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

The Opioid Epidemic: Helping Communities in Crisis

By Thomas Olivo, LCSW
Director, Integrated Treatment Program
Outreach Recovery Center

The opioid epidemic has impacted our families, friends, and communities. The New York State Office of Addiction Services and Supports (OASAS) estimates that 1 in 13 New York State residents suffer from a substance abuse disorder.[1] Among NYS residents, the number of overdose deaths involving any opioid increased 294 percent from 2010 to 2020.[2]

The rise in unintentional opioid overdose (both fatal and non-fatal) has clearly shown that treatment options to address opioid and substance use disorders need to be more accessible in our communities. The lack of treatment options to address the opioid epidemic is detrimental to individuals who have entered the contemplation and planning stages of change. The individual seeking change should have the ability to choose from all types of treatment options, including the variety of medications used to treat opioid and substance use disorders. Treatment options for addiction have not been adequate when compared to treatment options for other diseases.

Methadone was first approved for the treatment of OUD in the 1970s. Research conducted in the years since its approval has reinforced methadone's safety and effectiveness in reducing overdose deaths, illicit opioid use, and the transmission of infectious diseases such as hepatitis C and HIV - while improving retention in care compared with treatment without medication.[3]

Although providers and clients have lists of resources and treatment programs throughout the state, accessible Opioid Treatment Programs remain scarce in many areas. SAMHSA's opioid treatment program directory lists only 139 OTPs in the state of New York.[4] This is not sufficient for a state with a population that is estimated to be 19, 677,151.[5]

On January 17, 2023, we opened our Integrated Opioid Treatment Program at Outreach Recovery Center, located in Brentwood, NY, offering an additional methadone maintenance program for our community. Since its opening, we have been able to mitigate waiting lists and offer individuals easier access to this level of care. We have been able to prevent individuals from having to spend the entirety of their day commuting to a location up to 50 miles away from their living area. Having an OTP central to one's residence allows individuals to also address other priorities such as family responsibilities, self-help, and employment.

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Behavioral Health News Spotlight on Excellence Interview with Mary Brewster, Associate Commissioner for Harm Reduction at the New York State Office of Addiction Services and Supports (OASAS)

By Staff Writer
Behavioral Health News

Watch the Interview with Mary Brewster, Associate Commissioner for Harm Reduction at NYS OASAS

David Minot, Executive Director of Mental Health News Education, the non-profit organization that publishes Behavioral Health News, interviewed Mary Brewster, Associate Commissioner for Harm Reduction at the New York State Office of Addiction Services and Supports (OASAS). The mission of OASAS is to improve the lives of New Yorkers by leading a comprehensive system of addiction services for prevention, treatment, harm reduction and recovery. In this interview, Mary discusses the importance and life-saving potential of harm reduction approaches for substance use disorders and overdose prevention.

David Minot: Hi, and welcome to the Behavioral Health News Spotlight on Excellence series, where we feature exceptional leaders and innovative health care solutions that are raising the standards of care in the behavioral health community. My name is David Minot, and I am the Executive Director of Mental Health News Education, the nonprofit organization that publishes Behavioral Health News and Autism Spectrum News. Our mission is devoted to improving lives and the delivery of care for people living with mental illness, substance use disorder, and autism, while also supporting their families and the professional communities that serve them.

Today, we're speaking with Mary Brewster, Associate Commissioner for Harm Reduction at the New York State Office of Addiction Services and Supports, also known as OASAS. Mary, thanks so much for being here today!

Mary Brewster: Thanks for having me. I'm excited to be here!

David: To start off our conversation, can you give me an overview of the new Division of Harm Reduction at OASAS? What is its mission and what is your role as Associate Commissioner?

Mary: Absolutely. I am shockingly coming up on my one-year anniversary at OASAS - time has flown by! I started with the agency in September 2022 and I'm the first Acting Associate Commissioner for our division. This division is brand new to our system of care, but I would be remiss to not say that harm reduction is not new to our OASAS system of care. It's something that our providers have long practiced. But when Dr. Chinazo Cunningham, who is our Acting Commissioner, started in the beginning of

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The Critical Role of Peer Support Programs to Sustained Substance Use Disorder Recovery

By Geoffrey Neimark, MD
Chief Medical Officer
Community Care Behavioral Health Organization

Many people who have used behavioral health services can attest to the profound benefits of connecting with someone with shared experience. Finding others with common lived experience - often referred to as peers - and learning about their challenges and resilience are particularly valuable for those in substance use disorder (SUD) recovery, as such connections offer hope validation, and frequently provide helpful wellness strategies. Recognizing the immense benefit of peers, Community Care Behavioral Health Organization (Community Care), a part of UPMC Insurance Services Division, has worked with its county and service providers in Pennsylvania to optimize the use of peers both across the provider network and within the organization. Such peer inclusion has resulted in positive outcomes and enhanced recovery for our members.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines peers as "people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment… people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process" (SAMHSA).

Over the past few decades, health systems have increasingly recognized the immense benefit of incorporating peers into the behavioral health space and have embedded peers in the recovery treatment continuum. The many benefits of peer inclusion include improved quality outcomes around engagement and retention

Geoffrey Neimark, MD

in treatment; increased follow up rates; decreased readmission rates; higher member satisfaction levels; and reduction of unplanned care costs.

Peer Support is Uniquely Valuable

The capacity of peers to engage, aid, and connect with members in recovery has been recognized across provider organizations as being highly beneficial and impactful. Community Care conducted interviews with supervisors at mental health programs across Pennsylvania that include peers in service delivery. These interviews revealed that some of the greatest values of peer support within the mental health treatment space were the peers' ability to build rapport with individuals, offer support in ways that other staff could not, and keep individuals engaged in services within their communities.

Peer Support Helps Realize Key Quality Outcomes

Among adult Community Care members who received peer services after admission to an inpatient psychiatric or SUD residential service, there was an 18 percent reduction in psychiatric readmissions and a 66 percent reduction in SUD readmissions. Larger reductions in SUD readmission were noted among adults receiving peer support substance use services versus a matched comparison group receiving outpatient service alone.

Peer Support Helps Connect People to Needed Services

Community Care's Warm Hand Off intervention was designed to link individuals experiencing a behavioral health crisis (often a near-fatal drug overdose) to effective treatments, with the aim of increasing participation in ongoing SUD treatment. Each year, thousands of individuals meet with a peer or case manager after a hospitalization or emergency care event. To date, 76 percent of those individuals were connected to SUD services within seven days, illustrating the vital role peers can play in care linkage.

Peer Run Programs Are Successful

Recovery Support Centers (RSC) are peer-led, drop-in centers designed for individuals with behavioral health and other rehabilitation needs. These centers focus on supporting individuals with complex needs. Peers at RSCs help individuals regain hope and maintain recovery. Surveyed individuals who received RSC services report feeling hopeful about their future. In addition, outcomes for individuals receiving RSC service show high self-reported levels of recovery, service satisfaction, and engagement in their care.

Peers Are an Essential Component of Community Connection

Community Care employs Certified Peer Specialists (CPS) and Certified Recovery Specialists (CRS) in various capacities. CPS support members and facilitate Community Care's Statewide Member Advisory Boards. They also provide training and support to CPS and CRS providers and staff across contracts. Community Care also employs CPS/CRS in the role of community health workers (CHWs) who are tasked with helping members access support and services within their communities. As part of their duties, CHWs meet with members at psychiatric and residential SUD facilities to assess reasons for admission, address social determinants impacting community tenure, and determine the members' motivation for ongoing treatment. Members who engaged with a CHW in 2022 as part of Community Care's community-based care management program experienced an 88 percent reduction in psychiatric hospital utilization and 79 percent reduction in residential withdrawal management compared to before their engagement in the intervention.

Peers are an integral part of recovery. By virtue of their lived experience, they are uniquely positioned to assist others in their recovery journeys. Their value is manifested in areas ranging from engagement in treatment to quality metrics outcomes. Community Care celebrates the work performed by peers and looks forward to exploring new possibilities for peer expansion and collaboration.

Community Care Behavioral Health Organization (Community Care) is a non-profit behavioral health managed care organization (BH-MCO) based in Pittsburgh, Pennsylvania. We are a subsidiary of UPMC and part of the UPMC Insurance Services Division. Community Care was created to support Pennsylvania's mandatory managed care program for Medicaid recipients, called HealthChoices. Since 1999, we have delivered behavioral health services to Medicaid recipients throughout Pennsylvania. Today, we serve over 1 million HealthChoices members in more than half of Pennsylvania's counties. More information can be found at ccbh.com.

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[1] *https://www.cdc.gov/nchs/products/databriefs/db379.htm Villarroel MA, Terlizzi EP. Symptoms of depression among adults: United States, 2019. NCHS Data Brief, no 379. Hyattsville, MD: National Center for Health Statistics. 2020.*

The Long History and Bright Future of Harm Reduction in New York State

By Mary Brewster, MSW and Dr. Kelly Ramsey, MD, MPH, MA, FACP, DFSAM, New York State Office of Addiction Services and Supports (OASAS)

Mary Brewster, MSW

Dr. Kelly Ramsey, MD

For the past year, the New York State Office of Addiction Services and Supports (OASAS) has implemented a new division among its pillars of prevention, treatment, and recovery services. The newly formed Division of Harm Reduction seeks to bring both the harm reduction philosophy and its practical strategies to the continuum of care for addiction services in NYS. Harm reduction is an evidence-based approach that is critical to empowering people who use drugs (PWUD) and equipping them with the life-saving tools and information to create any positive change. Harm reduction may not be entirely new to OASAS and many of its partners, however, the institutionalization and broad implementation of harm reduction is a considerable departure and leap forward from the history of substance use and addiction services and treatment in New York. Rooted in the Temperance Movement of the 1800's, abstinence has been the leading approach to substance use and substance use treatment. Abstinence was also seen as the only acceptable policy towards substance use nationwide. The draconian Rockefeller Drug Laws of 1974, saw among other things, the penalty of life imprisonment for possessing two ounces or more of heroin, cocaine, and cannabis. A system of punishment was created as opposed to a system of support and empowerment.

Practical in its approach, harm reduction was created to save lives and reduce disease transmission at the height of an epidemic. Harm Reduction works to empower PWUD and their communities to live healthy, self-directed, and purpose-filled lives. It accepts that each person is the expert of their own lives, and that recovery is individualized. It recognizes that abstinence from substances is not an actual requirement for full participation in society. With over 30 years of evidence-based, harm reduction services throughout NYS, mainstream embrace of the practice has been met with controversy and resistance from the very beginning.

Harm reduction approaches have been employed for decades, but really took shape in the 1980's. The first cases of what would later become known as AIDS, were reported in the United States in 1981. Observed for the first time in a cluster of people who inject drugs (PWID) and gay men, harm reduction became central in the fight to keep people alive. By 1984, half of all new HIV cases, the virus that led to AIDS, were among the PWID community. Organized by harm reductionists, syringe services programs (SSPs) were successful at preventing transmission of the virus and keeping people alive. SSPs were proven to be effective prevention programs that provided a range of services, including substance use treatment and overdose prevention education.

Launched in 1988 as a pilot project to allow for the establishment of an SSP to prevent the transmission of HIV, NYC SSPs were immediately met with controversy. The idea of providing PWID with the tools to use their substances was seen, and often still is, as "enabling their drug use". Opponents of harm reduction often believe that harm reduction is simply enabling PWUD rather than helping them use it more safely and decreasing potential harms. Due to the controversial nature of the pilot, it was shut-down after 14 months. Though it was short-lived, it demonstrated that HIV risk behaviors were modified by SSP participants. Also, in 1988 a congressional ban prohibiting the use of federal funds for SSPs was instituted. This ban was lifted in 2016 by the Obama administration. This legislation allowed federal funds to be used for SSP expenses, but still not for purchasing the syringes.

It wasn't until 1993 that SSPs were legalized throughout NYS. Since their adoption 30 years ago as a comprehensive harm reduction approach, new HIV cases among the injection drug use (IDU) community have decreased dramatically. Prior to the legalization of SSPs, IDU accounted for nearly half of all new HIV cases in NYS. Specifically, IDU was the risk factor for 57% of all new HIV cases among Blacks, 62% of new cases among Hispanics, and 58% of new cases among women in NYS. In 2022, new cases of HIV among the IDU community is only ~3%. Although SSPs have proven benefits, it is still a challenge to garner widespread support for their implementation.

The focus of many of the early harm reduction programs was HIV prevention. Founded during the crisis of the 1980-90s, harm reduction was proven to be an effective prevention strategy. With the fall of new HIV cases, came the rise of the opioid crisis in New York State. Since 2010, the number of overdose deaths involving any opioid have increased in New York. This sharp rise in fatal overdoses signaled that a shift was needed in how the community responded.

Naloxone, approved in 1971 by the Food and Drug Administration (FDA) to treat opioid overdoses, is a medication used to reverse or reduce the effect of opioids. Pioneered by the harm reduction community, NYS passed a life-saving law in 2006, making it legal in NYS for non-medical persons to administer naloxone to another individual to prevent an opioid overdose from becoming fatal. This comprehensive approach allowed for the provisions of naloxone and overdose prevention education at all SSPs and SUD treatment programs by becoming a registered Opioid Overdose Prevention Program (OOPP). Currently, over 850 registered programs offer training and provide naloxone to trained individuals.

Highly effective and safe, naloxone has saved thousands of lives from overdose. An opioid antagonist, naloxone can reverse the life-threatening respiratory depression associated with opioid overdose and block the effects of the opioids temporarily. As the opioid epidemic has continued to ravage communities throughout NYS, naloxone administration and distribution has become even more crucial. While naloxone is highly effective at reversing an opioid overdose, it is only effective if it is available and given at the time of the overdose. Research shows that when naloxone and comprehensive overdose education are available to PWUD and the community, overdose deaths decrease in those communities. In 2023, OASAS made naloxone available to all New Yorkers free of charge, expanding access to a life-saving medication.

Another core component of comprehensive harm reduction programs is the engagement of PWUD into SUD treatment services, including the initiation of medication for addiction treatment (MAT). There are only three FDA approved medications for opioid use disorder (MOUD). Buprenorphine, an opioid partial agonist, is considered a first line treatment for OUD. Buprenorphine normalizes brain anatomy and physiology, relieves physiological opioid cravings, and normalizes body functions without the negative and euphoric effects of the opioids used previously. Buprenorphine is associated with a ~50% reduced all-cause and opioid-related mortality in PWUD.

In 2002, buprenorphine became the first opioid agonist medication to treat OUD that can be prescribed or dispensed outside of an opioid treatment program (OTP). This fundamentally shifted who could treat individuals with OUD and how PWUD could engage in care. While this expanded who could prescribe buprenorphine, there were still barriers in

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Quality Integrated Care is Critical for the Recovery of Individuals with Mental Health and Substance Use Challenges

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

Integrated care works with the whole person in the world they are experiencing including their physical and behavioral health, as well as past trauma and other social determinants impacting their lives. Individuals with co-occurring disorders, when treated holistically, develop a trusting relationship with their treatment team, making recovery a reality.

The CDC reported last year that the total number of adults in the United States with both a substance use disorder (SUD) and co-occurrence of any mental health illness was 17 million (about 6.7 percent of the population) and the number of adults with a co-occurrence of an SUD and severe mental illness was about 5.7 million (2.2 percent of the population).

The cause and relationship of co-occurring disorders is unique for each individual. In some instances, chronic substance use can lead to mental illness, and in other cases, a person's mental illness can lead them to self-medicate and develop a substance use disorder.

But regardless of its origin, addressing co-occurring disorders can be challenging because of the complexity of each individual's experience. When we do not provide whole person integrated- care, and individuals receive fragmented and difficult to access services, their recovery is impaired. Services that effectively integrate mental health and substance use treatment must be available to all.

Highlights of Integrated Care In New York's Healthcare System

The New York State Offices of Mental Health (OMH) and Addiction Services and Supports (OASAS) have partnered to establish state of the art integrated care throughout our Crisis System. 988 is a universal call number for mental health or substance use crises that will provide immediate counseling and referral to additional services as needed. 988 can also connect individuals to our Mobile Crisis Teams who will go to where the person is and work together to resolve the crisis. Again, as teams expand, they are being trained to provide comprehensive integrated care.

Ann Sullivan, MD

And throughout the design and training for all services equity and inclusion for all is critical. Collaborating with underserved communities to identify policy and program needs has been a core component of crisis development in New York State. One targeted effort undertaken by OMH was to contract with a national training center to create a recipient-informed training for crisis response workers across the continuum of care that is specific to the needs and risks associated with LGBTQ+ individuals in crisis, with an even more targeted component geared towards LGBTQ+ youth, families, and older adults. In addition, a culture of treatment and practices focused on eliminating racial and ethnic bias, and ensuring inclusivity, is essential. Establishing culturally appropriate services that are available and accessible to all is a State priority.

In our Intensive and Supportive Crisis Stabilization Centers, jointly developed and licensed by OMH and OASAS, staff work with any adult, child, or adolescent experiencing a mental health and/or substance use crisis. The centers provide state of the art integrated evaluation, care, and comprehensive services in a safe and welcoming environment, 24 hours per day, seven days per week.

By providing urgent and immediate treatment, these Crisis Stabilization Centers can enable people to deal with their crisis and prevent the need for higher levels of care and unnecessary emergency room visits. The Centers have extensively integrated peer and recovery-oriented support services, as well as referral and follow-up services to ensure people continue to receive the support they need.

New York is also dramatically expanding our network of Certified Community Behavioral Health Centers, which provide nationally recognized integrated behavioral health care for mental health or substance use, regardless of ability to pay, place of residence, or age. Governor Hochul's $1 billion plan to overhaul and strengthen the State's mental health care system includes the tripling of the number of CCBHC's in New York from 13 to 39, to eventually serve an additional 300,000 New Yorkers.

CCBHCs have been developed across the country because they treat the whole person, each person's physical health, behavioral health, social and life needs. They are required to provide a comprehensive array of behavioral health services, so individuals don't have to piece together the support they need across multiple providers. They also provide care coordination to help people navigate behavioral health care, physical health care, social services, and the other systems in which they may be involved. CCBHC's are expected to provide peer services, counseling, and family support. The availability of peer services is an important element for all programs to ensure that clients have the opportunity to engage with those with lived experience throughout their recovery. Peers teach skills, share their unique understanding of the system, partner with other team members, model recovery, and assist individuals in developing their own recovery plan.

OMH has surveyed clients of CCBHC's and received many positive reviews, including: *"The first time I came to [the CCBHC] I wasn't ready to accept help for both mental health and substances, I only wanted to talk about my problems with substances… but as I started meeting with my counselor she explained how it would be good for me to learn about both so I started thinking about what I could do for my mental health more….When I went to other programs in the past I didn't have to talk about my mental health so that was new for me…"*

Another client said: *"…I was getting treatment for my depression and addiction for the past three years. I was stubborn at first, I didn't want to do anything but talk about my addiction, but they told me I should think about how my depression was making my life harder and eventually I started talking about that too. I started seeing a therapist and going to group (therapy) here…"*

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An Overview of Family-Based Substance Use Therapy

By Jordan Baker
Content Marketing Manager
Relias

Historically, individual therapy and group-based treatments have been the predominant modalities used in substance use disorder (SUD) treatment programs. However, there has been increased recognition among researchers, clinicians, and clients of the importance of family structure and how it plays a role in either maintaining or decreasing individual family members' substance use.

The Importance of Family-Based Substance Use Disorder Therapies

Family-based SUD therapies are not meant to help the person coping with addiction, but rather to help their families learn the behaviors and responses they need to adopt regarding a family member's addiction. This presents two main benefits to the family unit in therapy: they learn how to cope with their own feelings about their loved one's addiction and they learn how to help their loved one heal from their addiction as a family unit.

The importance of this type of therapy is only growing as the numbers of Americans dealing with SUDs continues to climb. Indeed, the number of Americans who died from an opioid overdose increased by six times between 1999 and 2021 (CDC, 2023). And this is just one example of the SUD crisis facing American families.

Due to the increasing regularity of SUDs in American society, 10% of children under the age of 18 live, or have lived, with at least one parent living with a SUD (American Addiction Centers, 2023). Through family-based SUD therapy, these children and their families can work toward a better future.

In the following section, we'll outline what you, as a behavioral health professional, need to keep in mind when your organization offers these types of services for families and clients.

Core Principles of Family-Based Therapies

According to SAMSHA (SAMSHA, 2020), all types of family-based SUD therapies share seven core principles that make them effective:

1. Perceive the importance of therapy on both the individual coping with a substance use disorder and the family of that individual.

Jordan Baker

2. Use a cooperative approach that does not place blame. This emphasizes the avoidance of authoritative and/or confrontational approaches to a family-based SUD therapy.

3. Discover harm-reduction strategies aside from or in addition to sobriety. These strategies should bring positive holistic health benefits to both the individuals in therapy and their family.

4. Include the wellness of the family, on top of the individual coping with SUDs, in the goals of the therapy.

5. Accede to the importance of family and friend relationships in the lives of individuals in therapy and how these social networks enable recovery.

6. Incorporate the family's cultural and community values into the therapy where appropriate.

7. Acknowledge the chronic and complex nature of substance use disorders and treat the family therapy in the same manner you would treat therapy for other serious conditions.

Effective Models for Family-Base SUD Therapies

Now that we have a basic understanding of family-based SUD therapies, let's explore a few of the methodologies available to mental health professionals. While this section is not exhaustive, it covers several of the more popular models of family-based SUD therapy and can serve as a starting point for your learning journey on the topic.

Community Reinforcement and Family Training

Community Reinforcement and Family Training (CRAFT) is an approach that helps families and friends get support for loved ones who have a SUD. CRAFT is a skills-based program that addresses the multiple areas of a family's life including self-care, problem solving, goal setting, and pleasurable activities.

CRAFT teaches loved ones behavioral and motivational strategies for interacting with their loved one who has a substance use disorder. The goals of CRAFT are (Roozen et al, 2010):

- Helping families to encourage their loved one to get treatment
- Reducing the loved one's substance use
- Improving the lives of families and friends who are concerned

Family Treatment Court

Family treatment courts (FTCs) are a collaborative approach to serving families with SUDs who also have children within the child welfare system.

A multidisciplinary team, including staff from SUD treatment programs, behavioral health agencies, child welfare, and other community agencies, come together to support the family. FTC provides the caregiver with the opportunity to abstain from substances as well as providing parenting support.

FTCs assess participants for intimate partner violence, trauma, and other mental health conditions in order to make appropriate treatment referrals. Families who participated in FTC were more likely to be reunified. Parents who participated in FTC were also more likely to stay in treatment (Center for Children and Family Futures and National Association of Drug Court Professionals, 2019).

Family Systems Model

There can be power and unison in a family system that can play a positive role in an individual's recovery from substance use disorder. In some instances, however, the family system can resist or interfere with the individual's efforts to make a positive change.

Also, the substance use problems of one family member can co-occur with family discord or another member's substance use, which can lead to greater family breakdown.

Making sense of these various dynamics is very challenging, and therefore knowledge of the Family Systems Model (Ackerman, 1984) is imperative. This model stresses the influence that family members have on another and views the family unit as a complex social system. Therefore, it can prove useful for understanding how many presenting behaviors, including substance use issues, affect the entire family.

Wrapping Up

Substance use disorders are never an easy thing for families to cope with. Not only do family members watch their loved ones struggle, but they, too, can experience various forms of trauma as a result. For behavioral health professionals, family-based therapies can help unravel the complex social interactions taking place within the family unit, allowing the members of the family to begin the healing process.

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Unlocking Success: 6 Ways Technology Enhances Substance Use Disorder Treatment and Access to Addiction Recovery Care

By Heather Martinez
Director of Specialty Solutions - Behavioral Health
NextGen Healthcare

In today's competitive market, for-profit addiction recovery organizations can employ sophisticated IT solutions to engage clients more effectively while streamlining operations and reducing costs. The right technology can radically transform an individual's path to recovery and ensure long-term organizational success. In this article, we'll explore six ways innovations in technology are revolutionizing addiction recovery and providing crucial access to potentially life-saving services.

1. Practice Management: Building a Strong Foundation

In the competitive addiction treatment industry, innovation is key to establishing a solid infrastructure, granting clients convenient access to services, and ensuring the efficiency organizations deserve. While many treatment centers accept health insurance, navigating the complexities of coverage can be challenging. It's crucial to detect and rectify claim errors promptly. This can include assessing your accounts receivable, managing month-end closing procedures, analyzing your payer mix, and leveraging customized financial reports to ensure a healthier cash flow.

A reliable practice management solution slashes time-consuming tasks and helps detect claim errors early. Seek a practice management platform that harmonizes your workflow across the revenue cycle, enabling your organization to operate more efficiently while providing real-time data and key performance indicators essential for informed business decisions.

2. Revenue Cycle Management (RCM): Optimizing Your Financials

Heather Martinez

Insurance coverage for for-profit substance use disorder (SUD) organizations can be perplexing. It's vital to consider the value of implementing new technology solutions in recovery facilities and how these investments can enhance long-term recovery rates.

Enabling swifter, more efficient revenue cycle management is critical to maximizing financial results. Opt for a solution or services company fostering efficiency and enforcing robust financial control mechanisms using established checks and balances. With an effective RCM services partner, your organization can reduce time and costs associated with resolving claims, denials, and accounts receivable (A/R) challenges. This approach can help your organization allocate fewer resources to operations management while increasing collections.

3. Medication-Assisted Treatment: Streamlining Evidence-Based Therapy

Evidence-based therapy such as medication-assisted treatment (MAT), combining therapy with medications like methadone, buprenorphine, or naltrexone, are commonplace at addiction treatment centers. In-person and telehealth services are employed to monitor and support individuals undergoing MAT, making treatment more convenient and accessible. It's vital to ensure your IT platform integrates software like Methasoft - a methadone dispensing system - to guarantee compliance with regulatory requirements and enhance communication, reporting and efficiency.

4. Interoperability: Safeguarding Client Information

A secure, comprehensive database for storing and swiftly accessing protected client information ensures the right care, dosages, and treatment protocols are administered to the correct individuals. For larger, multi-state treatment centers, maintaining a centralized database for client information is paramount. Securely managing and sharing client records among various providers ensures seamless continuity of care. Don't underestimate the importance of data security and privacy in technology-assisted recovery and the protection of sensitive information. Ensure your IT platform is secure and meets regulatory demands.

5. Patient Engagement: Overcoming Geographical Barriers

Teletherapy, powered by client engagement technology, eliminates geographical barriers, offering the convenience of tailored therapies without extensive travel. Whether the sessions are one-on-one, group-based, or a combination, individuals can participate from the comfort of their homes. The right software streamlines online scheduling, virtual sessions, and online payments. A virtual platform enables quick interventions that can prevent relapses and medical emergencies.

6. Embracing Mobility: A "Digital Front Door" to Recovery

Online access is reshaping SUD care. By creating a 'digital front door', clients can be empowered to engage and take charge of their treatment effortlessly. Solutions prioritizing health, safety, consumer demand, privacy, and efficiency can attract new clients while ensuring competitiveness.

To meet rising expectations, consider establishing new avenues for communication. Tools are available to enhance dialogue and keep clinicians and staff synchronized throughout the client journey. Electronic health record (EHR) software accessible from mobile devices, such as smartphones or tablets, is ideal. It enables scheduling appointments, processing online payments, and conducting virtual visits - offering convenience and productivity. Mobile apps designed for tracking sobriety, providing daily inspiration, or offering crisis intervention promote additional opportunities to enhance care and significantly enrich lives.

By harnessing these innovative IT solutions, for-profit addiction recovery organizations can make a profound impact on their clients' journeys to recovery while ensuring efficient and sustainable operations for years to come.

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Focus on Addiction Psychiatry: An Interview with Petros Levounis, MD, President of the American Psychiatric Association (APA)

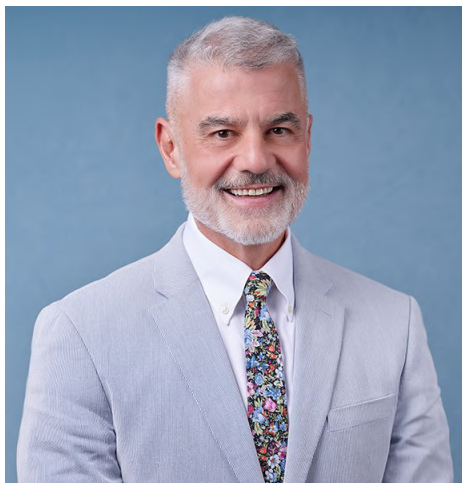
By Rachel A. Fernbach, Esq.
Executive Director and General Counsel
New York State Psychiatric Association (NYSPA)

The following are excerpts of an August 21, 2023, conversation with Petros Levounis, M.D., current President of the American Psychiatric Association. This interview has been edited for clarity.

First, congratulations on your new position as President of the American Psychiatric Association (APA). Can you tell us a little about your presidential theme of addiction psychiatry?

The APA presidential theme this year is "Confronting Addiction from Prevention to Recovery." Preventing and treating addiction is an everyday part of our work in psychiatry, but, to my knowledge, it has never been elevated to a presidential theme and it is certainly time to put it in the forefront of our thinking. Of course, the fact that I am an addiction psychiatrist was also a key factor. As part of my presidential theme, I have chosen to focus on four distinct campaigns, one for every three months during my term. These four campaigns are (i) vaping; (ii) opioid addiction, which coincides with Recovery Month in September; (iii) alcohol addiction, which coincides with the winter holidays when many people struggle with alcohol and other substances; and (iv) technological addictions, an emerging area of addiction psychiatry, which affects many of our young people. These campaigns will be publicized using a variety of tools, including innovative animation products to be posted on social media and in other media avenues, special articles and features in Psychiatric News, and interviews with major media outlets.

I imagine these priorities were informed by your background in addiction psychiatry. Can you tell our readers a little bit about why you chose to pursue a fellowship in addiction psychiatry as part of your medical training?



Petros Levounis, MD

When I was an undergraduate student, I majored in chemistry, which was not a popular pre-med major at the time. I chose chemistry because of my love for molecules and small things, which attracted me to organic chemistry, specifically. During medical school, I also completed a masters in sociology as I was interested in public policy and other factors that impact society. If you combine molecules and smaller things with culture, society and policy, that pretty much points directly to addiction psychiatry. Also, addiction is a psychiatric subspecialty with many connections to general medicine because intoxication syndromes and withdrawal syndromes are very close to topics in internal medicine. My father was a brilliant internist and I have always been quite attracted to the general medical side of our work.

Perhaps even more important than any of these issues are the patients themselves. I find caring for patients with addiction to be one of the most gratifying and rewarding aspects of my work. Individuals with addiction are some of the most disenfranchised and outcasted members of our society and there is so much misinformation about addiction treatment out in the world. When a patient receives quality treatment, whether through psychosocial interventions or medication interventions or both, they often do so well that the distance travelled between where the patient starts and where the patient ends is remarkable. Working with this population truly allows you to impact lives, and I have found that to be one of the most astounding aspects of my professional career.

Our readers would love to hear more about the APA's anti-vaping campaign.

There are several components to the dangers of vaping. First, many people, especially young people, do not appreciate that most vaping products contain nicotine. As we know, nicotine is one of the most addictive substances in existence. The way vaping products are advertised and marketed to young people is very misleading, particularly with respect to flavoring. A federal law was passed outlawing flavored vaping products. However, this law left a dangerous loophole which permits disposable vaping products to continue to be offered in multiple flavors. The APA is strongly advocating that flavors in all types of vaping products be prohibited. Flavored products give the image of being benign and natural, which is absolutely untrue. Using the appeal of certain flavors and scents is nothing more than a marketing ploy to lure young people to these dangerous products.

Further, vaping products are also very dangerous from a medical perspective because they contain heavy metals and other toxic substances that can result in direct tissue damage and harm. The fact that vaping products not only contain nicotine but can also cause other harm to our bodies is hugely underappreciated.

Finally, there appears to be a widespread misunderstanding that switching to vaping is a good and safe way to quit smoking cigarettes. This is simply not the case. There are plenty of other excellent FDA-approved interventions for smoking cessation, including medications (such as varenicline and bupropion), the nicotine patch, nicotine gum and other safe nicotine replacement therapies. These approved interventions, and not vaping, are the safest and best way to quit smoking.

One of the most interesting topics you have chosen to focus on is addiction to technology. We all joke about being permanently attached to our phones and other technology, but please tell us more about this type of addiction.

The vast majority of people who engage with technology will not become addicted to it, and there are many beneficial aspects to technology in both professional and recreational arenas. We are not trying to discourage positive use of valuable technology. However, we estimate that somewhere in the range of 3-5% of the population will end up meeting criteria for an addiction to technology. At present, addiction to Internet gaming is one of the best studied technological addictions. Technology addiction has now been included in the International Classification of Diseases and has been flagged in DSM-5-TR as a diagnosis for further study. I wouldn't be surprised if it is officially included in DSM-6. Other concerns include addiction to cybersex, social media, internet gambling, texting, and emailing, and online auctions and shopping. Current treatment modalities for technological addictions are primarily psychosocial. At this time, there are no specific FDA-approved medications directly focused on treating technology addictions, but psychiatrists can use medications customarily used to treat co-occurring psychiatric disorders. Between one-third to two-thirds of people with technology addiction will also have another psychiatric disorder, similar to figures for substance use disorders. Expertise in substance use disorder informs our current work with patients with addiction to technology.

see Psychiatry on Page 38

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When Happy Hour Isn't Always So Happy: One Clinician's Point of View

By Jose Cotto, LCSW
SVP, Residential Treatment
Institute for Community Living (ICL)

I am sure many of us reading the words "Happy Hour" get a little excited: as a time to socialize, network, and let loose. For some, it's a chance to be an extrovert - while an invisible cloak helps suppress insecurities, fears, and worries.

For many, in fact, happy hour is not really very happy. Instead, it often serves as an escape from a grueling current reality or long-ago experiences of pain and anguish.

Substance use occurs at different levels. Many of us are familiar with happy hour as a single event you take part in once in a while - what happens when it's an almost-every night occurrence? Or when we go way past that "hour" - make a night of it and discover the next morning many unexplainable charges in your bank account; or you're getting into work late more and more, feeling crappy because your body is still intoxicated the following day or you're getting more irritable with others?

This is when we know happy hour is no longer very happy - it goes from "fun and games" to something increasingly unhealthy.

Of course, we all have unhealthy habits, right? Or aren't living our healthiest life. How many times have you made plans to go to the gym weekly but only made it a few days out of the year? I'm raising my hand.

How many of us announced we'd get rid of soda or cut back on social media usage? How many of you have fallen in love only to see the relationship become toxic – yet you stayed? Love can turn into an addiction – like all addictions -- that is very difficult to break.

What if I told you that substance use, especially one that has gone on for years, has actually kept people alive? Has been a supportive "friend" and sometimes has felt like a life saver. I know many people whose substance use has enabled them to live through longstanding trials and tribulations. For these survivors, without substances, those negative experiences would have been too overwhelming, they would have drowned in their sorrows.

Change isn't easy regardless of how much we know we need to make changes.

That's where meaningful and accessible help comes in and where we at ICL come in.

Not only do we have specific services to support people in breaking their addictions (see sidebar on our new Hope & Recovery Center) but like all of our work, our addiction services are grounded in a fundamental understanding about the importance of human connection. As humans, connecting with others is an innate need and desire. At ICL, this understanding translates into working together to help a person believe again in themselves and remember the experience of joy.

Making this human connection plays a critical part in the journey from substance use gone wrong to full health and recovery. But it can be easily overlooked by a culture that assumes a substance use problem – and dealing with it - as a person's individual "choice." We tend to keep our

Jose Cotto, LCSW

distance, both in our professional and personal lives. Witnessing addiction can activate our moral compass, we pass judgment and forget that in a variety of ways, we all have unhealthy habits or addictions that can easily grow out of control.

People presenting with substance use issues are often viewed as "sinners" which somehow justifies the consequences that are imposed such as very high (and automatic) prison sentences for possession of insignificant amounts of a substance. This further marginalizes people - feelings of isolation and powerlessness take over and can worsen their addiction. We're punishing, instead of helping – so contrary to how we generally respond to people struggling with other medical conditions.

And our profession is not always ready with open arms to help. When a physical health or mental health provider learns that someone referred to their organization is struggling with substance use, they generally assume the person will require a higher level of care and is not "appropriate at this time" for their service. Even our licensing exams require that we bypass engagement and immediately send people showing signs of addiction to detox or a hospital when they may well not be ready for either of those intensive settings.

The stigma around substance use is so great that a very small percentage of behavioral health workers dedicate their careers to its treatment; as a result, resources are few and far between compared to other areas of physical and mental health.

Why is this such a common reaction, even for practitioners otherwise compassionate and ready to take on a myriad of challenges? The explanation starts with a lack of understanding about trauma and the critical importance of hope in successfully overcoming addiction.

I am proud to be part of the leadership team at ICL, an organization whose work is centered in trauma treatment and the many and varied factors that shape a person's life. Throughout the organization's more than 125 programs, this approach is grounded in a whole health model and principles referred to as TRIP – trauma-informed, recovery-oriented, innovative, and person-centered.

What this approach reflects - so important in addressing all health issues but especially in the realm of substance use – is an understanding of all factors (micro, mezzo, and macro) that lead to unhealthy substance use and utilizes practical and meaningful resources to move forward. At ICL and in particular in our East New York Health Hub where a full array of integrated services are available - we're looking beyond an individual's physical/mental health needs and at how Social Determinants of Health i.e. housing, food security, education and/or employment, and social network have brought the person, their natural supports and community to this point. That understanding is incorporated into a recovery plan and the full array of services offered. As a result of the organization's implementation of the whole health model, our Health Hub, just five years since opening, is one of the nation's most comprehensive health centers and has proudly added a state-licensed substance use disorder clinic to our mix of services.

We have the tools to treat substance use and addiction, but we have to find the will – and the resources – not only to offer more of it to the people who need it but provide it in the most effective way possible. At ICL, our integrated approach supports us as practitioners to help individuals confront – and overcome – even the most seemingly intractable challenges.

ICL Hope & Recovery Center Offers a Brighter Future

Earlier this year, ICL proudly opened the Hope & Recovery Center, an outpatient substance use disorder treatment and recovery program. A crucial component of our whole health service at the ICL East New Health Hub, the Center is an OASAS-licensed clinic offering a wide range of recovery and harm reduction Services.

The Hub offers integrated physical and mental health care, as well as resources for families and children, such as a food pantry and art studio, all under one roof. Now, individuals coming to the Hub can receive substance use disorder treatment along with primary care, psychotherapy, medication management, social rehabilitation, and more.

The need for substance use disorder treatment has never been greater. Many people struggled with isolation and anxiety during the pandemic, exacerbating mental health and substance use difficulties. The overdose crisis has reached historic levels - 2,668 individuals died of a drug overdose in New York City in 2021, an increase of 78 percent since 2019 and 27 percent since 2020. Alcohol-related deaths increased by 25 percent nationwide from 2019 to 2020.

To address these troubling trends, the Hope and Recovery Center offers trauma-informed interventions based on each person's needs and goals. Clients can access medication-assisted treatment; a variety of counseling services, including for family members and partners; overdose prevention training, and more. Everything at the center happens in a compassionate, safe, and nurturing environment.

"Often those we work with at ICL are high-need individuals who may struggle with multiple challenges, such as mental health and substance use, and they often face increased barriers to accessing care," said Jody Rudin, President and CEO of ICL. "With the Hope and Recovery Center, people now have a place to go for direct, coordinated support in their recovery journey. The Center reflects ICL's commitment to integrated, whole-person care focused on addressing an individual's physical, mental, and social well-being."

Drucilla Williams

The Center's dedicated team of professionals has a wide range of expertise. There are medical providers, psychiatrists, family therapists, licensed social workers, licensed mental health counselors, certified alcohol and substance abuse counselors, and peer advocates, all working in coordination to help patients achieve lasting changes.

"Hope is the most important thing for people recovering from a substance use disorder. Our goal at the Hope and Recovery Center is to work with each participant to create individualized plans to meet them where they are in their own recovery journey," said Drucilla Williams, vice president for addiction services. "Recovery is seldom a linear path and can look different for everyone."

To learn more about the Hope & Recovery Center and all ICL services contact us at (844) ICL-HOPE or email iclhope@iclinc.org.

Welcome to ICL's New
Hope & Recovery Center

An OASAS-licensed program for people struggling with substance use

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It is ICL's mission to help New Yorkers with behavioral health challenges live productive and fulfilling lives by providing comprehensive housing, health care, and recovery services. We take a trauma-informed approach — meeting the people we serve wherever they are, working together to support them in achieving their goals.

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Harm Reduction in Treatment: A Simplified Overview

By Meryl Camer, LCSW-R
Vice President, Clinical Services
WellLife Network

In the past, harm reduction was mainly associated with distributing clean needles to prevent the spread of infectious diseases. According to the Centers for Disease Control and Prevention (CDC) (2022), there were over 100,000 deaths related to drug overdoses in 2022. Treatment has evolved to include methods like Medication-Assisted Treatment (MAT) and Naloxone distribution to decrease opioid overdose risks. Harm reduction now covers a broader range of services beyond these tangible aids.

The current state of behavioral healthcare calls for a significant change among providers. The primary goal is to minimize harm, although some confusion exists over the exact definition of a harm reduction approach. Sadly, only 1 in 10 people with substance use disorders receive proper treatment. Challenges like COVID-19 and staffing shortages have made it increasingly difficult for providers to maintain adequate resources and attract experienced practitioners.

It's crucial to offer low-barrier solutions for those seeking help, but without enough practitioners, this becomes challenging. Harm reduction emphasizes the importance of respecting an individual's autonomy and addressing their unique needs.

To ensure person-centered treatment is more than just talk, clear policies and procedures need to be in place. The focus should be on supporting individuals with their goals and not punishing them. Providers must continuously adapt their strategies based on medical necessity, evidence-based approaches, and clinical assessments.

Meryl Camer, LCSW-R

The introduction of telehealth due to COVID-19 has expanded service access, but it should not replace in-person treatments completely.

WellLife Network offers a wide range of flexible treatment options tailored to each person's needs and preferences. They provide Naloxone training and kits as part of their Opioid Overdose Prevention Program and apply evidence-based practices to deliver effective care.

Furthermore, WellLife addresses the needs of various demographics such as women, LGBTQ+ individuals, people with co-occurring disorders, and more through specialized programs. Peer services also provide support by connecting people with self-help groups in the community.

Practitioners are readily available to assist families throughout an individual's treatment, and they provide same-day access to services with walk-in hours. This way, people struggling with substance use disorders receive the compassionate care they need to overcome their challenges.

The Prevention Program plays a significant role in educating and preventing addiction in communities. Schools use scientifically-proven resources to teach middle and high school students about addiction prevention. Educational talks within the community work towards breaking down stigmas and raising awareness about addiction. Moreover, social media campaigns help bring attention to prevention methods for a wider audience. All these efforts are closely monitored under the watchful eye of our Medical Director. The Prevention team keeps track of important data reported to the Department of Health and ensures clinical staff are properly trained to give out Naloxone training and kits.

WellLife Network's substance use programs play an essential role in promoting harm reduction strategies for individuals struggling with addiction. This comprehensive approach not only saves lives but also fosters a non-judgmental and compassionate environment. Through education, counseling, and various treatment options, the program empowers people to take control of their recovery journey while minimizing the adverse impacts of substance use on their lives and the community. At WellLife Network, harm reduction not only improves the overall health outcomes and well-being of those struggling with substance use but also empowers them to rebuild their lives with dignity, purpose, and hope.

For more information about WellLife Network's substance use programs or Naloxone training call: (631) 920-8324

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Opioid Settlement Funds an Opportunity to Strengthen Services

By John J. Coppola, MSW
Executive Director
NY Association of Alcoholism and Substance Abuse Providers (ASAP) / InUnity Alliance

The tragic loss of life and the impact of addiction on families and communities has been escalating in New York State annually almost every year for well over a decade. New York State's response has been inadequate and lives have been lost as a consequence. We believe the Magnitude of Response Must Equal or Surpass the Magnitude of Overdose/ Addiction Crisis.

Because of a strong federal response to the COVID-19 pandemic and our nation's addiction and overdose crisis, and because of New York State's aggressive action holding corporations responsible for behaviors that fueled the overdose and addiction crisis, new funding is available to support a strong prevention, treatment, recovery, and harm reduction effort. New federal funds and opioid settlement funds, which will be available for many years, provide New York State with an opportunity to launch a strong, sustained effort to address the epidemic levels of addiction and overdose that plague New York families and communities.

ASAP, currently merging with The Coalition for Behavioral Health to form InUnity Alliance, working with substance use disorder prevention, treatment, recovery, and harm reduction service providers; mental health service providers, and stakeholders from across New York State, have generated a comprehensive list of funding and service needs to guide deployment of federal funding and settlement funds in a manner that addresses current community needs and remedies structural weaknesses caused by historic underfunding.

John J. Coppola, MSW

ASAP and The Coalition have created the InUnity Alliance Policy Center as a centerpiece of its merger. The InUnity Alliance Policy Center will work with the Opioid Settlement Fund Advisory Board to ensure that the magnitude of services supported by newly available funds match the magnitude of the addiction and overdose crisis.

Guiding Principles

The InUnity Alliance is using the following Guiding Principles as a foundation for the development of our recommendations and encourages the Opioid Settlement Fund Advisory Board to use these guiding principles in their work:

- The magnitude of NY's response to record levels of overdose and addiction must be strong enough for every community to have access to SUD services *on demand*
- Justice, Equity, Diversity, and Inclusion should be used as a prism for funding decisions
- Reimbursement/funding must be sufficient to cover the full cost of delivering services
- Ensuring adequate staffing for SUD prevention, treatment, recovery, harm reduction, and mental health programs must be a priority.
- Funding from opioid settlements, federal block grant increases, and taxes on opioids and marijuana should be allocated in an equitable manner that responds to the diverse needs of communities and regions with emphasis on communities and people who are underserved and experience health disparities
- The Opioid Settlement Fund should be considered an ongoing funding source that can be used for ongoing projects and services. The work of the Opioid Settlement Fund Advisory Board will span close to two decades. Opioid Settlement Funds should not be considered one-time funding. They are long term funds that can be used to correct historic underfunding and inequity, structural racism, and a history of failure to meet the magnitude of the problem with a solution of equal or greater magnitude.

Recommendations

Opioid Settlement Funds should be allocated for the following prevention, treatment, recovery, and harm reduction services priorities:

1. Workforce Crisis
2. Fiscal viability of all service providers

see Settlement Funds on Page 36

New Tool Deployed to Help Veterans

By Elisabeth Kranson
Director
New York Certification Board

The prevalence of suicide, addiction to alcohol and other drugs, homelessness, unemployment, incarceration, physical and mental health challenges, and the need for health and social services is disproportionate among Veterans compared to the general population. Among Veterans, one in six who served in Iraq/Afghanistan have a substance use disorder, one in five suffer from PTSD and/or a major depression; in 2021, more Veterans died by suicide than were killed in 10 years of war. Veterans have many challenges when they are reintegrating into the community where they live. Despite the alarming level of need and demand for services, Veterans and their families are considered an *under*-served population because so many have not received the care they need and deserve.

All too often, Veterans and their families have had to rely on support generated by community-based organizations and volunteers. Thanks to the vision, advocacy, and perseverance of people and organizations committed to supporting Veterans and their families, there is hope and a path forward that can help Veterans to attain the health and happiness they deserve.

Elisabeth Kranson

A Visionary Response

At the Alcoholism and Substance Abuse Providers of New York State's (ASAP) Veterans Summit in Tarrytown, New York in 2019, Malik Hutchinson, a member of ASAP's Veterans Committee, expressed concern about inadequacies in the infrastructure needed by Veterans navigating the transition from military to civilian life. The Veterans Administration system helped some, but many Veterans were falling between the cracks. Malik was very concerned that Veterans suffering with addiction and/or mental health issues were at greatest risk for not getting the help they needed. He strongly advocated that a service should be developed where Veterans could be helped by people who understood their needs better than anyone else … other Veterans. The ASAP Veterans Committee took up the cause and the vision that Malik had created at the Veterans Summit became their vision as well.

At the request of the ASAP Veterans Committee, the New York Certification Board agreed to develop a Veteran Supported Recovery credential that could serve as a catalyst for Veterans to get the support they needed. With seed funding from the Mother Cabrini Foundation, the New York Certification Board (NYCB) began the work to develop a Veterans specific credential in March 2020. A group of subject matter experts composed of Veterans, military personnel, peer recovery professionals, and experts in peer certification, was convened to create the Veteran Supported Recovery (VSR) credential and a separate group of expert trainers was convened to develop the curriculum that would be used to train peers. While the training was designed to provide peer professionals with a solid foundation specific to working with Veterans, it was also designed for others who have an interest in working with Veterans. The VSR training was designed to broaden the knowledge/skill base of other professionals (including social workers, mental health counselors, and a broad range of professionals and volunteers) to better serve Veterans. Upon completion of the work to create the Veteran Supported Recovery credential and training curriculum, the ASAP/New York Certification Board VSR program was launched on Veterans Day 2021.

Strengthening Our Workforce

The New York Certification Board designed the Veteran Supported Recovery initiative for certified peer professionals who want to strengthen their knowledge and skills and attain the VSR specialty certification. The training curriculum is also designed for others looking to strengthen their work with Veterans and receive continuing education credits. The VSR Training and Certification Program includes a five-hour training module, required for certification candidates who are not veterans (now available online). This module is designed to give non-Veterans a more complete understanding of military culture, jargon, and values. The core 20-hour VSR training (available here) is designed to help people who work with Veterans and their families to strengthen their alignment with the

see Veterans on Page 36

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- Self-paced, sequential online training program builds on core competencies of Substance Use Disorder peer professionals, including Certified Addiction Recovery Coaches, Certified Recovery Peer Advocates and other recognized peer credentials nationwide
- Modules designed for military and to orient non-military
- Designed to serve as foundation for VSR specialty certification, but also to broaden the knowledge and skill base of professionals to better serve Veterans in Substance Use Disorder/Behavioral Health recovery
- Emphasizes person-centered, non-clinical approaches to building the Veteran's recovery capital and a sustainable life in recovery
- Expected to gain traction statewide & nationally as an important and accessible in-service training for anyone serving Veterans populations

Caring for Yourself: Learning to Live with a Substance Use Disorder

By Tia Dole, PhD
Chief 988 Lifeline Officer
Vibrant Emotional Health

Substance use and misuse have reached epidemic proportions across the United States. In a 2020 survey, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that more than 40 million individuals across the country over the age of 12 have a substance use disorder, with over 140,000 alcohol-related deaths per year (CDC, 2018). These numbers are staggering. As a clinician, many people ask me why individuals become addicted to substances (and there tends to be a lot of feeling behind that question). I can only say that there is no one answer. Sometimes, it's accidental, and a person can be prescribed medication that leads to addiction. For others, they are escaping what is happening in their lives. People can also experience a slow slide into more dangerous drugs simply because they are having a good time. Addiction looks different for everyone, and the etiology of it is as individual as any person's trauma. However, Substance Use Disorder is NOT a failure of character. Drugs and alcohol are *created* to make you feel good and can be addictive. That is its purpose. Unfortunately, the individual who is addicted is likely the one who will need to get themselves out of the addiction.

Tia Dole, PhD

One of the most challenging aspects of substance use and misuse (besides the obvious) is stigma. People struggling with substances often face an incredible amount of judgment from providers, friends, family and even co-workers. Folks who are addicted often internalize those same judgments - targeting one's willpower, personality, and abilities - and use them as a weapon against themselves, which can lead to giving up on the road to recovery. Additionally, different substances carry with them different perceptions - if you are addicted to fentanyl, you will be treated differently by others than if you were to be addicted to Xanax. In fact, different versions of substances carry with them different legal penalties (e.g., crack versus cocaine) thatare rooted in systemic racism. The perceptions of drug use and substances are related to class, race, and a whole host of societal factors that you, as the addicted person, have no control over. So, what do you have control over? Two things: 1) The help you seek and 2) how you approachyour own addiction. Caring for yourself as a person addicted to substances starts with *care* - thebelief that you are a person who deserves help.

As a clinician, I hear people say all the time, "That person needs AA!" Of course, we know that Alcoholics Anonymous is an abstinence-based program with religious/spiritual elements thatmay not work for everyone. For some people, abstinence is not the goal; reducing the amount of usage is what we are striving towards (e.g., Harm Reduction). So, back to the first point: "The Help You Seek." No one thing helps everyone. Are you looking to reduce usage? Do you want to go cold turkey? Do you want to connect with others during your journey? Do you have insurance? There are many questions that you can ask yourself in a precise moment. There are also online resources like the 988 Suicide & Crisis Lifeline (988lifeline.org/), where you can speak to someone and talk through what works for you, or SAMHSA (findtreatment.gov/), where you can find treatment based on your unique needs. In working with folks who are struggling with substance abuse, I try to stay away from words like"strength" and "willpower" - you can, and people do white knuckle their way into sobriety, but not everyone can, and the inability to do so does not make you a bad person.

This leads us to my second point: "How you approach your own addiction." Figuring out what might work to *get you where you want to be* is key. Again, sobriety may not be the goal - the goalfor you may simply be to not use certain substances daily. There is more than one way to approach addiction, but starting with kindness towards yourself and practicing forgiveness will go a long way toward realizing notable progress. The more you judge yourself, the less success you might see in yourself. Think about the stigma you hold against yourself and try to let it go.

You are more than your addiction, both now and after you've achieved your goals.

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HUMAN DEVELOPMENT SERVICES of WESTCHESTER

"WHAT MATTERS TO YOU, MATTERS TO US!" | WWW.HDSW.ORG

Human Development Services of Westchester has been involved in the evolution of community-based direct-care services for vulnerable populations in Westchester County for over fifty years.

We provide strength-based, person-centered, culturally competent services for over 3000 people each year, through a unique blend of inter-related programs.

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Inclusivity in Recovery: How Federation Adapts Addiction Services to Diverse Communities

By Samantha Matcovsky
Director, Marketing and Communications
Federation of Organizations

In the vital world of recovery services, there are many details to an individual's history and health that should be considered in order to provide a comprehensive care plan. One detail in particular isn't typically prioritized when it comes to environmental impact of an individual's recovery: sexual orientation and gender identity.

Federation of Organizations' (Federation) substance abuse recovery programs create a safe, inclusive, empathetic space for anyone looking to receive or educate themselves on recovery treatment. Over the last year, Federation initiated a program for LGBTQIA+-focused addiction services, which extends beyond the intake form to create a sense of belonging and address the important intersection of identity, mental health, and substance abuse. Substance abuse does not discriminate, and neither should treatment.

This is a common trend for Federation when it comes to providing recovery services; Federation aims to break any barriers that may prevent an individual or community for seeking or receiving the care they deserve. Treatment and services are highly tailored to the individual or participant's needs…and if there isn't a service

Samantha Matcovsky

constructive enough for the participant, Federation will adapt.

"In the mental health field, with a person-centered approach, you have to look at everything about your participant. When I first started working in the field, there was a strong heteronormative assumption, merely because no questions were asked," comments Colleen Jeffus, LCSW, and Federation's Associate Director of Clinical Services. "Over the last few years, it has become much more apparent how important this is. There are more suicides, more substance abuse disorders, and more coming out stories in environments that have yet to prioritize inclusivity. As an LGBTQIA+ clinician, I knew that this had to be addressed in treatment."

Those who identify as lesbian, gay, bisexual, transgender or questioning often face social stigma, discrimination and harassment, and are at increased risk for substance use disorders. According to the National Institute on Drug Abuse,[1] this population has higher substance use rates than the general population.

Federation's mobile teams travel to community sites and homes to provide outreach and services to LGBTQIA+ individuals, including counseling and support, as well as Narcan kits and training and other harm reduction services. They are steadily building relationships with other community organizations that serve the LGBTQIA+ population to help spread the word about their many services and reach more individuals.

"Federation's help has put me on the right track from the start. I needed a push towards getting better, and I could tell the team was passionate about my recovery," comments a recent participant. "'Life Isn't Binary' is their gender expansion group; they open the floor for anyone that does not identify as cisgender so they can have a safe place. This was the first time I felt seen as a trans woman."

For over fifty years, Federation has served Long Island and New York City individuals, focused mainly on mental health services as well as residential and homeless services. However amidst the harrowing peak of the opioid epidemic, Federation demonstrated unwavering dedication to its mission of healing and support.

To help combat the crisis, New York State certified Federation of Organizations as an Opioid Overdose Prevention Provider, enabling access to unlimited Narcan kits and training. As a growing addiction recovery service provider, Federation's OASAS (New York State Office of Addition Services and Supports) Clinic in Copiague, New York, provides group, individual and family therapy, psychiatric evaluations and medication management, medication assisted treatment, peer services, Narcan training and many more services, based on each individual's needs.

Amongst other Federation centers, the Wyandanch Clinic, also on Long Island, provides person- and family-centered integrated care services for individuals with mental health issues and co-occurring substance use disorders. Services include a wide range of therapies as well as crisis management, a 24-hour crisis hotline, care coordination and assistance with vocational, housing, rehabilitation and benefits/

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An Epidemic Rages On: "Treatment" Is Not Enough

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

Unprecedented rates of substance abuse and mental illness have afflicted nearly every segment of our population in recent years. This intractable public health crisis has led healthcare professionals, policymakers, and other stakeholders to reexamine longstanding assumptions concerning the underpinnings of behavioral health and to consider novel (and controversial) interventions. Individuals with comorbid mental illness and Substance Use Disorder (SUD) encounter additional obstacles to effective care and are at significantly greater risk of poor health outcomes and other adverse events. This can be attributed, at least in part, to the prevalence of physical health conditions among those dually diagnosed with mental illness and SUD (Dickey et al., 2002). There are a host of other factors, however, that must be addressed to improve the health and overall wellbeing of this exceptionally vulnerable population.

By some indications, this *should* be an auspicious time to seek and to receive treatment for a behavioral health condition. According to the American Psychological Association, almost 90% of individuals surveyed repudiated stigma

Ashley Brody, MPA, CPRP

against persons with these conditions, and a comparable majority agreed they can improve with effective treatment (American Psychological Association, 2019). In addition, more Americans are enrolled in therapy than at any other point in our history (Ducharme, 2023). Nevertheless, we continue to bear witness to the most tragic manifestations of mental illness and substance use on a scale we would have considered unimaginable merely a decade ago. Deaths by suicide rose to a record level in 2022 (Centers for Disease Control and Prevention, 2023). Although deaths by overdose reached a record level in 2021 and declined slightly during the first half of 2022, they remained 50% higher than they were prior to the COVID-19 pandemic (Baumgartner & Radley, 2023). This paradoxical pairing of peak engagement in behavioral healthcare amid widespread tragedy illustrates the futility of approaches that rely solely on our healthcare system to remedy problems whose root causes remain deeply entrenched in enduring socioeconomic ills.

Authors Anne Case and Angus Deaton have documented the intersectionality of socioeconomic, political, and epidemiological trends that produce "deaths of despair" among broad segments of our population. These authors describe a confluence of developments that contributed to the first decrease in life expectancy in nearly a century (Case & Deaton, 2021). Their research affirms an a priori proposition that privations borne of pervasive unemployment, chronic and comorbid medical conditions, and other significant life challenges exact psychological tolls that frequently manifest as clinical depression, suicidality, and substance use. The individuals of interest to Case and Deaton include those who have been largely left behind by our "modern" (i.e., information) economy. They generally inhabit rural areas, have lower levels of educational attainment, and are broadly represented in the manual trades and at greater risk of physical injury and chronic medical conditions. They also proved especially susceptible to exploitation by pharmaceutical companies that peddled profoundly addictive opioid drugs and produced an epidemic of abuse whose ravages persist unabated (Case & Deaton, 2021).

These authors addressed certain ills unique to Appalachia and other rural regions, but their conclusions may be broadly applied to other populations deprived of fundamental necessities for a healthy and productive life irrespective of geography or other demographic factors. An extensive body of research has converged on a central conclusion concerning the relatively modest impact of healthcare on overall population health. By some estimates, "traditional" (i.e., clinical) care accounts for merely 20% of health outcomes. A considerably larger share may be attributed to the conditions in which people live, learn, work, and socialize (commonly known as Social Determinants of Health (SDoH) (Whitman et al., 2022). These findings have garnered attention from providers, payers, and policymakers alike, and they now inform a variety of approaches that aim to correct socioeconomic imbalances that perpetuate or exacerbate chronic illnesses. For instance, Harm Reduction and Housing First are leading evidence-based practices commonly employed among individuals with comorbid mental health and substance use conditions for whom conventional interventions have proven unsuccessful. One study employed a randomized controlled trial (RCT) to examine the differential effects of Housing First versus conventional (i.e., "abstinence-based") care among a cohort of dually diagnosed individuals.

Those assigned to the experimental group received housing coupled with appropriate support services regardless of their perceived "readiness" for it. That is, their placement was not conditioned on abstinence, a remission of psychiatric symptoms, or other prerequisites that often present barriers to engagement among the most vulnerable and compromised populations. By contrast, participants assigned to the control group were required to abide by certain conditions in order to access or to maintain their housing as is customary within many programs and service settings. The investigation found members of the experimental group enjoyed greater housing stability and community tenure than members of the control group. Furthermore, experimental group participants did not exhibit a worsening of symptoms or deterioration in their overall health status despite ongoing substance use and disengagement from behavioral healthcare services (Tsemberis et al., 2004).

The foregoing findings do not suggest Housing First or similar interventions that facilitate individuals' access to SDoH are panaceas. Interventions applied in a community-based context affect individuals to whom they are targeted and others in proximity. This was illustrated by another study that examined a Housing First approach applied within a congregate setting (i.e., one that included both individuals who used substances and those who abstained from them). Some study participants endorsed the flexibility and ease of access characteristic of the Housing First model, whereas others expressed ambivalence toward its application within congregate settings. The latter participants suggested continuing substance use by some individuals compromises the sobriety of others who aspire to abstinence (Kozloff et al., 2013). Other analyses suggest Housing First is effective at the individual level but has failed to yield appreciable decreases in homelessness overall, especially within certain regions or municipalities that tout its benefits (Knight, 2014). Some critics suggest Housing First and similar "low barrier" approaches are uniquely suited to a subset of the homeless population that makes frequent use of institutional care due to untreated health conditions whose symptoms are exacerbated by homelessness, but they claim a broader application of such approaches to all vulnerable persons is misguided insofar as it neglects the importance of treatment and service engagement in the recovery process (Eide, 2020).

As our nation continues to grapple with enduring epidemics of substance abuse and mental illness, our interventions will inevitably be guided by emerging evidence and myriad social, political, and economic factors. Those entrusted with the lives of the most vulnerable would do well to remember that suffering borne of illness and addiction is often indistinguishable from the pain we experience when our basic needs go unmet.

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View the full list of references here.

Consumer Perspectives: Substance Use Treatment and Mental Health

By Frank
Services for the UnderServed (S:US)

This article is part of a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The 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.

I'm a New Yorker in my 50s. I have been receiving housing, therapy, and recovery services from S:US over the last three years.

Basically, I went from bad to great since I'm no longer in the shelter system. I have my own basic freedom, and S:US assisted me through that process by giving me ideas and solutions. They helped me get from Point A (the shelter) to Point B (permanent housing) and gave me a space to do what I need to do. They helped me get my depression under control. I'm at that level where I don't have depression anymore. I still have PTSD, but not as bad as it used to be. I'm not on any medication, and my therapist was like "Wow, that's good!"

Obstacles to Recovery and Healing

What gets in the way of recovery and healing is mostly the environment. For example, in the shelter, if there's something you want to do and there's no end in sight, you start to get depressed and kind of distant. And sharing a room with other people is difficult because you must deal with other people's issues.

When I was in South Carolina, there was basically nothing to do. Most people, if they weren't drinking, were using drugs. If they weren't using drugs, they were eating themselves to death. Coming to New York changed everything for me.

You just have to learn to focus on yourself and what you want to do until it manifests. Just take it one day at a time. That's how I got through it. It's a slow process. I'm getting there and keeping myself busy with school and

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Addressing Nicotine Dependence with Patients Who Have Mental Health and Substance Use Disorders

By Kristen Richardson, RN, CTTS and Danielle O'Brien, CTTS, CNY Regional Center for Tobacco Health Systems, St. Joseph's Health

Tobacco use remains the leading cause of preventable disease and death in the United States, accounting for approximately one in five deaths. An estimated 11.5% of U.S. adults are current cigarette smokers. That translates to 28.3 million adults in our country who are currently smoking. More than 16 million Americans are living with smoking-related disease.[1] Interestingly, the rates of cigarette smoking have actually declined significantly over the past 40 years, except among those with mental health or substance use disorders.[2]

It likely comes as no surprise to those who work with individuals experiencing mental health and substance use disorders that smoking rates among this population are high. The nicotine dependency rate for individuals with behavioral health disorders is two to three times higher than the general population.[3] And smoking rates are particularly high among people with *serious* mental illness. People with a mental health disorder who smoke are also likely to smoke more than those in the general population, putting them at an even greater risk.[4] While estimates differ, as many as 70-85% of people with schizophrenia and as many as 50-70% of people with bipolar disorder smoke.[5 6] Individuals with alcohol use disorders smoke at rates between 34 and 80%. And people with other substance use disorders smoke at rates between 49 and 98%.[7]

Rates of smoking among those experiencing inequities in multiple areas of their lives are higher, with the highest smoking rates of those with mental illness noted in young adults who have low levels of educational attainment and those living in poverty. [8]

It has historically been understood that smoking is more prevalent among people with depression and schizophrenia because nicotine, as a stimulant, may temporarily reduce symptoms of these illnesses. In particular, nicotine can improve low mood and difficulty concentrating.[9 10 11] Yet, it's been proven that smoking cessation correlates with an improvement in mental health, including a decrease in depression, anxiety, and stress, and overall improvement in mood and quality of life.[12] Furthermore, research has illustrated that smoking is actually associated with worse behavioral and physical health outcomes in people with mental illness, and that quitting smoking has clear benefits, including improving mental health. [13]

Most people who smoke want to stop and those with mental health and/or substance use disorders are just as ready to quit as the general population.[14 15 16] Smokers with mental illness and/or substance use disorders want to quit for many of the same reasons cited by others. However, they may be more vulnerable to relapse related to stress and other challenges. Smokers with mental health and/or substance use disorders report increased and more intense symptoms of nicotine withdrawal.[17 18 19 20]

Comprehensive tobacco control programs and enhanced efforts to prevent and treat nicotine addiction among those with mental illness and substance use disorders reduces morbidity and mortality.[21] And despite the common myth that those in treatment for mental health and/or substance use disorders cannot address nicotine dependence at the same time or risk

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Consequences of Blissful Ignorance: Marijuana's Health Risks

By Kristina Carvalho, MSW
Policy Analyst
Partnered Evidence-Based Policy Resource Center (PEPReC)

Marijuana use has increased recently as it gains the reputation for being a natural, risk-free drug. But it might not be as safe as you think. Marijuana does offer a variety of medicinal health benefits to those managing chronic pain, multiple sclerosis, inflammatory bowel diseases, and chemotherapy. It can also improve sleep quality and reduce anxiety at low doses. But 30% of people who use it are dependent on it, and there are plenty of side effects to consider, especially based on how it's consumed.

Smoking

Smoking is one of the most popular ways people consume marijuana, which is concerning given it may be the most dangerous. Regardless of how it is smoked (e.g., pipes, bongs, bowls, joints, blunts), it can be detrimental to heart and lung health.

For example, smoking marijuana can increase the risk of high blood pressure, stroke, heart disease, and other cardiovascular diseases, particularly in older adults.

Most notably, smoking can significantly damage lung tissues (e.g., scarred blood vessels, excess mucus, air pockets). Thus, marijuana smokers also have a greater risk of chronic bronchitis and report more health care visits than non-marijuana smokers.

Compared to cigarette smoke, marijuana smoke is more carcinogenic and deposits four times the tar because of different inhalation techniques. Though, there has yet to be a connection to lung cancer. Since there is a lag time of 30-40 years before lung cancer presents itself in tobacco smokers, scientists believe it is only a matter of time before we see the data show it for marijuana smokers as well.

Vaping

A newer consumption method, trendy among adolescents, is vaping. This involves inhaling vapor that is produced by heating dried cannabis flower ("dry herb"), oil concentrates or wax extracts at 160°C - 230°C.

When comparing the effects of vaping and smoking, several studies have shown that vaping marijuana eliminates exposure to harmful byproducts created by combustion (e.g., tar, carbon dioxide). Similarly, another study found that vaping dry herb produced a higher ratio of cannabinoids with fewer hazardous compounds.

While seemingly a healthier alternative to smoking, other research shows heating marijuana above 200°C can still expose you to carcinogens, like benzene. Oil concentrate vaporizers with vitamin E acetate are also strongly linked with the lung condition, E-cigarette or Vaping Product Use Associated Lung Injury (EVALI). Despite this, teens are still vaping marijuana and are twice as likely to report wheezing and whistling in the chest than when they smoke tobacco.

Edibles and General Brain Health

Edibles come in many forms such as baked goods or gummies, but despite what you hear, none of them are harmless because of the general impacts of marijuana on brain health.

Marijuana affects brain health by impairing learning, memory, and focus, no matter how it's consumed. This is why it is particularly dangerous for adolescents and pregnant people to partake. Research shows that users under age 18 have an increased risk of depression and suicidality, and can suffer permanent changes to their developing brain. Babies born to users can also have lower birth weight and behavioral issues.

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360 is More Than Just an Address, It's a Model of Care for The Mental Health Association of Westchester

By Darcy Tyler
Communications and Development Assistant, The Mental Health Association of Westchester (MHA)

In 2022, preliminary data released by the CDC indicated that more than 100,000 people had died from drug overdoses (CDC). This total marks a new annual record in nationwide drug overdose deaths and is twice the size of 2015's record, underscoring the alarming escalation of this crisis (NPR, Times Union).

With CDC provisional data projecting drug overdose death yearly rates to maintain at these levels and the 2021 SAMHSA Survey on Drug Use and Health indicating approximately 9.2 million adults nationwide currently experience co-occurring substance use and mental health disorders, there is an even more urgent need to adopt evidence-based, accessible, and person-centered care. (CDC, SAMHSA).

To effectively achieve person-centered care that targets the broad range of physical and emotional symptoms associated with substance use and co-occurring disorders, research emphasizes the importance of collaborative professional care. According to the National Institute of Mental Health (NIMH), this involves creating treatment plans that "blend the expertise of mental health, substance use, and primary care professionals" (SAMHSA, CDC). In this capacity, an integrated behavioral healthcare framework serves as an exemplary model in the field of behavioral health – one that The Mental Health Association of Westchester (MHA) continually aims to implement in our practice.

Integrated behavioral health care describes a model of care that fosters collaboration between behavioral and medical health providers and resources. Research demonstrates that when practices apply this framework, improved health outcomes result (Kwan et al., 2015). This is due to a practice's increased ability to accommodate an individual's whole health needs. Instead of only addressing an individual's presented condition, providers under this model are better equipped to detect and account for all the potential needs of an individual. This approach stands as an alternative to a historically separated behavioral and medical care system, which research demonstrates to be largely insufficient in providing accessible behavioral health care and successful diagnosis and treatment of mental health conditions (MHA).

Given the complexity that comes with treating and diagnosing substance use and co-occurring disorders, the ability to provide person-centered care tailored to an individual's needs is essential for effective treatment. This approach is a fundamental principle of integrated behavioral health care, and thus the reason for integrated behavioral health care's well-documented ability to better detect and treat substance use and co-occurring disorders (NIH - Prom et al., 2020; NIH). Within an integrated behavioral health care model, increased screening for mental health and substance use disorders, as well as medication-assisted treatment

Darcy Tyler

(MAT) services and recovery support can be incorporated into the established guidelines and procedures of a behavioral health practice (HRSA).

Furthermore, an integrated approach increases the convenience and accessibility of care. In an integrated setting, individuals can access care within the same network of a provider they trust, which can lessen the stigma associated with behavioral health care (NIH - Prom et al., 2020). Access to all care modalities in a single location can also mean long-term cost reductions associated with seeking care from multiple providers (Overview). Additionally, a network of collaborating providers can increase the efficiency in a professional's workflow, which is an important consideration as workforce shortages of mental health clinicians have only worsened as a result of the COVID-19 pandemic (ICSI, 2021). Workforce shortages have also impacted the availability of substance use treatment and medical professionals across the disciplines.

At MHA, integrated care is a leading principle of our practice. As chronicled in a previous Behavioral Health News article from MHA, our commitment deepened in 2018 with the acquisition of New York State Delivery System Reform Incentive Payment (DSRIP) program funds to provide integrated treatment to those with co-occurring disorders in our mental health clinics. The following year, MHA was awarded substantial grant funding from SAMHSA to further enhance and refine our integrated substance use disorder services through a Certified Community Behavioral Health Clinic (CCBHC) model. With this grant and subsequent rounds of funding, we were able to expand accessibility to MAT services and add Certified Alcoholism and Substance Abuse Counselors (CASACs), Care Managers, Employment Specialists and Peer Counselors to our staffing structure. This funding also enabled us to infuse integrated substance use treatment services beyond Westchester into our expanding Rockland clinic presence. That same year, MHA was awarded a Statewide Health Care Transformation Grant through the Department of Health, which provided vital funding for us to open our first co-located clinic dedicated to integrated, whole person health care.

Our new location at 360 Mamaroneck Avenue in downtown White Plains, New York is home to complementary, integrated health care services, including substance use disorder treatment and recovery services, mental health outpatient treatment and rehabilitative services, and primary and dental care. This comprehensive health center reflects MHA's dedication to providing integrated care that is professional, respectful and strengths-based in approach.

Culminating this June, this multi-faceted project includes MHA's first substance use disorder recovery and treatment clinic licensed by the New York State Office of Addiction Services and Supports (OASAS). A multidisciplinary team of care providers with different skill sets and training in evidence-based practices through a harm reduction approach are able to serve community members ages 12 and older, offering both group and individual care. Our robust staffing pattern includes Certified Recovery Peer Advocates, prescribers specializing in MAT, nurse practitioners, CASACs, care managers, employment specialists and clinicians. Our staff are also sensitive to the needs of special populations, including individuals who are pregnant and use opioids.

Across the hall, MHA's Office of Mental Health Article 31 licensed clinic offers mental health outpatient treatment and rehabilitative services through our Certified Community Behavioral Health Clinic model. We offer a variety of supports and services on a sliding scale, including therapy, intensive outpatient treatment (IOP), care management, peer support, employment services and more. We also offer the Encompass Program, a comprehensive integrated treatment program tailored to the needs of adolescents and young adults fits/entitlements services, among others affected with co-occurring mental health and substance use disorders.

Our new location is also home to Sun River Health, a Federally Qualified Health Center providing primary and dental care services one floor away from MHA's clinic spaces. Through close collaboration, both organizations are better able to provide a warm hand-off in referrals to additional services that promote whole person health. Additionally, MHA fosters a network of partnerships with community-based external treatment providers, physicians, hospitals, specialty clinics, behavioral health practitioners, housing supports for the homeless and other vital entities.

Recognizing the importance of integrated care in reducing barriers to behavioral health and substance use disorder treatment, we continually strive to enhance our commitment to this model and believe it is critical in addressing whole person health and each individual's unique recovery journey.

Nurturing Healing Within Our Homes: Pathways to Treatment Within the Family

By Megan Ryan, LMHC
Site Director, Bellport Outpatient Clinic Outreach

Nature versus nurture has plagued our educational and sociological philosophy for decades in social service and the mental health field. The idea behind treating addiction as a "family disease" has long been established in the understanding that there is a genetic component to addiction and that it can be traced from generation to generation, seemingly handed down through the bloodline. Research widely shows there to be a genetic piece to addiction and that if one were to have biological family members who have dealt with addiction, it is very likely that they may also struggle with symptoms. These could include poor impulse control and behavioral symptomology resulting in self-medicating as well as a higher likelihood that one will be exposed to addictive substances at a younger age. Therefore, individuals in families with a history of addiction may have more opportunity to develop maladaptive coping skills resulting in substance use, which could impact the occurrence of addiction or addictive behaviors over the lifespan. Conversely, there are arguments that those same components listed above could be introduced from a "nurture" perspective. If a person is born into this, no matter their genetic make-up, this same symptomology or behavior set could be seen in them, simply because of their surroundings.

Megan Ryan, LMHC

However, a greater reasoning could be made that these arguments do not matter once a person is suffering from addiction. What matters is how we can help when a loved one is seeking treatment. And the hard truth is that we may only see a successful outcome when the entire family system is treated. It may not matter if the symptoms of addiction come from a nature or nurture component but rather what we as providers do with the symptoms stemming from a family or home life that could impact someone to seek treatment and find success in recovery. It is the duty of those treating these individuals to treat the entirety of the client. To help us identify what comes next for the individual and those that love and care for them, we must fully consider their family relations, their day-to-day environments (home, work, social situations), past trauma and their genetics.

A deeper dive into the family system is necessary to truly understand what motivates someone to misuse substances, and to help us develop an effective treatment plan for them. It can be said that one of the most important pieces of substance use treatment is involving the entire support system in the therapeutic process. This can often help to identify more areas of support needed, and/or the role others play in the development of their symptoms and behaviors. Long gone are the days of the "identified patient." What we are seeing now is an increase in symptoms existing through an entire support system rather than just in one person, who the system would normally point their fingers at.

The assumption and hope are that the family wants the "identified patient" to heal and improve. However, the problem becomes when the support system is broken at the foundation. Are they able to move forward without having the "problem child?" What happens when the "problem" begins to heal? What happens when those in the support system do not take responsibility for their role in what has developed? What happens when the support system does not want to accept or recognize the problem because of the stigma associated with addiction or mental health? What happens when the support system no longer knows how to understand, communicate with, or support the healing individual?

Even with all these barriers and conflicts, there is still a pathway to healing and hope for those seeking recovery for their loved ones.

For a very long time, seeking treatment for substance use disorders looked very lonely, and at times filled with shame. Many people seeking treatment and their loved ones have tried to hide the fact that they are seeking help, because that means admitting there was something wrong. This does not have to be the case.

Currently at Outreach, we are working with OASAS on the EQUITY Grant, which participates in the SAMHSA TREE grant. This grant, and our efforts, focus on outcomes associated with transitional aged youth (TAY) individuals, ages 18 to 25 years old. We are expanding and training clinical staff on Evidence-Based Practices (EBPs) utilized with the individuals we treat, both TAY and beyond, and the idea or assumed result is simple. If we introduce EBPs into treatment at an early enough age and make a concentrated effort to pull in families along with treatment, will we be able to improve outcomes over the lifetime? We have identified Enhanced Cognitive Behavioral Therapy, Community Reinforcement and Family Training (CRAFT) and Multidimensional Family Therapy (MDFT) as the main avenues to achieving this result for the time being. Though the principle is simple and hopeful, the execution can be complicated.

As treatment providers it is our role to provide a safe space for our clients and to get them through the door so that we can bring skills to treatment that they will engage in. Introducing new EBPs, such as those described above, aims to bring family members into a client's treatment as well. The hope is that we can help them understand their role in both the addiction and the recovery process. Many family members or significant others do not understand their subconsciously unhealthy role in the codependent relationships that have formed over many years with their loved one. At times, these habits can be the hardest to break for both the client and their loved ones. Learning that "No" can be a complete sentence can be gut wrenching for some. But others may need even more, such as basic education on communication principles. Understanding that with recovery can come freedom, trust, growth, and evolution in relationships, or, at times, it may come with recurrence or having to set new boundaries. Further, providing a safe space for their loved one to heal is crucial. These are all things that family and significant others in treatment can provide.

Engaging in family centered treatments improves outcomes in perceived client achievements such as gaining employment or compliance with legal mandates, improved retention in treatment, improved familial relationships and parenting skills. It has shown to improve communication, consequential thinking, and creates goals that everyone involved can align with. It improves access to treatment for others in the community, even if by word of mouth. "If it helps me, maybe it will help you." It improves the presence of hope, and that growth and change are possible.

Significant other treatment and family therapies can be essential to a healing support system to learn how to be a healed unit rather than a broken one. If one member of the broken unit looks to heal without the rest following, it is very likely that the foundation will be difficult to build on. And, at the same time, significant others should remember that acceptance does not have to mean approval. If a loved one participates in the therapeutic process, it does not have to mean that they completely move on from all that has happened. It just means that it might be time for them to take on

see Family on Page 45

Enhancing Recovery and Pioneering Hope: Integrating Outpatient and Residential Treatment Amid the Opioid Crisis

By Dr. Carolann Slattery EdD, LCSW-R and James Hollywood, LCSW
Samaritan Daytop Village

The battle against addiction is a pressing concern, as communities across the United States grapple with the devastating impact of the opioid crisis. In response, the New York State (NYS) government has taken a pioneering step forward by introducing Comprehensive Integrated Outpatient Treatment Programs (CIOTPs), an innovative approach that combines the strengths of outpatient and opioid treatment programs. This visionary initiative merges services from the two to create a seamless continuum of care. The integrated model marks a significant step in the fight against opioid addiction by offering a more holistic, personalized, and effective path to recovery.

Substance use and mental health disorders are pervasive issues that affect millions of individuals worldwide. Fortunately, the field of addiction and mental health treatment has evolved significantly, offering a range of effective interventions to support individuals on their path to recovery. Among them are two prominent modes of treatment – outpatient and residential programs. Each modality has its own strengths and limitations. However, a groundbreaking approach in NYS forges a comprehensive integration between the two program types, harnessing the benefits of both to provide a more holistic and effective recovery journey.

The new developments in outpatient services increase the patient's access to Medication for Opioid Use Disorder (MOUD). Over the past five years, these changes have provided opportunities to strengthen and advance residential treatment.

NYS Office of Addiction Services and Supports (OASAS) created Residential Redesign, a set of new regulations and funding mechanisms to permit the establishment of integrated care in residential treatment settings. The Part 820 series of mental health laws provided the framework to incorporate addiction medicine, psychiatry, and health services while increase the staffing of licensed nurses, social workers, and mental health counselors. The additional staffing supported the work of CASAC counselors, recovery coaches, and program management to build a supportive environment for recovery to take root and grow.

Addressing the Opioid Epidemic With Innovation

The opioid epidemic has ravaged communities, cutting across demographic lines, and left countless lives in its wake. Recognizing the urgency of the crisis, NYS has embarked on a mission to reshape addiction treatment through Comprehensive Integrated Outpatient Treatment Programs. This innovative approach acknowledges the multifaceted nature of opioid addiction and offers a more comprehensive solution.

The Essence of Comprehensive Integration

Understanding Comprehensive Integrated Outpatient Treatment Programs

CIOTPs combine the principles of outpatient treatment and opioid treatment programs to create a powerful synergy for recovery.

While outpatient treatment provides flexibility and accessibility, opioid treatment programs offer specialized interventions, particularly for individuals struggling with opioid use disorder (OUD). Through this integration, individuals receive personalized, evidence-based care, tailored to their needs, regardless of the severity of their addiction.

A Perfect Fit for Complimentary Services – CIOTP & Residential Redesign

As a result of the national health care reform taking shape across the country, OASAS intended Residential Redesign as a way to implement the new developments. A hallmark of the Part 820 regulations for residential treatment was person-centered, trauma-informed care that uses evidence-based assessments and treatments and focuses on client outcome and satisfaction.

Both the 820-licensed residential programs and CIOTPs had aligned philosophies, practices, and missions. Partnering residential with outpatient programs was a logical next step. Clients would benefit from a network of care better suited to meet their personal treatment needs. The partnership would create a pathway for clients to receive a higher level of specialized care and, most importantly, gain access to methadone.

It is necessary to understand that addiction medicine specialists at licensed 820 residential programs cannot prescribe or dispense methadone to treat opioid addiction. Methadone can only be dispensed in an Opioid Treatment Program (OTP) or from a CIOTP licensed to provide methadone to residential treatment clients.

The clinical teams in the CIOTP and residential program work together to monitor the client's progress during residential treatment, adjust interventions as needed, and coordinate the client's return to the community. Discharge planning is more effective when the treatment team involved throughout the residential stay continues to work with the client transitioning into the CIOTP.

Key Features of CIOTPS

· Personalized Treatment Plans: CIOTPs offer tailored treatment plans that cater to individual needs. Whether an individual requires medication-assisted treatment, counseling, or a combination of both, the program ensures an approach that resonates with the client's unique journey.

· Flexibility and Continuity: CIOTPs embrace their flexibility. Individuals can access treatment to maintain daily routines, responsibilities, and connections. This continuity is essential for long-term recovery.

· Medication-Assisted Treatment (MAT): CIOTPs incorporate MAT, combining evidence-based medications like methadone, buprenorphine, or naltrexone with counseling and therapy. MAT not only reduces withdrawal symptoms and cravings but also addresses the physiological aspects of addiction.

· Holistic Approach: By merging outpatient treatment's focus on psychological and social aspects with opioid treatment's medical interventions, CIOTPs address the holistic needs of individuals battling OUD.

· Comprehensive Support: CIOTPs offer comprehensive support services, including counseling, therapy, medical care, social services, and peer support groups. This comprehensive approach tackles addiction from various angles, enhancing the chances of successful recovery.

· Community Integration: CIOTPs foster connections with local communities and

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Lessons Learned in Effectively Advancing Co-Occurring Competent Care

By William A. Mullane, PhD
Stephanie Marquesano, JD
and Michael Orth, MSW

Recently, there has been great emphasis on enhancing organizational co-occurring competency and for good reason. Climbing overdose and suicide rates, with bi-directional contribution from mental health (MH) and substance use disorders (SUD), reflect our need to do better serving those with multiple complexities. This push is not new, and this fact ought to have us take pause and reflect on why repeated attempts at arriving at a co-occurring competent system of care – prevention through recovery - have never fully succeeded and explore potential models for achieving this long-sought success.

Data suggests that 90% of people with SUD never receive SUD treatment and only 42% complete SUD treatment, meaning that only 4.2% of those with a SUD complete treatment. Approximately 50% of those with a MH or SU disorder—19.4 million Americans-- meet criteria for co-occurring disorders. Substance use is a known contributor to suicide, with a recent multiyear systemic review of completed suicides in Westchester County NY indicating that more than 80% of individuals who completed suicide were under the influence of substances at the time of their suicide. Additionally, those with co-occurring mental health and substance use concerns are more likely to experience trauma (e.g., sexual assault, car accident, robbery, etc.), a worse course of illness, and more likely to drop out or "fail out" of treatment. Despite these and other concerning findings, only between 9 and 18% percent of behavioral health providers have the capacity to treat those with co-occurring disorders.

There are many challenges in achieving systemic co-occurring competency. Foremost are siloed systems of research, education and training, and regulatory institutions and structures. Maintaining these silos has hindered progress towards integration, making it difficult to develop and sustain prevention programming and implement evidence-based treatment modalities for co-occurring disorders with fidelity. This leaves providers struggling to on one hand be proactive and on the other address the wide array of presenting concerns in a way that best meets the needs of the individual. Siloed educational (and licensure) systems leave providers often trained (and licensed) in either mental health OR substance use disorders, ill-prepared to provide integrated prevention and treatment. From community coalitions to intake coordinators to case managers to providers to the agencies themselves, these deficits often result in individuals with co-occurring disorders being referred to others who are perceived as possessing the requisite skill and experience. This fails to recognize two primary issues: 1) most providers (in mental health or substance use) also lack skill and confidence around addressing co-occurring disorders; and 2) most individuals with co-occurring disorders are either unaware that their mental health or substance use is problematic or unwilling to address them, making it unlikely that they will follow recommendations even in the correct environment. When organizations seek to address these provider deficits with targeted trainings, they often find it challenging to truly achieve co-occurring competency due to an inability to support supervision and fidelity assurances, as well as the high staff turnover rates experienced by many agencies. Separate regulatory bodies reinforce these siloed systems through often incompatible regulations and billing structures that further hinder successful integration efforts and fail to recognize the reality that the care of a meaningful percentage of those treated in both systems would benefit significantly from integrated, co-occurring competent systems of care.

Together, these systems unintentionally conspire to create care that is fragmented, resulting in individuals rarely receiving the gold standard of integrated care with a single clinician and psychiatric provider; instead, people often receive either consecutive (this, then that) or concurrent (this and that) treatment requiring those with more severe and complex presentations, who likely already struggle to make it to a single provider, to attend multiple appointments with multiple providers. This has a personal and financial cost. However, the news here is not entirely grim. There are several lessons learned from recent efforts in New York State (and elsewhere) demonstrating success with a number of opportunities available to continue to advance this work. However, it will require purposeful effort and sustained support from the system and requisite stakeholders. We summarize key strategies learned from these efforts in Westchester County over the last several years that have experienced some success.

Our first step was to assess the willingness and commitment of regional stakeholders to take a "system of care" approach to the delivery of co-occurring competent services that included the opportunity for shared leadership and meaningful partnerships, and exploration of effective evidence-based and data-driven practices. With the framework of the Regional Planning Consortium (RPC), focusing on transitions and integration within the Medicaid system, the Mid-Hudson Region chose to look at person-centered models of care, recognizing the potential for building a complexity-capable, integrated behavioral healthcare system. In November 2017, a two-day leadership forum was held entitled: "Creating a Welcoming and Integrated, Trauma-Informed System for Addressing Those with Co-occurring Disorders," led by systems change experts Dr. Ken Minkoff and Chris Cline. All 7 counties of the Mid-Hudson RPC sent teams comprised of county mental health directors, providers, hospitals, agencies, community organizations, family members, and peers. Also in attendance were representatives from the NYS Office of Mental Health and the Office of Addiction Services and Supports. Drs. Minkoff and Cline challenged the notion that individuals presenting with multiple complexities should be referred to "expert" treatment providers, effectively arguing that providers should adopt a "No Wrong Door" experience of care, meeting people where they are and welcoming those with complexities into treatment, meeting their needs rather than referring them out.

An outcome of the 2017 Forum was the identification of highly motivated champions who returned to their respective counties to form the Co-Occurring System of Care Committees (COSOCC). The Westchester County effort, led by the Westchester County Department of Community Mental Health (DCMH), brought together stakeholders from prevention, treatment, housing, care management, criminal justice, hospitals, among others. Critical to success was to evaluate how stakeholders could advance integration in their respective organizations and institutions. The Westchester COSOCC effectively helped the local government unit and participating organizations identify and share needs and resources to mutually

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SPOP
SERVICE PROGRAM FOR OLDER PEOPLE

HEALTHY AGING

Older Adults and Substance Misuse: Hiding in Plain Sight

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

Last winter "Lucy," an 87-year-old woman, was referred to Service Program for Older People (SPOP) by her primary care doctor. Lucy's husband had died during the Covid-19 pandemic, and she was struggling with unresolved grief, depression, and panic attacks. A retired teacher, she had enjoyed a long marriage and an active social life, and she felt overwhelmed by unaccustomed feelings of isolation and loneliness. We matched her with a therapist trained in complicated grief, and we also encouraged her to enroll in a peer-led bereavement support group. During the course of treatment Lucy focused on learning techniques to manage anxiety, and over time she opened up more and expressed concern that the glass of wine that she enjoyed with dinner increased to two or three each evening since her husband's death.

After a few months of treatment, Lucy began to recognize how a 12-step program could support her goals and enhance her individual therapy. She has now discontinued alcohol consumption, and she recognizes that her reliance on it was linked to the social isolation she had experienced, together with suppressed emotions associated with grief and the pandemic. She feels that she has moved beyond grief and is once again socializing with friends. At age 87 she feels stronger, healthier, and more independent.

Lucy's story is a stark reminder that, even though there is ample data showing that substance misuse increased during the pandemic, it is still easy to overlook it in an older population. At intake Lucy completed a screening for alcohol and substance misuse, but her focus was on her grief and depression, and she didn't consider that self-medicating with alcohol was a serious issue.

Nancy Harvey, LMSW

This is a familiar pattern in our clinic. SPOP is the only agency in New York City that is entirely dedicated to providing community-based mental healthcare for adults aged 55 and older. We operate a licensed behavioral health clinic that offers individual and group psychotherapy, psychiatry service, mental health screenings, assessments for social determinants of health, and connections to other providers for case management, meals assistance, or other concrete needs. We serve some 2,000 adults each year, and our client population is overwhelmingly low-income, medically frail, and socially isolated.

We have seen a significant increase in substance misuse in our client population over the past three years. During the pandemic some clients relapsed after years or even decades of sobriety, and others started to over-use alcohol, prescription medications, or other substances for the first time. One common theme that emerged was a tendency for individuals to underestimate the impact that substance use had on their well-being.

Our clinic staff is trained in modalities to treat the whole person, taking into consideration mental and physical health, family and interpersonal dynamics, social isolation, and other factors. This holistic approach allows us to honor the client's most pressing concerns while also discovering underlying patterns of behavior. In the case of substances, the client may not recognize a pattern of misuse until there is a physical or emotional crisis. For instance, an older person who may have been comfortable with heavy substance use earlier in life may find that they now struggle with increased irritability, insomnia, or unexpected falls – but they do not connect these symptoms to substance use until they have experienced an injury or other crisis.

We also work in partnership with outpatient substance abuse clinics in the region to make certain that our clients have access to treatment for addiction while our clinic focuses on the underlying mental health condition. That additional support is often critical to the client's success in achieving their goals.

There is no question that older New Yorkers suffered during the pandemic as they endured months of social isolation, food insecurity, emotional trauma, fear, anxiety, and, in many cases, the loss of friends and loved ones. At SPOP we are seeing this situation play out with increased urgency of cases, and greater numbers of adults experiencing substance misuse, symptoms of trauma, or complicated grief. Stories like Lucy's are a reminder that substance use may look different in an older person – and that we can all grow and change at any age.

Visit www.spop.org to learn more about SPOP and its work as a community-based mental healthcare provider for older adults.

"Decriminalization" is Misconceived: Towards Improved Drug Policy

By Michael B. Friedman, LMSW
Public Policy Analyst and
Mental Health Advocate

Recent reports about the problems that have emerged with Oregon's experiment in the decriminalization of drugs have rekindled debate about this approach to reducing the damage that results from the current policy of criminalizing illegal substances. I tilt against decriminalization as currently defined.

I feel very lucky that I was never caught using, storing, sharing, or selling marijuana when I was a young man. I think sometimes about how dreadfully different my life might have been, and I feel great sympathy for young people who have been caught and subjected to very severe penalties. That should never happen. Drug use of the kind that is an ordinary part of being a young person in America should not land them in jail or prison with ruined lives.

So, I am very sympathetic to the idea that the use of all illegal drugs should be "decriminalized", i.e., that there should not be criminal penalties for ordinary drug possession and use. And, of course, I am also sympathetic to the idea that this should be combined with a vast increase in the prevention and treatment of addiction.

But it seems to me that the current policy of "decriminalization" is misconceived. It protects illegal drug users from criminal prosecution but does nothing at all about illegal drug producers and dealers. For them, the failed policies of the "War on Drugs" continue; and, as a result, decriminalization does nothing to disrupt the illegal drug business, which is the source of drug-related violence and of overdose deaths due to adulterated drugs.

Advocates for humane drug policy need a broader conceptual approach, much broader. But unfortunately, most discussions of drug policy focus exclusively on the so-called "illicit" drugs—cannabis, cocaine, heroin, methamphetamine, etc. This is a very limited view of the dangers of substance misuse or addiction. Tobacco is a dangerous substance; there are nearly 500,000 tobacco-related deaths a year in the United States. Alcohol is a dangerous substance; there are about 150,000 alcohol-related deaths every year. Many medicines are dangerous if used incorrectly; the number who die from the misuse of prescription and over-the-counter drugs is unclear.

Despite their health risks, the production, distribution, sale, and use of tobacco, alcohol, and medications are not criminalized; **they are regulated**. And this approach is generally regarded as striking a reasonable balance between the government's obligation to protect people from harm and its obligation to protect individual freedom.

Regulation certainly has a better outcome than the criminalization of "illicit" drugs, which has been an abysmal failure. It has resulted in the overpopulation of jails and prisons (disproportionately with people of color), ruined lives, broken families, widespread corruption, and violence perpetrated by dealers of illegal drugs that overflows into poor communities, especially poor communities of color. In addition, despite the war on drugs, drug overdose deaths have been increasing at an alarming rate.

It is worth recalling that there was once a war on alcohol in the United States, which was also an abysmal failure. The remarkably successful end of prohibition was not the decriminalization of drinking.

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Jorge R. Petit, MD, Appointed to SAMHSA Center for Substance Abuse Treatment National Advisory Council

By Staff Writer
Behavioral Health News

We are thrilled to announce that Jorge R. Petit, MD, was recently appointed to the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) National Advisory Council.

Dr. Petit will be joining the SAMHSA CSAT National Advisory Council this month and look forward to working with renowned national experts and professionals on improving access to and reducing barriers to addiction treatment services. "We all know that it is not just a matter of clinical necessity but a fundamental cornerstone of health equity to ensure that every individual, regardless of their background or circumstances, has an equal opportunity to reclaim their well-being and rebuild their lives," stated Dr. Petit.

The National Advisory Council plays a pivotal role in guiding and advising SAMHSA's efforts to address substance use disorders and promote effective treatment strategies. Comprising a diverse and knowledgeable group of professionals from various fields, including healthcare, academia, research, and community advocacy, the Council convenes to provide valuable insights, recommendations, and expertise to enhance the development, implementation, and evaluation of programs and policies aimed at improving the lives of individuals and families affected by substance abuse. Through its collaborative efforts, the SAMHSA CSAT National Advisory Council helps shape a comprehensive and compassionate approach to prevention and high-quality, effective substance use disorder treatment and recovery services, contributing to the overall wellbeing of communities and individuals across the nation.

Mental Health News Education, publisher of Behavioral Health News and Autism Spectrum News, is especially proud of Dr. Petit's new appointment as he is a long-time Member of the Board of Directors. Congratulations Jorge!

Jorge R. Petit, MD

When the Unexpected Happens: The Importance of Policies and Procedures

By Sally Whitaker Bergquist
Senior Risk Management Consultant
Irwin Siegel Agency

Providing specialized consultation in the field of addiction treatment risk management is an essential function of our organization. We see firsthand that providers supporting the treatment and recovery of substance use play a critical role in maintaining the safety of each individual seeking care It is not uncommon for these individuals to feel emotionally and physically vulnerable when seeking substance use treatment. An unfortunate reality is that an unexpected event, such as the one outlined below, could occur when organizations do not implement comprehensive internal controls through comprehensive policies and procedures:

A twenty-four-year-old male is admitted to a residential treatment provider for substance use withdrawal. The day after admission, he was found by staff to be unresponsive in his room. Resuscitation efforts are attempted but not successful. It is an event many professionals fear and dread in their human service role.

One significant role of care providers is to recognize the risk of harm, assess the risk, and implement proper procedures to maintain patient safety. When an unexpected event occurs, such as the example above, the organization's written policies and procedures should be reviewed by the leadership team. They may also be reviewed by the state's accrediting/ licensing agency, the plaintiff's attorney representing the deceased client, and the defense attorney representing the insured organization. Organizations should take the time to ensure their policies and procedures follow state guidance and meet best practice criteria.

When incidents occur, organizations are held to the precise standards they have in effect at that time. Be sure your policies and procedures are strong.

Over time, the standard of care is sure to evolve to best provide the highest quality of service delivery. Changes in healthcare, culture, and technology can impact these standards. As your policies adapt to comply with the updated standard of care, it is important to keep a record of any policies that have been modified or updated. This should always include the dates the preceding policy was in effect. With so many policies online, there may be a tendency to update and hit "save," but it is important to remember to always keep a copy of the original policy to verify the standard of care in existence at that point in time.

Sally Whitaker Bergquist

When developing written policies and procedures, consider the standard of care or how things are performed in your local area. For example:

- How do other organizations in your area that provide the same or similar service perform this activity?
- How does your state licensing agency view this activity?
- What are the state laws or regulations?
- What does the Department of Public Health require for these patients?

Finally, consider the requirements of Federal or national agencies. What are the requirements of the Centers for Medicare and Medicaid for an organization such as yours? What does your professional organization recommend?

One of the other most important aspects of policies is *employee compliance*. It is crucial for your employees to realize the importance of policies and not to simply do what they have always done over the years. If the organization has well written, detailed policies, but a review of events determines your employees are not compliant with the policy, it is important to delve into the issue. Ask why there is non -compliance. Questions to consider might include:

Do employees know how and where to find the current policy?

- Are policies accessible to them online?
- Do employees know where the current policy is located and how to access the policy 24 hours per day/7 days per week?

Are the policies up to date?

- How are employees informed of policy changes and new policies?

Are your policies realistic?

- Is there a need for additional education, different equipment, or additional training on equipment? Be sure your employees can comply with the policy as written.

Are your policies too detailed?

- An overly detailed, complicated 30-page emergency response plan will not be helpful for employees overseeing a high -stress situation. Keep it manageable.

Ultimately, internal controls are the first line of prevention for all providers, especially in the addiction treatment space. Written policies and procedures should be referred to frequently and should function as a road map for your organization. They should be relevant and up to date. A review process should include assessing any incident trends that occurred between reviews. This could identify an area that is uncovered by the current policies and procedures. Ensure your employees know where to locate this information and are notified of any updates or changes.

Irwin Siegel Agency has become synonymous with expertise and customized programs for Addiction Treatment and Behavioral Healthcare Providers since its inception in 1960. We are pleased to offer a comprehensive insurance program through an A++ rated global insurance company. As a Program Administrator, ISA strives to provide tailored property and liability insurance and risk management solutions that meet the unique needs of organizations like yours. We work directly with your current agent or broker! To learn more, call 800.622.8272 or visit siegelagency.com.

If You Are Feeling Alone and In Despair, You Can Find Help at
The Many Programs and Organizations Found in Behavioral Health News
Never Give Up Hope - There is a Caring Community Near You

Substance Use Disorder Prevention and Treatment Services: A Social Justice and Health Equity Perspective

By Jorge R. Petit, MD
Behavioral Healthcare Executive Leader
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Substance Use Disorders (SUDs) present a complex and multifaceted public health challenge that disproportionately affects marginalized communities, exacerbating existing health disparities and social inequities. These marginalized populations encompass groups facing social, economic, and structural disadvantages, including racial and ethnic minorities, individuals of lower socioeconomic status, LGBTQ+ individuals, and those experiencing homelessness or justice involvement. The impact of SUD within these communities extends beyond individual health concerns, encompassing broader social, economic, and systemic implications. Enhancing access to addiction services and reducing barriers within a social justice and health equity framework demands a multifaceted approach that intentionally addresses systemic, structural, and individual factors.

Jorge R. Petit, MD

Racial and ethnic disparities in prevalence rates of substance use disorders (SUDs), as well as overdose deaths, are compounded by many factors, such as, historical trauma, systemic racism, limited access to quality healthcare/insurance, accessibility of treatment services, chronic stressors, lack of access to education and employment opportunities, and childcare/transportation barriers, to name a few.

Research consistently reveals that racial and ethnic minority groups, such as African Americans, Hispanics, and Indigenous peoples, often exhibit higher rates of SUD compared to White populations. Homelessness is linked to a higher addiction and SUD risk; many homeless individuals also struggle with mental health issues, unemployment, food insecurity, and limited healthcare access. LGBTQ+ individuals face unique stressors like discrimination, family rejection, and isolation, leading to higher substance use rates as a coping mechanism. Incarcerated individuals are more likely to have a history of addiction and SUD. Marginalized youth, like those in foster care or involved with child welfare systems, have elevated SUD rates. Adverse childhood experiences, trauma, and disrupted family structures contribute to their susceptibility to substance misuse.

Recent data from the Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health indicated that the percentage of people aged 12 or older who used illicit drugs in the past year was higher among American Indian or Alaska Native (36%) or Multiracial individuals (35%) than among Black (24%), White (23%), Hispanic (19%), or Asian individuals (11%) (see Figure 1 on page 41). Similarly, the 2020 CDC Vital Signs Report revealed that overdose death rates (number of drug overdose deaths per 100,000 people) increased 44% for Black individuals and 39% for American Indian and Alaska Native (AI/AN) individuals compared to 2019 (see Figure 2 on page 41). Overdose death rates in older Black men were nearly **7x** as high as those for older White men and in counties with greater income inequality, overdose deaths for blacks were **2x** as high compared to communities with less income inequality.

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Moving Toward Recovery After Discharge with OARS™

By Tony Salvatore, MA
Director of Development
Montgomery County Emergency Service

Like many psychiatric hospitals, Montgomery County Emergency Service (MCES), located in Norristown, PA, serves adults with primary serious mental illness many of whom also have a co-occurring substance use disorder (COD), sometimes involving opiates. This "double trouble" puts them at greater risk of poor treatment adherence, relapse, frequent involuntary hospitalization, and, of course, overdose.

COD patients needing inpatient care may often receive it sequentially. They are treated initially at a psychiatric or addiction facility depending on their primary diagnosis and are then transferred to another facility to address their secondary diagnosis. It falls to the patient to align the often-divergent treatment modalities and philosophies.

COD patients may be resistant to care or unable to adhere to a dual disorders aftercare program. They often resume substance use, discontinue mental health treatment, and experience a return of symptoms of serious mental illness such as depression, suicidal ideation, self-injury, and psychosis. Family members, providers, police, or emergency department physicians may seek involuntary psychiatric care on their behalf and the cycle begins anew.

In the mid-1990s, MCES noted that seventy-five percent of admissions involved a secondary substance use disorder (SUD) diagnosis. The majority of these patients were involuntary and had experienced a potentially life-threatening crisis. Moreover, this patient population had a high level of recidivism marked by several stays yearly within weeks of each other.

MCES's initial effort at inpatient COD care blended mental health and substance use care principles and staff with experience in both fields. The program helped patients understand how mental illness is affected by substance use, how mental illness impacts sobriety, and why treatment for both must be simultaneously maintained. It incorporated drug and alcohol rehabilitation treatment concepts and techniques. Individual and group counselling, recovery and educational groups, and AA and Narcotics Anonymous meetings were part of the program strategy.

At the time, the program was seen as innovative and had success deterring repeated hospitalizations. However, relapse within weeks of discharge remained a problem for many COD patients.

In early 2002, a multidisciplinary group of MCES staff formed a task force to deter relapse among MCES patients. Over several months they assessed the relapse prevention needs of MCES patients, reviewed the literature on relapse, and evaluated available relapse prevention resources. They produced a strategy for COD patients and staff to work together to identify the risks, the signs, the triggers, and the steps to be taken to avert relapse.

COD patient engagement and self-help were essential. A booklet entitled *My Action Plan for Relapse Prevention* (MAP) was created to facilitate this process. This excerpt states its purpose:

This work-book is designed to encourage you to take an active role in your wellness.

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Empowering Recovery: How Technology Supports Those with Substance Use Disorders

By Kelsey Silver, LMFT
Assistant Vice President of Quality and Data Analytics, Outreach

The journey of overcoming substance use disorders (SUD) is multifaceted and often daunting. However, recent technological advancements have proven to be formidable allies in this quest, offering hope and innovative solutions. From the vast capabilities of data analytics to the immediacy of telehealth and the comprehensive nature of patient portal access, technology is reshaping the landscape of addiction treatment and recovery.

Data Analytics

Although providers are likely accustomed to utilizing data analytics for performance metrics. In the realm of healthcare, raw data is also a goldmine of clinical insights waiting to be unearthed. For those with SUD, the power of data analytics can be harnessed to predict relapse triggers, understand patterns of use, and tailor interventions for maximum efficacy. Machine learning models, for instance, can analyze a patient's history, physiological markers, and behavioral patterns, forecasting potential high-risk situations or environments. By providing such predictions, caregivers can preemptively address concerns, ensuring that individuals have the necessary support before facing potential relapses.

Innovative predictive analytics may be top of mind for providers, but data visualization and accessibility are equally essential in putting information in the hands of decision makers within behavioral healthcare organizations. Access to real time data around health equity, outcomes, and monitoring improve client health, access, and success.

Telehealth

The emergence of telehealth has been revolutionary, especially for individuals who might not have easy access to in-person care due to geographical constraints or stigmatization fears. Virtual consultations break down these barriers, allowing patients to connect with therapists, counselors, and peer support groups from the comfort and privacy of their homes. This constant lifeline ensures that help is always available, thereby minimizing feelings of isolation - a critical factor in the recovery journey.

Patient Portal Access

Patient portals have elevated the concept of self-care and autonomy in the recovery process. These digital platforms allow individuals to track their progress, access educational materials, and communicate with their care teams. By having access to this information and resources at their fingertips, patients are better equipped to understand their condition and actively participate in their treatment plans. Moreover, these portals can integrate with wearable devices, offering real-time monitoring of vital parameters and ensuring timely interventions.

Clinical Decision Support (CDS) Systems

Among the myriad technological tools aiding those with substance use disorders (SUD), Clinical Decision Support (CDS) systems stand out due to their potential to enhance the decision-making processes in clinical scenarios. These sophisticated software interfaces are designed to provide healthcare professionals with evidence-based clinical knowledge and patient-specific information, assisting in making precise decisions. Here's how they play a crucial role in the context of SUD:

- Evidence-Based Recommendations: CDS systems sift through vast medical databases to offer treatment recommendations based on the latest research and best practices, ensuring that patients receive optimal care tailored to their unique circumstances.
- Drug Interaction Alerts: For those with SUD, it's crucial to monitor potential interactions between medications used in recovery and other prescribed drugs. CDS systems can provide real-time alerts about possible harmful combinations.
- Risk Assessment: Using AI and data analytics, these systems can assess a patient's risk of relapse based on a variety of factors, allowing clinicians to intervene proactively.
- Monitoring & Alerts: For patients under medication-assisted treatment (MAT), CDS systems can monitor dosages and send alerts if there's a potential for misuse or if a dose is missed. Alerts when at risk clients miss appointments can ensure reach out and life-saving intervention and interoperability with hospitals can increase follow-up after emergency department visits.
- Patient History Access: By offering a holistic view of a patient's history, including past treatments, behavioral patterns, and associated health conditions, clinicians can make informed decisions that consider the entirety of a patient's journey.

Incorporating Clinical Decision Support systems into the treatment paradigm for substance use disorders not only streamlines the clinical process but also ensures that care is evidence-based, personalized, and proactive. As we advance technologically,

see Technology on Page 44

Harm Reduction: A Bridge Back to Life

By Rebecca Linn-Walton, PhD, LCSW
Chief Strategy Officer
Services for the UnderServed (S:US)

Harm reduction is a decades-long, well-established, effective tool in reducing illnesses, deaths, and other negative consequences of problematic substance use (Jones et al., 2022). This approach has never been more important as in the current overdose crisis (Perera et al., 2022). Harm reduction practices have evolved over time in their complexity and person-centered approach, as practitioners, support service providers, and other professionals can attest, harm reduction in action means providing whatever support the individual needs to survive until healing is possible (Lopez et al., 2022). For many in care at a large NYC nonprofit organization, this means helping New Yorkers get into and stay into housing as the centerpiece to their healing journey.

Services for the UnderServed (S:US) is large NYC nonprofit providing crisis, supportive, permanent housing and care to adults and families with serious mental illness, intellectual and developmental disabilities, HIV/AIDS, substance use challenges, and sometimes all the above. Our entire workforce is dedicated to helping New Yorkers live with autonomy, respect, and dignity, and to achieve their goals. Harm reduction is central to our mission. Leadership and supervisors have worked hard to create a culture shift in recent years so that this practice can be implemented from the front door through staff supervision. As one of the largest supportive housing providers in New York State, and with 11 shelters across New York City, harm reduction has had to move beyond the walls of our clinic and clinical staff. S:US recognizes that there are many pathways to stability for people who use substances, and that the road can often include ongoing struggles. Rather than using an abstinence-based approach, we work with individuals to identify their goals for recovery and help them take the steps to get there.

S:US has integrated harm reduction practices across the spectrum of care and housing through a combination of concrete and free tools, education, and approaches to interacting with persons served. Throughout shelters and supportive housing, individuals are trained in using and sharing Narcan kits, fentanyl tests strips, and most recently, S:US was one of the first organizations in NYC to begin distributing xylazine test strips. S:US also partnered with the health department to open the first public health vending machine in the city. These free life-saving materials are easily accessible and New Yorkers have been traveling from across the city to access safer substance use, sex, and health products.

Our clinic staff are trained in harm reduction approaches, education, and how to address personal internal biases that could get in the way of nonjudgmental support for those we serve. We have Medication Assisted Treatment teams across Brooklyn, Harlem and the Bronx which provide dedicated services for people with substance use challenges who want to explore medication in addition to treatment. We offer a flexible model for New Yorkers, including light touch, traditional therapy, case management, and ongoing medication support.

We also recognize that not everyone who would benefit from substance use treatment is engaged in it. For this reason, S:US engages in daily harm reduction support in shelters and supportive housing. Dedicated harm reduction and health educators share tools and training with residents and staff, and many of our most effective trainers leverage their lived experience to help both the workforce and persons served. This unique experience allows education to move beyond basics of testing and overdose response and allows for complex conversations around how to manage monthly income to both

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The Hidden Impacts of Overdose: Four More Reasons We Must Stop the Epidemic

By Dr. Lawrence Weinstein
Chief Medical Officer
American Addiction Centers

The recent overdose epidemic has brought the issue of substance use front and center as a mainstream problem. That means now is the time to harness our collective efforts to devise mainstream solutions. As we celebrate International Overdose Awareness Day, it's essential that we recognize the hidden impacts of this tragic trend and implement programs that save lives and help reduce the burden on families, first responders and communities.

Where substance use disorder (SUD) and overdose were once largely considered to be problems that only affected those living on the fringe of society, we now recognize they affect all walks of life and people of every socioeconomic class, race, gender and lifestyle. With over 106,000 overdose deaths in 2021 alone (the most recent year for which data is available)—not to mention the untold number of overdose survivors—odds are that almost everyone has been directly affected by this tragic trend.

If loss of life isn't heartbreaking enough, unless you've been directly impacted by an overdose, few realize that every overdose has far greater implications beyond the acute situation. The impact doesn't end when naloxone is administered, a person is taken to the hospital for treatment, or to the morgue. In fact, every incident has a ripple effect on the individual, their family, first responders and the community at large.

Future Health Implications

Overdose deaths get most of the attention, but surviving one is not a clean slate. Roughly a million nonfatal overdoses are treated in emergency departments each year, and the ill effects can cause irreversible brain damage, long-term impairment of motor skills, coordination and memory, and lifelong muscle spasms or a staggering gait. Even nonfatal doses can have a severe impact on internal organs, causing damage to heart valves, pulmonary edema, irreversible kidney damage and hypertension. If a person collapses in a slumped-over position, it could cut off circulation to the lower extremities, potentially requiring amputation.

In fact, one JAMA study showed that the most common causes of death during the first year following a nonfatal opioid overdose were substance use-associated disease like HIV, chronic respiratory diseases and viral hepatitis, along with circulatory disease and cancer. Increased rates of depression, impulsivity and suicidal ideation are also common with the highest rates of suicide among females.

Addiction is a Family Disease

SUD affects far more people than just the afflicted individual; it can destroy the entire family. Similarly, those who are close to someone who overdoses can feel immense loss, guilt and anger that their loved one didn't receive or accept help in time to prevent the incident.

Loved ones may also feel shame due to the stigma of SUD, and they may not get the same level of sympathy or support as those who lose loved ones to any other kind of tragic accident or natural cause. This combination of emotions can cause family members to withdraw or internalize their emotions, further complicating their grief and creating fertile ground for mental health issues—and even their own SUD—to take root.

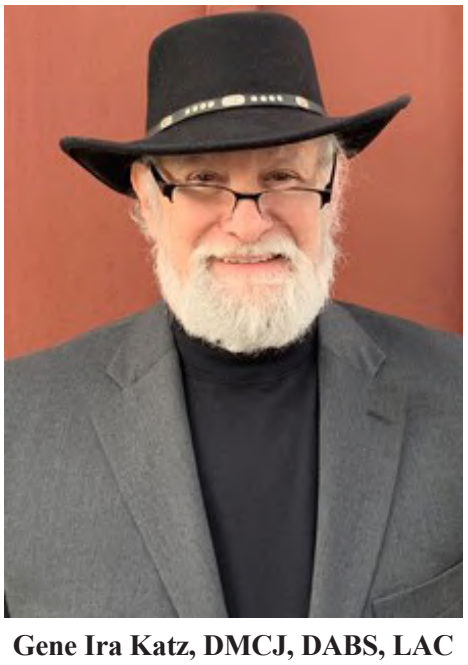
The Toll on Frontline Responders

Some of the most "invisible" victims of the overdose epidemic are the paramedics,

see Overdose on Page 36

Compulsive Sexual Behavior and Pornography Viewing as Addictions

Dr. Gene Ira Katz, DMCJ, DABS, LAC
Executive Director
Positive Pathways Institute



Gene Ira Katz, DMCJ, DABS, LAC

Addiction can occur in many forms. Often, it is assumed that physical dependence, characterized by withdrawal symptoms, is required for someone to be diagnosed with an addiction disorder, but the fact is that behavioral addiction can occur with all the negative consequences in a person's life minus the physical issues faced by people who compulsively engage in drug and alcohol abuse.

Process Addictions are defined as behavioral problems that involve a lessening of control, persistent seeking, and significant harm even though no addictive substance is involved. According to the International Journal of Preventative Medicine, behavioral science experts believe that anything capable of stimulating a person can be addictive; and when a habit changes into a compulsion, it can be considered as an addiction. Researchers also believe that there are several similarities between drug addiction and behavioral addiction diagnostic symptoms, except that the individual is not addicted to a substance, but to the behaviors or the feelings brought about by the required action. In addition, the physical signs of drug addiction may be absent, but behaviorally addicted individuals will undergo the same consequences brought about by addiction to alcohol and drugs as well as exhibiting other obsessive behaviors.

The Diagnostic and Statistical Manual of Mental Health Disorders, aka the DSM -5-TR, published by the American Psychiatric Assn (APA), lists 300+ mental and behavioral health diagnoses accepted in the US, and a few other countries, but recognizes gambling as the only process addiction. While the DSM does acknowledge numerous unusual sexual behaviors under the general heading of Paraphilias (discussed in detail later), the APA does not recognize various Compulsive Sexual Behaviors as mental heath disorders *per se*, despite the vast amount of research and evidence that provides compelling support for such a diagnosis.

Aside from the DSM, most of the world relies on the ICD, or International Classification of Diseases, published by the World Health Organization (WHO), as the official book of mental and behavioral diagnoses, and the WHO has chosen to include Compulsive Sexual Behavior Disorder (CSBD) in their recently published 11th edition, the ICD-11. With a designated code of 6C72, CSBD, is described as the inability to control sexual behavior despite negative consequences. With this decision, the world's health experts have determined that such behaviors merit an official diagnosis. The disorder is also known as Hypersexuality and Sex Addiction.

In their policy statement, the Society for the Advancement of Sexual Health (SASH) states that having reviewed the available evidence, there are several diagnostic models currently under investigation, all of which reflect an underlying clinical condition requiring dedicated assessment, and treatment. Sexual Addiction and Pornography Addiction are two such models. Additional models include Hypersexual Disorder, Out of Control Sexual Behavior, Unspecified Impulse Control Disorder, and Sexual Compulsivity, amongst others. A growing body of empirical research supports the serious clinical concerns on which these various models seek intervention. Among this empirical evidence are dozens of studies supplying neuroscience evidence consistent with the presence of addiction, primarily in Internet pornography users, but also in "sex addicts" generally. There is research evidence that also supports other diagnostic labels, such as Hypersexual Disorder.

SASH also notes that the preponderance of the recent neuroscience research points to substantial evidence of addiction -related brain changes in Internet pornography users. This also appears to be an outgrowth of the relatively new technology-saturated environment. Numerous researchers have found that streaming pornography is potentially addictive, and may help to explain a surge in non-organic, psychogenic sexual dysfunctions and abnormally low sexual desire in some users, whether or not they are addicted.

Not all forward-thinking organizations dedicated to the advancement of enlightened sexuality agree with SASH's findings, or the World Health Organization's decision to include Compulsive Sexual

see Compulsive on Page 42

Settlement Funds from Page 16

1. Strengthening existing programs to address gaps in service

2. Expanding services in underserved communities

3. Infrastructure support

Workforce Crisis

- Funding should be used for workforce retention to cover costs such as: childcare, health/dental insurance, pay equity, student loan repayment, tuition assistance, scholarships (BIPOC Scholarship fund to support increased senior management/ clinical roles), employee wellness services, and more. (Tuition assistance and student loan forgiveness would only be possible with settlement funds because SAMHSA does not approve use of their funds for this purpose)

- Special support to hire additional staff who reflect the culture and experiences of the people and community served

- Statewide workforce training focused on use of evidence-based tools

- Support for recovery coaches and recovery peer advocates including recruitment, training, certification, job placement

- Reimbursement for certification fees (CASAC, CPP, CRPA, etc.)

Fiscal Viability

- A permanent Fiscal Stabilization Fund should be established to provide emergency assistance to programs experiencing cash flow or deficit issues when revenue does not cover the full cost of delivering services

Strengthen Existing Programs to Address Gaps in Service

- Address unmet needs especially in under-served BIPOC communities

- Incorporate anti-racism principles into continuum of services statewide using training and technical assistance

- Strengthen services for LGBTQ+, women/with children, people involved with criminal legal system, aging persons, and persons living in underserved communities

- Provide harm reduction and help people access treatment particularly people who use drugs and have risk for overdose, and people with co-occurring MH disorders

- Ensure that programs state-wide receive funding for naloxone

- Strengthen addiction peer services in treatment, recovery, harm reduction settings

- Fund evidenced-based environmental prevention strategies and community coalitions to link prevention resources and expand reach to vulnerable populations

- Strengthen/expand existing recovery services

- Expand prevention services targeting individuals, families, and communities.

Expand Services in Underserved Communities

To address issues related to health equity and inequity in service infrastructure, funding should be provided to expand existing programs and create new capacity to address unmet need.

- Provide funding for new services in underserved communities that address specific underserved populations and specific services that are lacking

- Support creation of the Leadership Institute addressing BIPOC leadership development

Infrastructure Support

- Support continued access to telehealth via purchase of equipment, connectivity and technologies that create force multipliers for staff (laptops with web cams, smart TVs, hardware and data plans to support tele-health)

- Create technology infrastructure for data collection, analytics, reporting tools, and regional/statewide dashboards and analytics so that programs can access data to inform decision-making and create a robust data collection/survey system for annual surveys, ad hoc requests for information, and enhanced responses to crisis situations like COVID

- Provide funding for clinical technology tools (recovery apps, notebooks for journaling etc.)

- Ensure that programs are always equipped with PPE

The Opioid Settlement Fund Advisory Board has a vital voice in the decision-making process regarding how New York State will use Opioid Settlement Funds. This voice is critical as funding decisions are made during the State's budget process for close to two decades. InUnity Alliance and our Policy Center are committed to working with the Advisory Board to address the impact of the opioid overdose and addiction crisis and the historic underfunding of substance use prevention, treatment, recovery, and harm reduction.

To learn more about the work of the InUnity Alliance Policy Center and our advocacy work, contact Kyle Plaske, Deputy Director at 518-596-4542 or KPlaske@asapnys.org.

Veterans from Page 17

specific needs of Veterans.

TVSR training is helpful for participants interested in expanding their peer recovery knowledge base, learning how to effectively navigate the challenges of supporting a Veteran with a substance use disorder, preparing for VSR certification, or earning approved continuing education hours for renewal of ASAP-NYCB peer recovery certifications. All VSR trainings are online with closed captioning for persons with hearing challenges.

The New York Certification Board is working to increase awareness about their VSR initiative with the hope that it will serve as a catalyst for strengthening the workforce, enhancing services for Veterans, and helping to improve the health and quality of life for Veterans and their families. Like other peer professionals, VSR professionals work in a wide variety of settings. They work in community-based substance use programs, recovery centers and recovery-oriented clubhouses, community mental health agencies, Veterans hospitals and community-based Veterans programs, as well as in Veterans housing and employment programs, or wherever Veterans are served.

To learn more about Veteran Supported Recovery and services that address the needs of Veterans and their families, attend the ASAP Veterans Summit or contact us at: 518-426-3122 or EKranson@asapnys.org.

Caring from Page 18

Tia Dole, PhD, is the Chief 988 Suicide & Crisis Lifeline Officer at Vibrant Emotional Health. Dr. Dole is a licensed clinical psychologist and a long-time advocate for the rights of those with intersectional identity. Prior to stepping into the role of Chief 988 Officer, Dr. Dole was the Executive Director of The Steve Fund, the nation's only organization focused on the mental health and emotional well-being for young people of color. Additionally, Dr. Dole was the Chief Clinical Operations Officer at The Trevor Project, the world's largest suicide prevention and crisis intervention organization for LGBTQ youth. Dr. Dole oversaw all The Trevor Project's crisis services programs as well as their volunteer community and increased their impact by a factor of four.

After completing her bachelor's degree at Carleton College, Dr. Dole received her Master's degree in Developmental Psychopathology from Columbia University (Teacher's College), and she received a Fulbright Fellowship to study Forensic Psychology in Switzerland. She then completed her doctorate in clinical psychology at Fordham University. Dr. Dole is a published author and sits on several committees. One of her passions is normalizing mental health conditions within communities of color, LGBTQ communities, and helping people get access to services. She is based in New York/New Jersey.

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Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community

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Overdose from Page 34

public safety and medical professionals who are charged with first response in overdose events. As if these individuals didn't already suffer PTSD from the ordinary emergencies they treat every day, seeing an overwhelming number of overdose incidents day after day takes a tremendous emotional toll, creating feelings of burnout, exhaustion and helplessness.

Many are also frustrated with barriers to treatment that perpetuate the overdose cycle, which often leaves them treating the same individual multiple times—sometimes within the same 24 hour period. Considering the burden these individuals carry, it's no wonder many suffer from compassion fatigue, which can put lives at risk.

Community-Wide Impacts

The cumulative effect of these impacts can be severely detrimental for communities. The added demand on healthcare facilities strains an already overwhelmed system, and the frequency of overdose events makes it difficult for first responders to attend to other emergencies in a timely manner. Not to mention the stress forces many providers to leave their jobs and is a deterrent for new people entering those fields. The economic impact of the lives lost, loss of workforce due to addiction, lost productivity due to the emotional strain on loved ones is hard to quantify but is undeniable.

That's why none of us have the luxury of considering addiction and overdose to be someone else's problem. We all bear the burden and therefore all have a role to play in the solution.

Steps for Making a Positive Impact

First, raising awareness is essential. Days like International Overdose Awareness Day send a strong message to those who are struggling with addiction and those left behind that help is available. It's important that we remember those we've lost without the stigma and instead focus on the disease, treatment options and

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Crisis from Page 1

As it is common for individuals with a history of addiction to not address their health needs, we are assisting and referring clients to appropriate medical and wound care, while providing harm reduction and psychoeducation regarding opioid overdose prevention to individuals and their families. This includes Narcan training, fentanyl and xylazine testing strips, as well as safety planning that individuals can utilize during high-risk situations. While providing lifesaving medication, we also offer additional services such as counseling, case management, peer and vocational services. Additional referrals to housing and transportation services are offered and provided as well. As individuals are exposed to more resources and support, they have the option to increase their involvement in treatment. It is extremely beneficial that they are already established in a program and these additional services can be immediately included into their treatment plan.

Creating OTPs within our communities in greater numbers will reduce the stigma, much like the urgent cares centers we are now seeing on every corner. Using a person-centered approach, clinics can be designed to be warm and welcoming. We have seen a positive response to replacing the stereotypical line with comfortable waiting rooms and a private window for dosing. Staff trained in trauma-informed care and utilizing evidence-based practices such as Cognitive Behavioral Therapy and Motivational Interviewing enhance client engagement. Utilizing translation services can also expand services to many more individuals in need. For individuals who are unable to attend on-site treatment sessions, they have the option to attend individual and group counseling as well as psychiatric services with the use of technology and telehealth appointments. Mitigating such barriers contributes to maintaining client retention.

Thomas Olivo, LCSW

We have heard time and again from individuals receiving services at our OTP that this accessible service has changed their lives. The need to open more OTPs in our communities is essential in combatting the opioid epidemic. If we continue to have waiting lists for opioid treatment, we will continue to lose individuals that may have otherwise been integral in our society. We see firsthand that OTPs work, and we must continue our push to increase access to care for those who prefer this treatment modality.

Thomas Olivo, LCSW, is Director of the Outpatient Integrated Treatment Program, at Outreach Recovery Center in Brentwood, NY. Website: opiny.org, Email: Thomasolivo@opiny.org, Phone: (631) 521-8400 ext. 5179.

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Spotlight from Page 1

2022, one of the lenses and one of the priorities that she really was bringing with her was a focus on harm reduction. When she started in her role, this was one of the divisions that she created, taking the opportunity to recognize that harm reduction has long been happening in our continuum of care, but shining a spotlight on harm reduction and the work that we do.

Our mission is really to take harm reduction to our community, working with our over 1,700 providers throughout New York State to provide substance use services, helping them implement harm reduction, helping them understand what harm reduction is, and recognizing those opportunities to incorporate harm reduction theory and practices into their services and into their care. Not only am I working with our OASAS providers, but it's also our OASAS system and our staff here at OASAS - getting them to understand what harm reduction is and how to talk about harm reduction and really implement it across our continuum of services. My role is to lead the division. We are now a staff of four, still a very small staff doing this work. And the division is really structured around three different pillars that we're going to be focusing on.

The first is focused on education, technical assistance, and resources. Education is a huge part of my job and the division. What is harm reduction? How do we implement harm reduction? Again, getting out in front of the community, talking to them, doing a kind of "harm reduction 101." This is new for many of our providers. We are setting that baseline of what harm reduction is, providing technical assistance, not only to our system of care and our substance use disorder (SUD) providers, but also to OASAS staff. We're a state agency and we have civil service staff. Not everyone who works here comes in with a working understanding of harm reduction. WE are working with both our system of care and our staff here at OASAS and then providing resources. Harm reduction isn't just a philosophy and a theory of care, but it's practical resources that we provide. For example, we've just launched a huge campaign and project of getting naloxone, brand name Narcan, out into community, and getting fentanyl test strips and xylazine test strips out to our community. We are working to provide education on the theory of harm reduction and also give the practical tools that you need to implement harm reduction.

That's one pillar of my division. Another is to really focus in on the regulations, structure, and culture of OASAS - really looking at our regulations that regulate substance use treatment services throughout New York State and making sure that they support harm reduction. Harm reduction is about low-threshold care and removing barriers to care – making sure that our regulations can be implemented in a harm reduction setting and can support harm reduction. It's also thinking about our CASACs, our certified alcohol and substance use counselors, making sure that the education they receive has a focus on harm reduction and stands right alongside prevention, treatment, and recovery.

And then our third pillar is focused on special projects. This is where we get to have a lot of fun. I have a couple of initiatives that are running right now through our division and have my staff member, Cameron, working on all of those special projects to truly implement harm reduction services. And another part of my role is really incorporating harm reduction services into each bureau and division at OASAS, making sure that our prevention division has a harm reduction lens that it's using and viewing the work through moving forward.

And then we focus on adding any of those opportunities for assessment, education, and training. This is done in a few different ways - looking at our assessment tools and making sure that our assessment tools are low threshold, that we're only asking our participants and our clients the information that's truly needed to be able to provide them care and providing lots of education. For the next month, I'm out of the office almost the entire time traveling around the state of New York and talking about harm reduction - what does it mean? And then we have our training opportunities. We have "Learning Thursdays" with our Chief Medical Office team to be able to work with our providers to implement harm reduction into their care settings. It's a lot for the four of us, but we are new and we are growing. I think that's also the really exciting piece, that it's not often that you get to work with a state agency where you have an opportunity to create a brand-new division. We are really taking the opportunity to listen to community, discover what the community thinks our division should look like, and then responding to those needs of the community.

David: It sounds like you've been very busy in your first year!

Mary: Very busy, yes. I just came back from my first vacation! We've been doing lots of work.

David: In your own words, how do you define harm reduction, and what is its historical background?

Mary: I was very fortunate that I'm a social worker by training. I have my master's in social work and went to a macro practice school. I'm not a clinician but have definitely worked in clinical environments. And when I was in social work school, I learned harm reduction, which is not common. That's actually an uncommon thing to get to learn in grad school. And I was really fortunate that I learned harm reduction from Dan Bigg, a long-term harm reductionist who was known in our community as the godfather of harm reduction. Dan taught that harm reduction is any positive change. It's really thinking about what are those behaviors that we engage in that we would like to change and make healthier. And really, it's being able to celebrate any positive change that we happen to make. Again, really focusing on those behaviors in our life that we want to change and implementing that positive change. Again, I think it's a theory. It's that theory of what harm reduction is, but then it's also very practical. You take that theory and you implement it into your work. And it's helping your clients, your participants, your patients identify that change, helping them be the agents of change, and helping them support any change that they want to make. That's how I learned harm reduction. Again, very simple - any positive change.

Harm reduction has a long history. I said at the beginning that the Division of Harm Reduction is new, but the philosophy is not new to our OASAS system of care. Harm reduction came to us through the HIV/AIDS epidemic in the early 80s and 90s. Harm reduction, really, in the United States was born directly out of the HIV/AIDS community. In New York State, one of the first ways that harm reduction was really legalized and embraced was through the legalization of our syringe service programs (at the time known as syringe exchange programs) that happened in 1993. And the reason that these syringe exchange programs were implemented was because we were seeing in the HIV/AIDS community that one of the most perfect ways to transmit HIV and hepatitis was through the sharing of syringes. We recognized that we needed to create behavior change around people's injection drug use. But if they didn't have the ability to use a clean syringe for every injection, they were going to reuse syringes and share syringes. In 1993, New York State legalized syringe exchange to ensure

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Psychiatry from Page 10

Is there anything else you would like to share with readers of Behavioral Health News?

One interesting consequence of the pandemic is how it accelerated a focus on and awareness of mental health and mental illness. Before the pandemic, organized psychiatry would scream from the rooftops about the importance of mental health and substance use disorder treatment and all of sudden we find ourselves in a different position, where the public is asking us for information, support, resources and treatment options. Suddenly, the mental health community finds itself somewhat unprepared for this barrage of excitement and interest – a truly unique moment that we need to understand and take advantage of. We strongly encourage psychiatrists to engage with the public and the APA has many resources available to every member. Psychiatrists have reliable information that should be shared. We encourage our professionals to engage with the media and the community - go to your local radio station and educate people, write an op-ed for local newspaper, post on social media. Have your voice heard.

Rachel Fernbach is the Executive Director and General Counsel of the New York State Psychiatric Association, a division of the APA.

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Harm Reduction from Page 6

place that prevented many from engaging in treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) initially required that clinicians acquire a Data-2000 "X" Waiver to prescribe buprenorphine for the treatment of OUD. The removal of the "X" Waiver, in 2023, allowed for any clinician with a valid DEA registration for controlled medication to prescribe buprenorphine, increasing access to buprenorphine for all those in need.

Like SSPs before it, MOUD has not been fully embraced by the addiction community. Many falsely believe that MOUD is replacing one addiction with another addiction. To be in "recovery," one must fully abstain from all substances, including medications to treat the disorder itself. In October 2022, OASAS changed the regulations that oversee all SUD outpatient services to read "The Program shall provide FDA approved medications to treat substance use disorder to an existing patient or prospective patient seeking admission to an Office certified program in accordance with all federal and state rules and guidance issued by the Office." The shift away from total abstinence signified the continued embrace of harm reduction throughout the continuum of addiction services in NYS.

Building on the elimination of the "X" Waiver, the state launched the Buprenorphine Assistance Program (BUPE-AP). BUPE-AP will assist eligible uninsured or underinsured New Yorkers with the costs of buprenorphine for MOUD. BUPE-AP will allow SUD providers to enroll in the program to roll-out the benefit state-wide. With this project OASAS continues to support expansions to harm reduction services across NYS, including increasing and expanding access to life-saving MOUD.

In 2022, according to CDC provisional data, 6.358 New Yorkers died from an overdose, more than any year on record. From the very beginning, harm reduction has been at the forefront of a public health crisis. Harm reduction works to incorporate a spectrum of strategies that includes safer use, managed use and abstinence. It ultimately recognizes the rights of PWUD and aims to empower any positive change. It is hopefully through this embrace of harm reduction that we can finally turn the tides of this epidemic.

Mary Brewster, MSW, is Associate Commissioner, Division of Harm Reduction, and Dr. Kelly Ramsey, MD, MPH, MA, FACP, DFSAM, is Chief of Medical Services, at OASAS.

The New York State Office of Addiction Services and Supports (OASAS) oversees one of the nation's largest substance use disorder systems of care with approximately 1,700 prevention, treatment and recovery programs serving over 680,000 individuals per year. OASAS is the single designated state agency responsible for the coordination of state-federal relations in addiction services. Our mission is to improve the lives of New Yorkers by leading a comprehensive system of addiction services for prevention, treatment, harm reduction and recovery. Our approach is responsive, data-driven, person-centered, and prioritizes equity. Please visit us at https://oasas.ny.gov/.

Integrated Care from Page 7

A third client noted that all his service providers are on the same page: *"I like that my counselors and my Peer talk and they all seem like they're working together to help me. I know my therapist is talking to my doctor (psychiatrist) because my doctor showed me how he can see the notes from my therapy and how they're sending messages to each other through the computer. I love that I can see everyone in one place when I come in for my appointments, this is a 'one stop shop' and I really feel like they're really making my life better."*

Other clients pointed out the CCBHC's have helped them with numerous tasks beyond their immediate healthcare needs, including arranging transportation, navigating Medicaid paperwork, obtaining housing, and finding employment.

Despite the success of the CCBHCs in providing integrated care there are still certain challenges that must be addressed in the integration of mental health and substance use treatment into all our services which often requires a change in the treatment culture of the individual clinic or service provider. To help address these challenges and cultural changes, OMH provides training and technical assistance to healthcare providers through the Center for Practice Innovations on best practices for implementing integrated care.

Another joint endeavor of OMH, OASAS, and the Department of Health (DOH) is the Opioid Use Disorder Capacity Building Initiative, which engages all specialty mental health clinics in New York State to ensure individuals with psychiatric conditions and co-occurring opioid use disorders (OUD) have access to evidence-based care, including screening for OUD, and access to Naloxone Kits and medication assisted treatment for OUD. This effort has led to significant increases in the number of individuals served in mental health clinics with OUD who are identified and treated for their substance use.

Finally, OMH is also working with OASAS to ensure that the school-based mental health clinics we license include screening and services to identify and address substance use. Such integrated early intervention and prevention strategies are critical to embedding integrated whole person care throughout all we do.

In summary, individuals with co-occurring disorders need holistic integrated care in facing their challenges on the road to recovery.

As OMH implements the initiatives in the Governor's historic plan to strengthen the State's mental healthcare system, we are doing so with the understanding that viewing clients holistically and providing quality integrated treatment and supports that are sensitive to all the social determinants impacting their well-being ultimately leads to improved health outcomes for all New Yorkers living with mental illness and substance use disorder.

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resources, enabling individuals to build a strong support network outside of the treatment setting. This integration is vital for sustained recovery.

Benefits of CIOTPs

· Reduced Stigma: By integrating opioid treatment with outpatient programs, CIOTPs help reduce the stigma associated with MAT. This normalization encourages more individuals to seek help without fear of judgment.

· Improved Accessibility: CIOTPs enhance treatment accessibility because clients receive specialized care without the constraints of residential stays. This is particularly advantageous for individuals who may have work, family, or other commitments.

· Higher Retention Rates: The flexible and less restrictive nature of CIOTPs often leads to higher retention rates. Individuals are more likely to engage in treatment when it aligns with their daily lives.

· Long-Term Success: CIOTPs focus on sustained recovery by equipping the individual with the tools and support needed to manage triggers, prevent relapse, and achieve long-term success in the recovery journey.

Understanding Outpatient and Residential Programs

Outpatient Programs: Outpatient treatment programs offer individuals the flexibility to attend therapy sessions and receive treatment while continuing with their daily lives. This approach is ideal for those with less severe substance use or mental health disorders, as well as individuals with strong support systems at home.

Residential Programs: Residential or inpatient treatment programs provide a structured and immersive environment for individuals to focus solely on their recovery. With 24/7 support and a tightly knit community, residential programs are better suited for individuals with severe addiction or mental health issues, inadequate home environments, or a history of unsuccessful outpatient treatment attempts.

The Power of Integration: Residential and Outpatient Programs

The concept of integrating outpatient and residential treatment programs involves a seamless transition between the two levels of care. Integration is not just about a smooth handover from one program to another; it is about the creation of a cohesive and continuous journey that optimizes the strengths of both approaches.

1. Gradual Progression: By integrating outpatient and residential programs, individuals can experience a gradual step-down approach. The gradual progression ensures a smoother transition from the highly structured residential environment to the more flexible outpatient setting. The measured pace reduces the likelihood of relapse, as individuals are continuously supported while adapting to increased independence.

Carolann Slattery, EdD, LCSW-R

2. Personalized Continuum of Care: Every individual's journey through recovery is unique. Integrating both types of programs allow for a personalized continuum of care. Treatment plans can be tailored to an individual's changing needs, ensuring they receive the right level of support at the right time.

3. Consistency in Therapeutic Relationships: A key advantage of comprehensive integration is the continuity of therapeutic relationships. As they transition, clients can maintain connections with the same therapists and peers they have come to know and trust. This consistency bolsters the therapeutic alliance and contributes to better treatment outcomes.

4. Skill Consolidation: Residential programs often provide intensive skill-building and coping strategies. Integration with outpatient care ensures that individuals can practice and consolidate these skills in real-life situations. The practice helps them apply what they have learned in a supportive yet less controlled environment.

5. Relapse Prevention: One of the primary objectives of any treatment program is to prevent relapse. Integrating outpatient and residential care enhances relapse prevention efforts. The integration allows individuals to navigate triggers and challenges in both supervised and unsupervised settings, while still receiving professional support.

Challenges of Implementation

While the benefits of comprehensive integration are substantial, its implementation is not without challenges. Coordination between different treatment teams, maintaining consistent communication, and addressing insurance and logistical issues are crucial aspects requiring careful consideration. Building a successful integration must involve reviewing and amending workflows, cross-training staff (on the two program models), and modifying the electronic health record to share information between the programs.

Key Components of CIOTPs

· Personalized Treatment Pathways: Everyone's journey through recovery is unique, and CIOTPs recognize this diversity. CIOTPs create treatment plans that factor in a client's medical history, substance use patterns, psychological well-being, and social context.

James Hollywood. LCSW

· Access to MAT: MAT, including medications like methadone, buprenorphine, and naltrexone, is a cornerstone of CIOTPs. These medications mitigate withdrawal symptoms, reduce cravings, and pave the way for a more stable recovery.

· Psychosocial Support: Addressing the psychological and emotional aspects of addiction is integral to CIOTPs. Therapies, counseling, and support groups provide the necessary tools for coping, healing, and personal growth.

· Community Integration: CIOTPs foster connections between individuals and their local communities, empowering them to build a support network that extends beyond the treatment setting.

· Continuity of Care: The integration between outpatient and opioid treatment programs ensures a seamless transition, maintaining a consistent level of care and support throughout the recovery journey.

Advantages of CIOTPs

· Holistic Healing: By combining medical interventions, psychological support, and social connections, CIOTPs address the complex needs of individuals, resulting in holistic healing and long-term well-being.

· Reduced Stigma: Integrating MAT within the comprehensive framework helps combat the stigma often associated with medication-based approaches, encouraging more individuals to seek help.

· Higher Engagement and Retention: The flexibility and inclusiveness of CIOTPs contribute to higher engagement and retention rates, fostering a sense of empowerment and commitment to recovery.

· Long-Term Recovery Focus: CIOTPs place a premium on sustained recovery. By equipping individuals with skills, resources, and support, these programs enable them to navigate challenges and embrace a life beyond addiction.

Disadvantages of CIOTPs

While NYS CIOTPs offer a promising approach to address the opioid crisis, it is important to acknowledge that no system is without its challenges. Here are some potential disadvantages associated with CIOTPs:

1. Limited Accessibility: CIOTPs might not be easily accessible to all individuals due to geographical constraints, transportation issues, or the lack of CIOTP facilities in certain areas. These issues could result in uneven access to comprehensive treatment, leaving some individuals (and communities) underserved.

2. Resource Allocation: Implementing CIOTPs requires financial resources, trained staff, and infrastructure. In resource-strapped areas, the availability and quality of CIOTPs might be compromised, impacting the overall effectiveness of the approach.

3. Complexity of Coordination: Coordinating care between different treatment providers, counselors, therapists, and medical professionals can be challenging. Coordination that is not seamless might lead to gaps in care and miscommunication, and ultimately affect the treatment outcome.

4. Cultural Sensitivity: CIOTPs need to be culturally sensitive to cater to diverse populations. If the programs do not consider cultural differences, language barriers, or unique community needs, they might not effectively engage and retain participants from various backgrounds.

5. Stigma Associated with Methadone: While methadone is an evidence-based medication for OUD, there still exists a stigma associated with its use. Some individuals might avoid CIOTPs that incorporate methadone due to fears of judgment or concerns about dependency on the medication.

6. Potential for Discontinuity: The transition from the structured environment of residential treatment to the outpatient setting might pose challenges for some individuals. The potential for discontinuity in care could lead to relapse if individuals are not adequately prepared for the shift.

7. Resistance to Medication: Not all individuals with OUD respond positively to MAT like methadone. Some might experience adverse effects or find MAT to be an ineffective option for managing their cravings and withdrawal symptoms.

8. Reduced Focus on Abstinence: CIOTPs prioritize harm reduction and stabilization over strict abstinence. While this approach is rooted in compassion, it might not resonate with individuals who are committed to achieving complete sobriety and fear that the program might not align with their goals.

9. Reliance on Patient Compliance: CIOTPs rely on patient compliance and engagement. If individuals do not actively participate in counseling or therapy, or consistently follow their treatment plans, they might not achieve the desired outcomes.

10. Potential for External Influences: CIOTPs transition individuals into their home environments sooner. This exposes them to potential triggers and negative influences that might hinder their recovery process.

Conclusion

While NYS CIOTPs offer a forward-looking approach to addressing the opioid

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Drug Policy from Page 30

It was a thoroughgoing system of regulating the production, distribution, sale, and use of alcohol.

It is also worth recalling that the way that the United States got control of the "snake oil" salesmen of the 19th century was not by criminalizing the use of phony medications but by a system that made medications that are safe and effective available via prescriptions from physicians and other means. The Federal Food and Drug Administration studies and approves medications. Manufacturers are subject to safety protocols. Drug distributors and drug stores are required to control their sales. Medicine users get instructions on use.

Tobacco is also subject to regulatory controls including restrictions on age of purchase. And the use of tobacco has declined dramatically because of remarkably effective public education campaigns.

These approaches and not decriminalization of drug use should be models for the reform of drug policy in the United States. Thoroughgoing regulatory control rather than criminal control should be the core policy.

The regulatory control of dangerous substances is sometimes referred to as the "legalization" of drugs. But this is very misleading. The term suggests unlimited access to substances that may or may not be safe, and no one supports that. Government control of potentially dangerous substances is necessary. But that can be accomplished via a comprehensive, regulated system that includes manufacture, distribution, sale, use, and very importantly prevention and treatment.

Decriminalization? Yes, no one should be subject to criminal penalties for the ordinary use of what are currently illegal drugs. Yes, there should be a vast increase in prevention and treatment. But this needs to be combined with a new approach to controlling the supply of currently illegal drugs by making them available safely; by regulating manufacture, distribution, and sale; and by criminalizing those who go outside the regulated system.

Michael Friedman is a retired social worker who has worked as a behavioral health advocate for over 50 years. He is the author of over 250 articles, essays, book chapters, and more. Most can be found at www.michaelbfriedman.com.

Michael B. Friedman, LMSW

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other projects.

That's what causes problems: not doing anything and dwelling on things. That's why I keep myself busy.

Mental Health, Homelessness, and Other Challenges

I've overcome homelessness, depression, and substance use disorder. I'm proud of myself for making progress.

The most difficult experience was being in the shelter and taking medication that didn't agree with me to where it was wreaking havoc on my body. I gained weight and got hypertension. Once my doctor told me, I started eating healthy and working out. Then the doctor took me off the medicine.

I'm slowing but surely losing weight. Going to school helps too. It's just a matter of changing my environment.

Joining the Brooklyn Clubhouse

I'll start being involved in the S:US Clubhouse soon. The Brooklyn Clubhouse provides comprehensive, recovery and rehabilitation services to adults living with a mental illness and/or co-occurring substance use. The program offers individuals access to the necessary tools to obtain and maintain employment, cultivate meaningful relationships, participate in recreational opportunities for socializing, overcome stigma, and pursue wellness in a supportive and nurturing environment. The Clubhouse provides valuable social and vocational opportunities, support from peer advocates, and assistance in developing critical life coping skills and work readiness. Clubhouse members participate in all aspects of its operation, including recruitment of new members, hiring staff, organizing activities, and orienting new members. Peer counselors drive and enhance the recovery-oriented environment, which encourages members to find their own voice, recognize their strengths, and use available support and services to facilitate their own recovery.

What I'm going to do is get involved in their media and communications work. I want to do video production that shows my progress from not only being in a shelter and moving into permanent housing, but also everything I've achieved in between. I want people to get a visual of my journey instead of just reading about it. If they see me in the way of my progress, they'll be inspired to say, "Oh, he's doing it. I need to go in that direction."

I started going to school this spring for media arts, liberal arts, and radio at Kingsborough Community College, and I expect to graduate in 2025.

Messages for Others Experiencing Similar Challenges

I have encouragement to share with people who may be having a hard time and experiencing some of the challenges that I've been through.

S:US doesn't just help you with your mind, they help you with your body and your spirit. They have events like cooking classes and yoga. They go all the way around. I would recommend going to S:US if you want to be well-rounded, because I'm a perfect example of that thanks to the S:US Wellness Works Clinic in Brooklyn.

You can't help anybody if you can't help yourself and get it together. S:US gives you the benefit of getting it together, from therapy to support groups. We encourage each other in those groups.

I want to be an inspiration to get others to be inspired. Not for ego purposes, but for people to know that you can achieve greatness.

Learn more about S:US' Behavioral Health Services, including recovery services, at sus.org/our-services/behavioral-health.

Risks from Page 24

We also know that marijuana increases the likelihood of developing psychoses (e.g., schizophrenia) and is associated with accelerated brain aging (e.g., smaller hippocampi). All of these negative impacts on brain health are why consuming marijuana edibles isn't the risk-free golden ticket.

Reducing Harm

There really is no healthy way to consume marijuana: potency has dramatically increased in the last 20 years and research has only scratched the surface on the potential health effects. But there are ways to mitigate some of the risk.

For those who plan to continue smoking, there are a couple ways to soften the blow. It's important to learn about the materials in your rolling papers before use and avoid holding smoke in your lungs for more than one or two seconds.

For those who choose to vape, consider switching from oil concentrate and wax extract vapes to a less harmful dry herb vaporizer. Make sure to still research the quality of materials in the device, as some are made from low-quality plastic.

For edible users, try limiting your dose and usage altogether. It is also important to stay in a safe place during the high to avoid other standard risks like motor vehicle fatalities.

Although edibles seem to offer the least amount of risk, future studies should explore the long-term impact of all consumption methods. For now, the best ways to protect yourself are to be educated about the risks of marijuana use and minimize its harm whenever possible.

Kristina Carvalho, MSW is a Policy Analyst, at Partnered Evidence-Based Policy Resource Center (PEPReC), a partnership with the Boston University School of Public Health.

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2. Health benefits of cannabis. Forbes Health. Published February 27, 2023. Accessed June 6, 2023. https://www.forbes.com/health/body/health-benefits-of-cannabis/

See the full list of references here.

Kristina Carvalho, MSW

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hope, just as we would for cancer or any other chronic illness.

It's also an opportunity to remind people what to do in the event of an overdose: *always* call 911 first, administer naloxone if available, administer rescue breaths if needed, and stay until help arrives. These simple steps could save a life.

We must also prioritize education about the dangers of hidden substances, such as fentanyl. It, along with fentanyl analogs and other adulterants, can be mixed with other substances without the user's knowledge, putting them at much greater risk of overdose. Being aware of that risk can encourage those with SUD to be more mindful and cautious.

Harm reduction strategies like making naloxone readily available, needle exchange programs and supervised consumption sites can help, but we also must make SUD treatment more accessible and include referrals to treatment as part of every OD-first response encounter. Evidence-based treatment can reduce SUD, health harms and overdose deaths, and the longevity and quality of treatment directly relates to lower mortality rates. We should also prioritize medication-assisted treatment to help individuals achieve and maintain sobriety.

For first responders, professional

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Perspective from Page 32

Furthermore, SUD can exacerbate other existing health disparities; individuals grappling with SUD often experience poorer physical and mental health outcomes, including an increased risk of infectious diseases, mental health disorders, and chronic illnesses. The co-occurrence of SUD and other health conditions further strains the healthcare system's capacities and leads to inferior overall health outcomes.

Numerous barriers exist when seeking SUD treatment, including limited access to healthcare facilities, transportation challenges, lack of insurance coverage, and cultural stigma associated with seeking help for addiction. These barriers impede timely and effective interventions, resulting in delayed or inadequate care. In a 2020 study, Black patients were half as likely to obtain treatment following non-fatal overdose compared to Hispanics and Whites. The economic burden of addiction, encompassing healthcare costs, lost productivity, legal involvement, and strain on social services, can perpetuate cycles of poverty and hinder economic mobility.

Language barriers and cultural insensitivity in healthcare settings can alienate marginalized individuals seeking SUD services. Cultural factors may influence how addiction is perceived, acknowledged, and addressed within different communities, necessitating culturally competent care to ensure effective treatment.

The impact of SUD on marginalized communities intersects with various social determinants of health, such as housing instability, food insecurity, and lack of access to education and employment. These create a cycle of disadvantage that not only contributes to the onset of SUD but also obstructs recovery and sustained wellness. SUD can perpetuate across generations within marginalized communities, establishing a vulnerability cycle. Children born to parents with SUD may experience adverse childhood experiences, heightening their likelihood of developing SUD themselves. This cycle underscores the necessity of comprehensive prevention and intervention efforts.

The impact of SUD extends beyond individuals to entire communities. Elevated addiction and SUD rates can strain community resources, disrupt family structures, and contribute to an environment of instability and insecurity. Recovery necessitates a support network, access to treatment programs, and resources to navigate challenges. Marginalized individuals often lack these essential resources, hindering their ability to overcome addiction successfully and attain sustained recovery.

In my estimation, the principles of Social Justice must be grounded in the pursuit of fairness, equality, and the elimination of systemic health disparities. These principles are highly relevant to SUD prevention and treatment, offering a framework for equitable care access, disparities resolution, and ensuring that all individuals receive the supports and treatment necessary for their recovery.

Efforts to address SUD in marginalized populations must consider the underlying social determinants of health, provide culturally sensitive, inclusive, and trauma-informed care, and offer accessible treatment while reducing stigma, focusing on community-based interventions. Tailored prevention and treatment strategies for these populations can contribute to reducing systemic health disparities.

Addressing the significance of SUD within marginalized communities demands a comprehensive approach that incorporates health equity initiatives, targeted policies, culturally sensitive interventions, and acknowledges the unique challenges faced by these communities. Providing tailored solutions is crucial to reducing SUD-related health disparities, breaking cycles of disadvantage, and fostering a more equitable and just society. Such efforts can enhance individual well-being and strengthen the resilience of entire communities.

Resources

988 Suicide & Crisis Lifeline: 988 Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals in the United States.

SAMHSA's National Helpline, 1-800-662-HELP (4357) (also known as the Treatment Referral Routing Service), or TTY: 1-800-487-4889 is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members facing mental and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations. Also visit the online treatment locator, or send your zip code via text message: 435748 (HELP4U) to find help near you. Read more about the HELP4U text messaging service.

NYS OASAS HOPEline: Call 1-877-846-7369 or texting HOPENY (467369) for help and hope 24 hours a day, 365 days a year for alcoholism, drug abuse and problem gambling. NYS OASAS Treatment Availability Dashboard to Search For State Certified Outpatient Or Bedded Programs here.

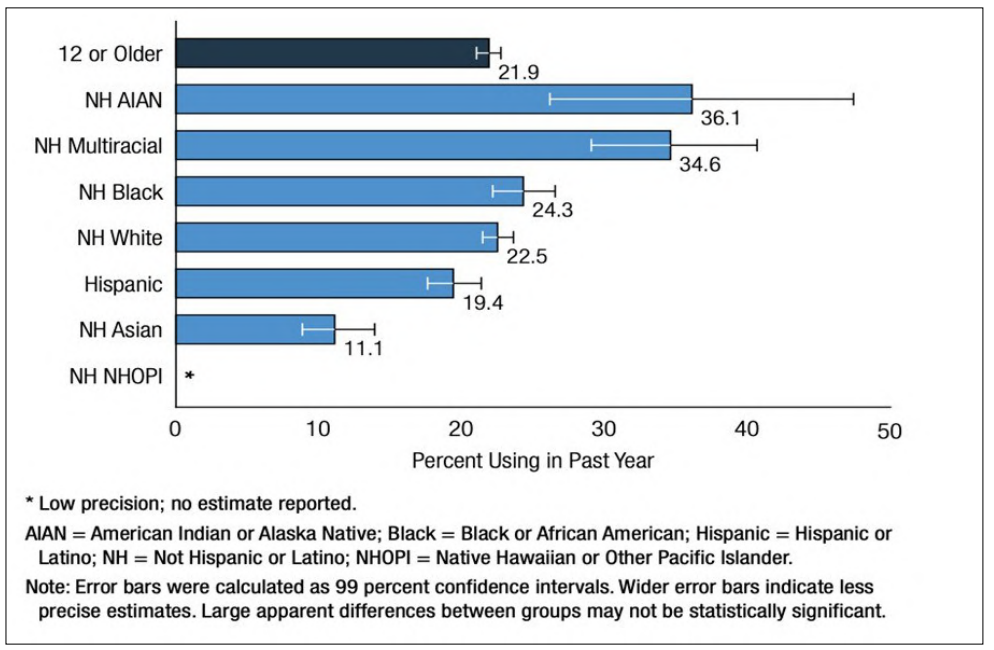

Figure 1 - Past Year Illicit Drug Use: Among People Aged 12 or Older; by Race/Ethnicity, 2021

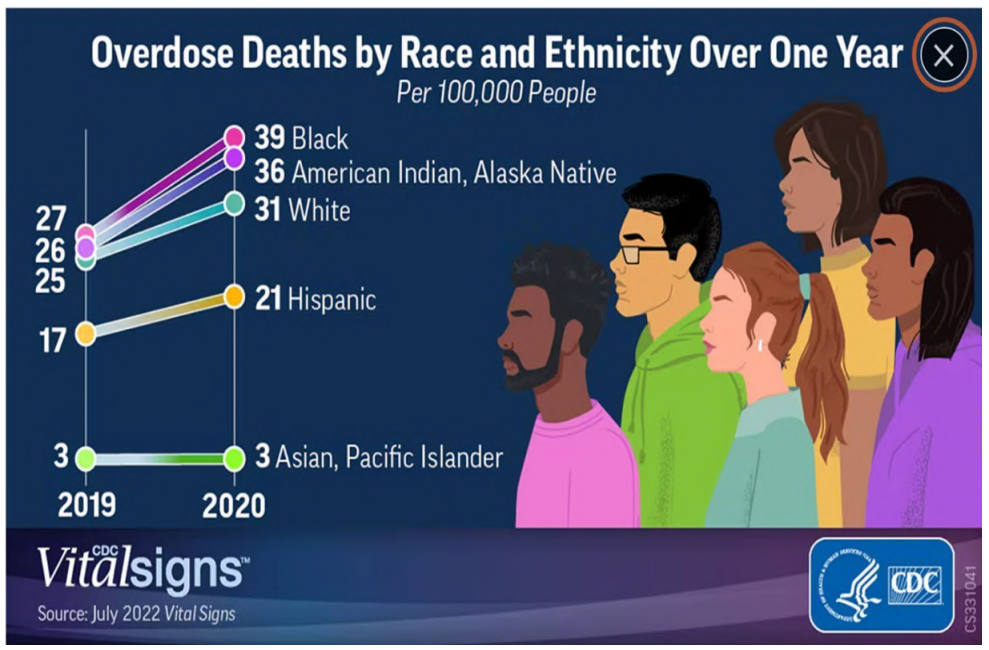

Figure 2 - Overdose Deaths by Race and Ethnicity Over One Year

Behavioral Health News Winter 2024 Issue

"The Roll of Housing and Employment in the Recovery Process"

Deadline: December 12th 2023 Call (570) 629-5960 to Discuss Your Ideas

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entitlements services, among others.

In furthering Federation's efforts for health equity, the nonprofit launched a new MOST (Mobile Opioid Support Team) in Suffolk County. They have begun deploying mobile teams to high-opioid use areas and will have two exam rooms, counseling, case management education, and more. Why is this so innovative and crucial? The more people you reach, the more you can help. There is no one-size-fits-all treatment solution and Federation literally comes equipped with all of the necessary tools.

"We have had many people come to our clinic for court-mandated substance use disorders services. They may sit with their arms crossed, denying they have a problem. But we'll talk to them and start to peel back the onion. We might see the wheels turning as they come to realize, 'Maybe I do have a problem that needs to be addressed.' Similarly, when our outreach teams are in the field, many of the individuals they encounter are not ready to seek help," Jeffus commented. "But our counselors are able to engage them in conversation and, after several of these conversations, some people feel more comfortable taking the leap to enroll in more intensive services."

Federation's impact continues to grow across Manhattan, Bronx, Queens, Brooklyn, Suffolk County and Nassau County. With multiple new programs in development, expanding existing programs, as well as the upcoming unveiling of two residential buildings in Brooklyn and Far Rockaway in Queens, Federation of Organizations consistently proves their influence as agents of change in the ever-evolving social landscape. To learn more, please visit www.fedoforg.org.

Footnotes

1. "Substance Use and SUDs in LGBTQ* Populations," National Institute on Drug Abuse, https://nida.nih.gov/research-topics/substance-use-suds-in-lgbtq-populations

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safely use and also pay rent and other costs of living. This allows our residents to remain stably housed, so that case managers and wellness coaches can continue to engage those who might benefit from additional treatment and support. Harm reduction becomes not an approach but a conversation, where those we serve feel heard and seen with compassion. Such meaningful conversations allow people served to share the depths of their experience honestly, and from that place begin their healing journey. These are the interactions that stick with us as we turn our lives around, for those of us who have been where we see others in our care. While tools help us survive while using, it is the compassionate interactions that let us see that another reality is possible for us too.

The opioid epidemic has been devastating. For many of us, this has meant losing friends, colleagues, and loved ones. Everyone in the field has been affected by this loss. When we share our recovery stories, so many of us call out the moments of kindness we received, sometimes in the very depths of our pain. It pierces through and helps guide us. This is where we are working to raise awareness about harm reduction at S:US.

At S:US we are committed to empowering the people we serve through person-centered, holistic care. Harm reduction can look different from one instance to the next. For those in supportive housing, it can be working with case managers and wellness coaches to successfully pay for rent and living costs each month, rather than lose their housing due to using all their money for substances. Every New Yorker has a right to dignity and respect in their care. Helping individuals use safely and with fewer negative consequences is central to this care.

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Rebecca Linn-Walton, PhD, LCSW

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Behavior Disorder in the ICD-11. In their official policy statement on Sex Addiction, the American Association of Sexual Educators, Counselors and Therapists (AASECT) recognizes that people may experience significant physical, psychological, spiritual, and sexual health consequences related to their sexual urges, thoughts or behaviors. However, AASECT recommends that its members utilize models that do not "pathologize" consensual sexual behaviors. In addition, AASECT does not agree that sufficient empirical evidence has been found to support the classification of sex addiction or porn addiction as a mental health disorder, and they do not find that the current sexual addiction training and treatment methods, and educational pedagogies, are adequately informed by accurate human sexuality knowledge. Therefore, it is the position of AASECT that linking problems related to sexual urges, thoughts or behaviors to a porn/sexual addiction process cannot be advanced as a standard of practice for sexuality education, counseling, or therapy.

As for the core issues underlying this discussion, pornography appears to be one of the major drivers behind the designation of Compulsive Sexual Behavior as an addiction. Pornography has been around as long as humans have created art. The word is derived from *porni* – meaning prostitute, and *graphein* – to write, meaning any work of art of literature that depicted prostitution. A carved limestone figurine of a woman whose breasts and hips have been exaggerated to emphasize her fertility-- known as the Venus of Willendorf -- has been dated c. 25,000 BCE, and several similar ivory fertility figurines have been dated even earlier. Thousands of explicit erotic figures were carved on the walls and columns of Indian temples before 1000 AD, and a tradition of intricately detailed sexually themed art prints and ivory figures were created in Japan beginning around 700 AD. Fast forward to the era of French postcards, which began around the late19th Century, usually showing suggestive or explicit images of women in various stages of nudity, with or without paramours. The 1920's - 1940's was the heyday of the so-called Tijuana Bibles, little booklets, cheaply printed on pulp paper and featuring sexually based send-ups of popular comic characters, such as Betty Boop and Popeye. This was also an era of pin-up magazines, so called because the images were meant to be cut out and pinned up on the wall. By the 1950's, advances in inexpensive 8mm movie making and projection equipment created an explosion of amateur pornographic films that were sold though an underground network of distributors.

In America, pornography was illegal from 1873- 1957 under the Comstock Act, after which Roth vs. the US redefined pornography and made it legal, except for material depicting children. This led to a proliferation of so-called nudie magazines, notably Playboy, and by the late 70s, the heat had been turned up considerably with more explicit imagery in periodicals like Hustler and Penthouse. This also coincided with advancements in inexpensive home video equipment which led to a veritable flood of amateur pornography, in addition to much slicker productions, eventually giving rise to the multi-billion-dollar porn industry we have now, worth over $100 billion annually.

In the US today, well over 60% of men and 40% of women consume pornography online each month. About 50% of all Internet traffic is related to sex. According to the Journal of the American Medical Association, Psychiatry Division about 200,000 Americans maybe classified as porn addicts, 40 Million Americans regularly visit porn sites, every second 2.5 Billion Emails containing porn are sent or received, and 25% of total Internet searches are related to pornography. This is a mass phenomenon that has had a profound effect on our society, especially for the uncounted individuals who compulsively view this material. In addition, there are over 1500 online dating 'hookup' sites with an estimated 60 million regular users. Clearly, there's a lot of non-marital sex going on. How many of these customers could be diagnosed with Hypersexuality?

Of course, not all consumers of porn, or customers of dating apps, exhibit Compulsive Sexual Behavior Disorder, but as can be attested by numerous therapists in private practice, as well as those who work in addiction clinics, such as American Addiction Centers, the rise of this phenomena has been dramatic and significant over the past decade or so.

According to the Mayo Clinic, some signs that one may have compulsive sexual behavior include:

· Having repeated and intense sexual fantasies, urges, and behaviors that take up a lot of time and feel as if they're beyond one's control.

· Feeling driven or having frequent urges to do certain sexual behaviors, feel a release of the tension afterward, but also feel guilt or deep regret.

· Trying without success to reduce or control sexual fantasies, urges or behaviors.

· Using compulsive sexual behavior as an escape from other problems, such as loneliness, depression, anxiety, or stress.

· Continuing to engage in sexual behaviors despite them causing serious problems. These could include the possibility of getting or giving someone else a sexually transmitted infection, the loss of important relationships, trouble at work, financial issues, or legal problems.

· Having trouble making and keeping healthy and stable relationships.

A final word regarding Paraphilic Disorders, which were mentioned earlier. The DSM defines 8 types of these conditions, including pedophilia, exhibitionism, voyeurism, sexual sadism, sexual masochism, frotteurism, fetishism, and transvestic fetishism – however these 8 categories include over 300 different variations, some of them quite dangerous for both the paraphilic individual, and for anyone who they may become fixated upon. Some dangers may include possible lethal outcomes for one or both parties. There is no doubt that some of the very graphic pornographic material available will feed into the more dangerous of paraphilic sexual obsessions, and an official, recognized diagnosis that includes compulsive porn viewing may help to promote better treatments for such individuals.

Contact Dr. Gene Ira Katz at geneirakatz@yahoo.com or at 720-339-8174 (leave confidential message). Learn more about Dr. Katz here.

Lessons from Page 28

support one another in advancing co-occurring competent systems. Participating entities drafted and voluntarily adopted a charter that explicitly states that each organization will work to advance a co-occurring system of care. Additionally, participating organizations support each other in advancing co-occurring competency by sharing knowledge and expertise, with a focus on licensing/regulatory, quality improvement, and prevention/ community engagement. Participating organizations also utilize a tool--the Compass-EZ-- to evaluate their level of co-occurring competency and establish goals, including promoting a welcoming atmosphere from the time an individual makes initial contact through assessment, planning, treatment, and recovery supports. Further, organizations revised promotional and educational materials, including websites and brochures, to explicitly state that people with complex needs are welcomed into treatment, and that the organizations themselves are committed to advancing co-occurring competent care.

As Westchester COSOCC members began goal-setting and prioritizing next steps, several provided opportunities for staff to be trained in foundational approaches to co-occurring competent care. Funding provided by The Harris Project Inc. supported countywide workshops and the opportunity to have Dr. Minkoff work with agencies and staff to address specific topics of interest. The County began working strategically with the New York State Psychiatric Institute's Center for Practice Innovations (CPI) to enhance offerings. CPI helped develop a set of "core competencies" and continues to bring a "stages of change" lens to the effort. WJCS partnered with the Center on Alcoholism and Substance Abuse to implement trainings
across its clinics, seeking to challenge notions about the success of consecutive and concurrent models of co-occurring treatment while advocating for a "No Wrong Door" approach. Universally, efforts have been made to address staff concerns, myth-bust around certain preconceived ideas, and provide follow-up training, consultation, and supervision to build comfort and ensure successful implementation. CPI also worked with Westchester DCMH to develop a countywide co-occurring system of care orientation and learning collaborative.

In the spring of 2021, The Harris Project Inc. received funding to support a pilot of Encompass – a modular evidence-based treatment protocol for those 12-29 with co-occurring disorders. Encompass uses cognitive behavioral therapy and motivational enhancement therapy to facilitate acquisition of new skills and coping strategies, reducing harmful substance use and improving mental health with motivational incentives reinforcing changes in substance use and increasing engagement in non-drug pro-social activities. Treatment consists of approximately 17 weekly outpatient individual sessions and may include a family component to ensure that parents/caregivers have the tools needed to support their teen/young adult during all stages of recovery. Several youth-serving agencies joined the pilot, now in its third iteration, with more than 50 clinicians from six agencies participating. WJCS has been a leader with more than a third of its clinicians either fully certified or in the process of certification in Encompass, and its own clinical consultation meetings to support fidelity. This effort has led to a larger commitment to building a wraparound model of care for teens and young adults with co-occurring disorders. This includes a wraparound coordinator, parent/guardian/loved one support, and a bolstering of CODA (Co-Occurring Disorders Awareness) prevention education.

William A. Mullane, PhD

Stephanie Marquesano, JD

Michael Orth, MSW

In furtherance of this commitment, WJCS has taken the lead in supporting staff delivering CRAFT (Community Reinforcement and Family Training) with fidelity. Since those with co-occurring disorders often have greater challenges, including a lack of social support, providing a modality like CRAFT can support parents/guardians/loved ones is important. CRAFT helps concerned significant others to effectively support their loved ones entering and remaining engaged in treatment, undoing traditional harmful confrontational approaches popularized by television. Training staff in CRAFT is necessary because staff, like our clients and their families, are exposed to those same harmful confrontational approaches, and staff are seldom trained in systems interventions like CRAFT.

Another "missing piece" has been the ability to help youth navigate to positive, prosocial, non-substance related activities. Most recently, we launched a curated platform in Westchester County that relies on youth leaders who work with an adult coordinator to develop in-person and online activities and programs. The platform, named "Inclure" (Encompass in French), aligns with a key element of Encompass which asks clients to complete two prosocial non-substance involved activities each week. It also draws youth who have chosen to be substance free, as well as allies of substance free lifestyles.

Another lesson learned throughout this journey is the need to enhance the motivation of individuals to make changes in problematic substance use given that a major barrier to substance-involved individuals seeking treatment is lack of awareness of a problem and that many seeking treatment for SUD often lack the desire to change their substance use. Although many staff are trained in Motivational Interviewing (MI), and many believe they utilize MI, arguably few practice it with sufficient fidelity. In recognition of this, with support from Opioid Settlement Funds provided by DCMH to WJCS, WJCS is providing staff with significant training in the use of MI. That training will use a supported implementation model like that utilized in the Encompass pilot, which includes training plus ongoing supervision and implementation consultation. MI advances co-occurring competency and better prepares our system of care to work with individuals who do not always come into care motivated to make needed changes. Utilizing MI enables individuals to find their intrinsic motivations for change and make the most of other evidence-based treatments, including evidence-based treatments for co-occurring disorders.

Another lesson is that our systems must inoculate themselves against staff turnover that is largely attributable to wages. Without significant advances in behavioral health care rate reform and meaningful enforcement of behavioral health care reimbursement parity, there must be creative solutions. While there are likely several approaches to addressing this need, one approach taken by WJCS is to invest in training of supervisors in co-occurring competent supervision through approaches like Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA: STEP) which offers a mechanism for organizations to train supervisors in supporting their supervisees in the use of MI. Such promising practices support organizations in retaining training gains by investing in supervisors to support staff to effectively work with individuals with multiple complexities.

Finally, it is critical to remember that the development of co-occurring competency is not simply an initiative, it is a transformation. As such, support must be provided through strategic and integrated funding and by investing in research and evaluation of promising and evidence-based practices.

About the Authors

William A. Mullane, Ph.D., is a clinical psychologist and is the Director of Innovation, Integration, and Community Partnership at Westchester Jewish Community Services. He also serves as a Co-Chair for the Westchester County Co-Occurring System of Care Committee as well as a Co -Chair for Coordinated Behavioral Health Services' (CBHS) Co-Occurring Disorders Taskforce.

Stephanie Marquesano, JD, is the founder and president of The Harris Project, Inc., a 501(c)(3) non-profit organization founded after the accidental overdose death of her 19-year-old son, Harris, who also faced challenges with co-occurring disorders. The Harris Project Inc. is an organization dedicated to the prevention of co-occurring disorders (COD) through its CODA (Co-Occurring Disorders Awareness) model, and the development and implementation of best treatment practices (including the building of a co-occurring system of care) to meet the complex needs of the individual. She serves as a member of the NYS Opioid Settlement Fund Advisory Board, co-chairs the Westchester County Co-Occurring System of Care Committee, and serves on several regional and statewide committees bringing her perspective to this critical topic.

Michael Orth, MSW, is the Commissioner of the Westchester County Department of Community Mental Health, a branch of county government responsible for planning, oversight, education, and coordination of services and supports for individuals, and their families, with mental illness, developmental/intellectual disabilities and substance use challenges. He has served the Department in various capacities for more than 30 years.

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This workbook is designed to assist you to recognize early signs of relapse and to independently develop and apply behavioral skills to reduce the risk of relapse. This book will help you recognize relapse as something that can be in your control.

The booklet was a tool to assist the COD patient in developing a personal action plan to prevent relapse. The plan was put together in individual and group sessions during their inpatient stay at MCES. The completed booklet-based plan was designed to be used actively after discharge. It was to be reviewed daily for a week or two and then at regular intervals. Patients learned that using the plan developed in the MAP booklet prepared them to spot the subtle signs of relapse.

The MAP program enabled COD patients to take a tangible relapse prevention resource home with them and apply what they had learned during their hospitalization. While MAP was often initiated in inpatient groups, it was a self-help tool that could be used independently in any setting. This is demonstrated by the requests for copies that MCES has received for the past twenty years from all over the US, including several each year from inmates at correctional facilities.

The weeks after discharge from a psychiatric hospital are a high-risk period for patients, especially for those with COD. Stressors and challenges are effectively

on-hold in an inpatient setting. At discharge there is an abrupt transition from a highly structured and supportive environment to one much less so. Resilience and coping skills may be inadequate, and patients experience a recurrence of mental illness symptoms leading to self-medication and relapse.

Adherence to the discharge plan and their MAP helped many COD patients manage to return to community living. However, some patients needed a strong framework to keep them on track to recovery and sobriety on a day-to-day basis, at least temporarily. This led to the development of the Ongoing Abstinence Recovery Schedule™ (OARS), a voluntary program offered by our Allied Therapy Department to guide and support patients in preparing a personal daily/weekly recovery schedule to sustain a sober lifestyle after discharge.

During their stay, MCES COD patients complete an individualized OARS covering:

· Their triggers and how to deal with them

· 101 sober enjoyment options

· Planning spiritual/quiet time

· Daily/weekly activities

OARS guides patients in developing a personal daily and weekly hour-by-hour recovery schedule while at MCES that can be followed at home or in an outpatient setting. Patients going to rehabilitation are advised to defer OARS during that treatment but include what they learn.

OARS enables patients to organize their day in terms of:

· Medication times

· Outpatient times

· Peer support times (e.g., AA, NA meetings)

· Spiritual/quiet times

· Sober recreation/relaxation times

These elements are blended with family time, meals, sleep hours, work hours, childcare, shopping, and other activities. OARS subtly reinforces social connections, minimizes downtime that may affect sobriety, and keeps a focus on necessary tasks and obligations.

OARS aids in retaining the benefits of inpatient treatment and facilitates continuing progress in recovery after discharge. OARS fosters a structured lifestyle and self-discipline. MAP is a tool for managing the substance use side of their co-occurring disorders. OARS gives patients a means to manage their daily living in a manner conducive to promoting recovery, sobriety, and wellness.

OARS requires a considerable investment of effort and commitment by patients. MCES acknowledges the effort patients make participating in OARS. An important component is recognition and reinforcement of patient commitment, enthusiasm, and success. Patients who complete OARS receive a certificate of accomplishment, and their achievement is celebrated in recovery groups and at awards ceremonies.

OARS graduates have fewer rehospitalizations and longer intervals between readmissions. MCES has incorporated OARS parameters into its electronic medical record system so it can measure OARS performance and outcomes over time. The MCES COD Committee, which includes both clinical and administrative staff, oversees the OARS program and related services.

Going forward, MCES plans to try to do more follow-up in the community after discharge with OARS graduates to directly support their recovery and reduce their risk of readmission. The latter will benefit us as our payers increasingly use performance-based reimbursement approaches incentivizing fewer and less frequent readmissions by high utilizing patients.

Montgomery County Emergency Service is a nonprofit mental health crisis service founded in 1974. More information is available at www.mces.org. Questions about this article may be directed to Tony Salvatore at tsalvatore@mces.org or 484-754-2447. Tony wishes to thank Mike Melcher, Karen Gribosh, and Tom Siolek, Jr., among the many individuals who contributed to MCES's COD efforts over the years, who reviewed this article for accuracy.

Technology from Page 33

the fusion of human expertise with digital precision offers a beacon of hope for those navigating the challenges of SUD.

Technology's pivotal and emerging role in aiding those with substance use disorders cannot be understated. By marrying innovation with empathy, we are not only offering better tools for recovery but also fostering a more compassionate, accessible, and individualized approach to care.

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relapse by doing so, research shows that integrated treatment, with concurrent therapy for mental illness and nicotine addiction, proves to have the best outcomes.[22 23 24 25 26 27]

Systemic, evidence-based screening and treatment of tobacco dependence is integral to improving patient health outcomes. These standards are in alignment with the US Public Health Service's Clinical Practice Guideline - *Treating Tobacco Use and Dependence*: 2008 update, which includes best practice systems strategies for organizations to use with their clientele. Systems Strategy One ensures that a tobacco-user identification system is present in every clinic. That system should include the evidence-based tobacco dependence treatment prompts of the 5A's: Ask, Advise, Assess, Assist and Arrange. Systems Strategy Two ensures that education, resources, and feedback are present to promote provider intervention. The final Systems Strategy is to identify dedicated staff at a given provider location to dispense tobacco dependence treatment and assess the delivery of this treatment with other staff members in the office.

For more information on how to best address tobacco use, visit the Center for Disease Control website to identify your state's tobacco control program contacts.

Kristen Richardson, RN, CTTS

Danielle O'Brien, CTTS

Kristen Richardson, RN, CTTS, and Danielle O'Brien, CTTS, are the Director and Program Coordinator, respectively, of the Central New York Regional Center for Tobacco Health Systems at St. Joseph's Health in Syracuse, NY. The program is funded through a grant from the New York State Department of Health Tobacco Control Program. More information can be found at http://www.nyhealthsystems.org. Kristen Richardson or Danielle O'Brien can be reached directly at Kristen.Richardson@sjhsyr.org and Danielle.L.Obrien@sjhsyr.org.

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See the full list of references here.

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crisis, it is important to recognize and manage the potential disadvantages and challenges of this treatment model. By acknowledging potential drawbacks of CIOTPs, policymakers and healthcare professionals can work to mitigate them, maximize benefits, and minimize any negative impacts.

Comprehensive integration between outpatient and residential treatment programs marks a significant step forward in the realm of addiction and mental health recovery. By combining the strengths of both approaches, individuals can experience a more gradual, personalized, and effective journey toward sustainable healing.

By integrating outpatient and opioid treatment, NYS is redefining addiction treatment. The focus on individualized care is lighting the way to a brighter future for those affected by opioid addiction. In fact, CIOTPs are proving to be a transformative pathway to recovery. The new program type recognizes the complexity of addiction and the resilience of the human spirit.

As the field of treatment continues to evolve, embracing the integrated approach of CIOTPs has the potential to revolutionize how we approach recovery, offering clients newfound hope and optimism on the path to lasting wellness.

Dr. Carolann Slattery, EdD, LCSW-R is VP for Outpatient Services and James Hollywood. LCSW, is VP of Residential and Recovery Services at Samaritan Daytop Village.

Resources

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The Changing Opioid Crisis: development, challenges, and opportunities Nora D. Volkow, M.D.1, Carlos Blanco, M.D. Ph.D.1 1National Institute on Drug Abuse, Bethesda, MD 20892Mol Psychiatry. 2021 January ; 26(1): 218–233. doi:10.1038/s41380-020-0661-4.

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their own healing as well.

The underlying principle is that recovery is possible for individuals and families, and hope is still alive. Recovery is something to be proud of and grateful for. Recovery deserves to be celebrated by the recovered, their community and loved ones.

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counseling, and having informal conversations with colleagues and friends about the stress of the job can help reduce the impact of PTSD from frequent overdose response. Organizations should also implement role switching to minimize time in the field, reduce burnout and give responders a mental and emotional break from the trauma.

Finally, we must find ways to make community mental health resources more readily available through walk-in clinics and telehealth, and to expand the number providers, especially in areas most impacted by the overdose epidemic. Not only is SUD itself often driven by underlying mental health issues, but the impact of SUD and overdoses on families and communities is creating a secondary mental health crisis that must be addressed before it turns deadly.

Dr. Lawrence Weinstein is Chief Medical Officer at American Addiction Centers. In addition to nearly 20 years of experience in managed behavior healthcare and senior leadership, he has also been in private practice, providing individual and group diagnostic psychotherapeutic services, family therapy and addiction psychiatry.

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that if you were an injection drug user, you were able to get access to a clean syringe every single time you used and you didn't have to share those with anymore. It was really through the HIV/AIDS community that we got harm reduction here in the United States. In other parts of the world, especially in England, they've been practicing harm reduction since the 1970s. It just took us a little bit longer to adopt it. But it really was during a public health crisis – an epidemic – that we were experiencing in the 80s and 90s that activists said, "What we're currently doing isn't working. We have to do something else. And what can we do?" And harm reduction truly was one of the answers to the problems that they had.

David: It is so interesting to learn about the history that has led to where we are with harm reduction today. What makes harm reduction services so critical right now? And are they evidence-based and proven to be effective?

Mary: As you know, we are in the midst of an opioid epidemic. In 2021 (we don't have confirmed data for 2022 yet) across the United States, over 100,000 people died in one year of unintentional drug overdose. If COVID-19 hadn't come along, this would have been the largest public health crisis we had ever had - the largest epidemic we would have ever had in one year. During the HIV/AIDS epidemic, it took almost 9 - 10 years to reach 100,000 deaths from HIV/AIDS. We are reaching those numbers every single year - we're really in a crisis right now. We're in a drug poisoning and an overdose crisis. Right now in New York State, and this is a really sobering statistic that I think is really important, one person dies every five and a half hours of a drug overdose. When you come into New York City, those numbers are even worse - it's one every three hours. When I started working in New York State or in New York City specifically in 2017, that statistic was one person every eight hours. The problem is only getting worse. More people are dying. And I think when you're in a community and you see that kind of loss of life, you have to take a look around and say, "We have to do something differently. What we have historically been doing is clearly not enough. We have to look for all ways and opportunities to implement any positive change to help people live another day." And I think that's why harm reduction is so important right now.

A huge component of harm reduction is really removing as many barriers as we possibly can to get an individual engaged into care. An example of that is in my division where we're funding 15 organizations throughout the state to implement a low threshold buprenorphine project. Buprenorphine is a medication for opioid use disorder. It's really the gold standard of medication for addiction treatment. It used to be that there were many barriers that a person had to overcome in order to gain access to a life-saving medication for opioid use disorder. And so, part of this project is focused on how we can remove those barriers. How can we have a person present to one of our programs and say, I have opioid use disorder and I'm ready to start medication for addiction treatment today? And how can they then leave that appointment with a prescription in hand to start that medication? That's new and revolutionary for us. It used to be that if a person was prescribed buprenorphine and they have a toxicology screening come back and it shows that it's positive for cocaine, they were disengaged from care. Their medication was taken away from them because they were not abstaining from all substances. And we have to recognize that this isn't a requirement for gaining access to medication. I was on a call this morning where we were discussing this - would you do that to a person who had diabetes? Would you cut them off from care if their A1C numbers were not improving? If they weren't adhering to the nutrition plan that you gave them? No. That's a moment to be able to wrap around even more services to them and say, "Ok, you have the medication. What else is going on and how can we help you?" I think that's where we are right now. That's why harm reduction is so important and why we should embrace it.

Harm reduction is absolutely evidence-based. Again, syringe exchange programs started in the United States or in New York City in 1993. They had been happening on the West Coast since 1988. It's been over 30 years now, almost 40 years. That's terrifying. It doesn't feel like it's been that long ago. Almost 40 years of evidence to show that syringe exchange programs are effective at decreasing HIV and hepatitis C rates. We know that for a fact. Medication for opioid use disorder. Again, those gold star medications, - buprenorphine and methadone - they're associated with at least a 50% decrease in mortality. No other medication that we have does that for a disease state. That's evidence-based. We know these medications are effective at keeping people alive. We've seen the peer distribution of naloxone. Naloxone is the medication that is used to reverse an opioid overdose. It's a life-saving intervention with people who are most likely to witness their peers experience overdose. And we know that having peers distribute naloxone has led to that increase in naloxone and is not associated with an increase in substance use. We know that naloxone saturation helps drive down those overdose numbers. Because when someone is able to witness an overdose and has a life-saving medication in their hand, we know that they can save a life. I think that the research is there, and it really does show that implementing harm reduction and low-threshold services helps people engage in life-saving care.

David: You're so right - engaging peers to save lives with naloxone is such an effective and proven method of harm reduction. How does the harm reduction approach align with existing prevention, treatment, and recovery models in the field?

Mary: The way that I think about harm reduction is as a continuum, it's a buffet. Prevention, treatment, and recovery are all harm reduction interventions. Preventing and delaying initiation of use, that's harm reduction. Pat Zuber-Wilson is our Associate Commissioner of Prevention and she and I work closely on what harm reduction messaging look like because prevention is all a harm reduction message. Treatment is harm reduction, right? We just talked about medication for opioid use disorder. That's a harm reduction strategy because it is decreasing risk associated with substance use. Even if a person uses methadone only one time a week, they don't go every day for their take-home doses, they just go one time a week. That's one instance where we know they are using a safe substance that is regulated for them to use. And recovery is also harm reduction. Recovery is individualized - that's something that we at OASAS have recognized for a long time. Recovery is harm reduction, recognizing of course that abstinence may not be where everyone lands on that continuum of use to abstinence, but recovery is 100% harm reduction. Again, my division doesn't stand apart from prevention, treatment, and recovery. I stand alongside them in working to ensure that all of our services, that the common thread that we're pulling through, are a harm reduction message and are done through a harm reduction lens.

David: Harm reduction, as you know, does have its critics and controversies. In your view, why is that? And what steps are you and OASAS taking to increase acceptance of harm reduction among both people who use drugs and service providers?

Mary: I think that there is this common misconception that harm reduction is against recovery, against treatment, and is against abstinence. That is absolutely not the case. I think what harm reductionists recognize is that we can't mandate care to a person - that a person has to be engaged in that care - and again, recognizing that treatment and recovery has to be individualized. And that can be very controversial. People think that harm reductionists are condoning substance use, that we are encouraging people to use drugs. I would say that's partially true. We're not telling people to stop using drugs. What we're encouraging is safer drug use, safer substance use.

You know, as a harm reductionist, I recognize that substances have been a part of our history forever. Think back to the Greeks and the Romans. They drank wine. Wine is a mind-altering substance and we have been drinking wine for thousands of years. Substances will always be a part of our reality and harm reduction recognizes that. We aren't trying to eliminate substances. We're trying to minimize any of the risks and dangers that are associated with substance use. And I think that can be very controversial when you're talking about drugs. You know, here in the United States, we've done a really, really good job of demonizing substance use and demonizing people who use drugs. And we see the negative consequences of substance use, especially as we've criminalized substances and we've seen all of the arrests. I think that harm reduction is often questioned, "How can you support someone using drugs?" I'm not supporting their substance use. I'm supporting them using safely. That's our goal, to keep people alive and to keep them safe so that if they ever decide to engage in treatment and recovery, we are there for them. I hate this phrase, but I think it's really important: A dead person can't recover. And that's why harm reduction is so important to us. Again, a lot of controversy still around substance use, a lot of controversy around harm reduction. You know, in 1993 syringe exchanges became legal and they're still controversial, even though we have all the data to show how effective they are at preventing HIV and hepatitis C, which was their intended purpose.

The way that OASAS is trying to increase acceptance of this approach is through the creation of our Division of Harm Reduction and that the philosophy of harm reduction care is something they believe in. Increasing acceptance is done through working with the OASAS provider systems. You know, I've told all of our providers, "Invite me into your staff meetings. I'm happy to come in and talk about what harm reduction actually is and what harm reduction isn't." I think it is a really important conversation, but what is harm reduction? It's important to explain it, to take a lot of that myth out of what harm reduction is, debunk these preconceived notions, and really explain what harm reduction is from a very basic level. Explain why we're embracing it and how a person can actually implement harm reduction services into their system of care. You need a lot of education and training.

David: You spoke earlier about the demonization of drugs and drug users. That makes me think of stigma and how the stigma around substance use is one of the biggest barriers for people seeking and receiving the help they need. How does stigma play a role in working with people who use drugs and what steps can be taken to reduce this stigma?

Mary: Yes, I think stigma is our biggest barrier to working with people who use drugs. They experience stigma everywhere. They have institutional stigma against them. There's social stigma against them, internalized stigma, not feeling valued, not feeling self-worth because "I'm a person who uses drugs." I come from the HIV/AIDS community. I'm very aware of stigma. It's been something that's followed me my entire career. I actually remember my first job interview right out of grad school and it was with an HIV/AIDS service organization. And the Executive Director asked me if I felt comfortable having the word AIDS on my resume because that's a big black check mark on my resume that I've worked with HIV/AIDS.

I think stigma is especially prevalent when you're working with the most marginalized communities, and people living with HIV/AIDS are some of the most marginalized. People who use drugs are some of the most marginalized members of our community as well. Stigma follows them everywhere they go. And stigma absolutely kills people because it stops them from coming into our door for care.

I think some of the steps that we can take is the language we use - making sure that the language that we use is not stigmatizing people. You'll notice I don't call people "substance abusers." I don't call people "addicts." That's stigmatizing language. It is important to make sure that we use person-first language such as people who use drugs, a person who uses drugs, and not using words like junkie, right? That's such a stigmatizing word. And also not using the words clean and dirty. I think a lot of times we use what I consider to be slang when we're talking about your toxicology screenings and we should really be using really clinical language. That's a clinical test that a person takes. It's not clean or dirty, it's positive

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or negative. Their urine was positive for, their urine was negative for. I think that's really important because if a person is clean, that implies that they used to be dirty and people aren't dirty, we're not dirty people.

We really think the language that we use matters, the way that we talk about people who use drugs matter, and just recognizing people's humanity and recognizing that people, regardless of whether they use substances or not, are worthy of dignity and respect is a good place to start. It takes a lot of work. We all have a bias, right? And I think it's as service providers, it's recognizing what our own bias is and being able to talk about that bias and work through it. Behavioral Health News is not one of them, but the media in general has done a really good job of stigmatizing people who use drugs. If you look at the New York Post any day of the week, you will see horrible headlines referring to people who use drugs as junkies. That language is so inflammatory to use. I understand it sells newspapers, but when we hear that language it should be called out. I think it's really important to correct people's language and explain that this is the reason we don't say addict. There's a reason that we say "a person with a substance use disorder." I think that's a huge way that anyone can address stigma and work to de-stigmatize drugs and people who use drugs.

David: I agree that the language we use is so important. We are always looking to avoid the use of stigmatizing language in Behavioral Health News. Can you provide some specific examples of how harm reduction is successfully being implemented in New York State to save lives?

Mary: Absolutely. New York State is leading the way in implementing innovative harm reduction and addiction services. Colleagues from across the country contact us to learn about the programs we have successfully rolled out. Some impactful initiatives we have undertaken since 2006 include creating opioid overdose prevention programs. Through these programs, even those without medical training like myself can access the medication naloxone. Naloxone reverses opioid overdoses and saves lives. In 2006 we began building these programs, and we have since expanded them dramatically. Now OASAS is making naloxone widely available to providers in our health systems and directly to New Yorkers in need. People can easily obtain naloxone through a website where they enter their information and we ship the medication to them. We have also made fentanyl test strips available statewide to both residents and providers. This is crucial because fentanyl is involved in over 80% of fatal overdoses. The test strips allow people who use drugs to test their substances for fentanyl contamination. If positive, they can make informed decisions to reduce their risk of overdose. By getting naloxone and test strips into the hands of those who need them most, we empower New Yorkers to take actions that save lives.

I'm proud that even though state government can be slow to act, we quickly pivoted when the drug xylazine began appearing in the supply. We rapidly made xylazine test strips available to people who use drugs. This allows them to test for contaminants beyond just opioids. Our partners at the New York City Department of Health and Mental Hygiene and the state Office of Drug User Health were also quick to establish drug checking programs. These allow people to bring in substances to be tested so they can make informed choices about use.

Another lifesaving area we have decades of experience in is syringe service programs. Our partners at the Department of Health oversee these programs, which have operated in New York for over 30 years. We now have over 30 syringe exchange programs across the state, reaching New York City and remote areas alike.

I'm originally from Kansas where shockingly there was not one statewide syringe exchange program as of 2002. Meanwhile we have over 30 programs serving New Yorkers. Expanding these services remains a point of pride.

Additionally, we have expanded medication for addiction treatment, known as MAT, into all state jails and prisons. Incarcerated individuals with opioid use disorder now have access to these potentially lifesaving medications. Ensuring connections to care so they can continue their MAT upon release is also a priority.

I will briefly note the overdose prevention centers run by OnPoint in NYC. These are not overseen or funded by OASAS or the Department of Health. And I should make sure to mention that Governor Hochul has not taken a position on overdose prevention centers. These are not legally operated, but a tenet of harm reduction is you do what's right, not what's allowed. These are the only two overdose prevention centers in the nation. They're located in East Harlem and Washington Heights, which have some of the highest rates of fatal overdose deaths in the city, where one person is dying every three hours. They recognized there was a need for these services, and so they implemented the overdose prevention centers, which are new to the United States, but not new globally. There are over six countries that have overdose prevention centers. In their first year and a half of operation, they reversed over 1,000 overdoses. That's 1,000 lives that they saved in one year. These centers are highly controversial, but they're saving lives. Controversy aside, our job as service providers is to make sure that our clients are thriving, living healthy lives, and living to see another day. That's what OnPoint is doing.

David: Wow, the impact you're having and the number of lives you're saving is really incredible. To wrap up, what message of hope or encouragement would you like to share with the substance use disorder community about the potential of harm reduction?

Mary: While harm reduction is not new, we are expanding its reach and ensuring it has a seat at the table. With our division's growth and singular focus on harm reduction, I hope to see more programs statewide and more lives saved.

I'm thrilled we have a major naloxone distribution project underway, saturating communities with this lifesaving medication. If someone witnesses an overdose, they now have the tools to intervene. It seems these efforts are gaining acceptance, which is heartening.

Tragically, it took the staggering loss of life from overdoses for many to recognize the importance and urgency of harm reduction. But I'm hopeful the tide is turning. More people understand we must take action - we cannot continue business as usual. All hands are needed on deck for this work.

There's an excellent TED Talk by the sociologist Johann Hari called Everything You Know About Addiction is Wrong. He concludes that for too long we have been singing war songs about drugs, when we should have been singing love songs to people who use drugs.

I think we are starting to embrace that mindset of leading with love and compassion. We must keep our doors open, meet people where they are, and engage them in whatever way we can to support positive changes. That is my hope, and I sincerely hope we can curb the devastation addiction has brought our communities.

David: Thank you for sharing such an inspiring and thoughtful message. It's clear you and your team are dedicating tremendous effort to bring these ideas to fruition. Your commitment to meeting people with compassion comes through loud and clear.

Mary: I appreciate you taking the time to have this conversation. It's been a pleasure to share details about the meaningful harm reduction initiatives happening here in New York and at OASAS. My hope is that audiences not only learn about the progress being made, but also gain a deeper understanding of the compassionate, person-centered philosophy behind our work. If we lead with an open heart and make human connections, real change is possible. Thank you again for this opportunity to discuss how we can build healthier, safer communities together.

For more information about harm reduction initiatives and resources from the New York State Office of Addiction Services and Supports (OASAS), please visit oasas.ny.gov/harm-reduction and stay tuned for our next installment of the Behavioral Health News Spotlight on Excellence Series.

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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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