative Analysis of African American and Caucasian Online Graduate Students. The Journal of Negro Education, 74 (Mental Health America), 53–62.

Schwartz, R. C. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. World Journal of Psychiatry, 4(Rockville, 2019), 133–140.

Slavery in America. Ferris State U. (n.d.).

Spagnolo, Murphy, A. A., & Librera, L. A. (2008). Reducing Stigma by Meeting and Learning from People with Mental Illness. Psychiatric Rehabilitation Journal, 31(3), 186–193.

Suicide. (2022, March). The National Institute of Mental Health.

Ward, E. C., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. Nursing research, 62 (Williams, 2011), 185–194.

Williams, M. T. (2011, 11/2). Why African Americans Avoid Psychotherapy. Psychology Today.

Wirth, J. H., & Bodenhausen, G. V. (2009). The Role of Gender in Mental-Illness Stigma: A National Experiment. Psychological Science, 20(2), 169–173.

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on fire, so I moved into the shelter. But I was still working, and then I put in for the New York State housing lottery. They called me up, they brought me over, they showed me the place, and on my birthday a year later I moved in. I've been in this studio apartment in an S:US Supportive Housing complex ever since, for 22 years," said Wiley.

"I talked to S:US about finding a job and they have been helping me with my job search. I know that I can ask for help if I need it and they follow through. I'm having financial issues right now but that's what the job search is for. I'm doing OK. I know I'm not the only one who needs money. With patience, I get what I need," said Steve.

Support from S:US

All of us receive support from S:US – whether it's help finding food, housing, job training, therapy or other mental health support, etc. S:US is a social justice agency and food security is one of the social justice pillars at S:US. S:US is deeply committed to ensuring an equitable, participatory food system by supporting the food security of the people they serve, like us, and elevating their voices and power within food system work. By food security, we mean universal access to adequate nutritious, affordable, and culturally/personally appropriate food. Food security means more than just access. Being food secure means having food available, having access to that available food, having that access and availability be stable over time, and having the tools and knowledge to use the food to meet nutritional, dietary, cultural, and personal or household needs.

"S:US staff help with lots of things. They help me with the groceries, help keep track of doctor's appointments, escort me to appointments, help me fill out documents for benefits, whatever I need," said Anna.

"When I first moved here, I didn't know about food pantries and whatnot. The building manager gave me the address for the Salvation Army and I've been going there. I was working at the time (now I'm retired and I volunteer there). But he said, 'Well, you can get free food from the Salvation Army once a month,' and he gave me the address and everything. I think the first three years here I was getting food there once a month," said Wiley

"I've been in an S:US program for a couple of years and it's working for me. S:US staff support you when you want to go back to school. My wellness coach helps with SNAP recertification ahead of time. She asks if I have food and I like that. I tend to isolate myself so I like that they check in on you. They make sure you're eating and drinking water. I feel safe where I'm at. If anything is wrong, I know I can go downstairs and get help," said Sherese.

"S:US has a list of pantries they give you when you need food. Some are close by so I go to those. They have canned goods, vegetables, sometimes dairy products, cereal, stuff like that. It's a balance of buying my own food and going to pantries when I don't have enough," said Francisco. "The S:US staff help whenever I need it. They helped me find pantries. I know how to apply for food stamps by myself," said Glen.

SNAP and Food Pantries Are Essential

Most of us feel pretty good about our food situations right now because we receive benefits from the Supplemental Nutrition Assistance Program or SNAP (commonly called food stamps). We are able to regularly get food from food pantries, and get services and help from S:US. Without this support, we would not have access to sufficient food supplies or food of adequate quality to meet our needs. But as prices increase, we worry that we won't be able to afford the food we like. Access to a variety of food is especially important for those of us who have various health concerns, like diabetes, kidney failure, and mental illness. And getting SNAP or going to the food pantries carries stigma, despite these vital resources helping many people during different times of their lives.

"I get groceries at the 24-hour market near me. Sometimes I go to Costco. S:US helps me find pantries. I have a son who has autism. He has sensitivity to textures in foods, low tolerance to certain foods. His food is not the same as what I eat," said Anna. "SNAP is usually not enough to cover food. I go to pantries if I have time. Otherwise I just eat what's at home. I bring up my food issues with S:US and they help. They gave me a one-time grant to buy groceries and gave me a list of pantries in the neighborhood. If I have enough funds, it's easy to find food I like. It's just a matter of having enough funds. Fruits and vegetables cost more. I would like to get them if I had the budget."

"I go to food pantries and friends help out when I need help. I can go down to the office of my building when I need food. My case worker will bring back bread, meat, stuff like that. I also go to the supermarket across the street," said Francisco. "Usually SNAP covers all the food but sometimes it doesn't. I like to eat vegetables when I can get them, but they're expensive. Don't get me wrong, I eat meat. At times, I can get the food I like. Sometimes I get the stuff I need but not the stuff I want."

"I go to food pantries every Monday and Thursday. I can walk there. I go to the market next door for food too. I don't have trouble affording it with my food stamps. Food is usually available at the market," said Glen.

"My food situation is that I'm very grateful to get $281 in food stamps per month. We have a variety of supermarkets in the area, so usually I find that I go to the one with the cheapest prices," said Jackie. "I've been in mental health for 14 years, and I've been getting food stamps for 14 years because the three essentials are food, clothing, and shelter, correct? So, I'm very blessed that the government has given me food, clothing, and shelter for all this time. And I'm very grateful to them."

"Since I volunteer at the Salvation Army and I get food stamps, my food situation is good. I'm the only one in my apartment, so I don't have to worry about getting food or expenses for anybody else," said Wiley.

"I go to food pantries once in a while. I don't like going because it's inconvenient to go wait on the line. The selection isn't great; sometimes I go over there and waste my time. I might go to one around the corner after this. The food plan in my building and the food stamps cover everything I need," said Steve. "I normally look for food that's on sale in the supermarket and I just get that."

"My SNAP covers the food I get, but the price of food is going up. I'm surrounded by supermarkets, but they all sell the same products. The Bronx (where I live) is not one of my favorite places to get food; I don't really find things I like in this neighborhood. I'm also part of a nutritional program at Kings County Hospital where I receive services. I get treatments in Brooklyn so I usually get my groceries in Flatbush and bring them home. In the nutrition program at the hospital, we swap recipes, we do potlucks, and sometimes they have food for the holidays, so that helps. I go to the food pantry weekly," said Sherese.

Supporting Our Community

"Because I volunteer at the Salvation Army, I go to the food pantry four days a week. But that's food for other people. And what I also do is: For the people in my building that can't make it to the pantry, I pick up their ID for them, and I'll bring the food to their apartments," said Wiley. "I'm also the primary caretaker for my building's patio garden/urban farm."

S:US has urban farms at many of their supportive housing sites (including ones where several of us live), providing free fruits and vegetables, nutritional programming, and employment opportunities for people like us who are served by S:US. And they've started a community fridge project to support the community too – for a couple of us, there are community fridges outside our buildings.

Messages for Others Experiencing Similar Challenges

We've all been inspired by stories from other people who've been through what we've been through. We'd like to offer words of encouragement to other people like us.

"Don't be afraid to ask for help. If you say something, you never know what can happen," said Anna.

"If they're doing good, keep doing what you're doing. But if they're not doing good, tell them it's better to be homeless than hopeless. That's my story. Better to be homeless and hopeless, because if you're hopeless, you're just gonna stay in the streets. If you're not hopeless, you're gonna try to get off the streets," said Wiley.

"If you're working with a group of people that are concerned about you, that have helped you to live in functional maintenance, a roof over your head, something to eat, clothing, shelter, if you've managed to achieve that, my first recommendation to anyone would be: have a level of gratitude," said Jackie. "And then second of all, I would say for the same people that are working with you, to cooperate with them in order to achieve functional maintenance."

"I learned not to challenge my disability but just live it–to not just take medications but have a good support system, which S:US provides. When I go to treatment, I see a lot of people who would benefit from S:US. I hope the organization can support more people that need it too," said Sherese.

We're all grateful for the support we receive that prevents us from experiencing food insecurity, and helps us build stable lives where we can thrive.

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individuals who have a diagnosis of Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED); and individuals with a diagnosis of substance use disorder (SUD) or who have a Co-Occurring Disorder (COD). Our goal is to provide high-quality, evidence-based care directly to our targeted population by bringing the care to them and by supporting specific neighborhoods, allowing us to serve previously unreached communities. We aim to continue to expand our use of FFT services by expanding our ability to provide in-home, family-trained therapists. This dynamic model also allows us to create access to telehealth services for these communities by providing such access through the BH mobile units.

We have collaborated with community agencies and secured multiple locations for the mobile units in targeted communities for both Westchester and Rockland County. Additionally, we have collaborated with the several municipalities and community agencies for continued collaboration partnerships, ensuring our efforts are meeting the needs of the community. We have developed and continue to strengthen relationships and community partnership with numerous referral sources in Rockland and Westchester. Collectively, these organizations serve the LGBTQ+ population, minority communities, individuals with co-occurring disorders, and families and individuals living in poverty, which are the demographics we have identified as having the greatest need and benefiting the most from DTR. Through these connections, we have developed a schedule for the mobile units in Rockland and Westchester counties that maximizes efficiency and reaches clients who would not otherwise have access to quality behavioral health services.

Through our behavioral health mobile units and the increased presence of mental health services delivered right within the community, we help normalize support and combat stigma related to mental health challenges and service engagement. Additionally, through the support and presence of a Peer Specialist, we help demonstrate the value of lived experience, promote a potential professional pathway for others and reduce bias about employment opportunities for individuals living with mental health challenges.

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just as Kurt Hahn established in the 1930s. (Robinson, 2019).

In 1975, the NY Times extolled the achievements of Harvard-educated Dr. K.N. Udupa, who substantiated the mental and physiological benefits of hatha yoga, an Indian practice dating back to the 2nd century BCE. Numerous scientific studies since have supported Dr. Udupa's findings, further illuminating how yoga can promote a sense of well-being and improve physical health, reduce tension and stress, thereby enriching our psychological and emotional state (NY Times, 1975; Britannica, 2022).

Yoga does not require any special physical prowess or stamina and could easily be learned from books or video clips. However, to be certain of correct posture alignments, an introductory yoga class or two is advisable. Open-minded students will likely notice the relaxation potential resulting from this ancient practice right away (Baklouti, et al. 2023).

Deep relaxation – one goal of hatha yoga -- is even easier than walking, as it involves no physical movement at all, and is quite easy to do, although beginners may need to learn how not to fall asleep. This involves lying on one's back upon a comfortable surface, with arms and legs slightly apart, and then consciously relaxing each part of the body as completely as possible, from the tips of the toes up through to the top of the head, keeping the mind fully awake and aware. Practiced for 3000 years, this procedure is safe and reliable. After becoming comfortable with the protocol, it is possible to relax one's entire body at will in less than a minute (Baklouti).

Mindfulness, a related practice, involves comfortably sitting or lying down and purposely centering one's attention on the present moment. By focusing on the here and now, those who regularly practice mindfulness are less likely to worry, feel anxiety, have regrets, etc. Mindfulness has also been proven to be highly effective in reducing stress, lowering blood pressure, relieving chronic pain, and improving sleep (Harvard, 2023). Again, a class or two is advisable at first.

Of all the techniques presented here, humming may seem the least likely method to produce meaningful results, however, as reported by the Mayo Clinic, the scientific evidence is substantial and conclusive. Even just five minutes of humming is much more than just a self-soothing sound, as it also can reduce stress, induce calmness, and enhance sleep, as well as lower the heart rate and blood pressure and boost beneficial neurochemicals that elevate mood… and no particular musical skills are required (Goldman, 2017; Graff-Radford, 2021).

Drumming is another simple practice requiring no advanced musical talent. In many ancient cultures, villages would regularly come together to dance, chant, and make rhythmic noises with drums, sticks, rocks, and anything else that could make a sound. Beyond the ritualistic and societal associations, they also experienced the positive mental, emotional, and health benefits of drumming in a group setting, which also has since been scientifically substantiated. One ten-week study conducted by the Royal College of Music confirmed numerous positive effects of group drumming, including reducing depression by as much as 38%, and anxiety by 20%, while improving social resilience by 23% and mental well-being by 16%. These benefits were still being experienced months later (RCM, 2016).

Another self-care element that belongs on this list is limiting the intake of caffeine, and processed sugar, omnipresent substances in much of what we consume and well known for substantially contributing to anxiety, stress, and mood dysregulation. That momentary joy of a candy bar or the quick jolt from a caffeinated beverage also takes a toll on our sense of well-being in the long run. Is the momentary rush worth it?

Contact Dr. Gene Ira Katz at geneirakatz@yahoo.com or 720-339-8174 (leave confidential message). Learn more about Dr. Katz here.

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opioid overdose. Kits are readily accessible in all of our locations. Our outreach teams provide harm reduction services such as fentanyl strip testing, Narcan training, access to shelters, and support services on many other social determinants of health to New Yorkers experiencing street homelessness. Clinicians at our two clinics and satellite are trained in harm reduction, anti-stigma psychoeducation, and overcoming their own internal biases regarding medication, acceptance of relapse in persons served, and other challenges to positive countertransference. S:US is launching a Public Health Vending Machine later this year, in partnership with the local health department. The machine will provide free harm reduction products for safe use, sexual health, as well as feminine care supplies, along with information on services available.

But effective harm reduction is more than handing out Narcan kits and training clinicians.[9] Harm reduction is about ameliorating conditions that make it challenging for the person served to meet their overall life goals and recognizing that social identity reconstruction is critical for recovery[10,11,12] of people served. Effective support means demonstrating harm reduction practices daily, providing anti-racist care, and undoing systemic harm by the entire agency embodying the mission, from the front door to the services provided.[13]

Here is an illustration of how we operationalize S:US' core values to eradicate stigma using a harm reduction framework that honors the full agency of persons served:

- **Respect for all:** The staff see persons served as whole human beings whose lives matter and then in partnership with persons served, identify stages of change the persons served are in and offer interventions to meet them where they are.
- **Integrity in all actions:** Staff is aware of their institutional power and shares that by following the lead of persons served and reminding them of their role as the subject in charge of their recovery.
- **Maximizing individual potential:** Staff offers persons served all available resources to maximize safety in all their choices so they can live another day and achieve their goals.
- **Continuous quality improvement:** Staff uses strength-based approaches to remind persons served of their past successes, resilience, willpower, and commitment to recovery and motivate them to reach for far more and better.
- **Supportive culture:** The staff provides strong representation and the ability to connect through shared culture, experience, and understanding. It also means the staff has experienced the same systemic barriers and injustices as persons serve.
- **Commitment to creating opportunities for all:** Persons served are encouraged and offered the right tools to meet their life goals of acquiring jobs, becoming parents, graduating college, moving into an apartment/home, getting married, and volunteering just like people in their communities who are not living with a substance use and or mental health diagnosis.

S:US creates an environment of collective healing and empowerment by celebrating and supporting persons served and staff accomplishments, including healing care for people with mental illness, persons with substance use, those experiencing housing instability, etc. Through the complete acceptance of a person served' s full humanity, S:US creates the space where stigma is eradicated, and care is empathetic and person-centered.

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Footnotes

1. Park, J. (2021). Who is hardest hit by a pandemic? Racial disparities in COVID-19 hardship in the US. *International Journal of Urban Sciences*, *25*(2), 149-177.

2. Bagley, S. M., Schoenberger, S. F., Lunze, K., Barron, K., Hadland, S. E., & Park, T. W. (2023). Ambivalence and Stigma Beliefs About Medication Treatment Among Young Adults with Opioid Use Disorder: A Qualitative Exploration of Young Adults' Perspectives. *Journal of Adolescent Health*, *72* (1), 105-110.

3. Goffman E (1963) Stigma: Notes on the Management of Spoiled Identity. New York, NY: Simon and Shuster

4. Livingston JD, Milne T, Fang ML, et al. (2012) The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. Addiction 107(1): 39–50.

5. Room R (2005) Stigma, social inequality and alcohol and drug use. Drug and Alcohol Review 24(2): 143–155.

6. Fitzgerald T, Purington T, Davis K, et al. (2004) Utilization of needle exchange programs and substance abuse treatment services by injection drug users: Social work practice implications of a harm reduction model. In: Mancoske R, James S and Shelby D (eds) Practice Issues in HIV/AIDS Services: Empowerment-Based Models and Program Applications. NY: Routledge, pp.107–125

7. Hartwell S (2004) Triple stigma: Persons with mental illness and substance abuse in the criminal justice system. Criminal Justice Policy Review 15: 84–99.

8. Michaud, L., van der Meulen, E., & Guta, A. (2023). Between care and control: Examining surveillance practices in harm reduction. *Contemporary Drug Problems*, *50*(1), 3-24.

9. Murray, B. J., Copeland, V., & Dettlaff, A. J. (2023). Reflections on the Ethical Possibilities and Limitations of Abolitionist Praxis in Social Work. *Affilia*, 08861099221146151.

10. Hughes K (2007) Migrating identities: The relational constitution of drug use and addiction. Sociology of Health & Illness 29(5): 673–691.

11. Koski-Jannes A (2002) Social and personal identity projects in the recovery from addictive behaviors. Addiction Research and Theory 10: 183–202.

12. McIntosh J and McKeganey N (2000) Addicts' narratives of recovery from drug use: Constructing a non-addict identity. Social Science & Medicine 50 (10): 1501–1510.

13. Tóth, M. D., Ihionvien, S., Leduc, C., Aust, B., Amann, B. L., Cresswell-Smith, J., ... & Purebl, G. (2023). Evidence for the effectiveness of interventions to reduce mental health related stigma in the workplace: a systematic review. *BMJ open*, *13*(2), e067126.

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victims of crime than perpetrators. Yes, some people with mental illness are homeless or live in isolation and squalor but many live quietly with their families and friends or independently in decent housing. Yes, some people with mental illness are cut off from reality and highly dysfunctional, but relatively few. About 20% of the American population has a mental illness in any given year, and 50% will have a mental illness in their lifetime. The vast majority of them lead apparently normal lives most of the time. They work, go to school, live as part of families, have friends, have interests. Their suffering is often quiet and unnoticeable to almost everyone. Their illness often disrupts functioning to some extent, but most are able to carry on. Even people with severe and persistent psychiatric disabilities can have lives that they find personally satisfying and meaningful.

Community education efforts also focus on the effectiveness of treatment and rehabilitation. Sadly, of course, few of them get good treatment, not only because there isn't enough available but also because the stigma they, their families, and their communities carry with them keeps them from seeking professional help.

Creating Opportunities

The good news is that it appears that stigma is less widespread than it used to be. The bad news is that despite decades of community education and pressure on the media to create more realistic images, stigma is still very much alive and very damaging. It continues to have dreadful consequences for people with mental illnesses and their families.

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- As a result of stigma, some people with mental illness often feel dreadful about themselves, a kind of inner shame, and a need to hide their illness from the world or themselves.

- As a result of stigma, many people do not seek help.

- As a result of stigma, family members sometimes feel that they are to blame or that they are tainted by their family member's illness.

- As a result of stigma, it is difficult for people known to have a mental illness to get a job, to get into college, to get housing, and even to be a fully accepted member of a religious congregation.

- As a result of stigma, some children with serious emotional disturbances are excluded from mainstream education and recreational activities.

- As a result of stigma, it is exceedingly difficult to defeat the sentiment of "not in my backyard" that blocks the development of housing and other programs for people with mental illnesses in the community.

- As a result of stigma, there is a persistent belief that people with serious mental illness need protection and supervision and that many, many more of them should be confined in hospitals for long periods of time.

What Can Be Done to Address the Consequences of Stigma?

First and foremost is insisting on respect for the rights of people with mental illness. This has been done with anti-discrimination legislation such as The Fair Housing Act and the Americans with Disabilities Act. It has also been done with judicial rulings such as the Donaldson Decision in 1975 and the Olmstead Decision in 1999.

In addition, there have been policy and legal changes and program developments to address the consequences of stigma. People with mental illness have difficulty getting access to decent housing in the community; therefore, develop housing programs and develop legal tools to override community resistance. People with mental illness have trouble getting jobs; therefore, create vocational rehabilitation and jobs programs for them. People with mental illness tend to be socially isolated; therefore, create psychosocial clubs; young adults with mental illness cannot get into college; therefore, create supported education programs. People with serious mental illness have difficulty getting good medical care; therefore, develop health care programs designed for them.

These are examples of creating opportunities for people with mental illness that have been substantially closed due to stigma. All have been put into practice over the past 40+ years to some extent. More such programs are needed, of course.

In addition, there are program possibilities that so far as I know have not yet been pursued. One that I think could be very useful is a community chaplaincy program. In hospitals, chaplains are available to help patients to get the religious experiences that many of them seek. There is no counterpart in the community where, sadly, many houses of worship do not welcome people with serious mental illnesses. A community chaplain could help win acceptance of people with mental illness in the religious community.

Progress Addressing Stigma

Over the past 60 years, much has been done to help people understand that mental illness is an expectable part of human life, that treatment can be effective, that mental anguish need not be a part of one's life, and that even people with the most severe mental illnesses can recover - can, that is, create lives of personal meaning and satisfaction.

Has stigma been overcome? Not by a long shot. But we have made some progress; and with greater investment in public education, with continued vigilance about the rights of people with mental illness, the growth of effective programs, and the development of new ways to open opportunities for people with mental illness, I am confident that we can make much more.

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References

American Psychiatric Association, 2021, What are anxiety disorders? Retrieved from https://www.psychiatry.org/patients-families/anxiety-disorders/what-are-anxiety-disorders

American Psychological Association, 2023, Anxiety. Retrieved from https://www.apa.org/topics/anxiety

American Psychological Assn, 2022, Stress in America. Retrieved from https://www.apa.org/news/press/releases/stress/2022/concerned-future-inflation

Baklouti, S., Fekih-Romdhane, F., Guelmami, N., Bonsaksen, T., Baklouti, H., Aloui, A., Masmoudi, L., Souissi, N., & Jarraya, M. (2023). The effect of web-based Hatha yoga on psychological distress and sleep quality in older adults: A randomized controlled trial. Complementary Therapies in Clinical Practice, 50, 101715. *Science Direct*.

Britannica, 2022 Hatha Yoga. Retrieved from https://www.britannica.com/topic/Hatha-Yoga Ellison, J. A., Greenberg, L. S., Goldman, R. N., & Angus, L., 2009, Maintenance of gains following experiential therapies for depression. Journal of Consulting and Clinical Psychology, 77 (1), 103–112. Retrieved from https://doi.org/10.1037/a0014653

Fancourt, D., Perkins, R., Ascenso, S., Carvalho, L. A., Steptoe, A., & Williamon, A. (2015). Effects of group drumming interventions on anxiety, depression, social resilience and inflammatory immune response among mental health service users. PLoS ONE, 11(3).

Goldman, J., 2017, The-Humming-Effect

Graff-Radford, M., 2021, Humming your way to relaxation. Retrieved from https://connect.mayoclinic.org/blog/living-with-mild-cognitive-impairment-mci/newsfeed-post/humming-your-way-to-relaxation/

Harvard, 2023, Mindfulness, Retrieved from https://hr.harvard.edu/mindfulness Mayo Clinic, 2023, Depression (major depressive disorder), Retrieved from https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007

Meers, Z., 2023, Long term effects of stress and anxiety, Retrieved from https://pathways-psychology.com/long-term-effects-of-stress-and-anxiety

Ming, T.E., 2022, Can you teach a love for adventure? Retrieved from https://www.nationalgeographic.com/adventure/article/paid-content-can-you-teach-a-love-for-adventure

New York Times, 1975, India evaluating effects of yoga, retrieved from https://www.nytimes.com/1975/11/30/archives/india-evaluating-effects-of-yoga-researchers-find-practice-relieves.html

National Alliance on Mental Illness [NAMI], 2023, Anxiety disorders. Retrieved from https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Anxiety-Disorders

National Institute of Mental Health [NIMH], 2022, Prevalence of any anxiety disorder among adults. Retrieved from https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder

National Institute of Mental Health [NIMH], 2022, Major depression, Retrieved from https://www.nimh.nih.gov/health/statistics/major-depression

New York State Department of Environmental Conservation [DEC], n.d., Immerse yourself in a forest for better health. Retrieved from https://www.dec.ny.gov/lands/90720

Office of Disease Prevention and Health Promotion, 2023, Managing stress, Retrieved from https://health.gov/myhealthfinder/health-conditions/heart-health/manage-stress

Pathways Psychology Services, n.d., Climb every mountain and find your path.

Riopel, L., 2019, 26 Mental Health Exercises & Interventions Based on Science.

Robinson, S., 2019, Doctors urged to prescribe woodland walks for mental health problems. Retrieved from https://www.news-medical.net/news/20190610/Doctors-urged-to-prescribe-woodland-walks-for-mental-health-problems.aspx

Royal College of Music, 2016, RCM finds drumming has positive impact on mental health. Retrieved from https://www.rcm.ac.uk/about/news/all/2016-03-16rcmfindsdrumminghaspositiveimpactonmentalhealth.aspx

WebMD, 2021, Mental benefits of walking. Retrieved from https://www.webmd.com/fitness-exercise/mental-benefits-of-walking

World Health Organization [WHO], 2021, Stress. Retrieved from https://www.who.int/news-room/questions-and-answers/item/stress#

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Behavioral Health News (BHN) (formerly Mental Health News), published by the 501(c)(3) nonprofit organization Mental Health News Education, began as a quarterly print publication in 1999. In response to readership feedback, BHN became an online-only publication in 2021. BHN is committed to improving the lives of individuals living with mental illness and substance use disorder as well as their families and the professional communities that serve them by providing a trusted source of science-based, education, information, advocacy, and quality resources in the community.

BHN provides hope through education by collaborating with leading provider agencies and educational institutions across the US that are improving lives every day. The publication serves to unite and improve our evolving systems of care, build bridges, and increase visibility to connect consumers to quality community programs and evidence-based services, bring awareness to important policy issues, and advocate to address the harmful effects of the stigma which surrounds mental illness and substance use disorders in the community.

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