

Chronic Pain and Its Impact on Behavioral Health

Beyond the Pain: Insights From Individuals Living With Chronic Pain

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

Chronic pain is a significant contributor to disability among Americans, with an estimated 51.6 million people experiencing chronic pain that lasts longer than three months. (Rikard, Strahan, Schit, & Guy, 2023). Regardless of its source — whether medical or unexplained origin — chronic pain can have detrimental effects on physical, psychological, and social well-being, significantly impacting the quality of life for those affected. Due to these detrimental effects, mental health therapists are essential in helping chronic pain sufferers manage their condition. However, many chronic pain sufferers do not seek mental health services due to feeling unaccepted, disbelieved, and disempowered by mental health providers (Darlow et al., 2013). The best way for mental health therapists to understand the impact of chronic pain is by learning directly from those experiencing chronic pain, who can provide insights into the challenges associated with chronic pain



(Apkarian, Baliki, & Geha, 2009; Suso-Ribera, Camacho-Guerrero, McCracken, Maydeu-Olivares, & Gallardo-Pujol, 2014).

Even though exploration of the lived experiences of chronic pain sufferers may uncover potential approaches that therapists can use with clients experiencing

chronic pain, there is limited research (Osborn & Rodham, 2010). To contribute to this gap in the chronic pain literature, I interviewed 10 individuals with chronic pain who were between the ages of 42 and 65 and currently lived with chronic pain. Chronic pain durations ranged from four

to 10 years. I asked open-ended questions that centered around the challenges of living with chronic pain.

Stigma

All interviewees reported stigma, ranging from doctors not believing pain intensity to challenges obtaining pain medications to friends not believing their chronic pain.

One interviewee explained, “I feel like a criminal picking up my meds. Yes, they are opioids, but I am not an addict; I am in pain...Every time I pick up my meds, the pharmacy tech gives me the ‘disgusted’ look.”

All interviewees limit discussions with family and friends regarding their treatment because some view them as “druggies” or “just faking it to get pain pills.”

Another interviewee said, “Since I do not have a visible injury, it is difficult coping with the misunderstanding from others. Some question whether I am lying about my pain intensity.”

Another interviewee reported harassment when using Costco handicapped parking spaces. “People say I am lying to

see Beyond the Pain on page 31

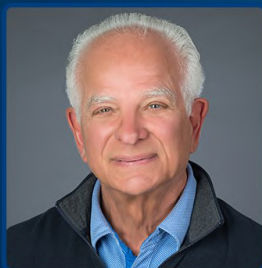
CELEBRATING 25 YEARS · 1999 - 2024

MENTAL HEALTH NEWS EDUCATION
PUBLISHER OF AUTISM SPECTRUM NEWS AND BEHAVIORAL HEALTH NEWS

2024 Leadership Awards Reception

Celebrating Outstanding Leaders Making a Difference in People's Lives

Thursday, May 16, 2024 at 5:00 PM



Bruce E. Feig

Senior Healthcare Consultant
Sachs Policy Group
Healthcare Leadership Award



Rita M. Gardner

President and CEO
Melmark
Excellence in Autism Award



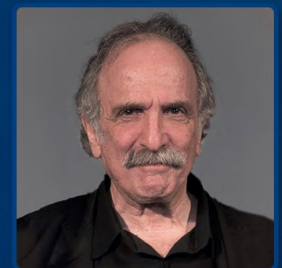
Dr. Rosa M. Gil

President Emeritus
Comunilife, Inc.
Diversity and Community Health
Leadership Award



Relias

Dr. Rola Aamar (Accepting)
Partner, Behavioral Health Solutions
Corporate Leadership Award



Harvey Rosenthal

Chief Executive Officer
The Alliance for Rights and Recovery
(Formerly NYAPRS)
Lifetime Achievement Award

[Click Here for Details and Registration](#)

A smiling woman with short dark hair, wearing a grey turtleneck sweater and dark pants, stands with her arms crossed in a modern office environment. The background shows office desks, chairs, and windows. The text is overlaid on the image.

Transform how
you **hire & train**
your staff.

RELIAS
relias.com

Table of Contents

Chronic Pain: And Its Impact on Behavioral Health

- 1 Beyond the Pain: Insights From Individuals Living With Chronic Pain
- 4 Suffering Across Settings: Multidimensional Care for Chronic Pain
- 6 Improving Staff and Patient Satisfaction with Compliance Technology
- 8 Does Medical Cannabis Treat Chronic Pain?
- 8 A Transformative Shift in New York’s Medicaid Landscape
- 10 A “Prescription” for Integrated Care for Chronic Pain
- 12 Aging, Pain, and Behavioral Health Challenges
- 14 Seeing Through Crisis: A Behavioral Health Approach to Chronic Pain
- 16 NYSPA Report - Chronic Pain and Behavioral Health
- 18 Chronic Pain: Good Advice is Easy to Give but Hard to Take
- 18 Revolutionizing Healthcare: The Future of Integrated Care for All
- 19 Recovery: An Ongoing Process, Not a Destination
- 20 Chronic Pain, Quality of Life, and Suicidal Behavior
- 21 Chronic Pain and Its Impacts: Possible Management Options
- 21 Insights from Personal and Professional Frontlines
- 22 75 Years: AHRC New York City to Celebrate Milestone Anniversary
- 23 Fifty Years Forward: NYPCC’s Journey of Hope and Healing
- 24 Understanding and Addressing Childhood Trauma
- 24 Adolescent Gambling: A Growing Concern
- 25 Disparities in Pain Management
- 25 Your Options for Responding to Mental Illness Stigma
- 26 Anxiety and Psychosomatic Symptoms in Schools
- 27 The STAR Program’s “Stop Mental Health Stigma” Campaign
- 27 Breaking Mental Health Stigma in the NYC Hispanic/Latino Community
- 28 Breaking the Stigma with ICAN’s Innovative Campaign
- 28 Combating Mental Health Stigma in a Rural Community
- 29 A Toolkit for Overcoming Mental Health Stigma in BIPOC Communities
- 29 Empowering Communities through Inclusion and Anti-Stigma Efforts
- 30 Stories of Stigma in the Healthcare System

Editorial Calendar

Summer 2024 Issue

Caring for Older Adults

Deadline: June 13, 2024

Fall 2024 Issue

Navigating the Challenges and Potential of Virtual Mental Health and Addiction Care

Deadline: September 12, 2024

Winter 2025 Issue

Understanding Suicide and Its Impact on Family and Friends

Deadline: December 10, 2024

Spring 2025 Issue

Behavioral Health Services for Children, Adolescents, and Families


Deadline: March 13, 2025



Contact us for information about advertising and article submissions

Stay Connected with BHN

Find over 1,500 behavioral health articles and 95 back issues at www.BehavioralHealthNews.org



Behavioral Health News Update

BehavioralHealthNews.org

Subscribe to receive the bi-weekly BHN Update newsletters featuring even more behavioral health education, information, advocacy, and resources!



Since 1999, Behavioral Health News has been your trusted source of education, information, advocacy, and quality resources on mental health and substance use disorder treatment and services.

Behavioral Health News Sponsors

PLATINUM



GOLD



SILVER



Sponsoring Behavioral Health News includes more than just this logo placement!

[Learn More About the BHN Sponsorship Opportunities](#)

Suffering Across Settings: Multidimensional Care for Chronic Pain

By Nicole Polashenski, DO
Associate Medical Director
Community Care Behavioral
Health Organization

The multidimensional suffering encompassed by chronic pain conditions, combined with their prevalence, demands a multidisciplinary approach to management. The direct impact that chronic pain has on physical distress, as well as emotional state, sleep, stress levels, and coping systems, highlights the importance of behavioral health integration. There is a bidirectional relationship between chronic pain and behavioral health conditions - with chronic pain conditions increasing the risk for the development of behavioral health problems and chronic pain being a symptom commonly experienced by individuals with behavioral health conditions. Social determinants of chronic pain (including poverty, unemployment, adverse childhood events such as abuse, and exposure to violence) necessitate the integration of social interventions with clinical interventions. Resultant psychological, social, and functional impairments related to the experience of chronic pain may exacerbate disability in this population (Kohrt, Griffith, & Patel, 2018).

A person-centered approach includes timely access to behavioral health interventions, physical and behavioral health care coordination, addressing health-related social needs, and education around self-management strategies (Eaton et al., 2015). The approach incorporates behavioral health treatments, such as cognitive behavior therapy, trauma-focused psychotherapy, and behavioral activation, with psychosocial interventions to enhance social support. This approach targets the transdiagnostic features of chronic pain (impaired emotional regulation, sleep disturbance, avoidant coping, and demoralization) that can fuel further physical and emotional distress. It also addresses the physical, psychological, and social implications of living with chronic pain (Kohrt, Griffith, & Patel, 2018).



Nicole Polashenski, DO

The variability in how individuals experience pain underscores the use of a biopsychosocial framework for effective management. Chronic stress states can make individuals more sensitive to the experience of pain and at higher risk for a host of maladaptive coping responses. Individuals with a history of trauma are at a particularly elevated risk of demoralization due to a cycle of aversion responses combined with motor, autonomic, and endocrine system activation, which can worsen both pain and psychological suffering. As the intensity and duration of such distress increases, the subsequent demoralization can impact the risk of suicide if it progresses to feelings of hopelessness, helplessness, and further despair. Psychotherapy can be a valuable tool in introducing hope and motivating positive behavioral change via various psychotherapeutic approaches (De Figueiredo & Griffith, 2016).

Community Care Behavioral Health Organization (Community Care), a non-profit behavioral health managed care organization part of the UPMC Insurance Services Division, is committed to ensuring access to evidence-based behavioral health treatment and physical-behavioral health integration. Given that individuals

who have serious behavioral health conditions are a medically vulnerable population, the integration of physical and behavioral health services is an existing focus and initiative to improve the physical health status of these individuals that can also be applied to populations experiencing chronic pain. Community Care's **Behavioral Health Home Plus** model is a comprehensive approach to physical and behavioral health integration as part of treatment and recovery for adults with serious behavioral health conditions or opioid use disorder. The model incorporates wellness coaching, effective coordination, collaboration between physical health and behavioral health providers, and population health learning collaboratives. Case managers and certified peer specialists serve as "health navigators" to assist individuals in achieving health and wellness goals. The model supports whole-person care by creating an environment of wellness, activating individuals to better manage their overall health, and attending to social determinants of health. The model's learning collaboratives disseminate education, tools, and resources to providers around topics that pertain to collaborative care, including the impacts of traumatic stress and social determinants of health on chronic pain. Community Care has also provided education around physical-behavioral health integration to **Pennsylvania HealthChoices'** contracted **Federally Qualified Health Centers (FQHC)** via behavioral health-focused learning sessions, during which the topic of behavioral activation for individuals with chronic pain has been presented.

UPMC Community HealthChoices is one of three Managed Care Organizations (MCOs) that manage **Pennsylvania's Community HealthChoices** program. Plan medical directors provide behavioral health case consultation for UPMC's Community HealthChoices service coordinators to support individuals with complex physical and behavioral health needs, often including chronic pain. These are opportunities for case-by-case discussion around challenges in chronic pain management -

including social determinants of health needs and social impairments associated with chronic pain, the importance of coordinated multidisciplinary care and emphasizing behavioral health interventions that promote engagement with the pain providers. Educational sessions are offered to UPMC Community HealthChoices providers by Community Care via a summer institutes series, and topics include the intersection of chronic pain and substance use disorders.

Digital applications offer opportunities to promote self-management strategies that can be uniquely valuable in chronic pain management. Community Care offers members access to a free mobile wellness application called **RxWell** that provides health coaching to support self-management strategies and improve overall wellness through several behavioral health and lifestyle program offerings. It also provides educational content and activities based on cognitive behavior therapy to increase resilience and promote behavioral change.

Pharmacological interventions for pain management, particularly reliance on opioid analgesics, can be fraught with risks, including diversion, addiction, and overdose. The opioid epidemic further highlights the importance of the implementation of mitigation strategies (Volkow & McLellan, 2016). **UPMC Health Plan** and **Community Care** provide opioid educational resources to providers. Pharmacy initiatives include provider outreach to promote evidence-based opioid prescribing, early prevention of opioid use disorder via identification of high-risk members and referral for various interventions, and overdose prevention strategies. This also includes a robust opioid/medication-assisted treatment (MAT) outreach program implemented by UPMC Health Plan Pharmacy. The program identifies members using high dose opioids where the risk of overdose and addiction is elevated, those with concurrent potentiators on board (thus increasing risk of overdose),

see *Suffering on page 38*



People. Activated.

At Workpartners™, we call our unique approach to human capital management "People Activation". We believe it is the key to ensuring that your company and your employees flourish. Our confidential employee assistance program (EAP) connects individuals who need support to services and programs with powerful data analysis, clinical solutions, and HR technology.

Workpartners EAP can help

LEARN MORE

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.
Copyright 2023 Workpartners. All rights reserved.

workpartners 
the people activation company

SIMPLY THE BEST

Doctors.
Hospitals.
Customer Service.



With UPMC Health Plan, you have the best people, places, and programs all working together. Whether you seek care from doctors and hospitals in our large community network or world-renowned UPMC, you can count on getting high-quality care where and when you need it. All UPMC Health Plan members can call to get award-winning service from our Health Care Concierge team. Our goal is to connect every member to the best care and deliver the best help for every visit and on every call. Every time.

PARTNERS IN CARE

UPMC HEALTH PLAN

For UPMC Health Plan "best" information go to www.upmchealthplan.com/best.

Nondiscrimination statement

UPMC Health Plan¹ complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression.

¹UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-489-3494 (TTY: 1-800-361-2629).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電 1-855-489-3494 (TTY : 1-800-361-2629)。

Improving Staff and Patient Satisfaction with Compliance Technology

By InvisALERT Solutions
ObservSMART

In Healthcare, behavioral health experiences significant challenges, including physical and psychological components of patient well-being. Successfully addressing these challenges involves integrating data-driven technology into quality of care. This article delves into the correlation between behavioral health and patient and staff satisfaction, emphasizing the transformative role of technologies.

Traditional rounding methods on the market today often have limitations that do not consider the complex care workflows of behavioral health and the importance of compliance. They are confined to a block of time without assurance that staff were with patients during observation. In contrast, proximity-required compliance-driven tools can offer a shift by ensuring consistent check-ins on patients without confining them to their rooms and encouraging a true 15, 30, or 60-minute interval. This shift ensures patient safety and staff engagement, enhancing the patient's well-being.

Proximity-required technology like ObservSMART promotes staff engagement and fosters collaboration and rapport between patients and staff. By giving staff the front-line tools they need, with reminders and alerts to make certain that patients are seen every 15, 30, and 60 minutes, rather than blocks of time, healthcare staff establish stronger relationships and gain deeper insights into patients' needs and there is less opportunity for incidents. This heightened engagement allows personalized care tailored to individual needs and conditions in real time, elevating patient satisfaction levels.

Central to effective patient safety and care management is recognizing behavioral health and pain as a multifaceted experience encompassing both physical and

psychological distress (APA). Technologies can integrate assessments, including pain and depression scales, into routine rounds, enabling comprehensive patient well-being evaluation. Through easy access to documentation and analysis of patient progress, staff members can promptly identify areas requiring intervention, optimizing treatment and patient satisfaction (ObservSMART).

Moreover, technology like ObservSMART addresses not only patient safety but can also ensure environmental safety. By consistently monitoring patients and their surroundings, the risk of falls – a common concern in healthcare settings – is also significantly mitigated. Consistent checks reduce the likelihood of adverse events associated with medicated-induced drowsiness or impaired mobility, fostering a safer care environment.

Technology that offers an integrated data-driven approach to patient care provides real-time insights into physical and psychological aspects of patient well-being. ObservSMART reporting and in-app reporting allow staff members to quickly identify trends and patterns in patient data, facilitating informed decision-making and proactive interventions. By leveraging technology to gather and analyze data points that suggest areas for improvement – whether physical, mental, or emotional – staff can customize treatment plans to address patients' evolving needs much more effectively.

Compliance technology can support health management initiatives and promote preventive care measures. In behavioral health settings, staff may use historical data to identify trends for patients at risk of self-harm, falls, suicide, pain, elopement, and many other concerns. This approach improves overall environmental awareness and contributes to significant cost savings by mitigating risk.

Technology can also improve staff and patient satisfaction by ensuring patient safety and staff engagement, supporting complex



workflows, and promoting a better quality of care. By leveraging the capabilities of compliance tools like ObservSMART, healthcare organizations achieve better operational efficiency and communication. As technology continues to evolve, the role of compliance technology in healthcare will only become more essential in improving the staff and patient experience.

Compliance technology not only improves patient and staff satisfaction but also contributes to the overall efficiency of healthcare. By utilizing technology, staff can document patient progress while providing real-time insights. Using rounding technology in behavioral health settings may reduce administrative burdens, minimize paperwork errors, and streamline communication between care teams. This improved efficiency allows healthcare organizations to allocate resources more effectively, reduce operational costs, and ultimately improve patient care quality.

Furthermore, using portable, proximity-required technology eliminates the need to constantly go back and look at hours of video footage to know if staff are completing their observations with patients. Physicians have greater confidence that patients are being checked on and don't feel the need to automatically default to a 1:1. The technology also allows for tighter observation intervals (i.e., 5 or 7 minutes), as opposed to defaulting to a 1:1. This can free up staff for other patient care (ObservSMART).

Compliance technology seamlessly integrates with electronic health record (EHR) systems. Tools that integrate with EHR systems can update patient records,

document care interventions, and provide real-time alerts and notifications to care teams. This integrated approach to healthcare improves communication, reduces medical errors, and enhances patient safety and satisfaction.

In conclusion, consistent checks, staff engagement, data, and technology offer a transformative approach to facilitate staff and patient satisfaction and quality of care in behavioral health, with various symptoms such as depression and chronic pain. By using innovations like proximity-required monitoring technology, personalized care delivery, and proactive risk mitigation, you empower care teams to navigate complex healthcare landscapes confidently, improving the patient and staff experience.

Technologies like ObservSMART are determined to find a solution to ensure adherence to safety protocols and positively influence patient experiences. For more information, reach out to cshows@invisalertsolutions.com or visit www.observsmart.com.

References

American Psychological Association. (n.d.). Understanding chronic pain. Retrieved from www.apa.org/topics/chronic-pain

National Institute of Mental Health. (n.d.). Behavioral health trends in America. Retrieved from www.nimh.nih.gov/health/statistics/mental-illness

ObservSMART. (n.d.). Retrieved from www.observsmart.com/



Patient and Staff Satisfaction

Missed or late observations in behavioral health settings may cause sentinel events. Utilizing compliance technology, learn how to increase staff and patient satisfaction with tools like ObservSMART.



Observation | Compliance | Safety



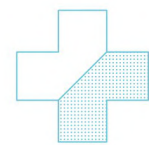
Patient and Staff Satisfaction



Leveraging compliance technology and data to improve safety, patient care, and treatment

LEARN MORE:

www.ObservSMART.com



Does Medical Cannabis Treat Chronic Pain?

By Grace Hennessy, MD
Associate Chief Medical Officer
for Addiction Psychiatry
New York State Office of Addiction
Services and Supports (OASAS)

An estimated 20% of adults in the United States experience chronic pain (Zelaya, 2020). For many years, opioid analgesics were the primary medications prescribed for chronic pain, but the significant increase in opioid prescriptions at high doses and for long durations has been associated with unprecedented increases in opioid use disorder, overdose, and death (Dowell, 2022). Concerns about these potential complications of prescribing opioids for chronic pain management, along with limited evidence of their long-term effectiveness, are reflected in national guidelines that strongly encourage the use of non-opioid and non-pharmacologic treatments for chronic pain (Dowell, 2022).

In recent years, medical cannabis, defined as cannabis or cannabinoid medication used as medical therapy to treat medical conditions or alleviate symptoms, has emerged as an alternative to opioids for chronic pain treatment. Currently, medical cannabis is legal in 38 states and the Dis-



Grace Hennessy, MD

trict of Columbia, with pain as the most common qualifying condition (ProCon.org, 2023). Among adults with chronic pain living in states with medical cannabis laws, 25% have used medical cannabis, demonstrating the growing interest in this treatment option (Bicket, 2022).

Cannabis contains more than 60 cannabinoids, with $\Delta 9$ -tetrahydrocannabinol (THC) and cannabidiol (CBD) being the most active at the cannabinoid receptors. Although the mechanisms by which cannabinoids produce analgesia are not fully understood, activation of the two cannabinoid receptors found in the brain, spinal cord, and immune cells decreases pain and inflammation (Hill, 2017). THC, the main psychoactive compound in cannabis, produces effects such as euphoria and anxiety and has effects on pain, muscle relaxation, nausea, and appetite stimulation (Legare, 2022). Conversely, non-psychoactive CBD similarly affects pain and muscle relaxation and has anti-inflammatory, antioxidant, and anticonvulsant effects. Medical cannabis that combines THC and CBD may be better than THC alone for the treatment of pain because CBD may both enhance and oppose certain pharmacologic effects of THC (Johnson, 2010; Russo, 2006; Hayakawa, 2008).

The effectiveness of medical cannabis as a chronic pain treatment has been the subject of numerous clinical trials. To date, three systematic reviews of clinical trials found that the use of cannabis-based medications by adults with chronic pain was associated with a higher incidence of pain reduction when compared to placebo (Whiting, 2015; Solmi, 2022; McDonagh,

2022). These studies also found medical cannabis was more likely than placebo to produce adverse events such as dry mouth, dizziness, drowsiness, nausea, and vomiting. While providing important evidence about the effectiveness of and adverse events associated with medical cannabis, most studies included in the reviews were short-term, lasting from one to six months, and primarily focused on adults with neuropathic pain, limiting the generalizability of the findings.

Another focus of research studies has been the relationship between medical cannabis for chronic pain and changes in prescription and illicit opioid use. Indeed, opioid prescriptions decreased by 14.4% after states implemented medical cannabis laws (Bradford, 2018). Additionally, in several studies, adults using medical cannabis for chronic pain have reported decreased use of opioids (Boehnke, 2016; Sohler, 2018; Okusanya, 2020; Takakuwa, 2020), although one study found an association between medical cannabis use and increased use of opioids and other prescription medications (Caputi, 2018). The cross-sectional nature of these studies and the reliance on self-reporting, however, limits the applicability of the results to the larger population of adults with

see Cannabis on page 38

New York Health Equity Reform: A Transformative Shift in New York's Medicaid Landscape

By Joshua Rubin, MPP
Principal
Health Management Associates

On January 9, 2024, New York's Department of Health received its long-awaited amendment to our Medicaid 1115 demonstration, newly rebranded NYHER (NY Health Equity Reform). It's not as flashy nor as generously funded as the special purpose DSRIP (Delivery System Reform Incentive Payment) demonstration, but it's likely to have a longer-lasting impact. DSRIP always had a beginning, a middle, and an end. NYHER is here to stay because NYHER is the 1115 that serves as the foundation of our Medicaid system. It's been in place, in one form or another, since 1997.

NYHER has added a new cornerstone to New York's Medicaid system. Now, in addition to healthcare services (always the core of Medicaid) and the later added behavioral health services (including HARP, CORE, and HCBS), we are adding services for health-related social needs (HRSN) to this policy authority that underlies our system. We are in the process of defining a certain set of human services as "medically necessary." It might seem obvious that food and shelter are "medically necessary," but it took Medicaid six decades to get there.

New benefits will include nutrition support, housing support, transitional housing, transportation, case management, and screening for HRSN. The benefits will be,



Joshua Rubin, MPP

however, limited to a subset of the Medicaid population, children, and people with complex and/or chronic health conditions and/or social complications. In 2027, the roughly \$1.4 billion per year set aside to pay for medically necessary HRSN services will be rolled into the managed care capitation rate, a new stone in New York Medicaid's foundation.

In addition to adding new services, the state is determined to add new providers. Somewhere between nine and 13 (NYC will have somewhere between one and five), new Social Care Networks (SCN) are currently being procured to create networks of community-based organizations (CBOs) that provide HRSN services. SCNs are intended to weave together the CBOs in a region, providing them with

billing support, quality improvement processes, technology infrastructure, and (at least someday) negotiating leverage. Like lead health homes, independent practice associations (IPA), and regional health information organizations, they are designed to provide the connective tissue that enables healthcare services to function in an organized way. They are designed with a business model the state expects to outlive half a billion dollars of start-up funding. When the results of the SCN procurement are announced, we will know how attractive that business model is. I predict much interest.

Although funding for HRSN services and the SCNs that enable them is the largest portion (\$3.7 billion) of the \$6.7 billion investment, the amendment has other important components. \$700 million has been set aside to address New York's healthcare workforce crisis. \$48 million is set aside to forgive loans for people working in the safety net system. An additional \$646 million will be used to recruit new direct care workers and provide career ladder training to existing licensed, credentialed, and unlicensed care providers.

Importantly, the new approval makes a meaningful dent in the stigma baked into the Medicaid system when it was created in the 1960s, waiving something called the IMD (Institutions for Mental Diseases) exclusion, a rule as outdated as its name. Simply put, services that would otherwise be reimbursable by Medicaid haven't been because they have been provided in a substance use disorder (SUD)

setting (an IMD). Now, providers will be able to receive Medicaid revenue for these services even if they're provided in a SUD setting. A waiver of the similarly archaic IMD exclusion for mental health settings is reportedly being processed.

Another significant investment (\$2.2 billion) is being made to move some struggling hospitals from a fee-for-service payment system to a global budget model. In exchange for desperately needed operational support, these hospitals (about a dozen hospitals spread across four counties downstate) will have to move toward a global payment system, offering some financial certainty and predictability through an alternative payment model.

Lastly, the state's proposal for healthcare planning infrastructure was approved, although somewhat diminished. The state had proposed a set of Health Equity Regional Organizations (HERO...the approval's best acronym) echoing the SCN regions. While HERO still accounts for about 2% of the waiver dollars, only one HERO is approved to cover the whole state.

The approval has set off a race to utilize these dollars wisely, assess their impact, and plan for their sustainability...all before April 1, 2027. The SCN procurement is underway. Others are sure to follow. The Department of Health has an enormous amount of work to do, as do providers of different kinds across the state. It is going to be a busy three years.

Joshua Rubin, MPP, is Principal at Health Management Associates.

\$1,000 - \$3,000 SIGN-ON BONUS*

WE'RE HIRING!

NYC & LONG ISLAND



Become a part of the WellLife Network Team and provide hope and inspiration to assist individuals in attaining their life goals of health, recovery, wellness, and independence.

TO APPLY IN ADVANCE, SCAN QR CODE



**On designated openings*

EMAIL TODAY:

HumanResources@WellLifeNetwork.org

WellLife Network is an equal opportunity employer.

COMPETITIVE BENEFITS PACKAGE

- 401(k) matching
- Medical, Vision & Dental Insurance
- Disability Insurance
- Employee Assistance Program (EAP)
- Flexible Spending Account/Dependent Care Account
- Life insurance (Term and Whole)
- Paid Time Off
- Referral Bonus Program
- Tuition Assistance
- Gym Pass
- WLN is a Qualifying Employer for the Public Service Loan Forgiveness (PSLF) Program
- Leadership Training
- Mentorship Opportunities
- Career Development Extensive Training programs
- Internship Opportunities



A “Prescription” for Integrated Care for Chronic Pain and Associated Conditions

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

Arising incidence of physical pain, and chronic physical pain in particular, necessitates a comprehensive examination of its underpinnings and relationship with other dimensions of health and wellbeing. This poses unique challenges for behavioral healthcare providers who operate amid a deeply entrenched dualism that continues to treat “mind” and “body” as separate phenomena. Despite recent advances in integrated care and a broader recognition of the role of Social Determinants of Health (SDoH) and Health Related Social Needs (HRSN) in health outcomes, providers operating in New York State remain subject to highly Balkanized licensing and regulatory structures that impede fully holistic approaches. The mere existence of separate governmental entities charged with oversight of healthcare and social welfare providers (e.g., Department of Health, Office of Mental Health, Office of Addiction Services and Supports, etc.) perpetuates models of care designed to treat discrete constellations of symptoms in lieu of people. The widespread comorbidity of physical and behavioral health conditions coupled with prevalent psycho-



Ashley Brody, MPA, CPRP

social and environmental stressors underscores the urgency to address all health and social welfare challenges in an integrated manner. An emerging body of research suggests individuals dually diagnosed with chronic pain and behavioral health conditions are at exceptional risk of adverse outcomes in the absence of fully integrated and holistic approaches.

Physical pain is commonly defined as “chronic” if it persists for at least three

months, and it afflicts approximately one-fifth (20%) of American adults (Reid, 2024). Chronic pain is associated with decreased quality of life and diminished productivity and, by some estimates, accounts for \$635 - \$650 billion in medical expenses annually (Vadivelu et al., 2017). Its incidence has also increased in recent years, particularly among individuals at lower socioeconomic levels (Huzar, 2021). One investigation revealed a 14% increase in the incidence of chronic pain between 2002 and 2018 among financially stable individuals (i.e., those whose household income was four times the poverty level) and a 42% increase among those whose household income was only twice the poverty level (Huzar, 2021). When chronic pain is present in individuals with mental health conditions and other significant life challenges, its effects are frequently debilitating.

Extensive research has explored the association between Major Depressive Disorder (MDD) and chronic pain, and many findings affirm a reciprocal relationship between these conditions. MDD is present in 5% of the general population, but its incidence rises precipitously among individuals with chronic pain. One study found that 30% - 45% of chronic pain patients also meet the MDD criteria (Demyttenaere et al., 2007). Most researchers agree this relationship is multifaceted and cannot be attributed to a singular cause. Investigations of myriad biological, social, environmental, and psychological mechanisms underpinning this association have produced competing hypotheses and opened additional avenues of inquiry.

Nevertheless, the disparate incidence of chronic pain and depression among members of select socioeconomic and demographic populations indicate these, more than other factors, account for this relationship and reinforce its reciprocity. In addition, individuals dually diagnosed with chronic pain and MDD are at greater risk of opioid misuse and abuse. Some studies have demonstrated patients with MDD are more likely to receive opioid medications and in higher doses than patients without MDD. This trend poses obvious health and safety implications in view of an enduring opioid abuse epidemic that has had particularly deleterious effects on vulnerable populations (Edlund et al., 2010). This trend also underscores the imperative to promote alternative interventions for chronic pain and MDD that address the social, psychological, and environmental conditions that perpetuate these conditions. To this end, initiatives that target individuals’ social care needs should improve their overall quality of life and mitigate stressors known to exacerbate chronic pain and depression.

Research concerning the relationship between chronic pain and other forms of mental illness is comparatively limited, although some studies have revealed correlations between chronic pain and various personality and neurodevelopmental disorders. For instance, individuals with a diagnosis of borderline personality disorder (BPD), a personality disorder characterized by affective dysregulation, an un-

stable sense of self, and volatile interpersonal relationships, are more likely than members of the general population to experience chronic pain (Sansone & Sansone, 2012). Various causal mechanisms underpinning this association have been posited, including some that implicate iatrogenic factors. Healthcare professionals frequently stigmatize individuals with BPD since their behaviors may be perceived as “difficult” and their symptoms a product of personal choice or “misbehavior” (Sheehan, Nieweglowski, & Corrigan, 2016). Healthcare providers who harbor such beliefs (if only on an implicit level) regarding individuals with BPD are inclined to regard patients’ symptoms with skepticism or outright contempt. This skepticism may extend to patients’ reports of chronic pain and preclude the accurate identification of causes and potential treatments for pain (Newton et al., 2013). Instances of practitioner bias are surely not limited to patients with BPD, and such bias amid dual behavioral health and opioid abuse epidemics poses a grave threat to the most vulnerable members of our community.

Recent advances in integrated care and increased attention to the conditions in which people live, learn, work, and socialize promise to mitigate stressors known to exacerbate disorders of all types for which conventional (i.e., medically driven) approaches have proven ineffective. New York State is poised to achieve additional progress following the federal government’s approval of a Medicaid Waiver under Section 1115 of the Social Security Act through which healthcare and social welfare providers may claim additional resources to address individuals’ social care needs. By no means is this initiative a panacea for our ailing health and social welfare system, but its potential to further the cause of integrated care may yield enduring benefits for the most vulnerable among us, including those who must endure chronic pain and other impediments to health and wellbeing.

For more information, contact Ashley Brody, MPA, CPRP, at (914) 428-5600 (x9228) or abrody@searchforchange.org.

References

Demyttenaere, K., et al. (2007). *Mental disorders among persons with chronic back or neck pain: results from the World Mental Health Surveys*. *Pain*, 129(3), 332-342. <https://pubmed.ncbi.nlm.nih.gov/17350169/>

Edlund, M.J., et al. (2010). *Trends in use of opioids for chronic noncancer pain among individuals with mental health and substance use disorders: the TROUP study*. *The Clinical Journal of Pain*, 26(1), 1-8. www.ncbi.nlm.nih.gov/pmc/articles/PMC2917238/

Huzar, T. (2021, May 19). *More and more US adults have chronic pain, new study shows*. *Medical News Today*. www.medicalnewstoday.com/articles/mor

see Prescription on page 33



Search for Change, Inc. has been rebuilding lives for over 40 years. It continues to be a leader in the field of recovery, enabling the most vulnerable among us to establish valued roles within the community. Services provided are integrated, person-centered, and fully aligned with leading principles of healthcare reform that aim to improve quality, reduce cost, and enhance recipients’ overall experience.

- Residential Services
- Housing Development
- Respite Services
- Home and Community Based Services
- Homelessness Prevention Services
- Peer Specialist Training
- Private Care Management
- Mobile and Transitional Outreach Services
- 24-Hour Support Services
- Vocational Rehabilitation and Career Support Services

The opportunity to obtain affordable housing, to secure gainful employment, and to establish valued roles within the community is made possible through programs and services offered by Search for Change.



400 Columbus Avenue, Suite 201E
Valhalla, NY 10595
914-428-5600
www.searchforchange.org

QUALITY MENTAL HEALTH IS OUR PRIORITY

CHILD TREATMENT

Provides a nurturing, therapeutic, home-like environment integrating the principles of Applied Behavior Analysis, which promotes positive reinforcement for socially appropriate behaviors.

ADOLESCENT TREATMENT

Specialized treatment for a wide range of psychiatric conditions including: depression, anxiety, trauma-related disorders, oppositional defiance, and psychosis.

ADULT TREATMENT

Comprehensive evaluation and specialized treatment for adults managing psychosocial stressors and life challenges including: depression, anxiety, and psychosis.

ADOLESCENT PARTIAL HOSPITALIZATION

Full-day group treatment for teens 13 - 17 years old experiencing difficulty managing behavior at home or school.

ADULT PARTIAL HOSPITALIZATION

Full-day group treatment program for adults managing psychosocial stressors and life challenges including: depression, anxiety, and psychosis.

INTENSIVE OUTPATIENT TREATMENT

Short-term, medically supervised outpatient treatment; an alternative to, or transition from inpatient care.



WESTCHESTER

For information or to make a referral call

1-800-528-6624

24 hours a day ● 7 days a week

800 Cross River Road ● Katonah, New York 10536

SARATOGA

For information or to make a referral call

1-800-959-1287

24 hours a day ● 7 days a week

30 Crescent Avenue ● Saratoga Springs, New York 12866

www.fourwindshospital.com

SPOP

SERVICE PROGRAM FOR OLDER PEOPLE

HEALTHY AGING



Aging, Pain, and Behavioral Health Challenges – Untangling the Threads

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

Armand is a 78-year-old gay man who has lived with chronic pain for over ten years. A retired actor who enjoyed a successful career on stage and as a mentor for young actors, he now has multiple health conditions including arthritis, a history of cancer, and complications from spinal surgery. He is able to ambulate only with assistance and he rarely leaves his home. He was referred to the SPOP clinic two years ago with symptoms of major depressive disorder and generalized anxiety disorder, and at intake he indicated that he felt isolated, fearful, depressed, and worried about his finances.

SPOP (Service Program for Older People) is the only agency in New York City that is entirely focused on providing community-based behavioral and mental healthcare to adults age 55 and older. Our primary program is a behavioral health clinic that provides treatment at our office and 20 satellite locations in the city, via telehealth, and in the home for clients who are deemed homebound due to physical or psychiatric disability. We work with hospitals, older adult centers, and other aging services providers to reach out to adults who would not otherwise have access to behavioral healthcare, including those who are marginalized as a result of poverty, disability, race, ethnicity, sexual orientation, gender expression, or other factors.

Armand's case stands out as an example of an individual who was already at risk for physical or mental health disparities – he is financially disadvantaged, gay, isolated, medically frail, and lacking familial supports. His overall fragility was further exacerbated by chronic pain and an inherent mistrust of the healthcare system after decades of feeling the need to hide his sexual orientation from providers.

Recognizing the complexity of his profile, we paired him with an especially empathic clinical social worker with expertise in chronic illness and lived experience as an LGBTQA+ person. He met with her using telehealth, quickly established a therapeutic rapport, and worked toward treatment goals to manage his depression and anxiety. He also enrolled in a therapy group at SPOP for older adults



Nancy Harvey, LMSW

with chronic illness and pain, where he was able to share compassionate support with others who were also living with pain. The increased social contact boosted his mood, and the group enhanced the work that he was doing with his individual therapist.

One of Armand's greatest challenges was the fact that he was entirely alone, with no family, partner, or advocate – a situation that is all too common among older adults in the LGBTQA+ community. His therapist reached out to the Friendly Visiting Program at SAGE, the national center for advocacy and support for older LGBTQA+ adults, and they connected him to a volunteer visitor who has now been with him for 18 months. She has become a good friend and a reliable source of companionship and conversation, and her visit is a high point of Armand's week.

Armand's therapist also connected him to other community resources including home-delivered meals, legal services for advance care planning, and an affordable assisted living facility where he has applied for housing. He is currently engaged in a form of life review therapy where he reflects on the highlights of his life and career, and he often breaks into song during his sessions. While he continues to live with serious medical challenges and pain, he has a far more positive life view and feels less alone on his life journey.

SPOP serves adults age 55 and older and about 75% of our client population is over age 71. Hospitals and medical providers are among our leading sources of

referrals, and at least two-thirds of our clients are managing a serious medical condition or chronic pain.

Pain and mental illness share the same system circuitry in the body – the central nervous system – and they impact one another both neurologically and emotionally. We know that pain exacerbates the risk of suicidality in older adults and we have learned that somatic therapy, which focuses on the body, can reduce the impact of pain. All of our clinicians are trained in the use of somatic techniques, such as breathing, visualization, and relaxation exercises, which help to release muscle tension and address physical discomfort and pain while also reducing symptoms of anxiety, depression, and post-traumatic stress.

Physical pain is highly subjective, and we often see clients who feel desperate for validation and acknowledgement of their pain. We use therapy groups to address this challenge, as participants acknowledge the feelings of one another in a supportive setting. We also connect clients to other

community supports, such as friendly visiting and home-delivered meals, to address social isolation and concrete needs. And we prescribe medications for mental health needs that can sometimes also improve pain.

Armand is just one of hundreds of clients we will see this year who suffer from chronic pain. He is older and frailer than when he first came to SPOP, but he now feels he is in control of his life. He has learned techniques to manage his pain and mental health symptoms, is less isolated, and has a plan in place if he is no longer able to live in his apartment. He has found deeper meaning in his life's work, as he recalls his days on the stage during therapy sessions, and he treasures his relationship with his Christy, his friendly visitor. Physical pain is still part of his life, but it no longer defines him.

Visit www.spop.org to learn more about SPOP and its role as a community-based behavioral healthcare provider for older adults in New York City.

SPOP

SERVICE PROGRAM FOR OLDER PEOPLE

The SPOP community congratulates
Nancy Harvey on 34 years of outstanding leadership
and an unwavering commitment to the behavioral
health and well-being of older adults.

Warmest wishes for a happy retirement.

SPOP

302 West 91st Street
New York, NY 10024

www.spop.org

Visit our Sister Publication Autism Spectrum News
For a Library of Autism Resources and Support

AutismSpectrumNews.org



We're Hiring!

Visit our website for more information

www.concernhousing.org

Everyone deserves a place to call home.

**JOIN A TEAM COMMITTED TO HELPING BRING
*NEW YORKERS HOME!***

NOW HIRING!
*\$1,000 - \$5,000 Sign-On
Bonuses Available!*

Excellent Opportunities Available!

**Human Services
Finance
Administrative
Maintenance
Property Management**



Are You Looking For a New Employment Opportunity?

Seeing Through Crisis: A Behavioral Health Approach to Chronic Pain

By Issy Francis, BSN, RN,
and Dani York, LCAT, RDT
Services for the UnderServed (S:US)

Pain is a subjective experience, which means it is influenced by an individual's perceptions, emotions, beliefs, and cultural factors. When assessing pain, healthcare providers rely heavily on the individual's self-report to understand the nature, intensity, and impact of their pain experience. In other words, "pain is what the patient says it is" (Miller et al., 2017). Pain is not always directly correlated with observable signs or specific physiological changes. Therefore, healthcare providers must trust and respect the individual's self-report of pain, even if it does not align with objective measures or expectations. Validating and addressing the individual's pain experience is essential for providing compassionate and effective care. In addition to the use of evidence-based assessment tools such as the Numeric Rating Scale (NSR), The Visual Analog Scale (VAS), and the Verbal Descriptor Scale (VDS), behavioral observation provides a view into the unique experience of pain. Behavioral observation can indicate pain through facial expressions, vocalizations, body movements, and decreased activity levels (Cook et al., 2012). However, pain may also be expressed through a range of emotional responses.



Pain is broken down into acute pain and chronic pain. Chronic pain is a broad term that encompasses a range of embodied experiences. It is defined as persistent or recurring pain that lasts for an extended period, typically beyond the expected healing time of an injury or illness, usually lasting for three months or longer (Chronic Pain, n.d.). For people in treatment and recovery, chronic pain may be the result of trauma, a significant medical condition(s), or both. It often presents as physically debilitating and emotionally

destabilizing, placing individuals in crisis. It can lead to conditions like depression, anxiety, and even exacerbate pre-existing mental health issues.

Conversely, mental health challenges such as stress or trauma can worsen the experience of chronic pain. It is crucial for behavioral health providers to understand that chronic pain can increase vulnerability, amplify pain, and increase the risk for suicide and suicide ideations (Dydyk, 2023). Pain may also lead to long-standing substance use and isolation. Mistrust of helping professionals because of negative encounters with providers, treatment-resistant pain, and other barriers to care often prohibit participants from seeking treatment, thus continuing the crisis cycle. At Services for the UnderServed (S:US), the Treatment and Recovery Services team recognizes the critical importance of developing healthy and trusting rapport with people served, acknowledging the factors contributing to ruptures in, and barriers to essential care. Understanding pain as a crisis creates an opportunity to address the complex factors that result in distress.

S:US is one of the largest community-based health and human services organizations in New York State. It works intentionally and daily to correct societal imbalances by providing comprehensive and culturally responsive services. The agency offers treatment and recovery services to address a vast range of needs – focusing on mental health, wellness, and substance use recovery – impacted by social determinants of health. For individuals who, because of chronic pain, have experienced co-morbid mental health and substance use challenges, the emotional impact is vast and dangerous. Therefore, treatment at the S:US Wellness Works Certified Community Behavioral Health Clinic (CCBHC) provides treatment and recovery services to those individuals through person-centered and uniquely individualized interventions. The CCBHC model ensures that any individual who walks through their door has access to excellence in care for mental health and substance use treatment needs. S:US' CCBHCs immediately connect individuals with an integrated team of professionals to assess the individual's stated needs

and extend wrap-around care.

Chronic pain often intersects with mental health in complex ways. The role of providers in treatment and recovery settings is to address the distress caused by chronic pain from a holistic approach, tending to the physiological and psychological components at the core of pain. A range of emotions accompany the body's response to pain. "One of the most disruptive features of pain is the emotional distress. The typical emotional reaction to pain includes anxiety, fear, anger, guilt, frustration, and depression" (Linton et al., 2011). Emotional crises are deeply personal and impact functioning: individuals are unable to work, attend vocational programs, feel disorganized or disoriented, experience shame, engage in substance use to curb unwanted thoughts and feelings, or act with impulsivity. Many remain unable to actuate self-care behaviors. From a crisis management approach, it is essential to address both the physical and psychological aspects of pain management to optimize outcomes and promote healing. "The challenge is to assess risk and to manage the crisis without acting in ways that the patient experiences as invalidating or minimizing their problems while, at the same time, fostering autonomy" (British Psychological Society, 2009). Providers fortify these goals through expanded therapeutic lenses.

A case example to illustrate some of the treatment approaches used at S:US is that of EG. EG is a 60 y/o Latin man treated at the S:US Wellness Works CCBHC in Brooklyn. He was referred by his supportive residence case manager in the context of uncontrolled outbursts of anger, verbal aggression toward others, and escalated threats of violence. Following intake and evaluation, EG was given diagnoses of Bipolar Disorder, Antisocial Personality Disorder, Chronic Obstructive Pulmonary Disease, Chronic Viral Hepatitis C, Human Immunodeficiency Virus (HIV) disease, and Opioid Dependence in remission. EG self-reported chronic back pain, which contributed to significant distress. Treatment focused on the emotional components that aggravated the distress caused by pain.

Managing chronic pain often requires a comprehensive and multidisciplinary approach, involving various healthcare providers such as physicians, pain specialists, physical therapists, psychologists, and other allied health professionals (Staudt MD, 2022). EG was referred to the Psychiatric Nurse Practitioner for an evaluation to assess for medical and mental health comorbidities, and the treatment team collaborated with his medical providers and housing residence to wrap-around care and decrease the potential for harm. Twice weekly sessions mitigated against negative outcomes.

Early in treatment, EG presented as volatile, projecting anger towards the therapeutic alliance. He spoke about the lack of support and effective medical interventions specific to his pain, exacerbated by a history of trauma and years of incarceration and institutionalization. EG perceived danger around him yet

Do you have a passion for helping others?

S:US provides recovery and treatment services to thousands of New Yorkers facing behavioral health challenges. We are hiring to support the health and wellbeing of the people who seek our services. Full-time positions are available at multiple locations throughout New York City and Long Island.



Excellent health benefits. Union benefits.
Generous paid vacations and holidays.
Flexible schedules. Ongoing training and career advancement opportunities.

Join our team and change lives. Visit sus.org/careers or email SS-HRRecruiter@sus.org to apply.

S:US



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.

Dedicated to empowering the individuals and families we serve to achieve self-sufficiency, we are a social service organization providing quality behavioral health, rehabilitative, health, residential, and community stabilization services in Westchester County.

- The Living Room Crisis Day Respite Program
- HOPE House Clubhouse Program
- Transitional and Permanent Supportive Housing
- Eviction Prevention & Housing Counseling
- Home and Community Based Services
- Homeless Outreach
- Care Management Services
- Supportive Employment
- Supportive Education
- Social Engagement
- Peer Support

CREATING COMMUNITY SINCE 1968



HDSW - Main Office
930 Mamaroneck Ave,
Mamaroneck, NY 10543
(914) 835-8906

The Living Room
930 Mamaroneck Ave,
Mamaroneck, NY 10543
(914) 882-8659

HOPE House - Clubhouse
100 Abendroth Ave,
Port Chester, NY 10573
(914) 939-2878

NYSPA Report - Chronic Pain and Behavioral Health: Underlying Data and Regulatory Responses

By Rachel Fernbach, Esq,
and Jamie Papapetros
New York State Psychiatric Association

The Centers for Disease Control and Prevention (CDC) defines chronic pain as pain lasting more than three months that can result from an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause.¹ Studies find a strong correlation between pain and mental health conditions², and individuals living with chronic pain are at increased risk for depression, anxiety, and substance use disorders. Data published by the CDC estimates nearly 21% of US adults (51.6 million persons) experience chronic pain, and nearly 7% (17.1 million persons) experience high-impact chronic pain.³ The CDC reported chronic pain as the leading cause of disability in the United States in 2019.⁴

The intersection between chronic pain and behavioral health conditions is well-documented.⁵ According to the CDC, chronic pain has been linked with depression, Alzheimer's disease and related dementias, higher suicide risk, and substance use and misuse⁶, and a 2017 study found that 35-45% of individuals with chronic pain also experience depression.⁷ The Anxiety & Depression Association of America reports chronic pain disorders are common in those with anxiety disorders.⁸ In 2023, new research from The University of Arizona estimated that nearly 1 in 20 adults in the US experience co-occurrence of chronic pain and anxiety or depression, which results "in functional limitations in daily life."⁹

Jennifer S. De La Rosa, PhD, Director of Strategy for The University of Arizona Health Sciences Comprehensive Pain and Addiction Center and lead author of the study, stressed the importance of the results, stating, "The study's findings highlight an underappreciated population and health care need – the interdependency between mental health and chronic pain."



Rachel A. Fernbach, Esq.

In 2020, Mental Health America (MHA) released a report with data collected from its online mental health screening program that identified a connection between mental health and chronic pain.¹⁰ The MHA report includes an analysis of the responses from over 161,000 individuals who completed the screening between 2015 and 2019 who were experiencing both chronic pain and mental health conditions. Among the main findings of the report:

- Individuals with arthritis or other chronic pain are more likely to screen positive or moderate to severe for a mental health condition (79%) than the general screening population.
- 48% of people who completed the PTSD screening reported a chronic health condition and chronic pain.
- Veterans and active-duty military are the special population groups most affected by arthritis or chronic pain.

In addition, individuals with chronic



Jamie Papapetros

pain were more likely to have also received treatment or support for their mental health than those without chronic pain. The MHA report notes that "People who experience adversity or emotional or physical trauma in childhood also have a higher risk of chronic pain in their adult lives. Fifty-five percent of people who have experienced multiple adverse childhood experiences (ACEs) have chronic pain."

The MHA report suggested policy and practice recommendations, including urging primary care physicians to initiate proactive conversations about chronic pain and mental health, engaging in trauma-informed care, patient-centered care and use of shared decision-making tools, integrating peer support, expanding interdisciplinary teams, investing in research for tools that work with diverse populations and incorporating such research into medical school curricula. In addition, the report calls for behavioral health services "as a central feature of care for arthritis or other chronic pain" and adds, "care should include a focus on trauma, stress, anxiety, depression, PTSD, coping skills, and resilience-

building as opposed to solely substance use-focused services and supports."

Various stakeholders prepared the federal Pain Management Best Practices Inter-Agency Task Force Report and includes a series of best practices for managing acute and chronic pain, including medications, restorative therapies, interventional procedures, behavioral health approaches, and integrative health.¹¹ The report devotes several pages to addressing patients with both chronic pain and mental health and substance use comorbidities, stating, "Given the intersection between psychiatric/psychological symptoms and chronic pain, it is important that the behavioral health needs of patients with pain be appropriately and carefully evaluated and treated with the concurrent physical pain problem."

Healthcare leaders and regulators have also addressed these issues. Effective July 1, 2019, The Joint Commission (the "Commission") expanded its pain assessment and management standards applicable to behavioral healthcare organizations. These standards are an important tool for acknowledging the intersection of chronic pain and co-occurring mental illness and substance use disorders. The Joint Commission is a global nonprofit organization that accredits and certifies more than 22,000 healthcare organizations and programs across the United States. It offers voluntary accreditation and certification of healthcare organizations, programs, and services and focuses on ensuring safe and high-quality patient care. The Commission also develops standards for care delivery that form the basis of its evaluation process.

The Commission publishes the R3 Report (referring to Requirement, Rationale, and Reference), which summarizes the rationale and references for Joint Commission evaluation requirements. Issue 20 of the R3 Report, issued on December 21, 2018, outlines the following additional requirements that apply, among others, to accredited behavioral healthcare organizations.

see Responses on page 39



The New York State Psychiatric Association

Area II of the American Psychiatric Association

Representing 4,000 Psychiatrists in New York

Advancing the Scientific and Ethical Practice of Psychiatric Medicine

Advocating for Full Parity in the Treatment of Mental Illness

Advancing the Principle that all Persons with Mental Illness Deserve an Evaluation with a Psychiatric Physician to Determine Appropriate Care and Treatment

www.nyspsych.org



Certified Community Behavioral Health Clinic



BASED OUT OF EAST NEW YORK HEALTH HUB, ICL'S CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC) IS DESIGNED TO IMPROVE ACCESS TO A COMPREHENSIVE RANGE OF MENTAL HEALTH, SUBSTANCE USE DISORDER, AND OTHER SOCIAL SERVICES FOR VULNERABLE INDIVIDUALS.

Locations Served:

- *Bedford Stuyvesant*
- *Starrett City*
- *Brownsville*
- *East New York*
- *Cypress Hills*
- *Ocean Hill*

AVAILABLE IN BOTH ENGLISH AND SPANISH, ICL'S CCBHC SERVICES ARE DESIGNED TO:

- Identify persons with complex health conditions—especially co-morbidity of behavioral health and physical health conditions
- Identify support systems for the person
- Foster commitment from family and peers
- Heal and strengthen relationships between family members, as well as manage and coordinate the comprehensive needs and care of each family member

Coping With Chronic Pain: Good Advice is Easy to Give But Hard to Take

By Michael B. Friedman, LMSW

Like many people, I live with pain every day. I'm lucky that, for the most part, my pain is tolerable and doesn't interfere too much with my life. I walk slowly—but I walk. I sleep badly, but I sleep. It's tough to sit in a car going long distances. Fortunately, my wife now does the driving, and we can travel for a few hours at a time. I'm often grouchy, but I still have people I enjoy being with and who seem to enjoy being with me. I'm sometimes very distressed that my body has betrayed me, but I also get a great deal of satisfaction from the things that I do. There are medications other than opioids that help when I need them. Usually Tylenol. Sometimes cortisone. I have to be very careful about the medications I take because I have diabetes and chronic kidney disease. The anti-depressants often used now for my kind of pain make me impotent. Some doctors have urged me to take them anyway. "What does sex matter at your age?" I've been asked. On to the next doctor.

Ten years ago, the pain I had to live with was much worse. Over a period of two years, I lost the ability to walk except very, very slowly with a walker. I used a



Michael B. Friedman, LMSW

wheelchair so that I didn't delay others too much. The pain would become so bad that it brought me close to tears, and on those occasions, I used an opioid or, preferably, vodka—a very effective painkiller. Eventually, after seeing about fifteen medical professionals, a tumor inside my spinal column, putting pressure on the spinal cord, was discovered. It was re-

moved. I learned to walk again; my pain diminished so that I was no longer tempted by opioids. But my spinal cord is damaged and deteriorating. Thus, constant pain in my leg.

So, I know a thing or two about chronic pain, about the experience of it, about the disheartening, angering impact of it. As I did some research to prepare to write this piece, I began to wonder whether the professionals who give advice about how to live with pain really understand what it's like.

The advice they give sounds right and is pretty much the same as the advice that mental health professionals give for everything—coping during the pandemic, delaying dementia, tolerating the slings and arrows of life in a troubled world, etc.

For example, in its article on coping with chronic pain, the Cleveland Clinic notes, "Four major lifestyle factors can affect your chronic pain and help minimize it." Four "pillars," they call them. They are - get ready for this - reduce stress, exercise, eat well and sleep well.

Give me a break! As if, being told this, my eyes would be opened, and I would calm down, go to the gym, give up the foods that make me happy, and, just like that, close my eyes in a room without a TV at night and sleep peacefully except for getting up to pee.

It's good advice, of course. But it is as

hard to take as it is easy to give.

Reduce stress? Ok, maybe I could do meditation or practice "mindfulness," whatever that is. But stress has been my lifestyle forever; it is hard to change now. Do the experts have any idea how stressful it is to work or socialize while in pain? Or how stressful it is not to know when pain is going to make it impossible to do what you've planned or to find anything pleasurable?

Exercise? Off the couch, Mr. Potato! Hell, I'm not on the couch. I'm at the computer writing, editing photographs (I'm a semi-professional photographer), trying to read (did I mention my macular degeneration?) Etc. Not to mention the fact that I, like millions of others with or without chronic pain, just don't have the discipline to exercise, and telling us that we should doesn't help much. A little more guilt, some additional self-loathing. Not to mention the fact that **exercise is painful** when you've got chronic pain!

Eating well? Come on—this is the most obese nation in the world. Besieged by advertising for delicious fast foods filled with calories and God knows what else that's bad for you. Not to mention that foods and drinks that make us happy and help us cope with stress, like ice cream and martinis, are not what we should be

see Advice on page 32

Revolutionizing Healthcare: The Future of Integrated Care for All

By Jorge R. Petit, MD
Quality Healthcare Solutions, LLC

In a landmark move, the U.S. Department of Health and Human Services (HHS), through CMS, **announced** today the Innovation in Behavioral Health (IBH) Model. This initiative is a game-changer in healthcare, especially for underserved and marginalized communities where health disparities are most pronounced. This new model supports the President's mental health strategy and implements an action item in the **HHS Roadmap for BH Integration**.

For the last decade or so I have been a strong advocate for developing and implementing on the vision of a "no wrong door, one-stop shop" access to high quality, person centered, accessible, affordable, timely and culturally and linguistically integrated array of medical, behavioral and social care supports, needs, services and treatments. I firmly believe this is possible and within our reach. This new model is exactly all that and, in my estimation, **Certified Community Behavioral Health Clinics** (CCBHCs) are the obvious setting where to integrate and provide this array of integrated services.

Why Integration Matters

1. Holistic Approach: Behavioral health is inseparable from physical health. The IBH Model acknowledges this intercon-



Jorge R. Petit, MD

nection by integrating mental health, substance use disorder treatment, and social supports with traditional medical services.

2. Improving Access in Marginalized Communities: Health disparities are more prevalent in marginalized communities due to factors like economic instability, racial discrimination, and inadequate access to healthcare. The IBH Model's emphasis on community-based, inter-professional teams can significantly improve access to comprehensive care in these areas.

3. Breaking Down Barriers: The traditional separation of physical and behavioral health services leads to fragmented care and poorer outcomes. This model promotes a no wrong door approach, ensuring that irrespective of how individuals enter the healthcare ecosystem, they will have access to a full spectrum of services.

4. Technology as a Catalyst: The model's focus on health IT infrastructure is pivotal. In communities where digital literacy and access are barriers, enhancing health IT can lead to better management of health records, appointment scheduling, telehealth, and remote consultations, thereby improving patient outcomes.

5. Economic Benefits: By providing integrated care, the model aims to reduce overall healthcare costs. This is particularly beneficial for underserved communities, where economic barriers often prevent access to quality healthcare.

6. Empowering Communities: The model isn't just about healthcare delivery; it's about empowerment. Educating and engaging communities in their health management can lead to sustained improvements in health outcomes.

The Road Ahead

The IBH Model is set to launch in Fall 2024 and operate for eight years in up to

eight states. This is a significant step towards a more equitable healthcare system. However, its success will depend on effective implementation, continuous evaluation, and community engagement.

In my continued advocacy of integrated care and in light of this new model and the recent approval of **NYS's 1115 Waiver Amendment** I am heartened and optimistic about what is to come. We should all monitor the roll-out of this innovative model and the potential impact this will have on those most in need. Let's remain hopeful and proactive. It's time to embrace a healthcare system that is based on personal dignity, equity and sees the individual as a whole, finally recognizing the inextricable link between the brain, body, and all the health-related social factors. Check out my last bog on **Healthcare's New Frontier: Addressing Social Determinants for Better Outcomes**.

This article has been republished with permission. The original article, published on January 12, 2024, can be found [here](#).

Jorge R. Petit, MD, is a Behavioral Healthcare Leader, Author, and Founder/CEO of Quality Healthcare Solutions, LLC. Dr. Petit is also a long-time Board Member and past Chair of Mental Health News Education, the publisher of Autism Spectrum News and Behavioral Health News. For more information, visit his website: www.drjpetit.org, blog: [Behavioral Health: Matters](http://BehavioralHealthMatters.com), LinkedIn: Dr. Jorge Petit, MD, or Substack: drjpetit.substack.com.

Recovery: An Ongoing Process, Not a Destination

By Barry B. Perlman, MD

At its core, the idea of “Recovery” expresses an amalgam of aspiration and hope. From practice, I learned that each patient has highly individual ideas of recovery. Examples: A man was pleased when a change from a traditional antipsychotic to clozapine, a more potent medication, meant a diminished frequency of psychiatric hospitalizations and improved function at home. A woman with a history of recurrent depression and opioid dependency felt a sense of personal triumph after successfully coming off methadone maintenance therapy even as she sustained a stable mood. For another, it was being able to live in supportive housing while being employed in a supportive work situation.

Understanding what recovery means for those with serious and persistent mental illness (SPMI) is important because New York State, with a population of 19.5 million, is estimated to be home to 846 thousand adults with SPMI, about 5.4 % of its adults. In truth, SPMI touches all of us because it affects many families and communities as a consequence of homeless mentally ill living on our streets and significantly impacts the state budget both directly and through Medicaid. Those designated as having SPMI are persons large-



Barry B. Perlman, MD

ly diagnosed with Schizophrenia, Bipolar Disorder, refractory Major Depression, intractable Post-Traumatic Stress Disorder, and severe Obsessive Compulsive Disorder.

Perhaps the reason that recovery from SPMI is harder to understand than from the flu or a fracture is that nothing is visibly amiss. Their recovery is closer to someone who has incurred a stroke in that the extent

to which they may regain various functions is not apparent at the time of the event. Across their lifetimes, those with SPMI usually have a bumpy up-and-down course with periods of advancement punctuated by relapses. The aim of treatment is to assist each individual to progress as far as possible in reaching their personal potential. As such, recovery remains an ongoing story without a predetermined destination.

Fortunately for New Yorkers, the NYS Office of Mental Health licenses a broad array of “recovery-oriented services” meant to assist persons with SPMI depending on their needs at differing times. These services are the tools of recovery; they include crisis services, inpatient hospital admission, partial hospitalization, continuing day programs, housing offering differing levels of support, and differing intensities of community-based care from clinics to intensive outreach programs. It is useful for families to familiarize themselves with the array of available services in order to better advocate with mental health professionals on behalf of their loved ones with SPMI.

A case synopsis of a patient I treated for decades provides a sense of which services are utilized during periods of acute illness and “recovery.” First seen as a college freshman because of depression, what followed was entirely unexpected. Early on, his condition severely deteriorated, requiring multiple psychiatric hos-

pitalizations and extensive use of Electroconvulsive therapy after psychiatric medications failed to arrest his slide. Once his acute illness stabilized, he began to rebuild his life. He benefitted from the structure of a Continuing Day Treatment program while remaining in therapy. Over several years, he moved from his parent’s home through various levels of supportive housing before being able to live independently. All the while, he managed to graduate from college and attend graduate school. Spiritual counseling provided enrichment unavailable through psychotherapy. At my retirement, he was a married man and father, a successful social worker, and an adjunct professor of social work. It was an outcome neither of us could have foreseen and know to be rare. Appropriately, he continues in treatment.*

These case vignettes make clear the need for humility about the prognoses of those with SPMI seeking mental health care. Where the recovery journey may lead often can’t be foreseen at the beginning of treatment. To carry the journey as far as possible, we must keep working together with clinicians, patients, and families, employing available modalities. Along the way, a person with SPMI will benefit from differing combinations of services. Setbacks are discouraging for

see Recovery on page 32



ACMH’s **Crisis Residence** provides guests with 24-hour support from peer counselors. A care navigator engages guests with providers and appointments.

- Up to 7 day stays
- Adults currently experiencing a mental health crisis or being discharged from psychiatric hospitalization
- Resident of NYC
- Medically stable
- Stable housing or shelter placement to return to

Referrals:

https://www.acmhny.org/wp-content/uploads/2020/12/Respite_Enrollment_Form_2.20.pdf

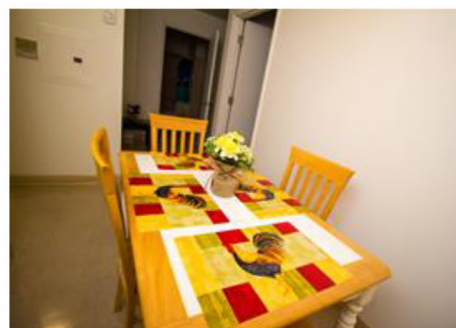
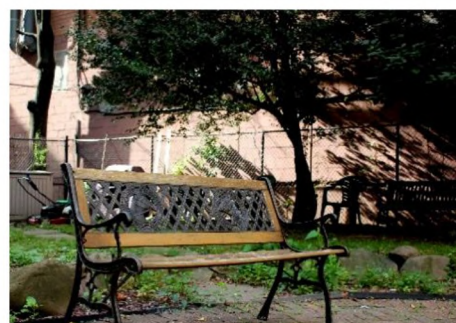
Enrollment confirmed within 24 hours.

Contact: Kearyann Austin, M.S., LMHC, 212-274-8558, ext. 408

www.acmhny.org

ACMH Residential Crisis Support

at two Manhattan locations:
E. 2nd Street & W. 167th Street



For more information:

https://www.acmhny.org/wp-content/uploads/2020/02/acmh_respite_brochure_2019.pdf

Chronic Pain, Quality of Life, and Suicidal Behavior

By Thomas Grinley MBA, CMQ/OE, CLYB, Program Planning and Review Specialist, New Hampshire Department of Health and Human Services

In the mid-1970s, Quality of Life (QOL) was identified as a key medical concept (Berlim and Fleck, 2003). Readily adopted in oncology, the concept spread through different fields of medicine and eventually to psychiatry. Many tools were developed to take QOL from a subjective concept to a measurable attribute. Some of these tools, such as the Quality of Life Interview and the Wisconsin Quality of Life Index, were designed specifically to measure QOL for individuals with severe and persistent mental illness.

Balazs et al. (2018) noted that QOL can be a significant mediator between peer and emotional problems and suicidal behavior in adolescents. Hoefler (2020), noting the sparsity of similar work with adults, found that life-altering events (divorce, grieving, isolation) significantly impacted the quality of life. Hoefler argued these became enabling conditions for attempting suicide.

Hadi et al. (2019) found that “The multidimensional negative impact of chronic pain leads to poorer QoL among patients with chronic pain compared to the general population and patients with other long-



term conditions.” Chen et al. (2023) made a direct connection between chronic pain and suicidal behaviors. They found that scoring just one standard deviation above the mean for pain had a 51% higher risk of suicidal behavior. Many others have followed this path, and the link between chronic pain, quality of life, and suicidal behavior is now well established.

Themelis et al. (2023) emphasized, “Living with chronic pain has been identified as a significant risk factor for sui-

cide.” In fact, after accounting for mental health disorders, 8.8% of deaths by suicide can be attributed to chronic pain. Using the most recently available suicide statistics, that is more than 4,000 people losing their lives to suicide because of chronic pain. We know that deaths by suicide are but a fraction of thoughts of suicide, so it is a significant factor in all suicidal behaviors. They discussed the concept of mental defeat as part of this link between chronic pain and suicidal

behavior. Tracing the concept from work on trauma, they identified the link between mental defeat and chronic pain as being recognized by 2007, with “mental defeat defined as negative appraisals of self in relation to pain.” Catastrophic thinking about chronic pain can lead to this mental defeat.

Gibbs (2021) made a simple observation that “suicide happens when the outward pressures of life are greater than the inward ability to cope in that moment.” Chronic pain leads to catastrophic thinking, leads to mental pain, leads to suicidal behavior. The pain simply becomes too much to bear.

Grinley and Gillan (2023) stated that addressing quality of life was key to reducing suicidal behaviors. However, it is difficult to address quality of life without first addressing the chronic pain at the root of poor QOL.

Hadi et al. found six themes linking chronic pain with QOL: “interference with physical functioning, interference with professional life, interference with relationships and family life, interference with social life, interference with sleep, and interference with mood.”

At this point, however, it becomes important to distinguish between different types of suicidal behavior. Those who take their lives by suicide are a fraction of

see Life on page 33



Comprehensive Treatment for Adolescents, Adults & Families Impacted by Substance Use & Co-Occurring Disorders

WJCS offers a systemic evidence-based approach to recovery from substance use and co-occurring disorders that includes:

- 6-week Intensive Outpatient Treatment Program for ages 18 and older
- Encompass, a modular evidence-based treatment for substance use and co-occurring mental health concerns, comprised of motivational interviewing, CBT, motivational enhancements to reward progress in recovery, and psychopharmacological treatment
- Psychiatric evaluation & treatment, including Medication Assisted Treatment
- CRAFT family treatment program
- Overdose prevention training and supplies
- Peer support services
- Case management
- Vocational and educational counseling

To inquire about services, please call us at (914) 607-4500. To learn more, please go to www.wjcs.com or contact William A. Mullane, Ph.D., at 914-761-0600 x3211; wmullane@wjcs.com.

wjcs
Westchester Jewish
Community Services
Strengthening Lives.
Shaping Futures.

www.wjcs.com
914.761.0600
845 N. Broadway
White Plains, NY 10603

the **harris** project
PROUD PARTNER
UJA Federation
NEW YORK

Outreach Recovery Center Integrated Opioid Treatment Program is Now Open!



Our Integrated OTP offers voluntary, long-term medication assisted treatment and support services to adults 18 years and older, with opioid use disorders and co-occurring conditions.

We provide Methadone maintenance, Vivitrol and Suboxone. Individuals receiving treatment have access to the full array of behavioral health services available through Outreach's extensive network of outpatient and residential programs on Long Island, in Queens and Brooklyn, New York.

Services include:

- Medication evaluation & management
- Psychiatric evaluations
- Individual & group therapy
- Peer support
- Case management
- External referrals
- Specialized support groups for veterans
- Educational seminars and vocational counseling
- Specialized services & programs for veterans



Safe, Accessible, Affordable & Personalized to Meet Your Needs

Location:

Outreach Recovery Center Integrated OTP
Pilgrim State Psychiatric Center
998 Crooked Hill Road, Building 5
Brentwood, NY 11717

OTP Service Hours:

Monday-Saturday, 7:00 AM to 2:00 PM (Hours expected to be further extended by spring 2023)
*Note: Monday-Friday the OTP is closed for one-hour, from 11:00 AM to 12:00 PM.

For questions or to set up a confidential consultation, call us toll-free at 1-833-OPINYORG (674-6967)

Scan QR Code to learn more about Outreach



OPINY.ORG



*All ages, genders & languages served (translation services provided at no cost)

*Sliding scale payment options available

*Medicaid & most insurances accepted

The program is licensed by the NYS Office of Alcoholism and Substance Abuse Services

Chronic Pain and Its Impacts: An Overview and Possible Management Options

By Veera Mookerjee, PhD, LMSW
Founder/Director
Resolveera

When a person goes through depression, the impact of that weight can manifest in the form of physical pain and other bodily discomfort. On the other hand, chronic pain has a significant effect on behavioral health. Recurring physical pain can lead to mood swings, lack of appetite, lack of self-care, changes in behavior and attitudes, as well as isolation.

What Is Chronic Pain and Its Impact

Chronic pain, as defined by [Johns Hopkins Medicine](#), “is long standing pain that persists beyond the usual recovery period or occurs along with a chronic health condition. It may affect people to the point where they can’t work, eat properly, participate in physical activity, or enjoy life.”

The physical manifestation of chronic pain can have an emotional impact on the person experiencing the pain, which can easily transform into depressive symptoms. Chronic pain is recurring for at least 90 days, daily or frequently. Chronic pain could be a repeated health condition due to seasonal triggers or issues like lack of



mobility. Pain measurements range from mild to severe and require timely, accessible, and accurate management.

Current Findings on Chronic Pain

A recent NIH study in 2023 demonstrated that chronic pain among adults in the USA is a frequently occurring new health condition when compared with diabetes or

hypertension. The study claims that the impact of chronic pain is about “21% among adults” (Nahin RL, Feinberg T, Kapos FP, Terman GW, Estimated Rates of Incident and Persistent Chronic Pain Among US Adults, 2019-2020). Chronic pain, a continuous feeling of discomfort of various intensities, is a condition that limits the way we function and our ability to focus. Chronic pain is notorious for turn-

ing people into substance abusers as they try to numb the pain.

Going by the NIH study, chronic pain is like a pandemic. Pain affects one individual but can potentially impact that individual's caregivers. From identifying the pain triggers to effective treatment, pain engulfs the person who experiences the variety of pain intensity and the caregiver equally. Both keep trying ways to control the pain at their levels. Nearly all of us have experienced mild to severe pain in our lives. As mentioned before, pain that keeps recurring is chronic. Pain has both physical and psychological impacts on an individual, ranging from temporary mobility issues to substance abuse in the form of excess pain medication used to control the experience and intensity of pain. Often, with chronic pain issues, uncontrolled pain refers to a stage when pain medication is in use as prescribed by the provider. Still, due to age, environmental triggers, or the chronic nature of the pain, there is no change in the severity of the pain. In such situations, often, a person uses trial and error methods to control pain, hence creating a very high chance of pain medication abuse or overdose. Referring to the same NIH study, chronic pain

see Options on page 35

Insights from Personal and Professional Frontlines

By Steve Miccio
CEO
People USA

Living with chronic pain is a physically exhausting experience that extends far beyond physical discomfort. I know this both from my own lived experience with peripheral neuropathy and major nerve damage and as the CEO of People USA, a peer-led non-profit that serves individuals with behavioral health challenges, many of whom struggle with chronic pain as well. It is an unrelenting companion that often brings along adverse mental health and cognitive impacts. The physical pain and subsequent mental health struggles can completely reshape an individual's life. Understanding these complexities is crucial for effective coping strategies and improved quality of life. Chronic pain has a profound impact on overall quality of life, including mental wellbeing. According to a survey conducted by the American Pain Society, over 50% of individuals living with chronic pain report experiencing moderate to severe disruptions in their daily activities, social relationships, and emotional wellbeing.

I was 17 when I began to feel pain in my feet and legs. I ignored the pain and continued being youthful and playing sports, mountain climbing, working and even skydiving regularly. When I reached my twenties, the pain grew to a level



where I could barely walk, and finally had to use a wheelchair by the time I hit 30.

Research suggests that chronic pain can lead to structural and functional changes in the brain. Areas associated with processing pain, such as the prefrontal cortex and limbic system, may undergo alterations, affecting cognitive processes. Additionally, the constant barrage of pain signals can overload the brain's capacity, disrupting its ability to focus and concentrate. That is what happened to me. I can personally relate to individuals we serve at People USA who often report difficulties with memory, attention, and decision-making. This cognitive fog, commonly referred to as "pain brain," can be debili-

tating, impacting everyday tasks and overall productivity.

Beyond cognitive challenges, chronic pain takes a toll on mental wellbeing. It is common for individuals to experience depression, anxiety, and mood disturbances as they navigate the complexities of their condition. The relentless nature of pain can wear down resilience, leading to feelings of hopelessness and despair. In fact, studies have shown that individuals with chronic pain are at a significantly higher risk of experiencing depression. I was severely depressed in my 30's even though I was on medication that allowed me to walk. However, the pain never went completely away. According to research

published in *JAMA Psychiatry*, 30-50% of individuals with chronic pain also meet the criteria for clinical depression.

Moreover, chronic pain often disrupts sleep patterns, exacerbating psychological distress. Sleep disturbances not only contribute to mood disorders but also further exacerbate cognitive difficulties, creating a vicious cycle of pain, sleeplessness, and mental challenges. It was in my 30's that I was hospitalized in a psychiatric hospital. I was in severe distress.

Furthermore, the emotional impact of chronic pain extends beyond the individual suffering. Family members and caregivers often experience heightened stress and emotional strain as they witness their loved one's struggle with pain. This dynamic can strain relationships as it did for me and create additional challenges in coping with chronic pain. Many of the individuals we serve at People USA become isolated from their loved ones, which causes an added layer of loneliness and despair. The link between chronic pain and suicidal ideation is significant. A study published in the *Journal of Pain Research* found that individuals with chronic pain are three times more likely to report suicidal ideation compared to those without chronic pain. The study underscores the urgent need for mental health support for chronic pain patients.

Individuals grappling with chronic pain encounter numerous hurdles, yet there are

see Insights on page 33

75 Years: AHRC New York City to Celebrate Milestone Anniversary on May 13th, 2024

By AHRC New York City

It is with pride in an unsurpassed history and great hope for the future that AHRC New York City kicks off its 75th year with a Gala on May 13th. The organization began in 1948 with a \$3 ad in the New York Post placed by Ann Greenberg, a Bronx housewife whose young son with developmental disabilities had been denied access to school. She was looking for other parents to form a play group, and the response was overwhelming. Within a year, hundreds of New York City families of children with disabilities had banded together to create what would, within a decade, become a grassroots human rights movement of great magnitude that spanned across the city and the country.

Many other disability organizations had their start later in the 1950's, but AHRC NYC was the trailblazer. Its power was, and remains, its family roots.

The Power of Families

Founded by parents and still governed by a Board comprised primarily of family members, the credo that propels the organization in all it does is based on the idea that people with developmental disabilities are entitled to access and opportunity so they can live full and equitable



Gathering of AHRC New York City founding members in 1949

lives. The organization's history is one of not only providing supports – some of the “firsts” in the field - but also of advocacy. From being a plaintiff in the Willowbrook lawsuit to calling for change in legislation and public policy, advocating for better education, living arrangements, prospects for work, and fuller lives in the community, AHRC NYC led the way. In its earlier years, AHRC NYC was at the forefront of

leading the newly arising provider community in its advocacy efforts and in developing provider associations. Reflecting on our history, Board President Ray Ferrigno, a parent of a young man with autism, sums it up well, “There are many challenges to be met. But whatever the obstacle, our sense of resolve is unshakable. That is the major lesson we learned from our founders. We have made enor-

mous strides in all these years, but there is still so much to be done.”

AHRC NYC's 75th Anniversary is a celebration of far more than the organization. The event celebrates the history of services and supports for people with developmental disabilities in New York City, the achievements made by people with developmental disabilities and their families, the dedication of the entire provider community, as well as many different community partners who have embraced AHRC NYC's vision of a world where the power of difference is embraced, valued, and celebrated.

Honoring Champions

The May 13th Gala will reflect on AHRC NYC's legacy and embrace a future of growth, championing the rights and opportunities of people with disabilities. The event's **Hall of Honor** will recognize individuals and groups for their exceptional dedication and contributions to the intellectual and developmental disabilities community, shaping the legacy of AHRC NYC. **The Hall of Honor** includes: **Maureen E. O'Brien, President and Chief Executive Officer of New York State Industries for the Disabled** honored for her tireless efforts in creating

see Anniversary on page 38



V!brant Emotional Health

supports youth and young adults develop skills that will sustain them throughout adulthood. We prepare young people to find and retain employment, continue their development with training programs, and pursue secondary and higher education goals.

Find out more at vibrant.org/asc

**EMPOWER
FUTURES.
IGNITE
CHANGE.**



Fifty Years Forward: NYPCC's Journey of Hope and Healing

By Elliott Klein, MBA
Chief Executive Officer
New York Psychotherapy and
Counseling Center (NYPCC)

Reflecting on the 50th anniversary of the New York Psychotherapy and Counseling Center (NYPCC) evokes a profound sense of pride and gratitude in me. Having been an integral part of this organization for 40 of those years, with two decades as CEO, I have been privileged to witness and contribute to our evolution and impact. Our journey, rooted in a single office in Queens, has blossomed into a beacon of hope, illuminating paths to wellness for countless individuals across New York City.

From Humble Beginnings to Far-Reaching Impact

Our story began with a simple yet powerful conviction: access to quality mental health care is a right, not a privilege. This belief has guided every step we have taken, from our early days in a modest Briarwood, Queens office to our expansion across the city's boroughs. Today, our reach extends to over 25,000 individuals annually through facilities that have become synonymous with healing and hope.

This growth is not just a measure of our success but a reflection of the increasing need for compassionate and comprehensive mental health services. Each of our centers, now spanning buildings up to 75,000 square feet, is more than just a space for therapy; they are sanctuaries where individuals and families can find solace, understanding, and pathways to recovery.



Elliott Klein, MBA

Investing in Our Greatest Asset: Our Staff

The backbone of NYPCC's enduring legacy is our dedicated team. Understanding the intrinsic link between caregiver well-being and patient care, we have cultivated an environment that supports our staff's professional growth and personal wellness. Wellness initiatives promoting work-life balance, ongoing training and development, and mental health awareness ensure that our team is not only equipped to provide exceptional care but also feels valued and supported.

The establishment of the NYPCC Academy exemplifies our commitment to excellence. By offering Continuing Education credits and fostering a culture of learning, we empower our employees and extend our reach beyond our walls, impacting the broader mental health community. This focus on education ensures that our employees remain at the cutting edge of mental health practice, benefitting both

those we serve and the field at large.

Embracing Diversity, Cultivating Inclusion

NYPCC's strength lies in our diversity. Over 85% of our employees are bilingual and bicultural, which enables us to offer culturally sensitive treatment, bridging language barriers and fostering a deep sense of trust with our clients. This approach is not just about providing services in multiple languages; it is about respecting and understanding the cultural nuances that shape one's experience with mental health treatment. This inclusivity is crucial for effective care and is a cornerstone of our practice.

Championing Mental Health Awareness and Advocacy

Our commitment to mental health extends beyond individual care. Through community outreach and educational programs, we have taken an active role in challenging the stigma that still surrounds mental health. Initiatives like our annual anti-bullying coalition community fairs demonstrate our proactive approach to societal issues, showing that our commitment to well-being extends to creating safer, more supportive communities.

These efforts are vital not only for changing perceptions but also for advocating for policies that support mental health care accessibility and equity. As we engage with local communities, policymakers, and other stakeholders, we aim to build a more informed and compassionate society where mental health is prioritized and supported.

Reflections on Leadership and Legacy

Leading NYPCC through decades of change and challenge has been the honor

of my lifetime. The landscape of mental health care has evolved dramatically during this time, influenced by advancements in research, changes in public policy, and shifts in societal attitudes. Navigating these changes has required resilience, innovation, and an unwavering commitment to our core values.

As I reflect on our journey, I am struck by the countless stories of transformation and healing that have unfolded within our centers. These stories are a testament to the power of compassionate care and the resilience of the human spirit. They inspire us to continue our work, pushing boundaries and exploring new ways to serve our communities.

The Road Ahead: NYPCC's Vision for the Future

Looking to the future, I am filled with optimism and resolve. The challenges facing mental health care are significant, but they are matched by our passion and dedication to meeting them head-on. Our vision for the next 50 years is bold and expansive, driven by the belief that everyone deserves access to the care and support they need to thrive.

This vision includes expanding our services to reach even more individuals and communities, leveraging technology to enhance access and efficacy, and continuing to advocate for systemic changes that support mental health wellness. We are committed to being at the forefront of mental health care, pioneering new approaches, and building partnerships that amplify our impact.

Elliott Klein, MBA, is the CEO of NYPCC. He can be contacted at elliottklein@nypcc.org or by visiting our website at nypcc.org.



At NYPCC, we believe everyone deserves access to the best mental health care, and we translate this belief into action every day.



OPEN 7 DAYS A WEEK



VIRTUAL & IN-PERSON APPOINTMENTS AVAILABLE



EARLY MORNING/LATE EVENING APPOINTMENTS AVAILABLE



COMMUNITY OUTREACH



BILINGUAL STAFF



EVIDENCE-BASED THERAPIES

Bronx Child & Family Mental Health Center
 579 Courtlandt Avenue, Bronx, NY 10451
(718) 485-2100

Bushwick Child & Family Mental Health Center
 102 Pilling Street, Brooklyn, NY 11207
(718) 602-1000

East New York Child & Family Mental Health Center
 2857 Linden Boulevard, Brooklyn, NY 11208
(718) 235-3100

Understanding and Addressing Childhood Trauma

By Jeniffer Cruz, PhD, NCSP
Psychologist
Behavior Therapy Associates

Everyone experiences scary or difficult events in their lives. For some children, these events can be so frightening or dangerous that they can have a lasting impact on their well-being. Trauma refers to the physical, cognitive, and emotional responses to an event (or events) that is physically or emotionally overwhelming or life-threatening. Children's responses to a traumatic event can have negative effects if left untreated.

Trauma can be the result of a single incident, like the unexpected death of a loved one, a serious accident, or experiencing a natural disaster. It can also be chronic or ongoing, such as repeated instances of neglect, bullying, and exposure to family or community violence. Communities can also experience trauma through discrimination and racism that can affect future generations. While trauma from a single event can be impactful, research tells us that children who experience a higher number of Adverse Childhood Experiences, or ACEs, are more likely to have negative consequences that continue into adulthood. Early exposure to many ACEs can lead to excessive stress that can impact brain development. This may affect attention and learning and



make it challenging to form positive relationships with others. Regarding education, the impact of trauma has been associated with higher rates of suspension and expulsion, higher dropout rates, increased referrals for special education, and lower academic performance. The long-term effects of trauma on physical and mental health include increased risk of conditions like diabetes, cardiovascular diseases, depression, and suicide (Centers for Disease Control and Prevention, 2019).

Signs of childhood trauma vary based

on age and developmental level. For example, children who are preschool-aged or younger may display a regression of skills they previously acquired (e.g., toileting, talking), poor eating habits, and sleep disturbances such as nightmares or fears around falling asleep. Elementary children can present with sleep challenges, difficulties concentrating in school, and retelling the event often, while teens may express feelings of shame and guilt about the event or engage in risky behaviors like drinking or using harmful substances.

If a child has experienced a traumatic event, families should find ways to support safety and predictability, including returning to previous routines like mealtimes and bedtimes. Creating opportunities for expressing feelings in a safe, supportive environment as a family can also be beneficial. Caregivers are encouraged to answer children's questions about the event honestly while also using words and phrases that match the child's level of understanding. Depending upon the event, children may

have concerns about their own safety or the safety of loved ones, and creating an explicit plan for safety can help alleviate their worries. Engaging in joyful activities together, like reading a book or watching a movie and discussing character emotions or playing games and drawing, can provide children space to express themselves in multiple ways. Although it may be difficult, caregivers should continue to set appropriate limits and boundaries, as this promotes consistency and predictability in the child's life.

Caregivers will want to pay attention to significant changes in their child's behavior and seek out additional support from a mental health professional if these changes are extreme or persist for several weeks. Current evidence-based treatments, such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT), will include components to help both children and their caregivers receive the tools they need to cope with the event. Treatment can help children and families identify unhelpful thoughts, learn skills to help cope with thoughts and feelings about the trauma, provide parenting strategies, create a plan for dealing with trauma reminders, and develop a trauma narrative to increase the child's exposure to the trauma in a safe and controlled setting. Children will develop the tools they need to prepare themselves for a future after trauma.

Schools can meet the needs of students who have experienced trauma. They can adopt policies and procedures that emphasize a positive school climate that will promote safety and trust within the school community. In fact, practices used to enhance school climate and trauma-informed practices are aligned. Trauma-informed care incorporates principles of safety, peer support, trust and transparency, collaboration, empowerment and choice, and cultural, historical, and gender

see Trauma on page 41



Behavior Therapy
ASSOCIATES

ESTABLISHED 1979

We're proud to offer services throughout the U.S.
www.BehaviorTherapyAssociates.com

Providing comprehensive clinical, consulting, and school-based service for children through adults, families, schools, organizations, and sports teams.

Michael C. Selbst, PhD, BCBA-D
Executive Director

732.873.1212
info@BehaviorTherapyAssociates.com
35 Clyde Road, Suite 101
Somerset, NJ 08873



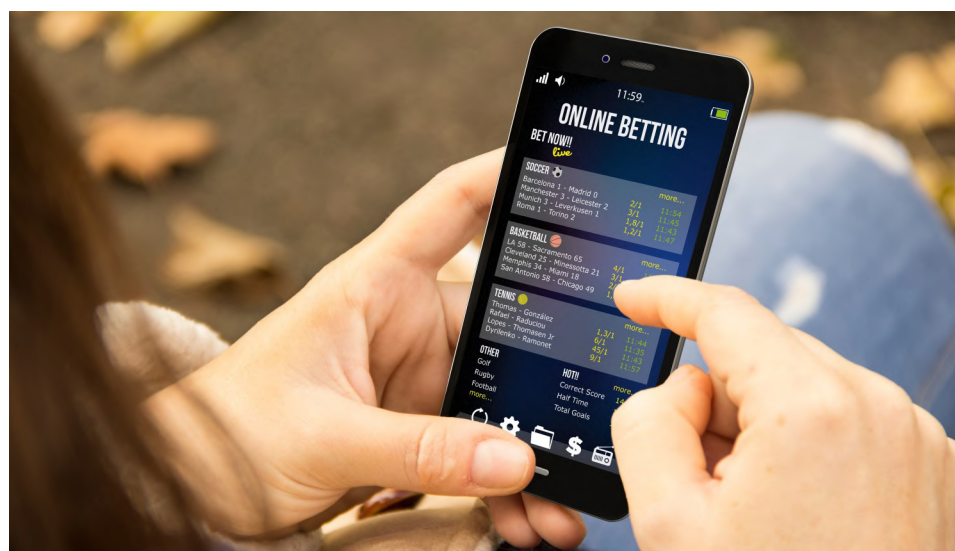
Adolescent Gambling: A Growing Concern

By Richard Anemone, MPS, LMHC
Behavioral Mental Health
Counseling PLLC

Adolescent gambling has turned into a difficult issue that can have huge negative ramifications for the individual, family, and communities.

A representative sample of 2,274 US residents aged 14–21 participated in a random telephone survey. Findings revealed that 68% had engaged in gambling in the past year, with 11% doing so more than twice per week. The rates of problem and pathological gambling were comparatively lower than those observed in a prior adult survey that employed the same questionnaire (Welte et al., 2007).

Gambling among adolescents can take several forms, including access to online gambling websites and apps, which offer a wide range of options, including casino-



style games, sports betting, and online lotteries. These platforms are often easily accessible and may not have strong age verification measures. Informal gambling

activities include card games, dice games, or betting on sports events among themselves or peers. Older friends or family members can purchase lottery tickets and

scratch cards. Social media and gaming where users can buy and sell virtual items, loot boxes, or engage in other forms of simulated gambling.

Adolescents may engage in gambling for various reasons, including the thrill and excitement of risk-taking, and the potential for winning can be appealing to adolescents who seek thrill and novelty. Peer pressure and the desire to fit in with peers who gamble may contribute to adolescents' involvement in gambling activities. Some adolescents may turn to gambling as a way to escape boredom, stress, or other emotional challenges they are facing. A limited understanding of the potential consequences and risks associated with gambling may lead adolescents to participate without recognizing the long-term impact. Exposure to gambling through advertisements, movies, or online content can normalize the behavior and

see Gambling on page 41

Disparities in Pain Management: Examining Cultural Inequities And the Critical Role of Behavioral Health Providers

By Crystal Taylor-Dietz, PsyD
National Director of Behavioral Health
Services, Devereux Advanced
Behavioral Health

For decades, pain management and the treatment of chronic pain (CP) have proven to be a complex, costly, and challenging area within the healthcare industry.

While advancements in best practices for treating CP have evolved to include multimethod and multidisciplinary team approaches that incorporate analgesics, physical therapy, psychotherapy, and complementary/alternative medicines, the traditional unimodal biomedical model is still apparent and often leads to poor outcomes (Edmond, Heapy, Kerns, 2019). Disparities in socioeconomic status, race, sexual orientation, and gender further affect access and opportunities for marginalized populations to receive the most effective treatments (Center for Disease Control; Cohen, Vase, Hooten, 2021). In addition, an individual's experience of pain and the implications of ineffective treatment are impacted by sociocultural factors such as systemic discrimination, bias, and **cultural stigma** (NIH Heal Initiative).



In 2020, the International Association for the Study of Pain (IASP) revised its definition of pain. The new definition states that pain is “an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.” The definition further clarifies that pain can be experienced without identifiable evidence of tissue damage.

Implications on Society

Chronic pain can have significant functional and financial implications for individuals, families, and society as a whole. According to the Centers for Disease Control and Prevention (CDC), an analysis of National Health Interview Survey data revealed that in 2021, an estimated

51.6 million people (20.9% of US adults) experienced CP, with 17.1 million (6.9% of US adults) experiencing high-impact CP, which significantly impacts day-to-day functioning.

Children also suffer from CP when it is not associated with a disease. Although research is more limited in this area, and prevalence rates vary, a systematic review noted 4% to 88% of children and adolescents experienced various areas of pain (King et al., 2011), and other research showed prevalence rates for a pediatric population of 25% (Perquin et al., 2000). In addition, COVID-19 has contributed to increases in CP cases related to stress about the pandemic and long COVID-19 symptoms (Abramson, 2022).

In addition to the substantial impact of CP on individuals and families, there is a considerable financial burden to society that results from healthcare costs and loss of work productivity. A study conducted by the Institute of Medicine's Committee on Advancing Pain Research, Care, and Education concluded that the total financial burden to the US in 2010 ranged from \$560 billion to \$635 billion, which, at that time, was “nearly 30% higher than the combined cost of cancer and diabetes

see Disparities on page 40

Your Options for Responding to Mental Illness Stigma (Protectively, Collaboratively, or Assertively)

By Dan Berstein, MHS
Chief Advocacy Officer
Mindquity

I have been open about my bipolar disorder for almost twenty years. Immediately after I spoke at my first mental health awareness event, I was met with feedback and gratitude. People thought it was a brave thing for me to speak up about my mental illness to fight stigma. But the truth is, I felt I *had* to reveal my mental health problems because I was *scared* of being stigmatized. When I had my first manic episode, I was at college and Facebook had just come out. I was nervous that people were going to gossip about me, and I would never know who knew what about my mental health history, so I felt I had to take control of my own story to stop my anxiety. I wanted people to know that they did not have leverage over me. Because I was telling people myself, anyone who knew about my condition would know it was not a secret skeleton in my closet.

After close to two decades of being public with my illness, I still am not always sure when stigma, microaggressions, and discrimination are impacting my life. These things are difficult for anyone to notice because our society is often not as sensitive to prejudices and discrimination about mental illness as it is to prejudices regarding other conditions and

diversity groups - and because, like most biases, mental illness stigma is often hidden, unintentional, and systemic.

Through my work with the Mental Health Safe Project, I have developed tools to help people navigate the confusion of the stigma experience. Recently, we have created the “Stigma Can Look Like” campaign to educate others about how mental illness stigma can manifest in everyday life and to help people become aware when they believe they are experiencing stigma and connect them to options to respond.

We have shared an image from the campaign at the top of this article. You can also visit mhsafe.org/options to learn more.

Five Steps for Responding to Stigma (The 5 C's)

In this article, I will share a 5-step framework (the 5 C's) for deciding how to respond when you believe mental illness stigma may occur. Then I am going to share examples of ways you might respond protectively (meaning you focus on self-care and may choose

not to do anything), collaboratively (meaning you work to connect with the other person to have a learning experience), and assertively (meaning you take action to assert your rights more unilaterally because the other person is not collaborating).

Whenever something stigmatizing happens, we can **Clarify** what happened in case it was a potential misunderstanding, **Cope** with how we feel from the trauma, **Collect** evidence so we have a possible way to prove there is a problem, **Cultivate** personal and professional support options, and **Consider** the next step of whether we want to act.

Below is a guide summarizing some questions you can ask yourself at each stage (tools to help you at each stage are available at mhsafe.org/options):

5 Steps for Responding to Stigma

1. **Clarify** what happened (Did this occur?)

- Is this stigma and/or discrimination?
- Is this unclear?
- What are some other possible explanations?

2. **Cope** with trauma (How do you feel?)

see Your Options on page 42

Anxiety and Psychosomatic Symptoms in Schools

By Eve McCoog, LCSW,
and Sara Battaglia, LSW
First Children Services

P psychosomatic symptoms are the physical and physiological experiences caused by mental or emotional conflict or distress. Often, they are dismissed as being imagined or exaggerated, likely because they are part of someone's internal experience. It is important to note psychosomatic symptoms are very real for the people experiencing them and can have a major impact on their ability to function and meet the demands of daily life. These psychosomatic symptoms are one of the most effective ways for clinicians to determine one's internal distress. As hormones, like adrenaline and cortisol, are released during a stress response, our neurological and endocrine systems display the effects of that stress.

A simple way to think about these internal experiences is by comparing them to toothpaste inside the tube. No one can see the toothpaste until it is expressed, just as no one can see our internal experiences until they are expressed as words, actions, or even pain. Commonly experienced psychosomatic symptoms include changes



in our breathing and/or heart rate, shakiness or trembling, tension in our muscles, headaches, backaches, temperature changes such as hot flashes or chills, tingling, numbness, shivers, stomachaches, digestive issues, sense of dread, panic, hopelessness.

Often, psychosomatic symptoms experienced by adolescents are a result of anx-

ety. Anxiety is not always a disorder; sometimes, anxiety is a necessary function that alerts our body to potential danger. It also may arise when anticipating something that may bring us physical or emotional discomfort, distress, or harm. For children and adolescents in school, this can include fear of failure or making mistakes on assignments or in front of

peers. Another source of anxiety may be a lack of emotional safety resulting from negative past experiences, both at home and at school. During adolescence, there may be a developmentally appropriate lack of self-confidence, which can morph into a source of anxiety as it leads to negative self-talk and increased belief in negative outcomes. Students who lack effective self-regulation skills may experience higher anxiety due to an inability to self-soothe. Finally, poor sleep, hygiene, eating, and other poor self-care habits impede our adolescent's ability to regulate, process, and manage their worlds, leading to mental and emotional distress.

A major factor contributing to the increase in psychosomatic symptoms, particularly in adolescents, is the effect of the coronavirus pandemic beginning in 2020. Experts are only beginning to study the effects of the pandemic but already see a significant increase in the frequencies of psychosomatic symptoms and negative emotions especially in younger people. Uncertainty is a huge component of anxiety. That, coupled with things like the fear of infection and the measures taken to stop the spread of the virus, add to the likelihood of emotional distress.

see *Schools* on page 32

Crisis from page 14

suppressed the presence of fear. His emotional landscape manifested as intolerable physical pain, presenting as a cyclical crisis, impairing healthy functioning, and increasing the use of medications to self-soothe.

As EG continued to maneuver through the complexities of the therapeutic relationship, the introduction of arts-based interventions focused on his propensity to use his hands, as he is a self-identified tinker (a person who travels from place to place mending metal utensils as a way of making a living) and electrician by trade. Structured arts-based directives created space for exploration of the noted emotional content, which was previously too uncomfortable to examine. In conjunction, mindfulness-based stress reduction tools re-grounded EG, and outbursts decreased due to strategies in place to appropriately direct and hold feelings of anger and agitation. EG's preoccupation with pain shifted to a focus on writing, meditation, and visual arts, which strengthened a more positive sense of self. EG felt safe in this alliance through the direct confrontation of misdirected anger, persistence in tolerating the discomfort with the intimacy required to maintain a therapeutic relationship, and a willingness to confront his fear and sadness.

Back spasms continued intermittently, yet the intensity of chronic pain diminished, and exploration of medical interventions resumed. EG invited vulnerability, so when pain emerged during the session, he ceased to lash out and instead allowed himself to be held by compassion. EG's chronic pain was no longer prominent as it retreated, which allowed



Issy Francis, BSN, RN

the re-emergence of EG as a tinker, Artist, and in relationship with providers. EG's treatment is in accordance with S:US' philosophy of care, "When an individual's life is put on hold for circumstances unique to them, establishing a relationship with them is step one. It's our guide to the services we provide. We don't empower people. We give people the tools to empower themselves." By understanding the contextual components of chronic pain, individuals like EG rediscover their own unique potential and strength-based skills to flourish.

If we treat chronic pain to uncover emotional pain, we create pathways to connection with self and others. While addressing the complex interplay between mental health, chronic pain, and its comorbidities, providers must pay regard to the unique needs and circumstances of everyone to develop personalized treatment. This may involve medical interventions, psychological support,



Dani York, LCAT, RDT

lifestyle modifications, and social services to optimize outcomes and improve overall well-being.

Issy Francis, BSN, RN, is Director of Nursing and Dani York, LCAT, RDT, is Director of Clinical Support & Enhancement at Services for the Underserved (S:US).

To learn more about Services for the Underserved's approaches to care, visit sus.org, call 212-633-6900, or email info@sus.org.

References

1. Miller LE, Eldredge SA, Dalton ED. (2017) "Pain Is What the Patient Says It Is:" Nurse-Patient Communication, Information Seeking, and Pain Management. *Am J Hosp Palliat Care*. 2017 Dec;34(10):966-976. doi: 10.1177/1049909116661815. Epub 2016 Aug 4. PMID: 27496829.
2. Cook, K., et al. (2012) *J Pain Symptom Manage*. Author manuscript; available in PMC 2014 Sep 1. *Published in final edited form as: J Pain Symptom Manage*. 2013 Sep; 46(3): 413-421. Published online 2012 Nov 15. doi: 10.1016/j.jpainsymman.2012.08.006.
3. Dydyk, A.M. (2024), Conermann T. *Chronic Pain*. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-2023 Jul 21. Available from <https://www.ncbi.nlm.nih.gov/books/NBK553030/>.
4. *Chronic Pain*. (n.d) The Johns Hopkins University, the John Hopkins Health System. Review. <https://www.hopkinsmedicine.org/health/conditions-and-diseases/chronic-pain>.
5. Staudt MD., (2022) The Multidisciplinary Team in Pain Management. *Neurosurg Clin N Am*. 2022 Jul;33(3):241-249. doi: 10.1016/j.nec.2022.02.002. Epub 2022 May 25. PMID: 35718393.
6. The British Psychological Society & The Royal College of Psychiatrists. National Collaborating Centre for Mental Health (UK). (2009). *Borderline Personality Disorder: Treatment and Management*. *Borderline Personality Disorder: Treatment and Management*. NICE Clinical Guidelines, No. 78. <https://www.ncbi.nlm.nih.gov/books/NBK55407/>.
7. Steven J. Linton, William S. Shaw (2011). Impact of Psychological Factors in the Experience of Pain. *Physical Therapy*, Volume 91, Issue 5, 1 May 2011, Pages 700-711, <https://doi.org/10.2522/ptj.20100330>.



NY State Mental Health Stigma Reduction Community Projects

These projects were funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction



Breaking Down Barriers: The STAR Program's "Stop Mental Health Stigma" Campaign

By Michelle Melendez, MS, LCSW, CHC, and Jose Iorio
The STAR Health Center

In an era where mental health discussions are often shrouded in misunderstandings and misconceptions, the "Stop Mental Health Stigma" campaign emerges as a beacon of hope and enlightenment. Spearheaded by the STAR Program at SUNY Downstate Health and Sciences University and generously funded by the New York State Office of Mental Health, this initiative seeks to dismantle the barriers of stigma surrounding mental health care. Through the dedicated efforts of individuals like Jose Iorio, a media and marketing consultant for the STAR Program, and Michelle Melendez, MS, LCSW, CHC, the Behavioral Health Director at STAR Health Center, the campaign is making significant strides toward creating a more understanding and supportive society.

The Power of Social Media in Combatting Stigma

Jose Iorio's insights reveal the pivotal role of social media in altering perceptions and encouraging open dialogues



The STAR Program's Stigma Reduction Project interviewed people with lived experience and mental health service providers.

about mental health. By leveraging platforms that reach millions daily, the campaign employs a variety of content formats — from informational posts and personal testimonials to roundtable discussions and interactive quizzes. These efforts aim to educate and foster a sense of community and inclusivity, indirectly

touching the lives of those grappling with mental health issues.

Collaborating with organizations like The Adolescent Education Program (THEO Program) further amplifies the campaign's message, extending its reach and impact. It's a testament to the power of unity in addressing complex societal challenges.

Engaging Content, Engaging Minds

The STOPMentalHealthStigma.com website serves as the campaign's central hub, offering a wealth of resources, information, and engaging activities designed to challenge stigma. Its success is evident in the diversity of its users and the depth of engagement, as evidenced by the significant traffic it has attracted since its inception. This engagement provides valuable insights into public attitudes towards mental illness and stigma, highlighting the widespread need for love, support, and understanding.

A Community United

Michelle Melendez shares the campaign's multifaceted approach, which extends beyond online efforts to include suicide prevention training, Mental Health Awareness Month activities, and workplace mental health strategies. Particularly noteworthy is the campaign's focus on listening to and incorporating the experiences of high school and early college students, especially within African American and Caribbean communities. This inclusive strategy ensures that the voices

see *STAR Program* on page 39

Breaking Mental Health Stigma in the NYC Hispanic/Latino Community

By NAMI-NYC

At NAMI-NYC, we often say 1 in 5 of us is affected by mental illness, and the other 4 are family, friends, neighbors, and colleagues. We are ALL impacted by mental illness. Most interventions are for the individual, but it's critically important to remember the first ring around the person — their friends and family.

NAMI-NYC is the only non-profit offering free mental health programs and support directly to family members caring for a loved one with mental health challenges. Together, we offer peer-led, peer-run classes, 40 support, and social groups, a Helpline in 180 languages, family mentoring, and more to help New Yorkers with mental illness - and their families - on the road to recovery.

At NAMI-NYC, we also focus on breaking the stigma, especially in underserved communities. Due to our unique position to assist families, we wanted family support to shine in our PSA video for Hispanic/Latino New Yorkers. The

FREE Mental Health Programs & Support

212-684-3264
helpline@naminyc.org

Learn more: www.naminyc.org/find-support

Hispanic/Latino community specifically faces significant stigma surrounding mental illness, as well as challenges accessing care. Language barriers and the lack of bilingual practitioners are just a few of the reasons many Hispanics/Latinos are left without the support they need. In addition, the COVID-19 pan-

demic has disproportionately impacted this community.

Despite these challenges, NAMI-NYC has made efforts to address stigma and improve access to care through its Spanish language programs and this campaign. At NAMI-NYC, it's more than offering translation and interpretation, but devel-

oping customized culturally responsive programs, led and run by volunteers, and in this case, community members who identify as Hispanic/Latino.

The success of the PSA project is also largely attributed to thorough research and community engagement. Through extensive field studies, NAMI-NYC gained valuable insights into the attitudes and needs of the Hispanic/Latino community regarding mental health. This research guided the development of the PSA video and informed the organization's outreach and distribution strategy. We conducted the interviews in English and Spanish on the streets of New York City. These interviews were audio recorded, and then we organized the data by theme, age, race, and zip code. Some of these insights included:

"I don't talk to my family about mental health. I don't know if it's a cultural obstacle, but both my parents are immigrants, and they never really held that kind of space for open dialogue."

see *NAMI-NYC* on page 39



NY State Mental Health Stigma Reduction Community Projects

These projects were funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction



Mental Health: Everyone Has It. Every Day. Breaking the Stigma with ICAN's Innovative Campaign

By Integrated Community Alternatives Network (ICAN)

Integrated Community Alternatives Network (ICAN) is an innovative human service non-profit providing individualized traditional and non-traditional service and care to the highest-risk individuals and families with social, emotional, mental health, and behavioral challenges. ICAN's team of over 275 staff consists of care managers, service coordinators, social workers, support specialists, clinical staff, and an extensive Independent Practice Association (IPA) of 300+ providers who work together to provide a platform for support, family reunification, and preservation to over 2,400 individuals and families each day. We serve six counties in the Mohawk Valley region through over 20 programs that assist and empower individuals prenatally through end-of-life. We have an amazing culture and love the work we do.

Mental health is threaded through each of our programs and is top-of-mind for every member of our ICAN team. We do



Naz presenting to a group of students at Frankfort-Schuyler Central School District

our best work for the community by empowering our staff to take great care of themselves and their families so they can do this vital work each day.

We were overjoyed to receive funding for the New York State Office of Mental Health Stigma Reduction Project, which helped us advance our goal of reducing

the stigma of asking for help. Once awarded, our creative team created an innovative campaign to engage Mental Health Ambassadors to deliver an impactful message to area youth. Unique and inclusive outreach and a "let's make it amazing!" approach to creative work are where our team shines.

We chose teenagers and pre-teens as our audience. On top of the stresses of simply navigating the world at that age, our young people are still finding their way through a major collective trauma and dealing with constant connectedness and incessant barrage of social media.

To make the campaign as successful as possible and ensure that we developed a message that would resonate with youth, we formulated an online survey to gather imperative insight from teens. We asked them a series of questions about mental health: what it means to them if they have negative or positive connotations when they hear the term, how often they think about it, and who they talk to for guidance or help. With close to 150 responses, we

see ICAN on page 37

Combating Mental Health Stigma in a Rural Community

By Yates INSYGHT

Like all communities, stigma plays a role in an individual's willingness to access mental health treatment and support. To combat this, Yates INSYGHT, in partnership with the Yates County Community Services Department, chose to promote a countywide initiative focused on promoting comfort in talking about mental health and wellness and seeking support and treatment to reduce stigma around this topic. With the support of OMH funds, Yates INSYGHT was able to execute various initiatives, including the placement of billboards and a county transportation bus wrap with messaging normalizing the need to seek treatment for mental health and the synonymy of seeking physical health treatment. To add to this message, Yates INSYGHT distributed postcards to all Yates County addresses, encouraging normalization of the conversation around mental health and the need for support. Each postcard contained direct access to local and national mental health resources. 225 posters were created and distributed countywide, emphasizing the message to normalize mental health, person-first, strengths-based, positive lan-



guage, and promote anti-stigmatizing techniques, each offering easy access to local and national mental health resources and supports via a QR code. In addition, Yates INSYGHT was able to execute a social media campaign with boosted messaging, allowing us to reach an additional 46,000 individuals in and around Yates County.

Through partnerships with local businesses and organizations, Yates County stigma efforts were able to expand further. Yates County supported efforts through a tabling display of education on mental health prevalence and stigma impact, as well as local resources and support at our local County Office Building. The display became the initial visual for any community member or staff entering the Office Building for reasons such as the Department of Motor Vehicle Needs, Public Health, Office for the Aging, Community Services and C-SPOA, Department of Social Services, and Legislative

meetings. A local ice cream business, Seneca Farms, partnered with Yates INSYGHT to develop and promote a mental health matters sundae and offered additional advertising support via their 15k social media followers and business billboard. Our largest event consisted of a countywide celebration on Children's Mental Health Awareness Day in which 640 t-shirts were distributed and worn with the message "Mental Health Matters," and individuals chalked the sidewalks with positive, mental health-affirming messaging. Yates INSYGHT was overwhelmed with the number of partners and community members willing to support this initiative and create a safe space for individuals to feel comfortable and confident in themselves and seeking support as needed. All participants rallied to promote their support through social media outlets and a universal hashtag to reach a larger audience.

Yates INSYGHT primarily targeted the

residents of Yates County, including children, youth, adults, and families of the Migrant Community, Mennonite Community, and those individuals of middle to high socioeconomic status who may not actively seek necessarily mental health treatment due to cultural or environmental stigmas. Yates INSYGHT also aimed to target individuals of the LGBTQ+ community who may face limited access to stigma-free treatment within their community in our efforts. We had the opportunity to utilize a wide range of partners and individuals in creating our messaging and initiatives to ensure we reached our desired populations through System of Care work and focus groups. Some of these partners included our school systems, faith-based communities, Public Health, community clinics, Chamber of Commerce, Social Services, and Community Services.

Reflecting on the work completed through stigma funds, Yates INSYGHT positively impacted many realms of mental health stigma. Our efforts aimed to reduce the negative attitudes and shame one may feel around talking about and seeking treatment for their mental health conditions. We were able to transform the

see INSYGHT on page 37



NY State Mental Health Stigma Reduction Community Projects

These projects were funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction



WeSpeakNYC: A Toolkit for Overcoming Mental Health Stigma in BIPOC Communities

By Dana L. Collins, PhD,
St. Mary's College of California,
and Lauren Gonzales, PhD,
Columbia University Medical Center
Department of Psychiatry

WeSpeakNYC

Research has consistently demonstrated that BIPOC (Black, Indigenous, and People of Color) communities experience disproportionately low access and utilization of mental health services in the United States. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently found only one in three Black adults with a mental illness receives treatment (SAMHSA, 2022) despite the fact they're **more likely** than White adults to report persistent symptoms of emotional distress (CDC, 2021). Recent data also shows that **35.1%** of Latinx adults with mental illness receive treatment each year compared to the United States average of **46.2%** (SAMHSA, 2022). Asian Americans and Pacific Islanders (AAPI) are the least likely of any U.S. group to receive mental health treatment; in 2020, only 20.1% of AAPI adults with a mental illness accessed treatment (SAMHSA, 2022). Social and structural factors, such

as systemic racism, limited availability of culturally appropriate mental health care, and stigma, have contributed to these disparities in service utilization for BIPOC individuals. Thus, our project aimed to challenge mental illness stigma in BIPOC communities in the NYC area by using a community-based participatory approach to develop culturally relevant tools. We chose a participatory approach because we believed it would help ensure that the tools felt applicable to the communities we created them with and for. In addition, participatory approaches differ from traditional approaches that mental health intervention design and research typically use, in which community members have very little agency and opportunity to give input and make decisions for themselves. Given that BIPOC individuals and communities have historically and currently experience marginalization, which contributes to stigma, sharing power and centering community voices felt essential.

We began our project by initiating partnerships with three New York City-based mental health organizations, [Brooklyn Community Services \(BCS\)](#) in East Brooklyn, [Services for the Underserved \(S: U.S.\)](#) in East Harlem, and [Montefiore Medical Center's Bronx Health Collective \(BHC\)](#) in the South Bronx. We chose these organizations based on their predominately serving BIPOC communities and because they were located in different boroughs, which we believed would make the project relevant to a wide segment of New Yorkers. In addition, we chose organizations based on one of us having previously established a relationship with them, as we recognized that trust would be an essential component to successful partnerships. Establishing the partnerships involved discussing the projects' purpose, goals, and timeline with the organizations' leadership and other stakeholders.

With the support of each organization's leadership, we held open community dis-

cussions at each location. Two meetings happened in person at the organizations, and one was held via Zoom. During these meetings, we asked community members what they thought was important to include in anti-stigma toolkits developed for their communities. Using our grant funding, we could compensate all community members who participated as partners in this project. The community meetings were a key part of our project's design, given that our goal was to use a participatory approach in which the people and communities our toolkit and website were meant to benefit had active involvement in the project from start to finish. This was important to us from a collaboration and inclusivity standpoint, but also because we know that historically, especially concerning mental health and marginalized communities, policymakers, researchers, and clinicians often take from these communities and do not give back. This exploitation can lead to further mistrust, stigma, and reluctance to partner with researchers and clinicians in the future. Mental illness stigma, especially, is an area where it is crucial to involve lived experience to avoid perpetuating these power

see WeSpeakNYC on page 36

Empowering Communities through Inclusion and Mental Health Anti-Stigma Efforts

By Melissa Clark
VP of Community Impact
United Way of the Dutchess-Orange
Region (UWDOR)

Thank you so much for including me in this project. Thank you to the NYS Office of Mental Health for their support. We are thrilled to present the work we accomplished as part of the Stigma Reduction Project.

My name is Melissa Clark, VP of Community Impact at [United Way of the Dutchess-Orange Region \(UWDOR\)](#). UWDOR has a long history of Community Impact and anti-stigma practices. We were founded in 1937 and, working with our supporters, "fight for the Health, Education and Financial Stability for every person in our community." We provide extensive capacity building and resources to our hundreds of local nonprofit partners, including funding, volunteers, essential items, training, food access programming, and a 24/7/365 human services hot-



line. Through our partnerships and programs, we can help 1 in 4 people in our community, over 214,000 people!

The Stigma Reduction Project had several components. We hosted MLK and

Juneteenth Equity challenges that encompass a variety of diversity, equity, and inclusion (DEI) topics related to mental health, racial equity, gender equity, LGBTQIA+, ageism, and ableism. Each

day, participants receive a link to an article, video, and podcast encouraging them to learn and unlearn themes DEI topics. The different modes are to accommodate different preferred learning methods.

Additionally, we hosted a Community Conversation around Food Insecurity and looked at the intersectionality between mental health, food access, and other social determinants of health. Community members and service providers attended. We also hosted two Nonprofit Professional Development Workshop days focused on DEI concepts and mental health stigma reduction. Attendees of all components were made up of different areas of the population, including hard-to-reach populations, BIPOC folks, and marginalized populations. In total, 1,008 people participated in various Stigma Reduction Project activities.

We are proud of our DEI work. DEI work has been our consistent focus, and we ensure it is at the top of our minds in all of the programming we execute.

see Equity Challenge on page 34



NY State Mental Health Stigma Reduction Community Projects

These projects were funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction



Stories of Stigma in the Healthcare System

By Melissa Wettengel, NYCPS, MPH
Chief Executive Officer
Hands Across Long Island, Inc. (HALI)

For Hands Across Long Island, Inc. (HALI), stigma is personal. As a peer-run organization, our mental health recovery “lived expertise” informs our services, which all address structural stigma or population-level disparities experienced by people having psychiatric diagnoses and/or a disability and experiencing poverty, isolation, and homelessness.

Another disparity our community faces is one life and death. People with certain psychiatric diagnoses have an average lifespan of 25 years shorter than the general population, primarily based on higher rates of metabolic, respiratory, and cardiovascular disease. (Parks et al., 2006). The causal factors are complex, but research shows one contributing factor is stigma experienced within the healthcare system. Troubling experiences occurring in the



Overshadowed participants, filmmaker Lucy Winer, and HALI staff after “wrapping” on film day #1

literature range from microaggressions to an over-emphasis on “stability” over wellness to the potentially life-threatening

phenomenon of diagnostic overshadowing, where reported physical symptoms are incorrectly attributed to a psychiatric

diagnosis (Melamed et al., 2019). While disturbing, there is some good news here: stigma is workable. Studies show that “contact-based” interventions, or direct messaging delivered by people with lived experience, are extremely effective at ameliorating stigma (Collins et al., 2012; Corrigan et al., 2014).

This was the origin of HALI’s *Overshadowed: Stories of Stigma in the Healthcare System* video project, produced in partnership with award-winning documentary filmmaker Lucy Winer (*Unlocked, Kings Park: Stories from an American Mental Institution*.) *Overshadowed* started with a series of focus groups with 45 people in various settings: SPA housing community residences, PROS programs, and recovery centers (thanks to our partners Options for Community Living and the Association for Mental Health & Wellness for help with this process.) We asked participants about general experiences with medical care and then about

see HALI on page 34



ADVANTAGE MOSAIC GROUP

Advantage Mosaic Group is a Minority Women Owned Business Enterprise (MWBE) membership organization that provides Managed Services, Programmatic Support and leveraged Group Purchasing. We pride ourselves on providing world-class services and products that enable agencies and organizations to reduce administrative costs and maximize the quality of services provided, without sacrificing their mission and vision.



CONSTANCE BROWN-BELLAMY, MPA
PRESIDENT AND CO-FOUNDER
CONSTANCE@ADVANTAGEMOSAICGROUP.COM



REID ANTHONY
CEO AND FOUNDER
REID@ADVANTAGEMOSAICGROUP.COM



OUR PARTNERS



THE BONADIO GROUP
CPAs, Consultants & More



VIBRANT BRANDS



Integra HR



Mutual of America
Financial Group
Retirement Services • Investments



DELANEY VERO



Atlantic



LAMB
Insurance Services



Pandion
OPTIMIZATION ALLIANCE



PO BOX 38145
ALBANY, NY 12203
UNITED STATES

(518)-248-6441
WWW.ADVANTAGEMOSAICGROUP.COM

Visit our website to learn more about our services!

Opioid Use Disorder Care That Saves Lives

Crossroads helps people get their lives back from opioid addiction with evidence-based, comprehensive outpatient treatment.

- Over 26,000 patients served monthly across 110+ centers
- A 6-month retention rate 2.5x greater than the national prescriber average
- 90% of patients in full remission at 12 months of treatment

Call 866-627-0152 today to learn more about Crossroads and how we serve our communities with compassionate, convenient OUD treatment.







Call 866-627-0152 today to learn more.

Beyond the Pain from page 1

get parking spots since I do not look handicapped.”

Isolation

As interviewees expressed, stigma results in isolation and a reduced support network. All interviewees reported their chronic pain as hidden and that they are resigning to the pain, enduring living with the pain, and reducing their social activities. They felt unsupported and isolated, with one individual mentioning, “I feel very lonely during my doctor visits since he is pain-free and doesn’t understand what it feels like to be in constant pain.”

Another interviewee shared, “I am so tired of hearing, ‘I know what it is like to be in pain,’ and then they follow up with, ‘I hurt my shoulder, and I was in pain for four weeks.’ They have no clue what chronic pain is like!”

Others discussed feeling discomfort with increasing dependence on others. One interviewee mentioned, “After asking my adult son for help shopping, he gave me the impression that my pain was not really that bad, and I just need to work through the pain. Hence, I am reluctant to ask family for help; I just work through the pain.”

Moreover, interviewees mentioned experiencing guilt and social withdrawal when asking for help. One stated, “I don’t like others expecting too much from me, but I also don’t want them to feel sorry for me. Weekly, I go for a walk with a friend. I walk a lot slower. I know she is frustrated with not being able to walk faster, but if I try to walk faster, she tells me to slow down and save my energy.”

Spouses

Eight married participants described the frustration their spouses experienced with the increased household duties and physical tasks.

One interviewee explained the frustration she and her husband experience with caring for the kids. “I wish I could hold my kids more and read to them. When my husband is playing with them or reading to them because I have too much pain, my momma heart breaks. I want to be the one playing. I know my husband wishes I could do more with the kids; he works and comes home to kids eager to play.”

However, the eight participants reflected on how understanding their spouses are. “My wife always knows when I hurt, or my energy has decreased. She is so empathetic but also encourages me to push myself a little more when I am in pain.”

Medical Providers

Interviewees reported frequent interactions with medical providers where their pain and credibility were questioned. After repeatedly telling her primary physician of constant fatigue, one interviewee explained, “My doctor said to eat healthier and exercise more. She implied that walking would reduce my pain.”

Another participant reported, “My doctor thinks I am a drug-seeking patient. He



Heidi Hillman, PhD, BCBA-D, LMHC

does not prescribe enough to last one month. I must be stingy with my pain meds, so I don’t run out.”

Mental Health Therapists

Interviewees reported varied experiences with mental health providers.

“Overall, my experience has been hit or miss. It is challenging finding a therapist who takes me seriously.”

“I have seen psychiatrists and therapists; half the time they act like I am a criminal when I discuss my treatment or that I use medicinal marijuana for pain.”

Other interviewees reported more positive experiences. “It was nice to discuss things most people don’t care about, or I cannot discuss with others without being judged.”

“Get away from pills and focus on lifestyle changes. Are my coping habits healthy, and are there ways I can change my mindset to help manage my pain? My therapist is here for me and can be counted on.”

“I need a sounding board, someone who is an outlet for me to air out my frustrations. I can tell my therapist anything, and she did not judge; it was so relieving.”

Rejection

All interviewees compared themselves to others, viewing themselves as less than.

“I feel like I have failed since my body is not doing what I want it to do.”

Another interviewee said, “I am not living up to my own expectations, and I feel like such a failure. I don’t blame people for not wanting to be around me...I can’t do anything because of the pain!”

Another interviewee who is a mom said, “No one wants to be around someone who is always in pain. I tell my husband he sticks around because he must. I hate that part of me; my pain hurts myself, my husband, and my kids. No one wants me.”

An interviewee said, “I am so defective, this body. I can only do the bare minimum to take care of myself. I feel like I am broken. Can I get a refund? That is a joke.”

Pets

Eight interviewees own at least one cat or dog. The interviewees said their pets

simulate human relationships.

“It is interesting how animals are like people with their personalities.”

“Dogs don’t have any judgments about you. It is refreshing because humans, even when we have good intentions, we judge each other.”

The interviewees reported increased psychological wellness and decreased pain, depression, and anxiety. One interviewee said, “I know my dog is an animal, but I see him as a family member, my best friend.”

Another interviewee called his dog, “My fur baby, and I am a dog parent.”

All interviewees viewed their pets as emotionally supportive and described their pet interactions as comforting and supportive. One interviewee said, “My two cats can sense physical or emotional distress, and they jump in my lap to comfort me.”

Another interviewee explained, “My cats look at me in a way like they are saying, I know you hurt today; let me love you a little more so you feel better.”

Another interviewee mentioned they take their dog everywhere, “from the grocery store to trips.”

“My dogs are amazing! I get excited coming home and seeing them no matter how tired, painful, or aggravated I feel.”

Conclusion

As awareness of psychosocial factors in chronic pain increases, so does the need for mental health therapists to familiarize themselves with chronic pain. Insight into the lived experiences of chronic pain sufferers could enable therapists to under-

stand and support clients with chronic pain. Given the relative lack of research on the lived experiences of individuals with chronic pain, further research would enhance understanding and training in this area, ultimately improving support for individuals suffering from chronic pain.

For more information, Heidi Hillman can be reached at hhillman@ewu.edu.

References

Apkarian, A. V., Baliki, M. N., & Geha, P. Y. (2009). Towards a theory of chronic pain. *Progress in Neurobiology, 87*(2), 81-97.

Darlow, B., Dowell, A., Baxter, D. G. G., Mathieson, F., Perry, M., & Dean, S. (2013). The enduring impact of what clinicians say to people with low back pain. *Annals of Family Medicine, 11*(6), 527-534.

Osborn, M., & Rodham, K. (2010). Insights into pain: A review of qualitative research. *Reviews in Pain, 4*(1), 2.

Rikard, S. M., Strahan, A. E., Schmit, K. M., & Guy, G. P. (2023). Chronic pain among adults: United States 2019-2021. *Morbidity and Mortality Weekly Report, 72*, 379-385.

Suso-Ribera, C., Camacho-Guerrero, L., McCracken, L. M., Maydeu-Olivares, A., & Gallardo-Pujol, D. (2014). Social problem-solving in chronic pain: An integrative model of coping predicts mental health in chronic pain patients. *Journal of Health Psychology, 21*(6), 1015-1025.

Building Your Career is Personal.

1 on 1 Online Instruction at home!

Convenient, stress-free, private.

Free/no tuition/gov’t paid. Free loaner laptops.

Your choice of your own personal NYSED licensed Instructor.



1hr classes, 8am-8pm, 7 days/week

Rolling enrollment. Start anytime.

Earn your Certificate in Microsoft Word, Excel, Outlook, PowerPoint, Keyboarding & other work skills demanded by most Employers (Indeed.com)

Learn at your pace, take 3-7 months, no deadlines.

And, the Center, in Partnership with Jawanio, Yonkers, will make sure you get a well paying job; PT/FT, close to your home.

Call/text/email Lizzie to arrange for an interview:

914-557-1318 cell, lizzie@freecenter.org

Start your career path today!



The Center for Career Freedom

185 Maple Ave, White Plains, NY 10601

• 914-288-9763 • Freecenter.org •

14yrs & up

We love Students with Special needs!

Schools from page 26

Virtual schooling, masking, and isolation have impacted social and academic expectations and functioning. While attempting to prevent the spread of the virus, we may have also prevented the development of healthy coping, social, and problem-solving skills that students are naturally exposed to during in-person learning. Additionally, as children and adolescents were forced to cope with the loss of learning and the absence of social support, some unhealthy coping skills became more common.

Several challenges arise for children and adolescents struggling with psychosomatic symptoms. One of the most noticeable is avoidance or refusal of schoolwork or even going to school. Another psychosomatic symptom seen often in a school setting is hypo-arousal or “shutting down.” This may look like students who are unable or unwilling to make eye contact, appear withdrawn, refuse to talk or answer questions, or refuse to move to another room or make necessary transitions. At the opposite end of that spectrum, we may also see hyperarousal or explosive behavior in response to anxiety. This may look like yelling or shouting, throwing objects, hitting or kicking self and others, running around or even out of the classroom, and frequent or uncontrollable crying. Also of note, a potentially less noticeable manifestation of school-related stress and psychosomatic symptoms is a negative relationship to food or body image along with difficulty or refusal to eat in public.

**Eve McCoog, LCSW**

Through awareness and understanding of psychosomatic symptoms and their causes, adults can help children and adolescents build resiliency and skills to manage stress responses and, in turn, psychosomatic symptoms. Cognitive behavioral therapy is an evidence-based therapy that focuses on the connections between our thoughts, emotions, and behaviors. CBT encourages examining and restructuring unhelpful thinking patterns, particularly those commonly associated with psychosomatic symptoms, including residual impacts of the pandemic. Adults can help adolescents identify and challenge negative self-talk, develop self-efficacy, and increase self-esteem through validation.

**Sara Battaglia, LSW**

There are many school-based interventions for reducing psychosomatic symptoms and increasing emotional and academic functioning. First, providing psychoeducation on anxiety and psychosomatic symptoms can make it easier to manage. Everyone can benefit from increased emotional literacy, which consists of recognizing, identifying, understanding, expressing, and tolerating emotions in themselves and others. This is essential for self-regulation. Mindfulness can be used to regulate and reduce psychosomatic symptoms. Mindfulness can be thought of as a technique that involves noticing what’s happening in the present moment without judgment. Mindfulness

practice can include relaxed breathing, which slows down the nervous system; grounding exercises like counting, talking to an adult, taking a walk, getting a drink, listening to music, writing or drawing, or doing something funny. Mindfulness practice can easily be individualized and implemented anywhere. Finally, developing a calming corner, which is a designated space in the classroom for dysregulated emotions with specific strategies to regulate and soothe, may benefit students.

Through increasing awareness of psychosomatic symptoms, we can reduce suffering for our adolescents and implement skills and strategies to resolve their sources. Most importantly, we increase connection and support by acknowledging things we cannot see but are still real.

First Children Services is a family-operated and family-centered organization of teachers, therapists, paraprofessionals, and support staff working with 80+ school districts throughout New Jersey and Pennsylvania to provide behavior therapy, counseling, and support services, and is in network with Medicaid and most major insurance companies in NJ and PA. The process of integrating mental health services with more traditional behavioral approaches like ABA is what sets us apart and is truly the best for the children and their families. We aim to build true continuums of care across all our service lines and populations and strive to deliver life-changing outcomes to exceptional kids.

Advice from page 18

eating and drinking except in great moderation. Personally, I happen to like vegetables, and I’ve given up alcohol because it contributes to gout—a very painful condition from which I also suffer from time to time. But I also like a good steak rippled with veins of fat. And champagne. It’s bad enough to live with pain. To deprive ourselves of great food and drink—that’s asking a lot.

Sleeping well? Judging from advertising on TV, at least half the people of America are searching for something to help them sleep. And all of the information sheets about chronic pain tell us that pain contributes to insomnia. We all know that pain is worse at night when we are not doing something that might distract us from the pain. But—snap of the fingers—we’re supposed to change our sleeping habits. No more naps. No more TV while lying in bed.

Use the bed only for sex and sleep. “Sleep hygiene”, as it’s known. And no more dwelling on my pain while lying sleepless in the darkness of my bedroom! Right!

OK, OK. It’s all good advice, and it is undoubtedly worthwhile to work at managing stress, taking care of your body, and practicing sleep hygiene. But give me a break; this is not easy. And, to say it again, I wish the tip givers understood better than they seem to that giving good

advice is easy, but good advice is hard to take.

Michael B. Friedman, LMSW, is a retired social worker and mental health advocate who continues to advocate for improved care for people with cognitive and/or behavioral health conditions as a volunteer. His writings are available at www.michaelbfriedman.com. He can be

Recovery from page 19

everyone, but all must persevere, striving to regain lost ground and progress while maintaining an atmosphere of hope.

* (For those interested in knowing more about this case, [click here](#) to read the essay which we co-authored.

Dr. Perlman is a member of the Board

of Mental Health News Education, the nonprofit organization that publishes Behavioral Health News. His memoir, [Rearview: A Psychiatrist Reflects on Practice and Advocacy In a Time of Healthcare](#)

System Change, was published in 2021. He is a past President of the New York State Psychiatric Association and past Chair of the NYS Mental Health Services Council.



Email Us Today
to Be a Part of Our
Upcoming Issues!

Summer 2024 Issue
Caring for Older Adults
Deadline: June 13, 2024

Fall 2024 Issue
**Navigating the Challenges and Potential of Virtual
Mental Health and Addiction Care**
Deadline: September 12, 2024

Winter 2025 Issue
Understanding Suicide and Its Impact on Family and Friends
Deadline: December 10, 2024

Spring 2025 Issue
Behavioral Health Services for Children, Youth, and Families
Deadline: March 13, 2025

Life from page 20

those who attempt. Additionally, those who attempt are but a fraction of those with thoughts of suicide.

Dent (2020) explored the role of pain in Joiner's theory about the acquired capability for suicide. Pain tolerance and fearlessness about death can increase the capacity for suicide. Joiner's theories also highlight the distinction between those with suicidal ideation and those who act upon those thoughts. Joiner argues that one must develop an acquired capability for suicide to make that step toward action. How does chronic pain affect this equation?

Dent summarized previous research as showing those in chronic pain to be less pain tolerant and more sensitive to pain. This should lessen the risk of suicidal behaviors. Dent, however, makes a point that lower pain tolerance for those with chronic pain may result in greater distress, which could increase the risk of suicidality.

Dent went on to theorize that those with a higher level of pain tolerance would report lesser amounts of chronic pain and, therefore, less distress from chronic pain. In other words, the converse of theories of suicide capacity may not be the same for those experiencing chronic pain. Specifically, high pain tolerance may lower risk, and low pain tolerance heightens risk.

Van Orden et al. (2010) conceptualized the idea that a sense of liability could be a key component of suicidal capacity. They compared this to thinking that "my death is



Thomas Grinley MBA

worth more than my life." Importantly, one of the factors they considered in liability thinking was distress from physical illness.

This may be where quality of life comes into play. Let's say we have two individuals with chronic pain. One with a high tolerance for pain reports lesser pain burden and, therefore, a likely better quality of life. Versus an individual with a low pain threshold and a decreased quality of life. The key factor of quality of life can explain what appears to be a contradiction of Joiner's concept of acquired capacity for suicide.

To conclude, we must take quality of life into consideration in suicide preven-

tion efforts. A key component of quality of life is chronic pain. Therefore, as if easing the burden of chronic pain were not enough, we must address chronic pain as if we were addressing suicide prevention.

Thomas Grinley MBA, CMQ/OE, CLYB, is Program Planning and Review Specialist at the New Hampshire Department of Health and Human Services.

References

Balazs J, Miklosi M, Halasz J, Horváth LO, Szentiványi D and Vida P (2018) Suicidal Risk, Psychopathology, and Quality of Life in a Clinical Population of Adolescents. *Front. Psychiatry* 9:17. <https://doi.org/10.3389/fpsyt.2018.00017>

Berlim, M.T. & Fleck, M.P.A. (2003) *Quality of life: A brand new concept for research and practice in psychiatry*. *Brazilian Journal of Psychiatry*, 25(4), 249-252,

Chen, C., Pettersson, E., Summit, A.G. et al. Chronic pain conditions and risk of suicidal behavior: a 10-year longitudinal co-twin control study. *BMC Med* 21, 9 (2023). <https://doi.org/10.1186/s12916-022-02703-8>

Dent, N. A. (2020). *The Moderating Role of Pain Tolerance and Fearlessness about Death (The Acquired Capability for Suicide) in the Relationship between Chronic Low Back Pain and Suicidal Behaviour* (Doctoral dissertation, Fielding Graduate University).

Hadi MA, McHugh GA, Closs SJ. Impact of Chronic Pain on Patients' Quality of Life: A Comparative Mixed-Methods Study. *J Patient Exp*. 2019 Jun;6(2):133-141. doi: 10.1177/2374373518786013. Epub 2018 Jul 5. PMID: 31218259; PMCID: PMC6558939.

Hoefler, Karen, "Quality of Life of Adults Who Have Attempted Suicide" (2020). *Electronic Theses and Dissertations*. Paper 3684. <https://dc.etsu.edu/etd/3684>

Kristy Themelis, Jenna L. Gillett, Paige Karadag, Martin D. Cheatele, Nicholas A. Giordano, Shyam Balasubramanian, Swaran P. Singh, Nicole KY Tang. Mental Defeat and Suicidality in Chronic Pain: A Prospective Analysis, *The Journal of Pain*, Volume 24, Issue 11, 2023, Pages 2079-2092, ISSN 1526-5900, <https://doi.org/10.1016/j.jpain.2023.06.017>

Van Orden KA, Witte TK, Cukrowicz KC, Braithwaite SR, Selby EA, Joiner TE Jr. The interpersonal theory of suicide. *Psychol Rev*. 2010 Apr;117(2):575-600. doi: 10.1037/a0018697. PMID: 20438238; PMCID: PMC3130348.

Wilson KG, Kowal J, Henderson PR, McWilliams LA, Péloquin K. Chronic pain and the interpersonal theory of suicide. *Rehabil Psychol*. 2013 Feb;58(1):111-115. doi: 10.1037/a0031390. PMID: 23438008; PMCID: PMC3998981.

Insights from page 21

avenues they can explore to bolster resilience and enhance their overall wellbeing. I found as I was trying to recover both emotionally and physically, some of these suggestions helped me:

- Education and Self-awareness stand as pivotal starting points. Many in this population lack the language to articulate their mental and cognitive struggles, despite understanding their physical condition. Recognizing the interconnection between these facets can empower individuals to better navigate their condition.
- Physical Activity and Exercise, though daunting, hold promise. Engaging in gentle activities like walking, swimming, or yoga can assuage symptoms and uplift mood. Gradual escalation, overseen by healthcare experts, promises enduring advantages.
- Social Support emerges as a lifeline. Maintaining ties with friends, family, and support circles proves vital in pain management. Emotional reinforcement, practical aid, and a sense of belonging mitigate the psychological toll. Isolation, common due to physical



Steve Miccio

limitations, is curtailed by nurturing relationships.

- Peer interactions offer invaluable solace and understanding, especially for mental health challenges linked to chronic pain. When I discovered peer support, it was my new hope for recovery and drove me to become the executive director of People USA. The following highlights how peer support has served me and how we use them at People

USA to serve individuals on this arduous journey:

- Mutual Understanding and Validation: Shared experiences foster validation, assuaging feelings of isolation. Support groups provide a non-judgmental space where individuals can express emotions freely, finding solace in mutual empathy.
- Emotional Support: Peers extend empathy and encouragement, alleviating the burden of solitary struggles. Knowing they are not alone fortifying individuals, instilling hope and resilience.
- Practical Coping Strategies: Support groups exchange coping mechanisms, offering tools for managing pain and mental health. Shared insights empower individuals to navigate their path toward healing.
- Mentorship and Community: Seasoned members inspire newcomers, highlighting recovery's feasibility. Participation engenders a sense of belonging, combating the isolation endemic to chronic pain.

Peers and support groups offer a lifeline to individuals grappling with mental health issues due to chronic pain. Through shared understanding, emotional support,

practical coping strategies, and a sense of belonging, these networks play a vital role in fostering resilience, empowerment, and healing. By connecting with peers who understand their journey, individuals can find the strength and support needed to navigate the challenges of chronic pain with courage and perseverance.

Chronic pain presents complex challenges that extend beyond physical discomfort. Cognitive fog, mood disturbances, and disrupted sleep patterns compound the struggle. Moreover, chronic pain exacts a toll on loved ones, magnifying emotional strain.

I still live with chronic pain; however, I have been able to improve my quality of life by using many coping strategies, including constant medical monitoring and educating my loved ones. Having support is so important and we at People USA want people to know that we are here to support them. We will continue to offer coping mechanisms: education, exercise, social support, peer support, practical tools, validation, and empowerment. By embracing these resources, individuals find a sense of belonging that help minimize negative symptoms and fosters hope and perseverance in the face of chronic pain's unyielding assault on wellbeing.

Steve Miccio is CEO of People USA.

Prescription from page 10

[e-and-more-us-adults-have-chronic-pain-new-study-shows](https://pubmed.ncbi.nlm.nih.gov/26780206/)

Newton, B.J., Southall, J.L., Raphael, J.H., Ashford, R.L., & LeMarchand, K. (2013). *A narrative review of the impact of disbelief in chronic pain*. *Pain Manage-*

ment Nursing: official journal of the American Society of Pain Management Nurses, 14(3), 161-171. <https://pubmed.ncbi.nlm.nih.gov/23972867/>

Reid, S. (2024, February 5). *Chronic pain and mental health*. [HelpGuide.org](https://www.helpguide.org/articles/illness-disability/chronic-pain-and-mental-health.htm)

Sansone, R.A., & Sansone, L.A. (2012). *Chronic pain syndromes and borderline personality*. *Innovations in Clinical Neuroscience*, 9(1), 10-4. <https://pubmed.ncbi.nlm.nih.gov/22347686/>

Sheehan, L., Nieweglowski, K., & Corrigan, P. (2016). *The stigma of personality disorders*. *Current Psychi-*

atry Reports, 18(1), 11. <https://pubmed.ncbi.nlm.nih.gov/26780206/>

Vadivelu, N., Kai, A.M., Kodumudi, G., Babayan, K., Fontes, M., & Burg, M.M. (2017). *Pain and psychology – A reciprocal relationship*. *The Ochsner Journal*, 17(2), 173-180. <https://www.ochsnerjournal.org/content/17/2/173>

HALI from page 30

the impact – if any – people thought their psychiatric diagnosis had on the care they had received. We held more formal phone interviews for those interested in sharing more of their stories.

By the end of this process, we had spoken to 45 people. We did not set out to find stories that “villainized” providers, and we are glad to say that many of the people we interviewed happily found medical providers with whom they had a trusted relationship. Other experiences shared were less positive:

- “There have been times when I speak up, and all [doctors] say is ‘oh, we have to increase your meds,’ like my speaking up or being annoyed is a symptom of my mental health, not the reality.”
- “I feel nervous and like they are hurting me with all the medicine. Not everything is explained to me.”
- “I don’t feel comfortable talking about [mental health] with my doctor; I feel like they judge or don’t get it.”
- “They treat us with “kid gloves” when we have mental illness.”
- “Just because they haven’t heard of or experienced what we are going through before doesn’t mean it isn’t real. I feel belittled and like they think I am lying.”
- “[When I have concerns about my physical health], I start getting paranoid. When these issues come up is when I start to hear and see things that are not supportive.”
- “When you tell them about your mental illness, just like everyone else, they don’t understand. He feels like it is impossible to hear or see hallucinations. He is a great doctor, but he just doesn’t understand.”



Melissa Wettengel, NYCPS, MPH

- “I don’t want to tell my doctor [about my mental health] because she will be scared of me.”
- “It makes me upset when they repeatedly ask if I am on drugs or what medications I am on.”

Eight participants agreed to share parts of their stories on camera. HALI gathered with Lucy and her crew (the original *Kings Park* cinematographer, sound engineer, and editor!) at our Recovery Center in Central Islip. The resulting videos show in equal measure what interviewees describe as quality care and what they would like to see change.

Our goal was to present the videos to medical professionals and assess any difference in their thinking about the stigma people might experience in their care. We presented to 3 of Long Island’s Federally Qualified Health Centers (FQHCs) that provide integrated care in underserved areas: Harmony Healthcare and Charles Evans Center in Nassau County, and Sun River Health in Suffolk.

Upon watching the videos, audience members – with roles ranging from medical directors to nurses to dentists - engaged in a lively dialogue. One professional

talked about being “moved to tears.” Another discussed the challenges of providing person-centered care “within a 15-minute appointment.” Several mentioned the need for “all medical professionals” to experience *Overshadowed*, particularly staff in emergency departments and especially medical students just beginning their careers.

HALI then had the privilege of presenting to medical students at Hofstra University/Zucker Hospital School of Medicine. One participant shared how glad he was to see the project so early on in his career. The Zucker Hillside Director of Undergraduate Medical Education, Timothy R. Kreider, MD, PhD, shared:

Overshadowed is a powerful workshop with compelling videos showing how our healthcare system can sometimes poorly serve patients who have mental health diagnoses. I wish all healthcare professionals could learn from this moving project about how to take better care of some of our most vulnerable patients.

HALI measured the overall effectiveness of the *Overshadowed* presentation through a short pre- and post-survey for the medical professionals asking whether and how a patient’s mental health status might affect their care experience and the professional’s provision of care. After presenting the videos to 39 medical professionals, we received 38 completed surveys to compare. We were not sure how impactful a 45-minute presentation could be, but we were surprisingly pleased:

- While there was some uncertainty beforehand about how a psychiatric diagnosis might impact comfort-seeking medical care, afterward, everyone agreed.
- All respondents showed an increased awareness of stigma.
- All participants agreed or strongly agreed that hearing the stories in *Overshadowed* helped them better understand how people experience the impact of stigma in healthcare.

- We also saw some increase in medical professionals saying they could think of examples where focusing on a mental health condition resulted in medical issues or necessary treatment being overlooked.

Moving forward, HALI wants to increase the scalability of the *Overshadowed* project by creating a stand-alone short educational film that is available for download. We are especially interested in increasing our reach to staff at hospitals, where diagnostic overshadowing is most documented, and to medical students, where we have an early opportunity for education. HALI is also interested in producing additional content that will amplify our community’s voice by collecting more stories from people who are not engaged in care at all, including unsheltered people.

Hands Across Long Island, Inc. (HALI) has provided peer support services since 1988 and is the largest employer of peer professionals on Long Island. We serve people with mental health, co-occurring, and trauma-related life challenges through non-clinical services, including advocacy, supportive housing, employment support, wellness coaching, and community bridging from hospitals and prisons. For more information, contact support@hali88.org.

This project was funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction.

References

Collins, R., Wong, E., Cerully, J., Schultz, D., & Eberhart, N. (2012). Interventions to reduce mental health stigma and discrimination: A literature review to guide evaluation of California’s mental health prevention and early intervention initiative.

Corrigan, P. W., Michaels, P. J., Vega, E., Gause, M., Larson, J., Krzyzanowski, R., & Botcheva, L. (2014). Key ingredients to

see HALI on page 37

Equity Challenge from page 29

We have an internal DEI committee that plans and implements our internal programming. Each month, we focus on a different theme month. For example, February is Black History Month, March is Women’s History Month, and April is when we focus on neurodivergence. Committee members take turns hosting a monthly lunch and learning Zoom with videos and discussions. This venue is a safe space for staff to connect and discuss their experiences. Newer team members have mentioned that these opportunities demonstrate UWDOR’s commitment to inclusive practices.

The DEI Committee researches resources for upcoming equity challenges and ensures smooth implementation. Organizations may borrow any of the vetted resources by visiting www.uwdor.org/socialequitychallenge. I am also happy to speak with folks who would like to bring a similar program to their organization – you can email me at mclark@uwdor.org. Additionally, the DEI committee collects data to ensure the themes are specific to community-level feedback and interest. Pre- and post-surveys were completed for the different Stigma Reduction Project activities. Pre- and post-survey data were

particularly helpful in determining people’s level of learning and suggesting topics for future activities. UWDOR staff members also participate in a dozen community coalitions and collect anecdotal data about DEI trends and emerging barriers. Measurement was managed by collecting registration data and tallying community outreach mechanisms, including social media, community listservs, email lists, and direct outreach.

We always want to be cognizant of potential participation barriers, especially for hard-to-reach populations. For these particular activities, that meant ensuring people had access to virtual learning, hosting activities that could be accessed at all hours of the day, and keeping in mind that some topics could be potentially uncomfortable for people who may have lived experiences related to their particular circumstances.

Best Practices for Program Replication

For organizations that may want to implement similar programs, best practices to consider are as follows:

- **Make DEI a permanent part of your internal and external organizational programming** - This will build community and institutional trust and en-

sure your organization is a welcoming place for staff and volunteers.

- **Steal/borrow our research (uwdor.org/socialequitychallenge)** - We have collected over 200 high-level, vetted DEI resources that may benefit your community and internal stakeholders.
- **Utilize several community outreach mechanisms** - Consider expanding your methods to reach potentially marginalized populations.
- **You already have the resources - leverage them** - Consider the resources you already have: staff, volunteers, interns, and Board Members. What experience can they bring to such an initiative?
- **Ensure roles are identified** - Consider which staff/volunteers can work together to successfully roll out DEI programming for your community.
- **Measure for impact** - Implement pre and post-surveys and other data collection methods that may strengthen this programming.
- **Consider alignment of priorities along with funding proposals** - Most

funders seek proposals demonstrating a commitment to DEI principles. You are showing your equitable and compassionate leadership by going above and beyond in this area.

- **Tell your story** - Only you can speak to the community about the important work you do daily to empower your community. Likely, you are already utilizing many equitable community best practices. Make sure your community is aware of your great work!

Thank you again to *Behavioral Health News* for offering this opportunity to share our work! Thank you to the NYS Office of Mental Health for their partnership and support. If you have any questions regarding our work and bringing this work to your organization, please do not hesitate to contact me at mclark@uwdor.org. Thank you for all you do!

Melissa Clark is Vice President of Community Impact at United Way of the Dutchess-Orange Region (UWDOR). Visit their website at www.uwdor.org.

This project was funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction.

Options from page 21

is one of the primary reasons for the opioid epidemic in the USA (Nahin RL, Feinberg T, Kapos FP, Terman GW, Estimated Rates of Incident and Persistent Chronic Pain Among US Adults, 2019-2020).

Common Pain Management Practices

Opioids create that much needed numbness to fade the experience of pain. Still, with continued use, individuals become vulnerable to the practice and may indulge in enjoying the numbness even when the pain is non-existent. Hence, chronic pain and the way pain management occurs do have a significant impact on an individual's decision-making capacity and judgment.

To look at the progression from pain to chronic pain, it is important to understand the process regarding physical impact and corresponding pain management practices. Chronic pain does not occur overnight since the nature of such pain is recurring. Chronic pain starts with certain levels of mildness and gradually leads to uncontrolled pain. Pain that is chronic now likely began as a mild and nagging pain that was likely considered to be a temporary phase or environmental factor.

Since over-the-counter (OTC) analgesics are readily accessible, a common pain management practice is to take this OTC medication as needed. Very often, one fails to realize that what seems like a one-time pain management step may often lead to an addiction with anticipated and repeated use. By nature, when pain occurs, we immediately want to address it with medication for quick relief. Unfortunately, due to the narcotics in pain medication, one can easily get addicted, and often, individuals take pain medication in anticipation, even when the pain is not occurring. Hence, chronic pain creates anxiety and fear. The mind is preoccupied with pain, and the only solution seems to be the pain medication that provides instant relief.

Socio-Emotional Impact of Chronic Pain

A common impact of pain affects mobility and strength. When pain occurs, our mobility gets restricted, thus affecting our functioning, skills, confidence, and self-esteem. While physically we are restricted in ambulating, the impact is psychological and emotional. The lack of independent functional ability triggers a sense of low self-esteem. We initiate harvesting negativity about ourselves and self-judge our capacity. We interpret and anticipate what others would think of us due to our lack of functional capacity triggered by chronic pain, such as those slow walks, the need for support to change positions, and the continued reminder of the ache. While at night, the world around us sleeps in peace, chronic pain wakes us up, and then it's hard to fall back to sleep. These impacts of pain leave us with self-pity and frustration — emotions that make us unhappy. Such involuntary changes in lifestyle develop negative thoughts that clutter our minds and lead to irritability, intolerance, and frustration. Thus, chronic pain is directly



Veera Mookerjee, PhD, LMSW

linked to the manifestation of initial negative thoughts, finally leading to depression. Often, pain and depression occur together, one being the physical impact and the latter being the emotional/mental impact. People with chronic pain illustrate that, especially for joint pain support, when they use prolonged metal supportive frames, commonly called braces, they observe changes in that part of the body. Patients report bruises, permanent marks, and even thinning of that body part compared to the symmetrical look they had before the chronic pain management via braces. Thus leading to body image issues.

Young adults with chronic pain share being self-conscious to use a cane or other devices to support ambulation because they are embarrassed to step out in public with a mobility device at their age. Chronic pain directly attacks the social identity of many. Regardless of age, chronic pain leads to a clutter of emotions and negative feelings.

Chronic pain also creates an environment of helplessness among older adults. Patients compare their lives to when they had controlled pain, but when the pain returns, it creates a state of helplessness. They feel life is not worth living. The impact is worse for older adults since this population presents higher comorbidity and lower immune capacity.

It is important to consider environmental factors, as well. Social Determinants of Health (SDOH) such as socioeconomic conditions, food habits and lifestyles, adherence to treatments and medication, self-awareness, and sociocultural practices significantly impact chronic pain management and associated psychological outcomes. Pain management options depend on the individual's economic conditions; several private providers may not accept Medicaid as primary coverage. Since pain impacts movement, job options are heavily limited for the individual, affecting socioeconomic conditions. Lifestyles and attitudes towards accessible and affordable pain management play a key role, too. Diet management and food habits play a major role in pain medication intake. People may choose self-treatment over provider suggestions at the initial stages of pain management and may seek help when the pain intensity gets out of control. Often, in such conditions, individuals need continued caregiving and regular pain management.

Chronic Pain Among Older Adults Enrolled in Managed Long-Term Care (MLTC) Services

As a healthcare professional in Care Management, the author is experienced in working with older adults from diverse backgrounds dealing with chronic pain. Community members, especially older adults who are enrolled in Managed Long Term Care services, always have a chronic pain-related goal and intervention as a requirement in their annual Care Plan. The approaches to treating chronic pain vary based on culture and attitudes towards life. Often, older adults accept chronic pain as an associated change in the body about age, while others try to fight it out so that they may remain independent as long as possible. There have been many in the spectrum of chronic pain who experience a lot of self-esteem issues due to pain and find it extremely difficult to cope with the pain. Most of the older adults with chronic pain need Long Term Care services since they require assistance with their activities of daily living. Most of the seniors seeking help develop chronic pain due to various arthritis diagnoses, post-fall effects, age-related changes in the body, bone health, and variations in activities. Of course, seasonal triggers and pain as an associated health condition hold equal importance. While chronic pain triggers anxiety, it is also a leading cause of mood swings among this older population. Due to pain, people forego social gatherings and impose isolation, thus leading to self-imposed loneliness and depression. Often, people with uncontrolled chronic pain have expressed the lack of worth they feel about themselves and how they have given up on any pain management options.

Living with pain becomes acceptable to many seniors since they believe their age is to be blamed for persistent health issues and chronic pain. A significant number of seniors in various communities teach themselves to come to terms with chronic pain. Seniors think that due to their associated health issues, pain management is limited and ineffective. For instance, an older adult might not accept a knee replacement as a remedy for chronic knee joint pain and accept tolerating the pain intensity. Seniors may stop physical therapy at another level because they fail to experience the change that occurs slowly. In addition, many community members who forego recommended pain management treatments refer to a friend or a relative who reported a treatment ineffective. In such cases, patients even refuse to go for a second opinion, voluntarily confirming their recommended treatment to be ineffective.

As a seasoned care manager in an MLTC program, the author recalls adding pain management interventions to all patient-centered care plans to ensure pain management education for all enrollees. In MLTC, the goal is to help the MLTC program members embrace a better lifestyle with accessible and appropriate pain management options. To help older adults stay away from getting addicted to pain medication narcotics, they are provided monthly education on topical pain management options, and Physical Therapy (PT) is encouraged as a pain management technique. Daily short walks and simple exercises are encouraged to maintain a positive mood while managing

pain, and proper diet and identifying pain triggers are taught. Yet a significant number of older adults enrolled in MLTC services live with moderate to severe pain intensities due to comorbidities and age. Self-care of these members and their caregivers is mandatory to address chronic pain and its impact on behavioral health.

Summary

Pain is a physical experience that leaves traumatic experiences. Chronic pain is living that trauma regularly. While being present physically, pain can control mood and one's entire socio-emotional behavior. Chronic pain impacts our physical and mental health and ruins our self-care process. It makes people anxious, stressed, embarrassed, isolated, and lonely to the extent that people often fall prey to overdose of pain medication, even leading to narcotics addiction.

Chronic pain can control people's lives, social skills, and willingness to engage in activities. Often, people train themselves to be numb to their pain if it is tolerable to avoid judgment. People suffering from chronic pain actively avoid disclosing the condition for fear of losing their jobs, leading to financial crisis, anticipating that they may be judged incapable of their professional role. This constant fear often creates burnout, leading to significant depressive symptoms that need to be treated on time.

Conclusion

Chronic pain has a direct connection to depression. Chronic pain and depression supplement each other and easily get enhanced if left untreated. Consulting with professionals and relaying the symptoms to relevant providers on time may help in breaking the cycle of repetitive pain and hammering down the link between chronic pain and depression. People benefit from appropriate education and access to treatments and therapies to address both symptoms. Insurance coverage also plays a key role in the administration of effective treatment. Hence, adequate room should be provided to the person with chronic pain to explore experimental treatment options for pain management by insurance plans. On the other hand, private providers should consider contracting with insurance plans that provide coverage to significantly low-income group patients since chronic pain does not choose its prey based on economic status.

Older adults mostly report chronic pain, but in truth, it is not an age-related issue. Hence, one with chronic pain is not aging ahead of time and should not self-victimize by ageism. Believing that chronic pain occurs in a certain community or due to a particular health condition only is not true either. Chronic pain is not a topic of medical racism. A significant physical health concern creates equally strong mental health impacts. Chronic pain and depression can be seen as the two faces of the same coin. With proper information and education, timely identification and treatment, and affordable and accessible treatment, the condition can be effectively treated, and its associated depressive syndrome can be avoided.

Veera Mookerjee, PhD, LMSW, is Founder/Director of Resolveera.

WeSpeakNYC from page 29

imbalances and exacerbating the problem.

After these meetings, we compiled and analyzed the notes and used the common themes to guide the toolkit and website development. For example, following several community members' advisement that the website and toolkit include information about inpatient and outpatient treatment rights, we included information on how patients can learn about their rights. Similarly, several members suggested we include information about non-clinical ways to address mental health, such as art, and in response, we compiled a list of relevant resources. Most of what the community members shared related to self and public stigma, so these became our primary focus. This was in line with our goal of sharing information about mental health stigma and challenging misinformation and misconceptions. Much of the website and toolkit are devoted to sharing foundational information about what mental health is and why it's important, why stigma happens, why it happens in BIPOC communities, and how we can fight stigma. Thus, the website and toolkit have the potential to help those who have some familiarity with mental health, mental health stigma, and want to care for their mental health, as well as those who have less knowledge about mental health. To highlight the community-based participatory nature of the project, we named the toolkit and website WeSpeakNYC. When the content was complete, we translated it into Spanish to make it accessible to individuals who pre-

fer materials in Spanish. We next hired a website developer and graphic designer to format the content. Our original plan had been to work with individuals who have lived experience with mental illness. To find designers, we recruited directly from the organizations we'd partnered with and also contacted NAMI (National Alliance on Mental Illness) New York and colleagues who work to address mental illness. To move the project forward within the agreed-upon timeline, we ultimately hired designers without lived experience.

Once the toolkit and website creation neared completion, we met with each of our community partners to plan community showcases. These showcases were intended to officially distribute the tools and celebrate and honor our community partners' work. In addition, the showcases were an opportunity to hear stories from community members with lived experience. Sharing and hearing these stories was another way to center community voice and a powerful means of challenging stigma. Of note, the website is still up and running as of this article's writing, and anyone may access it at www.wespeaknyc.org.

With the project completed, we have reflected on our work, particularly what worked well and what could have been done differently. We hope that other agencies interested in doing anti-stigma work, particularly using a collaborative approach, might consider our reflections. When partnering with community organizations, it's important to be mindful of their constraints because they often have limited time and other resources to devote

to new initiatives. We recommend ongoing open and honest discussions about who can contribute what and being open to revising plans as needed. This may be particularly true regarding timelines, collaborating to set realistic timelines is critical, and for many tasks, it's helpful to allot more time for completion than you might initially think is necessary. While we worked closely with our community partners once we began the projects, we developed the initial proposal independently. This was due to timing and other logistical constraints, but we recognize that developing the proposal would have been ideal. Co-authoring the proposal and collaboratively making decisions about the project's direction can lead to outcomes that feel more relevant to the community, communicates clearly to community partners that their input is indeed valued, and can help to increase buy-in and commitment.

Dr. Collins is the Director of Counseling and Psychological Services at St. Mary's College of California. She provides direction for clinical services for the student population, outreach to raise awareness about and address mental health, consultation, and training for the wider campus community. Before relocating to her home state of California and while the project was ongoing, she worked at Montefiore Medical Center in the Bronx, NY, where she was a faculty member in the Department of Family and Social Medicine. There, she provided family medicine residents with education on addressing the psychosocial components of health.

Dr. Gonzales is a faculty member at Columbia University Medical Center's Psychiatry Department in NYC. She conducts research and training through the Division of Behavioral Health Services and Policy Research. She provides clinical services and training at the Lieber Recovery Clinic to individuals with serious mental illnesses. Her research focus is on stigma and social determinants of mental health. Across her roles, the broader mission is to improve mental health services for individuals with SMI via a focus on systemic correlates of mental health and recovery-oriented care.

We express our ongoing gratitude to our community partners, Brooklyn Community Services, Services for the Under-served, and the Bronx Health Leaders of Montefiore Medical Center's Bronx Health Collective. Your investment of time, energy, and wisdom made a difference in challenging mental illness stigma in NYC's BIPOC communities.

This project was funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction.

References

CDC, 2021. Health United States, 2019. Table 46. <https://www.cdc.gov/nchs/data/abus/abus17.pdf>

SAMHSA, 2022. Results from the 2019 National Survey on Drug Use and Health: Mental Health Detailed Tables. Table 8.39B <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>



This Year Behavioral Health News Can Help Put Your Organization's

Vital Programs and Services

In the Spotlight !

Review Our Many Advertising Opportunities

Then Call: (570) 629-5960

To Discuss a Marketing Plan

ICAN from page 28

had the start of a road map for our campaign. Just over 40% of respondents think about their mental health every day, and 22% think about it many times a week.

As we started to craft the campaign slogan, there was a lot of creative thinking, along with consulting our team of ICAN mental health professionals and researching nationwide mental health campaigns and messaging. There were also a lot of simple, straightforward conversations among our team, their friends, and colleagues on parenting, mentoring, and working with our clients. What do we say to our kids? How do we guide those we serve? What were some first-hand lessons learned? We wanted to develop a strong slogan that could be worked into everyday conversation, that would be memorable, and that would truly do the work of reducing stigma by positioning mental health as something as important as physical health. Our Director of Clinical Services is famous for saying, “Everyone has mental health!” and our survey showed us that for many teens, it’s on their minds every day. The campaign slogan emerged triumphantly:

“Mental Health: Everyone Has It. Every Day.”

We proposed the slogan to the key stakeholders on the project, got the green light, and it was time to bring it to life.

Mental Health Ambassadors were key to the campaign’s success and building the message through many avenues. We identified individuals in our community who WE knew focused on mental health but who youth might be surprised to hear from speaking about it publicly. Those we approached to participate in have diverse interests, skills, and strong platforms to share their stories.

The three who worked with us are:

1. Liz Ellis, Morning Show Host on KISS FM and Promotions Director at Roser Communications
2. Al Marro, Youth Care Coordinator at ICAN and Professional Mixed Martial Arts Fighter
3. Naz Deloach, Artist, Producer, and Owner of Dreamer Studio. (Through participating in this campaign, Naz started working with ICAN as a Facilitation Specialist in fall 2023!)

The Ambassadors didn’t know each other coming into the campaign, so we had to provide a space for them to meet each other, tell their stories to each other and our creative team, and build rapport before diving into promoting the campaign. They each had a relatable “hook” to their mental health journey that became the foundation for their stories. We focused on the pivotal moments they had in realizing that they needed to own their mental health – monitor it, manage it, and move through it, sometimes literally day by day.

We also used that time together to run the campaign slogan by them and to get feedback and buy-in. After all, they had to deliver it and live it!

We began with a photo shoot to have professional imagery to use throughout the marketing pieces we needed. Then we set up a Content Day at Liz’s studio to conduct pre-recorded interviews and radio spots to air on multiple stations. Our marketing team created all campaign materials in-house – graphic design, scriptwriting, photography, video shooting and editing, email marketing, and social media management. We had a series of posters put up in elevators and public spaces.

Small autograph cards accompanied the Ambassadors to visits and they signed them for students. On the back was their message and the number to the Suicide Prevention Hotline. We ordered stickers, buttons with the slogan, and t-shirts.

One of our favorite pieces created was a fillable handout for students prompting them to reflect or answer based on the Ambassador’s “catchphrases” from their stories: “Find it. Do it. Every day.” and “Find your people.” and “Be sure to reach back to help others.” It provided actionable items that young people could do right away.

We worked closely with ICAN’s Community Education and Training program to invite Ambassadors into already-scheduled school training. Al and Naz worked with 225 middle and high school students in one visit, and all three Ambassadors hosted a group at KISS FM, where Liz could give them a tour and talk about her work on the popular local radio station. All three Ambassadors continue to be very involved in our ongoing programming in organic ways, from work as employees to presentations to collaborating non-profit partners.

We heavily leaned on our social media platforms, and our posts were amplified by our Ambassadors, reaching tens of thousands during the campaign. Messaging went out through our email marketing to thousands of individuals, videos were posted on YouTube, and we crafted individual Ambassadors spotlights on our website. Their stories were perfect to use, expand, and use snippets as needed across many platforms in different formats.

We gathered quantitative results for the campaign through expected, traditional ways: social media reach, email opens, views on videos, number of handouts, stickers, and buttons given out, and number of students reached through programming. We also stayed in touch with the Ambassa-

dors and garnered qualitative feedback from them – students and teachers reaching out to them, Liz’s listeners commenting to her on mental health, a spike in Naz’s music streams, and perhaps most importantly, their continuance of working their messages into their everyday work. We hope that teens will always remember our Ambassadors’ school visits and that the slogan meant something to them.

We continue to hear ICAN staff use the slogan in passing at work and embedding it into work with their clients. What started out to be a campaign with the intent of having an “every day voice” has indeed begun to permeate every day conversations. Staff who table at various community events and job fairs take materials with them and continue to spread the message.

A campaign like this will shine with additional time, applications, exposure, frequency, platform expansion, new Ambassadors, and more! There’s lots of creative exploration to dive into and a lot of momentum from this first run. The impact can be monumental for our youth as we continue to foster the message that mental health is important and something we live with and manage. Every. Day.

Campaigns take time. Movements and mindset change take even more time. For anyone working in this space alongside us, be patient with yourselves, your creativity, and your audience. They need to hear the message many times and then make an internal behavioral decision to adopt it into their lives. There has been a lot of stigma built up surrounding mental health over decades. It will take us all working together to lift each other over these barriers.

This project was funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction.

INSYGHT from page 28

way our community views individuals with mental illness and encourage a framework of community support for those needing help. Lastly, our efforts aimed to emphasize the prevalence and normalization of mental health across our many organizations and local businesses, creating a safer, supportive space for those daily. Early focus group work and research showed us that most individuals, youth and adults, enrolled in our two primary outpatient behavioral health clinics were Medicaid Eligible individuals, meaning of a lower socioeconomic status. Through our efforts, we aimed to see an increase in the number of individuals reaching out and engaging in mental health treatment and the number of individuals covered under commercial insurance options. While this data has not yet been shared, we look forward to reviewing these results. Because of our ability to reach a larger

number of Yates County individuals through boosting and advertising, Yates INSYGHT and our C-SPOA were able to see an increase in the number of individuals engaging one-on-one through our social media and website for assistance in engaging with mental health treatment and/or support both clinical and community-based.

Yates INSYGHT felt we successfully increased conversations around mental health and comfortability in talking about mental health across Yates County. To this day, we still see this unfold. Community members continue to wear “mental health matters” t-shirts, and many posters distributed continue to be displayed countywide. In addition, Yates INSYGHT has seen an increase in the number of organizations and local businesses reaching out to coordinate and attend mental health -promoting gatekeeper training, with many taking place in the past year and scheduled in months to come. Yates INSYGHT has also gained additional part-

ners attending and contributing to our ongoing mental health awareness and stigma reduction subcommittee that meets monthly and identifies ways to continue the work started in this initiative.

In reflecting on our successes and challenges in executing our mental health stigma initiative, Yates INSYGHT felt it important to share a few recommendations for other counties or coalitions aiming to address and combat mental health stigma. First, the work makes a difference no matter how big or small the effort is! Don’t underestimate the ability of a community to unite and work together to execute project goals; don’t be afraid to engage with and involve local businesses and organizations outside the regular behavioral health field. These partners will play a vital role in expanding efforts and messaging outside the field of local behavioral health and offer the ability to grow social networks and support for those who may be struggling or in need. Lastly, stigma efforts and mental

health promotion should not cease with the end of the grant or funding opportunity; rather, the funds should be used to help lay the groundwork for future, continuing efforts!

Yates INSYGHT represents the System of Care for Yates County, a spectrum of community-based services and supports dedicated to overcoming challenges and meeting the needs of children and youth at risk of or experiencing serious emotional disturbance and their families. Yates County, being a small, rural community, has made great efforts to support its individuals in achieving collective wellness and had the opportunity to collaborate with the Office of Mental Health (OMH) in support of this through funds aimed at promoting mental health awareness and reducing stigma across a variety of realms.

This project was funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction.

HALI from page 34

contact-based stigma change: A cross-validation. *Psychiatric Rehabilitation Journal*, 37(1), 62-64

Melamed, O. C., Fernando, I., Soklaridis, S., Hahn, M. K., LeMessurier, K. W., & Taylor, V. H. (2019). Understanding engagement with a physical health service: a qualitative study of

patients with severe mental illness. *The Canadian Journal of Psychiatry*, 64(12), 872-880.

Parks, J., Svendsen, D., Singer, P., Foti, M. E., & Mauer, B. (2006). Morbidity and mortality in people with serious mental illness. *Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council*, 25(4), 1-87.

Individuals - Couples - Families - Older Adults
Medicare Provider - Addiction and Recovery Therapy

Mindy Appel, LCSW, ACSW, LMFT

mindyappel.com appelmindy@gmail.com

Located in Delray Beach, FL Call for Appointment (561) 926-7858

Cannabis from page 8

chronic pain. One longitudinal study of adults newly registered in a medical cannabis program with pain who use opioids currently underway in New York City looks to clarify how the long-term use of medical cannabis influences opioid use (Cunningham, 2020). In addition to addressing this general question, this study will also examine the effects of different THC and CBD content and routes of administration on a variety of pain syndromes.

In summary, the effects of cannabis on pain modulation have heightened interest in medical cannabis for the treatment of chronic pain. Although the current evidence for its effectiveness has limitations, there have been some promising findings. Current and future longitudinal studies can only help elucidate the role of different types of medical cannabis with variable THC and CBD content and routes of administration in the treatment of a wide variety of pain syndromes.

Grace Hennessy, MD, is the Associate Chief Medical Officer for Addiction Psychiatry at the NYS Office of Addiction Services and Supports.

References

Zelaya CE, Dahlhamer JM, Lucas JW, et al. (2020). Chronic pain and high-impact chronic pain among U.S. adults, 2019. NCHS Data Brief, no 390. Hyattsville,

MD: National Center for Health Statistics. Dowell D, Ragan KR, Jones CM, et al. (2022). CDC Clinical Practical Guidelines for Prescribing Opioids for Pain – United States, 2022 *MMWR Recomm Rep*, 71(3):1-95.

ProCon.org (2023). State-by-State Medical Marijuana Laws. Available: <https://medicalmarijuana.procon.org/legal-medical-marijuana-states-and-dc/>. Accessed March 2, 2024.

Bicket MC, Stone EM, McGinty EE (2023). Use of cannabis and other pain treatments among adults with chronic pain in U.S. states with medical cannabis programs. *JAMA Netw Open*, 6(1):e2249797.

Hill KP, Palastro MD, Johnson B, et al (2017). Cannabis and pain: a clinical review. *Cannabis Cannabinoid Res*, 2(1):96-104.

Legare CA, Raup-Konsavage WA, Vrana KE (2022). Therapeutic potential of cannabis, cannabidiol, and cannabinoid-based pharmaceuticals. *Pharmacology*, 107(3-4):131-149.

Johnson JR, Burnell-Nugent M, Lossignol D, et al (2010). Multicenter, double-blind, randomized, placebo-controlled, parallel-group study of the efficacy, safety, and tolerability of THC: CBD extract and THC extract in patients with intractable cancer-related pain. *J Pain Symptom*

Manage, 39(2):167-179.

Russo E, Guy GW (2006). A tale of two cannabinoids: the therapeutic rationale for combining tetrahydrocannabinol and cannabidiol. *Med Hypotheses*, 66(2):234-246.

Hayakawa K, Mishima K, Hazekawa M, et al. (2008) Cannabidiol potentiates pharmacological effects of delta (9)-tetrahydrocannabinol via C.B. (1) receptor-dependent mechanism. *Brain Res*, 10:1188:157-164.

Whiting PF, Wolff RF, Deshpande S, et al. (2015). Cannabinoids for medical use: a systematic review and meta-analysis. *JAMA*, 313(24):2456-2473.

Solmi M, De Toffol M, Kim JY, et al (2023). Balancing risks and benefits of cannabis use: an umbrella review of meta-analyses of randomized controlled trials and observational studies. *BMJ*, 382:e07248.

McDonagh MS, Morasco BJ, Wagner J, et al (2022). Cannabis-based products for chronic pain. *Ann Intern Med*, 175(8):1143-1153.

Bradford AC, Bradford WC, Abraham A, et al. (2018). Association between U.S. State medical cannabis laws and opioid prescribing in the Medicare Part D population. *JAMA Intern Med*, 178(5):667-672.

Boehnke KF, Litinas E, Clauw DJ (2016).

Medical cannabis use is associated with decreased opiate medication use in a retrospective cross-sectional survey of patients with chronic pain. *J Pain*, 17:739-744.

Sohler NL, Starrels JL, Khalid L, et al. (2018). Cannabis use is associated with lower odds of prescription opioid analgesic use among HIV-infected individuals with chronic pain. *Subs Use Misuse*, 53:1602-1607.

Okusanya BO, Asaolu IO, Ehiri JE, et al (2022). Medical cannabis for the reduction of opioid dosage in the treatment of non-cancer chronic pain: a systematic review. *Syst Rev*, 9(1):167.

Takakuwa KM, Hergenrather JY, Shofer FS, et al (2020). The impact of medical cannabis on intermittent and chronic opioid users with back pain: how cannabis diminished prescription opioid usage. *Cannabis Cannabinoid Res*, 5(3):263-270.

Caputi TL, Humphries K (2018). Medical marijuana users are more likely to use prescription drugs medically and nonmedically. *J Addict Med*, 12(4):295-299.

Cunningham CO, Starrels J, Zhang C, et al. (2020). Medical marijuana and opioid (MEMO) study: Study protocol of a longitudinal cohort study to examine if medical cannabis reduces opioid use among adults with chronic pain. *BMJ Open*, 10(12):e043400.

Anniversary from page 22

meaningful employment opportunities for people with disabilities; Sheryl White-Scott, MD, FACP, FAAIDD, Senior Medical Advisor at AHRC New York City, and a Board of Director of the Human Services Research Institute, honored for her lifelong commitment to ensuring the well-being of patients with intellectual and developmental disabilities; Beth Haroules, Esq., Senior Staff Attorney and Director of Disability Justice Litigation at the American Civil Liberties Union of the New York Affiliate of ACLU is recognized for her lifelong dedication to defending the rights of people with disabilities; Rebecca A. Seawright, Assembly Member for New York's 76th Assembly District, and Chair of the People with Disabilities Committee of the New York State Assembly is recognized for her legislative



work and dedicated advocacy for the rights of people with intellectual and developmental disabilities; Mitchell Bloomberg, Chairman-Elect of the AHRC NYC Foundation Board, and Co-President of International Lights, is honored for over 30 years of dedicated service on both the AHRC NYC Board and Foundation Board and for raising millions of dollars to support AHRC NYC programs; and AHRC NYC's *Our Broadway* takes center stage in the Hall of Honor. This inclusive theat-

rical experience, where performers with disabilities collaborate with Broadway stars, brings magical moments to life, and AHRC NYC recognizes three Broadway veterans and performers—Dale Hensley, Gavin Creel, and Thayne Jaspersen.

Other honorees will include **Sharyn Van Reepinghen, the AHRC NYC Anne Kraus Award** named in memory of a formidable AHRC NYC volunteer. Sharyn has demonstrated exceptional dedication to AHRC NYC's mission. And

Kerri Neifeld, Commissioner of the NYS Office for People with Developmental Disabilities, is the Recipient of the **Leadership in Government Award** for her exemplary leadership and visionary commitment to enhancing services for people with developmental disabilities. **Errol Louis**, New York City journalist and host of Inside City Hall on Spectrum News NY1, who brings decades of distinguished experience in political journalism, will serve as the Master of Ceremonies. Mr. Louis knows New York better than any journalist today, and since AHRC NYC is quintessential New York, who better to shepherd attendees through the evening program?

Be a part of building a more inclusive and empowered community. Support the work of the organization. To learn more about the event and AHRC NYC's history, [click here](#).

Suffering from page 4

those utilizing multiple providers/pharmacies, and other factors such as history of overdose or substance use disorder. Pharmacist interaction through the MAT program also screens for social determinants of health to make appropriate referrals to the UPMC Health Plan or community resources.

The UPMC integrated delivery and finance system supports the integration of comprehensive care. Across the insurance

services division, UPMC Health Plan and Community Care provide access to comprehensive physical and behavioral healthcare, focusing care collaboration and incorporation of appropriate pharmacy interventions. The synergy of these components promotes the relief of the multidimensional suffering associated with chronic pain conditions.

Nicole Polashenski, DO, is Associate Medical Director of Community Care Behavioral Health Organization.

References

De Figueiredo, John M., and James L. Grif-fith. "Chronic pain, chronic demoralization, and the role of psychotherapy." *Journal of Contemporary Psychotherapy*, vol. 46, no. 3, 5 Apr. 2016, pp. 167-177, <https://doi.org/10.1007/s10879-016-9331-x>.

Eaton, Simon, et al. "Delivering person centred care in long term conditions." *BMJ*, 10 Feb. 2015, <https://doi.org/10.1136/bmj.h181>.

Kohrt, Brandon A., et al. "Chronic pain and mental health: integrated solutions for global problems." *Pain*, vol. 159, no. 9, Sept. 2018, pp. S85-S90. *Supplement 1*, <https://doi.org/10.1097/j.pain.0000000000001296>.

Volkow, N. D., & McLellan, A. T. (2016). Opioid abuse in chronic pain — misconceptions and Mitigation Strategies. *New England Journal of Medicine*, 374(13), 1253-1263. <https://doi.org/10.1056/nejmra1507771>.

Responses from page 16

The Commission added a new requirement for acute 24-hour settings, which requires the entity to assess pain and treat or refer for treatment, which strategies may be nonpharmacologic, pharmacologic, or a combination of approaches. The rationale notes: "Pain, especially chronic pain, frequently occurs together with mental and/or substance use disorders. These conditions must be co-managed to achieve progress in treatment for the affected individuals. If pain screening suggests a physical pain assessment is indicated for the individual, acute medically supervised behavioral health settings should assess and respond to physical pain by providing or referring the individual for treatment." Under this new standard, acute-care settings that provide 24-hour care must demonstrate competency in assessing, treating, and referring patients who present with pain. The requirement includes management of pain along with mental health and substance use disorders, which are often co-occurring.

The Commission requires practitioners working in acute 24-hour settings and providing direct care, treatment, or services must participate in education and training on pain assessment and pain management consistent with the scope of their license. In this case, the rationale states: "Psychiatric and behavioral conditions have been associated with chronic pain, long-term opioid prescription receipt, and opioid misuse. Individuals with chronic pain generally require extensive biopsychosocial assessment and multidisciplinary treatment. Therefore, to provide quality care, practitioners must be knowledgeable about pain assessment, multiple modalities of pain treatment, early identification and prevention of harm from opioid therapy, and adverse health and well-being outcomes associated with physical pain. The organization can increase practitioner competence in pain assessment and management by providing access to evidence-based educational resources."

STAR Program from page 27

of those most affected by stigma are heard and valued, fostering a culture of empathy and support.

Looking Forward

The findings from the campaign under-

Additional requirements have been put in place on the federal and state levels to address training in pain management and substance use disorders. For example, several years ago, New York imposed on prescribers a new training requirement in pain management, palliative care, and addiction. Once every three years, prescribers must complete at least three hours of coursework or training on the following topics: New York State and federal requirements for prescribing controlled substances, pain management, appropriate prescribing, managing acute pain, palliative medicine, prevention, screening and signs of addiction, responses to abuse and addiction and end of life care. In addition, the federal Drug Enforcement Administration recently imposed a new 8-hour training requirement on all DEA-registered practitioners on the treatment and management of patients with opioid or other substance use disorders. This one-time training mandate includes an attestation of completion as part of a prescriber's next DEA registration renewal.

Finally, a new Commission requirement mandates that healthcare organizations facilitate practitioner access to Prescription Drug Monitoring Program databases, which prevent misuse and diversion of prescription medications. Many states require that prescribers consult a prescription drug monitoring program before prescribing controlled substances for their patients. For example, in New York, the Internet System for Tracking Over-Prescribing (I-STOP) law, enacted into law in 2013, requires prescribers to consult the Prescription Monitoring Program Registry (PMP) before issuing a prescription for New York Schedule II, III, and IV controlled substances. The PMP, which must be consulted at least 24 hours before writing a Schedule II-IV prescription, provides prescribers with secure access to their patients' prescription histories. Since initiating the PMP program in 2013, New York has joined more than 30 other states in a data-sharing collaborative that permits interstate access to controlled sub-

stance prescription information. Access to prescription drug monitoring programs is essential to ensuring safe and well-monitored utilization of controlled medications that assist in the treatment of mental illnesses, such as benzodiazepines, stimulants, and sleep aids.

score the importance of targeted outreach, particularly towards younger and male audiences who may be less represented yet profoundly affected by mental health stigma. The demographic data collected serves as a crucial guide for future initiatives, ensuring that efforts are directed where they're needed most.

As we reflect on the achievements of the

stance prescription information. Access to prescription drug monitoring programs is essential to ensuring safe and well-monitored utilization of controlled medications that assist in the treatment of mental illnesses, such as benzodiazepines, stimulants, and sleep aids.

The addition of these standards to the accreditation and review standards of The Joint Commission is an excellent example of the commitment of the healthcare system to recognize and adequately address chronic pain and its impact on behavioral health. In conclusion, September is known as Pain Awareness Month. The National Institute of Neurological Disorders and Strokes recognizes this time as "...an opportunity to reflect on the needs of millions of people with chronic pain, as well as the research that we hope will better prevent and treat it."¹² The 2023 designation touted promising research underway to provide a better understanding of the biology of different pain conditions, recognizing potential pain targets, and testing new treatment approaches. Ideally, healthcare professionals and care systems will work together to address these complex interconnected issues and ensure that the highest level of care is provided to those in need.

Rachel Fernbach, Esq. is the Executive Director and General Counsel of the New York State Psychiatric Association and a Partner of the firm Moritt Hock & Hamroff LLP, where she concentrates her practice in the area of not-for-profit law and health care law with a specialty in psychiatry and other mental health services.

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

"Stop Mental Health Stigma" campaign, it's clear that the journey towards a stigma-free society is a collective one. We can all contribute to a future where mental health is understood, accepted, and supported through education, engagement, and empathy. The STAR Program's initiative is not just a campaign; it's a movement toward hope, healing, and ultimately, change.

video underscores the crucial need for caregivers to prioritize their well-being. Family members can't change their loved ones. Instead, family members must learn, change, and grow in a way that impacts the entire family dynamic. At NAMI-NYC, with greater knowledge and support, caregivers are empowered to better understand and manage their roles, fostering healthier relationships with their loved ones.

Once the PSA was complete, NAMI-NYC deployed a comprehensive distribution strategy. We curated a toolkit for community members to share the PSA, including email templates, social media posts, posters, and more. We utilized organic channels such as our website landing page, monthly newsletter, standalone emails in English and Spanish, as well as social media posts. Local media outlets aired our PSA, including CUNY TV, BRIC, Queens Public Television, Manhattan Neighborhood Network, BronxNet, and FY EYE. Our outreach to more than 25 community organizations serving Hispanic/Latino New Yorkers resulted in a deeper partnership with the Brooklyn Public Library. Together, we hosted a community conversation and in-person focus group on the PSA, as well as a mental health resource fair at their central branch.

To measure the impact of our PSA project, we hosted three community discussions, including pre- and post-surveys and focus groups, two virtually and one in-person at the Brooklyn Public Library. The project's impact exceeded expectations, significantly reducing mental health

Footnotes

1. https://www.cdc.gov/injury/pdfs/bsc/BSC_Background_Overview_Progress-GL-Update_6_28_cleared_final_D_Dowell-508-fx.pdf
2. <https://www.psychiatry.org/news-room/apa-blogs/chronic-pain-and-mental-health-interconnected>
3. <https://www.cdc.gov/mmwr/volumes/72/wr/mm7215a1.htm>
4. https://www.cdc.gov/injury/pdfs/bsc/BSC_Background_Overview_Progress-GL-Update_6_28_cleared_final_D_Dowell-508-fx.pdf
5. <https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf>
6. <https://www.cdc.gov/mmwr/volumes/72/wr/mm7215a1.htm#contribAff>
7. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5472077/>
8. <https://adaa.org/understanding-anxiety/related-illnesses/other-related-conditions/chronic-pain>
9. <https://healthsciences.arizona.edu/news/releases/study-shows-millions-people-live-co-occurring-chronic-pain-and-mental-health-symptoms>
10. <https://www.mhanational.org/mental-health-america-reports-strong-connection-between-chronic-pain-and-untreated-mental-health>
11. <https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf>
12. <https://www.ninds.nih.gov/news-events/directors-messages/all-directors-messages/september-pain-awareness-month-we-are-all-together#:~:text=Each%20September%2C%20Pain%20Awareness%20month,better%20prevent%20and%20treat%20it.>

This project was funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction.

Michelle Melendez, MS, LCSW, CHC, is Behavioral Health Director and Jose Iorio is Media and Marketing Consultant at the STAR Health Center at SUNY Downstate Medical Center.

stigma observed among participants after viewing the PSA video. Using our pre/post-surveys, we saw a significant increase in the likelihood of seeking help in case of a mental health emergency, willingness to speak to others about mental health challenges, and openness to connecting to a supportive mental health community like NAMI-NYC. We also saw a dramatic shift in attitudes towards people living with mental illness before and after the PSA, including acknowledgment of stigma for this group and that mental illness could affect anyone.

For other organizations looking to implement successful anti-stigma campaigns, we recommend conducting thorough research

see NAMI-NYC on page 41

NAMI-NYC from page 27

"I don't really talk about my feelings and emotions that are the most vulnerable with my parents."

"...when I'm feeling something negative, something dark inside of me, that's when I talk to my psychologist, or I also speak with God spiritually."

We were ready to shoot our PSA from this programmatic expertise and field research. The narrative unfolds, depicting the strained relationship between a mother and daughter due to her daughter's mental health challenges. The mother realizes she, too, needs support to navigate her role as a caregiver, parent, and family member. The

Disparities from page 25

(Gaskin & Richard, 2011).” Those numbers also excluded the treatment of children and adults living in institutional settings (e.g., correctional facilities and psychiatric facilities).

History of Disparities

Prior to 1960, CP was thought of primarily as a physical health condition treated through medical interventions. This often led to only modest improvements in pain management. In addition, retrospective research studies examining the history of medication management for pain revealed significant differences in the administration of pain medication for Black and white patients in the US, highlighting systematic undertreatment of Black adults and children.

The disproportionately low rate of pain treatment was present even when Black patients were being treated for specific medical diagnoses that caused pain, such as the treatment of fractures in the emergency room and appendicitis (Hoffman et al., 2016).

Racially biased beliefs about biological differences between Black and white individuals have been historically documented by scientists and physicians, and for centuries, those beliefs were utilized to justify the inhumane treatment of Black people in medicine.

While advances in medical, psychological, and racial equity research have highlighted pervasive racial inequality and moved the field toward efforts to eliminate racial health disparities, current research reveals significant cultural bias in healthcare and in the treatment of CP (Hoffman et al., 2016).

Research between 2016 and 2021 exposes cultural disparities in the treatment and prevalence rates of pain issues in the U.S. Hoffman and colleagues published a study in 2016 that showed 50% of White medical students and residents endorsed at least one racially biased belief about biological differences between Black and white individuals (e.g., Black skin is thicker than white skin). The full sample of medical students was then shown case examples of a white and a Black patient experiencing pain. Those medical students who held at least one biased belief about racial differences rated the Black patient’s pain as lower than the white patient’s pain and provided treatment recommendations that were less accurate than their white counterparts.

In addition, CDC data from 2016 and 2021 revealed higher prevalence rates of chronic pain for cultural groups, including non-Hispanic American Indians or Alaskan Natives, Military veterans, women, adults who identify as bisexual, individuals living in rural areas, and individuals living in socioeconomic conditions where family income falls below the national poverty level.

A New Strategy

Additional research and advancements in understanding CP now view pain from a biopsychosocial perspective that focuses on the biological, psychological, and social influences on pain perception and the causes and effects of CP.

Given that CP is often comorbid with mental health and substance use disorders



Crystal Taylor-Dietz, PsyD

and the complex biopsychosocial interactions impacting them all, it became apparent that a biomedical framework alone was not an effective approach for pain management. Following devastating results from the over-use of opioid medications for pain and extensive research published in 2011 by the Institute of Medicine deeming chronic pain as a public health issue, in 2016, the US Department of Health and Human Services developed a national pain strategy proposing the need for health professionals across all disciplines to engage in treating pain management (Edmond et al., 2019).

Best practice standards for treating pain now encourage the use of non-pharmacological approaches when indicated and promote the involvement of behavioral health professionals and alternative and complementary therapies. While there has been an increase in integrated healthcare clinics and specialty mental health clinics for treating CP, the consistent use of multidisciplinary teams to address pain from a biopsychosocial perspective has been slow and continues to reveal significant disparities in access and treatment (Casio & Demyan, 2023).

The pain experiences that have accompanied COVID-19 present even more urgent and challenging needs for pain interventions that require medical professionals to understand how to validate and treat a patient’s experiences of pain, even when there is no evidence of physical pathology (Abramson, 2022).

The Role of Behavioral Health Professionals

Numerous psychological treatments and interventions for treating CP have been developed and researched since 1960. Cognitive behavioral therapy (CBT) is the most widely used psychological treatment, with ample research supporting its effectiveness in reducing pain and increasing psychological and physical health (Jensen & Turk, 2014).

Research also supports other effective interventions, such as mindfulness-based interventions and biofeedback (Casio & Demyan, 2023). In addition to providing psychological interventions, psychologists and other behavioral health professionals have expertise in assessing, conceptualizing, and treatment planning from a biopsychosocial perspective, which provides a complementary area of specialty

to primary care physicians and other medical staff. Behavioral health professionals are typically well versed in facilitating and collaborating on multidisciplinary teams and can provide consultation on understanding the complex bi-directional biopsychosocial factors of mental health, substance use, and experiences of pain.

While there is little research on health disparities in pain management with behavioral health professionals specifically, we know all individuals harbor biased beliefs that can negatively impact behavior and interactions.

Psychologists and behavioral health professionals are often educated and trained in understanding bias and other identity and social factors related to culturally sensitive and responsive treatment. These areas of expertise are necessary for addressing the systematic cultural bias and discrimination identified through extensive research and would contribute to more appropriate and adequate treatment of all people suffering from CP.

Behavioral health professionals are also highly skilled in building rapport with individuals and their caregivers, allowing for the development of a trusting relationship where education for individuals and families may be better received.

Behavioral health professionals can assist systems of care through the following action items specifically related to addressing cultural disparities in pain management (Sabin, 2020):

1. Conduct and facilitate educational programs with multidisciplinary teams on cultural bias, implicit bias and disparities in pain management to help professionals gain greater awareness of their own biases and implications related to treatment disparities.
2. Develop data collection systems that track pain assessments and demographics related to race, gender, socioeconomic status, and other cultural factors to identify disparities within each system of care.
3. Decrease the discretion of individual professionals in treating CP by following established best practices, guidelines, and system protocols.
4. Develop protocols for engaging in comprehensive assessments of pain and comorbid mental health and/or substance use conditions that incorporate a biopsychosocial, cultural formulation for understanding presenting concerns that then facilitate treatment planning.
5. Continue conducting research on developing standard objective measures for assessing pain that are not fully reliant on patient self-reports and subjective interpretations by providers.

Devereux Advanced Behavioral Health is one of the nation’s largest nonprofit organizations, providing services, insight, and leadership in the evolving field of behavioral healthcare. Founded in 1912, Devereux operates a comprehensive national network of clinical, therapeutic, educational, and employment programs that positively impact the lives of tens of thousands of children, adults – and their families – every year. The organization’s unique approach combines evidence-based interventions with compassionate

family engagement.

With more than 6,000 employees working in programs across the country, Devereux is a trusted partner for families, schools, and communities, serving many of our country’s most vulnerable populations in the areas of autism, intellectual and developmental disabilities, specialty mental health, education, and foster care. For more than a century, Devereux Advanced Behavioral Health has been guided by a simple and enduring mission: To change lives by unlocking and nurturing human potential for people living with emotional, behavioral, and cognitive differences. www.devereux.org

References

- Abramson, A. (2022). Patients turn to psychologists for new chronic pain strategies in the COVID-19 era. *Monitor on Psychology*, 53(6). <https://www.apa.org/monitor/2022/09/understanding-managing-pain>
- Center for Substance Abuse Treatment. *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders*. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2012. (Treatment Improvement Protocol (TIP) Series, No. 54.) 3, Chronic Pain Management. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK92054>
- Cohen, S. P., Vase, L., & Hooten, W. M. (2021). Chronic pain: an update on the burden, best practices, and new advances. *Lancet* (London, England), 397(10289), 2082–2097. [https://doi.org/10.1016/S0140-6736\(21\)00393-7](https://doi.org/10.1016/S0140-6736(21)00393-7)
- Cosio D, Demyan A. Behavioral Health Specialists in Chronic Pain Care: An Overlooked Asset. *Practice Pain Management*. 2023 January/February;23(1).
- Edmond SN, Heapy AA, Kerns RD. Engaging Mental Health Professionals in Addressing Pain. *JAMA Psychiatry*. 2019;76(6):565–566. doi:10.1001/jamapsychiatry.2019.0254
- Gaskin DJ, Richard P. The Economic Costs of Pain in the United States. In: Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington (DC): National Academies Press (US); 2011. Appendix C. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK92521/>
- Jensen, M. P., & Turk, D. C. (2014). Contributions of psychology to the understanding and treatment of people with chronic pain: Why it matters to ALL psychologists. *American Psychologist*, 69(2), 105–118. <https://doi.org/10.1037/a0035641>
- King, Saraa,*; Chambers, Christine T.b; Huguet, Annab; MacNevin, Rebecca C.b; McGrath, Patrick J.b; Parker, Louiseb; MacDonald, Amanda J.c. The epidemiology of chronic pain in children and adolescents revisited: A systematic review. *Pain* 152(12):p 2729-2738, December 2011. | DOI: 10.1016/j.pain.2011.07.016

Perquin, C. W., Hazebroek-Kampschreur,

see Disparities on page 41

Trauma from page 24

issues (SAMHSA, 2014). School climate is a broad term that also encompasses prioritizing students' physical and emotional safety as well as nurturing positive and supportive relationships. Empowering students by offering choices will provide a sense of control and agency. Incorporating daily rituals such as morning meetings or individual check-ins can facilitate positive adult-student interactions. Finally, setting clear, predictable expectations will build trust amongst students and staff. Staff members can be trained to recognize signs of trauma in their students and partner with families to select appropriate accommodations to aid in students' learning. Teachers may notice students withdrawing from others, emotional outbursts that are more intense and/or more frequent, crying more easily, poor academic performance, or sleeping in class. Schools can consider accommodations to support the child, including reducing assignment length, giving extended time, and allowing the child to regularly connect with a school-based mental health professional if they are experiencing emotional difficul-



Jeniffer Cruz, PhD, NCSP

ties (NASP School Safety and Crisis Response Committee, 2015).

Additionally, incorporating social and emotional curricula can teach both students and teachers to identify ways to express emotions effectively, choose helpful coping strategies to manage difficult emotions, and ask for help from others when they are

struggling. When working with children who have experienced trauma, adults should prioritize taking care of themselves to avoid compassion fatigue, which can occur when we are constantly taking care of others. Eating three meals a day, drinking plenty of water, and having a consistent sleep schedule are a few common self-care strategies. Other opportunities can include incorporating enjoyable exercise into daily routine, like dance or yoga, and practicing a simple mindfulness activity, like a body scan, which can help keep them alert to any changes that might indicate they are experiencing compassion fatigue. Staff can develop a "tap-out" system to take a break and trade places with other staff members when they recognize their emotions are heightened so they can ensure that the students' needs are still being met. Importantly, adults should have patience and compassion not only for the students they serve but for themselves as well.

Childhood trauma can have lasting negative impacts, but support from families, schools, and communities can help children heal.

Jeniffer Cruz, PhD, NCSP, is a licensed

psychologist in New Jersey and a Nationally Certified School Psychologist. She works at Behavior Therapy Associates in Somerset, New Jersey. She can be reached at jcruz@BehaviorTherapyAssociates.com and at www.BehaviorTherapyAssociates.com.

References

Centers for Disease Control and Prevention (2019). Adverse Childhood Experiences (ACEs) Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

NASP School Safety and Crisis Response Committee. (2015). Supporting Students Experiencing Childhood Trauma - Tips for Parents and Educators. Bethesda, MD: National Association of School Psychologists.

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Gambling from page 24

make it seem socially acceptable. Adolescents may also see gambling as a way to make quick money.

Several predetermined risk factors may also contribute to the development of problematic gambling behavior in adolescents. These factors include a family history of gambling problems or addictive behaviors. Mental health conditions, such as depression, anxiety, or ADHD. Adolescents from lower socioeconomic backgrounds as financial stressors can contribute to the appeal of gambling as a potential solution. Adolescents with impulsive tendencies may be more prone to problematic gambling. The use of substances, such as drugs or alcohol, is often associated with an increased risk of engaging in problematic gambling behavior. Insufficient parental monitoring and involvement in an adolescent's life may also increase risk.

Understanding these factors can help parents, educators, and healthcare professionals identify and address potential issues before they escalate into problematic gambling behavior in adolescents.

The long-term dangers associated with adolescent gambling include gambling addictions, financial problems, mental health issues, emotional family distress, and legal consequences.

Adolescents may access gambling

through online platforms, fake IDs, or by participating in informal or underground gambling activities. To address adolescent gambling, parents, educators, and communities need to take proactive steps to educate adolescents about the risks of gambling, monitor online activities, implement parental controls on devices, limit access to funds, be a role model, encourage healthy hobbies, and encourage open communication about finances and decision-making.

Warning signs of adolescent gambling may include sudden shifts in behavior, such as increased secrecy, mood swings, irritability, or withdrawal from family and friends. A noticeable decline in academic performance, missed assignments, or a lack of interest in previously enjoyed activities. Unexplained money problems, frequent borrowing, or stealing to fund gambling activities. Constantly talking about or being preoccupied with gambling-related topics, even if it's just casually discussing odds or strategies. Changes in Social or a shift in friendships, particularly if the new friends are involved in gambling activities. Items of value going missing, potentially sold or pawned to finance gambling. Engaging in deceptive behavior, such as lying about the extent of gambling involvement or hiding losses. Increased levels of stress, anxiety, or depression may be linked to gambling activ-

ities. Persistent attempts to recover losses through continued gambling, leading to a cycle of escalating bets. Neglecting responsibilities at home, school, or work due to a focus on gambling.

If you observe these warning signs in an adolescent, it's essential to approach the situation with empathy and seek professional help from a mental health professional or a support organization specializing in gambling addiction. Cognitive-behavioral therapy (CBT) is the most effective therapy mode for treating gambling disorders. CBT aims to identify and modify unhealthy thought patterns and behaviors related to gambling. Motivational interviewing, a client-centered approach, can also enhance motivation to change. Family therapy may help address the impact of gambling disorder on relationships and involve loved ones in the recovery process. Support groups like Gamblers Anonymous also provide a sense of community and understanding. In severe cases, medications such as selective serotonin reuptake inhibitors (SSRIs) or opioid antagonists may be considered in conjunction with therapy.

If you or someone you know is struggling with gambling-related issues, don't hesitate to reach out for support. The National Problem Gambling Helpline is 1-800-522-4700. The helpline is open 24 hours a day, seven days a week. The help-

line is 100% confidential and connects the caller to local health and government organizations that can assist with their gambling addiction.

Richard Anemone has a master's degree in psychology and is licensed as a mental health counselor in New York State. He owns a private practice, Behavioral Mental Health Counseling PLLC, in which he provides counseling as well as training, presentations, and technical support to individuals, families, groups, and organizations with a specialty in gambling addiction, anger management, intellectual developmental disabilities, and psychiatric disorders. Richard is also the Senior Vice President of the IDD division at ICL. ICL helps New Yorkers with behavioral health challenges live healthy and fulfilling lives by providing comprehensive housing, health care, and recovery services. He can be reached at Richard.Anemone@BMHC-NY.com.

References

Welte, J. W., Barnes, G. M., Tidwell, M. O., & Hoffman, J. H. (2007). The Prevalence of Problem Gambling Among US Adolescents and Young Adults: Results from a National Survey. *Journal of Gambling Studies*, 24(2), 119–133. <https://doi.org/10.1007/s10899-007-9086-0>

NAMI-NYC from page 39

and remaining open to all feedback and insights from the community. Although we focused on the Hispanic/Latino community, we kept our interviews open to anyone who wanted to chat. We authored an original report detailing Black, brown, and AA-

PI community findings. Many of these individuals shared the difficulties of talking about mental health in immigrant families. As a result, this PSA now stands as a foundational resource for future programming and campaigns, which could be tailored, for example, to New Yorkers in mono-lingual Chinese or Arabic communities.

This project was funded by the New York State Office of Mental Health and the New York State Tax Check-off Funds for Mental Health Stigma Reduction.

For over 40 years, NAMI-NYC has been a lifeline for individuals and families affected by mental illness. We urge you to utilize our PSA, available at

www.naminyc.org/psa, to spread awareness and connect individuals with the necessary resources. Whether you're embarking on your own PSA project or seeking guidance, we welcome your questions and are eager to share our insights and feedback. To get in touch, visit www.naminyc.org/helpline.

Disparities from page 40

A. A., Hunfeld, J. A., Bohnen, A. M., van Suijlekom-Smit, L. W., Passchier, J., &

van der Wouden, J. C. (2000). Pain in children and adolescents: A common experience. *Pain*, 87(1), 51–58. doi:10.1016/S0304-3959(00)00269-4

Rikard SM, Strahan AE, Schmit KM, Guy GP Jr.. Chronic Pain Among Adults — United States, 2019–2021. *MMWR Morb Mortal Wkly Rep* 2023;72:379–385. DOI: [http://](http://dx.doi.org/10.15585/mmwr.mm7215a1)

dx.doi.org/10.15585/mmwr.mm7215a1.

Sabin, A. (2020). How we fail Black patients in pain. aamc.org/news/how-we-fail-black-patients-pain

Your Options from page 25

- How was I harmed in ways I am aware of and may not realize?
 - What self-care resources can I access?
 - How can I stay regulated, manage early warning signs, and address crises?
3. **Collect** evidence (What can you prove?)
- How can I appropriately document possible stigma, microaggressions, and/or discrimination?
 - How can I keep an open mind that it may not be intentional, or it may be my sensitivities contributing to my reaction?
4. **Cultivate** support (Who can help you?)
- How can I decide who in my personal and professional life or what third parties I can contact for support?
 - What are appropriate ways to seek support?
 - How can I be mindful in navigating the awkwardness, professionalism norms, and vicarious trauma that comes from my sharing my story with supporters?
5. **Consider** your rights, options, and limitations (Should I respond? How?)
- What are the relevant organization policies, laws, and rights that may help me?
 - What are the practical realities that may make it not feasible for me to exercise those options (delays, burdens, backlashes, ambiguities, my sensitivities)
 - What are the possible self-protective, collaborative, and assertive options to move forward, and how can I pursue them?
 - What choice do I want to make (not what anyone says I should do)?

An Example of a Protective Response

Even if we believe we are sure that something stigmatizing happened, we may decide to protect ourselves from the stress or backlash from speaking up. For instance, as a speaker living with bipolar disorder, there have been many times that participants in one of my programs or professionals who have hired me to speak say upsetting things that feel demeaning.



Dan Berstein, MHS

Once, someone told me, “I never would have guessed you were bipolar until you started speaking so fast at the end,” - and sadly, this is amongst many upsetting comments I have regularly encountered. Even though, in my head, I had **clarified** that this was stigma, my **coping** was to let it go rather than deal with the difficult conversation about addressing it.

Kevin Nadal, an expert on microaggressions, prepared a guide to respond to microaggressions that contain similar advice - microaggressions are so frequent, so upsetting, and so hard to discuss that his guide suggests people consider whether it is safe to bring up the issue and worth doing at all given the pain. The point is not to trivialize the immense trauma from each instance of stigma - but rather to acknowledge that the world is an ocean filled with endless possible stigma, and we might drown if we try to fight every drop of it.

An Example of
A Collaborative Response

Part of my work has been addressing published guidance that teaches people discriminatory practices regarding individuals with mental illnesses, including guidance with inappropriate recommendations to screen out parties who have these conditions or otherwise treat them differently. This is often illegal under the Americans with Disabilities Act (ADA), but many people sadly do not realize that mental illness discrimination is an issue, so they often don't believe they are doing anything wrong by publishing instructions to screen people with mental health conditions. You can read some examples of this problem in the dispute resolution

world in an article at <https://bit.ly/ABADiscrimination>.

In this case, because this information was published, it was easy for me to **clarify** that the problem was real and to **collect** evidence from the published guidance. **Coping** is still important - it is painful to read this type of material, to appreciate how these kinds of policies and practices are demeaning countless people with mental health problems like mine, and to encounter the indifferent, confused, or avoidant reactions of people who might be dismissive when I bring it to their attention - so I **cultivate** support in my life from my therapist, my friends and support system, and other professional contacts before I address the issue. Then, I **consider** my options, and because I am a mediator, I offer ways to collaborate and discuss the issue. This has often led to great successes and learning opportunities, including people changing their policies and publications. For examples of this in the dispute resolution world, visit mhsafe.org/preventing/ and mediate.com/ending-mental-illness-discrimination-in-dispute-resolution-and-beyond-some-2023-updates.

Collaborating with others can be hard. It involves being vulnerable, forgiving, and showing empathy to the idea that most people are not purposely stigmatizing someone. It requires self-care as well.

An Example of
An Assertive Response

There are also times, after considering our options, we may decide to file some kind of complaint. Organizations such as schools or workplaces have non-discrimination and non-retaliation policies to protect you from backlashes after making a complaint, though they are sometimes poorly implemented.

We also have legal protections under federal, state, and local disability laws. I have had some success in filing complaints, including times when discriminatory content was changed. But even these successes can be taxing - it can be painful to sometimes see my complaint dismissed right away, to experience cold reactions from various institutions, to have my pain trivialized, and to endure long, sometimes costly, investigatory processes only to receive little information at the end.

One goal of the Mental Health Safe Project is to give people tools to make the complaint process easier and to also fill in the gaps from many of the “Know Your Rights” circulating pamphlets. Yes,

you have rights, but sometimes asserting them can be very hard. You often have to be able to **collect** tangible proof, which is difficult when someone is not publishing harmful content, as I mentioned earlier. There is a lot to **cope** with because you are often a lone individual engaging in an adversarial process with some institution. At mhsafe.org/options, you can see some resources to help you **consider** your next steps while having a full sense of the burdens and backlash that may come with some of these more formal processes. Additional assertive options include speaking up to tell your story and seeking help from less formal advocacy efforts.

Conclusion: Stigma Hurts,
and You Have Choices

Every act of stigma is hurtful, disruptive, and it can seem like its effects ripple forever. Unfortunately, the world is filled with mental illness stigma, and people living with mental health problems are affected by it regularly, in some ways that can be seen and in many ways that cannot. Sadly, many of the perpetrators of stigma do not know they are doing it. They are hurt, too, because they create problems they do not understand.

It is impossible to notice, prevent, or address every act of stigma. But when we choose to reflect on something that happened and make our own choices about how to handle it, we can use the five-step (5 C's) framework to clarify what happened, to cope with the feelings, and take care of ourselves, to collect evidence, to cultivate support, and to consider our options of how we can move forward - perhaps by acting protectively toward ourselves, or by collaborating with others, or by asserting our rights.

See more information and campaign images at www.mhsafe.org/options.

Dan Berstein, MHS is a mediator and mental health expert living with bipolar disorder, working to help people use conflict resolution best practices to have empowering mental health communication and prevent mental illness discrimination. As Chief Advocacy Officer of Mindquity, Dan works to help legal organizations have resources to prevent inadvertent discrimination and respond when it occurs. Dan also wrote the American Bar Association book, *Mental Health and Conflicts: A Handbook for Empowerment*, and he leads advocacy efforts through the Mental Health Safe Project, with free resources available at www.mhsafe.org.

2023 Mental Health Stigma Roundtable Discussion Series

View Details and Watch the Four Roundtables

BEHAVIORAL HEALTH NEWS



Mental Health News Education Board of Directors

Chair

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

Vice-Chair

Yvette Brissett-André, MPA, Executive Director and CEO
Unique People Services

Secretary

Peter D. Beitchman, DSW, LMSW, Principal
Behavioral Health Consultation

Treasurer

Keri Primack, CFP, Managing Director, Senior Client Advisor
Quent Capital, LLC

Members of The Board

Anita Appel, LCSW, Senior Health Care Consultant
Sachs Policy Group

Mary Brite, LCSW, CASAC, Chief Compliance Officer
Outreach

Jonathan P. Edwards, PhD, LCSW, ACSW, Program Consultant
New York City Department of Health and Mental Hygiene

Ann-Marie K. Foster, MPA, FACHE, President and CEO
Phoenix Houses of New York/Long Island

Debbie Pantin, MSW, MS-HCM, President and CEO
Outreach

Barry B. Perlman, MD, Past President
New York State Psychiatric Association

Jorge R. Petit, MD, Founder/CEO
Quality Healthcare Solutions, LLC

Joshua Rubin, MPP, Principal
Health Management Associates

Jarod Stern, Senior Managing Director
Savills

Kimberly Williams, MSSW
Mental Health Consultant

Founding Chairman

Alan B. Siskind, PhD, LCSW

Executive Staff

Ira H. Minot, LMSW, Founder

David Minot, Executive Director

Behavioral Health News is a Quarterly Online Publication of Mental Health News Education, Inc., a 501(c)(3) Nonprofit Organization

All inquiries regarding advertising, sponsorships, and submitting an article should be directed to:

Ira H. Minot, LMSW, Founder, MHNE and Publisher, Behavioral Health News

(570) 629-5960 • iramintot@mhnews.org • 460 Cascade Drive, Effort, PA 18330 • BehavioralHealthNews.org

Mental Health News Education, Inc. does not endorse the views, products, or services contained herein. We are not responsible for omissions or errors. Mental Health News Education, Inc. is not responsible for articles submitted to us without the final approval of the organization's Executive Director, CEO, or Public Relations Department. All articles and advertisements are subject to final approval by the publisher. We reserve the right to edit any article sent to us.

Disclaimer of Endorsement and Liability: The information, opinions and views presented in Behavioral Health News (BHN) reflect the views of the authors and contributors of the articles and not of BHN, or its publisher. Publication of articles, advertisements, or product information does not constitute endorsement or approval by BHN and/or its publisher. BHN and/or its publisher cannot be held responsible for any errors or for any consequences arising from the use of the information contained in this publication. Although every effort is made by the publisher to see that no inaccurate or misleading data, opinion, or statement appear in this publication, the data and opinions appearing in articles including editorials and advertisements herein are the responsibility of the contributors concerned.

The publisher accepts no liability whatsoever for the consequences of any such inaccurate or misleading data, information, opinion, or statement.

Copyright © 2024 Mental Health News Education, Inc. All rights reserved. Content contained in this publication may be reproduced for one-time personal use. However, anyone wishing to reproduce and distribute any content from within this publication for purposes other than personal use must request this intention in writing directly to the publisher. Failure to do so will be in violation of the copyright held by this publication.

BEHAVIORAL HEALTH NEWS

Your Trusted Source of Mental Health and Substance Use Disorder Education, Information, Advocacy, and Community Resources

www.BehavioralHealthNews.org



#YourTrustedSource since 1999

[Current Issue](#) • [Advertise](#) • [Submit an Article](#) • [Editorial Calendar](#)
[Join Our Mailing List](#) • [Articles by Topic](#) • [Issue Archives](#) • [Event Calendar](#)



Behavioral Health News By The Numbers

- A targeted autism readership of over **160,000** annually online
- A searchable online database of over **1,500** articles available for free
- An online archive of over **95** quarterly issues going back to 2001

About Behavioral Health News

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.

For information about [advertising](#) and [article submissions](#), contact Ira Minot, Publisher, at iramint@mhnews.org.