BEHAVIORAL HEALTH NEWS

YOUR TRUSTED SOURCE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER
EDUCATION, INFORMATION, ADVOCACY, AND COMMUNITY RESOURCES

SPRING 2025

VOL. 12 NO. 4

Behavioral Health Services for Children, Adolescents, and Families

Crisis Support for Youth: Expanding Home-Based and Community Care in NY

By Dr. Ann M. Sullivan
Commissioner
New York State Office of Mental Health

Without question, our children and youth benefit greatly when they have a safe, stable, and nurturing environment to call home. These elements, when coupled with positive relationships, provide a strong foundation to support brain development and resilience, which enables our youth to thrive throughout their lives.

This positive environment is even more critical for youth who have mental health challenges. Being able to live in a nurturing home surrounded by positive relationships can have a remarkably positive impact as they mature into adults.

But maintaining this environment isn't simple, and as mental health problems present in children and teens, they and their caregivers may experience crises. At these times, they can benefit from intensive and focused mental health programs.

Ann M. Sullivan, MD

That's why New York State is implementing evidence-based and research-backed programming to support youth and families in times of crisis. This includes Home-Based Crisis Intervention, Youth Assertive Community Treatment, and High-Fidelity Wraparound Care Management – all programs aimed at keeping children and adolescents where they are most likely to have the best possible outcome: At home in their community.

New York State's specialized Home-Based Crisis Intervention model solely serves children and youth and is geared toward families needing intensive support to avert unneeded psychiatric hospitalization or residential treatment. This program provides individualized and family-driven care to children from the age of 5 up until they turn 21. Services include clinical interventions and case management to help them stay in a safe, stable, and nurturing environment.

Home Based Crisis Intervention supports families with a child or adolescent experiencing a psychiatric crisis, which can include suicidal thoughts, aggressive outbursts, lengthy periods of school avoidance, or self-injurious behavior. Referrals may come from any provider or community member aware of the need, including the family or youth themselves.

As a crisis service, program staff typically arrive at the individual's home within two business days and then provide around-the-clock support seven days per week. The youth and their family are typically served for four to six weeks by one interventionist, which can benefit the youth and the family by providing the consistency and predictability of working with one program staff during this stressful time.

First established in New York City in 1995, Home-Based Crisis Intervention now exists in 55 counties throughout the state, with work underway to cover the remaining seven counties within the year. OMH funds 41 teams – each including a supervisor and multiple interventionists – serving about 1,800 families annually.

Last year, four additional teams were developed specifically for children and youth with mental health and intellectual or developmental delays, with an additional six of these specialized teams expected to be added shortly. Once completed, this expansion is expected to nearly double the total number of children and youth diverted away from unnecessary psychiatric hospitalizations and out-of-home treatment.

Recent data reported by these teams is

see Crisis Support on page 26

ObservSMART

INNOVATIVE COMPLIANCE TECHNOLOGY

Transforming healthcare settings with proximity-required safety monitoring, 1:1 assurance and proactive alert interventions for at risk patients

Observation | Compliance | Safety

Table of Contents

Behavioral Health Services for Children, Adolescents, and Families

Medicaid and Behavioral Health Policy

Peer Support & Lived Experience

Editorial Calendar

Summer 2025 Issue
Supporting Maternal Mental Health and Reducing Stigma
Deadline: June 19, 2025

Fall 2025 Issue
Understanding and Treating Anxiety and Depression
Deadline: September 10, 2025

Winter 2026 Issue
Behavioral Health Care Workforce Development and Innovation
Deadline: December 9, 2025

Spring 2026 Issue
Supporting Peer Services in Behavioral Health
Deadline: March 12, 2026

* * *

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 BehavioralHealthNews.org

Behavioral Health News Update

BehavioralHealthNews.org

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

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

Mary Brite, LCSW, CASAC, Chief Compliance Officer
Outreach

Treasurer

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

Members of The Board

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

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

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 New York

Samuel Wesley Jackson, MD, Clinical Director of Psychiatry
Erie Family Health Center

Danika Mills, MSW, LCSW, MPS, LCAT, CCM,
Head of Care Operations , Grayce

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, Principal
Health Management Associates

Founding Chairman

Alan B. Siskind, PhD, LCSW

Executive Staff

Ira H. Minot, LMSW, Founder

David Minot, Executive Director and Publisher

Behavioral Health News Publication Sponsors

PLATINUM

People Get Better With Us ICL

ObservSMART

GOLD

Community Counseling & Mediation
We're here to help

SILVER

Family Care Center | Transforming Behavioral Health

Caring for the Community NYPCC Est. 1974

S:US Services for the Underserved

SPONSORSHIP DETAILS	PLATINUM	GOLD	SILVER
Advertising and Article Space - With forward placement in four consecutive quarterly issues of BHN - View the current issue for examples	Full Page Advertisement	Half Page Advertisement	Quarter Page Advertisement
Leaderboard Advertising on BHN Website - Run sitewide on 1,500+ article posts with no paywall - Positioned below the top BHN logo	2 months	1 month	–
Top Banner Ad in the BHN Update Newsletter - View an example	3 Newsletters	2 Newsletters	1 Newsletter
Linked Logo Placement for 1 Year - On the BHN website - In four BHN quarterly issues - In all 52 BHN Update newsletters	1 Year	1 Year	1 Year

Contact us for information about becoming a Behavioral Health News sponsor

---

Behavioral Health News is a Quarterly Online Publication of Mental Health News Education, Inc., a 501(c)(3) Nonprofit Organization. Founded by Ira Minot, this publication has served as a trusted resource for the behavioral health community for over two decades.

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

David Minot, Executive Director, Mental Health News Education, and Publisher, 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, opinions, or statements 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, opinions, or statements.

Copyright © 2025 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.

Leveraging Technology to Enhance Mental Health Services for Children and Families

By Amy E. Witek, MS, NCC
Clinical and Training Support Specialist
Institute for Community Living (ICL)

Technology-driven approaches to mental health care have transformed the way services are delivered, making support more accessible and tailored to individual needs. Children and families can particularly benefit from this movement because digital tools enable novel pathways to the implementation of impactful and effective interventions. Utilizing telehealth and interactive platforms can transcend traditional barriers to mental health, including sourcing, geography, stigma, and resource shortages, all while also improving outcomes.

Mental health struggles among children and families are on the rise, with anxiety, depression, and behavioral issues among the most frequent. While care is desperately needed, many children with behavioral and developmental disorders go without proper care. Technology can help with these challenges, as it can facilitate greater access to services and broaden the availability of evidence-based interventions in a flexible and scalable manner (Centers for Disease Control and Prevention, 2019). Moreover, technology promotes early intervention, which can mitigate the effects of untreated mental health conditions later on. Virtual tools help pinpoint at-risk youth, allowing families and professionals to intervene before conditions worsen. This proactive approach helps to limit hospitalizations and school interruptions, which in turn is conducive to resiliency and health in children.

Mental health care is more accessible thanks to telehealth, which allows families to connect with providers remotely. This approach alleviates logistical burdens, such as travel and scheduling challenges, rendering ongoing therapy and psychiatric consultations much more viable. Research indicates that telehealth therapy is comparable in effectiveness to in-person treatment, especially for cognitive-behavioral methods (Hilty et al., 2013). In particular, adolescents often respond positively to the privacy and convenience of virtual sessions, which can promote client engagement while removing some of the stigma sometimes associated with traditional therapy (Lindhiem et al., 2017). In addition, telehealth can offer more regular check-ins, which provide ongoing support between formal therapy sessions.

In addition to telehealth, ongoing support through digital interventions (e.g., mobile applications, self-guided therapy programs, online support groups) is critical. Gamified techniques and cognitive-behavioral principles are employed by interactive platforms aimed at children to promote emotional regulation and coping skills (Firth et al., 2017). Digital psychoeducation, parenting resources, and virtual communities extend learning into caregivers' lives as well. An additional advantage of these means is that clinicians are able to monitor shifts in real-time and tailor interventions to fit the changing needs of each family (Fleming et al., 2018). Digital tools like these are giving families a sense of empowerment by building self-efficacy and providing caregivers with strategies to help them promote their child's emotional and behavioral health. Moreover, the use of AI on digital platforms can provide even greater customization and personalization for mental health interventions, providing specific recommendations and adaptive strategies based on user engagement and progress.

By using analytics, mental health services can provide a platform where the service provider can keep track of the progress of treatment, capture changes in symptoms, and identify early warning signs. Such tools can aid in intervening early and proactively, allowing clinicians to respond to issues before they have an opportunity to arise (Waring et al., 2019). Secure data-sharing systems can also facilitate coordination between families and their mental health providers so that care is more integrated and responsive. Device learning also aids clinicians in recognizing the patterns and characteristics of mental health conditions, enabling more accurate diagnoses and treatment planning. These innovations help ensure that children and their families receive just the right amount of support at just the right time, allowing effective intervention to occur much earlier without unnecessary delays.

While technology brings a wealth of new opportunities in mental health services, there are also some important considerations. Not every family has the same access to digital tools, underscoring the need for systematic solutions to avoid disparities. In addition, the damaging effects of a data breach can affect the whole alliance, and this is why data security is imperative to securely utilizing telehealth options. Digital interventions can make a difference, but they need to supplement—not replace —traditional therapy, especially for families with complex needs. Access to these technologies should not favor higher-income groups, and policymakers and mental health professionals should work toward ensuring that digital solutions do not further narrow an already high disparity in mental health care access.

There is true potential for technology to transform mental health care for children and families by improving accessibility, engagement, and personalization. Telehealth, digital interventions, and data-driven approaches establish new opportunities to uplift mental well-being. Careful implementation is key to addressing barriers, protecting privacy, and ensuring that these innovations deliver value when integrated into day-to-day care. When used alongside traditional care models, technology can assist mental health professionals in better supporting the children and families they so sincerely want to help.

Amy E. Witek, MS, NCC, is Clinical and Training Support Specialist at Institute for Community Living (ICL).

References

Centers for Disease Control and Prevention. (2019). Children's mental health. https://www.cdc.gov/childrensmentalhealth/index.html

Firth, J., Torous, J., & Nicholas, J. (2017). The efficacy of smartphone-based mental health interventions for anxiety and depression: A systematic review and meta-analysis. *The Lancet Psychiatry, 4*(1), 3-13. https://doi.org/10.1016/S2215-0366(16)30347-X

Fleming, T., Merry, S. N., & Stasiak, K. (2018). Our digital future: The use of technology to support mental health in young people. *Lancet Psychiatry, 5*(8), 641-650. https://doi.org/10.1016/S2215-0366(18)30242-2

Hilty, D. M., Luo, J., & Johnston, B. (2013). The effectiveness of telepsychiatry in the treatment of children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*(3), 254-262. https://doi.org/10.1016/j.jaac.2012.12.005

Lindhiem, O., Bennett, C. B., Rosen, D., & Silk, J. (2017). Mobile technology boosts the effectiveness of psychotherapy and behavioral interventions. *Clinical Psychology Review, 54*, 17-32. https://doi.org/10.1016/j.cpr.2017.03.009

Waring, M. E., Baker, M. K., & Allison, J. J. (2019). Predictive analytics in mental health care: Early detection and intervention. Mental Health Research, 9(1), 23-35. https://doi.org/10.1016/j.mhr.2019.01.002

ICL's Emerson-Davis Family Center

Institute for Community Living's (ICL) Emerson-Davis Family Center is an innovative program that offers permanent and transitional housing to parents who have experienced homelessness, are experiencing mental health issues, and who are at risk of losing custody or are seeking to be reunified with their children.

Emerson-Davis provides 24/7 support, including

- *Comprehensive case management services*
- *Trauma-informed, in-home family support services to promote independent living skills*
- *Tutoring*

By offering stable, affordable housing and on-site supportive services, ICL has helped more than 74% of our clients in this program reunify or remain with their children.

Community Counseling & Mediation (CCM) Launches New Bond Street Clinic to Support Child and Adolescent Mental Health in Brooklyn

By Douglas Brooks, LCSW-R,
and Carmen Collado, LCSW
Community Counseling & Mediation

Community Counseling & Mediation (CCM) is proud to announce the grand opening of our Bond Child and Adolescent Article 31 Mental Health Clinic, a new facility dedicated to serving the behavioral health needs of youth and families in Brooklyn. The clinic will officially open on Thursday, May 9, 2025, at 10:00 AM, at 9 Bond Street, 6F in Brooklyn, NY 11201, and we are honored to welcome New York Office of Mental Health Commissioner Dr. Ann Sullivan, CCM's President and CEO, and myself, Carmen Collado, Chief Operating and External Relations Officer, for this exciting occasion. The ribbon-cutting ceremony will take place at our new location in Downtown Brooklyn. Community partners, elected officials, and supporters are warmly invited to attend. If you'd like to attend, please send your RSVP to Sophia Romero-Benz at sromero-benz@ccmnyc.org by May 1.

This opening marks a significant step forward in our mission to ensure that all children, adolescents, and young adults—especially those from underserved communities—have access to high-quality, culturally responsive, and affordable mental health care.

Why a New Clinic? Why Now?

Across the country, young people are facing a growing mental health crisis. Rates of anxiety, depression, self-harm, and suicide ideation among adolescents are at an all-time high, with particularly alarming trends among Black, Latino, and LGBTQ+ youth. The contributing factors are complex and multifaceted—from the impact of social media and cyberbullying to fears about climate change, political instability, school safety, and economic hardship. Social determinants of health—such as poverty, housing insecurity, systemic racism, and limited access to quality care—further exacerbate these challenges.

At CCM, we recognized the urgent need for a dedicated space that could respond to these realities head-on. Our new Bond Street Clinic is designed to meet this moment, offering evidence-based, trauma-informed, and culturally affirming care in a welcoming and accessible setting.

A Comprehensive Array of Services

The Bond Clinic will offer a wide range of services tailored to the emotional, psychological, and social development needs of children and adolescents, including:

- Individual Therapy
- Family and Couples Therapy
- Group Therapy, including:
    - Anger Management
    - Bereavement Counseling
    - Parenting Support
- Child and Adolescent Counseling
- Play and Art Therapy

see New CCM Clinic on page 36

Understanding Trauma-Informed Care for Young Children and Families in the Shelter

By Joseph Esheyigba, LMSW, MPA, SIFI
Vice President of Homeless Services
Services for the UnderServed (S:US)

Services for the UnderServed (S:US) is one of the premier and largest community-based social services agencies in New York State. Its mission is to “drive scalable solutions to transform the lives of people with disabilities, people in poverty, and people facing homelessness: solutions that contribute to righting societal imbalances.” S:US creates a compassionate environment through a combination of concrete social services in our shelters for adult families, single adults, and families with children. We prioritize offering essential social services that cater to the unique needs of those we serve. We understand that trauma can profoundly impact young children, youth, and families, affecting their physical and mental health, as well as their economic and housing situations. By embracing a trauma-informed approach, we strive to support and empower individuals and families on their journey toward healing and stability. [iii]

In this article, I will explore the effects of trauma on homeless individuals and families, discuss trauma-informed care as a healing approach, and examine the impact of homelessness on both those directly affected and society as a whole. Homelessness is an intractable social problem for which there are no easy solutions. Many factors contribute to the onset, duration, and type of homelessness amongst individuals of all ages. Homelessness, at its core, signifies the profound loss of not just a home but also community, stability, safety, and vital social connections. The demographic landscape of people experiencing homelessness reveals a nuanced and pressing reality in our society. This population is increasingly younger, with a notable rise in women with children, youth, and people of color facing these challenges. [ii; v]

S:US’ goal and vision is to eradicate chronic homelessness and keep New Yorkers healthy. Many advocates for the homeless argue that to effectively eliminate homelessness, we need to increase the availability of supportive housing, provide government-subsidized vouchers, and boost the supply of affordable permanent housing. Additionally, it is essential to offer wraparound services once participants transition from shelters to permanent housing to help prevent them from returning to the shelter system. The trauma associated with homelessness can be particularly severe for young children and families living in shelters. [iv]

Understanding Trauma-Informed Care (TIC) for young children and families in our shelters involves more than just addressing the trauma experienced by the people we serve. It is a framework that acknowledges the significant impact that trauma can have on an individual. This approach is currently being used in our shelters and various settings and is shifting the mindset from “What’s wrong with you” to What happened to you.” Part of the engagement process is recognizing that service providers must have a complete picture of a person’s life situation, both past and present, to promote effective care. [i]

Trauma-Informed Care (TIC) is not a specific treatment; rather, it is a comprehensive approach to delivering services that incorporates an understanding of trauma into practices, care, and policies. The goal of TIC is to create an environment that is safe, supportive, nurturing, and empowering for both the people served and staff. Understanding TIC as a healing approach in our shelters is crucial for effective service delivery and case management practices. TIC emphasizes the importance of providing a supportive environment that acknowledges and respects the impact of trauma on individuals. [vii]

There are six guiding principles of Trauma-Informed Care, which are essential for effective service delivery to the people we serve.

1. **Safety:** Ensuring the physical and emotional safety of people served and staff by creating a secure environment. This space allows participants to explore and process traumatic memories without the fear of re-traumatization. For example, in our facilities, during the intake process and subsequent interventions, our social services staff meet with a person served in a private setting to conduct a family assessment. Before starting the assessment, the participant is reassured that they are in a safe space. They are informed that if they do not wish to share their past experiences, that is perfectly okay. As they become more familiar with the shelter system and begin their emotional healing, they are encouraged to open up, knowing they can talk about their past and present situations in a safe environment. [v; vii]

2. **Trustworthiness and Transparency:** Staff build trust by communicating consistently and calmly. Establishing consistent boundaries is essential for fostering a trusting relationship. Trustworthiness and transparency are fundamental to our approach. Our staff is dedicated to applying these guiding principles when counseling people served. We communicate clearly and proactively to ensure that they understand the information shared with them. If clarification is needed, we reiterate key points to provide complete clarity. For example, one of the tasks assigned to a participant is to open a public assistance case. Our staff guides them through the process and provides counseling on how to create an account on the public assistance portal. [vi]

3. **Empowerment and Choice:** This principle empowers trauma survivors by emphasizing their strengths, providing them with choices in decision-making, and encouraging their active participation in achieving goals. Trauma survivors may experience a sense of powerlessness. To address this, staff facilitate empowerment by incorporating the voices of the people they serve in the Independent Living Plan (ILP) and encouraging them to share their opinions on the activities they participate in. For example, in our shelters, we prioritize empowering people served to take an active role in crafting their own housing plans. They have the freedom to choose the borough they wish to live in or explore options outside of the five boroughs. Our approach to case management is rooted in a participant-driven model, which fosters collaboration and personal growth. This participant-driven strategy transforms the relationship between staff and the people we serve. Staff recognize that each person is a valuable participant who understands their own needs and aspirations. This collaborative spirit enhances their autonomy in making informed housing choices. In contrast, in a provider-driven model, individuals may be seen as problems to be solved, leading to a focus on

see Trauma-Informed Care on page 26

How to Talk to Your Kids About Cyberbullying

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

While bullying is an act of intentional aggression carried out repeatedly over time and occurring within a relationship characterized by an imbalance of power (Center for the Study and Prevention of Violence, 2008), cyberbullying is threatening or hurtful messages or images being sent using an electronic device (e.g., cell phone, computer). Because it is often done indirectly or anonymously, cyberbullying is less visible to external parties and often difficult for adults to detect and address such behavior (Nansel et al., 2001). The challenge for parents is to know when their child is being cyberbullied and what to look out for.

Cyberbullying is a type of bullying that takes place over digital devices like cell phones, computers, and tablets. Cyberbullying can occur through SMS, Text, and apps, or online in social media, forums, or gaming where people can view, participate in, or share content. Cyberbullying includes sending, posting, or sharing negative, harmful, false, or personal/private information content about someone else, causing embarrassment or humiliation. Some cyberbullying crosses the line into unlawful or criminal behavior (stopbullying.gov).

Those who are cyberbullied are also likely to be bullied offline (Hamm, Newton, & Chisholm, 2015). Cyberbullying can result in serious emotional problems for victims, including depression, anger, and sadness. Those who are targeted by cyberbullying also reveal that they are often afraid or embarrassed to go to school. Research shows long-term consequences that include lower self-esteem, poor academic achievement, and poor psychosocial adjustment as adults. Victims of bullying report more severe anxiety symptoms than others, including social anxiety, depression, low self-esteem, and suicidal ideation (Shetgiri R., 2013).

Because cyberbullying can occur anonymously, cyberbullies can act more aggressively as they assume there will be no consequences. In face-to-face bullying, the bully can view the impact as the attack happens, whereas cyberbullies cannot see any of the immediate outcomes, often resulting in further aggression (Kowalski, Giumetti, Schroeder, & Lattanner, 2014). Motivations behind cyberbullying include a lack of confidence or desire to feel better about themselves, a desire for control, finding it entertaining, and retaliation (Hamm, Newton, & Chisholm, 2015). Those who cyberbully are more likely to have anxiety, depression, less life satisfaction, less self-esteem, and face drug and alcohol abuse (Kowalski, Giumetti, Schroeder, & Lattanner, 2014).

Signs of Cyberbullying

Some youth may be too embarrassed or ashamed to talk to their parents if they are being cyberbullied, and parents may not always recognize when it's happening to their child. However, one should be mindful of the following warning signs (Stop Bullying, 2021).

- Watch out for increases or decreases in device use, including texting.
- Your child exhibits hyper-emotional responses (laughter, anger, upset) to what is happening on their device, hides their screen or device when others are near, and avoids discussion about what they are doing.
- Social media accounts are shut down, or new ones appear.
- Your child starts to avoid social situations, even those that were enjoyed in the past, or becomes withdrawn or depressed, and loses interest in people and activities, especially if you see declining grades, loss of interest in schoolwork, or not wanting to go to school.

What Can Parents Do

The digital world is constantly evolving with new social media platforms, apps, and devices, and children and teens are often the first to use them. As a parent, you want to be *proactive* rather than *reactive* to ensure that your child is safe by keeping the lines of communication open and listening to their concerns. We can start by talking about what cyberbullying is and how to stand up to it safely (Understood.org, 2025). Dedicate time to understand what devices, apps, and technology your child is using. Work with them to decide who can see their profile, send direct messages, or comment on their posts by adjusting the account privacy settings. Keep technology out of your child's bedroom where it can be used without supervision, and use a cell phone contract to help manage your child's technology use.

If you know your child is experiencing cyberbullying, here are some helpful practices to keep in mind when discussing. Cyberbullies often want to get a reaction; the best response is none - don't let them know their plans have worked. Sign off the computer to ignore attacks and walk away from it. If they get mean messages, take the person off their buddy or friends list. If the harassment continues, save the evidence. This could be important proof to show parents or teachers if the bullying doesn't stop (Child Mind, 2025). Just as we *child-proof* our homes with toddlers, we need to *bully-proof* their sense of self – what *they like* is what matters, not what someone else says about them. This prevents the cycle of negative self-talk that can happen in adulthood. We need our children to understand that they don't have to feel *any less* because of what someone says or what they think.

When you feel your child needs more intensive interventions, mental health agencies like the New York Psychotherapy and Counseling Center (NYPCC) can support both you and your child. NYPCC has been a pioneer in addressing bullying, establishing the first anti-bullying coalition (ABC) in the Bronx in 2018 to create awareness of the signs of bullying, help children and parents learn strategies to address the problem, and connect families with support resources. 20% of people who have been bullied experience some kind of mental health problems later in life. These can range from Post Traumatic Stress Disorder (PTSD) to inexplicable bouts of anger to a lifetime of feeling inferior to other people (Shetgiri R., 2013). Trained therapists can address feelings of depression, anxiety, or

see Cyberbullying on page 39

Transcranial Magnetic Stimulation (TMS) for Teens: A Breakthrough Treatment for Adolescent Depression

By Chuck Weber, DO
Founder and Chief Medical Officer
Family Care Center

Adolescence is a critical time for emotional and mental development. During this period, a variety of factors influence mental well-being, including family dynamics, peer relationships, school environments, and community support. Positive connections with others promote resilience, while struggles such as bullying, social media, perceived isolation, or family conflict can contribute to mental health challenges.

Depression, in particular, poses significant challenges during adolescence, with Major Depressive Disorder (MDD) affecting up to five million U.S. teens aged 12-17. Alarmingly, research shows that 30–50% of these adolescents do not respond well to traditional treatments, which can result in long-term consequences.

Given the impact depression can have on academic performance, social relationships, and overall well-being, finding effective and accessible treatment options is essential.

The FDA Approval of Transcranial Magnetic Stimulation (TMS) for Adolescents

The FDA recently approved TMS as a treatment for MDD in adolescents aged 15-21, expanding its previous approval for individuals 18 and older. This provides a promising option for teens who have not responded to antidepressants or psychotherapy alone.

While TMS has shown great promise, it is most effective when used alongside other treatments, including talk therapy and appropriate use of medication. Selective serotonin reuptake inhibitors (SSRIs) are typically the first-line treatment for pediatric depression and anxiety. For teens with treatment-resistant depression, TMS can serve as an additional therapy to enhance the effectiveness of their ongoing medication and therapy regimen.

How TMS Works

TMS is a non-invasive treatment that uses magnetic stimulation to target specific areas of the brain. It primarily focuses on the left dorsolateral prefrontal cortex (DLPFC), which plays a crucial role in the regulation of mood and behavior in depression.

Typically, a full course of TMS involves 30 sessions, administered five days per week over a six-week period. Each session lasts around 20-40 minutes, depending on the patient's needs.

A thorough assessment is conducted, including TMS mapping, to personalize the treatment. Mapping determines the ideal intensity, frequency, and placement of the magnetic pulses for each individual. Once mapping is complete, patients begin their scheduled sessions.

During sessions, electromagnetic coils are positioned on the scalp, delivering targeted magnetic pulses to stimulate the brain and help "reset" the neural activity linked to depression. The non-invasive nature of TMS means that patients can undergo treatment without significant disruption to their daily lives, making it a convenient option for teens who continue their usual activities, like school, athletics, and social engagements, while undergoing TMS.

Diagnosis and Assessments for TMS

Before beginning TMS, health care providers typically use validated screening tools like the Patient Health Questionnaire-Adolescent (PHQ-A). This questionnaire is specifically designed to assess the depth of depression in adolescents, capturing critical aspects such as specific suicidal ideation and planning that may not be addressed by the standard depression questionnaire for adults. By using the adolescent-specific screening tool, clinicians can more accurately assess the severity of depression and determine whether TMS is appropriate.

Benefits of TMS for Adolescents

TMS offers several key advantages for teens, especially for those who struggle with the side effects of medication or have difficulty adhering to treatment regimens:

- **Non-Invasive:** TMS doesn't require surgery or systemic medications, making it a less intimidating option for teens, and is strictly an outpatient procedure.
- **Minimal Side Effects:** Most teens experience only mild discomfort during or immediately after the initial treatment(s), which typically resolves quickly and does not interfere with daily life.
- **Outpatient Convenience:** Teens can continue their daily routines, including school and extracurricular activities, without significant disruption, making it easier to stay engaged socially and academically.
- **Improved Emotional Regulation:** By enhancing brain function, TMS helps adolescents better manage mood swings, reduce impulsivity, and improve decision-making skills.
- **Long-Term Benefits:** Unlike some treatments that offer only short-term relief, TMS has been shown to produce lasting improvements in mental health and overall quality of life for many patients.
- **Improved Quality of Life:** Since anxiety disorders frequently co-occur with depression in adolescence, targeted TMS treatment can improve overall well-being by addressing both conditions simultaneously.

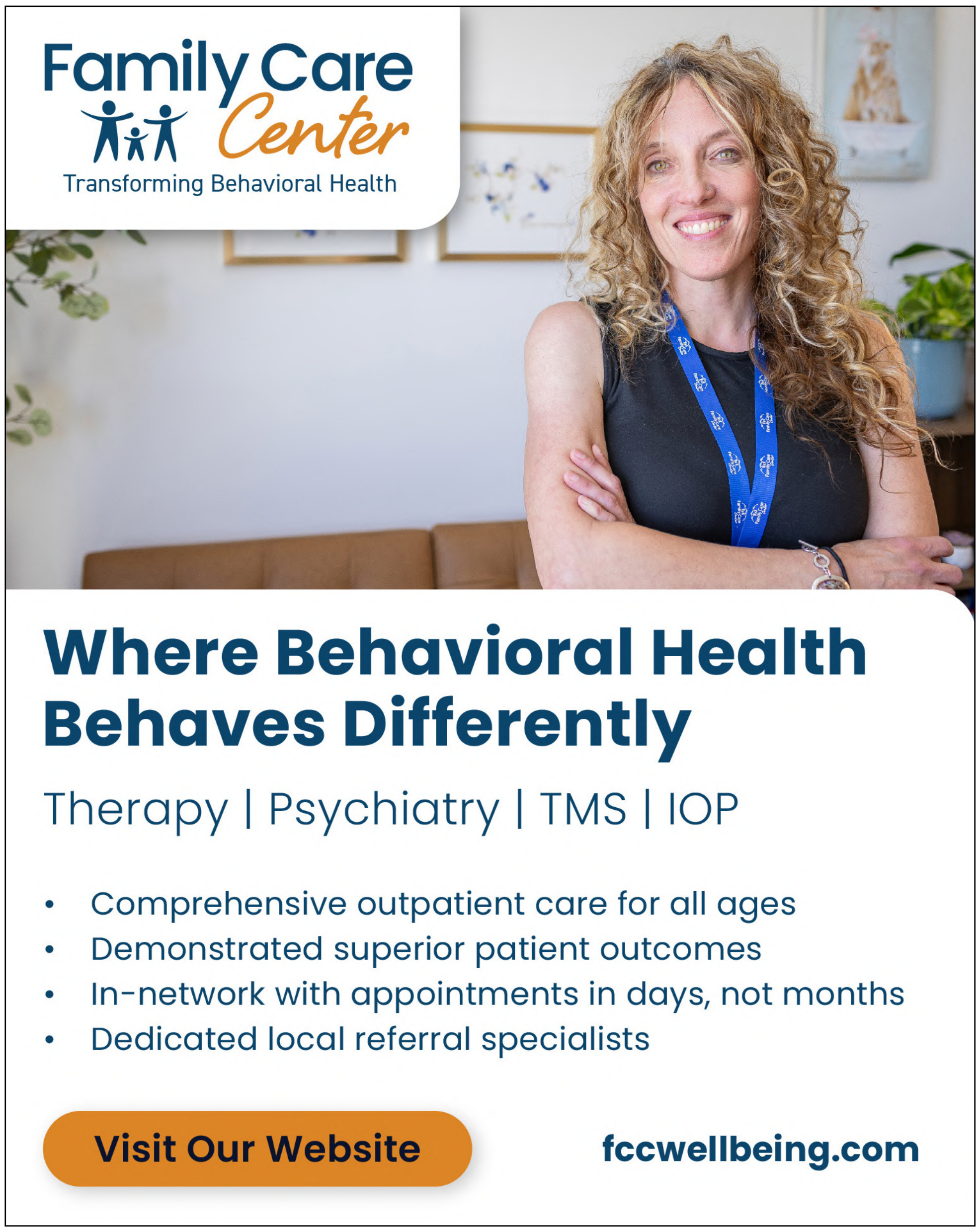
Efficacy of TMS for Teens

Over the past few years, increasing evidence has supported the use of TMS to treat depression and anxiety in adolescents. In March 2024, the FDA granted clearance for repetitive TMS (rTMS) as an adjunctive treatment for teens with depression. This approval was based on a large study of more than a thousand adolescents with depression.

- In this study, 59% of patients who completed at least 20 TMS sessions showed significant improvement in their symptoms, and 36% achieved remission. Many patients that achieve remission can reduce their medications.
- Additionally, a strong correlation was found between reductions in depression and anxiety symptoms, emphasizing the broader therapeutic impact of TMS.

Other studies have also confirmed the effectiveness of TMS for treating depression in adolescents (Qiu et al., Zhang et al., 2019).

see TMS for Teens on page 38



A Dual Crisis:
Understanding the Rise in Youth Suicide and Substance Use Disorders

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

As a psychiatrist and parent of two teenage boys, youth health and wellbeing are critically important to me, both professionally and personally.

I am deeply concerned about the increasing prevalence and complexity of co-occurring disorders in youth, where mental health disorders coexist with substance use disorders (SUD), underscoring the critical need for more effective interventions and treatment strategies.[1] We are seeing a rising incidence of youth suicide and overdose deaths—these primarily driven by opioids—all exacerbated by the COVID-19 pandemic, the impact of social media (bullying and body image issues), stigma, and inadequate access to specialized services and treatment options.

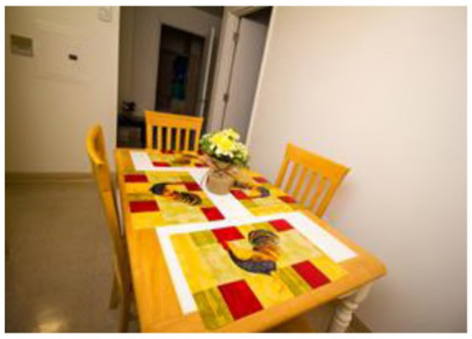
Research has shown that adolescence is a vulnerable period for the onset of mental health and substance use disorder, with significant correlation and influence between poor mental health, suicidality, and substance misuse/use among youth.[2] For example, adolescents may use substances as a maladaptive way to cope with the symptoms of a mental health disorder, only to find that the substance misuse/use amplifies their emotional and psychological challenges. In adolescents, these risks can disrupt social and developmental progress (young people are still developing critical coping and decision-making skills), at times leading to poor academic performance, strained family relationships, and increased social isolation. Ultimately, these are impacted by the challenges in accessing effective treatment—in 2023, only 1 in 5 adolescents with a substance use disorder received treatment for their condition in the past year.[3]

Additionally, the overdose epidemic has deeply affected adolescents, often within their own homes—a recent study showed that more than 321,000 US children lost a parent to drug overdose between 2011 and 2021.[4] Additionally, Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 1 in 8 children aged 17 or younger live with at least one parent with an SUD.[5] These conditions potentially increase the risk for abuse, neglect, mental health conditions, and substance use disorders.[6] Despite these serious impacts, we still don't have a robust body of adolescent-specific research, which hampers the development of effective interventions aimed at adolescents at risk.[7]

The 2023 Youth Risk Behavior Survey[8] among US high school students highlights several concerning trends[9]:

- 40% persistent feelings of sadness or hopelessness in the past year.
- 20% seriously considering attempting suicide in the past year.
- 16% making a suicide plan in the past year.
- 9% attempting suicide in the past year.
- 22% drinking alcohol in the past 30 days.
- 17% using marijuana in the past 30 days.
- 4% misusing prescription pain medication in the past 30 days.

see Youth Suicide on page 40



Supporting Adolescents in Eating Disorder Treatment: The Impact of Family Involvement

By Jillian Lampert, PhD, MPH, RD, LD, FAED, Vice President of Communications and Brand
Accanto Health

For mental health professionals and those invested in behavioral health, understanding the role of family in eating disorder treatment is essential. All eating disorder treatment patients benefit from, and most often require, a personalized and multi-faceted approach to care where clinical interventions lay the foundation for recovery and family involvement provides essential reinforcement. While clinicians provide therapeutic guidance, families serve as a daily source of support and stability.

Eating disorders are complex mental health conditions that require specialized intervention. Before patients themselves, family members may notice changes in their loved one's eating habits, exercise routines, moods and emotions, or general wellbeing. For some, they may push food around their plate, orient their days or conversations around food/exercise, or avoid eating around others altogether. For family members, these and similar behaviors are often unsettling, and addressing them can feel daunting.

Families may worry about upsetting their loved ones or damaging their relationship. However, familial support, empathy, and guidance are essential in helping them take the necessary steps toward recovery. Families can play a crucial role in helping their loved ones seek out and identify the treatment they need —care that goes beyond what general therapy or primary care can provide. Early intervention is key, as eating disorder behaviors become increasingly entrenched over time, making recovery more difficult. Connecting loved ones with appropriate treatment as soon as concerns arise can lead to better outcomes.

Preparing for the Challenges of Treatment

Beginning treatment can be a complex emotional experience for anyone suffering from an eating disorder. The anticipation of confronting their condition may trigger heightened anxiety, distress, or resistance. Some patients may be angry, fearful, or sad, while others may feel a sense of relief knowing they are finally getting the help they need. All of these emotions are normal.

Family members offer reassurance and stability. Checking in with their loved ones about their emotions and reinforcing the value of treatment can be helpful. The structure of treatment—including therapy, nutritional education and meal planning, medical and psychiatric support, and education for the family—creates a path toward healing.

Providing Support During Treatment

Educating families about eating disorders is an essential first step in fostering a supportive environment. To ensure a successful recovery, a patient's support system (most often, their family) requires an understanding of the complexities of these illnesses in order to offer informed and compassionate support and avoid any missteps or counterproductivity which might set back treatment and recovery.

It is critical for all family – spouses, siblings, parents, children, caregivers, extended family, etc. – to be mindful of language and behaviors around food, bodies, and even seemingly mundane related subjects like diets, workout trends, or commentary on anyone else's body (i.e., celebrity weight loss). Everyone – especially family members of eating disorder patients – should avoid commenting on others' appearance or eating habits, even if the intent is positive. Statements like, "You look so much healthier now," or "I'm glad you ate all your food," or anything related to food and/or body can be heard differently than you intended. Instead, parents and caregivers should focus on their overall well-being by expressing sentiments such as, "I'm proud of you" or "I love you no matter what."

Throughout treatment, patients will face a number of doubts, worries, and concerns that they will rely on their support system to work through. For families, the approach is to address these concerns from a place of love and unconditional support.

A common sentiment in individuals struggling with an eating disorder is "I'm fine." For many prospective patients, extra support from a loved one is required to take that first step to get help as well as follow through with treatment. For families, it's important to address the "I'm fine" myth head-on, reassuring their loved ones that seeking treatment does not make them any less capable, strong, or worthy of love. They've done nothing "wrong;" rather, they have an illness that requires medical attention.

In times of doubt, when faced with questions about the "right time" to seek treatment, it is critical for families to seek help early and manage concerns about external factors like work or school like they would with any other serious illness.

Finally, it is important that families refrain from comparing their loved one's recovery to others' experiences. Each person's journey is unique, and progress may look different for everyone. They should avoid making assumptions about their child's recovery based on outward behaviors—checking in with them rather than presuming how they feel is more effective.

When in doubt, just ask. As a family member, you may not have all the answers. Your loved one may not either, but together, a dynamic of open communication and support **is** possible. The bottom line? Be the person they can say anything to without judgment or shame.

Practical Ways to Support a Child in Treatment

1. **Encourage specialized treatment from the start.** Early intervention is key in eating disorder recovery. Family members can provide the needed support for patients to take the first steps toward recovery and help them navigate the process of seeking out specialized treatment beyond primary care or generalized therapy. Eating disorders require targeted, multidisciplinary care, and the sooner a patient enters an appropriate program, the better their prognosis.

2. **Help ease their transition.** Treatment settings, whether residential, day programming or outpatient, can feel unfamiliar and intimidating. If possible, assist with adjusting to their new routine by providing transportation, visiting, sending supportive messages, or helping assume some of their regular responsibilities like pet or child care.

3. **Ask what support they need.** Regularly

see Eating Disorder on page 26

NYSPA Report: Measurement-Based Care - One Piece of the Puzzle in Ensuring Quality Care and Addressing the Crisis in Children’s Mental Health

By Cathryn A. Galanter, MD
Stony Brook University

We are all painfully aware of the children’s mental health crisis (Office of the Surgeon General, 2021). It has affected our children, adolescents, young adults, and their family members. It also impacts those of us who interact with children through our work: the mental health professionals, of which there are not enough, the pediatricians, many of whom are now developing greater expertise to assess and treat mild to moderate mental health conditions, and the teachers, who spend their days with children and may feel ill-equipped to address all of their social and emotional needs.

There is not a quick fix to solving this crisis and it will take a multi-pronged approach. I direct a Division of Child and Adolescent Psychiatry at an Academic Medical Center. I am fortunate to work in an environment with teams that provide children and adolescents with outstanding evidence-based care. Unfortunately, there are not enough of us to serve all the children that need help in our community. In response to that need, we work to expand our reach. We train the next generation of clinicians through psychiatric residencies and fellowships, nurse practitioner schools and residencies, and psychology and social work internships. We conduct research to better understand the mechanisms of disease. We have also developed models to collaborate with other professionals, such as pediatricians, who have learned that they can screen, assess, treat, and refer when needed. We are also expanding our school mental health partnerships by adding to our long-standing school program that provides specialty evaluations for children with complex needs. We will be adding programming to provide a tiered system of care, which will provide school staff with education about mental health and wellbeing to enhance the school environment and targeted interventions (consultation, assessment, brief treatment, and referral for students) for students with greater needs.

The Crisis challenges us to develop creative ways to increase access to youth mental health care. As we increase access, we must also ensure quality. Accordingly, there has been a move to use evidence-informed rating scales to support clinical decision-making. Rating scales are an efficient way to identify and track symptoms in a standard fashion, but they are not meant to be diagnostic or to replace a clinical interview. They can be used to screen and also support clinical decision-making and have been used to support measurement-based care (MBC), an evidence based clinical practice to improve the quality of mental healthcare quality. Symptoms are identified with a patient-reported outcome measure through routine screening or as part of a more in-depth assessment. The measure, or rating scale, is repeated throughout the course of treatment to inform clinical next steps. MBC has been implemented in primary care settings (Sarvet, 2020), is recommended as part of school mental health programming (Connors and Hoover, 2025) and can be used in varied psychotherapeutic settings to optimize child psychotherapy. Evidence on the efficacy of MBC is growing. While there is more data on MBC in adults, a meta-analysis showed that the impact on children and

see Measurement-Based on page 55

Empowering Families, Supporting Youth: CEC Health Care's Comprehensive Behavioral Health Model in Glen Cove

By Erin Barrett, LCAT
Assistant Director of Children and Adolescent Services
CEC Health Care

CEC Health Care in Glen Cove, NY, offers comprehensive behavioral health services to children through an integrated approach, combining resources from the CEC Article 31 (OMH) Clinic, Certified Community Behavioral Health Clinic (CCBHC), and the Community Mental Health Promotion and Support (COMHPS) program. This integrated model addresses the diverse needs of children and their families, covering mental health, trauma, and social well-being. The site also houses a Federally Qualified Health Center (FQHC), providing primary medical care, making it easier for families to access coordinated, comprehensive healthcare in one location. CEC's integrated approach enhances the overall patient experience, ensuring seamless, holistic care.

A Community Needs Assessment: Identifying Gaps in Services

In 2023, the CEC CCBHC conducted a Behavioral Health Needs Assessment in the Glen Cove community, revealing a significant gap in youth mental health services, with no current capacity in the area to meet the growing demand for treatment. Interviews with local schools reported being overwhelmed by issues like homelessness, suicidal ideation, and school avoidance. With 1 in 5 children in the U.S. experiencing mental health disorders and 60% lacking care, the need for services like those provided by CEC Health Care is critical (National Alliance on Mental Illness, 2021).

Furthermore, the needs assessment highlighted Glen Cove's demographic diversity, with 30% of the population being foreign-born, primarily Spanish-speaking. Many of the children had experienced trauma both in their home countries and during their migration to the United States. These children face additional challenges related to mental health, as studies show that immigrants, particularly refugees, have higher rates of post-traumatic stress disorder (PTSD) and anxiety (American Psychological Association, 2019). These findings emphasized the urgent need for mental health services that were not only accessible but also culturally competent.

Expanding Access to Care in January 2024

In response to these pressing needs, CEC Health Care's OMH Clinic in Glen Cove began providing mental health treatment to children aged 6 and older in January 2024. The clinic's team was carefully assembled, including bilingual mental health counselors, social workers, creative arts therapists, a child psychiatrist, and psychiatric nurse practitioners, all with prior experience in working with youth. This multidisciplinary team is able to address a wide range of concerns, such as bullying, depression, anxiety, school avoidance, and trauma. The importance of a multidisciplinary approach to childhood mental health care has been supported by research, which shows that integrating various treatment modalities is essential for addressing the complex needs of children facing mental health challenges (National Institute of Mental Health, 2020).

About 15% of the clinical work, particularly with parents, is conducted in Spanish, ensuring that language barriers are not an impediment to treatment. This approach has been instrumental in providing accessible services to families in need, particularly in a community with a high percentage of Spanish-speaking residents. Research has shown that cultural and language competence in mental health services significantly improves engagement and outcomes for immigrant populations (Chavez et al., 2016).

Family Support: The Role of the Family Peer Advocate

In addition to clinical services, CEC Health Care recognizes the importance of supporting the families of children receiving mental health care. The CCBHC program includes the services of Family Peer Advocates, individuals who have personal experience as caretakers for someone with a mental health or substance use diagnosis. These advocates help parents navigate the complexities of behavioral health treatment, understand the therapeutic process, and prioritize their own well-being alongside that of their children.

The Family Peer Advocate is an additional layer of support that has been invaluable in helping parents feel more empowered and informed as they engage with the mental health system. The importance of family involvement in mental health treatment has been demonstrated in numerous studies, with research showing that parent engagement can significantly improve treatment adherence and outcomes for children (U.S. Department of Health & Human Services, 2021).

Community Outreach and Immigrant Support

The CCBHC's COMHPS team provides mental health outreach and wellness services throughout the Glen Cove community and neighboring school districts. One of the team's primary focuses has been providing special presentations to immigrant youth. A COMHPS staff member, who himself is an immigrant, shares his personal experiences with the children, helping them process their feelings about coming to a new country and the challenges they face. Research on trauma-informed care emphasizes the importance of using peer-led support, particularly for immigrants, as it fosters trust and helps children relate to the material being shared (Lester et al., 2016). Children who participate in these presentations may later be referred to CEC Health Care or other providers for more formal treatment, ensuring that they receive the appropriate care based on their needs.

Additionally, the COMHPS Team recently began scheduling "Art Expressions" at the Nassau County Juvenile Detention Center as a way to allow those youth to express their feelings in a safe environment.

Creative Arts Therapy: Empowering Youth to Express Emotions

In addition, creative arts are utilized in individual therapy sessions, allowing children to express their emotions and build aspirations for the future. These sessions provide an opportunity for youth to explore their trauma in a safe and creative environment. Creative arts therapies are particularly effective for children in processing trauma and expressing emotions in a non-verbal way (Pipher, 2002).

see CEC Health Care on page 42

The Kids Are *Not* Alright: How Seismic Changes in the Childhood Experience Have Undermined the Health of a Generation

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

Our nation's youth are in crisis. Such a sweeping characterization of an entire demographic would ordinarily border on hyperbole, but as Robert F. Kennedy proclaimed when he announced his candidacy for the Presidency nearly 60 years ago, "These are not ordinary times." In October 2021, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association issued a joint statement that declared a National State of Emergency in Children's Mental Health. This declaration enumerated several measures policymakers and governmental authorities must institute to address epidemics of anxiety, depression, suicidality, and associated indications of severe distress now prevalent among children and adolescents. These included increased federal funding to promote evidence-based screening, diagnosis, and treatment services; removal of regulatory barriers to telemedicine and related technologies; promotion of school-based mental healthcare; advancement of trauma-informed care; and creation of career pathways for aspiring child and adolescent behavioral healthcare providers, among others (American Academy of Pediatrics, 2021). This declaration was issued during the peak of the COVID-19 pandemic and partially in response to a precipitous rise in the incidence of mental illness that accompanied it. It should be noted, however, that the decline in child and adolescent mental health began long before the arrival of the novel Coronavirus. An extensive body of academic research has revealed a disconcerting trajectory in youth mental health that began in the post-World War II period and persisted throughout the ensuing decades.

Some investigators suggest the origins of this crisis may be located in sweeping sociocultural upheaval of recent decades that has significantly altered our collective approach to child-rearing. These researchers have examined the correlation between children's loss of unstructured time to engage in activities of their choosing independently of adult involvement and oversight (i.e., "free play") and a decline in their mental health and overall wellbeing, and they have explored potential causal mechanisms underpinning this association (Gray et al., 2023). Chudacoff (2007) documented a continual decline in opportunities for children to engage in free play that began in the mid-1950s as adults exerted increasing control over their activities. Chudacoff's findings are supported by other studies, one of which sought to quantify this decline during the last two decades of the 20th Century. This study elicited parents' reports of their children's activities via surveys administered in 1981 and again in 1997, and it revealed a 25% decrease in time children spent playing during this period. Playtime was replaced by structured activities, most of which entailed the involvement or oversight of adults. That is, between 1981 and 1997, children of the parents surveyed experienced marked increases in the amount of time spent in school, completing schoolwork at home, conversing with others in their homes, and shopping with their parents (Hofferth & Sandberg, 2001). A loss of play time might appear to be a relatively inconsequential development with few, if any, ill effects on children's mental health, but a body of evidence has emerged in recent years to indicate free play has salutary effects on children's happiness and promotes their acquisition of essential life skills and eventual independence. In a comprehensive review of the literature on this subject, Yogman et al. (2018) described key findings on which investigations have converged, all of which affirm the value of free play and suggest its absence might imperil children in ways heretofore unknown to parents and policymakers alike. In summary, the play has been shown to promote safe, stable, and nurturing relationships among participants and to facilitate their cultivation of numerous competencies, particularly within the realm of executive functioning (Milteer & Ginsburg, 2012).

The foregoing findings are aligned with others that have explored the relationship between children's free play and their Locus of Control (LOC). As conceptualized by leading researchers on this subject, individuals with an *external* LOC generally attribute events and circumstances to factors beyond their control, whereas those with an *internal* LOC exhibit a greater sense of agency and empowerment in navigating life's challenges (Gray et al., 2023). A low LOC is predictive of anxiety and depression among children and adults (Sullivan et al., 2017). Conversely, a high LOC is commonly associated with greater self-control, improved self-esteem, and better mental health outcomes overall (Churchill et al., 2020; Buddelmeyer & Powdthavee, 2016). Twenge et al. (2004) documented both a marked increase in the incidence of depression and anxiety among children and adolescents and a decrease in their LOC throughout the second half of the 20th Century. Such an inverse correlation does not constitute evidence of a causal relationship, but when viewed alongside studies described above, it suggests young people have experienced a gradual disempowerment that has compromised their overall health and wellbeing. This trend would be worrisome even in the absence of the sociopolitical and economic upheaval of recent years. The rapid incursion of social media into the lives (and minds) of our youth, widespread environmental degradation, mounting political polarization, and economic volatility represent existential threats to an already fragile generation.

Additional research has explored a general decline in child and adolescent physical health as evidenced by rising rates of obesity and associated ailments among our youth. According to the Centers for Disease Control and Prevention (CDC), approximately 19.7% of Americans between the ages of 2 and 17 are obese. Moreover, in the past three decades, rates of obesity have doubled for children and tripled for adolescents. Obesity significantly increases the risk of hypertension, dyslipidemia, irregularities in glucose metabolism, and other chronic physical health conditions. It is also deleterious to child and adolescent social, behavioral, and emotional wellbeing (Galler et al., 2024). Depression, anxiety, eating disorders, Attention Deficit Hyperactivity Disorder (ADHD), and low self-esteem are common among obese youth (Kalarchian & Marcus, 2012), and some studies have revealed a reciprocal relationship between obesity and certain mental health conditions. For instance, youth with depression are at an increased risk of developing obesity, and obese youth are predisposed to depression (Luppino et al., 2010). These findings suggest interventions designed to promote child and

see Kids are Not Alright on page 51

Breaking the Cycle: How Cultural Competence in Behavioral Health Can Improve Early Intervention for Black and Brown Youth

By Clementina Jose, LMSW
Program Manager
City University of New York

Cultural competence in behavioral health refers to the ability of health care providers to understand, communicate with, and effectively interact with individuals across cultures. It includes being aware of the cultural factors that influence an individual's experiences and worldview, including race, ethnicity, language, and socio-economic status. For Black and Brown youth, culturally competent behavioral health services are vital to ensuring they receive care that respects and acknowledges their cultural backgrounds. This practice also helps reduce misunderstandings and biases that may arise when providers do not account for cultural influences.

Research has shown that cultural competence in mental health services leads to better engagement, trust, and treatment outcomes for minority groups. For instance, when providers recognize and respect cultural differences, youth feel more understood and are more likely to engage in treatment (Sue et al., 2009). This trust can lead to earlier intervention, preventing mental health challenges from escalating into more severe issues later in life. Moreover, cultural competence can foster a sense of empowerment for the youth, making them feel validated in their experiences and less likely to internalize feelings of shame or guilt for seeking help. By promoting these open and supportive interactions, culturally competent care also encourages long-term health-seeking behaviors and a commitment to ongoing treatment.

The Cycle of Disadvantage and Mental Health Challenges

Black and Brown youth often experience a unique set of stressors that can negatively impact their mental health. These include systemic racism, discrimination, poverty, and historical trauma, which can manifest in feelings of alienation and mistrust of authority figures, including healthcare providers. These stressors are compounded by a lack of culturally competent behavioral health professionals, leaving many youths without appropriate care.

The absence of early intervention can perpetuate a cycle where untreated mental health issues lead to academic struggles, behavioral problems, and even involvement with the criminal justice system. According to the American Psychological Association (APA), Black and Brown children are disproportionately affected by mental health challenges but are less likely to receive appropriate care due to a variety of barriers, including lack of access, stigma, and cultural insensitivity (APA, 2021). This cycle continues, further entrenching the inequities they face in life. Addressing these challenges with culturally competent care can help break this cycle, providing youth with the opportunity to thrive academically, socially, and emotionally.

Breaking the Cycle: How Cultural Competence Helps

Cultural competence helps to break this cycle by ensuring that behavioral health providers are equipped with the knowledge and skills necessary to provide services that are sensitive to the cultural needs of

see Cultural Competence on page 42

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

Developments Towards Greater Social-Emotional Support Before and After Birth

By Evelyn Blanck, LCSW,
New York Center for Child Development,
Meg Baier, LMSW,
and Andrew Cleek, PsyD
NYU McSilver Institute

A robust body of interdisciplinary research has converged to show that healthy social-emotional development in pregnancy and the first five years sets the foundation for children's long-term physical and mental health. When problems emerge, it is easier and far more effective to address them when children are young to keep them on track developmentally and to avert longer-term problems. Despite this knowledge, few professionals have access to training on early childhood mental health and development or in providing dyadic relationship-based interventions.

Healthy social-emotional development for infants and toddlers is dependent on the quality and consistency of their relationships with parents and caregivers. To address the mental health needs of infants and young children we need to support the health and mental health of the caregivers and strengthen the parent child dyad through a two-generation focus.

In recognition of this need, in 2016 the New York City Department of Health and Mental Hygiene (NYC DOHMH) funded the Early Childhood Mental Health Network to build the capacity of outpatient clinics located across NYC to address the mental health needs of children birth to 5 years of age, their siblings and their caregivers. A major component of this Network was the funding of a training and technical assistance center to build the capacity and competencies of professionals in family serving systems to identify the social-emotional and mental health needs of young children and their families beginning in the prenatal period.

The New York City Early Childhood Training and Technical Assistance Center (TTAC) is a partnership between the New York Center for Child Development (NYCCD) and the NYU McSilver Institute for Poverty Policy and Research (McSilver). NYCCD has been a major provider of early childhood mental health services in New York, with expertise in informing policy and supporting the field of Early Childhood Mental Health through training and direct practice. McSilver houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), Peer TAC, YTAC (YouthACT Technical Assistance Center), and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation support statewide to all behavioral healthcare providers across NYS.

TTAC integrates NYCCD's core expertise in perinatal and early childhood mental health with McSilver's business and technical support and infrastructure to create a dynamic training center that advances clinical practice and incorporates emerging research knowledge. We also focus on business sustainability and disseminating key knowledge to all those who touch the lives of pregnant persons and young children to ensure that they are mental-health informed. TTAC strives to equip practitioners in licensed mental health clinics, early care and education settings, and other child serving systems with the knowledge and tools they need to support the healthy social emotional development of New York's youngest children.

see TTAC on page 37

How Gen Z Can Lead the Fight Against the Youth Mental Health Crisis

By Marilyn Jacob
Youth Mental Health Director
NAMI-NYC

1 in 5 U.S. children experiences a mental health condition, and suicide is now the second leading cause of death among young people. In New York City, we are facing an unprecedented youth mental health crisis, and the systems in place to address these needs are failing—especially for those from underserved communities. At the same time, the mental health workforce shortage leaves countless young people without access to the care they need. We can't let this continue. It's time to urgently act and provide young people with the tools and support they need to manage their mental health and access professional care.

Prevention is critical to ending the youth mental health crisis. The goal is not to wait until young people are in crisis but to give them the resources they need before they reach that point. That's why NAMI-NYC has launched peer-led mental health programs for teens. Through our Teen Helpline, teens can ask any mental health questions, such as how to find a therapist. At our weekly virtual support group, Connection Corner, teens can share what's on their minds and create community. Who is taking the lead here? Near peers, or young people close in age with lived experience, respond to those Helpline calls and facilitate the support group. As the program grows and matures, we will train teens with the tools and skills to take on this role – teens helping teens.

NAMI-NYC has decades of experience delivering evidence-based peer support programs. These include educational presentations, support groups, family mentoring, and our Helpline—all led by individuals who have lived experience with mental illness. Our team of Board members, staff, and volunteers have faced mental health challenges themselves or supported loved ones through their struggles. We know firsthand how effective peer support is in helping people manage their mental health.

The reality is this: young people are already seeking mental health guidance from their peers, not from adults or traditional mental health professionals. This can either continue unchecked, or we can bring our peer support expertise to meet their needs. NAMI-NYC has the resources to recruit, train, and support youth leaders who will guide their peers to wellness and self-advocacy.

Peer support is not the same as therapy. While Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) are invaluable tools for managing mental health, peer support offers something different. Peer support is built on shared lived experience, where young people can speak openly about their struggles and feel understood by someone who truly "gets it." For all the behavioral health professionals, teachers, guidance counselors, and anyone who works with teens: peer support complements therapy—it does not replace it. It's a critical layer of care that can bridge the gap until young people can access professional services. And unlike self-diagnosis or misinformation on social media, peer support provides accurate, empathetic, and trusted guidance.

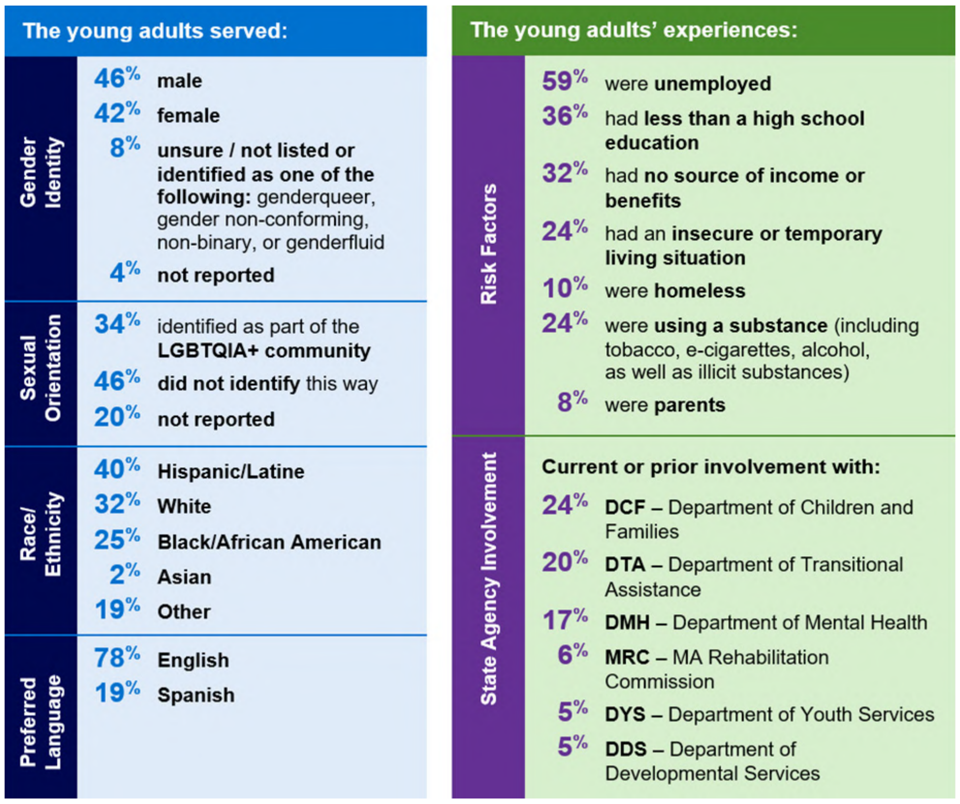
Near-peer volunteers facilitate spaces where young people can share their stories, navigate the mental health system, and advocate for themselves and each other. This isn't just a stopgap—it's an essential service that empowers young people to help themselves and change the mental health system for the better. We must seize this opportunity to train and equip young leaders to support their peers and prevent future harm.

see Gen Z on page 24

Young Adult Access Centers: A Massachusetts Model for Supporting Young Adults with Behavioral Health Challenges

By Holly Swan, Carter Pratt, Michael Vassello, and Gustavo Carvajal, ForHealth Consulting at University of Massachusetts Chan Medical School, Betsy Edes, and Heidi Holland, MA Department of Mental Health

The Massachusetts Department of Mental Health (DMH) Young Adult Access Centers are unique community spaces that serve young adults with mental health and co-occurring behavioral health concerns and support them with their transition to adulthood. These 10 Access Centers are tailored to young people ages 16 to 26, and provide drop-in services, person-centered peer mentoring, and behavioral health assistance without the need for a clinical referral or health insurance. Staff at the Access Centers includes peer mentors who are trained in evidence-based and -informed practices. The areas of support (e.g., employment, personal-effectiveness and well-being) provided by the Access Centers are modeled on the evidence-supported Transition to Independence Process (TIP) Model.[1] With state funding and federal grants, Access Centers are run by community-based agencies in high need areas across the state. All services are free.



The young adults served:

	%	
Gender Identity	46%	**male**
	42%	**female**
	8%	**unsure / not listed or identified as one of the following:** genderqueer, gender non-conforming, non-binary, or genderfluid
	4%	**not reported**
Sexual Orientation	34%	identified as part of the **LGBTQIA+ community**
	46%	**did not identify** this way
	20%	**not reported**
Race/ Ethnicity	40%	**Hispanic/Latine**
	32%	**White**
	25%	**Black/African American**
	2%	**Asian**
	19%	**Other**
Preferred Language	78%	**English**
	19%	**Spanish**

The young adults' experiences:

	%	
Risk Factors	59%	were **unemployed**
	36%	had **less than a high school education**
	32%	had **no source of income or benefits**
	24%	had an **insecure or temporary living situation**
	10%	were **homeless**
	24%	were **using a substance** (including tobacco, e-cigarettes, alcohol, as well as illicit substances)
	8%	were **parents**
State Agency Involvement		**Current or prior involvement with:**
	24%	**DCF** – Department of Children and Families
	20%	**DTA** – Department of Transitional Assistance
	17%	**DMH** – Department of Mental Health
	6%	**MRC** – MA Rehabilitation Commission
	5%	**DYS** – Department of Youth Services
	5%	**DDS** – Department of Developmental Services

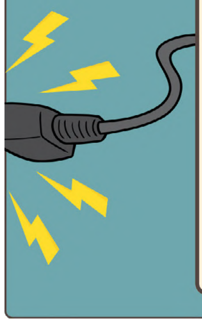
Young adults served by the Access Centers

Young adulthood is when most behavioral health issues emerge, complicating a successful transition to adulthood.[2] Access Centers prioritize young adults with higher risk for behavioral health concerns, particularly when they experience co-occurring substance use concerns, are not actively engaged in services, or experience other significant challenges: transitioning from juvenile justice supervision or foster care; pregnant or parenting; homeless or at risk of homelessness; unemployed or marginally employed; struggling in school or have dropped out; commercially and sexually exploited; are without a caring adult.

The Access Centers are affirming and inclusive spaces that provide:

- Peer mentorship and support from young adults with similar lived experiences.
- Trauma-informed behavioral health services.
- Social activities and a community that offers a culture of belonging, refuge, and opportunities for growth.
- Linkages to needed community services.
- Evidence-supported interventions (e.g., TIP) empower young adults to identify goals and develop and support plans to achieve these goals.
- Amenities and resources to meet basic needs, such as computer and internet

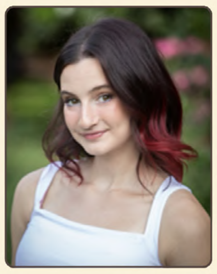
see Access Centers on page 43



TRUTH FROM TODAY'S YOUTH

Plugging into youth discourse to inspire intergenerational connection and spark meaningful social change in mental health.

WRITTEN BY YOUTH, FOR THOSE WHO CARE ABOUT YOUTH.



SOPHIE SZEW

Uplifting Disabled Youth Organizing Online: Interdependence and Activism in Digital Spaces

By Sophie Szew
Youth Mental Health Advocate,
Writer, and Junior,
Stanford University

Young disabled organizing today exists in the context of a deep-rooted tradition of reclaiming oppressive and inaccessible spaces into sites for liberation. The Disability Critical Race Studies (DisCrit) framework, as outlined by Stanford scholar Dr. Subhni Ammana, posits that racialization is a disabling force. Thus, the social constructions of race and disability are deeply intertwined. This position acts of resistance and organizing that have taken place in carceral spaces, including ghettos, concentration camps, and prison cells, as acts of disability justice.

It is this history of resistance–through organizing, fighting, caregiving, reconnection with decolonial traditions, and often even mere survival–that provides the foundation for disabled youth to combat systems of oppression and advocate for accessibility through the reclamation of the very spaces that often exclude them. The story of the reclamation of an inaccessible structure to advance inclusion is documented in the critically acclaimed documentary Crip Camp, which tells the story of a group of disabled youth who organized an accessible summer camp in 1968. Campers and counselors worked together to ensure everyone's accessibility needs were met, creating a radically inclusive haven. It was a glimpse into the possibility of a more just future for disabled youth, and it stood as proof that it is indeed possible to change society to allow disabled young people to participate in the activities they were systematically excluded from. The modes of communal care and interdependence practiced at Crip Camp, from collective decision-making to inclusive art-creation to the centering of mental well-being, all have roots that trace back to the resistance, survival, and decolonial traditions of the racialized and disabled communities most harmed by the systems of ableism and white supremacy that reify the power-hierarchies in place today—the root cause behind the chronic inaccessibility that continues to plague society.

Many former campers featured in Crip Camp went on to engage in other reclamatory acts of organizing: blocking off inaccessible New York City streets with wheelchairs or occupying state and national capitals to advocate for the passage of legislation like Section 504 and the Americans With Disabilities Act. All of these demonstrations took inaccessible elements of society—summer camps, streets, and buildings—and reclaimed them as sites for liberation. Structures that were once staunch reminders of systemic oppression became sites for collectivization and empowerment to address the factors that perpetuate that oppression in the first place. These actions made the world more just for disabled youth as they led to the enactment of policy change, dissemination of knowledge, and advancement of inclusion via cultural shifts.

Disabled youth today are following suit, adapting their reclamatory disability justice praxis to a world where many structures that define daily life exist in the digital realm. In fact, disabled youth are building communities in virtual spaces to enact change and make *organizing* more accessible. The organizing tactics often used around the world today, from protests to community-building to campaigning, all have foundations in the work of the aforementioned disabled and racialized communities forced into carceral realities. However, this organizing—in an act of cruelly ironic injustice—is often inaccessible. Mass organizing events often pose a risk for immunocompromised members of the disabled community. Marches, teach-ins, and even artistic demonstrations are often inaccessible for those with communication, intellectual processing, and mobility-related disabilities.

Disabled youth are responding by creating radically accessible organizing spaces online. They are moderating virtual panels that include accessibility tools like re-speaking, transcripts, and ASL interpreters. They are leading knowledge dissemination campaigns written in accessible language, building radically inclusive communities, and practicing interdependence and communal care through online forums. They are engaging in communal care and promoting collective mental well-being throughout their organizing efforts.

Additionally, the incorporation of digital modes of communication into already-established organizing networks has allowed disabled youth to contribute to organizing spaces they have long been excluded from. For instance, disabled young people have long lacked recognition in student-led political organizing networks that advocate for the passage of legislation that advances disability justice, such as the High School Democrats of America (HSDA). The coalition was founded in 2005, and its student leaders have supported disability-rights-related policies since its inception, but disabled youth themselves did not have formal decision-making power and representation within HSDA's structure until the disabled caucus was founded in 2024.

As current HSDA disability caucus Communications Director Ariana Zafrin explains, online organizing allows for both the formation of the caucus and the sustainment of its programming. In January of 2025, Zafrin planned, executed, and organized an entirely virtual panel that connected HSDA disability caucus members to mental health policy activists, drawing on previous experiences conducting outreach on social media to connect with panelists, circulate promotional materials, engage in the coordination and community-building necessary to conduct the event and extend the conversations about the interconnectedness of mental health and disability justice into ongoing organizing efforts.

Zafrin also shared that online advocacy spaces have provided her with access to the framework and language of disability justice itself; she has found representation of otherwise-isolating experiences, and this has empowered her to continue to work relentlessly to make the world a better place for her generation. It is absolutely essential to collaborate intergenerationally to protect and uplift access to these digital organizing spaces and allow youth like those at the helm of the HSDA Disability Caucus to continue to have a voice in youth leadership. Young disabled organizers have been the charge for social justice throughout history, and virtual platforms will allow them to continue to do so in an increasingly digitized future.

Sophie Szew (she/they) is a youth mental health advocate, writer, and Junior at Stanford University. She was appointed by the Secretary of Health and Human Services to advise the federal government on mental health policy as the youngest member of the Substance Abuse and Mental Health Services Administration (SAMHSA) National Advisory Council. Sophie's storytelling first gained national recognition during the MTV Mental Health Action Forum at the White House, where she met with President Biden and his administration to advocate for systemic mental healthcare justice. Sophie's lived experience, expertise, and activism have also led them to advise numerous organizations on youth mental health issues, including Mental Health America, Born This Way Foundation, the National Alliance on Mental Illness, and Project Unloaded. In March of 2023, she testified in front of the California State Senate about the need to hold social media platforms accountable for harming youth, and since her social media advocacy has been covered by the Today Show, the LA Times, NBC, CBS News, and has landed her a spot on the 2025 Forbes 30 Under 30 Social Media List. Sophie combines her calls for policy change with poetic storytelling, serving as the inaugural poet for LA Mayor Karen Bass.

The Impact of Social Media on Youth Mental Health: Risks, Benefits, and Family Approaches

By Elizabeth Callahan, MA, BCBA
Board-Certified Behavior Analyst
Behavior Therapy Associates

In recent years, the conversation around social media and youth mental health has become urgent and deeply personal for many families. Parents are increasingly wary of the role smartphones and social media play in their children's lives, fueled by the spotlight on growing evidence linking excessive screen time to rising rates of anxiety, depression, and declining attention spans (Twenge et al., 2018). Bestsellers like Jonathan Haidt's *The Anxious Generation*, initiatives such as Wait Until 8th for social media adoption, and school districts debating cell phone bans reflect a growing societal reckoning with how digital engagement impacts adolescent well-being. At the same time, social media offers benefits that cannot be ignored—it provides community, educational resources, and mental health support, particularly for marginalized youth (Naslund et al., 2020). Understanding this complex relationship requires a thoughtful approach, balancing risks with opportunities while equipping families with strategies to navigate the digital landscape effectively.

The Risks of Social Media on Youth Mental Health

Experts from the U.S. Surgeon General's office, the American Psychological Association (APA), and the American Academy of Pediatrics (AAP) have all raised concerns about the potential harm excessive or unregulated social media use can pose to youth. Research increasingly points to negative psychological, developmental, and neurological effects, with certain populations—such as BIPOC and LGBTQIA+ youth—experiencing unique vulnerabilities (Anderson & Jiang, 2018).

Mental Health Challenges

Numerous studies have linked excessive social media use with heightened anxiety and depression among adolescents (Keles et al., 2020). The definition of "excessive" social media use varies across studies, but it is generally characterized by the volume of daily screen time (often exceeding 3–4 hours). However, other definitions focus on behavioral patterns, such as difficulty controlling use, compulsive, or problematic use that interferes with daily life (e.g., neglecting responsibilities or experiencing distress when unable to access social media).

The mechanisms behind these associations include disrupted sleep, increased social comparison, and exposure to cyberbullying (Orben et al., 2019). Adolescents who spend more than three hours per day on social media are at a significantly higher risk for mental health issues compared to their peers who engage less frequently (Abi-Jaoude et al., 2020).

Sleep Disruption

Adolescents who use social media before bedtime often experience sleep disturbances, as the blue light emitted from screens interferes with melatonin production, delaying sleep onset and reducing overall sleep quality (Leone & Sigman, 2020). This, in turn, can contribute to emotional dysregulation, increased stress, and poor

see Social Media on page 44

Supporting Childhood Behavior: Early Strategies for Success

By Jeniffer Cruz, PhD, NCSP
Licensed Psychologist
Behavior Therapy Associates

Behavioral disorders in childhood can be challenging for families and school professionals and can have lasting negative effects on wellbeing if left untreated. The 2021-2022 National Survey of Children's Health showed that 7% of children between 3 and 17 years old had been diagnosed with behavioral disorders. Common disorders diagnosed during childhood include Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, and Oppositional Defiant Disorder. Presenting concerns often associated with these disorders include refusing to follow directions, arguing with authority figures, and acting impulsively, as well as more severe behaviors such as emotional outbursts and aggressive behavior. These behaviors can lead to stress for caregivers and significant challenges in the school setting. With early identification, there are opportunities to support these children and their caregivers, families, and teachers through education and skill-building to prevent behavior problems from worsening.w

Importance of Early Assessment and Intervention

Before implementing any intervention, a comprehensive assessment should be conducted to establish which interventions will work best. Examining the child's strengths and needs, developmental and medical history, cultural considerations, and family dynamics can offer insight into possible influences on the child's behavior and the most appropriate strategies for behavior management. Understanding the functions of the child's behavior can also help determine what situations may trigger certain behaviors and which preventative and contingency strategies will best meet the function while also increasing positive behavior and reducing negative behavior.

Further, examining school readiness skills can provide key details regarding the child's functioning that can help identify areas where the child may have difficulty. Child factors as they pertain to school readiness include language development, physical well-being, cognitive skills, and social-emotional development. Promoting school readiness through early intervention can have long-term impacts on academic achievement and overall well-being (Williams et al., 2019). Several evidence-based interventions can be used to support children with behavioral disorders. Although the following list is not exhaustive, it includes certain antecedent strategies, consequence strategies, and skills that can be impactful in managing behaviors in many children.

Choices

Increasing opportunities for children to make choices can be a simple yet effective way to avoid significant behavioral issues. Allowing children to make decisions regularly can increase their sense of autonomy. In schools, providing choices during instruction can also increase their engagement (Ennis, Lane, & Flemming, 2021). Choices can be incorporated in several ways, such as during activities (e.g., giving options for what to wear for the day) and between activities (e.g., doing one type of homework first). When giving a child options and choices, it can often avoid power struggles that tend to occur when demands are placed.

Consistency and Predictability

Establishing predictable routines can support children who struggle with behavior,

see Childhood on page 45

Supporting Siblings of Children with Behavioral Needs

**By Bianca Coleman, PhD, NCSP, BCBA-D
and Jeniffer Cruz, PhD, NCSP
Behavior Therapy Associates**

Behavioral health challenges continue to be a pervasive issue that impacts children and their families. According to the 2022-2023 National Survey of Children's Health, over 25% of children aged 3-17 were reported to have mental, emotional, developmental or behavioral problems. Commonly diagnosed conditions in children include Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Autism Spectrum Disorder (ASD). Other internalizing conditions, including anxiety and depression, can also be present in addition to behavioral disorders. These disorders are often characterized by significant challenges that impact individuals and families.

Siblings of individuals with disabilities may be at increased risk for poorer adjustment compared to their peers. For example, siblings of children diagnosed with ADHD tend to have an increased number of mental health challenges compared to typically developing peers who have typically developing siblings (Orm & Fjermestad, 2021). Children with siblings diagnosed with ASD have also been shown to have poorer adjustment outcomes compared to children with typically developing siblings (Meyer, Ingersoll, & Hambrick, 2011). Although there are studies that document negative outcomes, there is research to suggest that there are positive impacts on siblings and sibling relationships when one individual has been diagnosed with a behavioral health condition, especially when there is social support in place (Ferraioli & Harris, 2009; Shivers et al., 2019). Several factors may contribute to future outcomes for these siblings, including the severity of symptoms related to the disorder, sibling coping strategies, amount of social support the individuals and family receives, parental mental health, and level of family communication (Kirchhofer et al., 2022). Fortunately, there are support strategies and interventions to positively impact siblings and their adjustment.

Skills to Bolster

For siblings, increasing skills is critical in supporting their own emotional and behavioral adjustment. Skills to promote independence and involvement within the family can be beneficial; however, it is important to not overwhelm siblings with responsibilities and give them tasks that could put them in a parental role. Capitalizing on a sibling's strengths and interests can be a great way to acknowledge their contributions and unique attributes while also allowing them to feel more involved in family activities. Providing siblings with opportunities to feel a sense of control in their every day lives may be of benefit, particularly when situations arise during which they may have limited control. An example of this could include giving choices and soliciting their input whenever possible throughout the day.

Siblings may also benefit from developing certain social-emotional (SEL) skills to increase their ability to cope with difficulties that may arise. Specific SEL skills that can be fostered include teaching how to ask for help and support when needed and learning to express their emotions in helpful ways. This can be done through individual counseling or support groups for siblings of individuals with disabilities. Caregivers can also facilitate opportunities for open communication so that siblings can ask questions and express their feelings. Additionally, siblings may benefit from the development of their own action

see Siblings on page 46

Gen Z from page 20

Our young people, especially Gen Z, have faced a world of trauma—climate change, school shootings, global unrest, and a pandemic that robbed many of them of important milestones. But despite these challenges, Gen Z is resilient, compassionate, and ready to make a difference. They have the power to transform the mental health landscape, but they need our support to do so.

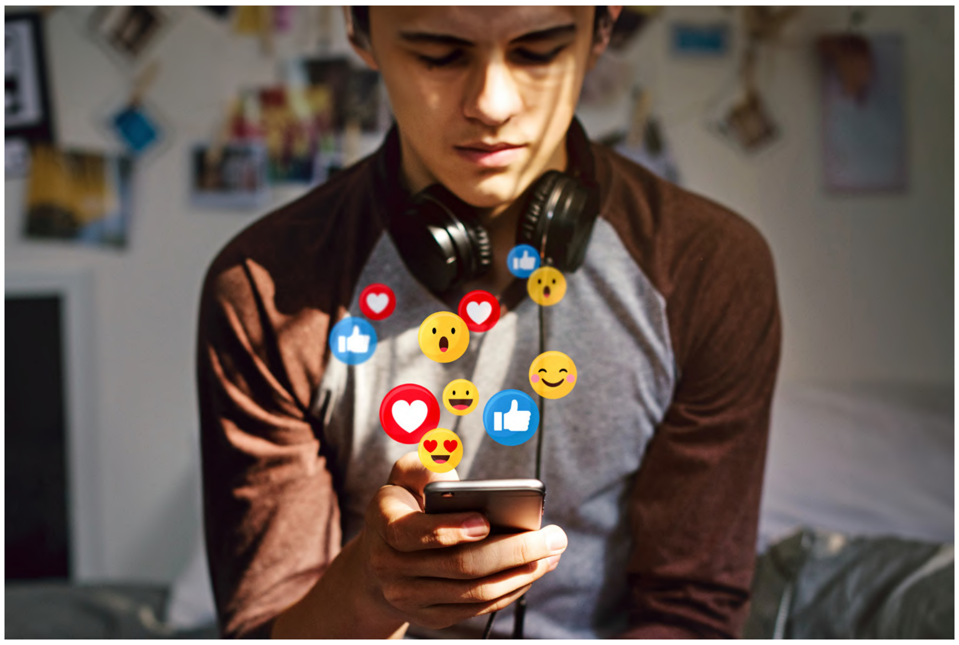
That's why we need your help connecting teens to these peer-based programs. When you refer a young person to our Teen Helpline, we prevent teens from suffering in silence. When properly trained, teens can handle difficult conversations and situations – and they will reap the rewards. Teens deserve support, community, and wellness.

Have your young person, student, client, or patient call NAMI-NYC's Teen Helpline, and let's end this youth mental health crisis now.

Marilyn Jacob is the Youth Mental Health Director at NAMI-NYC. The National Alliance on Mental Illness of New York City has been helping families and individuals affected by mental health challenges for over 40 years. Learn more at: www.naminyc.org/helpline.

Digital Well-Being: Managing Screen Time and Promoting Healthy Tech Habits in Families

By Temitope Fabayo, BA, MBA-HR
President
DMC HomeCare



From setting morning alarms to random late-night scrolling, screens have become our irreplaceable companions in daily life. For work, education, or entertainment, devices take over our routines. Recent Average Screen Time statistics by Exploding Topics show that the average person spends approximately 6 hours and 40 minutes daily glued to the screen.

However, this prolonged screen time comes at a cost, affecting the individual's sleep patterns and mental health. A report by the *National Center for Health Statistics* shows that 50% of teenagers aged 13-17 spend more than 4 hours on the screen connected to the internet, with a significant number of these adolescents experiencing anxiety and depression.

So, how can we tackle these challenges by taking back control over technology and using it mindfully? The good news is that with the help of many strategies, we can still use technology without being addicted to it.

Understanding Digital Well-Being

Digital well-being is maintaining healthy connections between people and a device, thus using it to benefit you rather than consume you. This practice demands mindfulness of asking yourself when, why, and how to engage with a screen in a way that prevents you from distractions, mental stress, and burnout. Being conscious of how you use the screen can make a big difference, resulting in technology helping you rather than taking over.

The Unseen Dangers of Excessive Digital Technology Use

Overusing regular digital devices isn't a minor inconvenience but a real trouble and can adversely affect an individual's health.

We, as adults, show kids how to live. But many of us are always on our phones. We wake up and immediately check our phones.

Kids see this and do the same. They spend too much time on screens, which can cause problems:

- Sadness and anxiety.
- Trouble talking to people face-to-face.
- Health issues, like being overweight or not sleeping well.
- Trouble paying attention in school.

Research published in the *National Library of Medicine* shows the impact of long periods in front of screens, resulting in disrupted sleep cycles and reduced energy levels of students, making them less productive and less academic. The screens that wipe out the blue light stop the body from producing melatonin and make it difficult to get to the path of restful sleep. People in modern society experience more stress and anxiety signs because there is a kind of necessity to stay online and respond in real-time. The social pressure with which people stay online can have adverse effects on their mental health. Thus, people may develop compulsive behaviors as a result.

see Screen Time on page 47

Bridging Cultural Gaps in Child and Adolescent Behavioral Health Services

By Oyindamola Williams, LMSW
Child and Family Therapist
Southwest Community Health Center

Cultural competence in child and adolescent behavioral health is just as essential as it is in mainstream adult services for effective care. According to the American Psychological Association (2021), while ethnic and racial minorities represent 40% of the U.S. population, they make up only about 16% of the psychology workforce. Families of immigrant origin or those from diverse ethnic backgrounds bring unique values, beliefs, and practices, all of which play a significant role in shaping how children engage with behavioral health services. However, cultural competence extends beyond conventional training programs. It must also be embedded in organizational hiring practices. Employing a diverse workforce, one that includes providers who not only speak the language but also share cultural backgrounds with the populations they serve, can significantly improve treatment outcomes (SAMHSA, 2021).

Language Barrier

For immigrant families, language isn't just a tool for communication; it's the key to understanding and being understood. Some children might speak fluent English, but their parents or guardians may not, making it difficult for families to fully engage in treatment. This creates a roadblock in the therapeutic process. When parents cannot fully communicate with the provider or when they have to rely on their child to translate, the therapeutic process suffers. It's not just the clinical details that are lost in translation; important emotional cues and family dynamics might also go unnoticed. The child, already under stress, may feel the added burden of interpreting for their parents, compounding the emotional strain.

But there is hope. Many community health centers are now adopting strategies to bridge these gaps, such as hiring bilingual therapists or offering interpretation services. These simple steps can make a world of difference, not only in ensuring that families feel heard but also in helping them access the support they need.

Cultural Misunderstandings

Cultural norms also play a big role. Parenting styles that work in one culture may seem unfamiliar or even troubling, to a provider who is unaware of the cultural context. What one family considers an acceptable form of discipline could be labeled "abuse" by a provider without the cultural competence to interpret it correctly. In these cases, the gap between a child's needs and the provider's understanding widens, making treatment not only ineffective but also emotionally damaging. In addition to this, a provider might classify a behavior as "resistant" or "defiant" when, in reality, the child is simply following cultural norms that emphasize emotional restraint. Without understanding this cultural difference, a provider might miss the signs of distress, leading to misdiagnosis and further alienation from the very system meant to help.

A Cultural Shift in Behavioral Health

Imagine a scenario where a child walks into a provider's office, but this time, the provider speaks their language, understands their cultural background, and approaches the session with openness and respect. The provider doesn't just provide clinical care; they create a space where the

see Cultural Gaps on page 45

Trauma-Informed Care from page 9

compliance with treatment plans rather than fostering empowerment and support. By embracing a participant-driven approach, we create a supportive environment that encourages growth and self-determination. [iv; v; vi]

4. **Peer Support:** Collaborating and connecting with others in both group and individual settings who have had similar experiences fosters a sense of belonging and validation. This feeling is essential to the healing process. For example, our Peer Specialist facilitates group activities centered on money management and budgeting. These sessions allow people served and staff to explore the concept of budgeting and its personal significance. Participants engage in meaningful discussions about their experiences, sharing valuable insights and strategies for effectively managing their finances and supporting their families, even in the face of various challenges. [vii]

5. **Collaboration and Mutuality:** Communicating with a sense of "doing with" rather than "doing to" is essential. Staff and persons served collaborate to create Independent Living Plans and service plans that help equalize power dynamics, making the participant feel empowered in their healing journey. During the Independent Living Plan (ILP) sessions, the participant's voice is recorded as they develop plans for transitioning from the shelter to permanent housing. The ILP focuses on the person served and is conducted in collaboration with them, fostering a sense of autonomy in their lives. [vii]

Joseph Esheyigba, LMSW, MPA, SIFI

6. **Cultural Sensitivity and Gender Awareness:** Individuals and families seeking shelter often come from marginalized communities and backgrounds. They frequently face discrimination, which can significantly affect their experiences of trauma and their responses to it. Service providers must be aware of these cultural factors and educated on how to address them to effectively support the healing process. Our shelters conduct group sessions focused on cultural awareness, where people served and staff engage in meaningful dialogue about their cultures. These discussions help participants understand how to adapt to their situations, reassuring them that they are not alone. The staff is present to provide guidance and support. [iv; v; vii]

The societal cost of homelessness is significant, as it impacts us all; homeless youth, children, and families are vital threads in the fabric of American culture. We must recognize and address this issue, for their well-being is intertwined with our collective strength and humanity. As dedicated service providers, S:US recognizes the vital importance of adopting Trauma-Informed Care as a transformative approach. This method allows us to deeply understand and effectively deliver therapeutic services, fostering a safe and nurturing environment for the people we serve. By embracing Trauma-Informed Care, we equip them with the skills and support they need to carry forward as they embark on their journey toward permanent housing. At S:US, we are united by a powerful vision: to eradicate chronic homelessness in our society and create a future where everyone has a place to call home. [iv]

Joseph Esheyigba, LMSW, MPA, SIFI, is Vice President of Homeless Services at Services for the UnderServed (S:US).

Footnotes

i. Bogle (2016-01-22) Trauma-informed Care: An Ecological Response (air.org/resource/journal-article/trauma-informed-care-ecological-response). American Institutes for Research. Retrieved 2019-10-13.

ii. Johnson, C & Marcus, L (2021) The Complex link between Homelessness and Mental Health.

iii. Popple, P.R. & Leighninger, L. (1996). Social Work, Social Welfare and American Society, (3rd ed). Boston, MA: Allyn & Bacon.

iv. Ranjbar, Noshene: Erb, Matt; Mohammad, Othman; Moreno, Francisco A (2020-01-01) Trauma Informed Care and Cultural Humility in the Mental Health Care of People from Minoritized Communities (pmc.ncbi.nlm.nih.gov/articles/PMC7011220/)

v. Resher, M.(2017) Facing the Facts. Trauma-Informed Practices in Homeless Intervention Services.

vi. Rose, S.M & Moore, V.L. (1995). Case Management. In R.L. Edwards (Ed-In-Chief), Encyclopedia of Social Work (19th Edition,pp.338). Washington DC: NASW Press.

vii. Swartz, N (2024) The 6 Core Principles of Trauma- Informed Care and their Role in Trauma Therapy.

Crisis Support from page 1

inspiring: A remarkable 81 percent of recipients in 2024 did not require crisis services within a month of their discharge. Participation in this program also helped keep families connected to services, with 87 percent reporting that they remained enrolled in at least one ongoing support.

Home-Based Crisis Intervention also helped clear a path for transitions to less intensive care. About 73 percent of recipients reported being enrolled in stepped down services, including care coordination, a mental health clinic, day treatment, high-fidelity wraparound, and Youth Assertive Community Treatment.

New York is the first state to adopt the successful Assertive Community Treatment model – also known as 'ACT' – to serve youth – from age 10 to young adulthood. Youth ACT teams include mental health clinicians, psychiatric prescribers, youth and family peer advocates, clinical support staff, and a program assistant. Each team offers comprehensive, around-the-clock support seven days a week, with youth and families utilizing these services for between 18 months and two years.

The state now supports 25 Youth ACT teams covering 33 counties. Teams have the capacity to serve between 28 and 36 children, each with significant psychiatric needs and at risk of needing out-of-home placement and intensive interventions. Additional teams are in planning, with the expectation of growing them to 42 statewide shortly.

Additionally, the state is pioneering an innovative care management approach called High Fidelity Wraparound, an evidence-based care management practice model for youth served by multiple systems. This initiative partners youth with significant mental health needs and supportive family members with a single care manager. This can help prevent those helping the child from becoming overwhelmed. There are now 24 locations using the High-Fidelity Wraparound approach, with more than 760 youth served.

These models come at a critical juncture. Youth mental health has been a growing concern, with many considering our state and nation to be at a point of crisis. Increased instances of trauma, anxiety, and mood disorders were only exacerbated by the COVID-19 pandemic. Providers are seeing more self-medication and a general decrease in social-emotional function among children and youth.

All three of these models play a central role in our efforts to care for youth. These services help youth and families in crisis work together in their homes and community to enable the young person to grow and thrive into the future.

Dr. Ann M. Sullivan is Commissioner of the New York State Office of Mental Health.

Eating Disorder from page 14

checking in can help determine how best to help. Patients may have specific requests that improve their comfort during treatment.

1. **Work collaboratively with their treatment team.** Ensuring alignment with the treatment plan is crucial. Families should communicate with providers, ask questions, and stay informed to maintain consistency in support.

2. **Offer a listening ear while supporting recovery goals.** Recovery is physically and emotionally exhausting. Treatment can feel overwhelming and challenging. Being present and creating a safe space for open dialogue helps individuals feel understood and supported without fear of shame or judgment. Being a strong supporter of ongoing commitment to and participation in care can help manage fears about treatment.

Sustaining Family Support Beyond Treatment

Parents and caregivers often struggle with guilt, wondering if they contributed to the development of the eating disorder. However, the reality is that these conditions are influenced by a range of biological, psychological, and environmental factors. While families are not to blame, their ongoing support is critical in the recovery process.

Prioritizing the family members' well-being is as important a concern as the patient's well-being. Supporting a loved one with an eating disorder is often emotionally taxing, and practicing regular self-care enables families to remain strong and steady. Seeking personal support through family groups or therapy can be beneficial, too.

By encouraging education, communication, and a shared commitment to healing, families can play a vital role in helping loved ones overcome eating disorders and reclaim a full, meaningful life.

Jillian Lampert, PhD, MPH, RD, LD, FAED

Dr. Jillian Lampert, PhD, MPH, RD, LD, FAED, is the Vice President of Communications and Brand for Accanto Health, the parent company of The Emily Program and Gather Behavioral Health. She oversees the public affairs, communications, and public relations activities, including cultivating and maintaining industry relations, leading organizational advocacy and policy involvement, supporting public relations highlighting the organization's role as an industry thought leader, and spearheading availability of key educational content available to the public and external providers.

Dr. Lampert is Co-Founder and President of the REDC, the national consortium representing eating disorders care focused on treatment standards, best practices, access to care, and collaborative research. She is also Treasurer of the Eating Disorders Coalition, a DC-based national organization for eating disorders policy and advocacy, and a Board Member of With-All, a Minnesota-based organization that empowers eating disorder prevention and strengthens support for recovery. She holds an adjunct graduate faculty position in the Department of Food Science and Nutrition at the University of Minnesota.

Parenting with Mental Illness: Breaking the Silence and Navigating the Challenges

By Vishwani Sahai-Siddiqui, MD
The Cognitive Quill

Mental illness affects millions of individuals worldwide, with an estimated 20% of adults in the United States experiencing a mental health disorder each year (NIMH, 2022). Among them, many are parents tasked with the responsibility of raising children while managing their own mental health. While discussions about mental illness have gained traction in recent years, the unique challenges faced by parents with mental illness remain underexplored. The intersection of parenting and mental health requires a nuanced approach, as stigma, inadequate support, and concerns about the well-being of children can compound the stress parents face.

Parental mental illness can manifest in various ways, depending on the condition and its severity. Disorders such as depression, anxiety, bipolar disorder, and schizophrenia can affect a parent's ability to engage consistently with their child, manage household responsibilities, and provide emotional stability. Research has shown that parental depression is associated with disruptions in parent-child bonding, increased use of punitive discipline, and higher rates of behavioral problems in children. Anxiety disorders can lead to overprotective parenting, potentially limiting a child's independence. Meanwhile, parents with bipolar disorder may experience mood fluctuations that affect their ability to maintain predictable routines.

Despite these challenges, many parents with mental illness raise well-adjusted children. Protective factors such as strong social support, stable treatment plans, and open communication within the family can mitigate negative outcomes. Research indicates that when parents receive adequate mental health care, their children are less likely to experience emotional or behavioral difficulties.

One of the primary barriers parents with mental illness face is stigma. Many fear judgment from family members, educators, and healthcare providers, leading to reluctance in seeking help. A study by Nicholson et al. (2004) found that parents often worry about child protective services intervening if they disclose their struggles. This fear may prevent parents from accessing resources that could benefit both themselves and their children.

Destigmatizing parental mental illness requires systemic efforts, including public awareness campaigns and education for healthcare providers on how to support parents without reinforcing fear. Parents who openly discuss their mental health conditions in age-appropriate ways with their children often foster a more resilient and understanding family environment. Research has shown that children who receive honest, reassuring explanations about a parent's mental illness are less likely to internalize blame or experience anxiety about the situation.

Strategies for Managing Parenting with Mental Illness

1. Prioritizing Mental Health Treatment - Effective management of mental illness is critical for both parent and child well-being. Evidence-based treatments, including cognitive-behavioral therapy (CBT),

see Parenting on page 41

The Mental Health Crisis Among Kids Is Growing - Can Tech Help?

By Scott Healy
CEO, Psych Hub

I've always been a believer that big challenges can be solved with creative ideas that leverage the best that people and technology have to offer, and this time, I can't think of a more critical challenge to address than safeguarding the mental health of our children. Our world is evolving at breakneck speed, and it's heartbreaking to see the escalating number of young people who are struggling. We urgently need to provide them with effective, real-world support.

According to the Centers for Disease Control and Prevention (CDC), anxiety and behavioral issues frequently overlap with childhood depression: about 74% of children experiencing depression also deal with anxiety, and 47% grapple with behavioral problems. And in a 2023 CDC study, 22% of high school students reported having seriously considered suicide in the previous year.

Technology has already proven to be a powerful force in improving mental health care, especially with new and increasingly effective tech-based solutions emerging all the time. This trend will enable us not only to reach more kids but to enhance the support they receive. That's why I believe digital tools are so important in addressing the mental health crisis among our youth.

The Growing Need for Digital Mental Health Solutions

Children and adolescents today live in a fast-paced, hyper-connected environment where online and offline stressors can blur into one another. I've witnessed schools, community groups, and health providers wrestling with the overwhelming need for mental health resources. Because of long waitlists and a scarcity of specialized professionals, many families are now turning to alternative solutions.

Digital mental health tools can help bridge these gaps. Apps and online platforms that provide screening, self-help modules, and peer support forums offer timely, on-demand assistance. They work in tandem with traditional services, making it easier for mild to moderate cases to find help more quickly. Early intervention can often stave off more serious problems later on—and I believe the private sector has a vital role to play in championing comprehensive, technology-driven approaches.

Expanding Access to Teletherapy and Online Counseling

When in-person therapy is in short supply or scheduling becomes a nightmare, teletherapy can be a much-needed lifeline for families. More than half of therapy sessions are now occurring online via teletherapy, and health plan coverage of teletherapy sessions is becoming more standard. Access to teletherapy reduces barriers related to travel, location, and social stigma. For young people in particular, they are often more comfortable connecting with mental health professionals in the comfort of their own space, allowing them to open up more freely.

Additionally, many online counseling platforms employ licensed therapists who specialize in working with children and teens. Flexible appointment times, the potential for more frequent sessions, and, most importantly, their adherence to evidence-based treatment practices proven to produce the best outcomes for youth and teens set these platforms apart from many in-person practices. Plus, streamlining administrative tasks like intake forms, insurance paperwork, and scheduling helps teletherapy providers minimize overhead, which can lower costs and increase efficiency.

see Can Tech Help on page 44

Lifting Voices to Transform the Care Delivery Experience for Children and Youth who have Complex Mental Health Needs

By Heidi Arthur, LMSW,
Ellen Breslin, MPP,
Jennifer Hodgson, PhD, LMFT,
Health Management Associates (HMA)
and Paige Pierce, BA,
Families Together in New York State

The preliminary findings from the national Lifting Voices family/caregiver survey align with and reinforce the Families Together New York State 2025 policy agenda. To find alignment is not surprising given that both the survey and agenda are the creation of caregivers for children and youth with complex social, emotional, mental health, and/or substance use conditions, and both are designed to support success for *all* children.

Lifting Voices aims to improve children's mental health care by elevating youth and family stories about their journeys accessing mental health and substance use disorder treatment for a child or youth who has complex needs. The Lifting Voices initiative includes two surveys: one survey for caregivers (of youth of all ages) and the other for youth ages 12-26. The surveys were developed by and for young people and their families to elevate the "lived experience" of youth and the "loved experience" of their families. The surveys gather data about the youth and family experience engaging with the system of care, accessing services, facing barriers, and experiencing the impact of unmet needs. Youth and families also share their recommendations for behavioral health providers, pediatricians, and schools.

Based upon an early glimpse of the responses across multiple states, families indicate:

- **Unmet mental health needs are hurting children**. Over half (64%) of families report that their child's life has been threatened by unmet mental health needs, and most (96%) report their child's education has been negatively impacted.

- **Access to Care is Limited**. Less than half of respondents report that appropriate mental health care (42%) or substance use care (36%) is available and accessible for their child.

- **Stigma is widespread**. 68% of families report that stigma has impacted access to care.

- **Support is insufficient**. Less than half report that schools (34%) or pediatricians (45%) are a source of support.

- **Unmet mental health needs are harming families**. 96% of families indicate that their own mental health has been negatively impacted by their child's unmet mental health needs; 84% of families indicate that a sibling's mental health has been negatively impacted by their child's unmet mental health needs; and 64% of families report that their marriage has been negatively impacted by their child's unmet mental health needs.

Families want providers to know that improved care for youth and families is a critical concern. Nearly half (48%) of the Lifting Voices families indicate that the mental health system has caused harm to their child.

see Family on page 38

Addressing Mental Health Disparities Among LGBTQ+ Youth

By Jordan Baker
Content Marketing Manager
Relias

Mental health challenges among LGBTQ+ youth have been an ongoing concern for human services organizations. This group faces higher rates of bullying, discrimination, and mistreatment than many other populations. As a result, they are more vulnerable to conditions such as anxiety and depression.

Given these disparities, it's essential for human services providers to understand how to effectively support LGBTQ+ youth. Below, we'll explore actionable ways your organization can help address the root causes of these mental health challenges and create a positive impact.

Key Risk Factors Impacting LGBTQ+ Youth Mental Health

Research consistently shows that LGBTQ+ youth are at a much greater risk for mental health struggles than their heterosexual peers. A 2021 study revealed that 42% of LGBTQ+ youth—and more than half of transgender youth—had "seriously considered attempting suicide." Additionally, surveys indicate that LGBTQ+ youth are six times more likely to experience depression and twice as likely to struggle with suicidal thoughts.

The widespread presence of mental health disorders within this group is largely driven by societal stigma and the violence they often encounter as a result. The CDC's 2019 Youth Risk Behavior Surveillance report highlighted major differences in the experiences of LGBTQ+ high school students:

- LGBTQ+ youth were more than twice as likely to experience dating violence compared to their heterosexual peers (16.4% vs. 6.7%).

- More than double the percentage of LGBTQ+ youth reported experiencing sexual violence compared to heterosexual youth (21.5% versus 9.0%).

- LGBTQ+ youth were over three times more likely to have been forced into sexual intercourse (19.4% vs. 5.5%).

- Nearly twice as many LGBTQ+ students faced bullying at school compared to their heterosexual peers (32% vs. 17.1%).

These and similar forms of mistreatment play a significant role in the high rates of mental health conditions reported by LGBTQ+ youth. However, research suggests that proactive efforts toward inclusivity and respect can help reduce these negative outcomes.

Strategies to Support LGBTQ+ Youth Mental Health

Despite the many challenges LGBTQ+ youth face, human services organizations can take meaningful steps to counteract these risk factors. Studies demonstrate that when LGBTQ+ youth feel supported in safe environments, their mental well-being improves. For example, transgender youth who are able to update their name and gender on legal documents and have their pronouns acknowledged report lower rates of suicidal ideation.

Below are some effective strategies your

see LGBTQ+ Youth on page 48

How to Talk to Your Child About Starting Therapy: A Guide for Parents

By Meir Flancbaum, PsyD
Licensed Psychologist and Director
Center for Cognitive Behavior Therapy

Parents consider starting therapy for a number of different reasons. You might be looking into options to help your child or adolescent manage mood challenges like anxiety or depression. Maybe you're interested in learning new parenting skills to address behavioral challenges and learn how you can best support your child. Or you may just want to make sure they have an additional resource to turn to for emotional support.

Skills-based therapies like cognitive behavior therapy (CBT) and dialectical behavior therapy (DBT) can teach you and your child different strategies to help address emotional struggles, improve your relationship, and more effectively navigate challenging situations. If you and your child have never been in therapy before, then you may not know the best way to approach the idea of starting therapy. To help you navigate that conversation, here are a few key tips to keep in mind.

Explain What Therapy is and Its Purpose

It's helpful for children of all ages to have a framework for the purpose of therapy and how it works. Taking the time to explain to your child why therapy is important is a good first step to help everyone make the most of the therapeutic experience.

Use language that is developmentally appropriate for your child's age. Make sure they understand that they will be working with a special kind of doctor called a psychologist. Younger kids may be receptive to the phrase "feelings doctor." This is someone who is there to help them talk about their problems and learn how to get more in touch with their emotions.

Older children would benefit from a more in-depth explanation of how a psychologist is someone who has specialized education and training. This is what makes a psychologist someone who can help them overcome challenges they may be having related to school, friendships, family, and other areas of their life.

Depending on the reasons you are starting therapy, you might use one of these approaches to help explain what therapy is for:

- **The "Coach" Approach:** Let your child know that a therapist is someone who will try to connect with them about their skills. Just like the coach on a sports team, their therapist is there to help them meet their goals. Even though pro athletes are great at what they do, they still have a coach to give them tips and tricks that help them learn how to improve.

- **Strengths & Weaknesses Approach:** Remind your child that everyone is good at different things and invite them to share some of the things they are good at (their strengths). Then, ask them if they think there are other things that they would like to improve (their weaknesses). Remind your child that hat therapy is a place where they can learn ways to strengthen their areas of weakness.

see Guide for Parents on page 36

The Hidden Dangers of Concussions in Kids and Teens

By Dr. Alina Fong
Clinical Director and Co-Owner
Cognitive FX

For decades now, concussions have been associated with high-impact activities like football or hockey. Parents might even be averse to allowing their children to participate in these sports because of the risk of head injury. The truth is that while these activities may put a child or teen at risk for a concussion, some non-contact sports and even sport-adjacent activities produce a large number of head injuries as well.

Sports like volleyball and soccer, as well as cheerleading and even dance, result in a large number of concussion cases, especially in teens and young girls. The physical demand of participating, coupled with the increased likelihood of falls and collisions, produces more concussions than one might think. The danger also stretches beyond the moment of impact, with head trauma triggering symptoms that emerge weeks or even months later, affecting not just physical health but mental well-being as well.

Mental Health and Concussions

The potential health impact of head trauma extends far beyond physical injuries to the scalp or skull. Depending on the area of the brain that sustains impact, young athletes may struggle with symptoms like emotional dysregulation, thinking problems, trouble maintaining focus, and mood swings, to name a few.

Even mild concussions, if not treated appropriately, can lead to post-concussion syndrome, which can include increases in anxiety and depression, as well as irritability, memory issues, and increased sensitivity to stimuli like light and noise. These symptoms can exacerbate existing mental health problems or even produce a cascade-like effect, where mood swings result in isolation that is then followed by depression over the situation.

The Role of Hormones in Concussion Recovery for Girls

One largely underrecognized factor in concussions, and specifically concussion severity in teen girls, is the role of the menstrual cycle and, more specifically, the ebbs and flows of hormones. Research appears to show that concussions sustained in the luteal phase of a girl's cycle — that is, the time immediately after ovulation but before menstruation — produce more severe and prolonged symptoms than concussions received outside of this window.

It is believed that progesterone levels are to blame for this increased risk, as the hormone can affect the brain's ability to recover after it sustains trauma.

Additionally, concussions can have an effect on hormone regulation after the fact. This is often the case when the pituitary gland is affected by an impact. The pituitary gland is credited with managing hormone function, and individuals with pituitary gland dysfunction can experience everything from mood disturbances to menstrual cycle irregularity. With these physiological factors in mind, it is of utmost importance that young female athletes who sustain a head injury be approached with a nuanced understanding of the role hormones play.

Recognizing Symptoms

Perhaps the biggest misconception about concussions is that they are always obvious

see Concussions on page 50

Helping Teens with Eating Disorders: Balancing Treatment and Academic Success

By Courtney Anderson, MA, LPC
Adolescent Program Manager
EDCare

For adolescents struggling with eating disorders, the pursuit of recovery often comes at a difficult cost: disruption to their education. The rigid structure of traditional schooling rarely accommodates the complex needs of students undergoing treatment, forcing many families to make an impossible choice between their child's health and their academic future.

Without proper support, students may fall behind, experience heightened anxiety about their coursework, or even resist treatment for fear of jeopardizing their education. The pressure to keep up with assignments while managing the physical and emotional toll of an eating disorder can create a vicious cycle, worsening stress, exacerbating symptoms, and ultimately prolonging recovery.

As behavioral health providers, educators, and families navigate these challenges, it is crucial to recognize that academic success and recovery are not mutually exclusive. With the right interventions—structured academic coordination, school accommodations, and family support—students can continue their education while prioritizing their health, ensuring a smoother transition back to school and long-term recovery success.

The Hidden Academic Toll of Eating Disorders

Eating disorders often emerge between ages 13 and 17, overlapping with some of the most academically demanding years of a student's life. Without intervention, these disorders can severely impact school performance due to both nutritional deficiencies and underlying mental health struggles.

Research finds that teens with eating disorders:

- Spend 70–90% of their waking hours preoccupied with thoughts of food, weight, and hunger, directly interfering with their ability to focus on academic tasks (NEDA, 2023).
- Experience cognitive impairment, including difficulties with concentration, memory, and information processing, due to malnutrition and anxiety (Giel et al., 2012).
- Miss significant amounts of school due to medical complications, therapy appointments, and hospitalization—leading to gaps in learning and social isolation (Watson et al., 2022).
- Face increased perfectionism, which can either drive obsessive academic behaviors or cause avoidance of schoolwork due to extreme self-criticism (Copeland et al., 2015).
- Are more likely to experience bullying or social stigma, which can lead to skipping school and further academic disengagement (Copeland et al., 2015).

These challenges not only affect grades and graduation rates but also place significant stress on families as parents juggle advocacy, treatment decisions, and their child's educational future.

see Eating Disorders on page 48

Embracing Healing: The Transformative Power of Trauma-Informed Care for Families

By Shanika L. Wilson, DSW, LCAS, LCSW,
Interim MSW Program Director
and Associate Professor
Department of Social Work at
North Carolina Central University

In recent years, the field of child welfare has witnessed a significant shift towards trauma-informed care (TIC), recognizing the profound impact of adverse experiences on children and families. This approach is revolutionizing how we support families in healing and thriving after facing adversity. As our understanding of trauma and its effects deepens, so does our ability to provide more effective, compassionate care to those who need it most.

Trauma-informed care is an organizational model designed to address the emotional needs of system-involved children who have experienced trauma (Bartlett & Rushovich, 2018). It's not just about treating trauma; it's about creating an environment that promotes healing and prevents re-traumatization. This approach recognizes that trauma affects not only individuals but entire families and communities.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma-informed care as a program, organization, or system that:

1. Realizes the widespread impact of trauma and understands potential paths for recovery
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices
4. Seeks to actively resist re-traumatization (SAMHSA, 2014)

Research has shown that TIC can significantly improve outcomes for children and families. A study by Murray et al. (2019) found that caregivers who received trauma-informed parenting training showed increased knowledge of trauma-informed practices, greater tolerance for misbehavior, and improved self-efficacy in caring for children with trauma histories. This highlights the importance of educating and supporting caregivers as part of a comprehensive trauma-informed approach.

The Impact of Adverse Childhood Experiences

The groundbreaking Adverse Childhood Experiences (ACE) study conducted by Felitti et al. (1998) highlighted the prevalence and long-term effects of childhood trauma. Even in predominantly white, middle-class populations, childhood trauma was found to be surprisingly common. This research underscores the importance of addressing trauma early and effectively.

The ACE study revealed a strong correlation between adverse childhood experiences and negative health outcomes in adulthood, including increased risk for chronic diseases, mental health issues, and substance abuse (Felitti et al., 1998). This connection between childhood trauma and adult health emphasizes the critical need for early intervention and support for families experiencing adversity.

see Embracing Healing on page 39

Addressing Child and Youth Loneliness: Family-Based Interventions to Improve Mental Health

By Eboni Wooley, DSW, LCSW
Psychotherapist/Adjunct Professor

** This is a composite case example. The names have been changed to protect the identities of the clients.*

Loneliness is not simply a feeling but a social determinant of one's overall health. Loneliness is a state of emotional distress that develops when one experiences a disconnect between their desire for social connection and their lived experiences. When discussing the importance of addressing loneliness, the conversation is often centered on older adults. However, the American epidemic of loneliness is also impacting children and youth at alarming rates.

Among Generation Z, 73% percent reported feeling alone sometimes or constantly (Bakhtiari, 2023). Additionally, a recent report found that 1 in 5 parents of Generation Alpha stated that their children have few or no friends (C.S. Moss Children's Hospital, 2024). Experiencing chronic loneliness during this critical developmental period increases their risk for mental health issues, substance abuse, poor interpersonal skills, and low self-esteem (Xerxa, 2023). By integrating family-based interventions into treatment with children and adolescents, clinicians can assist in strengthening the family bond in order to mitigate long-term potential negative outcomes of loneliness.

Recognizing Child and Youth Loneliness

While the feeling of loneliness is considered a normal emotion and a part of the human experience, increased and chronic feelings of being lonely have dire physical and mental health consequences (Yanguas et al., 2018). Therefore, in order to properly address loneliness in our youth, clinicians must be able to recognize the signs and symptoms of loneliness. For instance, one can view a child as being aggressive as a symptom of trauma; however, there is a strong correlation between feelings of being lonely and aggression. Children who have experienced feelings of isolation and disconnectedness from others often act out aggressively as a means to cope with an unmet need for connection (Almeida et al., 2021). Additionally, children and youth who have suffered from emotional neglect often lack the social skills to build social connections. These children may present as shy, timid, lacking self-confidence, anxious, and may engage in increased people-pleasing behavior.

Moreover, if young clients express a strong dislike for school, further assessment of social isolation should be conducted. Being bullied as a child or adolescent is a form of social exclusion that has been found to increase the risk of loneliness around ten times higher than their peers (Madsen, 2024). Experiencing being victimized by others can cause them to want to avoid social settings like school since they view them as unsafe spaces. Lastly, impoverished children and youth are twice as likely to experience feelings of loneliness due to the forced isolation of poverty (Akgül et al., 2023). Low-income families may be unable to afford social activities, such as field trips and sports, which can lead to social exclusion. Also, families living in disadvantaged communities may have fewer safe spaces for their children to socialize.

see Loneliness on page 49

Brain Disease or Moral Failure? Why the Label Matters for Addiction Recovery

By Dr. Charles Smith
Addictionologist
Recovery First

When I went to treatment 15 years ago, I was convinced that addiction wasn't a disease. And that, if it *were* a disease, it was self-inflicted. Many of the patients I care for today often have the same feelings, blaming themselves and living with shame despite the knowledge we have today. If more people truly understood it was a brain disease and not a moral failure, I believe we could end the stigma and save more lives.

Words Matter

When we talk about whether addiction is a moral failure or a brain disease, the label matters—a lot.

The American Society of Addiction Medicine defines addiction as "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences."

This definition signals an acknowledgment among the broader medical community that addiction is indeed a diagnosable mental health disorder and not a moral failure.

But this is an exceedingly difficult concept to grasp if you have not experienced addiction firsthand—or if you have watched addiction take hold of someone you love.

Why Can't They Just Stop?

Addiction is characterized by compulsive, uncontrollable substance seeking and use despite the negative consequences. This is the result of fundamental changes to a person's brain structure and function that occur with repeated drug or alcohol use.

In 2016, Dr. Nora D. Volkow, a renowned addiction expert and director of the National Institute on Drug Abuse (NIDA), published a landmark article about the neuroscience of addiction. Its findings really started to shift the conversation about the brain's involvement in this disease.

Since then, we have learned through multiple research studies that the brains of people with addiction are different from those without it. Functional MRI scans of addicted brains show a big dysregulation in the dopamine reward system and decreased oxygenated hemoglobin in the prefrontal cortex.

In other words, the portion of our brain that steers our impulse control and decision-making is operating suboptimally, making it increasingly difficult to "just say no."

Why Do Some People Get Addicted, While Others Don't?

As doctors, we can predict with near-perfect certainty who will and won't develop an SUD by looking at 5 primary risk factors:

1. Family history/genetics
2. Adverse childhood experiences
3. Dual diagnosis (i.e., co-occurring mental health conditions like anxiety, depression, bipolar disorder, or PTSD)
4. High tolerance

see Addiction Recovery on page 47

Creating a Continuum of Care: Addressing Mental Health Challenges Facing Youth & Young Adults in New York and Beyond

By Brenda Tong
and Jantra Coll
Vibrant Emotional Health

The mental health landscape for youth and young adults in the United States is at a critical inflection point. According to the World Economic Forum, the world's 1.2 billion young people, representing 16% of the global population, are facing a generational mental health crisis of unprecedented scale. In the United States, the statistics are distressing: 13% of young adults aged 18-25 and 22% of high school students experience serious thoughts of suicide annually.

New York reflects these concerning national trends, with nearly one-quarter (24.4%) of young adults between the ages of 18-34 reporting symptoms of anxiety and/or depression. These challenges are further intensified by modern stressors unique to today's youth: the constant pressure of social media comparison, intensifying academic competition, economic uncertainty, and the lingering psychological aftermath of the COVID-19 pandemic.

Amid this crisis, accessible and developmentally appropriate mental health resources for young people aren't just beneficial; they are life-saving. The objective in the last few years, across communities, has been to create an expansive *continuum of care* for mental health, a comprehensive system that provides a range of services and support to meet the needs of individuals and families over time, from initial assessment and intervention to ongoing care and discharge planning.

Brenda Tong (back middle) and Jantra Coll (second from right), along with Vibrant Emotional Health CEO Cara McNulty (third from left), visit with program staff at one of Vibrant's community program sites in the Bronx, NY.

Since 1969, Vibrant Emotional Health has been a pioneer in creating a robust support network that meets young people at various touchpoints in their mental health journey. Here are some of the ways that this system has been set up throughout New York City communities and on a national scale:

Vocational Training and Transitional Support

In 2024, a staggering 64.9 million young people aged 15 to 24 were unemployed, with the youth unemployment rate at 13.6% – more than triple that of adults. Concerningly, the unemployment rate for 16-19-year-olds in the U.S. alone almost matches at 12.9%, according to the latest data from the Bureau of Labor Statistics (though it is much lower for those 20 and older – around 4%).

To mitigate this troubling trend, especially among those for whom the traditional school setting is no longer viable and who are struggling with emotional and behavioral challenges, Vibrant runs Adolescent Skills Centers (ASC) aimed to prepare young people ages 14-22 to thrive in the workforce through comprehensive vocational training, educational programs,

see Vibrant on page 50

Understanding the Link Between Trauma and Substance Use in Adolescents

By Michiko Bailey Andrade
Consultant/Public Health Administrator
Bailey Andrade Consulting, LLC

Adolescence is a critical period of development, and exposure to trauma during this stage can impact mental health and behavior. Research consistently shows a strong connection between trauma and substance use among adolescents, with trauma often acting as a risk factor for developing substance use disorders (SUD). This article explores the complex relationship between trauma and adolescent substance use, highlighting key findings and potential interventions.

Trauma, such as physical or sexual abuse, domestic violence, or neglect, increases the likelihood of substance use in adolescents. Studies reveal that teens who have experienced trauma are up to three times more likely to misuse substances compared to their peers without such experiences. The intersection of trauma, post-traumatic stress disorder (PTSD), and substance use disorders (SUDs) among adolescents represents a significant public health concern. This complex interplay affects a substantial portion of the youth population, with far-reaching consequences for individual health, healthcare systems, and society in general.

The Department of Job and Family Services in the state of Ohio reports that in the National Survey of Adolescents, teens who had experienced physical or sexual abuse/assault were three times more likely to report past or current substance abuse than those without a history of trauma. In surveys of adolescents receiving treatment for substance abuse, more than 70% of patients had a history of trauma exposure.

Adolescents who experience traumatic events may develop psychological distress, including symptoms of post-traumatic stress disorder (PTSD). To cope with these challenging emotions and experiences, some teens might turn to drugs or alcohol as a form of self-medication. The self-medication hypothesis suggests that adolescents turn to substances as a way to numb emotional pain or cope with overwhelming memories. For instance, marijuana or alcohol may temporarily reduce anxiety or intrusive thoughts associated with trauma. However, this coping mechanism often exacerbates mental health issues and creates a cycle of dependency.

Bidirectional Relationship

The relationship between trauma and substance use is bidirectional. While trauma increases the risk of substance use, substance use itself can make adolescents more vulnerable to experiencing additional traumatic events. For example, drug use may lead to risky behaviors or environments where further harm is possible.

The Impact of Parental Substance Use

Parental substance misuse significantly contributes to the cycle of trauma and addiction in adolescents. When parents abuse drugs or alcohol, their children are more likely to have access to these substances at home and may learn unhealthy coping mechanisms from their parent's behavior. This environment can intensify the impact of early traumatic experiences, further

see Teen Substance Use on page 51

Preventing Youth Suicide: Intervention Strategies and Community Resources

By Tiffany N. Jackson, LMHC, MBA, NCC, QS, Counselor and Certified Intervention Training Trainer

The national suicide rate among adolescent youth has risen significantly over the years, surpassing other causes of youth fatalities. Suicide during childhood and adolescence is ranked as the second leading cause of death among these age groups. A 2022 study found that suicide was the second-leading cause of death for youth aged 10–14 and the third-leading cause for those aged 15–24. Between 2007 and 2021, suicide rates for youth aged 10–24 increased by 62 percent (SAMHSA, 2024).

Factors Impacting Youth Suicide

Over the years, various factors have contributed to the rise in youth suicide, including but not limited to bullying in schools, heightened symptoms of depression, the impact of the COVID-19 pandemic, grief due to the loss of a loved one, and the growing influence of social media and technology, which also encompasses cyberbullying.

These elements are reflected in numerous statistics, highlighting the devastation that affects not only families nationwide but also the communities these young individuals once belonged to. It is important that we recognize this as both a national and global crisis in order to implement the necessary changes and interventions to reduce and prevent the suffering and premature loss of our future generation.

Youth suicide is a complex and sensitive issue with numerous determinants. These variables affect not only the individual youth but also extend to societal influences. The underlying cause of suicidal thoughts in youth often stems from pain and a sense of hopelessness, leading them to believe that things will never improve. Known risk factors for suicidal ideations and behaviors include previous suicide attempts, mental illness, trauma-related adverse childhood experiences, family dynamics, isolation, and feelings of hopelessness. A 2017 study (Ertl, Crosby, & Blair, 2020) found that, disproportionately, female youth exhibit the highest rates of nonfatal suicidal behaviors, while male youth have the highest completed suicide death rates. Understanding that interventions like traditional therapy, which were common 20 years ago, may not resonate as much with today's youth is pivotal. Community leaders and resource providers must consider a variety of approaches when addressing mental health concerns. Some individuals may choose not to seek formal treatment at all, instead turning to family members or peers for guidance. Many mental health issues among youth may go unnoticed or undiagnosed. For suicide prevention efforts to be effective, they must go beyond traditional clinical settings and reach those who have not been diagnosed or have not yet received the appropriate treatment (Ertl et al., 2020). Preferences for handling mental health issues independently may vary across different contexts; therefore, it is essential to be culturally aware and competent in addressing the sociocultural factors at play. For instance, black individuals and other minoritized groups may feel pressured to "be strong" and persevere without seeking help due to cultural norms that frame mental illness as a "white man's

see Preventing Suicide on page 37

Justice Peer Support: On the Trauma of (and Resilience from) Incarceration

By Carl Blumenthal, MS, NYCPS, Convenor, Prison Reentry Program, Brooklyn, NY Quaker Church

Editorial Note: Given the recent NYS correction officers' strike, this article is especially timely. The strike, driven by concerns over staffing shortages and solitary confinement reforms, has coincided with the tragic deaths of nine incarcerated men (so far). This context underscores the urgency of the issues discussed.

What does "doing time" mean to you? During the Covid pandemic, it meant being stuck at home alone, or having your family drive you crazy. If you've been bedridden in a hospital or nursing home with unresponsive staff, you might have felt imprisoned too. Alternatively, novelist Ottessa Moshfegh writes, "living without love is like 'doing time.'"

Having spent weeks and months on inpatient psychiatric units, I, too, felt trapped, and, when I worked as a peer specialist in an ER, interacted with patients who were handcuffed to their beds by the police because they were "emotionally disturbed."

However, my passion for supporting (formerly) incarcerated peers with behavioral health challenges, as a certified justice peer specialist, originates from my childhood, when, between the ages of nine and 11, I was repeatedly caught stealing and vandalizing property. Instead of turning me over to the police, my highly educated, middle-class Jewish parents referred me to the Yale University Child Study Center.

Playing Chinese checkers with a boring psychiatrist for a year, so-called "play therapy," might have been punishment enough, but the shame of leaving fourth grade early for my appointments was worse due to the whispers of "cuckoo" from my classmates. On the one hand, my dad, who graduated Yale at 19, expected me to follow in his footsteps. On the other, my mom neglected me because she was preoccupied with my younger brother, diagnosed with mental illness at age five by the same treatment program. The result: I began a lifetime in and out of mental health care for bipolar disorder rather than starting young adulthood as a "juvenile delinquent."

Fast forward 55 years to 2017. While I'm working in the ER of Kings County Medical Center, Brooklyn, I'm volunteering for the prison reform project of the Quaker-affiliated American Friends Service Committee in Manhattan, where I correspond with incarcerated men who need health, education, and legal assistance. (See www.friendsjournal.org.)

Born and raised a Conservative Jew, I joined the Religious Society of Friends because their commitment to social justice was even greater than that of my liberal Jewish community, especially when advocating for mental health and criminal justice reforms.

Quaker Witness on Mental Health and Criminal Justice

At York, England, in 1796, Friends originated "moral treatment" of the mentally ill in a country retreat with what amounted to occupational therapy before establishing in Philadelphia the first private psychiatric hospital in the U.S. (1818). Dorothea Dix, a Unitarian, after visiting the York Retreat, advocated for similar "asylums"

see Incarceration on page 52

Enhancing Equity in Adolescent Mental Health: Expanding Access to Comprehensive Dialectical Behavior Therapy (DBT) Treatment

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

Over the last decade, the US has experienced a significant increase in mental health symptomatology and suicidality among children and adolescents, with the COVID-19 pandemic contributing to an even greater increase.

In 2021, the surgeon general deemed mental health concerns in children and adolescents a “national crisis,” and in 2022, data revealed suicide as the second leading cause of death for youth ages 10 to 14 and the third leading cause of death for youth, ages 15 to 19 (CDC). Children and adolescents from historically marginalized backgrounds are at a higher risk of developing mental health concerns due to social determinants of inequity (Murthy, 2022), which include those of low socioeconomic status, ethnic/racial minorities, and LGBTQ+ populations.

Although 2023 data from the Centers for Disease Control and Prevention revealed a slight decrease in mental health concerns and suicidality among youth, the need for increased mental health screening and accessibility to behavioral health services remains high.

While additional resources are needed for identifying youth who may be experiencing mental health symptoms or stress from adverse childhood experiences (ACEs), research shows increased screening does not automatically lead to commensurate rates of service utilization for these individuals. A cross-sectional study published in 2021 revealed that among a sample of 11,896 children, ages 2 to 17, whose screening results showed high distress symptoms and/or a high rate of ACEs, their rates of “no clinical contact” following screening ranged from 40% to 67% (Finkelhor, Turner, LaSelva, 2021). Similar to the existing analysis on treatment utilization, researchers determined access to behavioral health services appears to be a contributing factor to the lack of treatment follow-through. This highlights the need to focus on increasing access to effective, evidence-based therapies.

Implementing Dialectical Behavior Therapy

Given the increase in suicidality, depression, and other mental health diagnoses over the last decade, it is imperative clinicians providing mental health support are educated in the most effective evidence-based therapies (EBTs). Dialectical behavior therapy (DBT) is a cognitive behavioral therapy designed to treat individuals with a wide range of mental health conditions and emotional dysregulation challenges. Numerous randomized control trials (RCTs) and meta-analyses have found DBT to be the most effective evidence-based therapy for treating suicidality and self-injury for adults and adolescents and effective for other symptom presentations significantly impacted by emotional dysregulation (Hernandez-Bustamante et al., 2024 & Kothgassner et al., 2021). DBT is one of Devereux’s most widely used EBT and is implemented in a variety of treatment settings across the country, including residential treatment facilities, outpatient programs, and acute hospital settings.

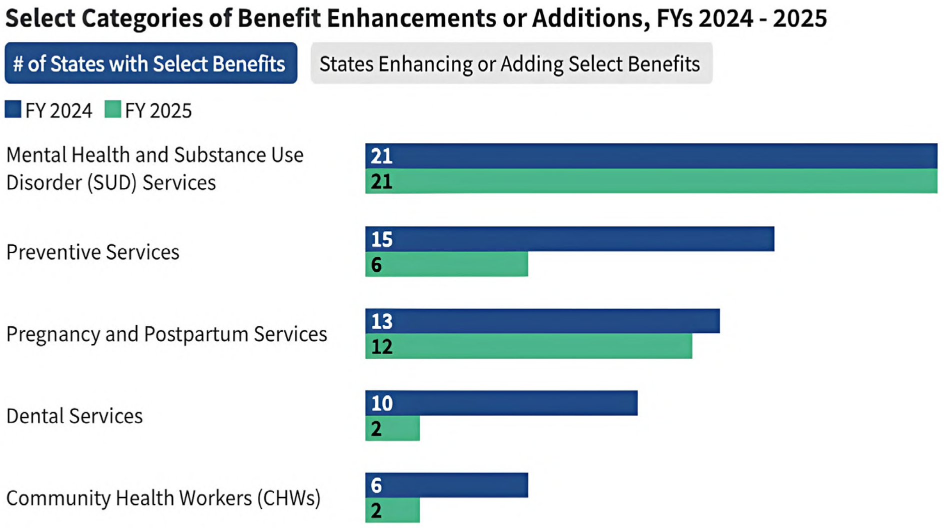
see DBT Treatment on page 54

Stretching Medicaid Dollars: How Behavioral Health Providers Can Stay Afloat

By Jeff Gershman
Square Medical Group
and Janie Tremlett
CWH Advisors

Many behavioral health providers around the country are trying to establish and implement alternative payment models in hopes of focusing on reducing costs and improving outcomes, especially for more acute patients. However, many states and health plans lag, creating a disincentive for already scarce behavioral health resources. There have been many articles and studies directed at understanding the continued shortages of providers, but payment solutions have not been addressed sufficiently. With potential looming cuts to Medicaid, access to mental health care will mostly likely continue to trend in a less-than-desirable trajectory. So, what can we do to trend in a better direction?

An example of the inherent structural problems was explained by the 2024 committee commissioned by CMS, stating in their findings, “the median state Medicaid program paid psychiatrists 81 percent of the Medicare fee schedule for psychiatrists (Zhu et al., 2023). In Medicaid, capitation rates are based on historical FFS Medicaid spending levels that typically occurred under a benefit structure that frequently imposed strict limits on behavioral health services. Therefore, the capitation rates are inconsistent with the benefit designs that define the responsibilities of the Medicaid Managed Care Organizations (MCOs).[1]



How do we get around these limitations and provide needed access to care? There are providers who are delivering innovative, longitudinal programs, including housing, Social Determinants of Health (SDOH), and case management services, which are positively impacting mental health and cost outcomes. How can they afford to provide these services? Some of these providers have worked with progressive MCOs to implement value-based care arrangements at typically bundled rates that include these services. Not surprisingly, the outcomes are much better than national trends.

Maybe the solution lies in a gradual implementation approach where case management is compensated for helping, especially co-occurring patients stay in recovery and get better. In many states, Medicaid doesn’t typically compensate for case management or care coordination, and if they do, it’s for patients with serious mental illnesses and/or specific populations like pregnant women. Benefit enhancements are being implemented in many states, including addressing Social Determinants of Health needs.[2] There are also benefit changes regarding Community Health Workers who may perform culturally appropriate health promotion and education, care coordination, and help accessing medical and non-medical services. The table depicts how many states have recently added these new benefits.

Incentives and compensation are at the heart of providing the care that is needed to reduce costs and change the curve. Refocusing on improving outcomes is best for the patient and for the industry. Consideration of case management/ care navigation as a starting point may help to simplify the change and help mitigate the provider shortage issue and access to care.

Jeff Gershman is CEO of Square Medical Group. Janie Tremlett is Partner at CWH Advisors. Jeff Gershman is CEO of Square Medical Group. Janie Tremlett is Partner at CWH Advisors.

see Medicaid on page 46

Does Listening to the Family Violate HIPAA? What Clinicians Need to Know When Working with Children and Vulnerable Adults

By Elaine M. Edelman, PhD, LCSW, CASAC-Adv, Professor of Practice
Kansas State University

Over time, good clinicians frequently come to similar conclusions. One of those conclusions is that family involvement in treatment can help the person in therapy find deeper and healthier relationships with important people in their lives. While it is not always possible to "fix what is broken" in family connections, meeting or speaking with a client's family or other loved ones can help the therapist understand who or what that person is dealing with. Despite the value of family involvement, certain myths prevail concerning HIPAA and contact with people in your client's support system. Many clinicians falsely believe that without a signed release of information, they are not supposed to *listen to* or *take a call from* a family member or outside support. Please note that I said "listen" and not "talk."

I spent years working with children and adolescents and on psychiatric inpatient units. The person you see in your work with youth and those who are hospitalized is a snapshot of who they are in that moment (which is true for all human interaction). What we can't see is the "person in their environment." The information that is not readily available is often at least as important as what the person presents to us.

I have encountered multiple instances in which a family member reached out to a clinician and was told by the treatment provider, "I can't talk to you because of HIPAA." A particularly disturbing situation occurred when a grandparent called a therapist to share that their young adult grandchild was in distress. The grandparent wanted to share what the family was seeing, which included increased, inexplicable conflict with the family. The clinician refused to listen to the information, citing HIPAA. The therapist's refusal to hear the information was particularly disturbing to the family member because the young person had a history of suicidal ideation and appeared to be deteriorating. A therapist might be concerned that even a discussion is disclosing that the person is in their care. In this case, the grandparent was paying the therapy bills. There was no "disclosure" that would have resulted from the therapist listening to what the family member was trying to share. Even in an inpatient hospital setting, without confirming or denying someone is in treatment, a clinician can say, "I am not authorized to disclose any information. Is there something you'd like me to know?"

So, what is a clinician to do? Consider the following:

- At the beginning of treatment, it should be standard practice to explain to clients that their information is confidential. The exceptions to that are in the case of suicidality, homicidality, child abuse issues (if that is relevant), or the need to coordinate emergency care. (These are standard HIPAA parameters).

- Ask the client for a signed HIPAA release for emergency contact. You can also ask if it's ok to share "psychosocial information" with family if it is deemed appropriate. It is important to note that not all clients would have an issue with family contact. (In the scenario cited

see HIPAA on page 42

The Impact of Leisure Activities on Mental Well-Being in Children and Adolescents with Prader-Willi Syndrome and Trauma

By MaryClaire Attisano, OTD, BS
Occupational Therapy Doctorate Program
Johnson and Wales University

Prader-Willi Syndrome (PWS) is a rare, complex genetic syndrome estimated to impact one in 10,000 to 30,000 individuals worldwide (National Library of Medicine [NLM], 2020). PWS is generated by a genetic mutation on Chromosome 15, causing a wide range of cognitive and physical disabilities (NLM, 2020). The following physical and cognitive dysfunctions can be seen in persons with PWS, mild to moderate cognitive impairments, learning disabilities, weak muscle tone or hypotonia, poor growth, delayed development, insatiable appetite, and behavioral challenges.

Other key features of PWS include mild to repetitive compulsive behaviors, tantrums, irritability and negative mood, growth hormone dysfunction, hyperphagia, increased risks of morbid obesity, psychosis, and autism spectrum disorders (Dykens, 2014). In addition to the physical features of the condition, daily life functioning and the ability to be independent can be negatively impacted by PWS. The trauma population for purposes of this intervention was defined as individuals who have experienced or lived through physical abuse, emotional trauma, or psychological trauma. Both populations face challenges significantly greater than the typically developing child. Additional care and specialized programming are often needed to complete daily tasks and maintain emotional regulation. The specialized care these individuals need for daily functioning qualifies them for residential or group homes with specialized care staff, a facility much like Latham Centers in Brewster, Massachusetts.

Latham Students completed leisure-based activities

Residential Care Facility and Leisure Engagement

Latham Centers is a direct-care residential facility housing children and adolescents who have experienced psychological, emotional, or physical abuse or children who have a PWS diagnosis. Latham's mission is to "create opportunities for independence, self-worth, and happiness for children and adults with complex special needs" (Latham Centers, 2022). Latham is a world-renowned facility providing both populations with "innovative treatments and support services for intellectually disabled children and adults and for individuals living with Prader-Willi Syndrome (Latham Centers, 2022). Direct-care staff at Latham provide 24/7 care to both the PWS and the trauma population to increase both populations' quality of life.

Among the interactive and comprehensive teams and services Latham can provide, there is still a need among students for engagement in leisure-time activities as defined as "nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep" (Occupational Therapy Practice Framework, 2020). The

see Prader-Willi on page 53

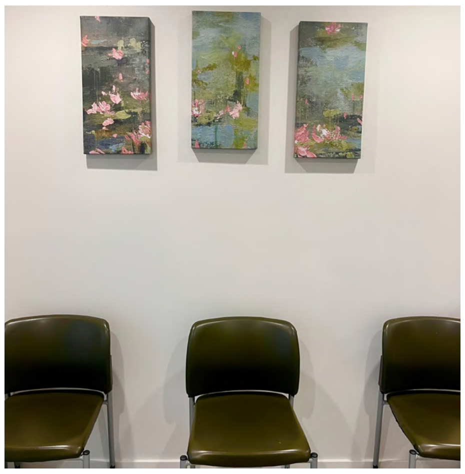
Entering the CCM Bond Clinic

Some of the games and artwork in our therapy play room

The wall and artwork in our therapy playroom

The CCM Bond Clinic waiting room and hallway

One of the CCM Bond Clinic therapy rooms



Artwork and seating in the waiting area

Douglas Brooks, LCSW-R
President and CEO

Carmen Collado, LCSW
COO & Chief of External Relations

New CCM Clinic from page 8

- Conflict Mediation
- Psychiatric Evaluations
- Medication Management
- Psychosocial Assessments

In addition to ensuring the social and emotional wellbeing of our clients is paramount, our clinicians use a wide variety of treatment modalities, including psychodynamic therapy, cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), person-centered therapy, solution-focused therapy, and psychoeducation. We emphasize flexible and accessible care, with extended weekday hours (9 AM to 7 PM) and Saturday sessions (9 AM to 5 PM). Telehealth options are also available for clients ages 10 and up.

A Culturally Grounded Approach

What truly distinguishes CCM's clinical model is our deep commitment to cultural humility and competence. We believe that effective mental health care must be grounded in an understanding of the client's lived experience—including their racial, ethnic, gender, and sexual identities. Our assessments, treatment planning, and therapeutic interventions are informed by a strengths-based lens that prioritizes the voices and values of the young people we serve. Through collaborative goal-setting and inclusive clinical conversations, we aim to foster a sense of safety, trust, and empowerment for every client.

Engaging Community: Breaking Stigma and Building Trust

We know that mental health stigma continues to be a significant barrier—particularly in communities of color and immigrant communities. That's why CCM is also committed to community engagement, education, and outreach.

Through partnerships with local churches, schools, and grassroots organizations, we are actively working to raise awareness, destigmatize mental health treatment, and equip families with tools and knowledge to support their children. This includes offering Mental Health First Aid training, educational workshops, and peer-led support groups. Our goal is not only to treat mental health issues but to create a community culture where asking for help is seen as a sign of strength.

Building on a Legacy of Care

Community Counseling & Mediation has been serving Brooklyn and Manhattan for over four decades. Since our founding in 1982, we've reached more than 60,000 individuals and families annually, delivering an integrated continuum of services in Mental Health, HIV/AIDS and Substance Use Treatment, Supportive Housing, Youth Development, and Family and Youth Peer Support.

The Bond Clinic is an extension of that legacy—an investment in the future of our youth and our communities. We are deeply proud to be expanding our footprint in Downtown Brooklyn and to be offering a safe space where young people can explore their emotions, strengthen their resilience, and receive the care they need to thrive.

Looking Ahead

As the mental health needs of our youth continue to grow, we believe that access to high-quality, culturally resonant care is not a luxury—it's a necessity. The opening of the Bond Child and Adolescent Clinic represents more than just a new program. It is a call to action: to listen to our youth, to support our families, and to build systems of care rooted in equity, inclusion, and compassion.

We look forward to welcoming the community on May 9, 2025, and we invite everyone to stand with us in championing mental wellness for Brooklyn's children and adolescents. Together, we can ensure that no young person feels alone in their struggle - and that every child has the opportunity to grow, heal, and reach their full potential.

Douglas Brooks, LCSW-R, serves as President and Chief Executive Officer, and Carmen Collado, LCSW, is the Chief Operations Officer and Chief External Relations Officer at Community Counseling & Mediation (CCM).

Learn more about Community Counseling & Mediation at www.ccmnyc.org. For inquiries, call (718) 802-0666, email info@ccmnyc.org, or visit us at our main office: Elm Place Clinic, 25 Elm Place, 2nd Floor, Brooklyn, NY 11201.

For more information about Community Counseling & Mediation's Bond Street Clinic, contact Carmen Collado, LCSW, COO and Chief of External Relations of CCM at ccollado@ccmnyc.org, or Sophia Romero-Benz, Communications & Marketing Coordinator at sromero-benz@ccmnyc.org or (718) 802-0666 ext. 231. You can also visit the clinic at 9 Bond Street, 6th Floor, Brooklyn, NY 11201.

Guide for Parents from page 29

Review the Therapy Process with Your Child

It's a good idea to let your child know what to expect before they attend their first therapy session. Let them know that it will be an opportunity for the therapist to get to know them. They will ask questions to learn more about their hobbies, interests, friends, and school. The therapist will want to hear about things that are going well in addition to the areas where they are struggling.

After gathering information, the therapist will use the next session to share what they think is going on, help set goals for therapy, and explain how they plan to work together to help achieve these goals. Then, in weekly sessions, the therapist will share different tips, tricks, and strategies with your child to help them work toward their therapy goals. They may even provide activities to practice at home, perhaps with a parent, to strengthen those skills.

Emphasize that Therapy is a Team Effort

When you present going to therapy as a way to resolve a "family issue," it helps your child feel less ostracized in the experience. Emphasize that you are going to therapy to help support them and that you are committed to supporting them in the process.

Therapy is about working toward a common goal and finding ways to work together to help address issues. Present participating

see Guide for Parents on page 49

TTAC from page 20

A key initiative of TTAC is offering training on Evidence Based Treatments to the early childhood–outpatient clinics as well as to some of our perinatal partners. TTAC also offers ongoing webinars focused on foundational as well as cutting edge issues around infant and perinatal mental health, all of which are archived and posted along with the webinar recordings on the TTAC website. Since its inception in 2016, TTAC has trained over 16,000 professionals.

The recently released Maternal Mortality Report cited mental health problems during pregnancy as a significant factor in maternal mortality. Although we have known about the importance of maternal health on infant and early childhood development, recent research has shown that parenting begins before birth as parents' experiences affect fetal development and behavior. To address the mental health needs of infants and young children we need to support the health and mental health of the caregivers beginning in pregnancy. The network expanded funding in 2023 to address the needs of those working in the perinatal period. As part of this expansion, TTAC has provided training and ongoing supports to the NYC Health Department's Newborn Home Visiting program and Nurse Family Partnership, and to the Citywide Doula Initiative, Brooklyn Neighborhood Health and Healthy Start.

NYCDD, in partnership with McSilver, is pleased to expand their partnership in NYS with a new initiative, Pathways to Professional Development; Building Foundations in Infant and Early Childhood Mental Health (Pathways), funded through the New York State Office of Mental Health. Pathways offers a core training series of cohesive and sequenced foundational webinars on infant and early childhood mental health practice tailored to the developing professional and experienced individuals alike, working in various disciplines across all child serving systems. Each webinar is offered live and also posted as an available training opportunity via the Learning Management System (LMS).

Evelyn Blanck, LCSW

Meg Baier, LMSW

Andrew Cleek, PsyD

In addition, Pathways is providing virtual and in-person training on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; DC:0-5. DC:0-5 was developed since existing classification systems such as DSM 5 did not adequately reflect the unique developmental and relational experiences of infants and young children. DC:0-5 is a multi-axial system that considers a child's clinical disorder only after issues such as the child's health, development, psychosocial stressors, and culture, as well as the nature of the child's relationship with important caregivers, have been assessed. This tool enhances the professional's ability to make precise diagnoses and strategically target mental health treatments and interventions for developmental disorders in the earliest years by identifying and describing disorders not addressed in other classification systems and by pointing the way to effective intervention approaches.

These initiatives have helped to build workforce capacity to equip all those who touch the lives of pregnant persons and families with young children to address the social-emotional and mental health needs at a time of maximum impact to set the stage for better health and mental health outcomes.

Evelyn Blanck, LCSW, is Executive Director of New York Center for Child Development. Meg Baier, LMSW, is Director of Healthcare Innovation, and Andrew Cleek, PsyD, is Deputy Executive Director of NYU McSilver Institute. To learn more about TTAC, please visit TTACNY.org. To learn more about Pathways please visit www.ctacny.org/special-initiatives/pathways-to-professional-development/ For questions, please contact ttac.info@nyu.edu.

Preventing Suicide from page 33

issue" (Castro-Ramirez, Al-Suwaidi, Garcia, Rankin, Ricard, & Nock, M. K., 2021).

Strategies and Community Resources

Preventing youth suicide requires a collaborative decision-making approach that involves the youth, recognizing the importance of community engagement in the development of "*gatekeepers*." Ertl et al. (2020) define the terminology *gatekeepers* as community members, including teachers, coaches, and healthcare providers, who are trained to recognize individuals at risk for suicide and refer them to appropriate treatment or support services. Some approaches include:

- **Faith-Based and Mental Health Integration**: Faith leaders can incorporate information regarding mental health challenges, suicidal thoughts, and behaviors into their work and teachings. They can also help by strengthening connectedness in their faith community, which is a key factor in decreasing youth suicide (Johnson, Harwell, Miller, & Rosenblum, 2024).
- **Community Engagement and Activities**: Community-based programs, such as mentorship initiatives like Big Brothers Big Sisters of America and volunteer services, offer invaluable opportunities for youth engagement. These programs focus on fostering personal growth by providing social support, helping young individuals feel connected, and reducing feelings of isolation (SAMHSA, 2024).

Tiffany N. Jackson, LMHC, MBA, NCC, QS

- **Individual Psychotherapy**: Individual therapy offers emotional support, helping youth express their emotional challenges. While this approach can be effective for some, it is imperative for it to be a client-centered treatment approach. Some youth may find this method of treatment unsatisfactory due to past negative experiences or a lack of trust in the provider (Horowitz, Tipton, & Pao, 2020).
- **Group Therapy and Peer Support**: Offering peer support-led groups can help youth share their experiences with one another and navigate through the challenges they face. Programs like Bring Change 2 Mind (BC2M), are a mental health awareness club focusing on schools with a high enrollment of historically underserved groups. In addition, Sources of Strength is a peer-led, evidence-based suicide prevention program for secondary schools. This program trains students to be peer leaders and connects them with adult advisors, both at school and in the community (Horowitz et al., 2020).

Youth Suicide Prevention
Is a Community Responsibility

Adolescence is a time of significant developmental change, both physically and emotionally. It is also a period of vulnerability as youth navigate a variety of pressures, from social relationships to the influence of social media and family dynamics. These elements can sometimes contribute to feelings of hopelessness, isolation, and suicidal ideations. Allowing mental health support to be more accessible, whether through school-based programs, peer groups, faith leaders, or community engagement, can provide youth with the opportunity to seek help when desired. Additionally, reducing stigma around seeking help is just as important in encouraging those who are struggling to reach out and not feel ashamed of their feelings. Understanding the conditions that lead to youth suicide is essential in shaping proactive, targeted interventions. Building a culture of care that prioritizes mental health, especially during adolescence, could be a powerful step toward reducing suicide rates among youth and saving the lives of generations to come (Cha et al., 2018).

Tiffany N. Jackson, LMHC, MBA, NCC, QS, is a nationally certified counselor and certified intervention training trainer in the state of Florida.

References

Center for Faith-based and Neighborhood Partnerships. (2022). Youth Mental Health and Well-being in Faith and Community Settings: Practicing Connectedness. Retrieved from www.hhs.gov

Cha, C. B., Franz, P. J., Guzman, E. M., Glenn, C. R., Kleiman, E. M., & Nock, M. K. (2018). Suicide among Youth: Epidemiology, (Potential) Etiology, and Treatment. Journal Child Psychology Psychiatry, 59(4):460-482. Retrieved from www.ncbi.nlm.nih.gov

Ertl, A., Crosby A. E., & Blair, J. M. (2020). Youth Suicide: An Opportunity for Prevention. Journal of the American Academy of Child & Adolescent Psychiatry, 59(9):1019-1021. Retrieved from ncbi.nlm.nih.gov

Horowitz, L., Tipton, M. V., & Pao, Maryland. (2020). Primary and Secondary Prevention of Youth Suicide, 145 (2): S195-S203. Retrieved from www.hhs.gov

Johnson, B. J., Harwell, E. J., Miller, C., & Rosenblum, L. B. (2024). Hope: A Guide for Faith Leader to Help Prevent Youth Suicide. Retrieved from www.hhs.gov

Mata-Greve, F., Johnson, M., & Blanchard, B. E. (2022). A Longitudinal Examination of Cultural Risk Factors of Suicide and Emotional Regulation. Retrieved from apa.com

Substance Abuse and Mental Health Services Administration (SAMHSA) (2024). Suicide Prevention Strategies for Underserved Youth. Retrieved from www.pcssnow.org

TMS for Teens from page 11

Pilot data from Family Care Center's recent adolescent study using a sequential bilateral TMS protocol found that patients showed meaningful progress after an average of 29 treatment sessions. While most medications take four to six weeks to be effective, more than half of patients responded positively to this six-week TMS course, with many experiencing significant symptom relief.

- **Depression Symptoms:** 64% of patients showed significant improvement in their depression symptoms, meaning their scores dropped by at least half. 57% saw their symptoms improve so much that they were considered in remission (very minimal or no symptoms). On average, depression scores dropped by 57%.
- **Anxiety Symptoms:** Of the patients who also took an anxiety test, 44% saw their anxiety scores cut in half, and 33% had their symptoms improve enough to be considered in remission. On average, anxiety scores dropped by 32%.

The results reflect similar data where the same sequential bilateral (SBL) protocol was applied to adults, and improvements were observed for both depression (Segal, Weber et al., 2023) and anxiety (Segal, Weber et al., 2024). Family Care Center plans to conduct additional TMS studies on adolescents with much larger sample sizes.

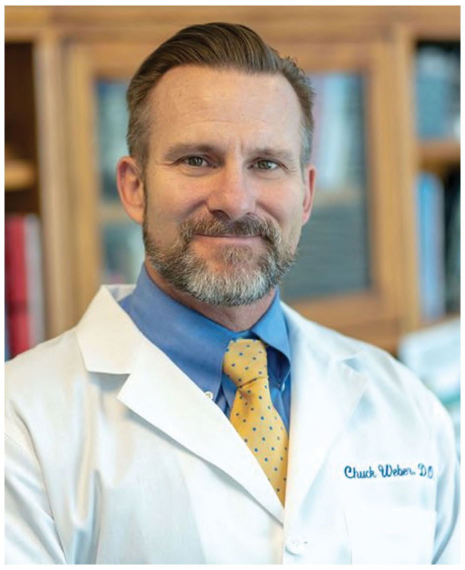
Integrating TMS into a Comprehensive Treatment Plan

A multi-faceted approach is often key to effectively treating adolescent depression, combining therapies that address both the mind and body. Integrating treatments like TMS into a comprehensive care plan can lead to improved outcomes for teens struggling with depression.

Recent clinical outcomes at Family Care Center demonstrate the importance of this multi-modal approach. Among patients receiving a combination of therapy, medication, and TMS, 95% saw a significant reduction in depressive symptoms within six months. This underscores the value of combining TMS with other treatments to address the complex nature of adolescent depression.

Empowering Teens and Families through Informed Decisions

By shedding light on the efficacy of TMS and its role in treating depression, this approach offers hope and guidance for teens and families facing mental health challenges. As awareness expands and more options become available, adolescent mental well-being stands to improve, paving the way for healthier individuals and stronger family support systems.



Chuck Weber, DO

Ultimately, understanding TMS empowers teens and their families to seek appropriate care, make informed decisions, and build resilience in the face of mental health struggles.

Chuck Weber, DO, is Founder and Chief Medical Officer of Family Care Center.

References

Croarkin PE, Aaronson ST, Carpenter LL, et al. Real-world effectiveness of TMS in adolescents and young adults with major depressive disorder. Transcranial Magnetic Stimulation 2024;1:100028.

Qiu H, Liang K, Lu, L. Efficacy and safety of repetitive transcranial magnetic stimulation in children and adolescents with depression: a systematic review and preliminary meta-analysis. Journal of Affective Disorders 2023;320:305-312.

Segal, S., Weber, C., & McNiece, S. (2024). Clinical outcomes in adolescents undergoing sequential bilateral 1 Hz/20 Hz transcranial magnetic stimulation for treatment-resistant depression. *Brain Stimulation*, 17(2).

Dwyer, J. B., & Bloch, M. H. (2019). Antidepressants for Pediatric Patients. *Current Psychiatry*, *18*(9), 26.

Family from page 28

One parent survey responder commented:

"Treat children who have mental health issues with the same warmth and kindness that you would have for medical illness. Behaviors are not the problem; they're the symptom."

As well, families seek to be actively engaged in the therapy process. Another parent shared in their recommendation for mental health providers:

"Wake up and pay attention... Listen to the families-- they know the child best. Spend time with the child and really just actively listen to what is being said."

Families Together in New York State supports and advocates for youth and families' voices in policy and systems change to ensure an equitable and inclusive journey that fosters belonging, wellness, and empowerment for all. The NYS Families Together 2025 Policy Agenda was created by families of children and youth with social, emotional, behavioral, and cross-system challenges. The Agenda advocates for coverage parity between commercial and Medicaid insurers to promote access to timely care provided through a robust continuum of mental health and substance use disorder services for all of New York's children, youth, and families. It also advocates for a 7.8% rate increase for mental health and substance use disorder treatment programs to support efforts to address the state's workforce shortage, plus additional funding to support the availability of Youth Peer Support.

These priorities amplify an array of opportunities that mental health and substance use treatment providers have to improve the care provided to youth and families in New York State. Certified Community Behavioral Health Clinics have financing support for a full array of evidence-based youth-centered and family-driven care, including care for the entire family and team-based care delivery that integrates Family Peer Advocates and Youth Peer Support. Evidence-based approaches for working with the family as a unit demonstrate better outcomes and treatment completion in fewer sessions (e.g., Berry et al., 2023; Lynch et al., 2022). Family-based care involves addressing change opportunities across all members of the system and not the child or youth alone. Stigma and the erroneous belief that mental health exclusively resides within an individual's locus of control are barriers to advancement (e.g., Saroca & Sargent, 2022). Family Peer Advocates and Youth Peer Advocates offer vital support to advance recovery and require thoughtful integration throughout the continuum of care.

Families Together NYS provides access to a variety of ongoing technical assistance events and trainings for Family Peer Advocates, supervisors, and Youth Peer Advocates. Families Together also hosts a statewide job board to support recruitment efforts for this critical workforce and shares guidance for starting Youth Advisory Councils to develop services that are truly responsive to youth needs. Additionally, staff at OMH-licensed, child-serving programs can also access free decision support for evidence-based and data informed care delivery to children and youth via the state's investment in Managing and Adapting Practice (MAP). The Evidence-Based Treatment Dissemination Center (EBTDC) serves as the hub for MAP training and credentialing under NYS OMH. This resource supports providers to identify the "next best action" based on research relevant to a child or youth's specific needs.

As well, robust school-based access to evidence-based interventions is increasingly available. The Staten Island Borough President's Office, in partnership with OMH's Suicide Prevention Center of NYS (SPCNY), has begun to implement one such model, guided by the Staten Island Behavioral Health Blueprint for Staten Island Children and Young Adults. The Blueprint established a north star goal of zero suicides and was developed with extensive community participation from educators, school leadership, treatment providers, mental health staff from community-based organizations, social service agencies, as well as clergy, parents, and youth. In 2025, these efforts led to the MISSION Project (Multi-tier Integrated Supports for Suicide Prevention Implementation and Outcomes in New York), funded by a 5-year SAMHSA Garrett Lee Smith Youth Suicide Prevention grant.

For youth identified to be at the highest risk for crisis (suicide or SUD overdose) and in need of immediate intervention, four of Staten Island's larger treatment providers have been enlisted to provide access to crisis de-escalation and a specialized intensive outpatient model within 24 to 48 hours. This model combines Collaborative Assessment and Management (CAMS) and Dialectical Behavioral Therapy (DBT), preferably with family participation and support from Family and Youth Peer Advocates. So far, the evidence suggests this approach is a game changer for families and youth. Providers are discovering that *not only can hospitalization be avoided, but that after only 5-6 weeks of intensive outpatient therapy, youth are going into remission and potentially avoiding the development of more serious mental health conditions*. This model allows youth to remain at school and at home in their community while receiving treatment without the disruption and trauma of the emergency room or hospitalization.

These efforts and innovations are improving the quality of care and advancing access to recovery by actively engaging families and youth. To learn from more families and youth ages 12-26, Families Together in New York State is supporting the dissemination of the Lifting Voices surveys. Both surveys remain open and available. To promote dissemination, just share the link: www.liftingvoices.org or contact the authors to learn how you can brand the surveys to support local community needs assessments, inform service planning, and otherwise advance the movement to improve care access and quality for youth and their families.

Heidi Arthur, LMSW; Ellen Breslin, MPP; and Jennifer Hodgson, PhD, LMFT, are all Principals at Health Management Associates (HMA), and Paige Pierce, BA, is the Chief Executive Officer of Families Together in New York State. The authors are the co-founders of the Lifting Voices initiative, experts in behavioral health care delivery from Health Management Associates, a national healthcare consulting firm, and Families Together in New York State, the statewide advocacy organization for families whose loved ones experience mental health and/or substance use disorders.

References

Berry, K. R., Gliske, K., Schmidt, C., Ballard, J., Killian, M., & Fenkel, C. (2023). The Impact of Family Therapy Participation on Youths and Young Adult Engagement and Retention in a Telehealth Intensive Outpatient Program: Quality Improvement Analysis. *JMIR formative research*, *7*, e45305. https://doi.org/10.2196/45305

Lynch, L., Moorhead, A., Long, M., & Hawthorne-Steele, I. (2023). The role of informal sources of help in young people's access to, engagement with, and maintenance in professional mental health care—A scoping review. *Journal of Child and Family Studies*, *32*(11), 3350-3365.

Saroca, K., & Sargent, J. (2022). Understanding Families as Essential in Psychiatric Practice. *Focus (American Psychiatric Publishing)*, *20*(2), 204–209. https://doi.org/10.1176/appi.focus.20210035

Cyberbullying from page 10

social isolation that may have been caused by cyberbullying and set up a plan that's right for the family.

Scott Bloom, LCSW, is the Director of Special Projects at the New York Psychotherapy and Counseling Center. He can be reached at SBloom@nypcc.org or (347) 352-1518.

Resources

Common Sense Media

Steps to Respect - Bullying prevention and friendship development (Committee for Children)

Eyes on Bullying Toolkit: What Can You Do?

15+ Make Time to Listen, Take Time to Talk…About Bullying - Conversation starters (Substance Abuse and Mental Health Services Administration)

Words That Heal: Using Children's Literature to Prevent Bullying (Antidefamation League)

PACER's National Bullying Prevention Center

Scott Bloom, LCSW

References

American Occupational Therapy Association, Inc, 2013. http://www.aota.org/Practice/Children-Youth/Mental%20Health/School-Mental-Health.aspx

Center for the Study and Prevention of Violence, 2008. An overview of bullying [Fact sheet]. Retrieved from http://www.colorado.edu/cspv/publications/factsheets/safeschools/FS-SC07.pdf

Child Mind, 2025. https://childmind.org/article/help-kids-deal-cyberbullying/

Hamm M. P., Newton, A. S., & Chisholm, A. (2015). Prevalence and effect of cyberbullying on children and young people: A scoping review of social media students. JAMA Pediatrics, 169, 770-777.

Kowalski, R. M., Giumetti, G. W., Schroeder, A. N., & Lattanner, M. R. (2014). Bullying in the Digital Age: A Critical Review and Meta-Analysis of Cyberbullying Research Among Youth. Psychological Bulletin, 140(4), 1073-1137.

Nansel, T. R., Overpeck, M., Pilla, R. S., Ruan, W. J., Simons-Morton, B., & Scheidt, P. (2001). Bullying behaviors among U.S. youth: Prevalence and association with psychosocial adjustment. JAMA, 285, 2094–2100.

Shetgiri R. Bullying and victimization among children. Adv Pediatr. 2013;60(1):33-51. doi: 10.1016/j.yapd.2013.04.004. Epub 2013 Jul 12. PMID: 24007839; PMCID: PMC3766526.

Stop Bullying.gov. 2021. How to Prevent Cyberbullying: A Guide for Parents, Caregivers, and Youth. https://www.stopbullying.gov/cyberbullying/what-is-it

Tzani, Calli. (2018) The Conversation.com. https://theconversation.com/childhood-bullying-can-cause-lifelong-psychological-damage-heres-how-to-spot-the-signs-and-move-on-100288

Understood.org; 2025. https://www.understood.org/en/friends-feelings/child-social-situations/online-activities-social-media/cyberbullying-what-you-need-to-know

---

Embracing Healing from page 30

Implementing Trauma-Informed Care in Child Welfare

Implementing TIC in child welfare systems is a complex process but one with promising results. Jankowski et al. (2019) evaluated a statewide trauma-informed care intervention and found improvements in trauma screening, initial case planning, and perceptions of system performance. This study demonstrates that systemic changes can lead to tangible improvements in care delivery and outcomes for families involved in child welfare.

Key components of implementing trauma-informed care in child welfare systems include:

1. Training staff at all levels on trauma and its impacts
2. Incorporating trauma screening and assessment into standard procedures
3. Developing trauma-specific interventions and evidence-based treatments
4. Creating a safe and supportive organizational culture
5. Collaborating with other agencies and community partners to provide comprehensive care

While understanding trauma is crucial, the concept of resilience is equally important. Resilience occurs when positive experiences outweigh adverse ones. Masten (2014) defines resilience as "the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development" (p. 6). The single most significant protective factor in preventing both childhood trauma and its adverse outcomes is the presence of a safe, stable, nurturing adult caregiver consistently present in a child's life (National Scientific Council on the Developing Child, 2015). This underscores the importance of supporting parents and caregivers in developing strong, positive relationships with their children.

Shanika L. Wilson, DSW, LCAS, LCSW

Trauma-informed care recognizes that healing happens in relationships. It emphasizes the importance of involving the entire family in the healing process. By supporting parents and caregivers, we can help break the intergenerational transmission of trauma (Kimberg & Wheeler, 2019).

Family-centered approaches to trauma-informed care include:

1. Providing psychoeducation to families about trauma and its effects
2. Offering family therapy and support groups
3. Teaching parenting skills that promote attachment and emotional regulation
4. Connecting families with community resources and support networks
5. Addressing parents' own trauma histories and mental health needs

The Future of Trauma-Informed Care

As we move forward, the focus is shifting towards creating trauma-informed systems that not only support children and families but also care for the well-being of providers and staff. This holistic approach recognizes that everyone in the system plays a role in healing and resilience.

Emerging areas of research and practice in trauma-informed care include:

1. Cultural adaptations of trauma-informed practices to better serve diverse populations
2. Integration of trauma-informed care principles into educational settings
3. Exploration of the intersections between trauma-informed care and social justice initiatives
4. Development of technology-based interventions to increase access to trauma-informed support

In conclusion, trauma-informed care offers a powerful framework for supporting families in healing from adversity. By understanding the impact of trauma, fostering resilience, and working together, we can create a future where families not only survive trauma but thrive in its aftermath. As we continue to refine and expand our approaches to trauma-informed care, we move closer to a world where every family has the support and resources they need to heal and grow stronger together.

Shanika Lavi Wilson, DSW, LCAS, LCSW (She/Her) is the Interim MSW Program Director and an Associate Professor in the Department of Social Work at North Carolina Central University. She can be reached at 919-423-7952 or via email at swils108@nccu.edu.

References

Bartlett, J. D., & Rushovich, B. (2018). Implementation of trauma systems therapy-foster care in child welfare. Children and Youth Services Review, 91, 30-38.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258.

Jankowski, M. K., Schifferdecker, K. E., Butcher, R. L., Foster-Johnson, L., & Barnett, E. R. (2019). Effectiveness of a trauma-informed care initiative in a state child welfare system: A randomized study. Child Maltreatment, 24(1), 86-97.

Kimberg, L., & Wheeler, M. (2019). Trauma and trauma-informed care. In M. R. Gerber (Ed.), Trauma-Informed Healthcare Approaches (pp. 25-56). Springer.

Masten, A. S. (2014). Global perspectives on resilience in children and youth. Child Development, 85(1), 6-20.

Murray, K. J., Liang, A., Barnack-Tavlaris, J. L., Navarro, A. M., Flett, G. L., & Zautra, A. J. (2019). The role of social support in the relationship between childhood trauma and depression among survivors of childhood trauma. Journal of Interpersonal Violence, 34(21-22), 4601-4623.

National Scientific Council on the Developing Child. (2015). Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper No. 13. Retrieved from https://developingchild.harvard.edu/resources/supportive-relationships-and-active-skill-building-strengthen-the-foundations-of-resilience/

Substance Abuse and Mental Health Services Administration. (2014). 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.

Youth Suicide* from *page 12

- 10% ever using illicit drugs.

Many of these issues are influenced by external factors, systemic inequities, and barriers, with stark differences in suicide and substance use disorder rates among youth across various demographic variations based on race, ethnicity, gender, sexual orientation, and geography.

Suicide rates and drug overdose deaths remain disproportionately high among non-Hispanic American Indian and Alaska Native youths[10], and many of the factors contributing to these high rates include systemic poverty, limited access to mental and SUD care, and significant historical trauma.[11] Recent studies have shown a worrying increase in suicide rates among Black children and teenagers, significantly outpacing other groups.[12] Additionally, boys are particularly at risk, constituting nearly 80% of suicide cases[13] and more than two-thirds of overdose deaths—90% of those deaths involved opioids, 84% involved illicitly manufactured fentanyl (IMF), and 25% involved counterfeit pills.[14] LGBTQ+ youth are at high risk, reporting significantly higher rates of sadness, hopelessness, suicidal behavior, and SUD compared to their heterosexual peers. Homophobia, bullying, and a lack of social support are significant factors that contribute to higher stress levels and mental health challenges.[15] LGBTQ+ youth are more likely to experience substance use as a coping mechanism for emotional and psychological distress.[16]

Socioeconomic factors and accessibility to behavioral health supports and services play a critical role in influencing outcomes among youth. Economic instability, lack of health insurance, and living in under-resourced communities influence the rates of suicide and substance use among youth; for example, lower socioeconomic status is often correlated with higher exposure to various risk factors for behavioral health conditions, including food insecurity, exposure to violence, familial instability, limited access to educational or employment opportunities.

There is often a significant disparity in the availability and accessibility of mental health and/or substance use services between urban and rural areas, with rural areas typically having fewer resources. This geographical disparity can delay the diagnosis and treatment of mental health and substance use disorders, allowing them to progress to more severe states.

Adolescents also face numerous barriers to accessing effective treatment for SUDs[17], including a lack of youth-focused SUD programming—typically abstinence-based with high rates of dropout[18], and limited availability to specialized residential treatment facilities, all too often with long wait lists and high costs.[19] Additionally, medications like buprenorphine are FDA-approved for 16 and older, and very few adolescents receive this medication. The majority of residential settings do not prescribe it to adolescents.[20]

Youth without health insurance or with inadequate coverage have a much harder time accessing or affording behavioral health services, which delays them from receiving timely and effective treatment for their mental health issues and SUDs. Accessibility is not just about physical availability but also about the relevance and sensitivity of the services provided.

Jorge R Petit, MD

There is a need for culturally competent care that takes into account the cultural, social, and linguistic needs of diverse populations, and the lack of such tailored care can discourage youth from seeking help or adhering to treatment plans.

In many communities, especially in lower SES or certain cultural groups, there is a significant stigma associated with mental illness and substance use, which we know prevents young people from seeking help due to fear of discrimination or misunderstanding from their family and peers. A recent study[21] focused on adolescent perspectives on the facilitators, barriers, and preferences for health services, specifically in addressing opioid use disorder (OUD). Key barriers included stigma, lack of motivation, and external influences from peers. Facilitators were supportive environments and accessible health services, underscoring the need for more effective health services that align with the preferences and actual environments of the youth.

These disparities and barriers call out the critical need for continued efforts in addressing behavioral health issues among youth and highlight the need for targeted interventions and policy adjustments to address the specific needs of our youth. Understanding the complex interplay between mental health disorders, substance use, suicidal ideation, and overdose risks is crucial in developing effective prevention and intervention strategies that can save lives.

Effective interventions require integrated treatment approaches that address both mental health and substance use simultaneously to improve outcomes[22]. Ongoing prevention efforts must be focused on enhancing behavioral health support, reducing access to means of suicide, overdose safety planning, and promoting social connectivity and resilience among youth.

Addressing the rising trends of mental health issues and substance use disorders among youth, with an emphasis on decreasing the rates of suicide and overdose, requires coordinated efforts from policymakers, educational institutions, communities, and the healthcare system.

Here are some recommendations that can start to make an impact on the dual crisis of youth suicide and substance use disorders:

Policymakers

1. **Enhance Funding for Mental Health Services:** Increase allocation of federal and state funds to expand mental health and SUD supports, services, and treatment options, especially in underserved areas and to at-risk groups.
2. **Support School-Based Health Programs:** Legislate for the integration of comprehensive behavioral health services in schools, including funding for school counselors and access to emergency behavioral health interventions.
3. **Enforce and Expand Mental Health Parity:** Ensure that mental health and physical health are treated equally in insurance coverage and rigorously enforce existing mental health parity laws to reduce disparities in treatment access.
4. **Promote Early Intervention Programs:** Invest in early screening and intervention programs within schools and community centers to identify mental health and SUD issues before they escalate.

Educational Institutions

1. **Implement Comprehensive School Behavioral Health Systems:** Develop and implement an integrated system that includes training for teachers on the signs of mental health issues and SUD, alongside providing in-school counseling services.

   Organizations like the School-Based Health Alliance work to integrate mental health services directly into schools, where mental health professionals provide counseling, crisis intervention, and ongoing support directly on campus. This not only reduces stigma associated with seeking help but also increases accessibility for students who might not have reliable transportation or parental support for off-campus appointments.

2. **Curriculum Integration:** Include well-being and behavioral health education within the school curriculum to raise awareness, reduce stigma, and promote health-seeking behavior among students.
3. **Crisis Management Protocols:** Establish clear protocols for handling behavioral health crises, including the availability of behavioral health professionals and clear pathways for immediate intervention and support.
4. **Peer Support Programs:** Facilitate peer mentoring and support programs that train students to recognize signs of mental distress among their peers and provide initial support or referral to professional help.

Youth MOVE National advocates for peer support roles within mental health and substance use treatment settings. These programs train young people who have lived experience with mental health conditions or recovery from substance use to provide support, mentorship, and guidance to their peers, which can be particularly empowering and effective in promoting recovery and resilience.

Communities

1. **Community-Based Outreach Programs:** Launch community outreach programs aimed at educating parents and youth about mental health and SUD issues—like Mental Health First Aid—focusing on early signs, prevention strategies, and available treatment options.
2. **Access to Community Centers:** Support the creation or enhancement of community centers that provide free or low-cost behavioral health services and act as safe spaces for young people to seek help.
3. **Partnerships Between Community Groups and Health Providers:** Foster collaborations between schools, local health services, and community organizations to create a cohesive support system that addresses the broad spectrum of youth needs.
4. **Cultural Competence:** Encourage community programs to incorporate culturally competent practices that respect and understand the diverse backgrounds of community members to ensure effective communication and intervention strategies.

Many communities have developed outreach programs that focus on educating youth about the risks associated with substance use, as well as strategies for emotional regulation and coping with stress. Programs such as the Community Anti-Drug Coalitions of America (CADCA) train youth leaders to conduct peer education sessions, enhancing community resilience and knowledge about substance abuse prevention.

Healthcare System

1. **Promote Interdisciplinary Collaboration:** Encourage cooperation among psychiatrists, psychologists, social workers, and pediatric providers to ensure a holistic approach to mental health care. Integrated care models that encompass physical and behavioral health lead to better patient outcomes[23]
2. **Implement Routine Screening:** Incorporate routine mental health and substance use screenings during medical visits for all youth. Early detection of mental health issues and substance use disorders can significantly improve the effectiveness of interventions. Early and universal screening for suicide and overdose risk, using tools like the Columbia-Suicide Severity Rating Scale (C-SSRS) and Zero Overdose (ZO) OD Safety Planning, is crucial. These can identify at-risk individuals promptly, allowing for timely interventions that can save lives and significantly reduce the incidence of suicide and overdose events among youth.
3. **Enhance Training:** Provide ongoing education and training for all healthcare providers on the latest treatments and interventions for mental health and substance use disorders. Special focus should be on emerging trends and evidence-based practices, especially focused on adolescents.
4. **Community-Based Initiatives:** Engage with and support community programs that work toward preventing mental health issues and substance use disorders in youth. This can include

see Youth Suicide on page 41

Parenting from page 27

medication management, and peer support groups, have shown efficacy in reducing symptoms and improving daily functioning (Hofmann et al., 2012). Parents should work with mental health professionals to create a treatment plan that accommodates their parenting responsibilities.

2. Building a Reliable Support System - Social support plays a crucial role in buffering the impact of mental illness. Studies indicate that parents with strong networks—including family, friends, and community support groups—report lower levels of stress and improved parenting outcomes. Engaging with local parenting support groups or seeking mentorship from other parents with similar experiences can provide validation and practical strategies.

3. Establishing Predictable Routines - Children thrive on stability, and establishing consistent routines can help mitigate the effects of a parent's fluctuating mental health. Structured schedules for meals, bedtime, and activities create a sense of security for children and reduce stress for parents. Parents experiencing depressive or manic episodes may benefit from external reminders, such as planners or digital alarms, to maintain these routines.

4. Age-Appropriate Conversations with Children - Research supports the benefits of open communication about mental illness within families. Children are often perceptive to changes in their parent's behavior and may develop fears or misconceptions if left uninformed. Explaining mental health conditions in simple, non-threatening terms can reassure children and encourage empathy.

Vishwani Sahai-Siddiqui, MD

The Role of Healthcare Providers and Policy Change

Healthcare professionals can play a pivotal role in supporting parents with mental illness by integrating parenting concerns into mental health treatment plans. Family-focused interventions, such as Beardslee's Family Talk intervention, have demonstrated effectiveness in improving communication and resilience among families affected by parental mental illness.

On a broader scale, policy changes aimed at increasing access to mental health care, expanding parental leave policies, and reducing financial barriers to treatment can enhance outcomes for affected families. Advocating for workplace accommodations, such as flexible scheduling for parents managing mental health appointments, can also make a significant difference.

Parenting with mental illness presents unique challenges, but with proper support, treatment, and reducing stigma, parents can provide their children with loving and stable environments. Breaking the silence around this topic is essential to creating a culture of understanding and proactive support. By integrating mental health care with parenting resources, society can empower parents with mental illness to thrive in their roles.

Vishwani's opinions are her own and are for informational purposes only. They are not intended to diagnose, treat, or provide medical advice. Please consult a qualified healthcare professional for personalized medical care.

Vishwani Sahai-Siddiqui is a residency- and fellowship-trained psychiatrist, now a medical writer and editor, and the owner of The Cognitive Quill. For more information, please visit cognitivequill.com or email vishwanipsychmd@gmail.com.

References

Beardslee, W. R., Solantaus, T., Morgan, B. S., Gladstone, T. R., & Kowalenko, N. (2011). Preventive interventions for children of parents with depression: International perspectives. *Medical Journal of Australia, 195*(3), S23-S25.

Creswell, C., Murray, L., Stacey, J., & Cooper, P. J. (2010). Parenting and child anxiety. *Clinical Child and Family Psychology Review, 13*(2), 151-163.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research, 36*(5), 427-440.

Kochanska, G., & Kim, S. (2012). Toward a new understanding of legacy of early attachments for future antisocial trajectories: Evidence from two longitudinal studies. *Development and Psychopathology, 24*(3), 783-806.

Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review, 20*(5), 561-592.

Meadows, S. O., McLanahan, S. S., & Brooks-Gunn, J. (2007). Parental mental health and child well-being: A longitudinal study. *Journal of Family Issues, 28*(8), 994-1014.

National Institute of Mental Health (NIMH). (2022). Mental illness. https://www.nimh.nih.gov

Nicholson, J., Biebel, K., Katz-Leavy, J., & Williams, V. F. (2004). The prevalence of parenthood in adults with mental illness: Implications for state and federal policymakers, programs, and providers. *Psychiatric Rehabilitation Journal, 28*(2), 186-194.

Pihkala, H., Sandlund, M., & Cederström, A. (2020). Children in Beardslee's family intervention: Relieved by understanding of parental mental illness. *International Journal of Social Psychiatry, 66*(3), 292-298.

Van Meter, A., Moreira, A. L. R., & Youngstrom, E. (2016). Meta-analysis of epidemiological studies of pediatric bipolar disorder. *Journal of Clinical Psychiatry, 77*(9), e1237-e1247.

Youth Suicide from page 40

participating in outreach efforts, providing expert advice, and facilitating workshops or seminars.

5. **Leverage Technology for Better Reach:** Utilize telemedicine and online technology-assisted care solutions to reach young people who may not have easy access to traditional healthcare settings. This is especially important in rural or underserved areas and among marginalized groups.

   There are a growing number of apps and online platforms that offer tailored mental health resources and connect young people with therapists via text, call, or video. These tools are designed to meet youth where they are—online—and provide confidential and immediate support for those who might be reluctant to seek face-to-face counseling. In NYC, the Department of Health and Mental Hygiene partnered with Talkspace to offer free mental health support program available to any teenager age 13 to 17.

As we confront the escalating trends of mental health issues and substance use disorders among youth, the need for a concerted, collaborative effort becomes ever more apparent. The healthcare system, policymakers, educational institutions, and communities must unite to expand and enhance behavioral health resources.

It is crucial that we continue to innovate and invest in comprehensive strategies that include early intervention, integrated school-based health programs, and community outreach that is culturally competent and accessible to all. Only through sustained commitment and proactive engagement can we hope to stem the tide of rising mental health and substance use challenges facing our youth today.

Together, we can build a foundation for a healthier future for our children, prioritizing well-being as part of our collective commitment to nurturing resilient and thriving homes and communities.

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, LinkedIn: Dr. Jorge Petit, MD, or Substack: drjrpetit.substack.com.

Footnotes

1. pmc.ncbi.nlm.nih.gov/articles/PMC9955022/pdf/children-10-00293.pdf
2. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0255799 https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf
3. Jones CM, Zhang K, Han B, et al. Estimated Number of Children Who Lost a Parent to Drug Overdose in the US From 2011 to 2021. JAMA Psychiatry. 2024;81(8):789–796. https://doi:10.1001/jamapsychiatry.2024.0810
4. https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.pdf
5. https://www.clinicaltherapeutics.com/action/showPdf?pii=S0149-2918%2819%2930308-X
6. oneill.law.georgetown.edu/addressing-the-opioid-epidemic-among-adolescents-in-the-united-states/
7. Centers for Disease Control and Prevention. (2024). Youth Risk Behavior Survey Data Summary & Trends Report: 2013–2023. Retrieved from https://www.cdc.gov/yrbs/dstr/.
8. cdc.gov/suicide/facts/data.html
9. cdc.gov/nchs/products/databriefs/db522.htm
10. cdc.gov/suicide/facts/data.html
11. Sheftall AH, Vakil F, Ruch DA, Boyd RC, Lindsey MA, Bridge JA. Black youth suicide: Investigation of current trends and precipitating circumstances. Journal of the American Academy of Child and Adolescent Psychiatry. 2022;61(5):662-675. dx.doi.org/10.1016/j
12. https://pmc.ncbi.nlm.nih.gov/articles/PMC9437900/pdf/nihms-1832384.pdf
13. https://www.cdc.gov/mmwr/volumes/71/wr/mm7150a2.htm
14. cdc.gov/yrbs/dstr/index.html
15. https://www.cdc.gov/mmwr/volumes/73/su/su7304a9.htm
16. kff.org/mental-health/issue-brief/teens-drugs-and-overdose-contrasting-pre-pandemic-and-current-trends/
17. oneill.law.georgetown.edu/addressing-the-opioid-epidemic-among-adolescents-in-the-united-states/
18. nida.nih.gov/news-events/news-releases/2024/01/residential-addiction-treatment-for-adolescents-is-scarce-and-expensive
19. https://pmc.ncbi.nlm.nih.gov/articles/PMC6003902/
20. https://www.jahonline.org/article/S1054-139X(24)00691-8/pdf
21. https://srrjournals.com/ijsrmd/sites/default/files/IJSRMD-2024-0032.pdf
22. bipartisanpolicy.org/youth-mental-health-and-substance-use-task-force/

Cultural Competence* from *page 18

Black and Brown youth. This not only improves the quality of care but also ensures that these youth feel seen, respected, and valued in the therapeutic process.

One key technique to foster cultural competence is **ongoing training** for behavioral health professionals. Training providers who recognize and understand the impact of systemic racism on mental health can help them better support youth who may be facing these challenges. For example, courses that address the historical and cultural factors influencing behavior, as well as the stigmas around mental health in various communities, can help providers offer more informed care.

Another important technique is **incorporating cultural knowledge** into treatment plans. By understanding the cultural significance of family dynamics, community ties, and traditional healing practices, providers can develop more comprehensive, individualized care plans. This is crucial for creating a therapeutic environment where youth feel understood and supported, ensuring higher levels of engagement.

Finally, **community collaboration** plays a vital role in enhancing cultural competence. Building partnerships with community leaders and organizations that represent Black and Brown populations can help providers better understand the specific needs of youth from these communities. This collaboration can also serve as a bridge to foster trust and ensure the delivery of care that resonates with the youth's cultural context, improving outcomes and reducing barriers to treatment.

Clementina Jose, LMSW

The Role of Early Intervention

The earlier mental health issues are identified and addressed, the better the outcomes. Early intervention can prevent mental health problems from escalating and promote healthy coping strategies, resilience, and overall well-being. For Black and Brown youth, culturally competent care in early intervention can have an especially profound impact.

By creating safe spaces where youth feel understood and supported, providers can encourage early help-seeking behaviors and prevent negative long-term consequences. Additionally, culturally competent early intervention can improve communication between youth, their families, and the larger community, fostering a holistic approach to care. For instance, incorporating the perspectives of families and communities can lead to more tailored interventions that resonate with the youth and their cultural context. A culturally grounded approach can also encourage youth to develop coping strategies rooted in their community's values, leading to more sustainable and meaningful healing practices.

Conclusion

Cultural competence in behavioral health services is not just a "nice-to-have" feature but an essential component of effective early intervention for Black and Brown youth. By understanding and respecting the cultural backgrounds of these young individuals, providers can break the cycle of disadvantage, improving engagement, trust, and mental health outcomes. As we work toward creating more equitable healthcare systems, cultural competence must be prioritized to ensure that every child receives the care and support they deserve.

Clementina Jose, LMSW is Program Manager of LaGuardia Community College. For more information on cultural competence in behavioral health and early intervention strategies, email Clementina at Clementinaconsults@gmail.com. You can also reach me by phone at 347-869-2251.

References

American Psychological Association. (2021). *Mental Health Disparities: Diverse Populations.* Retrieved from apa.org.

Sue, S., Cheng, J. K. Y., Saad, C. M., & Chu, J. P. (2009). *Asian American mental health: A social and emotional wellbeing perspective.* Springer Science & Business Media.

Williams, D. R., & Mohammed, S. A. (2009). *Discrimination and racial disparities in health: Evidence and needed research.* Journal of Behavioral Medicine, 32(1), 20–47.

CEC Health Care* from *page 16

Integrated Care and Positive Outcomes

CEC Health Care's collaborative approach to care—spanning multiple programs—has resulted in high satisfaction among both parents and children. Through regular communication and coordination between the OMH Clinic, CCBHC, and COMHPS teams, CEC has been able to provide effective, coordinated care that addresses the broad spectrum of issues children face. This integrated approach has led to positive outcomes for many families in the Glen Cove community, demonstrating the power of a multi-faceted, holistic model of care. A study published in the *Journal of Child and Family Studies* highlighted the positive impact of integrated behavioral health services on improving outcomes for children, particularly when multiple service providers collaborate (Cohen et al., 2018).

Erin Barrett, LCAT, is Assistant Director of Children and Adolescent Services at CEC Health Care.

Citations

American Psychological Association. (2019). *Mental Health and Immigrants: An Overview*. Retrieved from www.apa.org

Chavez, L., et al. (2016). *Culturally competent mental health care for immigrant populations. Journal of Immigrant & Refugee Studies*, 14(2), 162-177.

Cohen, J., et al. (2018). *Integrated Behavioral Health and Child Outcomes: A Collaborative Approach. Journal of Child and Family Studies*, 27(5), 1298-1309.

Lester, P., et al. (2016). *Peer-Led Support for Immigrant and Refugee Children. International Journal of Refugee Law*, 28(4), 341-357.

National Alliance on Mental Illness. (2021). *Mental Health in Children and Adolescents*. Retrieved from www.nami.org

National Institute of Mental Health. (2020). *Mental Health and Children*. Retrieved from https://www.nimh.nih.gov

Pipher, M. (2002). *The Role of Creative Arts in Trauma Recovery for Children. Journal of Child & Adolescent Trauma*, 6(3), 202-220.

U.S. Department of Health & Human Services. (2021). *Parent and Family Engagement in Child Mental Health Care*. Retrieved from https://www.hhs.gov

Erin Barrett, LCAT

HIPAA* from *page 35

above, the young adult actually had a positive relationship with the grandparent. It was the therapist who assumed the contact would be unwanted and a violation.) Your client can also specify limits around what can be disclosed or discussed.

- As with any protected health information, all communication should be done privately (by phone or in person). Any information shared should be handled in the same manner as all other protected health information.

- If a family member contacts the clinician without the client's knowledge, which is often common with children, it is appropriate to state (if the client has not given a HIPAA release) that you cannot share information due to HIPAA. ***But you can listen***. As a matter of clinical standards (as opposed to HIPAA standards), I would never agree to keep the contact with the family member from the client. I would inform the family that I would need to share with the client that we've spoken. No matter the nature of the information, I would not agree to "keep it secret." It is not clinically useful to have information you can't discuss with your client, and it is countertherapeutic for a therapist to be talking about a client without their knowledge.

Elaine Edelman

- Paradoxically, I would not necessarily try to discuss all these possible scenarios at the beginning of treatment. The client does not yet know you well enough to trust you and may be feeling vulnerable with their family. You cannot cover every contingency that might emerge around family contact. Discussing this too early might prematurely force the client to say, "No, I don't want you to have any communication with my family." Once that is made explicit, that must be respected.

Both as a child and adolescent therapist and an inpatient psychiatric social worker, families have contacted me and wanted me to listen to what they have to say. More often than not, information shared by them was helpful for assessment and treatment planning. Children, in particular, live in the context of their family and school. Not involving these systems may render the therapy less helpful than it could be. The connection to the family and the support system also creates pathways to enhancing community supports.

The important thing to remember is that HIPAA is designed to protect privacy and protected health information. Talking about a client without permission is a HIPAA violation. Listening is not and is often a means to create more effective and robust care.

Acknowledgment: David C. Barry, JD, MSW, LSW, for his review of this article.

Elaine Edelman, PhD, LCSW, CASAC-Adv., is Professor of Practice at Kansas State University.

Access Centers from page 21

access, personal hygiene facilities (e.g., showers and laundry), and stocked kitchens.

Evaluation of the Young Adult Access Centers

ForHealth Consulting at UMass Chan Medical School provides continuing evaluation support for the Access Centers by describing the population utilizing the Access Centers, tracking referral sources, monitoring service delivery, and reporting on young adult progress in key domains

Data are collected and managed using a secure electronic database hosted at UMass Chan Medical School.[6] Service data are provided by Access Center staff. For all other information, Access Center staff are asked to collect the data directly from the young adults. All data collection materials are available in English or Spanish.

This article presents data on who used the Access Centers in 2023, what their needs and challenges were, what services they received, and their progress over time.

Young Adults Served

A primary goal of the Access Centers is to engage young people who have not had their needs met elsewhere. In 2023, the 10 Access Centers served 1,292 young adults who engaged 13,074 times. Engagements include interacting with Access Center staff, participating in Access Center programming, or using the Access Center facilities. Thirty-nine percent of young adults engaged once with the Access Center; 22% engaged two to five times, 39% engaged six or more times.

Demographic data and data about current and past lifetime experiences that may influence the transition to adulthood are collected during an initial assessment.

Supports Sought by Young Adults

In 2023, young adults most often came to Access Centers seeking support for employment (49%), personal-effectiveness and wellbeing (37%), living situation (35%), education (34%), and community-life functioning (29%). Personal-effectiveness and wellbeing includes interpersonal relationships, emotional/behavioral wellbeing, self-determination, communication, physical health and wellbeing, and parenting. Community-life functioning includes daily living skills, leisure-time activities, and community participation.

Service Engagement

Young adults choose the services they receive and how they access them. Access Centers offer drop-in hours, groups, individual support services such as TIP and Peer Mentoring, and a variety of other options. The most frequent services provided by Access Centers include drop-in services, recreational activities, amenities, and check-ins with staff.

Approximately three-quarters of the young adults used drop-in services and participated in recreational activities, and over half used the amenities, checked in with staff, and took a tour/learned about the services offered. Of all one-on-one or group engagements provided in 2023, 37% provided support for young adults' emotional/behavioral wellbeing; 29% of the young adults who engaged in these services received emotional/behavioral wellbeing support.

Question or Domain	Percentage with high rating or increased rating after 6 months
Social connectedness (composite score)	**81%**
Functioning (composite score)	**81%**
Reduced frequency of negative feelings (composite score)	**79%**
Not bothered by psychological or emotional problems	**76%**
Overall mental health	**62%**

Table 1: Percentage of young adults that maintained a high rating or increased their rating from baseline to six-month reassessment on the listed NOMs questions or domains

Progress Made by Young Adults

Progress Measures - Changes in a young adult's situation, such as obtaining employment or housing security, can take time to occur, and often, there are smaller steps young adults take toward those goals. Approximately every three months while young adults are engaged at the Access Center, they are asked whether improvement has been made in each domain of interest.

Access Centers' Young Adult Self-Assessments - Access Centers receiving funding from federal grants are required to participate in the National Outcome Measures (NOMs) Client-Level Services Tool.[7] The NOMs tool collects data on life functioning, housing stability, education, and employment status, criminal justice history, perceptions of care received, and social connectedness. The tool is administered by Access Center staff at baseline and again approximately six months later to young adults who consent to participate in the NOMs interview.

Table 1 (above) shows the percentages of young adults that either maintained a high rating or improved their rating for specific NOMs questions or domains made up of multiple questions. Although the findings are encouraging, due to the small sample of young adults participating in the NOMs, these findings may not be generalizable to all young adults across all the Access Centers.

Young Adult Satisfaction with Services

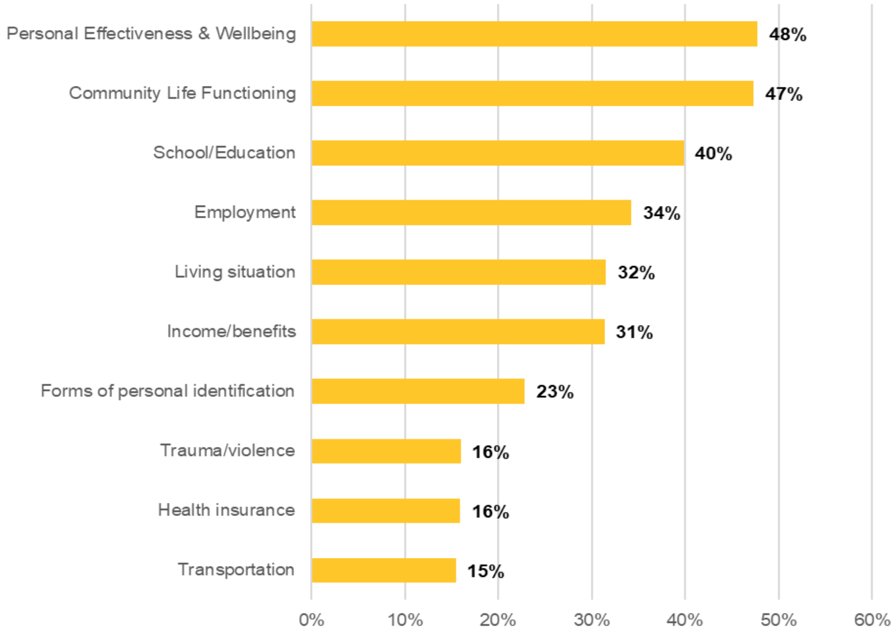
Young adults served by the Access Center express very high levels of satisfaction with the services they receive on the NOMs and in testimonials. For example, 99% of NOMs respondents said they would recommend the Access Center to a friend or family member and 97% said they would still get services from the Access Center if there were other choices. Young Adults describe the impact of the Access Centers on their mental health and social connectedness, as well as on obtaining critical life skills and support.

"[Access Center] has notably improved my mental health and quality of life. Connecting with people and getting out are very important to me and my mental health, both of which are provided by [Access Center] with the space to meet new people hang out with friends, as well as groups and future events to look forward to." – Young Adult

"It's really great that this place is a safe place, and at the same time, not only can you like make friends and just like chill but they help you with things. For example, I got my permit because I came here, I got my GED because I came here, and I've gotten jobs because I came here." – Young Adult

Summary

The transition to adulthood is a time of inherently great change in a young person's life. This transition is compounded when young adults face systemic barriers and forms of discrimination that negatively impact their mental health and wellbeing. The Massachusetts Young Adult Access Centers are successfully reaching a diverse group of young people and supporting them in their transition to full and healthy adult lives. Young adults served by the Access Centers are looking for and receiving support with personal effectiveness and wellbeing, community life functioning, education, employment, living situations, and financial security. Although this evaluation does not test the direct impact of the Access Centers on the lives of the young adults they serve, the initial assessment indicates that this population greatly benefits from the support and services provided by the Access Centers.



Percentage of young adults that had an improvement in domains with most improvement overall

Funding Acknowledgement

Development of this report has been supported in part by SAMHSA Grant H79SM084011 from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. The views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services and should not be construed as such.

Holly Swan, Carter Pratt, Michael Vassello, and Gustavo Carvajal are from ForHealth Consulting at University of Massachusetts Chan Medical School. Betsy Edes and Heidi Holland are from the Massachusetts Department of Mental Health.

Footnotes

1. Dresser, K., et al. (2015). Implementation of a Positive Development, Evidence-Supported Practice for Emerging Adults with Serious Mental Health Conditions: The Transition to Independence Process (TIP) Model. *The Journal of Behavioral Health Services & Research* 42(2): 223-237.

2. Curtin, S.C. (2020). *State Suicide Rates Among Adolescents and Young Adults Aged 10–24: United States, 2000–2018. National Vital Statistics Report*, 69(11).

3. Ramirez, A.G., Gallion, K.J., Aguilar, R., & Surette Dembeck, E. (2017). *Mental Health and Latino Kids: A Research Review*, Robert Wood Johnson Foundation. Retrieved from: https://salud-america.org.

4. Hafeez, H., Zeshan, M., Tahir, M.A., Jahan, N., & Naveed, S. (2017). Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review. *Cureus*, 9(4): e1184. doi:10.7759/cureus.1184.

5. Chang, A.R. & Slopen, N. (2023). Racial and Ethnic Disparities for Unmet Needs by Mental Health Condition: 2016 to 2021. *Pediatrics*, 153(1): e2023062286.

6. Harris, P.A., Taylor, R., Thielke, R., Payne, J., Gonzalez, N., & Conde, J.G. (2009). Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support. *J Biomed Inform, 42(2):377-81.*

7. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), National Outcome Measures (NOMs) Client-Level Measures for Discretionary Programs Providing Direct Services, Services Tool. OMB No. 0930-0285 Expiration Date 03/30/2025. Available at: https://spars.samhsa.gov/sites/default/files/2022-09/CMHSNOMSToolEnglish.pdf

Social Media from page 23

academic performance (Carter et al., 2016).

Body Image and Self-Esteem

The culture of curated perfection on social media fosters unhealthy social comparisons, particularly among teenage girls (Fardouly et al., 2018). Platforms like Instagram, which emphasize visual content, have been linked to increased body dissatisfaction and disordered eating behaviors (Holland & Tiggemann, 2016). The pressure of achieving perfection displayed via filtered and edited depictions of unrealistic beauty standards can be especially harmful to adolescents who may already be struggling with self-esteem.

Cyberbullying and Online Harassment

While social media often connects young people, it may also expose them to cyberbullying, which has been associated with increased rates of depression, anxiety, and even suicidal ideation (Kowalski et al., 2018). BIPOC and LGBTQIA+ youth are disproportionately affected, facing higher rates of online harassment that exacerbate existing mental health disparities (Craig et al., 2021).

Addictive Behaviors

Social media platforms are ultimately designed to maximize engagement through algorithms that exploit dopamine-driven reward mechanisms, making them particularly addictive for young users (Alter, 2017). Excessive screen time has been linked to difficulties with impulse control, attentional issues, and increased stress levels (Twenge & Campbell, 2019).

The Benefits of Social Media for Youth Mental Health

Elizabeth Callahan, MA, BCBA

Despite these concerns, social media is not inherently harmful. When used intentionally and in moderation, it can serve as a powerful tool for social connection, education, and self-expression.

Community and Social Support

For marginalized youth, social media can be a lifeline. LGBTQIA+ adolescents, for example, often find support and affirmation in online communities that may not be available in their immediate environment (Craig et al., 2021). Similarly, BIPOC youth engage with digital platforms to share experiences, access culturally relevant mental health resources, and build networks of support (Anderson & Jiang, 2018).

Access to Educational and Mental Health Resources

Many adolescents turn to social media to seek information on mental health, coping strategies, and academic resources (Naslund et al., 2020). Platforms like YouTube, TikTok, and Instagram have become spaces where mental health professionals share accessible, evidence-based guidance, helping to reduce access issues and the stigma around seeking help.

Identity Exploration and Skill Development

Adolescents use social media to explore their identities, express creativity, and develop new skills (Best et al., 2014). Platforms like TikTok and Discord allow youth to engage in hobbies, learn from peers, and build confidence in their abilities. When supported by healthy digital habits, these experiences contribute positively to personal growth.

Family Approaches to Navigating Social Media Use

Social media offers both opportunities and risks for youth, but one undeniable truth remains: it was designed to be addictive. Platforms leverage psychological and behavioral mechanisms to maximize engagement, often keeping users scrolling far longer than intended. While social media can foster connection and creativity, it also exposes children to harmful content, privacy risks, and unhealthy online interactions. The key takeaway is clear—content and limits matter. Families must take an active role in setting boundaries, encouraging mindful usage, and fostering open conversations about digital well-being. By understanding the intentional design of these platforms and equipping children with the tools to navigate them responsibly, we can help them harness the benefits of social media while mitigating its harms. The American Academy of Pediatrics (AAP) emphasizes the importance of proactive, engaged parenting when it comes to media use, advocating for evidence-based strategies such as setting screen time limits, modeling healthy digital habits, and maintaining open communication to support children in making safe and informed choices online (Chassiakos et al., 2016).

1. Establishing Boundaries and Guidelines. Create a Family Media Plan to set clear expectations about screen time, online behavior, and digital etiquette (AAP, 2016). Encourage tech-free zones, particularly during meals and before bedtime, to support in-person connection and healthy sleep habits.

2. Encouraging Open Conversations and Digital Literacy. Talk with children about the emotional impact of social media, helping them recognize harmful content and develop critical thinking skills. Model healthy online behavior, demonstrating balanced social media use and respectful digital interactions.

3. Promoting Offline Activities and Meaningful Engagement. Encourage participation in sports, arts, and community activities as alternative sources of fulfillment and social interaction. Use positive reinforcement to reward time spent engaging in offline interests rather than focusing solely on screen-time restrictions.

Social media presents both challenges and opportunities for today's youth and their caregivers. While excessive or unregulated use can negatively impact mental health, digital platforms also offer meaningful opportunities for connection, support, and learning. The goal isn't to vilify social media but to empower adolescents to use it thoughtfully and responsibly. By setting healthy boundaries, encouraging open conversations, and modeling a balanced approach to technology, families can help young people develop a positive relationship with the digital world—and along the way, we adults might just learn a thing or two about our own screen habits as well.

Elizabeth Callahan, MA, BCBA, is a Board-Certified Behavior Analyst at Behavior Therapy Associates.

Can Tech Help from page 27

How Schools Can Integrate Digital Resources for Student Well-Being

Schools are uniquely positioned to identify mental health needs early on and respond proactively to help students. One tested and proven method is supplying school counselors and nurses with digital tools for initial mental health screenings. Online questionnaires and assessments can catch warning signs sooner and guide students toward the best possible care.

Schools can also incorporate evidence-based apps that focus on coping strategies, mindfulness, or resilience. These resources typically work best when folded into a broader web of support, such as routine teacher check-ins and referrals to mental health specialists. Training faculty and staff to know when and how to discuss mental health challenges with students and to be effective "mental health allies" who can refer them to appropriate resources has proven to be effective in both K-12 and higher education settings. Embedding digital solutions into health classes, after-school clubs, and parent outreach programs can also have a meaningful impact.

Scott Healy

Of course, technology can't replace human relationships, but it can greatly enhance how services are provided. For instance, school-facing portals that are protected by strict privacy safeguards can track student progress over time. This makes it easier for counselors to keep tabs on how they're doing. From a business standpoint, collaborating with schools provides a clearly defined audience for high-impact, scalable solutions.

Challenges and Considerations in Implementing Tech-Based Mental Health Services

Even though digital mental health tools show great potential, major obstacles still exist. First is privacy. Because younger users are involved, extra care must be taken to protect their data and ensure compliance with regulations like HIPAA and COPPA. As companies gather sensitive information, keeping it secure is paramount to maintaining public trust.

Second, equitable access is a hurdle for many. Families in rural areas or with limited resources may lack reliable connectivity or suitable devices. If we want real progress in addressing mental health challenges, closing the digital divide is absolutely essential. Investing in broadband expansion, distributing mobile devices, and providing educator training are all key ways to address these disparities. Rural areas are typically where trained therapists are most scarce, so teletherapy and digital apps are a huge part of the solution as long as we continue to work to provide broad access.

Another concern is that some families doubt the effectiveness of online interventions because they worry about impersonal, generic experiences, which is understandable. A growing area that has generated much debate is the rise of AI-driven mental health chatbots. While concern about the impersonal nature of chatbots is understandable, studies have concluded they have great potential to offer effective support in situations where real-world human interaction, such as connecting to friends, family, or professional counseling, is not preferred or possible to achieve. It's crucial for businesses to invest in the continued optimization of these AI-driven tools as well as comprehensive training for therapists, teachers, physicians, and other healthcare workers to help them effectively utilize the full range of solutions that have proven to be effective.

In the end, we have to remember that digital options are part of a broader continuum of care. They're excellent for early-stage support or enhancing ongoing therapy, but severe cases still require in-person intervention.

As we work to optimize these tools and tackle issues like access and privacy, I truly believe we are creating a future in which technology will play an increasingly effective role in nurturing and developing a stronger, more resilient younger generation. The time to invest in these solutions is now. Let's bring them to a larger scale and keep our children's mental health firmly at the forefront.

Scott Healy is CEO of Psych Hub. To contact the Psych Hub team, please reach out to info@psychhub.com or visit the website at psychhub.com.

Childhood* from *page 23

particularly during transitions between activities. For example, children may have difficulty transitioning away from an activity they enjoy or grow frustrated when they are unable to access a toy or object because it is time to share. Knowing what to expect in various situations can often prevent certain behaviors from occurring. The use of frequent prompts and reminders of expectations before specific situations can help promote positive behavior. Various tools can help maintain routines, including visual schedules and reminders, timers, and checklists. For children who have difficulty remaining seated or attending for extended periods, provide predictable breaks that are built into their routine.

Communication Strategies

Another helpful strategy is to be clear and direct when communicating expectations with your child. When giving commands, be direct and use a warm but firm tone. For younger children or those with language or intellectual delays, using short phrases accompanied by visuals can help them communicate effectively. Sometimes, children have difficulty with waiting or not having access to a preferred object or activity right away (or even hearing the word "No!"), so using other phrases such as, "Not right now, but instead, we can…" or "First/then" or "When/then" can help reduce the likelihood of behavior challenges while also still enforcing boundaries. Relatedly, it is important to use the word "No" when you mean that an activity or object is not available at all and follow through with this directive.

For some children, behaviors are often precipitated by difficulties communicating their wants and needs to others, whether that be due to language or cognitive delays or other impairments that make it difficult to communicate. Functional Communication Training (FCT) is a procedure that teaches an individual how to use an alternative response to achieve their goal rather than engage in problem behavior and has been consistently used as an effective intervention for children, teens, and adults (Tiger, Hanley, & Bruzek, 2008). For instance, teaching a child to point to something they want (like a snack) rather than hit a person or an object and giving the child the snack *only* when they point allows the child to have their need met while also reinforcing more appropriate behavior.

The Power of Positive Reinforcement

One especially effective method for increasing positive behavior is through the use of positive reinforcement. Positive reinforcement uses various strategies to reinforce wanted behavior by adding something likely to increase that behavior. For example, giving specific and labeled praise after a child shares their toy with another child (e.g., "Nice job sharing your toy!") is likely to increase that child sharing again. In addition to praise, other examples of positive reinforcement include extra privileges, social rewards such as approval from others, and tangible rewards like stickers.

Supporting Social-Emotional Skills

Building social-emotional skills can also improve both short and long-term emotional and behavioral outcomes. Social-emotional learning (SEL) encompasses a broad range of skills, behaviors, and attitudes that fall under five interrelated competency areas: self-awareness, self-management, social awareness, relationship skills, and responsible decision-making (CASEL, 2020). Research has consistently highlighted the importance of SEL skills and their positive impacts on academic achievement and attitudes toward school, as well as their influence on reducing emotional and behavioral problems (e.g., Cipriano et al., 2024; Durlak et al., 2013). Supporting the development of SEL skills can involve teaching children to accurately identify and express their emotions with others, understand the impact their actions have on others, learn coping skills to manage their emotions, and improve their ability to make better choices.

Seeking Out Help

For families who continue to struggle with managing their children's behavioral challenges, seeking out the support of a mental health professional may be needed, as there are several evidence-based therapeutic approaches to promote positive parent-child relationships and reduce problem behaviors. Parent training programs can be helpful to build parents' skills in changing their child's behaviors. For instance, Parent-Child Interaction Therapy (PCIT) is a structured treatment approach originally intended for children ages 2-7 presenting with emotional or behavioral difficulties. In PCIT, both parents and children participate in treatment, with the therapist acting as the parent's coach to teach effective skills and assist the parent with implementing skills in vivo (or in real-time) with the child. Another effective treatment option is Behavioral Parent Training (BPT). BPT involves a therapist who works primarily with parents to target and define specific behaviors to address, learn the possible functions of these behaviors, identify prevention strategies to decrease the likelihood of the behavior occurring and implement consequence strategies to effectively increase or decrease the behaviors.

With the use of early strategies, children and families can learn more effective ways to interact and manage problem behaviors. Importantly, understanding the aspects of the whole child, which includes their strengths, challenges, and the environment in which they live, can help inform interventions and lead to healthier, happier lives.

Jeniffer Cruz, PhD, NCSP

Jeniffer Cruz, PhD, NCSP, is a Licensed Psychologist at Behavior Therapy Associates. To learn more, please visit behaviortherapyassociates.com, or call (732)-873-1212. Email inquiries can be sent to jcruz@behaviortherapyassociates.com

References

Child and Adolescent Health Measurement Initiative. (2021-2022). National Survey of Children's Health. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved March 11, 2025 from https://nschdata.org/browse/survey?s=2&y=51&r=1&#home

Cipriano, C., Ha, C., Wood, M., Sehgal, K., Ahmad, E., & McCarthy, M. F. (2024). A systematic review and meta-analysis of the effects of universal school-based SEL programs in the United States: Considerations for marginalized students. *Social and Emotional Learning: Research, Practice, and Policy, 3*, 100029. https://doi.org/10.1016/j.sel.2024.100029

Collaborative for Academic, Social, and Emotional Learning (CASEL). (2020). *The CASEL framework: What is SEL?* https://casel.org/casel-sel-framework-11-2020/

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. Child Development, 82, 405-432.

Ennis, R.P., Lane, K.L., & Flemming, S.C. (2021). Empowering teachers with low-intensity strategies: Supporting students at-risk for EBD with instructional choice during reading. *Exceptionality*, *29*(1), 61-79

Foote, R. C., Schuhmann, E. M., Jones, M. L., & Eyberg, S. M. (1998). Parent-Child Interaction Therapy: A guide for clinicians. *Clinical Child Psychology and Psychiatry, 3*(3), 361–373. https://doi.org/10.1177/1359104598033003

Tiger, J. H., Hanley, G. P., & Bruzek, J. (2008). Functional communication training: A review and practical guide. *Behavior Analysis in Practice*, 1(1), 16–23.

Williams, P. G., Lerner, M. A., AAP Council on Early Childhood, & AAP Council on School Health. (2019). School readiness. *Pediatrics, 144*(2), e20191766. https://doi.org/10.1542/peds.2019-1766

Cultural Gaps* from *page 25

family feels seen, heard, and respected. This is the power of cultural competence.

Cultural competence in child and adolescent behavioral health isn't just about understanding the specific beliefs of different cultures; it's about respecting the family's role in the child's well-being and understanding that parents from different cultural backgrounds may have different views on mental health, discipline, and child-rearing practices.

Without cultural competence, the healthcare system risks losing the trust of families who may already feel marginalized. This is especially true for immigrant families, who often come from countries where mental health treatment may carry a stigma or where the healthcare system is vastly different. For these families, building trust with the provider is essential for effective treatment.

Strategies for Enhancing Cultural Competence

Providers should engage in ongoing cultural competence training to better understand the communities they serve.

Behavioral health service agencies should mandate trainings and prioritize hiring professionals from diverse backgrounds or those who are bilingual to help bridge language gap.

Parents or caregivers should be actively involved in treatment planning, and throughout the process.

Providing family therapy sessions in culturally responsive manner, where possible, to ensure that everyone involved in the child's life understands the treatment plan and feels heard.

Offering materials, resources, and consent forms in multiple languages to ensure families fully understand their rights and treatment options.

In places where the mental health workforce lacks diversity, intentional efforts should be made to match clients with providers who share similar cultural backgrounds or have experience working with their communities.

Oyindamola Williams, LMSW

Oyindamola Williams, LMSW, is a Child and Family Therapist at Southwest Community Health Center. For more information, resources, please contact oyinwilliams01@gmail.com.

References

American Psychological Association. (2021). Demographics of the U.S. psychology workforce. www.apa.org/workforce/data-tools/demographics

Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). Improving cultural competence in behavioral health care. U.S. Department of Health & Human Services. store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf

Siblings* from *page 24

plan for when behaviors escalate in the home. If there are aggressive or challenging behaviors, it would be wise to provide siblings with a plan for how to respond and remove themselves from the situation for safety.

Psychoeducation and Sharing Information

The unpredictability of the family situation and environment, with associated factors such as a sense of control and access to information, has also been found to affect sibling risk (Incledon et al., 2015). Younger children may interpret a sibling's challenging externalizing behavior as "not liking me" or their sibling being upset with them, further negatively impacting their relationship or creating stress for the unaffected child. For these reasons, it is increasingly necessary not only for parents but also for siblings of individuals with behavioral challenges to receive psychoeducation and information about diagnoses, outcomes, and necessary support. Providing accurate and developmentally appropriate information about their sibling's diagnosis can help them better understand the behavior and needs. The information that is provided promotes continued transparency and communication about potential changes to the home environment and the needs and requirements of family members, including the siblings themselves.

Due to the potential of significantly different needs and strengths between siblings, there may be situations during which consequences, activities, parental attention, or support may be unevenly provided in these situations. Providing explanation or insight into the sibling, discussing these situations in advance, and outlining contingencies is key in order to promote understanding and acceptance of unavoidable differences which may exist. Understanding and acceptance through discussion can potentially stave off feelings of resentment, anger, and isolation, which may occur as a result of the focus being shifted to a higher needs child. Other potential effects of sharing this information may include empowerment stemming from the knowledge of what is needed to support their sibling and what potential role they can play.

Providing Dedicated Time and Attention

As a result of the increased needs of the individual who presents with challenging behavior, the parent may be less available to the sibling. Considering this, there is an increased need to provide consistent times of dedicated attention and engagement between the parent and that individual. These times can be scheduled or spontaneous; however, it may benefit both the higher needs sibling and the lower needs sibling to have these times scheduled. A predetermined dedicated time adds to the predictability and consistency of the family schedule and expectations. This also ensures that those times are less likely to be missed or moved due to a schedule that may already be filled with therapies and appointments.

Prioritizing the Care of the Caregiver

A parent or guardian who is experiencing significant levels of depressive symptoms, potentially as a result of caring for an individual with severe and persistent behavioral challenges, may be less effective in balancing the demands of multiple individuals with different developmental needs and may be less adept at providing both necessary emotional support and effective discipline. Further emphasizing the need for self-care, research suggests that a depressed caregiver may model less adaptive coping styles that are then adopted by their typically developing children (Meyer, Ingersoll, & Hambrick, 2011). Caregiver support can range from individual or family-based mental health services, respite care, or dedicated time engaged in various self-care tasks. Ensuring that caregiver needs are met calls for specific and dedicated services, time, or activities which provide rest, validation, or other types of support.

Connecting with Resources and Next Steps

Ongoing monitoring, assessing level of understanding, and continued connection with resources as the sibling moves through the lifespan is essential. Reassurances with regard to support that they may need or what is being provided to their sibling may be accomplished by multiple methods, including individual or family-based therapies or support sessions. When considering individual needs, research has suggested that beginning with treatments or support groups that include the entire family may be more effective for these siblings than individual treatments that do not address the characteristics and needs of the entire family (Meyer, Ingersoll, & Hambrick, 2011).

Many statewide or diagnosis-based organizations offer resources and support group opportunities for siblings to engage with community members who may help further their understanding, develop coping skills, and practice interaction strategies. To continue enhancing rapport and connections between siblings, many community agencies and organizations create opportunities for engagement surrounding mutual interests, host activities or events that allow for the sibling bond to be strengthened, and reinforce positive interactions.

In addition to strengthening bonds within the family network, siblings may require careful monitoring of their status or involvement in a social support network. Lower levels of social support are associated with more negative psychosocial adjustment among siblings of children with neurodevelopmental disorders (Kirchhofer et al., 2022). To further exemplify what is required, Cobb (1976) indicated that feeling loved, valued, and belonging to a group of some kind were among the key features of individuals who felt well supported by their social network.

Bianca Coleman, PhD, NCSP, BCBA-D

Jeniffer Cruz, PhD, NCSP

While it may be more evident that an individual displaying challenging behavior requires intensive support, their sibling may be overlooked in terms of immediate needs or underlying concerns. The functioning of one family member often has collateral effects on the dynamics of the household as a whole. From schedule alteration and the need for additional therapeutic support to periods of turmoil, conflict, and distress, the ripple effects from maintaining the needs of one sibling will inherently impact the other. From childhood to adulthood, the needs of an individual impacted by a higher needs sibling will vary and potentially require different levels of support and education. Community, social support, and therapeutic involvement encompass valuable resources for families and siblings of those who may display challenges with regard to externalizing and internalizing behavior.

Bianca Coleman, PhD, NCSP, BCBA-D, LBA, is a Licensed Psychologist and Behavior Analyst, and Jeniffer Cruz, PhD, NCSP, is a Licensed Psychologist at Behavior Therapy Associates. To learn more, please visit behaviortherapyassociates.com, or call (732)-873-1212. Email inquiries can be sent to jcruz@behaviortherapyassociates.com or bcoleman@behaviortherapyassociates.com.

References

Child and Adolescent Health Measurement Initiative. (2023). *2022-2023 National Survey of Children's Health (NSCH) data query*. Data Resource Center for Child and Adolescent Health. Supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved March 9, 2025, from childhealthdata.org.

Ferraioli, S.J. & Harris, S.L., (2009) The Impact of Autism on Siblings, *Social Work in Mental Health*, 8:1, 41-53, DOI: 10.1080/15332980902932409.

Iannuzzi, D., Fell, L., Luberto, C. *et al.* Challenges and Growth: Lived Experience of Adolescents and Young Adults (AYA) with a Sibling with ASD. *J Autism Dev Disord* 52, 2430–2437 (2022). doi.org/10.1007/s10803-021-05135-0.

Incledon E, Williams L, Hazell T, Heard TR, Flowers A, Hiscock H. A review of factors associated with mental health in siblings of children with chronic illness. Journal of Child Health Care. 2013;19(2):182-194. doi:10.1177/1367493513503584.

Kirchhofer, S. M., Orm, S., Haukeland, Y. B., Fredriksen, T., Wakefield, C. E., & Fjermestad, K. W. (2022). A systematic review of social support for siblings of children with neurodevelopmental disorders. *Research in developmental disabilities*, *126*, 104234. doi.org/10.1016/j.ridd.2022.104234.

Meyer, K., Ingersoll, B., & Hambrick, D. (2011). Factors influencing adjustment in siblings of children with autism spectrum disorders. *Research in Autism Spectrum Disorders*, *5*(4), 1413–1420. doi.org/10.1016/2fj.rasd.2011.01.027.

Orm, S., & Fjermestad, K. (2021). A scoping review of psychosocial adjustment in siblings of children with attention-deficit/hyperactivity disorder. Advances in Neurodevelopmental Disorders, 5(4), 381–395. doi.org/10.1007/s41252-021-00222-w.

Shivers, C. M. (2019). Empathy and perceptions of their brother or sister among adolescent siblings of individuals with and without autism spectrum disorder. *Research in Developmental Disabilities*, *92*, 103451. doi.org/10.1016/j.ridd.2019.103451.

Medicaid* from *page 34

Footnotes

1. Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans Copyright National Academy of Sciences. https://www.commonwealthfund.org/publications/explainer/2022/sep/behavioral-health-care-us-how-it-works-where-it-falls-short
2. Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024

Sources

https://bhbusiness.com/2024/01/31/low-reimbursements-threaten-behavioral-health-providers-bottom-line/#:~:text=Inside%20the%20reimbursement%20landscape,the%20most%20significant%20financial%20strain.

Jeff Gershman

Janie Tremlett

Screen Time* from *page 25

Strategies for Digital Well-Being

Everything in life requires balance, and so does technology use. Ditching screen time isn't easy, so you must balance on and off-screen time by practicing the following strategies.

1. Use of Digital Well-Being Apps. Have you ever thought about how much time you spend on your phone? Many apps like Apple's 'Screen Time' and 'Digital Well Being help you track daily device use and provide tools such as app usage and time off limits. Digital distractions aside, other productivity apps like 'Forest,' 'Detox,' and 'OffTime' can function as distractions by rewarding you for staying off-screen. There is evidence that handling screen time using such app-based interventions reduces screen time and encourages mindful use of technology. A study published in the *Journal of Medical Internet Research* suggests that these apps can effectively minimize screen time and promote mindful technology engagement.

2. Setting Tech-Free Zones and Times. Introduce areas throughout your house that forbid screens, including the dining space and your sleeping area. Live dinner conversations have become more prevalent, and improved bedtime rest results from technological restrictions. A nighttime screen ban beginning one hour before bedtime assists people in stopping their continuous evening screen usage.

3. Swap Screen Time for Offline Activities. Encouraging hobbies that avoid screen-related activities, like physical reading alongside sports and creative activities, leads to a noticeable decrease in total screen hours used. Promoting wellness programs by educational institutions and work environments provides scheduled digital device rest periods, which foster participation in traditional real-life activities.

Temitope Fabayo, BA, MBA

4. Group-Based Digital Detox Programs. Interventions provided through groups are more straightforward to introduce than those done personally, and social support provided through them will help individuals reduce their screen time. Programs like 'NUGU' have been used effectively to help students manage digital distractions. These programs use a digital usage environment to allow participants to set their digital usage goals through collaboration and make each other accountable for achieving them. Motivation and the probability of reducing digital consumption are built with having a sense of community.

5. Digital Detox Practices. Digital detox is a period of agreed-upon abstinence from digital devices. This allows one to reconnect with the physical world, reduce the amount of stress one is under, and enhance sleep quality. The National Day of Unplugging is when people are prompted to take a break from technology and spend time with things of the real world. One report by *Cyberpsychology, Behavior, and Social Networking* shows that a multigroup analysis was conducted among 500 young adults between 18 and 35 years of age to compare digital detox app users and non-users. Results showed that a high number of adults used digital detox apps. Thus, a regular digital detox can improve mental clarity and well-being.

Challenges in Implementing Digital Well-Being Strategies

Even as digital well-being tools and strategies are becoming available, there is a lack of effectiveness in implementing them. It is a regular occurrence that many individuals cannot maintain a self-imposed limit and tend to revert to old habits. Similarly, technology can also be used to counter and aid in the social use of the tool; peer pressure and workplace demands might not be so easy to disrupt, and utilizing less screen time. Better effectiveness may require the personalization of interventions with respect to individual needs and lifestyles.

Looking Ahead: The Future of Digital Well-Being

Future research is needed to determine the most effective digital well-being interventions. Awareness programs and encouraging responsible technology use can help educational institutions, as well as workplaces, play a role in promoting digital wellness. New Digital well-being technologies can be developed further to be more personalized and to help users adopt healthier digital habits according to their behaviors via artificial intelligence.

Conclusion

A healthy and happy life is balanced well by using technology. Since technology is here to stay, we cannot avoid it; rather, we can look for ways to use it. Maintaining a balance between online and offline life is essential. By incorporating small but effective changes—like using screen time apps, setting tech-free zones, and taking regular digital detoxes—we can reclaim our time and use technology as a tool for empowerment, not exhaustion.

Temitope Fabayo, BA, MBA, is President of DMC HomeCare.

References

Duarte, F. (2022, September 21). Alarming Average Screen Time Statistics (2024). Exploding Topics. https://explodingtopics.com/blog/screen-time-stats?utm_source

Nakshine, V. S., Thute, P., Khatib, M. N., & Sarkar, B. (2022). Increased Screen Time as a Cause of Declining Physical, Psychological Health, and Sleep Patterns: A Literary Review. Cureus, 14(10). https://doi.org/10.7759/cureus.30051

Rahmillah, F. I., Tariq, A., King, M., & Oviedo-Trespalacios, O. (2023). Evaluating the Effectiveness of Apps Designed to Reduce Mobile Phone Use and Prevent Maladaptive Mobile Phone Use: Multimethod Study. Journal of Medical Internet Research, 25, e42541. https://doi.org/10.2196/42541

Zablotsky, B. (2024). Daily Screen Time Among Teenagers: United States, July 2021 – December 2023. Daily Screen Time among Teenagers: United States, July 2021–December 2023, 513(513). https://doi.org/10.15620/cdc/168509

Addiction Recovery* from *page 31

5. Ease of access

Of these, the powerful one that we have no control over at all is our genetics. Research suggests that someone with a first- (parent, sibling) or second-degree (grandparent, half-sibling, aunt) relative with alcohol use disorder (AUD) has a 50% chance of developing an AUD themselves.

The family connection is so strong that we even see this pattern in people who have been adopted. Various studies in Scandinavia have found a high incidence of AUD in adopted children of biological parents with AUD, even if the child never saw alcohol in their adoptive home. Once alcohol was introduced in their lives, genetics took over.

Genetics and the other predictors of SUD mentioned above are so consistent that I can't even remember a recent patient who didn't have all the risk factors.

And yet, despite everything we know about addiction now, stigma and shame persist. It's like 500 years ago when people believed the world was flat. It took a long time for them to believe anything else.

It goes back to the brain and that prefrontal cortex—the poorly functioning decision-maker. That's the source of these hallmark symptoms that the public sees: people breaking the law, destroying relationships, and damaging their health. These symptoms look like choices and thus make the disease appear to be a failure of character.

Dr. Charles Smith

While it might be a "choice" to pick up that very first drink or drug, the ability to choose begins to decline significantly over time. According to NIDA, "the effects of prolonged exposure on brain functioning compromise that ability to choose, and seeking and consuming the drug become compulsive, often eluding a person's self-control or willpower."

Even those in the medical field struggle to fully understand this. I still talk to some gastroenterologists and ask them what they tell their cirrhosis patients. "We tell them to quit drinking," they'll say.

But that's not going to solve it. Addiction is a "medical disease" that requires specific treatment with thoughtful, evidence-based interventions the way any other chronic, life-threatening condition.

A Medical Emergency

When family members ask me how they can support their addicted loved ones, I say that they should give them exactly the same support they would give if the person had heart disease, cancer, diabetes, hypertension, or any other medical emergency. Because that's exactly what it is.

Consider someone who has heart disease. You see them walk up the stairs, get a little sweaty, put their hand over their chest, and say, "I'm short of breath." You're not going to say, "Just get over it." You're going to push them to get treatment because heart disease is deadly—and so is SUD.

But here's the good news: SUD can be treated, and the brain can heal over time.

By practicing healthy life and coping skills, the patient's oxygenated hemoglobin continues to rise. After two years, it's almost fully repaired. Then, a person's impulse to drink or not and their sense of right and wrong become clearer. Their decision-making process becomes more optimal—just as we would expect it. Why? Because addiction is a brain disease. The label matters.

As physicians, we need to do more to ensure we use the proper criteria to diagnose SUD and get people the help they need and deserve.

For the rest of us, we need to do more to watch the words we use when we talk about SUD so the 48.5 million Americans who suffer from this disease can find the courage to begin to heal.

Dr. Charles Smith is the author of "Understanding Addiction: Know Science, No Stigma" and an addictionologist at Recovery First, an American Addiction Centers facility in Hollywood, Florida.

Eating Disorders* from *page 30

Integrating Education into Eating Disorder Treatment

Preventing long-term academic setbacks requires a coordinated approach between treatment teams, schools, and families. Behavioral health providers play a critical role in ensuring that students remain engaged in their education while prioritizing recovery.

One key strategy is incorporating structured academic support within specialized treatment programs. Research suggests that students who receive academic coordination experience reduced school-related anxiety and transition more smoothly back into traditional learning environments (Foroughe et al., 2023). By integrating education into treatment models, students can continue their coursework while receiving the care they need, minimizing disruptions to their academic progress.

Equally important is navigating school accommodations through 504 Plans or Individualized Education Programs (IEPs). Under federal law, students with eating disorders qualify for accommodations that provide essential academic flexibility (U.S. Department of Education, 2023).

Behavioral health providers and therapists can help families advocate for these supports, ensuring that treatment participation is recognized as equivalent to school attendance, coursework loads are adjusted to accommodate recovery, and virtual learning policies prevent students from being penalized for missing online class sessions. Fostering emotional support within school environments also helps create a more inclusive and understanding academic atmosphere.

The Role of Family Therapy in Educational Advocacy

Courtney Anderson, MA, LPC

Emotion-Focused Family Therapy (EFFT) can be an effective intervention that equips parents with the skills to support both their child's mental health and academic success.

Through Emotion-Focused Family Therapy (EFFT), parents and caregivers learn to:

1. Understand the emotional underpinnings of academic anxiety—validating their teen's fears while reinforcing the primacy of health over grades. Eating disorders often stem from feelings of shame, guilt, or fear, and EFFT helps parents recognize and respond to these emotions in a supportive way.

2. Develop effective coaching techniques to support both mental health recovery and educational engagement. By equipping caregivers with tools to address distress and interrupt eating disorder behaviors, EFFT ensures that parents are active participants in the healing process rather than passive observers.

3. Repair relational stressors that arise from school pressure, perfectionism, and the fear of failure. Many adolescents with eating disorders struggle with rigid thinking patterns, particularly around school performance, which can fuel their disorder. EFFT helps families rebuild trust and create a home environment where recovery, rather than academic perfection, is prioritized.

Research suggests that families who actively participate in treatment interventions, including EFFT, report improved communication, reduced conflict, and greater confidence in supporting their child's recovery (Foroughe et al., 2023).

Nurturing Recovery and Academic Resilience

As behavioral health services for children and families evolve, it is critical to integrate educational advocacy into eating disorder treatment models. Schools, treatment centers, and families must work together to ensure that teens receive the comprehensive support they need to recover fully.

By implementing structured academic coordination, advocating for school accommodations, and leveraging family therapy interventions, behavioral health providers can help students maintain stability, reduce anxiety, and achieve long-term recovery without sacrificing their studies.

Courtney Anderson, MA, LPC, is the Adolescent Program Manager at ED-Care, a leading provider of comprehensive eating disorder treatment. She specializes in adolescent behavioral health, early intervention, and holistic approaches to eating disorder recovery. Courtney is passionate about advocating for policies that integrate mental health and education to support adolescents and their families in achieving lasting recovery.

References

Copeland, W. E., Bulik, C. M., Zucker, N., Wolke, D., Lereya, S. T., & Costello, E. J. (2015). Does childhood bullying predict eating disorder symptoms? A prospective, longitudinal analysis. *International Journal of Eating Disorders, 48*(8), 1141–1149. https://doi.org/10.1002/eat.22459

Foroughe, M., Browne, D. T., Thambipillai, P., Cordeiro, K., & Muller, R. T. (2023). Brief emotion-focused family therapy: A 12-month follow-up study. *Journal of Marital and Family Therapy, 49*(2), 394–410. https://doi.org/10.1111/jmft.12628

Giel, K. E., Zipfel, S., Alizadeh, M., Schäfer, L. M., Schnell, K., & Enck, P. (2012). Cognitive functioning in acute and weight-recovered anorexia nervosa patients. *Psychological Medicine, 42*(9), 2017–2026. https://doi.org/10.1017/S0033291712000301

National Eating Disorders Association (NEDA). (2023). Eating disorders in adolescents: Key facts and figures. Retrieved from https://www.nationaleatingdisorders.org/

U.S. Department of Education. (2023). Individuals with Disabilities Education Act (IDEA) and 504 Plans. Retrieved from https://www.ed.gov/idea

Watson, H. J., Yilmaz, Z., Thornton, L. M., Hübel, C., Coleman, J. R. I., Gaspar, H. A., & Bulik, C. M. (2022). Social and psychological risk factors for eating disorders. *Psychological Bulletin, 148*(3), 183–205. https://doi.org/10.1037/bul0000346

LGBTQ+ Youth* from *page 28

organization can implement to foster a healthier and more supportive community for LGBTQ+ youth.

Expand Access to LGBTQ+ Mental Health Services

A 2021 study by The Trevor Project found that nearly half of surveyed LGBTQ+ youth wanted access to mental health care but were unable to obtain it.

To better support LGBTQ+ youth in your community, consider developing dedicated counseling services or acting as a resource to connect them with the mental health care they need.

Mental health support extends beyond just counseling. Schools that provide LGBTQ+ support groups, alliances, and safe spaces contribute to improved mental health outcomes for LGBTQ+ youth. By facilitating access to these resources, your organization can play a critical role in fostering well-being.

Jordan Baker

Implement Anti-Stigma Education in Schools

Beyond creating safe spaces, addressing the root cause of discrimination is crucial. Schools play a key role in reducing stigma by educating students about LGBTQ+ issues and promoting acceptance.

This type of education is vital for improving LGBTQ+ youth mental health.

Studies show that individuals who experience stigma related to their sexual orientation or gender identity may struggle with self-acceptance and develop harmful coping mechanisms, such as substance use. These challenges can contribute to long-term mental and physical health issues.

To help combat stigma, your organization can offer training programs focused on anti-discrimination education. If schools are unable or unwilling to host these programs, consider offering them to parents, community leaders, and local organizations.

Collaborate with Other Community Organizations

LGBTQ+ youth don't just face challenges at school—many also experience difficulties at home. In some cases, family rejection leads to serious consequences such as physical or emotional abuse, homelessness, or food insecurity. These experiences can significantly impact mental health.

By partnering with organizations that address issues like food insecurity and homelessness, your organization can provide LGBTQ+ youth with the holistic support they need. For example, working alongside local food banks or shelters allows you to not only help youth through their mental health struggles but also address the root causes of their trauma by ensuring they have access to basic necessities.

Final Thoughts

While LGBTQ+ youth continue to face significant mental health challenges, human services organizations have the power to make a difference. By creating inclusive environments, expanding access to mental health care, promoting anti-stigma education, and collaborating with community partners, we can help LGBTQ+ youth lead healthier, more fulfilling lives.

Jordan Baker is passionate about e-learning and helping learners achieve their goals. At Relias, he works with subject matter experts across disciplines to shape healthcare content designed to improve clinical practice, staff expertise, and patient outcomes. See more of Jordan Baker's work at Relias.

Loneliness* from *page 31

Intervention Strategies and Recommendations

While the answer to dramatically reducing the rates of loneliness in children and youth is multifaceted, family-based treatment can have a lasting impact. Merging the principles of Narrative and Strategic Family Therapy, the clinician can utilize the strengths of both interventions to aid families in nourishing the family bond, building connections, and eliminating chronic loneliness.

- **Externalizing Problem.** One of the core elements of Narrative Family Therapy is identifying the problem(s) that the family is experiencing and building a detached perspective. The family is taught to discuss the problem as something separate from not only themselves but also separate from other members of the family.
- **Identifying Patterns.** A principle of Strategic Family Therapy is assisting the family in identifying dysfunctional behaviors and communication styles that reinforce the presenting problem. The clinician actively observes the family while paying attention to emotional exchanges verbal and nonverbal communication.
- **Empowering Your Voice.** Another useful approach of Narrative Family Therapy is working with each family member to discover their voice. Each family member should have the space to share their perspective and contribute to the narrative shift.
- **Direct Interventions.** Lastly, one of the core elements of Strategic Family is for the clinician to instruct the family to change behaviors in direct ways, such as giving family members clear tasks and/or directives in order to change the dysfunctional patterns that were identified.

Case Exploration

Eboni Wooley, DSW, LCSW

Bella* is a 12-year-old girl of Hispanic descent who was referred to a community-based mental health clinic by her school due to her misbehavior. In school, Bella would talk back to teachers, display aggressiveness toward her peers, and often refuse to do her work by tearing paper or leaving the classroom. Her mother reported similar behaviors at home, with aggression towards her siblings and poor impulse control. Bella was the youngest of three sisters who she lived with, along with her mother and stepfather. Bella's mother stated that her "tantrums" could last for hours when she did not get what she wanted, and other times she was withdrawn at home. Also, her mother stated that during her emotional outbursts, Bella would often state that "no one cares about her."

After working and assessing Bella, the author was able to determine that Bella suffered from chronic loneliness. At school, Bella did not have any peers that she considered consistent friends. She reported being bullied by her peers, with them laughing and making offensive comments about her weight. Bella claimed that the bullying would often trigger her outbursts at school. Through collaboration with her school, her school counselor confirmed that Bella had few friends, would often eat lunch by herself, and would be alone during social activities. At home, while Bella has siblings, they are several years apart in age, so she lacked the attention that she needed, which further contributed to feelings of loneliness. Her birth father had been absent for the past few years, leading to feelings of abandonment and rejection. Bella expressed feeling as though she had no one in the home that understood her. Working individually with Bella and conducting family sessions, the author was able to reduce Bella's symptoms with the following family-based intervention steps:

1. **Externalizing Problem.** Using this method, the author worked with Bella and her family on the importance of language. Bella was often called "bad" because of her behavior, which she then internalized. The family was encouraged to externalize Bella's misbehavior in order to avoid future incidents of Bella feeling othered and/or rejected.
2. **Identifying Patterns.** The principle was used to identify negative patterns at home that were reinforcing Bellas's behavior. For instance, Bella received a lot of attention when she engaged in misbehavior but rarely received attention for positive behavior. When she did show improvements, they were not acknowledged by the family. Due to her feelings of loneliness, attention, even if negative, was better than not receiving attention at all, therefore leading to emotional outbursts.
3. **Empowering Your Voice.** When working with the family, each member was given time and attention to share their thoughts and feelings. This method modeled to the family the importance of each member of the family feeling heard and allowed the other family members to understand how their actions impacted each other.
4. **Direct Interventions.** The family members were given directive measures in order to build connections. For instance, they were advised to start having daily family time, such as family meals, movie nights, game nights, etc. In addition, each day, they all had to share their "high/low" for the day with each other. Also, Bella's mom and stepfather were strongly encouraged to spend individual time with each child equally throughout the week.

After a few months of consistent family engagement in treatment, Bella saw great improvements. She reported reduced feelings of loneliness, better impulse control, and less emotional outbursts. Through collaboration with her school, they reported that Bella was less aggressive, which led to building relationships with her peers.

Family engagement in mental health treatment is paramount in order to improve the mental health of children and adolescents. Through innovative, evidence-based practices, we can combat the public health crisis of loneliness within our communities.

Dr. Eboni Wooley is a psychotherapist in New York City and an adjunct professor at New York University. To contact Eboni Wooley, DSW, LCSW, email edw303@nyu.edu.

References

Akgül, H., Güven, A. Z., Güven, S., & Ceylan, M. (2023). Loneliness, Social Support, Social Trust, and Subjective Wellness in Low-Income Children: A Longitudinal Approach. *Children (Basel, Switzerland)*, *10*(9), 1433. doi.org/10.3390/children10091433

Almeida, I. L. L., Rego, J. F., Teixeira, A. C. G., & Moreira, M. R. (2021). Social isolation and its impact on child and adolescent development: a systematic review. *Revista paulista de pediatria : orgao oficial da Sociedade de Pediatria de Sao Paulo*, *40*, e2020385. https://doi.org/10.1590/1984-0462/2022/40/2020385

Bakhtiari, K. (2023, July 28). Gen-Z, The Loneliness Epidemic And The Unifying Power Of Brands. Forbes. forbes.com/sites/kianbakhtiari/2023/07/28/gen-z-the-loneliness-epidemic-and-the-unifying-power-of-brands/

C.S. Moss Children's Hospital. (2024). *Facilitating friendships: Parents' role*. (Mott Poll Report). University of Michigan Health. https://mottpoll.org/reports/facilitating-friendships-parents-role

See the full reference list here.

Guide for Parents* from *page 36

in therapy as *"we* are going*"* instead of *"you* are going*"* to remind them that they are not alone. This small yet meaningful shift reminds the child that therapy is a team effort.

Be Honest with Your Child

When first starting therapy, it is common for parents to meet with the therapist before the child gets involved. You should be open with your child and make them aware that you had that meeting. Transparency is key— even a lie of omission can make your child feel misled and compromise their trust. As you continue with therapy, you may have additional parent-only meetings with the therapist, and you should share this information with your child as it occurs.

Respect Your Child's Privacy

While therapy is a team effort, it is also important to allow your child a sense of privacy in the therapy space. This is particularly true for older children and teens. It's okay to ask open-ended questions like "How did you feel about your session today?" but if your child is hesitant to open up, do not pry. Give them space so that they feel their privacy is respected. If your child thinks that they do not have privacy in this experience, they may be more resistant to engaging in therapy, which will limit its effectiveness. Generally speaking, if your child shares something critical with their therapist, the therapist will update you so that you know how best to support your child.

What to Do if Your Child is Resistant to Starting Therapy

Even after a thoughtful conversation about how therapy works and the ways in which it could be helpful, some children and adolescents will still refuse to attend. Your child's willingness to participate in therapy is an important part of the success of treatment. While you want to help your child and make sure they are supported, it's important not to push too hard.

There is strong evidence that parent training has a positive impact on your child's behavior. By working directly with a child psychologist, you can learn how to help shape your child's environment to support them in becoming their best self. In fact, a parent-focused approach is the most effective approach for learning strategies to help manage childhood concerns related to ADHD and disruptive behaviors. This can be a good first step for many families, and your therapist can help make a plan to get your child more involved when the time is right.

How to Get Started with Therapy

If you and your child are ready to get started with therapy, it's important to find a therapist who is the right fit. A good therapist will be able to support both you and your child, helping you work together to meet your shared goals. Searching for a psychologist who specializes in working with children can be a helpful starting point. A child psychologist who is trained in cognitive behavior therapy (CBT) can teach your child different skills to help manage behaviors and emotions and help you learn strategies to effectively support them.

This article has been previously published in the Jewish Link and is modified from an original article at centerforcbt.org/blog/.

Meir Flancbaum, PsyD, is a licensed psychologist and the director of the Center for Cognitive Behavior Therapy. The Center for Cognitive Behavior Therapy provides in-person CBT and DBT in New Jersey and telehealth in most states. We specialize in helping children, adolescents, young adults, and families navigate challenges such as ADHD, anxiety, tics, trichotillomania, depression, and suicidality. For more information, please visit www.CenterForCBT.org or call (732) 994-3456.

Vibrant from page 32

Brenda Tong

Jantra Coll

and mental health support. Recognizing a gap left unaddressed by other community programs, the goal is to provide a safe, inspiring, and nurturing environment where young people can achieve emotional well-being and security as they transition into independent adulthood. ASC programs are located throughout New York City, including in Manhattan, Queens, and the Bronx.

Participants work on resume writing, job interviews, professional development, budgeting, and general financial literacy. From there, they are connected to employment opportunities and encouraged to practice their on-the-job skills to gain applicable experience in a variety of professional environments.

Once participants enter the program, they are invited into a life-changing opportunity where they get to re-create their lives and reimagine their futures. However, it is vital to approach this work with the nuanced understanding of the needs and barriers that each young person holds. Our dedicated teams take great pride in the connection they make with each participant and the resulting vivification of each of their lives. Participants report feeling a sense of safety and security within the program, with the freedom to be open and honest with Vibrant staff. This facilitates the development of healthy coping strategies while furthering their education and life skills.

Collaborative Family Services

It has been widely studied that communal processes have a greater impact on healing and care. When a young person is in need of emotional or behavioral health support, it is important that the entire family system have access to caring services, such as individual therapy, weekly behavioral health support sessions, and peer support services. This service model reduces the feelings of isolation and stress, opens the doorway for personal empowerment, and disrupts the stigma around seeking supportive services for mental health.

For example, Vibrant's Youth & Family Wellness Services provide collaborative, strengths-based, and trauma-informed care to any child under 18 and their parents or caregivers in New York City. Families begin with an initial meeting with a therapist to discuss their individual strengths, needs, and preferences and determine which service would be the most helpful to them. Youth and their families then begin working with a team, which involves having weekly sessions with their providers. This enhances the spirit of collective care, where each member of the family is seen, held, and supported.

Additionally, Vibrant drives Family and Youth Peer Support (FYPS) services, which are dedicated to supporting and empowering families and youth from birth to 24 years of age who are facing emotional and behavioral health challenges. The New York City Department of Health and Mental Hygiene established a network of FYPS Alliances throughout New York City, including our Queens Alliance. Trained and credentialed family and youth peer advocates who have lived experience from successfully navigating similar challenges provide one-to-one support as well as evidence-based parenting classes and workshops. The program serves a range of at-risk populations, including those who are undocumented, uninsured, and/or undiagnosed, especially those who do not qualify for Medicaid, are navigating cultural stigmas around mental health, or have other culturally specific mental health needs, such as language requirements.

All services are provided on a voluntary basis, free of charge, and offered in English, Spanish, Mandarin, and Cantonese. The mission of these services is to enable families and youth to find the resources and skills that make them feel capable and confident in responding to the unique challenges that life can present.

Comprehensive Youth Case Management

Navigating systems of care can be complex and overwhelming. Comprehensive case management services can help families manage this process and get connected to the services they need.

Vibrant hosts the Children's Health Home program, which provides case management for youth under 21 with Medicaid insurance and qualifying chronic behavioral and medical conditions. Case managers assess each young person's physical, educational, medical, and social needs. Then, they connect the help-seeker with the appropriate providers and ensure coordinated care to achieve agreed-upon outcomes. This vital service operates throughout the Bronx, Brooklyn, Manhattan, and Queens.

Academic Assistance and Accountability

Although the overall school dropout rate has decreased from 7 to 5.3% over the last decade, more can be done. Barriers to academic success are especially prevalent for students of racial and ethnic minorities due to limited sources of quality support, socio-economic factors, and persistent trauma.

Programs such as The Fellowship Initiative (TFI) are working to lower this statistic further. Founded by JP Morgan Chase in 2010, TFI provides comprehensive academic, social, and emotional support to young men of color throughout high school across seven cities, including New York. Since 2015, Vibrant has partnered with TFI to offer social and emotional support services through Clinical Youth Specialists, who provide clinical support, case management, crisis intervention, and social-emotional wellness workshops for Fellows and their families. The overall program has achieved remarkable success with a 100% high school graduation rate and a 100% college admission rate among graduating Fellows.

Support Hotlines

Access to 24/7 call, text, and chat lifelines has become crucial for young people experiencing acute mental health crises, issues with substance use, and other emotional distress, offering confidential, accessible, and affirming help anytime, anywhere.

Among the many national crisis lifelines is the 988 Suicide & Crisis Lifeline, administered by Vibrant. Since its launch in 2022, it has become a critical service, receiving thousands of contacts every day from people of all ages, especially young people.

For New York residents, Here2Help operates several unique crisis hotlines, including NYC 988, the largest metropolitan contact center in the country, and specialized support lines for addiction and other needs.

Another hotline New York students can turn to is the BRAVEline, a collaborative effort between the United Federation of Teachers and Vibrant for anonymous bullying support. One in every five students reports an experience with bullying, but many of them do not know how or where to find trusted guidance. This free hotline and chat service connects children and adolescents with mental health professionals who listen to their problems, help them develop coping strategies, and share essential resources.

Setting Up for Success

It is clear that there is a rapidly growing need for thoughtful mental health services for young people with frameworks that can be replicated throughout the country. These community services are fundamental for young people and their families to cope with mental health challenges, pursue educational goals, and prepare for their future careers.

Vibrant Emotional Health is at the forefront of addressing these urgent needs as both a leading nonprofit dedicated to promoting mental and emotional well-being, and as the administrator of the national 988 Suicide & Crisis Lifeline network. Through a comprehensive ecosystem of specialized programs and services, Vibrant is committed to meeting these young people where they are, whether in crisis or simply seeking support for everyday challenges, and having a lasting motivational impact on their lives.

Even greater than the individuals and families served, Vibrant is working toward systemic change by creating pathways for youth and young adults to thrive emotionally and mentally into adulthood.

Brenda Tong serves as the Chief Program Officer, and Jantra Coll is the Vice President of Community Services at Vibrant Emotional Health.

Concussions from page 29

to an outside observer. The truth is that a person doesn't have to lose consciousness or even appear outwardly affected after they've sustained a concussion. Signs can be delayed and subtle, making them easy to overlook, especially in the hours afterward.

Instead of relying on the individual's subjective judgment as to whether or not they're "okay," look for the following in the days after:

- Changes in sleep patterns
- Increased irritability and/or mood swings
- Difficulty concentrating or trouble in school
- Headaches, dizziness, or sensitivity to light and sound
- Social withdrawal, anxiety, or depressive symptoms

For parents, it's often enough to know that their child sustained a head injury in order to make a doctor's appointment, but for the parents of young athletes, it may be very difficult to spot. If a child sustains a head impact — even an accidental or "minor" hit — monitoring their behavior in the days and weeks that follow is of utmost importance. The brain is an incredible thing, and it has a remarkable capacity to heal itself, making early intervention key to rapid recovery.

The brain is particularly receptive to rehabilitation in the weeks following an injury, and if at all possible, a therapy program should be implemented to restore function or prevent prolonged symptoms. However, in the case that a head injury is overlooked or otherwise missed, there is always something that can be done, especially in young people with developing brains. Post-concussion syndrome treatment protocols can clear the fog, restore diminished cognition, and help kids and teens overcome mood disorders, greatly enhancing recovery outcomes.

The Path Forward:
A Proactive Approach to Brain Health

It's incredibly important that professionals raise awareness around the risks of concussions in young people. Parents, coaches, and medical experts have to take a proactive approach to identifying head trauma and understanding the age- and gender-specific recovery challenges.

This awareness is the first step toward further protecting young athletes from long-term brain injury symptoms and ensuring that head trauma is treated with the utmost care. Seeking evaluations as soon as possible can ensure a shorter road to recovery.

Dr. Alina Fong is Clinical Director and Co-Owner of Cognitive FX.

Kids are Not Alright from page 17

adolescent health must be comprehensive in nature and address determinants of both physical and mental health and the inextricable relationship between "mind" and "body."

As the lives of our youth have become increasingly sedentary, regimented, and governed by innumerable factors outside of their control, their emotional and physical health has suffered in ways most would have considered inconceivable merely a generation ago. Efforts to promote access to evidence-based primary and behavioral healthcare for children and adolescents are laudable and essential to ameliorating their overall health and wellbeing, but they cannot reverse a catastrophic trajectory whose origins may be located in seismic sociocultural changes that began at least a half-century ago. A radical reconceptualization of the "childhood experience" is warranted, and we owe our youth nothing less if they are to become thriving adults equipped to navigate the challenges of the modern area.

Ashley Brody, MPA, CPRP, is Chief Executive Officer for Search for Change, Inc. The author may be reached at abrody@searchforchange.org or (914) 428-5600 (x9228).

Ashley Brody, MPA, CPRP

References

American Academy of Pediatrics. (2021). *A Declaration from the American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, and Children's Hospital Association.* aacap.org/App_Themes/AACAP/Docs/press/Declaration_National_Crisis_Oct-2021.pdf

Buddelmeyer, H., & Powdthavee, N. (2016). Can having internal locus of control insure against negative shocks? Psychological evidence from panel data. *Journal of Economic Behavior & Organization, 122,* 88-109. https://psycnet.apa.org/record/2016-08977-007

Chudacoff, H.P. (2007). *Children at play: An American history.* New York: New York University Press.

Churchill, S.A., Munyani, M.E., Prakash, K., & Smyth, R. (2020). Locus of control and the gender gap in mental health. *Journal of Economic Behavior & Organization, 178,* 740-758. sciencedirect.com/science/article/abs/pii/S0167268120302833

Galler, A., Thonnes, A., Joas, J., Joisten, C., Korner, A., Reinehr, T., Robl, M., Schauerte, G., Siegfried W., Weghuber, D., Weihrauch-Bluher, S., Wiegand, S., Holl, R.W., & Prinz, N. (2024). Clinical characteristics and outcomes of children, adolescents and young adults with overweight or obesity and mental health disorders. *International Journal of Obesity, 48,*(3), 423-432. pubmed.ncbi.nlm.nih.gov/38195831/

Gray, P., Lancy, D.F., & Bjorklund, D.F. (2023). Decline in independent activity as a cause of decline in children's mental well-being: Summary of the evidence. *Journal of Pediatrics, 260,* 113352. jpeds.com/issue/S0022-3476(23)X0008-0

Hofferth, S.L., & Sandberg, J.F. (2001). How American children spend their time. *Journal of Marriage and Family, 63*(2), 295-308. psycnet.apa.org/record/2001-06562-002

Kalarchian, M.A., & Marcus, M.D. (2012). Psychiatric comorbidity of childhood obesity. *International Review of Psychiatry, 24*(3), 241-246. tandfonline.com/doi/full/10.3109/09540261.2012.678818

Luppino, F.S., de Wit, L.M., Bouvy, P.F., Stijnen, T., Cuijpers, P., Pennix, B.W., Zitman, F.G., et al. (2010). Overweight, obesity, and depression: A systematic review and meta-analysis of longitudinal studies. *Archives of General Psychiatry, 67*(3), 220-229. jamanetwork.com/journals/jamapsychiatry/fullarticle/210608

Milteer, R.M., & Ginsberg, K.R. (2012). The importance of play in promoting healthy child development and maintaining strong parent-child bond: Focus on children in poverty. *Pediatrics, 1,* 204-213. https://pubmed.ncbi.nlm.nih.gov/22201149/

Sullivan, S.A., Thompson, A., Kounali, D., Lewis, G., & Zammit, S. (2017). The longitudinal association between external locus of control, social cognition and adolescent psychopathology. *Social Psychiatry and Psychiatric Epidemiology, 52*(6), 643-655. pubmed.ncbi.nlm.nih.gov/28271211/

Twenge, J.M., Zhang, L., & Im, C. (2004). It's beyond my control: A cross-temporal meta-analysis of increasing externality in locus of control, 1960-2002. *Personality and Social Psychology Review, 8*(3), 308-319. https://psycnet.apa.org/record/2004-18152-005

Yogman, M., Garner, A., Hutchinson, J., Hirsh-Pasek, K., & Michnick Golinkoff, R. (2018). The power of play: A pediatric role in enhancing development in young children. *American Academy of Pediatrics, 142*(3). https://publications.aap.org/pediatrics/issue/142/3

Teen Substance Use from page 32

increasing the likelihood of substance misuse among teens.

Research conducted by Dr. Hannah Carliner at Columbia University's Mailman School of Public Health highlights the profound impact of various forms of childhood trauma on future substance use. Her study revealed that experiences of abuse and domestic violence in childhood were strongly linked to increased drug use during adolescence. Additionally, other traumatic events such as car accidents, natural disasters, and severe childhood illnesses were associated with a higher likelihood of teens using marijuana, cocaine, and prescription drugs. These findings show the complex relationship between childhood trauma, parental substance abuse, and the development of substance use disorders in adolescents. They emphasize the need for early intervention and support for families affected by trauma and addiction to break this cycle and promote healthier coping strategies for young people.

Long-Term Consequences

Substance use during adolescence can have long-term consequences, including addiction, mental health disorders, and difficulties in social functioning. Adolescents who have both PTSD and SUD face a higher risk of poor treatment outcomes and more frequent relapses if treatment does not address both conditions simultaneously.

Michiko B. Andrade

Interventions and Prevention

Early intervention is necessary to break the cycle between trauma and substance use. Trauma-informed care, which addresses both the psychological effects of trauma and substance misuse, has shown promise in improving outcomes for affected adolescents. Prevention programs should focus on:

- Teaching healthy coping mechanisms.
- Providing access to counseling for trauma survivors.
- Educating families about the risks of parental substance misuse.

Additionally, integrating mental health services into schools and community programs can help identify at-risk youth early and support them before substance use becomes problematic.

Conclusion

The link between trauma and adolescent substance use emphasizes the importance of addressing childhood adversity as part of public health strategies. By targeting both trauma and its aftermath through prevention and treatment efforts, we can reduce the prevalence of substance use disorders and improve life outcomes for vulnerable adolescents.

Michiko B. Andrade is a strategic communication consultant and seasoned healthcare administrator with over 20 years in public healthcare management. She has extensive experience crafting and disseminating messages that promote intersectional approaches to health equity across public, mental, and behavioral health initiatives. Contact: consult@consultba.onmicrosoft.com.

References

Assim, A., & Kaminer, D. (2024). *Childhood Trauma Begets Substance Abuse Among Adolescents.* Retrieved from http://www.news.uct.ac.za/article/-2024-07-08-childhood-trauma-begets-substance-abuse-among-adolescents

Carliner, H., Martins, S. S., et al. (2016). *Trauma in Childhood Linked to Drug Use in Adolescence.* Retrieved from https://www.publichealth.columbia.edu/news/trauma-childhood-linked-drug-use-adolescence

National Child Traumatic Stress Network (2008). *Understanding the Links Between Adolescent Trauma and Substance Abuse.* Retrieved from https://www.nctsn.org/sites/default/files/resources/understanding_the_links_between_adolescent_trauma_and_substance_abuse.pdf

National Child Traumatic Stress Network (n.d.). *Trauma and Substance Use.* Retrieved from https://www.nctsn.org/what-is-child-trauma/populations-at-risk/trauma-and-substance-use

Ohio Department of Job & Family Services (n.d.). *Trauma and Adolescent Substance Use Disorder.* Retrieved from https://dam.assets.ohio.gov/image/upload/jfs.ohio.gov

PMC (2016). *Childhood Trauma and Illicit Drug Use in Adolescence.* Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC4964281/

PMC (2020). *Traumatic Events and Substance Use Disorders in Adolescents.* Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC7314975/

Incarceration from page 33

in the mid-1800s, which became state mental hospitals later. As designed by the Quaker psychiatrist and architect, Thomas Kirkbride, they were never meant to house more than 250 patients.

Also in the 1790s, the Philadelphia Prison Society, led by Quakers, introduced "solitary confinement" at the Walnut Street Jail and then helped build, in 1832, the Eastern State Penitentiary, isolating each prisoner in a cell where he was supposed to repent based on the notion that "silence is golden."

Both moral treatment and solitary confinement were meant to be more humane than shackling and crowding the mentally ill and criminally poor into filthy dungeons and by preventing corporal and capital punishment. Of course, "asylums" turned into the warehouses for troubled souls that a century later required "deinstitutionalization," a watershed that the behavioral health care system is still drowning in. Such early visitors to the Eastern State Penitentiary as Charles Dickens and Alexis de Tocqueville recognized "immoral treatment" when they saw it resulting in severe mental and physical illness. Today, solitary confinement has become the epitome of "a prison within a prison."

To make a long story short, as asylums grew what was "moral" often became coercive. Friends' Hospital still exists, but when it became a for-profit 25 years ago, the state required funding of the Thomas Scattergood Foundation in exchange, one of the leading groups devoted to behavioral health care innovation. By acknowledging that "recovery is possible," moral treatment has made a comeback in its influence on so-called "therapeutic communities," Soteria Houses, crisis respite centers, and the peer recovery movement in general.

Likewise, Quakers eventually recognized the error of their solitary repentance ways, and in 1975 established the now worldwide Alternatives to Violence Project in New York State that trains those incarcerated in non-violent responses to conflict, thereby lowering recidivism rates. As a form of mutual aid, these trained volunteers then train their compatriots. I, too, have been trained in their methods, and with the help of Judy Meikle, prisons coordinator for the regional New York Quaker Church, and members of my Brooklyn branch, have aided the reentry of several formerly incarcerated Friends who converted to Quakerism while in prison.

On the Trauma of (and Resilience from) Incarceration: One Friend's Experience

Born and raised in Harlem, Frederick "Rob" Robinson was released from a NYS prison in 2022. After a 20-year sentence and five attempts at parole, he was freed at the age of 63 during Covid as a "compassionate case" into the care of the New York Quaker Church because during his incarceration he had recognized "that of God in every person" by participating in Quaker silent worship (a form of group meditation) led by "outside" Friends, and then becoming a leader of those services himself.

This is just one example of Rob taking the advice of an "old-timer" at NYC's Riker's Island Jail the night that Rob was

Carl Blumenthal, MS, NYCPS

"shipped up the river:" "Do your 'bid' the way you can. Don't let anyone do it for you. You seem smart, motivated, sincere, remorseful. Find guys like yourself—in the law library and education programs. Become a 'house captain' (administration envoy). You went to college (graduated from the Ivy League's University of PA). How come you went to prison in the first place?" When Rob asked, "How will I find them?" the older prisoner replied, "They'll find you, if you're lucky before the bookies and dope pushers do."

To frame my discussion with Rob, I use the Prison Policy Initiative's prison trauma checklist and my courses from the NYS Academy of Peer Services' justice peer specialization that emphasize how much more likely peers involved with the criminal justice system are to have experienced adverse childhood experiences (ACEs) as expressed in mental illness and substance abuse that is then worsened by incarceration. This combines the "learned helplessness" of behavioral health care institutions with the further loss of rights known as "imprisonization."

Social Isolation: Incarceration Removes People From Society and Limits Their Personal Care

Rob: "All I saw for the first ten years was a 40-foot wall. No horizon. When I was transferred to a prison inside a fence, at least I could see the horizon. And at my last place in the Adirondacks, there were the mountains. Not that prison isn't crowded, but when I was released and got off Amtrack at 34th Street, the platform was so packed I caught my breath, with my arms shaking and sweating. Outside with the noise, cars, and people rushing, I had an anxiety attack. Even though I was motivated and had a good response plan, for the first three months I was a basket case.

Three years later, I still have a lot of work to do, especially because health conditions, like COPD and depression, that began in prison, have worsened. And this despite me being an athlete before. Now I'm not able to work anymore. Unfortunately, even with subsidized housing and food stamps, Social Security doesn't pay all the bills."

Family Disconnection: Separates People From Their Social Networks and Loved Ones When Not Abandoned by Them

Rob: "My family abandoned me, and I'm still estranged from my siblings. My mom and dad have passed and my nieces and nephews, who are all grown now, don't know me. It's still hard and when on the inside I had no visits, no mail, no goody packages. During birthdays and holidays, you're locked in a cage with no cards, no joy. Even listening to Christmas carols on the radio is sad. When you're finally released, who's there to greet you? At least I was blessed with Quakers in my life, my new family.

Hopelessness: Loss of Autonomy, Boredom, Stultifying Routines, and Lack of Purpose

Rob: "To the nth degree. The minute the judge sentences you and they put the handcuffs on. Plus, you have a double set of rules to follow. Prison infractions can land you in the SHU (secure housing unit or solitary) when you're not confined to your cell for violations of the "facility clock" or schedule. And then there's the convict code that is like learning another language, if you didn't already pick it up on the streets. Between the two, you're coming and going with no destination in sight."

Unpredictability: Never Knowing When Arbitrary Infractions Will Be Assessed With Cruelty Often the Result

Rob: "True on both sides of the bars, whether you're at the mercy of corrections officers or your fellow inmates. But discipline gets a bad rap. Take the prison structure and use it to your advantage by focusing on a job, your education, or participating in a religious group. That's the kind of discipline that the parole board wants to see, not just following the rules."

Overcrowding or Solitary Confinement: These Conditions Can Have Negative Effects on Mental Health

Rob: "Yes, being in general population, whether the hallways or mess hall, can be too much, so I would need to chill out in my cell. Never in solitary myself, but saw the effects on those who were, including suicides. And for those who survived, what are their chances on the outside, if they ever make it?"

Routine Exposure to Violence: This Includes Physical Assault and Sexual Abuse by Guards and Inmates, Whether as Victims or Witnesses

Rob: "From the moment you wake up, violence surrounds you and continues all day. It gives the officers something to do and justifies the system to the point that you can't think about it because it's ten times worse inside than on the streets. Yes, it's safer out here in the "real world."

Triggering Environments: Bright Lights, Loud Noises, Questioning by Staff, and Harsh Handling Can Be Triggering

Rob: "The environment is designed to punish you mentally, physically, and emotionally. The yards are constructed, the walls painted, and even the food made so everything is non-descript. And if you end up in the SHU you really find out what sensory deprivation is about."

Lack of Rehabilitation That Brands Incarcerated People: "Once an Inmate, Always an Inmate"

Rob: "Sure, it's an uphill battle, once institutionalized. I was a 40-something guy when I arrived, so I already had a life under my belt. But these younger guys have nothing to fall back on. Still, if you have any pride, you want to get better. I took my eye off the prize. You can't blame your family and the larger society for everything, though nine out out of ten raised in poverty end in poverty. For the ones who get out and don't want to change, you might as well go back. All about self-awareness. Not perfection, but progress. You get better every day. You've got to change the narrative. More than getting a second chance, you've got to be that second chance.

On the inside, I got a certificate in ministry and human services from Union Theological Seminary. But reentry is more than the essentials of food, shelter, and clothing. It's more recognized now than 30, even ten years ago, especially after Covid. You've got to treat the whole person. If you don't address the trauma of imprisonment, it will trip you up down the road. That means get a trauma therapist like I did. It's become my life's work. After Exodus Transitional Communities got me going, I became a case manager for them, in charge of 135 residents at one of their Queens' housing programs."

Post-incarceration Syndrome: Addiction Specialist Terence Gorski Coined This Tern to Describe the Trauma That Can Continue After Release. It's a Combination of Post-traumatic Stress Disorder, Institutionalization, and Other Factors

Rob: "I call it post-traumatic sentencing disorder."

Conclusion: "Nothing about us without us"

Rob: "Peer support can allow a safe space for those incarcerated to be able to share, explore, and heal from the trauma of involvement with the criminal justice system."

You don't have to be formerly incarcerated to become a justice peer supporter, but, fortunately or not, it helps. Helen Skipper, director of the Justice Peer Initiative, who organized the Academy of Peer Service's curriculum from which I quoted above, was in and out of the criminal justice system for 20 years before she got her degree in the field from the City University of NY's John Jay College. (See www.cityvoicesonline.org.)

Currently, Rob and I are part of an effort for welcoming recently released incarcerated individuals—trained in the Alternatives to Violence Project—to our Brooklyn church on what we call a "Landing Strip" for mutual support. I hope to not just apply the principles of justice peer support but also learn more from participants' firsthand knowledge of the criminal justice system.

Carl Blumenthal, carlblumnthl@gmail.com, was a community organizer and health planner for 27 years before becoming a peer specialist in 2002. He has worked in practically every behavioral health care setting.

Prader-Willi* from *page 35

students at Latham sought additional leisure-based activities to enhance their mental health.

Literature - Leisure Activity Engagement and Mental Well-Being

Existing evidence highlights socially active leisure time is associated with a lower incidence of psychiatric disorders in general, and, specifically, with affective, anxiety, and substance use disorders by young adulthood (Alakokkare et al., 2021). The study suggests to prevent mental disorders, families, schools, and other communities should continue to enhance and develop community-based social leisure activities for children and adolescents (Alakokkare et al., 2021). This is specifically applicable to Latham, as anxiety is significantly increased and experienced daily by both populations. Existing literature additionally asserts engagement in activities outside of school can shape outcomes of related learning experiences and opportunities (Coll et al., 2021). It has also been found among individuals with PWS engagement in more physical activities and leisure activities contributes to advanced cognitive and adaptive skills (Dykens, 2012). Additionally, lack of engagement in activities such as TV watching; among children with PWS, TV viewing was correlated with increased skin picking and more frequent and severe compulsive-like behaviors.

Among the trauma population of youth who have experienced residential care, also termed care-experienced youth, benefit from leisure-time activities that are active or movement-based. A study examining care-experienced youth found children's happiness and positive self-concept were related to engagement in active leisure activities (Coleman et al., 2009). Also found among youth who have experienced trauma, engagement in leisure activities increases confidence, competence, character, and connections (Sandford et al., 2019).

Methods

The implementation of leisure activities aimed to use existing evidence in the literature to facilitate engagement in meaningful leisure activities for both populations to further enhance mental well-being. The leisure activity intervention was provided in 2023 to Latham's residential community, enabling access to students with PWS and trauma histories. All Latham students were included in the leisure activity intervention to further support mental well-being. The intervention groups contained up to eight students and consisted of both populations. The intervention groups were held for at least forty-five minutes once a week during residential hours. After each activity session, all students completed data outcome measures and answered qualitative questions. The data outcome measures were analyzed to track changes to the student's overall mental well-being.

Leisure Activity Measures

All data collected was analyzed using a mixed methods approach to incorporate both qualitative and quantitative data. All qualitative data was collected through predetermined follow-up questions. Quantitative data was collected through the World Health Organization (WHO-5) Well-being Scale and The Zones of Regulation scale. The WHO-5 Well-being scale is a quantitative measure producing statistical data regarding mental well-being (Figure 1). The Zones of Regulation scale collected statistical data on the students' ranges of emotions based on categories (Figure 2). These categories are known as zones, and each zone corresponds to a color (i.e., blue zone, red zone, yellow zone, and green zone). The analysis will show how students are being impacted by the intervention based on the zones reported. All quantitative data was analyzed using the Qualtrics statistical software program.

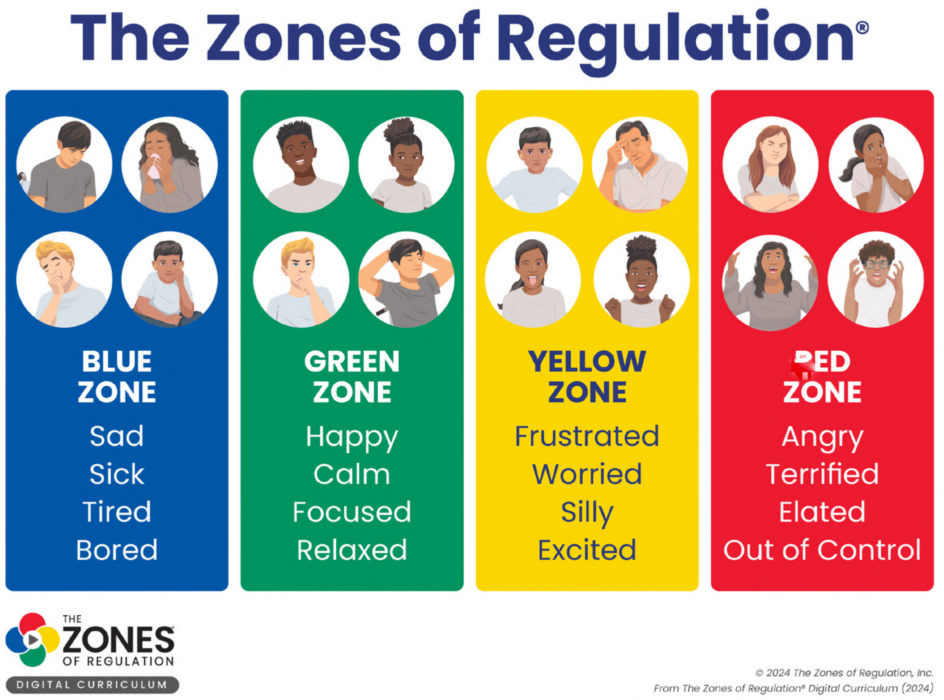
The WHO-5 questionnaire

Instructions:
Please indicate for each of the 5 statements which is closest to how you have been feeling over the past 2 weeks.

	Over the past 2 weeks...	All of the time	Most of the time	More than half the time	Less than half the time	Some of the time	At no time
1	... I have felt cheerful and in good spirits	5	4	3	2	1	0
2	... I have felt calm and relaxed	5	4	3	2	1	0
3	... I have felt active and vigorous	5	4	3	2	1	0
4	... I woke up feeling fresh and rested	5	4	3	2	1	0
5	... my daily life has been filled with things that interest me	5	4	3	2	1	0

Scoring principle: The raw score ranging from 0 to 25 is multiplied by 4 to give the final score from 0 representing the worst imaginable well-being to 100 representing the best imaginable well-being.

Figure 1



© 2024 The Zones of Regulation, Inc.
From The Zones of Regulation® Digital Curriculum (2024)

Figure 2

The qualitative data collected from the students was analyzed using a thematic analysis. This type of approach is being widely used within the social and health sciences (Braun & Clarke, 2014). This type of systematic analysis was used to analyze all qualitative data reported by the Latham students following the intervention sessions. At the end of all the intervention sessions, the students present were asked to answer a series of four follow-up questions (Table 3).

1. How did participating in the activity make you feel?
2. Would you participate in this activity again?
3. By participating in this activity, what new coping skill did you learn that you could use to reduce your current stress or anxiety level?
4. How does this statement make you feel, "I can positively manage my stress and or anxiety, and I feel positive about myself"

Table 3

Results and Conclusion

The 14-week leisure-based activity intervention outcomes contributed to improvements in Latham students' emotional regulation, activity engagement, and overall mental well-being, as suggested in the existing literature. The present study indicated that Latham students' engagement in weekly activities created peer connections and sustained students' attention. At the start of the leisure activity intervention, 21% of Latham students were engaged and participating in leisure-based activities. On week 11, 65% of Latham students were engaged in leisure-based activities. By comparison, active participation in leisure activities increased by 44% from week 1 to week 12. Latham students' engagement in activities increased weekly as the activities became a familiar part of residential programming. As students increasingly engaged, a sense of personal achievement was established, as suggested in previous studies, lessening initial anxiety previously impacting one's decision to participate. Students who consistently completed the Zones of Regulation scale showcased significant improvements. Most notably, students who indicated they were in the green zone (happy, focused, calm, proud zone) increased from 63% to 83% by week 14. The 20% increase in students identifying as being in the green zone after activity completion is noteworthy as the targeted population has significant challenges with sustaining emotional regulation.

All students who consistently participated in leisure-based activities repeatedly responded positively when asked if they would participate again. Among students who were consistently actively engaged provided 90% positive verbal feedback in response to specific qualitative questions. Students frequently replied with statements such as this activity made me "feel good," "happy," and "calm." Students additionally commonly replied with statements in reaction to the specific activities and interpreted them as "fun," "enjoyable," and "fun and relaxing." Furthermore, the implementation of leisure-based activities positively influenced the mental well-being of all children and adolescents with Prader-Willi Syndrome and children with trauma.

Future Implications for Residential Facilities

The conclusions drawn from the residential facility at Latham Centers housing both trauma and PWS populations can have applications in a wide variety of residential and non-residential facilities. The common populations to which these results could be applied include Down Syndrome, Angelman Syndrome, Schaff-Yang Syndrome, Fragile X syndrome, and Williams Syndrome. The results can be further applied to pediatric or adolescent populations with diverse physical or cognitive disabilities. The overall result of increased mental well-being of both populations at Latham presents promising future results and implications for other residential or non-residential facilities serving similar populations.

Additionally, this intervention can support future healthcare professionals or care providers in maximizing health, well-being, and quality of life for children and adolescents with PWS, trauma, or similar diagnoses to support daily functioning and sustain positive mental well-being.

Acknowledgments

I express my sincere gratitude to the

see Prader-Willi on page 55

DBT Treatment from page 34

While traditional treatment-oriented models of care focus on symptoms and their presentations, DBT emphasizes reducing feelings of hopelessness and revisits the concept of an individual's "life worth living goal," which is the vision of creating a life that is no longer compatible with the idea of suicide or other high target behaviors. The "life worth living goal" looks at living a life of balance (Linehan, 1993, p. 124).

DBT combines cognitive and behavioral interventions, mindfulness skills, and acceptance and change strategies to teach individuals effective ways to cope with emotional dysregulation and move away from ineffective coping methods, such as suicidal thoughts and behaviors, self-injury, substance use, and other impulsive actions. An effective DBT program requires clinicians to be trained in the principles, skills, and interventions of DBT. Clinicians are not required to be certified in DBT to provide DBT treatment. However, it is recommended they have foundational or intensive DBT training to ensure high-fidelity treatment. A comprehensive DBT program requires four main components of DBT, including (Linehan, 1993):

- Weekly group skills training
- Weekly Individual therapy
- Skills coaching (outside of scheduled sessions)
- A clinician consultation team

Challenges with Accessibility and Sustainability

Although EBTs are the gold standard for mental health treatments, many community-based health centers and treatment facilities face challenges in implementing high-fidelity, sustainable, evidence-based therapies, such as DBT (King, J.C. et al., 2018). When examining research regarding the sustainability of DBT implementation in healthcare settings, studies reveal the most common barriers are related to financing, resources (e.g., time commitment), clinician turnover, and administrative support (King et al., 2018; Quetsch et al., 2020).

In addition to the barriers listed above, insurance coverage for DBT therapy can be difficult to obtain because DBT involves many different components of therapy, some of which are not funded or are underfunded by insurance companies, particularly Medicaid (e.g., phone coaching, skills training for families, consultation teams). This is critical since treatment programs that primarily treat marginalized populations are more likely to be funded through Medicaid versus private insurance. While this is an understudied area of research specific to DBT, mental health disparity analysis reveals youth with public health insurance have less access to mental health services in general (James et al., 2015). A study assessing DBT youth treatment outcomes with private insurance compared to public/public eligible insurance holders reveals lower rates of treatment completion for youth without private insurance (James et al., 2015). While reasons for the lower rates of completion are multifaceted, this shows the reality of the challenges marginalized youth face when seeking and receiving mental health treatment.

Crystal Taylor-Dietz, PsyD

Given these factors, it is unsurprising that despite strong evidence of the effectiveness of DBT, service providers and families that use Medicaid often find it difficult to locate comprehensive DBT therapy in their demographic area, particularly when seeking community providers that accept Medicaid funding. DBT listservs and websites often highlight challenges with insurance coverage and locating comprehensive programs and well-trained clinicians in community health centers. These same listservs and websites often report it is much easier to find comprehensive DBT services in group practices and private facilities that only accept private insurance or out-of-pocket payers. This reveals the barriers marginalized groups face in accessing the most effective treatments for some of the most prevalent mental health concerns in our society.

Devereux's Commitment to Providing DBT

Since 2018, Devereux Advanced Behavioral Health has invested significant resources in the implementation, sustainability, and fidelity of DBT for its child-serving residential and outpatient programs focused on treating emotional and behavioral disorders. Devereux has collaborated with Treatment Implementation Collaborative, LLC (TIC), which provides quarterly consultation and training for behavioral health clinicians. In total, Devereux has invested in more than 150 hours of external DBT-specific training for clinicians and staff (approximately 30 hours/year) since 2020 and developed internal foundational trainings, in collaboration with TIC, for clinicians and staff. This training has allowed staff to obtain up to 30 hours of free continuing education credits per year. The organization also partners with an internal national consultant who supports DBT implementation across teams, as well as a national Fidelity Advisory Committee that consists of national and center clinical and operations representatives who oversee national implementation goals and fidelity of the model. These internal supports ensure Devereux provides multiple levels of leadership and administrative support for the implementation of DBT across its centers.

Devereux's training and support efforts have allowed the organization to provide comprehensive DBT services to more than 500 youth, the majority of whom are Medicaid recipients, with an additional 100-plus youth who have received DBT skills training as a supplement to other evidence-based treatment. Over the last two years, Devereux has experienced an increase in the number of individuals receiving DBT services on an annual basis.

Strategies for Sustainability, Achieving High Fidelity

To minimize barriers to sustainable, high-fidelity implementation, Devereux has developed a comprehensive system to evaluate and monitor the integrity of its DBT programs. This system includes coaching and feedback, monthly integrity monitoring of the four core modalities of DBT, and innovative dashboards for tracking integrity. This process ensures the provision of high-fidelity services for all youth who receive DBT therapy, recognizing this may be their only opportunity to access the comprehensive model and benefit from its effectiveness.

Devereux has made additional accommodations to the delivery of the model to increase access for a larger number of marginalized individuals and families by offering opportunities to engage in DBT through telehealth. Offering telehealth services has allowed individuals and caregivers to increase their engagement with the treatment model when transportation and parental schedules might have otherwise impeded participation. Devereux remains committed to offering comprehensive DBT and is dedicated to delivering these services with high fidelity to ensure all youth, regardless of their background or socioeconomic means, can receive evidence-based therapy that has a long-lasting, positive impact on their mental health.

About Devereux Advanced Behavioral Health

Devereux Advanced Behavioral Health is one of the nation's largest nonprofit organizations that provides services, insight, and leadership in the evolving field of behavioral healthcare. Founded in 1912 by special education pioneer Helena Devereux, the organization operates a comprehensive network of clinical, therapeutic, educational, and employment programs and services that positively impact the lives of thousands of children, adults – and their families – every year. Focused on clinical advances emerging from a new understanding of the brain, its unique approach combines evidence-based interventions with compassionate family engagement. Devereux is a recognized partner for families, schools, and communities, serving many in the areas of autism, intellectual and developmental disabilities, specialty mental health, education, and child welfare. For more than a century, Devereux Advanced Behavioral Health has been guided by a simple and enduring mission: To change lives by unlocking and nurturing human potential for people living with emotional, behavioral, or cognitive differences. Learn more: www.devereux.org.

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

References

Finkelhor D, Turner H, LaSelva D. Receipt of Behavioral Health Services Among US Children and Youth With Adverse Childhood Experiences or Mental Health Symptoms. JAMA Netw Open. 2021;4(3):e211435. doi:10.1001/jamanetworkopen.2021.1435

Hernandez-Bustamante M, Cjuno J, Hernández RM, Ponce-Meza JC. Efficacy of Dialectical Behavior Therapy in the Treatment of Borderline Personality Disorder: A Systematic Review of Randomized Controlled Trials. Iran J Psychiatry. 2024 Jan;19(1):119-129. doi: 10.18502/ijps.v19i1.14347. PMID: 38420274; PMCID: PMC10896753

James S, Freeman KR, Mayo D, Riggs ML, Morgan JP, Schaepper MA, Montgomery SB. Does Insurance Matter? Implementing Dialectical Behavior Therapy with Two Groups of Youth Engaged in Deliberate Self-harm. Adm Policy Ment Health. 2015 Jul;42(4):449-61. doi: 10.1007/s10488-014-0588-7. PMID: 25199812; PMCID: PMC4362888

King, J.C., Hibbs, R., Saville, C.W.N. et al. The survivability of dialectical behaviour therapy programmes: a mixed methods analysis of barriers and facilitators to implementation within UK healthcare settings. BMC Psychiatry 18, 302 (2018). https://doi.org/10.1186/s12888-018-1876-7

Kothgassner OD, Goreis A, Robinson K, Huscsava MM, Schmahl C, Plener PL. Efficacy of dialectical behavior therapy for adolescent self-harm and suicidal ideation: a systematic review and meta-analysis. Psychol Med. 2021 May;51(7):1057-1067. doi:10.1017/S0033291721001355. Epub 2021 Apr 20. PMID: 33875025; PMCID: PMC8188531

Lee, P., Lang, J. M., Vanderploeg, J. J., & Marshall, T. (2021). Evidence-Based Treatments in Community Mental Health Settings: Use and Congruence With Children's Primary Diagnosis and Comorbidity. Research on Child and Adolescent Psychopathology, 1-14

Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. Guilford Publications

Murthy VH. The Mental Health of Minority and Marginalized Young People: An Opportunity for Action. Public Health Reports®. 2022;137(4):613-616. doi:10.1177/00333549221102390

Quetsch, L.B., Herschell, A.D., Kogan, J.N. et al. Community-based behavioral health administrator perspectives on sustainability of Dialectical Behavior Therapy: a qualitative evaluation. bord personal disord emot dysregul 7, 5 (2020). https://doi.org/10.1186/s40479-020-0120-5

Syversen AM, Schønning V, Fjellheim GS, Elgen I, Wergeland GJ. Evaluation of dialectical behavior therapy for adolescents in routine clinical practice: a pre-post study. BMC Psychiatry. 2024 Jun 14;24(1):447. doi: 10.1186/s12888-024-05876-z. PMID: 38877441; PMCID: PMC11177375

Measurement-Based from page 15

adolescents may be greater than that of adults (Rognstad et al., 2023). These rating scales can also be used as a tool for clinicians to facilitate communication and engagement with patients and families by sharing results and indicating progress and areas where improvement is needed.

Many of these rating scales are publicly available, and thus, they are easily accessible. Some examples include the Patient Health Questionnaire for Adolescents Modified for Teens (PHQ-A available at glad-pc.org), which can help screen for depression, Self-Report for Childhood Anxiety-Related Emotional Disorders (SCARED, Birmaher et al., 1999) for anxiety and the Swanson, Nolan, and Pelham (SNAP)-IV Rating Scale (Bussing et al., 2008) and the Vanderbilt Assessment Scale Vanderbilt Diagnostic Rating Scales (Wolraich et al., 2003) for ADHD. Rating scales such as these are available in the public domain and can be found online. See, for example, the AACAP Tool box and the collection of rating scales on the REACH Institute's website. There is no "prescribed" method to deliver MBC, and the method may vary based on the setting. For examples of implementing MBC in school, see the SAMHSA report Advancing Measurement-Based Care in School Mental Health, or in psychotherapeutic practice, see the American Psychological Association's Measurement-Based Care Practices Center. One can also use a feedback system (see, for example, psychiatry.org or the meta-analysis by Rognstad et al. 2023). Below are two case examples to illustrate the use of MBC.

Case Example 1

Ava is a 16-year-old tenth grader who presents to her pediatric practice for her annual physical. When she checks in, she is given the Pediatric Symptom Checklist (PSC-17, Gardner et al., 1999), a generalized psychosocial screening which is available in parent and youth versions and comes in multiple languages. She also receives the PHQ-A. These are now given to all adolescents at well visits in this practice. The medical assistant flags the PSC-17 and the PHQ-A as both indicate signs of depression. During interview, her mother reported that she has seemed more tired lately and is uncharacteristically having trouble getting up in the morning on time for school. When the pediatrician speaks to Ava alone, he hears that she has been feeling sad and overwhelmed since the start of the school year. At times, she wonders if she would be better off dead, but she has no intent to harm or kill herself. The pediatrician discusses further with Ava and her mom that these signs are consistent with depression and recommends that she start medication and psychotherapy. The family wants time to think and consider the recommendations, so the pediatrician schedules a follow-up appointment. At the next appointment, Ava's PHQ-A score is even

Cathryn Galanter, MD

higher. She continues to report feeling depressed. The pediatrician shares this feedback with Ava and her mom. They agree to start medication and follow up with the referral for psychotherapy. At follow-up visits, Ava continues to complete the PHQ-A, and the pediatrician makes medication adjustments accordingly.

Case Example 2

Reggie is a 7-year-old boy who presents to a community mental health center referred by his school because he has been disrupting class. Prior to the first visit, his parents received a link to complete a number of rating scales online, including the SNAP-IV. Prior to the first appointment, the therapist noted that Reggie's SNAP-IV scores are consistent with ADHD but that there is no evidence of anxiety, depression, or conduct-disordered behavior. The parent reports that he is a handful at home; he is sweet and cheerful but has trouble paying attention and following directions. The therapist suspects that Reggie has ADHD, gets consent to communicate with the school, and asks his mom to give his teacher at Vanderbilt. At his next visit, he meets with the child and adolescent psychiatrist. The psychiatrist reviews the rating scales from the parents, teachers, and the assessment from the therapist. After her comprehensive clinical assessment, she diagnoses Reggie with ADHD, prescribes a stimulant medication, and refers the parents to the clinic's parent management training group. At his next visit, his father reports that his symptoms have greatly improved. However, the rating scales from both the parent and teacher report residual symptoms. The child and adolescent psychiatrist increases his medication dose. Once Reggie is on a stable regimen, the psychiatrist speaks with Reggie's parents and finds out that Reggie's pediatrician has agreed to treat Reggie's ADHD. The psychiatrist communicates with the pediatrician and discharges Reggie from the clinic. If we are responsive to children's remaining symptoms, they may recover faster and need less frequent treatment or even be ready to "graduate" from treatment, thus making way for other clients.

Implementing MBC presents challenges. For example, it is important to identify who will distribute the rating scales and ensure that they are returned so that the clinician can review them in a timely fashion, preferably during the clinical visit. In addition, findings from the rating scales may not be consistent with the clinical interview. In those cases, the clinician should use their clinical judgment of how to weigh the conflicting information to determine the best next steps. Research has demonstrated that feeling more positive and more skillful about MBC (i.e., higher self-efficacy) correlates with higher use of MBC (Jensen-Doss et al., 2025). This argues for the need for training and ongoing supervision to help clinicians use MBC.

Measurement-based care can be an effective way to support clinical decision-making, improve quality, and engage families in their clinical decision-making. It may be one piece of the puzzle in tackling the children's mental health crisis.

Cathryn A. Galanter, MD, is a Professor of Psychiatry and Division Director of Child and Adolescent Psychiatry in the Department of Psychiatry and Behavioral Health at Stony Brook University. She is a nationally recognized expert on child and adolescent psychiatry and a clinical and academic leader with a background in transforming educational and research programs, mentoring and supervising physicians and clinicians, and overseeing curriculum design. Her clinical and research interests include attention deficit hyperactivity and bipolar disorders, collaboration with pediatrics and schools, assessment and measurement-based care, and clinical decision-making.

References

American Psychological Association Measurement-Based Care Practice Center https://www.apaservices.org/practice/measurement-based-care accessed 03/18/2025

Birmaher B, Brent DA, Chiappetta L, Bridge J, Monga S, Baugher M. Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. J Am Acad Child Adolesc Psychiatry. 1999;38:1230–6. http://www.psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Child.pdf. Accessed 03/18/2025

Bussing R, Fernandez M, Harwood M, Hou W, Garvan CW, Eyberg SM, et al. Parent and teacher SNAP-IV ratings of attention deficit hyperactivity disorder symptoms: psychometric properties and normative ratings from a school district sample. Assessment.2008;15:317–28 www.myadhd.com/snap-iv-6160-18sampl.html accessed 03/18/2025

Chorpita, B. F., Daleiden, E. L., Park, A. L., Ward, A. M., Levy, M. C., Cromley, T., Chiu, A. W., Letamendi, A. M., Tsai, K. H., & Krull, J. L. (2017). Child STEPs in California: A cluster randomized effectiveness trial comparing modular treatment with community implemented treatment for youth with anxiety, depression, conduct problems, or traumatic stress. Journal of Consulting and Clinical Psychology, 85(1), 13–25.

Connors, E. H. & Hoover, S. (2025). Advancing measurement-based care in school mental health. Publication No. PEP24-01-030. Rockville, MD: Substance Abuse and Mental Health Advancing Measurement-Based Care in School Mental Health Accessed 03/18/2025

Gardner W, Murphy M, Childs G, et al. The PSC-17: a brief pediatric symptom checklist with psychosocial problem subscales. a report from PROS and ASPN. Ambul Child Health. 1999;5:225–36. www.massgeneral.org/psychiatry/treatments-and-services/pediatric-symptom-checklist Accessed 03/18/2025

Jensen-Doss A, Casline E, Woodard GS, Phillips DA, Lane E, Palafu T, Waye C, Ramirez V, Cheron DM, Okamura K. Provider Use of, Attitudes Towards, and Self-efficacy with Key Measurement-based Care Practices in Youth Mental Health Treatment: A Multi-site Examination. Adm Policy Ment Health. 2025 Jan;52(1):146-158. doi: 10.1007/s10488-024-01354-6. Epub 2024 Feb 9. PMID: 38334881.

Office of the Surgeon General (OSG). Protecting Youth Mental Health: The U.S. Surgeon General's Advisory [Internet]. Washington (DC): US Department of Health and Human Services; 2021. PMID: 34982518.

Patient Health Questionnaire 9: Modified for Teens. www.glad-pc.org. Accessed 03/18/2025.

Rognstad, K., Wentzel-Larsen, T., Neumer, S.-P., & Kjøbli, J. (2023). A systematic review and meta-analysis of measurement feedback systems in treatment for common mental health disorders. Administration and Policy in Mental Health and Mental Health Services Research, 50(2), 269–282

Sarvet B. Measurement-Based Care in the Pediatric Primary Care Setting. Child Adolesc Psychiatr Clin N Am. 2020 Oct;29(4):691-702. doi: 10.1016/j.chc.2020.06.009. Epub 2020 Jul 22. PMID: 32891370.

Wolraich ML, Lambert W, Doffing MA, Bickman L, Simmons T, Worley K. Psychometric properties of the Vanderbilt ADHD diagnostic parent rating scale in a referred population. J Pediatr Psychol. 2003;28:559–68 https://thereachinstitute.org/wp-content/uploads/2021/06/Vanderbilt_Parent_Rating_Scale.pdf accessed March 18, 2025

www.psychiatry.org/psychiatrists/research/registry accessed 03/18/2025

Prader-Willi from page 53

entire Latham community, especially the staff, the students, the board of directors, and the senior administration team for supporting this research. Participation by all contributed to the success of this research for the future benefit of children and adolescents in residential and non-residential settings seeking additional mental health programming. I sincerely thank Latham Centers and Johnson and Wales University's Occupational Therapy Doctorate Program for permitting this research.

MaryClaire Attisano, OTD, BS, is a member of the Occupational Therapy Doctorate Program at Johnson and Wales University. She can be reached via email at J02279927@jwu.edu.

References

Ahmed, U., K., Chowdhury, & Faruk, Md., O. (2021). Assessing well-being of persons with disabilities: Validation of the WHO-5

See the full reference list here.