Preparing the New Behavioral Health Workforce

By Andrew F. Cleek, PsyD and Boris Vilgorin, MPA

The Affordable Care Act marked a national healthcare reform effort, and within that context, New York State, led by Governor Cuomo’s Medicaid Redesign Team, is undergoing a substantial shift in publicly funded physical and behavioral health care. The authors have been deeply involved in the rollout of these changes dating back to the Adult Chronic Illness Demonstration Project (a precursor to Health Homes), the Adult Health Home Rollout, NYS Mental Health Clinic Redesign, and now, the transition to Managed Care. A consistent thread within each of these initiatives is the evolving skillset needed among the workforce. Hospitals, FQHC’s, Community-Based agencies, government, and payers are each struggling to identify the specific workforce skills needed for individual staff and organizations to succeed in this ever-evolving environment. This article draws from the authors’ experience developing the NYS behavioral health workforce to propose a number of core skills in which all staff need increased knowledge.

A key area that defines successful organizations across multiple different systems and provider types, is the ability of staff to communicate across roles. In our experience, organizations that have successfully adapted to recent changes are those where the administrative, program and clinical, finance, and HIT staff have regular and ongoing dialogue. When each of these systems operate in separate silos or do not collaborate, it does not bode well for the respective departments, or most importantly, the provider’s clients. Perhaps in the behavioral health system of a decade ago it was possible to know “your job only,” but in the new world, each staff member needs to know all of the different pieces fit together and understand their role within the overall organization and healthcare delivery system.

Familiarity with the following identified topics is necessary in order for each staff member to be successful:

1. Finance: In successful organizations, all staff have a basic understanding of where they fit in the overall funding structure of the agency. This includes a staff member’s role in generating revenue and supporting overall fiscal health of the organization. For example, front line clinicians need to understand how productivity and documentation affect their program’s bottom line. The program director not only

Behavioral Health News to Honor Peter Campanelli, PsyD, John Coppola, MSW, Linda Rosenberg, MSW, and Ann Sullivan, MD, at June 21st Leadership Awards Reception

By Staff Writer

Behavioral Health News will hold its Annual Leadership Awards Reception on June 21st at NYU Kimmel Center’s Rosenthal Pavilion. Jorge R. Petit, MD, Board Chairman of Mental Health News Education, Inc. (MHNE), publisher of Behavioral Health News, made the announcement saying, “We are extremely excited to be holding our second annual Leadership Awards Reception and equally excited to be honoring four outstanding leaders of the behavioral health community: Peter C. Campanelli, PsyD, John Coppola, MSW, Linda Rosenberg, MSW, and Ann Marie T. Sullivan, MD. We hope all of our colleagues and supporters will come out to pay tribute to our honorees and to help support MHNE’s behavioral health education mission.”

Peter C. Campanelli, PsyD, is Senior Scholar, Organizational and Community Services and a Senior Research Scientist for the McSilver Institute for Poverty Policy and Research at New York University Silver School of Social Work. Among other initiatives, Dr. Campanelli co-developed and co-directs NYU Silver’s six-module Advanced Certificate in Integrated Primary and Behavioral Health (IPBH). He is the former President and Chief Executive Officer of the Institute for Community Living.

John J. Coppola, MSW, is the first Executive Director of the New York Association of Alcoholism and Substance Abuse Providers, Inc. (ASAP). He has held that position since June of 1996. Mr. Coppola is responsible for representing the interests of substance use disorder and problem gambling treatment, prevention, recovery, research, and training providers throughout New York State. John serves on a variety of national, state, and local working groups and committees that address major issues affecting the field.

Linda Rosenberg, MSW, is President and CEO of the National Council for Behavioral Health. A healthcare architect who has advanced quality care for people with mental and substance use disorders, Linda is a national expert in the financing and delivery of mental health and substance services. Under her leadership, the National Council for Behavioral Health has become our nation’s most effective advocate for behavioral health prevention, early intervention, science-based treatment, and recovery.

Ann Marie T. Sullivan, MD, is Commissioner of the New York State Office of Mental Health (OMH). Dr. Sullivan was confirmed by the New York State Senate as Commissioner on June 20, 2014. New York State has a large, multi-faceted mental health system that serves more than 700,000 individuals each year. The Office of Mental Health operates psychiatric centers across the State, and also oversees more than 4,500 community programs, including inpatient and outpatient programs, emergency, community support, residential and family care programs. As Commissioner, she has guided the transformation of the state hospital system in its emphasis on recovery and expansion of community-based treatment, reinvesting over 60 million dollars in community services. Previously, she was the Senior Vice President for the Queens Health Network of the New York City Health and Hospitals Corporation.

Ira Minot, LMSW, Founder and Executive Director of MHNE stated, “Our Leadership Awards Reception this June will celebrate our 16th year of providing vital behavioral health education to the community. I am very honored that we will have this opportunity to pay tribute to four outstanding leaders of our community, and hope everyone will come out in support of their lifetimes of achievement.”
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Theme & Deadline Calendar

Behavioral Health News
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Summer 2016 Issue:
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Looking Ahead: The Future of Behavioral Health

By Arlene González-Sánchez, MS, LMSW

The New Behavioral Health Workforce: Changing with the Times

The medical field is constantly evolving and the addictions field is changing right along with it. To that end, the Certified Alcoholism and Substance Abuse Counselor (CASAC) job task analysis is updated on a regular basis. The most recent CASAC competencies included knowledge and skills related to screening, identification, integration and referral for co-occurring mental and physical health problems. Additionally, CASAC certified programs statewide, 56 Colleges/Universities and 33 Community Based Education programs, to offer a standardized 350 Hour Curriculum of SUD specific education.

In addition to Addiction Counseling programs OASAS also certifies Bachelors, Masters and Doctoral programs in Psychology, Social Work, Mental Health Counseling and Marriage and Family Therapy to ensure that students receive addiction specific coursework and work experience that is currently required for these disciplines. This prepares clinicians working toward NYS licensure to gain both mental health and addiction competencies that can be used in OASAS programs and other counseling and healthcare settings to provide integrated treatment.

There is also a fellowship opportunity for those individuals who are currently enrolled in or entering their second year of a Master’s Program that is also certified by OASAS as a CASAC Certificate Program. The fellowship is offered by the National Association of Addiction Professionals (NAADAC) and awards up to $20,000 toward tuition fees for those students who are currently, or committed to, working with minority populations and/or transition age youth. More information about this opportunity can be found at: http://www.naadac.org/nmfp-ac-eligibility-application-process.

Additionally, medical professionals will need to embrace further educational and experiential opportunities to learn more about SUDs. OASAS currently requires that all Medical Directors in OASAS certified programs also be Board Certified in Addictions. There will also be a need for additional Certified Addiction Registered Nurses and Nurse Practitioners to serve on the multi-disciplinary teams that treat clients in OASAS programs. This is important because individuals with co-occurring substance, mental health and/or physical conditions will need to have care that addresses all of their illnesses simultaneously without inadvertently making one or more worse due to lack of understanding of the interactions of the treatments being provided.

Fortunately, this has been foreseen for some time. In 2012, a study found that the implementation of the Affordable Care Act in 2014 would result in a significant increase in the need for professionals who are able to care for individuals with SUDs in a variety of managed healthcare settings [Vital Signs: Taking the Pulse of the Addiction Treatment Profession-Addiction Technology Transfer Center Network, 2012]. The same study also acknowledges the constant changes in technology and recognizes the importance of SUD treatment practitioners making sure they stay up to speed, building their computer and web-based technology skills.

More than Medicine: Skills to ‘Manage Care’ Needed

While the focus remains on the care and interest of the patient, there are other aspects changing in our field right now. Managed care is altering the landscape in which healthcare is delivered. Now that health insurance plans or health care systems are coordinating the provision, quality and cost of care for its enrolled members, addictions professionals need to know more and understand the principles of these payer systems. They will want to have a more comprehensive understanding of insurance and insurance companies to better understand how to work with payers, providers, patients and their families with regard to levels of care, reintegration and reimbursement.

Shortcut in the Workforce: Building Our Ranks

The new age of the addictions field is in dire need of professionals. A recent survey found that retention continues to be an ongoing challenge for SUD treatment facilities. According to respondents, the average staff turnover rate is 18.5 percent [Vital Signs: Taking the Pulse of the Addiction Treatment Profession-Addiction Technology Transfer Center Network, 2012]. Additionally, the Bureau of Labor Statistics has indicated that the Substance Abuse and Behavioral Disorder Counselor category is growing at a much faster than average rate nationally at 22% for the years 2014-24. But efforts are underway to attract more interested and compassionate individuals into the field and current addictions professionals can help.

There are several paths to take for anyone interested in pursuing a career in addictions. If you or someone you know is interested in working to address addictions in individuals, families and/or communities, head to www.nysoasas.ny.gov and click on Credentialing. There, you’ll find valuable information including eligibility requirements for Certified Alcoholism Substance Abuse Counselor (CASAC), Certified Problem Gambling Counselor (CPGC) or Certified Prevention Professional (CPP) and Certified Prevention Specialist (CPS). As stated above, the educational requirements for these credentials can be earned as part of an Associate’s, Bachelor’s, Master’s or Doctoral program in Psychology, Social Work or Counseling that are listed at this link: http://www.nysoasas.ny.gov/training/providers.cfm/providerType=AC-350.

Our community based CASAC certificate programs also offer opportunities for those that may already have degrees or are not seeking a degree at this time. Many second career individuals, who are retiring from one career and looking to continue to make a difference in people’s lives, are also taking advantage of these programs and the demand for new addiction counselors. Additionally, OASAS also approves two organizations to offer the Certified Recovery Peer Advocate certification for those individuals who are interested in serving those with SUDs in a peer capacity. Peer Advocates can work in OASAS programs or for agencies that are approved to offer Home and Community Based Services (HCBS) to individuals who qualify as members of Health and Recovery Based Services (HCBS) to individuals who qualify as members of Health and Recovery Programs (HARPs). More information on the OASAS approved Peer Advocate certification can be found at: www.nysoasas.ny.gov/recovery/PeerServices.cfm.

Education is not limited to those looking to get started in the addictions field. NYS OASAS is encouraging current professionals to expand their knowledge through ‘Learning Thursdays.’ This program see Future on page 36.
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Meeting the Challenges of Healthcare Reform: Preparing the Workforce for Transformational Practice Change

By Peter C. Campanelli, PsyD, Kyle H. O’Brien, DHSc, MSW, MSOT, LCSW, OTR/L, Dominic LaRocca, MPA, and Joseph Corniglia, BSW

The University Response to Re-Training the Workforce: Credentialing and Developing the Metrics of Practice Change

Higher education has historically been charged with preparing the workforce for health care delivery, specifically, by providing the training needed to produce competent professionals who have the capacity to provide high quality care. However, the vast majority of graduate health professional training programs are challenged to move away from training that prepares solo practitioners toward a new focus on collaborative interventions that involve evidence based treatments and technological advances. In 2010, as the ACA was signed into law, the New York University Silver School of Social Work (SSSW), under the auspices of the Dean of the SSSW, and in collaboration with the Office of Global and Life Long Learning and McSilver Institute for Poverty, Policy and Research, undertook the development of the Advanced Certificate program in Integrated Primary and Behavioral Health Care. This development was facilitated by an interdisciplinary and inter-governmental steering committee whose mission was to identify and develop a curriculum for a continuing education program that would allow participants to develop the necessary skills to successfully practice within the evolving health care system. Initially, five learning domains were identified which included (1) The Affordable Care Act; (2) Social Determinants of Health; (3) Person-Centered Planning; (4) Promoting Systems and Organizational Accountability; and (5) Providing Leadership through Times of Change. Subsequently, a sixth module, Trauma Informed Care, was added as an option to students interested in learning about the enormous impact that trauma has on health care outcomes (Fellitti et al., 1998). In addition, a seventh module, Culturally Specific Knowledge, was added in the role of prevention and wellness management within the context of case management and chronic illness. Table 1 on page 34 reflects each module and the topics areas covered within each.

During the committees work three important principals emerged that helped guide the structure of the advanced certification. First, it was believed that this training should be based on the most current literature related to health care practices during this time of change and it was also important to make sure the training experience was standardized. Each module is a carefully designed and outlined for students with a syllabus that includes guided readings in the current literature. Second, it was acknowledged that people who participate work during the day and therefore most modules are offered during the early evening hours and also utilize the Metrics of Practice Change.
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New York University Silver School of Social Work and its McSilver Institute of Poverty Policy and Research are providing human service and healthcare professionals the skills and knowledge necessary to succeed and advance in the transforming primary and behavioral healthcare systems.

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- 15% discount for applicants who have already completed one NYU SSSW certificate program
- 50% discount for veterans

Note that available seating is limited: class size is capped at 25.
Mayor Bill de Blasio and First Lady Chirlane McCray have released ThriveNYC: A Mental Health Roadmap for All. ThriveNYC is a plan of action to guide the city toward a more effective and holistic system that outlines 54 initiatives, 23 of them new, to support the mental well-being of New Yorkers. Additionally, ThriveNYC creates a model that can be applied nationally and a framework for advocacy.

ThriveNYC is a bold response to a challenging reality: one in five adult New Yorkers face a mental health disorder each year. Eight percent of high school students in New York City report attempting suicide, and more than one in four report feeling persistently sad or hopeless. Deaths because of unintentional drug overdose now outnumber both homicide and motor vehicle fatalities.

Many New Yorkers are suffering, even though mental health problems are treatable. In addition to the human toll, failure to adequately address mental illness and substance misuse costs New York City’s economy an estimated $14 billion annually in productivity losses.

Mayor Bill de Blasio

Office of NYC Mayor Bill de Blasio

NYC Mayor and First Lady Release Mental Health Roadmap

Mayor Bill de Blasio and First Lady Chirlane McCray

Two to three brief training sessions can significantly increase pediatricians’ use of techniques for identifying and treating young people with potential alcohol, substance use, and mental health problems, according to a new study in a large pediatric primary care clinic. Collectively known as screening, brief intervention, and referral to treatment (SBIRT), such techniques could be important tools for preventing and treating these common problems among young people. The study also found that pediatric practices can improve support for patients who need these services by adding behavioral health clinicians to their teams. A report of the study, which was funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), part of the National Institutes of Health, is now online in JAMA Pediatrics.

“Systemic barriers to SBIRT implementation remain, including time constraints and a lack of reimbursement. Further studies are needed to establish evidence that pediatricians can and do provide SBIRT to pediatric patients in primary care,” said Dr. George Koob, director of the National Institute on Alcohol Abuse and Alcoholism.

Research has shown that primary care physicians who conduct SBIRT with adult patients can reduce heavy drinking, its harmful consequences, and related health care costs. In recent years, mounting evidence has supported the use of SBIRT by primary care pediatricians to prevent substance use problems from starting or escalating in their young patients. However, physicians often face barriers to providing these services, including time constraints and a lack of training in SBIRT.

The new study, led by Stacy Sterling, Dr.P.H.(c.), M.S.W. at Kaiser Permanente Northern California in Oakland, compared practical ways to overcome both barriers in a general pediatric care clinic. In a two-year trial that involved nearly 50 pediatricians and about 1,900 adolescents, researchers measured SBIRT use among three groups of clinicians. “A ‘pediatrician-only’ group was offered three 60-minute SBIRT training sessions,” explains Ms. Sterling. “In the clinic, this group was then expected to conduct full SBIRT assessments and brief interventions by themselves as needed.” A second group of pediatricians had one 60-minute training session. In the clinic, this group was expected to assess patients and refer them as needed to clinical psychologists who had been “embedded” into the practices to conduct interventions.

A “usual care” group of pediatricians served as controls. They had access to the same clinical guidelines and tools, but did not take part in SBIRT training or have embedded clinical psychologists in their practices.

The researchers found that, following SBIRT training, the pediatrician-only group was about 10 times more likely (16 percent vs. 1.5 percent) to conduct brief interventions with patients deemed at risk, compared with “usual care” pediatricians. In the group of SBIRT-trained pediatricians that worked in tandem with “embedded” clinical psychologists the brief intervention rate was 24.5 percent, compared with 16 percent in the pediatrician-only group, and 1.5 percent in the usual care group.

“Both intervention arms administered more assessments and brief interventions than those in usual care,” notes Constance Weisner, Dr.P.H., M.S.W., at Kaiser Permanente Northern California in Oakland, and the University of California, San Francisco, the principal investigator of the study. “However, overall pediatrician attention to behavioral health concerns was still low. Embedding non-physician clinicians in primary care could be a cost-effective alternative to pediatricians providing these services, and future analyses of the study data will examine patient outcomes and cost-effectiveness of the two SBIRT modalities.”
Beacon Health Options Names Jorge Petit, MD To Lead NY Market

By Amy Sheyer, AVP, External Relations, Beacon

Beacon Health Options (Beacon), the nation’s premier behavioral health company, announced today that Jorge R. Petit, MD, has been named the Regional Senior Vice President for Beacon’s New York market. In this role, which began in September, Dr. Petit will work with stakeholders in the New York health care delivery system to develop strategies for improving behavioral health care throughout the state. This collaborative work will guide him in overseeing the delivery and coordination of mental health care and substance use disorder services for the company’s more than 5.5 million New York members.

“Jorge is a perfect fit to lead our New York team. He thoroughly understands the provider community and health care policies of New York as a result of his extensive consulting work and his three-year term as Associate Commissioner in the New York City Department of Health

Director for Integrated Care and Clinical Partnerships at the Institute for Family Health, a position funded by a Robin Hood Foundation grant to focus on how integrated care models can improve health outcomes and reduce poverty.

Dr. Petit has been appointed to numerous academic, hospital, professional and committee positions, including the North East Business Group on Health (NEBGH), Mental Health Task Force, One Voice Initiative and the Mental Health Workplace Summit. He has been tapped for his expertise on mental health issues by numerous broadcast news outlets, including, CNN, CNN Español, Fox News and NY1. He has also used his psychiatry expertise and hands-on experience in the community to write books and articles on various mental health issues, ranging from depression to emergency psychiatry to psychiatric administration and leadership. He currently serves as Chairman of the Mental Health News Education, Inc. Board of Directors, publishers of Behavioral Health News.

By National Institute on Alcohol Abuse and Alcoholism (NIAAA)

A survey of American adults revealed that drug use disorder is common, co-occurs with a range of mental health disorders and often goes untreated. The study, funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), part of the National Institutes of Health, found that about 4 percent of Americans met the criteria for drug use disorder in the past year and about 10 percent have had drug use disorder at some time in their lives.

“Based on these findings, more than 23 million adults in the United States have struggled with problematic drug use,” said George F. Koob, Ph.D., NIAAA director.

“Given these numbers, and other recent findings about the prevalence and under-treatment of alcohol use disorder in the U.S., it is vitally important that we continue our efforts to understand the underlying causes of drug and alcohol addiction, their relationship to other psychiatric conditions and the most effective forms of treatment.”

A diagnosis of drug use disorder is based on a list of symptoms including craving, withdrawal, lack of control, and negative effects on personal and professional responsibilities. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) no longer uses the terms abuse and dependence. Instead, DSM-5 uses a single disorder which is rated by severity (mild, moderate, and severe) depending on the number of symptoms met. Individuals must meet at least two of 11 symptoms to be diagnosed with a drug use disorder.

This includes the problematic use of amphetamines, marijuana, club drugs (e.g., ecstasy, ketamine, methamphetamine), cocaine, hallucinogens, heroin, non-heroin opioids (e.g., oxycodone, morphine), sedatives/tranquilizers, and solvents/inhalants. Face-to-face interviews were conducted to diagnose drug use disorder, as well as alcohol use disorder, nicotine use disorder, and various personality disorders.

The study, based on NIAAA’s National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III), found that drug use disorder was more common among men, white and Native American individuals, and those who are single or no longer married. Younger individuals and those with lower income and education levels were also at greater risk. Regional differences were found as well, with those living in the 13 Western-most states in the U.S. (including Alaska and Hawaii) more likely to have drug use disorder during their lives.

The study was led by Dr. Bridget Grant, Ph.D., Ph.D., (doctorates in psychology and epidemiology), of the NIAAA Laboratory of Epidemiology and Biometry. Dr. Grant’s lab conducts NESARC, a series of national epidemiological surveys that evaluate alcohol use, drug use and related psychiatric conditions. More than 36,000 people were evaluated using DSM-5 criteria. The study currently appears online in the Journal of the American Medical Association (JAMA) Psychiatry.

Similar to past research, the present study showed that people with drug use disorder were significantly more likely to have a broad range of psychiatric disorders, including mood, anxiety, post-traumatic stress and personality disorders. Individuals with drug use disorder in the past year were 1.3 times as likely to experience clinical depression, 1.6 times as likely to have post-traumatic stress disorder (PTSD) and 1.8 times as likely to have borderline personality disorder, when compared to people without drug use disorder. Drug use disorder was also linked to both alcohol and nicotine use disorder, with a three-fold increase in risk.

“The prevalence and complexity of drug use disorders revealed in this study coupled with the lack of treatment speak to the urgent need for health care professionals to be trained in proper techniques to identify, assess, diagnose, and treat substance use disorders among patients in their practice,” said Nora D. Volkow, M.D., director of the National Institute on Drug Abuse, which contributed funding to the study.
More than three years after the tragic shooting at Sandy Hook Elementary School sparked a national conversation on issues related to mental illness and the prevention of violence to self and others, Congress is closer than any point in recent history to act on bipartisan, bicameral comprehensive mental health reform legislation that many say would rank along with the Community Mental Health Services Act of 1963 and the Mental Health Parity and Addiction Equity Act of 2008 in terms of historical significance.

After Sandy Hook, leaders of the House of Representatives task force Rep. Tim Murphy, PhD (R-PA) with investigating and providing recommendations on federal mental health policies and priorities. What followed was a flurry of oversight hearings led by Murphy, reports, and stakeholder meetings that resulted in his introduction of the Helping Families in Mental Health Crisis Act of 2013 along with his lead Democrat partner Eddie Bernice Johnson, (D-TX). It should be said that both Murphy and Johnson are mental health clinicians (a clinical psychologist and psychiatric nurse practitioner, respectively) with significant real world experience in these issues outside of their responsibilities as sitting members of Congress.

Though his legislation was held up in Congress in 2013 and 2014, the re-introduction of the Helping Families in Mental Health Crisis Act (H.R. 2646) has received heightened interest and, as a critical step, passed out of the House Energy and Commerce Subcommittee on Health in November. Companion legislation has now also been introduced in the United States Senate by Bill Cassidy, M.D. (R-LA) and Christopher Murphy (D-CT). The Mental Health Reform Act of 2015 (S.1945) has a number of bipartisan cosponsors in the Senate, and its provisions substantially overlap Murphy’s efforts in the House.

These bills would institute a number of critical reforms to the nation’s fragmented mental health system.

Both bills would establish a new single coordinator for federal mental health resources and research. The duties and priorities of the proposed Assistant Secretary for Mental Health and Substance Use Disorders would emphasize the promotion of science-driven and evidence-based approaches to care. The Assistant Secretary would also evaluate mental health delivery models and disseminate evidence-based strategies to federal grantees and work to modernize and raise the profile of the Substance Abuse and Mental Health Services Administration.

Both bills would address pervasive workforce shortages among psychiatrists and other mental health clinicians. Representative Murphy has undertaken considerable effort to add workforce provisions to his legislation, and Senators Cassidy and Murphy have followed suit. The bills would require the development, implementation, and continuous review of a Nationwide Mental Health Workforce Strategy, among other provisions.

Both bills step up enforcement of the landmark bipartisan Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA, and subsequent expansion of parity in the Affordable Care Act, barred most health plans from discriminatory coverage or treatment limitations for individuals suffering from mental illness, including substance use disorders. While the passage of the Parity Act was monumental, much work remains to enforce the parity law and to realize its vision. These measures would strengthen parity through better coordinating enforcement activities, requiring relevant federal agencies to make important disclosures on compliance investigations, and strengthening oversight on insurers.

Both bills propose to boost financial support for important mental health research within the National Institutes of Health (NIH) related to brain disorders, innovative treatments and technologies, and the determinants of self and other-directed violence. As we know, federal funding supports the vast majority of research conducted by our nation’s medical schools and universities. Unfortunately, appropriations for the National Institute of Mental Health over the last five years have not kept pace with biomedical inflation.

Both bills would support funding for innovative models of care, like the landmark Recovery After Initial Schizophrenia Episode (RAISE) program, which helps individuals with schizophrenia lead productive, independent lives with aiming to reduce financial impacts on public systems. Overall, the bills are substantially focused towards improving care for individuals with severe and persistent mental illness.

The efforts of these mental health champions have enjoyed wide support from the advocacy community. For example, leaders of the House Energy and Commerce recently received a letter urging advancement of comprehensive mental health efforts from groups including American Psychiatric Association, American Psychological Association, the National Alliance on Mental Illness, Mental Health America, the American College of Emergency Physicians, and the National Council for Behavioral Health, among many other signatories.

Comprehensive mental health reform efforts in Congress have also received significant media coverage and editorial endorsements from outlets as diverse as the Wall Street Journal and the National Review to the Washington Post and San Francisco Chronicle. As someone who monitors Capitol Hill health policy coverage daily, I can say with confidence that the attention and coverage of this moment in mental health advocacy history is truly unique when judged by the quantity of blogs, email alerts, and inquiries from the likes of Politico, Congressional Quarterly, and other newspapers that cover the Hill.

Moreover, these bills have widespread bipartisan support among their sponsors’ colleagues. H.R. 2646 has 166 bipartisan cosponsors, and S. 1945 has cosponsors that range from hardline conservatives like Senator David Vitter (R-LA) to liberal stalwart Elizabeth Warren (D-MA). Notably, Paul Ryan, the freshly minted Speaker of the House of Representatives recently remarked that “we need to look at fixing our nation’s mental illness health system – an example, Tim Murphy, Congresswoman from Pennsylvania, has a bill that is working its way through Committee – I’m sure both parties have lots of ideas in this area, but we should make this a priority.”

This is not to gloss over the fact that clear challenges remain before the President’s signing ceremony for comprehensive mental health reform legislation. Further committee action and floor consideration are required for both H.R. 2646 and S. 1945 in their respective chambers. Though the bills are remarkably similar, any policy differences will need to be ironed out in a bipartisan and bicameral conference. Congress must also not let firearms politics sink the opportunity to substantially improve the nation’s mental health system. Moreover, federal budget and deficit worries frequently necessitate the identification of “payors” (corresponding cuts or raises in revenue) that would offset any proposed increases in mental health spending. Lastly, the nation and its political infrastructure are moving into the 2016 Presidential election season and all of the associated baggage that entails.

My sincere hope is that this clear momentum for enactment of comprehensive mental health reform translates into action by Congress.
A Behavioral Health Workforce for An Aging America

By Michael B. Friedman, LMSW
Adjunct Associate Professor, Columbia University School of Social Work

As efforts are made to improve America’s inadequate behavioral health workforce, the needs of older adults should be a central concern.

By 2030, Americans over the age of 65 will become as large a portion of the population as children under the age of 18. But there is far more interest in meeting the mental health needs of children than of older adults.

One of the reasons for this is the sense that older adults are not the future of America; children are. Obviously, children have more years of life ahead of them than older adults do, but a person who has lived to be 65 will, on average, make it to about 85; half will live longer.

Older adults do have a future. Not only will they survive for many years, they also will have many years in which they can enjoy life and contribute to the American society. Making the most of old age should be a major social goal and is a key challenge for America’s behavioral health systems.

The current behavioral health workforce is neither large enough nor adequately prepared to respond effectively to the specific needs of older adults.

It is important to understand that old people are not just adults who are older than younger adults. They are in a different developmental stage and experiencing significant changes both physically and psychologically.

The behavioral health workforce in an aging America needs to understand these developmental changes. It needs to be "generationally" as well as clinically and culturally competent.

Key characteristics of a generationally competent behavioral health workforce include:

Geriatric Clinical Competence: Behavioral health professionals and paraprofessionals need to make adaptations to clinical practice for older adults in a variety of ways.

For example, psychiatric medications have greater risks for older adults. These include increased rates of serious physical side effects, and especially of falls, which are the greatest cause of disability among older people.

In addition, older adults are likely to have chronic physical conditions as well as mental and/or substance use disorders. This makes integrated treatment critical for older adults. Of particular concern is physical pain, which can contribute to misuse and abuse of alcohol and painkillers.

More Than Just a Change in Title: New Statewide Effort Supports the Move from Case Management to Care Management

By Ruth Colón-Wagner, LMSW
Senior Projects Coordinator
New York Association of Psychiatric Rehabilitation Services (NYAPRS)

How does one move from working as a Case Manager to a successful Care Manager? The change in title is simply the exchange of one letter, the ‘c’ for an ‘r’. However, the change from one role to the other is not so simple.

It’s been almost five years since New York State initiated the Health Home initiative with the overall purpose of helping people live healthier lives. As with the change of title, the change may seem simple yet the impact on population health has the potential to be life altering. In this case, the purpose of Health Homes is simple, straightforward, and even noble.

The Health Home integrated approach to care for people with disabilities moves us from our traditional siloed treatments to more holistic approaches. Finally, someone realized that treating the whole person is best. While a major goal of this initiative is to save healthcare dollars, its new focus and design will serve us all well.

The “Triple Aim” emerged in 2008 and has since served as the foundation for the federal Affordable Care Act and state reform efforts including New York’s Medicaid Redesign initiatives. The idea is that the healthcare system will provide better care, people will become healthier and the system will provide more effective care at lower costs.

Traditionally, the healthcare system has used a fee-for-service billing structure. Now, with the system focused on improving health, it is changing in the direction of payment for value, over payment for volume - or per each contact.

With the advent of Health Homes and the changes that followed, silos are being eliminated and a uniform workforce is being created to assist people to achieve wellness with collaboration from all appropriate systems and supports. Case Managers have been transformed to “Care Managers” and tasked with working directly with the Health Homes.

The transformation required of this new workforce is significant. For a workforce that historically only navigated one system, the mental health system, the challenge becomes how to navigate the physical health system as well and how to navigate each person’s needs and the services that can assist them. The systems are highly complex and the Care Manager must now become the “expert” in understanding multiple systems – the person placed in the role of ensuring all people in this person’s support are tethered together, to continue the web analogy.

The broadened responsibilities of the new role of the Care Manager add a number of new competencies. Overall, the CM must be able to demonstrate competent engagement skills and knowledge of the Stages of Change (Prochaska, JO; DiClemente, CC, 2005) to even begin to work successfully.

Other competencies include the ability to integrate physical health, mental health and substance use treatments for people with multiple chronic conditions; knowledge and understanding of health, the impacts on health and social risks; intervention strategies; assessment and care planning; collaboration and referrals; ability to communicate with various disciplines within varied systems; providing care that is recovery oriented, person centered and culturally relevant; possessing the ability to provide care that is proactive and focuses on prevention and diversion instead of reactive traditional care;
Supervision: Paying Attention to the Soul, Not the Technique

By Samuel C. Klagsbrun, MD
Executive Medical Director
Four Winds Hospital

Although I’ve never been a psychoanalyst I did spend a year in analysis and took classes at the Columbia Psychoanalytic Institute. I left at the end of a year because being in practice at that time I came to realize that my own style of work was much more realistic, confrontational and time conscious than my analytic experience was and so I left the program.

Yet after over fifty years of practice and I am deeply appreciative of my analytic experience as short as it was! Being conscious of childhood history, being sensitive to dreams, unconscious thoughts and emotions as well as free associations has always made me sensitive to the patients ways in which today’s therapy may pay little attention to or ignores completely.

Picking up on those kind observations when my patients utter them has always led me to ask more profound questions and pursue issues which have frequently led to important matters which could easily have remained hidden.

By contrast, today’s psychotherapy style is leading us to a much more rapid approach to treatment. DBT, CBT, mindful-ness, psychopharmacology are all practical and offer realistic approaches to speeding up therapy. But I feel we have left the baby in the bath water—to use a very old fashioned word, we have abandoned the soul of therapy.

We might pay with current approaches ease the pain or depressive and anxiety symptoms effectively, but what about the person behind the symptoms?

My own experience with therapy stresses the nature of the relationship between the patient and the therapist. A patient who feels a profound connection to a therapist—who feels deeply understood—who feels the therapist “gets” him/her—who is feeling accepted and understood as a whole person, not as a diagnostic entity with symptoms, will invariably open up and reveal much more than a “patient” would.

Therefore as a supervisor I always stress the need to know the patient’s history in detail, as opposed to focusing primarily on the symptoms. I inquire about the relationships, successes and failures, goals and frustrations, losses and traumas as well as a detailed history of upbringing. I want to be able to feel whatever the patient is feeling. Once this information is given I will then focus on symptoms and diagnostic issues.

To start with, I strongly believe that the impact of early child experiences, whether positive or negative have a profound impact on a person’s life throughout their entire life. Subsequent life experiences, in my view, are always handled through the prism of the way we have all grown up. Let me offer an example. Obviously I will present a case whose identity will be disguised but the basic issues presented will be accurate and real.

One of my longest lasting patients in weekly therapy for many years is a woman in her 60’s. She raised with three adult children who was referred to me by her Internist who became alarmed with her wildly fluctuating, often hysterical behavior. He feared the danger of her accidently causing herself harm due to poor judgment, impulsivity, and out of control behavior.

In our early meetings, she insisted on getting pills to calm her down and was very reluctant to engage in any exploratory talk. At one point I told her to answer my questions, other-wise I would not write any prescriptions to calm her down. She reluctantly began to respond with deep resentment.

It turned out that she was born into a family of very damaging parents. Her mother was a massively controlling person. Her father was constantly furious, short-tempered, unreachable and critical. Her parents fought and argued constantly.

My patient Ruth, remembered closing the door to her room to shut out the screaming her parents did constantly, feeling frightened and crying. Her college years were a bit more stable, being away at school; however upon graduation she moved back with her parents and sank into depression. She was totally controlled by Ben’s wife in the language. It was as though he was saying things that were totally sacrilegious and wrong. Spending a lot of time encouraging him to express precisely those thoughts and to recognize the level of guilt he felt in expressing them as an indication of pathology—not wrong doing, became a theme of therapy for a long time.

Luckily Ben was introduced to a subsequent woman, Jane, who appreciated his artistic work and was apparently very interested in Ben becoming very independent. Her influence in Ben’s life made my work with him speed up considerably. The level of guilt in speaking about his mother never quite left him but decreased a great deal. Making decisions without checking with his mother became more frequent and interestingly enough Ben’s relationship with his father, who was an extremely weak man, also under the control of his wife, helped the father speak up more openly about his own wishes. Between Jane and Ben’s father, the atmosphere in the family changed gradually but significantly. Ben began spending much more time away from his parent’s home. He traveled more with Jane, at times not even staying in contact with his parents when away and most recently ended up moving into an apartment with Jane, and letting his parents know that he had made that decision. There are still times when he feels that he is doing something wrong in making independent decisions but he seems to be able to get over those feelings fairly quickly.

In both these examples both patients demonstrate the power and influence of a restricted upbringing on their adult life. The influence of their upbringing seeps into nearly every aspect of their adult lives and the amount of work it takes to become free of that early training is enormous and is essential to the patient’s growth and independence.
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Effective Supervision: An Essential Component to Enhancing Consumer Outcomes

By David Kamnitzer, LCSW-R
Senior Vice President, Rehabilitation and Support Services, ICL

The behavioral healthcare industry is facing a monumental time of change. The mental health field in particular is faced with putting more responsibility on consumers to drive their own treatment. No longer, it seems, will a person with mental health challenges be cared for in a prescriptive, or “by-the-book,” kind of way. When an agency says its model of care is person-centered and individualized, that means that consumers are given the challenge of driving their own treatment, with the help and guidance of a knowledgeable workforce. Staff today are trained to understand that our work with individuals must come from the core belief that hope and healing are possible and that recovery has many pathways.

What does this new healthcare environment mean for staff? It means they must begin to think about the individuals they work with from multiple lenses, learning to understand their own feelings and reactions and how that might impact a consumer’s actions. It means that supervisors must help the workforce buy into new models of care, models that sometimes require staff to look inward. It means that supervisors must help staff look at outcomes—Are consumers getting better? Is the treatment provided effective? —and must make asking about outcomes part of the supervisory discourse. Supervisors must help staff be objective, introspective, and reflective. And it is through this active and collaborative supervision that both consumers and staff will learn to be more effective agents of change.

The new frontier of managed care requires a degree of collaboration not seen before. Care providers will be speaking with one another and working with the consumer to help him or her get the best outcomes possible. So while this interaction may enhance a consumer’s future, staff must be willing to partner with collateral providers in a variety of new ways that may be quite unfamiliar at first. This interactivity may require more patience, a greater understanding of the system, and more accountability. Here is where supervision can offer its greatest reward. Staff can learn to listen more effectively to what consumers are saying as well as to what other care providers in the consumer’s network are saying. This coordination requires that staff be open, flexible, and honest with themselves and one another, as well as respectful of differing viewpoints. They must learn to accept feedback in a non-defensive manner and must be willing to integrate their supervisor’s consultation.

Supervision becomes even more important in this cooperative scenario because the supervisor wants to make sure that all staff members are effectively collaborating with one another. Supervision is where that care coordination can be discussed—working to make sure that everyone is looking to achieve the best possible outcomes for the consumer and understanding the pathways each member of the care team is taking to get there. Learning to update each team member’s activity with other providers is pivotal in making sure that the consumer’s goals are a priority.

In any field, an effective supervisor helps get the best out of his or her staff and motivates a worker to perform at an optimum level. Particularly in the behavioral health field, the best care is relationship-based—built on trust and mutual respect. This is true between staff and the consumer as well as between staff and his or her supervisor. The role of supervision must be one of respect, and it must be one of support. The supervisor is there for staff to bounce ideas off, to develop a plan for updating a consumer’s records, to help understand how to best inspire, and to entrust that staff members learn to trust themselves and their ideas.

Accountability is essential. Supervisors must help staff transition to this new healthcare environment, where we know that recovery is possible. Staff must learn to embrace their roles as helpers as consumers learn to advocate for themselves and their own goals. Supervisors must assess staff competencies and provide support in areas that need work while

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The Challenges of Hiring and Retaining Top Talent

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

Management consultant, educator, and author Peter Drucker stated, “Making a living is no longer enough. Work also has to make a life.” In this economic climate, many organizations have designed initiatives to nurture its rising talent. It makes good economic sense, as high-performance individuals can have a great impact on program results. However, retention strategies geared toward top talent often fall short of delivering anticipated results.

According to recent leadership development research by Harvard Business Review, disengagement by high-potential employees has been high since the beginning of the recession. According to one survey, nearly 40% of internal job moves made by staff identified as rising stars ended in failure. Additionally, more than 10 percent of all high potentials studied had reported actively seeking new employment. Many organizations may see their most promising employees leave as the economy rebounds.

We know that an organization’s greatest asset is its staff. But even top staff may look for new opportunities unless they have compelling reasons to stay. High employee turnover hurts both the company’s bottom line and morale. Research suggests that it can cost twice an employee’s salary to source and train a replacement. So how can we, as non-profit leaders, ensure success when interviewing and hiring?

The best salary that our budgets will allow is only the beginning. Interestingly, it is not always the most effective retention tool. We must make many efforts to retain our top performers.

Interviewing

According to organizational management research, organizations that use a team approach to interview and select candidates make smarter hiring decisions. The purpose of the interview team is to evaluate the skills and talents the candidate needs to be successful. It’s designed to reveal otherwise hard-to-detect strengths and challenges. Team interviewing involves multi-level staff that can determine if the candidate is a good fit with the organization’s culture and the populations they are serving. Each member can offer a different perspective about the candidate’s potential success in the new role. This enables collaboration and a sharing of insights and wisdom.

It’s important to interview a mix of both generalists and experts with the population your organization serves. Look for individuals who have a passion to grow, those who can fill in workplace gaps, and those who have a passion for working in specific areas. Make certain the candidates are very knowledgeable about those they are serving. Train, coach, and supervise staff strategically to prevent inefficiencies, job dissatisfaction, and burnout. Prepare staff as experts for special populations, such as older adults, immigrants, and people who have experienced trauma. Train them to supervise a mixture of staff, and to be culturally and racially competent. Encourage staff to bring their whole selves to the role.

Experts agree that at least one interview question should require the candidate to stand and address the group to determine if he/she can quickly think on their feet. This is especially true if presenting, speaking, or facilitating skills are desired. If the candidate must be particularly effective interpersonally, suggest that he/she interact with future reports or a client group.

Staff Development

Neglecting staff development can cost you top talent. Staff development requires high-quality supervision and training. A strong supervisory team contributes to a positive work environment and enables success. This is a critical competitive advantage in attracting and retaining good staff. Skilled supervision means clearly defining roles and expectations, and then ensuring supervisors have the competencies to perform successfully.

Strong organizations have both effective management and leadership. What is the difference?

According to The Wall Street Journal’s “Lessons in Leadership” Guide, managers need a diverse set of skills, including the ability to inspire and motivate. Or, as Peter Drucker put it, “Management is doing things right; leadership is doing the right things.”

According to career experts, it’s critical that the work consistently provides meaningful, gratification, and fulfillment of potential. These intrinsic needs are equally important as compensation – and oftentimes even more so.

Tips

• Hire the right person from the start. Ensure that candidates not only have the right skills, but also fit in with the organization’s culture and those they serve.

• Engage your staff. Create a positive work environment by giving respect, acknowledging accomplishments, and rewarding achievement. Give meaningful feedback, and never underestimate the power of praise.

• Be present for your staff. Pay close attention to your staff’s personal needs. Offer compassion, flexibility, and resources when possible. Regularly touch base to gauge stress level and overall happiness.

• Outline clear career paths. Build many ladders and establish custom career paths. Make sure there are multiple opportunities for advancement. Tell your staff how they can improve and move up. Make check-ins around career goals a part of supervision. Encourage supervisors to perform as both coach and supervisor.

• Create challenges. Give challenging assignments. Encourage staff to attend workshops, seminars, and trainings. Offer CEUs at your location, if possible, and support other continuing education efforts.

• Keep up with technology. Invest in the best equipment your budget allows so your staff feels equipped to perform necessary research and deliver the best results possible.

• Be mindful of work-life balance. The stars of an organization are often the first to experience burnout and compassion fatigue. They are often over-stretched due to managing many key projects. Promote balanced workloads and work-life balance.

New App Turns Compassion into Action to Help NYC’s Homeless

By Staff Writer
Behavioral Health News

Three New York technologists recently launched WeShelter, a new app that provides a way to take meaningful, immediate action in response to homelessness. WeShelter, available now for iPhones, allows New Yorkers to unlock sponsored donations with the tap of a button—in less than a minute. As it takes to send a text—support local non-profit homeless service partners. The entire process takes seconds, requires no monetary contribution from the user, and supports the effort to help people get and stay off the street. If a homeless individual needs assistance, the app can also connect users directly to a street outreach operator.

WeShelter was founded by Ilya Lyashevsky, Robb Chen-Ware and Ken Manning, experienced product managers, tech executives, and engineers. With a record 62,000 homeless people in New York City, like many New Yorkers, they felt compelled to help their neighbors who live on the streets.

“When you see someone on the street, you feel compassion and you have the impulse to help, but you’re not sure how,” said Ilya Lyashevsky. “Not all you need is your phone. The next time you pass someone on the street, you no longer have to feel like there’s nothing you can do.”

Robb Chen-Ware said, “As engineers, we wanted to develop a solution that captured the empathy people feel when they encounter someone living on the street, and let them take action simply and immediately—in less time than it takes to send a text—to support local non-profit homeless service partners. The entire process takes seconds, requires no monetary contribution from the user, and supports the effort to help people get and stay off the street.

WeShelter partners with thousands of organizations, including thousands of people, New Yorkers on this critical issue.”

Frederick Shack, Chief Executive Officer of Urban Pathways, one of the City’s leaders in providing a full range of services to homeless adults, from outreach to transitional and permanent housing, expressed similar sentiments. “Urban Pathways is proud to be a partner in this innovative approach to engage and connect with everyday New Yorkers on this critical issue.”

In speaking of Goddard Riverside’s involvement with the project, Stephan Russo, the organization’s Executive Director, said, “Goddard Riverside has been at the forefront of New York City’s homeless outreach efforts since 1979. We are keenly aware of the need for more public awareness of this important issue and are excited about the possibilities that the WeShelter app provides for raising public awareness and generating support for the vital work we do every day.”

For future versions of the app, WeShelter is working on expanding to provide real-time data to street outreach workers about homeless activity around the city. By mapping information collected from thousands of people, WeShelter would enable outreach teams to operate more effectively as they attempt to locate and assist people in distress. WeShelter also seeks to provide key facts about homelessness to its users, and encourages them to share the information on social networks, with the hope of fostering a better understanding of the issue in the community.

For more information, visit their website at www.weshelter.org or contact Ilya Lyashevsky at ilya@weshelter.org.
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Building a Quality Behavioral Health Workforce: 
Employing Service-User Perspectives Throughout Your Organization

By Kendall Atterbury, LMSW, Certified Peer Specialist, and PhD Candidate, Peer Initiatives Consultant, Community Access

With the introduction of Managed Behavioral Health Care in October of 2015 and the soon to be implemented Home and Community Based Services (HCBS), engagement of “peers” in the workforce has become a topic of considerable interest. HCBS introduces peer support as a Medicaid billable service giving organizations a financial interest in providing the service. In order to provide billable peer support, an organization must be formally designated to do so under HCBS, peer staff must be certified, and the scope of billable practice is defined by CMS. A peer is loosely defined as someone who has the lived experience of being a recipient of mental health services and/or someone who has been given a psychiatric label. The introduction of peer support as a billable service has the potential to mark progress in the delivery of mental health services. This potential will be compromised, however, if provider agencies are not able to absorb the distinct values, ethics, and intent of peer support as an alternative to traditional approaches to care delivery.

Peer support for people with psychiatric diagnoses is an evidence-based practice that has been demonstrated to improve quality of life outcomes for people who receive mental health services. While peer support has been a part of substance use recovery for some time, it has not been as quick to gain traction among many traditional mental health service providers. Peer support in mental health should be transformative for people and for systems. Drawing from the wisdom of Intentional Peer Support (IPS) developed by Sherry Mead, genuine peer support “doesn’t start with the assumption of a problem. With IPS, each of us pays attention to how we have learned to make sense of our experiences, then uses the relationship to create new ways of seeing, thinking, and doing” (www.intentionalpeersupport.org). Certified Peer Specialists thus have the potential to introduce a radically different approach to those experiences that non-peer providers see as barriers to mental health.

In part, Certified Peer Specialists help service-users develop the skills and confidence to advocate for themselves in a system that often works against their chosen interests. Certified Peer Specialists may advocate on behalf of service-users to ensure that they receive proper informed consent, participate in shared-decision-making, and receive truly person-centered care in an atmosphere that can too often dismiss these as unimportant. Certified Peer Specialists are ethically prohibited from either encouraging or discouraging people around issues of medication. It is not appropriate for providers to ask a peer support specialist to influence someone’s willingness to take medication. Peer support becomes an integral part of mental health service delivery that organizations understand both the values of peer work, the Code of Ethical Conduct by which they are expected to abide, and ideally the history of peer work. Job descriptions should reflect the particular skills and contributions peer support specialists offer. All of the above being in place, peer support is positioned to truly improve the quality of services on offer in mental health care.

As peer support finds a home under HCBS, it is critical that non-peer providers understand that peer support offers a path to recovery from trauma incurred in systems of care that are often alienating and stigmatizing as much as it offers recovery support from psychiatric distress itself. This requires non-peer providers to consider what role systems play in constructing and sustaining illness rather than recovery. It may require non-peer organizations to rethink the way care is delivered and structured. For Community Access taking the peer perspective seriously has meant transforming an entire organizational culture.

At Community Access the value of a person’s experience in systems of care is taken seriously, and for over 20 years, the organization has actively sought to develop a workforce with the goal of becoming 51% “peer.” What this means at Community Access moves far beyond common understandings of peer work particularly as it is defined under HCBS.

At Community Access, service-user experiences and perspectives are represented at every level of organizational structure from executive staff and senior management through direct service providers. This creates a culture that is sensitive and responsive to the needs of our tenants and program participants in a way not accessible when the voices of service-users are absent. There are very few peer specific positions, functionally eliminating the distance between peers and non-peers. Moreover, all direct service staff are trained through direct service provider training, reducing stigma and common misperceptions about what it means to be a service-user.

Building a behavioral health workforce that employs service requires an evaluation, and sometimes an amendment, of organizational policies and protocols that may place barriers to the employment of people who have been or continue to be service-users.

At Community Access, respect and value for service user experiences is written into the organization’s mission statement which explicitly states “We are built upon the simple truth that people are experts in their own lives.” Human resources, peer expertise, self-determination, harm reduction, and healing and recovery are the central organizational core values. Living into this commitment begins when a person applies for a job and continues throughout an employee’s training and work tenure. Regardless of position – whether or not a particular job is designated for a peer – regard for service-user experiences is taken seriously. Several mechanisms exist to ensure this attitude permeates organizational culture.

Central to building a workforce that incorporates service-user perspectives is a robust Human Resources department that recruits, hires, and retains people with diverse experiences. This includes removing barriers to employment for people who have experienced incarceration, homelessness, poverty, trauma, etc. This may require eliminating some educational barriers. It means understanding how to assess for lived experience during an interview while respecting legal limits. It means establishing organization-wide policies and protocols that make workplaces accommodating available to all employees. It means assuring that all employees receive regular and quality supervision and support. Perhaps most of all, it requires flexibility and continued conversations between Human Resources and organizational leadership. Human Resources departments, however, cannot singularly sustain an atmosphere that welcomes and highly regards service-users in the workforce. Organization-wide training is essential.

At Community Access, all direct service employees receive the organization’s core training. This training is designed and delivered by peers and non-peers. It supports new workers as they learn to implement the organization’s mission and values into their day to day work (including peer expertise). Core training extends for approximately 20 sessions and covers topics such as Committing to the Work and to Ourselves, Developing Ethical and Support Competencies, Mental Health, Healing and Recovery, Self-Determination, Trauma-Informed Services, and Working with Individuals in Extreme States and Crisis. The training department also hosts open workshops on topics of interest to which all employees, tenants, and program participants are invited. Continuing training framed around the organization’s mission and values helps to sustain a work culture that learns, grows, and succeeds because of the added value of employee lived experiences.

Establishing a culture that fully incorporates the service-user experience and perspective places a demand on organizations that look forward and are interested in the future at their own culture, policies, and programs. A strong Human Resources department and training arm are necessary, but not sufficient. Organizational culture must be open to change, from the leadership through direct service providers. Community Access has made this transition over time and has become a more effective provider as a result.

The goal of mental health services ought to be supporting people in the processes of personal recovery. Supporting recovery requires that mental health providers reduce system-induced trauma, stigma, and alienation. It requires giving respect and consideration to the voices and wisdom of those who have lived experience of both the mental health system and psychiatric struggles. It means giving those who have had such experiences a seat at the table. In the end, peer support is underwritten by values that respect the humanity and personhood of peers and non-peers alike. Peer values, at their core, are human values. Too often, however, people receiving mental health services are not offered these basic values, a consequence perhaps of the inevitable impersonal logic of systems. Re-establishing these values and overriding systems logic requires a committed human effort. The introduction of peer support under HCBS provides an opportunity to engage this effort. Non-peer providers can choose to take advantage of this opportunity to transform the very ethos of mental health service delivery. The decision rests on how seriously non-peers take the personhood of people who are currently in psychiatric crisis or who have experienced such a crisis and moved through it.

While billable peer support under HCBS is a particular service with a fairly narrow scope of practice, mental health service providers can choose to engage peer perspectives more fully. Doing so does not undermine services already offered; it improves current best efforts to support people in personal recovery. Working together, peers and non-peers can better achieve New York State’s Medicaid Redesign Goals that mirror the triple aim of improved quality, lower per capita costs, and better population health. The beginning step in working together, however, is not building a peer workforce; it is acknowledging the deep absence and need for such a workforce in the first place.

There is a Caring Community of Behavioral Health Organizations That You Can Turn To When Difficulties in Your Life Become Too Hard to Bear

Please Remember - To Never Give Up - You Can Work Things Out!!

A Message From the Board and Staff of Behavioral Health News
Need someone to talk to?

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Community Access now runs New York City’s first peer-operated support line. Open daily from 6 p.m. to 10 p.m., this support line is a contact point for New Yorkers experiencing emotional distress, offering an opportunity to connect with individuals who have had similar experiences.

communityaccess.org
A revolution in the payment and delivery of behavioral health services is poised to transform the healthcare industry and all of its participants. Key stakeholders, including service recipients and their families, medical professionals, social service and community-based organizations, governmental regulators, public and private payers, advocates and educators, to name a few, anticipate seismic shifts that will rattle the foundations of our service systems. Lasting repercussions, expected and unexpected, desired and undesirable, are inevitable.

Many with significant behavioral health needs rely on a publicly-funded service infrastructure that becomes more fragile in the face of increasing demand and diminishing resources. There are perhaps no resources more critical to the success of service organizations than their human resources—the deeply committed professionals and paraprofessionals who endeavor to improve the lives of those entrusted to their care despite significant challenges and modest remuneration. How might these resources be cultivated and deployed to properly address the emerging needs and contingencies of a transformed healthcare system? What is the charge of the new behavioral health workforce and what forms will it take? I proceed from an admittedly radical premise that this workforce should not be a workforce whose composition reflects the primacy of social and physical determinants of health in the recovery process. It should also be one that acknowledges the limitations of our conventional approach to the management of chronic illness. This approach erroneously applies an acute-care model of disease management more appropriate to the eradication of pathogens than the amelioration of conditions in which various factors, including genetics, socioeconomic status, lifestyle habits, historical influences (e.g., exposure to trauma, etc.) and the availability of social and emotional support networks are implicated. We must reconcile the medical and sociocultural history of this approach and the economic context in which it thrives with the current realities of chronic illness if we hope to promote meaningful and sustainable recovery for individuals with behavioral health conditions.

Our nation allocates a disproportionate share of resources to conventional healthcare (i.e., inpatient and institutional care, medical and surgical interventions, pharmacotherapies, etc.) at the expense of the many socioeconomic support services that bolster the health and wellness of our brethren in other industrialized societies. By some estimates traditional healthcare accounts for no more than 10% of our health status, whereas other factors, including stable housing, income supports, access to nutritious food, genetics and lifestyle habits (e.g., substance use, physical activity levels, etc.), social and emotional support networks and meaningful activity are significantly more determinative of our health and wellbeing (Sederer, 2013). Despite the relatively insignificant contribution of conventional healthcare to overall public health the United States commits 17% (approximately two trillion dollars per year) of its Gross Domestic Product (GDP) to healthcare spending, and it is expected to exceed 20% of GDP within a few years (Johnson, 2012). This is staggering when considered in contrast to an average expenditure (by share of GDP) of 9.3% for other industrialized nations (Organization for Economic Cooperation and Development, 2014). I am convinced beyond any doubt that if Dwight D. Eisenhower were alive today his concerns about our emergent medical-industrial complex would eclipse his fears of the military-industrial complex that proved so prescient in 1961.

The healthcare behemoth is comprised of extraordinarily lucrative pharmaceutical corporations, hospital and healthcare associations, insurers and legions of lobbyists charged to influence public policy in a manner that ensures compliance with and maximization of revenues. It is not surprising this approach led to the development of one of the most lucrative and influential industries on the planet. The pharmaceutical industry is the metaphorical hammer that regards all infirmities as nails, and as chronic illness has supplanted infectious disease as the malady of the new millennium Big Pharma continues to strike repeated blows at ever-increasing cost and diminishing returns. An acute-care treatment modality originally tailored to the eradication of disease is now routinely applied to the management of illness. Phenomena we classify as diseases typically originate in one bodily organ or organ system and arise from a verifiable exposure to pathogens or biological imbalances. These are the maladies for which pharmaceutical and other traditional medical and surgical approaches are most appropriate and effective. Chronic illnesses, however, including those in the behavioral health realm, implicate multiple organs and organ systems, arise from myriad biological and environmental causes and require corresponding interventions. Nevertheless, the pharmaceutical approach to the management of illness and disease continues to prevail.

Behavioral health and social service providers have witnessed an exponential growth in the use of pharmaceuticals in recent years. Chemical agents that have satisfied the Food and Drug Administration’s (FDA) standards of safety and efficacy are lucrative commodities for their manufacturers who enjoy longstanding patent protections after their products enter the marketplace. Even the most casual and uninformed of observers are cognizant of this, as all of us have been encouraged by countless advertisements to “ask our doctor” if Medication X is right for us. These agents customarily target the symptoms but not the causes of our afflictions. It is therefore unsurprising that individuals with behavioral health and comorbid medical conditions routinely visit their

The Foundations of a New “Wellness” Workforce

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

Ashley Brody, MPA, CPRP

see Foundations on page 40
Coming to Grips with Substance Use Issues Among Employees’ Young Adult Dependents

By Martin Rosenzweig, MD Senior Medical Director, Behavioral Solutions, Optum

The impact of substance use and mental illness on the workplace has been well documented. But how well do employers grasp what’s at stake when faced with employees whose adult dependents are grappling with a mental health or substance use issue? These employers are confronted with two significant challenges:

1. Hidden Costs: Employees’ dependent children ages 18 to 25 with mental health conditions or substance use disorder (SUD) contribute to higher benefits costs through increased claims. But what employers may not realize is that these costs may spiral out of control when young adults seek treatment at out-of-network facilities in states far from home.

2. Ripple Effect: Beyond the costs, the ripple effect of mental illness and SUDs are often preoccupied with managing their children’s conditions. These young adults may be unable to stay in school or keep a job. They may be in and out of hospital emergency rooms and rehabilitation treatment centers, or arrested for criminal activity. Family strains caused by these difficulties frequently spill over into the workplace. The resulting stress, anxiety and distractions may hinder parents from being fully engaged at work.

By understanding these conditions and their impact, employers can begin to take steps to contain costs and help their employees improve productivity.

Treatable Condition

SUD encompasses the abuse of alcohol and other drugs, including the use of legal substances such as prescription medications in ways not prescribed or recommended. It is important for the general public and for those impacted by substance use disorders to understand that a SUD is not an indication of moral or personal weakness. Rather, it is a chronic, complex brain illness – commonly associated with genetic and biological factors – that interferes with a person’s day-to-day ability to function. Unfortunately, the stigma associated with having a SUD often deters people from seeking treatment.

It’s important to recognize that SUDs are treatable. Indeed, treatment can help individuals recover their ability to live a full life. Success rates for treatment are roughly on par with recovery rates for other chronic diseases including asthma, diabetes and hypertension, according to the Office of National Drug Control Policy. Recovery is possible and is a reality for over 23 million Americans across the country.

Impact on Young Adults

Many mental health and substance use disorders begin when people are in their teens and 20’s. The numbers paint a stark picture.

- SUD rates among people age 18 to 25 are twice that of adults 26 and older (18.9% versus 7.0%, respectively, in 2012; Source: Substance Abuse and Mental Health Services Administration. [2013]. Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings [HHS Publication No. SMA 13-4795, NSDUH Series H-46].)
- Among 18- to 25-year-olds, 32 percent of those with any mental illness and 40 percent with a severe mental illness also have a substance use disorder (Source: Ibid.)

Why Costs are Soaring

Optum has seen a substantial spike in treatment costs among 18- to 25-year-olds in recent years. Our behavioral health claim costs for 18- to 25-year-olds soared 41 percent (per member/month) between 2011 and 2013. SUD monthly costs jumped 80 percent. (Findings from an Optum May 2014 analysis of behavioral care costs for dependents ages 18-25 among national, ASO and fully insured, HMO/PPO/POS membership.)

A significant portion of these costs is attributable to young adults receiving medical care at out-of-network residential treatment centers with high per diem charges.

Substandard quality at some of these facilities is another cost driver. In our experience, patients typically have higher relapse and readmission rates than those using in-network facilities closer to home. Recovery from SUDs is an ongoing process and individuals treated in their local communities are better able to connect with recovery support services to assist them in the process.

Inappropriate Treatment Settings

In our estimation, members may not receive the most appropriate or cost-effective treatment in out-of-network facilities.

With Hope, All Things Are Possible.

Reframing treatment around recovery and resiliency offers new hope and a bright future for those who live with mental illness. While everyone must follow their own path to recovery, every local community offers a unique set of supports, a few key principles can help ensure success:

- Person-directed support for the whole person, regardless of their age or stage in life
- Building on the strengths and abilities of each individual
- Cultural competence
- Techniques, tools, and technology to empower people to live purposeful lives
- Peer support from others who have been there
- Flexibility and innovation at every step
- Inspiring hope to drive recovery

At Optum®, we put these principles into action every day, serving individuals and communities in over 25 states. We’re proud to partner with state, county, community, and provider stakeholders in their efforts to further individual recovery.

See Grips on page 39
**Behavioral Health News**

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Behavioral Health News
Annual Leadership Awards Reception

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“Lifetime Achievement Award”

John J. Coppola, MSW
Executive Director
New York Association of Alcoholism and Substance Abuse Providers
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Linda Rosenberg, MSW
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“Leadership Award”

Ann Marie T. Sullivan, MD
Commissioner
New York State Office of Mental Health
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5:00 PM - 8:00 PM

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Proceeds from this event will go towards enhancing behavioral health education and awareness by expanding the free print distribution of Behavioral Health News and providing free access to the Behavioral Health News online library of science-based behavioral health information, education, advocacy and vital resources in the community.

Contact Ira Minot with any questions at: iraminot@mhnews.org or (570) 629-5960
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er the past several years, the primary focus of inpatient psychiatric treatment has moved to a model of brief treatment and shortened length of stay. There have been many factors driving this, including the advent of managed care. The main goal of inpatient treatment has become rapid assessment and psychiatric stabilization. Whereas once deeper psychological issues were treated on inpatient units, the current focus is on treating acute symptoms and returning patients to the community where they may work on longer term problems in outpatient settings. As a result, patients and families as well as inpatient and outpatient providers have had to adjust their expectations during inpatient stays. At NewYork-Presbyterian Hospital, where “We Put Patients First,” these changes were the driving force in identifying the need to assist Social Work staff in developing increased competencies and new tools tailored to meet the needs of the current healthcare environment.

At NewYork-Presbyterian/Westchester Division, approximately 40 Licensed Social Workers provide treatment to individuals, families and groups on 12 inpatient units. Our Social Work Department has a long established continuing education program. As patient lengths of stay decreased, it became evident that we needed to provide Social Workers with clinical training targeting the evolving needs of our patient populations, while simultaneously enhancing Social Workers’ competence, confidence and job satisfaction. In our annual staff satisfaction survey, Social Work staff told us that it was important to them to do meaningful clinical work with patients during their brief stays, and expressed an interest in trainings that would help them maintain their roles and professional identities as clinicians in a changing environment.

In order to address the needs identified by the Social Work staff, our Social Work Education Committee, comprised of senior clinical staff, considered skill sets required for care of patients during brief hospitalizations. The Committee felt strongly that providing brief treatment requires a high degree of proficiency in the use of our best practice clinical skills for assessment and intervention regardless of length of stay. We initiated a literature review on clinical Social Work in brief inpatient treatment and discovered that there were few articles. In fact, there seemed to be little written on the impact of shortened lengths of stay on outcomes, patient satisfaction, and follow-up in general. Similarly there was little literature on the impact on the practice of clinical Social Work, including the development of curriculum that focuses on clinical skills in brief treatment settings. One relevant article, “Everybody Puts A Lot into It! Single Session Contacts in Hospital Social Work” by Jill Gibbons, PhD, and Debbie Plath, PhD from the School of Social Sciences, University of Newcastle, Australia, explored Social Workers’ experiences of brief treatment in a hospital setting and supported our thinking that the best way to identify training needs and clinical best practices was to elicit this information from the staff themselves.

The Social Work Education Committee conducted focus groups with the Social Work staff that identified the skills that were useful in providing brief treatment sessions with their patients and what theoretical frameworks they used in their work. Additionally, the questions helped the staff to look more closely at their own attitudes and potential biases regarding the brief treatment model. They were also asked to identify what might be valuable for the patients using such a model and to examine what attitudes, behaviors, and skills can facilitate rapid alliance building and effective outcomes. In addition, we wanted staff input regarding realistic expectations as to what constitutes effective outcomes in a brief treatment setting.

From these focus groups, we learned that some staff were concerned that brief treatment would utilize less clinical skills than in longer term care. Overwhelmed, however, the information gathered from both staff and supervisors supported our hypothesis that brief therapy actually utilizes the same important skills in caring for both patient and family. The difference is that our patients’ critical areas of need have to be prioritized and conceptualized earlier in the treatment and implemented with a well-defined focus. Additionally, Social Workers need to be able to help patients and families establish clear expectations about the treatment outcomes from a brief inpatient stay. It became evident that to be able to effectively provide brief treatment, we had to adjust our mindset and embrace what we are able to accomplish within shorter lengths of stay.

The Committee gathered and synthesized the information from the Focus Groups, which was then incorporated and expanded upon in the development of a curriculum to be used for the first academic year of this initiative entitled: “Brief Inpatient Psychiatric Treatment: Clinical Social Work Practice.” The curriculum presented a clinically clear framework for brief treatment Social Work practice which focused on ten key competencies over sixteen training seminars. These included process skills that would help Social Work staff use time and organization skills to maximize efficiency in service of high quality care. Another process skill reinforced was the critical importance of always engaging in active listening toward the goal of rapport building with patients and families. Our curriculum focused on case conceptualization and treatment contracting over five seminars, allowing for ten hours of theory, discussion and practice sessions. We also focused on such issues as managing expectations, goal setting and benchmarking progress - all skills that reinforce interactive processes with patients and family members. Other topics included how to engage families and build bridges into the community after discharge, as well as concepts related to empowerment and recovery. In one of our final seminars, we focused on the importance of keeping a good work-life balance so that Social Work staff would be able to sustain their level of professional commitment and engagement in patient care and to minimize the risk of burnout.

Our Social Work Education Program was enthusiastically received by the staff. Program evaluations collected after each seminar indicated that the seminars had a high degree of relevance for daily social work practice and that they were supporting the need for the continuous identification and implementation of highly proficient clinical skills. These evaluations also indicated that staff were eager for ongoing educational programs that targeted the development of new skills and clinical skills that would effectively address the needs of our patients and their families, while recognizing the impact of the brief treatment model of care both for inpatient stays and for outpatient care.

Since the inception of this “Brief Inpatient Psychiatric Treatment: Clinical Social Work Practice,” our Social Work Department and the Education Committee continue to work together annually to develop curricula relevant to the needs of patients and families and to identify staff training needs that will ensure our practice skills will always be commensurate with those needs. In subsequent training years, we have addressed topics related to “Group Work in Brief Inpatient Psychiatric Treatment,” and “Working with Families in Brief Inpatient Psychiatric Treatment.” We believe that these efforts allow our Social Work staff to function optimally and to always honor that “We Put Patients First.”

Catherine Bookless, LCSW, is Program Coordinator of the Co-occurring Disorders Program; Andrew Bloch, LCSW, is Program Coordinator of the Second Chance Program; Michael Cavallaro, LCSW, is a Social Work Supervisor; Kathleen Friedman, LCSW-R, CSC, is Director of the Deaf and Hard of Hearing Program; Melodee Morrison, LCSW, is a Social Work Supervisor; and Barbara Walm Anche, LCSW, is a Social Work Supervisor; Michelle Sar done, LCSW, is a Social Work Supervisor; and Barbara Walm Anche, LCSW-R, is the Director of Social Work at NewYork-Presbyterian/Westchester Division.

For further information, please contact Barbara Waltman, Director of Social Work at bwaltman@nyp.org.
NewYork-Presbyterian’s expertise in accurate diagnosis and comprehensive psychiatric care is incomparable, providing services for all ages – from children and adolescents through older adults. Our psychiatry programs offer subspecialty clinical care in the full range of psychiatric diagnoses, provide a continuum of care from outpatient therapy through partial and inpatient hospitalization, and conduct neurobehavioral and psychopharmacological research that is advancing the field.
T
he behavioral health care workforce is one of the fastest growing in the country. Projections for 2020, based on U.S. Bureau of Labor statistics, forecast a significant rise in employment for substance abuse and mental health counselors with a 36% increase from 2010-2020 – greater than the 11% projected for all occupations.

This increase, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) Workforce Issues Report of 2013, is based on an expected increase in insurance coverage for mental health and substance abuse services brought about by passage of health reform and parity legislation; the rising rate of military veterans seeking behavioral health services; and the growing opioid epidemic.

SAMHSA’s prediction both confirms the value of our talented workforce and presents challenges for under-resourced social services to meet the increased demand.

As behavioral health care providers, we are confronted with a range of expectations: ensuring our services meet the needs of diverse populations with a complex set of problems; satisfying increased demands for demonstrated outcomes; and doing more with shrinking resources.

Helping us rise to these challenges at Odyssey House is our professional and dedicated workforce. This broad staff of 350 employees include licensed counselors, social workers, doctors, nurses, and dentists, wellness and recreational coordinators, facility and housing managers, educators, administrative, communications and financial managers, maintenance, nutrition, security and transportation coordinators.

All of these staff perform essential roles that keep our clients moving forward in their journey towards health and recovery.

While the roles our staff fulfill each day are quite different, the expectations are the same across the organization: that clients come first; policies and procedures are strictly adhered to; and our resources are tightly managed to be cost-effective and outcome driven. Accomplishing these tasks in a challenging human services environment where clients require intensive care for a myriad of emotional, mental, and physical health deficits, demands practice and training.

Investing in Training

Training is an integral part of ongoing performance management at Odyssey House. We encourage our clinical and administrative staff to take advantage of in-house training opportunities and offer tuition reimbursement towards the cost of professional accreditations and courses. In 2015, our employees earned 35 professional awards ranging from Credentialed Alcohol and Substance Abuse Counselor (CASAC) and Certified Addiction Recovery Coach, to Bachelor’s and Master’s degrees in social work and accounting.

The Odyssey House training department offers a range of professional development options that support direct service and management staff in both progressing their careers and delivering the highest quality care to our clients. Workplace trainings are adaptive to our service environment, track trends and study client profiles, monitor client management systems, and review incidents, chart audits, and quality assurance activities. Training is delivered by experienced licensed staff including medical doctors, clinical social workers, mental health counselors, and certified rehabilitation recreation counselors.

In 2015, clinical staff participated in one or more training sessions that included both group workshops and online individual courses that focused on motivational interviewing, opioid overdose prevention, level of care placement, diagnosis using DSM-5 criteria, ethics and boundaries, safety and crisis management for mental health workers, and cultural diversity and competency.

And we also offered administrative trainings including clinical recordkeeping, documenting medical necessity, fire safety, workplace safety, electronic health record keeping, incident reporting, HIPAA and other confidentiality rules, and basic writing skills.

Focused and Flexible Online Training

We recently enhanced our capabilities with the addition of flexible web-based training. This online system, offered by Relias Learning Management Systems (RMS), further allows staff to refresh their skills and stay up-to-date with regulatory changes ushered in by the 2010 Affordable Care Act and the Mental Health Parity and Addictions Equity Act of 2008. Topics covered include general administrative management requirements like corporate compliance and ethics, fire safety, HIPAA overview, sexual harassment/discrimination prevention, hazardous chemicals, infection control, quality improvement, blood-borne pathogens, and first aid refresher.

We are also utilizing RMS to deliver a range of clinical management trainings including: Screening, Brief Intervention, and Referral to Treatment (SBIRT) for individuals with substance use issues, domestic and intimate partner violence, overview of clinical supervision, best practices in substance use treatment engagement, structured group therapy approaches, co-occurring disorders, and HIV/AIDS.

Odyssey House is committed to developing and maintaining a professional behavioral health care workforce. The clinically focused in-service trainings we offer can be used towards CASAC continuing education credits and many are also approved for New York State Social Work continuing education hours.

By making training a priority, our staff can work in confidence, assured they have the resources and skills they need to succeed in a demanding and rewarding workplace.
mental health providers are increasing has taken on a number of dimensions. As the drive toward integration un-

to medical providers. can, with proper privacy protections, develop electronic record systems that share information between behavioral and medical providers. In addition to integration models, in

care providers have embarked on an intensive effort to enhance collaboration and

to coordinate care.

Across the country the medical and mental health communities have developed new approaches to the total care of the individual. These efforts have been described as “integration” or “co-location” (Raney, 2015). In practice, the models take several general forms. First, there are new expectations that primary care providers monitor behavioral health parameters such as depression and anxiety. Regulatory expectations dictate the administration of instruments such as the PHQ-9 measure for depression. Subsequent interventions in the primary care setting include pharmacologic treatments coupled with counseling and consultation. A complementary, although less popular model entails locating primary care providers in mental health settings for ease of access. In contrast to these approaches, other groups have co-located full medical and mental health services in the same delivery system. In our area, mental health and primary care providers have embarked on an inten-
sive effort to enhance collaboration and develop integration.

In addition to integration models, in New York’s statewide Health Homes pro-
gram, individuals with chronic medical and psychiatric conditions receive care management to best coordinate services delivered by community medical and psychi-

and concomitant health problems. illness are at greater risk for tobacco use and concomitant health problems.

Registered nurses (RNs) have 2-4 years of training and are licensed by the State. In WJCS group homes they play a central role in the care of the more than 100 individuals with developmental dis-

mental health services in the same delivery sys-

In WJCS group homes they play a central role in the care of the more than 100 individuals with developmental dis-

ment of diabetes. These factors reinforce the emerging consensus that behav-

or share information between primary care providers and medical specialists in the community, and work with our psychiatric providers to develop, administer, and assess the impact of psychiatric treatments. Their role is particularly critical given the wide range-

of treatments with more regular laboratory studies of diabetes indicators and choles-

tor, periodic weight monitoring, and regular blood pressure measurements. Coupled with increased surveillance is an expectation of more consistent outreach to primary care providers to obtain critical information regarding diagnosis, labora-

tory results, and prescribed medications. This data is now regularly summarized in the “Continuity of Care Document,” the so -called “CCD,” that is an integral part of all electronic medical records. This document facilitates the rapid transmission of infor-

Food and Drug Administration’s “Continuity of Care Document,” the so-called “CCD,” that is an integral part of all electronic medical records. This document facilitates the rapid transmission of infor-

Nurses and social workers are licensed by the State. In WJCS group homes they play a central role in the care of

To define the care model for medical and psychiatric patients, WJCS, as the only Medicaid Provider Organization in Westchester County providing mental health services, has developed a unique model that combines managed care (including care management) and care delivery in a single setting. This model is designed to enhance care coordination and reduce unnecessary duplication of services. The model is based on the principles of primary care, behavioral health, and social services, and is delivered by a multidisciplinary team of professionals.

The model includes the following key elements:

1. Medical and psychiatric services are provided in a single setting, reducing unnecessary duplication of services.
2. Care is coordinated by a care manager, who works closely with the patient and their family to ensure that all aspects of their care are being met.
3. The care team includes a primary care physician, a psychiatrist, a behavioral health specialist, a social worker, and other professionals as needed.
4. The care team utilizes electronic health records to share information and coordinate care.
5. The care team focuses on prevention and early intervention to improve outcomes.

WJCS is committed to providing comprehensive behavioral health services to all who need them, regardless of their ability to pay. We accept a wide range of insurance plans, and offer financial assistance to those who qualify. Our team of experts is dedicated to helping our patients achieve the best possible outcomes.
Developing Workforce Knowledge Through Technical Assistance

By Daniel Ferris, MPA and Meaghan Baier, LMSW

The transition to Medicaid Managed Care holds the promise of moving the behavioral health system toward the triple aim. It requires many organizational changes, from responding to and managing shifting resources, to shifts in job descriptions and roles to which agencies must acculturate. The result, if the changes achieve the aim, will be reflected in superior behavioral health care, better outcomes for clients, and lower costs.

The New York State Office of Mental Health and Office of Alcohol and Substance Abuse Services (OASAS) have funded the Managed Care Technical Assistance Center (MCTAC) to develop tailored training, tools, and resources to target the workforce in a variety of different platforms and capacities. This article addresses the need for technical assistance in any transition and certainly in one as complex as New York State’s transition to managed care. It also provides an overview of available resources for behavioral health providers as they make the transition.

In addition to physical changes such as new forms, new processes, and new technology, the transition requires a change in mindset for all levels—from board members to frontline staff. Board members and executives must conceptualize a shift in their organization’s role, and staff members must be kept informed of how these changes will impact them. Additionally, a result of this shift is ambiguity in a number of areas, and staff should be acknowledged for the changes they are managing, along with the potential instability they experience. In many instances the transition can mean a heavier workload for providers especially as they estimate volume for new services, and build an infrastructure to support the requirements of a new system. To balance this, communication and transparency become critically important to ensure staff and senior leadership alike understand the goals and benefits of the new system as well as the very real impact that health care transformation has on the staff providing services.

As provider type, populations served, and staffing levels vary across the behavioral health field, training must accommodate for this diverse range of needs by offering technical assistance to best engage and support providers using a variety of methods, tactics, and settings. The collaborative partnership of MCTAC involves government, health plans, providers, advocacy groups, academic, and research-based organizations, all of whom participate in a dynamic working partnership in the development and delivery of technical assistance with the common goal of supporting and improving the delivery of behavioral health services in New York State. Training content and priorities are informed by providers in the field, and directly linked with provider needs relating to Managed Care readiness. MCTAC provides training and resource content through a variety of platforms, including Face-to-Face Presentations and Conferences, Web-Based Trainings, Learning Communities, Office Hours, Tools and Resources, and Self-Learning. Materials from all offerings, including slides, recordings, Q&A, and other developed resources, are available on the MCTAC.org website and circulated via e-mail to newsletter recipients on a weekly basis. This “clearinghouse” function serves to highlight and disseminate information from state partners and other colleagues working to support this system transformation. Additionally, MCTAC has implemented a constant and robust feedback loop through training evaluation forms for all offerings, and the creation of the MCTAC.info@nyu.edu email box fields questions and acts on inquires from the field. This prioritization of user and provider experience seeks to address training topics and ongoing assessment of specific provider needs.

One of the most critical functions of MCTAC is to provide information. Prevention-based training and learning communities offer one opportunity for this work. Attendees are encouraged to share information and resources with their colleagues and generate new questions and ideas facilitated through informal information sharing or through the establishment of a managed care implementation task force and a more deliberate meeting and support infrastructure.

Tools and resources are another crucial element of this work. These tools, developed in collaboration with the array of state, plan, advocacy and agency partners include a managed care language guide; definition of top acronyms; a plan matrix with information spanning all designated plans in NYC, with update planned for the rest-of-state and children’s implementation; a consultant directory, and many others currently in development. Tools have been developed to save valuable time for providers and plans, and can be readily accessed on the MCTAC.org website.

Through its partnership with CASA Columbia, MCTAC is working with OASAS on systems redesign initiatives particularly focused on the residential system, promoting medication assisted treatment, and clinic redesign.

Efforts to support providers and staff extend beyond New York’s largest cities.
By Robert J. Fletcher, DSW, ACSW, NADD-CC, Founder and CEO

NADD

Individuals with mental illness (MI) co-occurring with intellectual/developmental disability (IDD) have complex needs and present clinical challenges to the professionals, programs, and systems. These individuals are among the most challenging, expensive, and intractable to work with. Although the situation has been improving, there are still many instances when the two relevant service delivery systems (behavioral health and developmental disabilities) deny services, believing that the appropriate provider of services should be found in the other service delivery system. Service providers and clinicians often feel poorly prepared to serve this challenging population, and as a result they may choose not to work with individuals who have these co-occurring disorders.

NADD, whose mission over the past 30+ years has been “to advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care,” has developed a series of initiatives aimed at raising the confidence and quality of the workforce providing services to individuals with MI/IDD. Divided between training and certifying competence, these initiatives are designed to result in improved quality of life for individuals receiving services, increased knowledge and competency for staff, as well as overall cost savings.

Training Component

NADD offers training by recognized experts in the field on all aspects of mental health concerns in individuals with intellectual/developmental disability. Our new training initiative centers on offering train-the-trainer sessions based on Mental Health Approaches to Intellectual/Developmental Disability: A Resource for Trainers by Robert J. Fletcher, Daniel Baker, Juanita St Croix, and Melissa Cheplic. A flash drive is included with this book, which has Power-Point slides to facilitate offering trainings. Ten modules are covered in these trainings:

- Module I: What Is a Dual Diagnosis?
- Module II: Building on the Basics: Understanding Assessment Practices in Dual Diagnosis
- Module III: Mental Health Evaluations: Mental Status Examinations (MSE)
- Module IV: Signs and Symptoms of Mental Illness
- Module V: From DM-ID to DM-ID-2
- Module VI: Support Strategies
- Module VII: Adaptive Therapy for People with IDD
- Module VIII: Childhood and Adolescence
- Module IX: Aging
- Module X: Inter-Systems Collaboration

Learning objectives are included for each module and pre- and post-tests are included in an appendix, as well as in an accompanying work book: Trainee Workbook for Mental Health Approaches to Intellectual/Developmental Disability.

Accreditation and Certification

With the NADD Accreditation and Certification Programs, NADD, in association with the National Association of State Directors of Developmental Disability Services (NASDDS), has established standards and benchmarks for services provided to individuals who have intellectual and developmental disabilities co-occurring with mental illness. The NADD Accreditation and Certification Programs were developed to raise their level of care, as well as to provide recognition to those programs and professionals offering quality care.

The NADD Accreditation and Certification Programs are composed of four interrelated programs: Accreditation for programs, Competency-Based Clinical Certification, Competency-Based Dual Diagnosis Specialist Certification, and Competency-Based Direct Support Professional Certification.

The NADD Accreditation Program

NADD developed the NADD Accreditation Program to improve the quality and effectiveness of services provided to individuals with a dual diagnosis through the development of competency-based...
Dual Career Path Development: A Critical Component of Staff Retention and Development

By Virna Little, PsyD, LCSW-R, SAP, CCM, Senior Vice President, The Institute for Family Health

The creation and implementation of a dual career path program can dramatically improve an organization’s ability to provide quality care to patients. Most organizations offer only one track for advancement for employees, the entry into management. Employees choosing not to enter into management are often left with little or no opportunities to advance within the organization. Longer ten and employees who choose not to pursue management for whom man- agement is not a skill set they either possess or wish to acquire feel advancement is not possible and often choose to leave the organization. A dual career path program creates multiple opportunities for staff to develop outside of entering into management. Dual career path programs should be intentional and well planned, if done correctly dual career path programs can be mutually beneficial for both employees and employers.

Dual career paths can be especially beneficial for front line clinicians who, after several years in an organization, would like to advance and have some job diversity outside of direct clinical care. As an example, many organizations are implementing electronic record systems, an ideal individual to provide tech support, help choose, create or implement a system is a clinician who uses or will use the system on a daily basis. A dual career program allowing clinical staff to partici- pate in these activities, obtain necessary certifications or training allows them to grow and advance and provides the organization with a technology workforce with “real life” experience with the sys- tem. Additionally, these staff have credi- bility with other clinicians in the organi- zation a critical element in electronic re- cords training and development.

It is critical that the creation of a dual career path program is not perceived by staff as work that is in addition to their current tasks, that the opportunities are replacing some current responsibilities and are meant to provide opportunities for professional growth and development. As part of the rollout of a dual career program job descriptions need to be created or changed, managers need to be trained and at times a dual reporting structure needs to be created. Thought needs to be paid to how responsibilities will be “back filled” as individuals take on dual roles. The Institute for Family Health has created multiple dual role positions in behavioral health, creating a model that allows for clinicians to be in direct care a self-sustaining amount of time and have a dual role in other areas.

A number of factors contribute to this discrepancy between individuals in need of treatment and the services available. While addiction is increasingly recognized as a medical illness, ongoing stigma remains about substance use and other behavioral health disorders. Limited insurance coverage for addiction related services also contributes to the treatment gap.

Traditionally, the bulk of addiction services have been provided outside the medical model by non-physician staff. Greater acceptance of the notion of addiction as a disease has shifted that some- what, with greater physician involvement in treatment, particularly over the last few decades. Most physicians, however, do not receive sufficient education about addiction during medical school and resi- dency, leading to a physician workforce that is inadequately equipped to provide substance abuse treatment services. Ad- diction specialists, individuals who have received additional training and practice in substance abuse treatment, are a critical component in closing this treatment gap. Specialists can provide direct care as well as support primary care and other provid- ers in the treatment of individuals with substance use disorders. When primary care is unable to provide the availability of expert consultation, they can be more confident in their ability to treat individuals with addiction. Addiction specialists can also serve as educators, helping to ensure evidence-based care models are followed and providing guidance about resources such as self-help and specialty addiction treatment programs with which primary care providers may not be familiar.

The first physicians to become board-certified in addiction were psychiatrists. Since 1991, the American Board of Medical Specialties has recog- nized addiction psychiatry as a subspe- cialty, requiring fellowship training and a certifying exam. While these specialists have been a welcome addition to the field, the number of addiction psychiatrists is not sufficient to meet the treatment needs of individuals with substance use disorders.

Non-psychiatric physicians specializing in the treatment of substance use disorders are called specialists in Addiction Medi- cine. Addiction Medicine is distinct from Addiction Psychiatry, and is one of the few multidisciplinary specialties, meaning that addiction medicine physicians come from a wide range of primary specialties such as family medicine, internal medicine, pediat- rics, emergency medicine, obstetrics and gynecology, and surgery. A certifying ex- amination has been offered since the 1980s, first by the American Society of Addiction Medicine (ASAM) and since 2007 by the American Board of Addiction Medicine (ABAM), an independent board which oversees the exam, as well as pro- moting the mission of physician training.

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Increasing the Addiction Workforce: Fellowship Training in Addiction Medicine

By Abigail J. Herron, DO, FAPA, FASAM, Director of Psychiatry and Director of the Fellowship in Addiction Medicine, The Institute for Family Health

Substance use is one of the most significant public health issues in the United States. Annual costs related to crime, lost work productivity and health care due to use of tobacco, alcohol, and illicit drugs exceeds $700 million annually (http://www.drugabuse.gov/related-topics/statistics). In 2013, an estimated 9.4% of the population (24.6 million Americans aged 12 or older) were current illicit drug users. Slightly more than half (52.2 percent) of Americans aged 12 or older (136.9 million people) were current alcohol users, with nearly one quarter (22.9 percent) reporting binge alcohol use. (Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, September 4, 2014. The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings, Rockville, MD.)

Despite the prevalence of medical illness in this population, their high utilization of health care services, and the increasing availability of effective treatment options, large numbers of individuals with substance use disorders still do not receive treatment. In most settings, substance abuse treatment is not readily available in coordination with medical treatment, leaving individuals to receive care from specialty treatment centers. These specialized settings however, are not sufficient to meet the need for treatment. The 2013 National Survey on Drug Use & Health estimated that 22.7 million individuals aged 12 or older needed treatment for an illicit drug or alcohol use problem. Of these, only 2.5 million received treatment at a specialty facility for addiction (SAMHSA, 2014).
Workforce Development Needs of Addiction Professionals in New Jersey

By Diane Litterer, MPA, CPS
CEO and Executive Director
New Jersey Prevention Network

A unique structure has been created to support the training and workforce development needs of addiction professionals in New Jersey. Through the NJ Department of Human Services Division of Mental Health and Addiction Services, a statewide Addiction Training & Workforce Development (ATWD) program has been funded to provide all required educational courses for initial certification and renewal credits to support individuals interested in becoming New Jersey addiction counselors. As CEO and Executive Director of NJPN, I am proud that our agency is the steward of a comprehensive workforce development program that has remained ahead of the curve in preparing New Jersey’s counseling professionals. It is a model that is worthy of attention and replication to provide opportunities for qualified individuals to receive quality education focused on addiction.

The ATWD program also attends to internship placement for students under approved supervision, and provides training for clinical supervision credentialing. As a result of this coordinated effort, students learning is reinforced in their work environment and required clinical hours and 270 educational hours are accumulated simultaneously. The ATWD program has produced 582 credentialed professionals of which 54% became licensed certified Alcohol and Drug Counselors (LCADC) and 46% became certified alcohol and drug counselors (CADC). The ATWD students reflect NAADAC’s direction that provides a tiered system of credentialing, indicated by increasing levels of education (beginning with a minimum of an associate degree, and progressing to a bachelor’s and master’s degree). Each tier leads to an increase in the clinician’s scope of treatment.

Diane Litterer, MPA, CPS

Of students who have already become licensed or certified since graduating from our program, 54% are Master’s-level LCADC clinicians; 25% are CADC’s with a Bachelor’s degree; and of the ATWD Bachelor’s-level graduates, 25% of them then earned a Master’s degree after obtaining their CADC.

New Jersey Prevention Network (NJPN) has been trusted with the ATWD grant to provide all initial certification coursework, mandatory renewal courses, internship connections and customer service to guide professionals along the path to state certification. The emphasis in class and throughout the internship is on learning and employing empirically-tested best-practices for clinical effectiveness in the treatment of substance use disorders. This requires extensive attention to emerging trends in the field, including diagnosis and treatment for Co-occurring Disorders, identifying and treating trauma issues, the use of Medication Assisted Treatment, and providing a culturally competent, diverse, and welcoming environment for clients from all walks of life.

Tony Polizzi, LCADC, has been an ATWD instructor since 2006. “I have seen remarkable growth in new and credentialed students while teaching these courses. I have taught on both the undergraduate and graduate level at state universities, and the diversity of experiences, academic training, and backgrounds of the participants in this community-based program provide an even richer environment for learning. The ATWD structure gives me the opportunity to provide a combination of counseling, teaching, modelling, supervising, and mentoring while delivering educational material, theoretical foundations, and intervention skills. A favorite theme that runs through most classes is the process of change taking place, the adaptation of new ideas, the exposure of and elimination of biases, the ‘cultural’ transformation of the students over the course of their involvement in the classroom environment. It is very rewarding to see the evolution of an empathetic person willing to develop the attitudes and skills necessary to become an effective counselor.”

A primary goal of the Addiction Training Workforce Development initiative is to produce well-trained, competent clinicians to be employed in stable, effective treatment agencies. To achieve this, several scheduling models were tested and the result was the creation of multiple statewide training sites within or local treatment or substance abuse prevention facilities. The program model for initial certification includes multiple training sites from which students select a primary location to attend the 45 required courses that are staffed by rotating trainers. This structure promotes student networking among local treatment professionals to support job placement and community-learning circles. Additionally, this allows trainers to work with students for up to a year of nearly 25% of them then earned a Master’s degree after obtaining their CADC.

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see New Jersey on page 39
Governor Cuomo Signs Executive Order
To Protect Homeless Individuals During Inclement Winter Weather

From the Office of Governor Andrew M. Cuomo

Governor Andrew M. Cuomo issued an Executive Order on January 3, 2016 to protect homeless individuals from inclement winter weather where temperatures decline to 32 degrees or below. The order will ensure that homeless individuals are directed to shelter during inclement winter weather which can cause hypothermia, serious injury and death. It also requires homeless shelters to extend their hours of operations so that those without shelter can remain indoors. The State will assist local social services districts if they are lacking facilities, resources or expertise.

EXECUTIVE ORDER
Emergency Declaration Regarding Homelessness During Inclement Winter Weather

WHEREAS, New York State is currently in the winter season and is subject to inclement winter weather that poses an imminent danger to public health and safety; and

WHEREAS, such inclement winter weather means air temperatures at or below 32 degrees Fahrenheit, including National Weather Service calculations for windchill; and

WHEREAS, when such inclement winter weather occurs, it presents a threat to the life, health, and safety of the State’s citizens, particularly to persons who are homeless, including the risk of hypothermia and potentially death; and

WHEREAS, pursuant to the New York State Constitution, the State of New York has an obligation to provide for the aid, care and support of persons in need and to protect and promote the health of its citizens; and

WHEREAS, it is imperative that the State act to ensure that such aid, care and support is provided to address the needs of the State’s homeless population, which need is further heightened during the winter months; and

WHEREAS, homelessness is an issue that impacts citizens in all regions of the State, from large cities to small towns and rural communities; and

WHEREAS, certain parts of the State are facing a crisis of homelessness unprecedented in recent history; and

WHEREAS, the State has a comprehensive system of more than 77,000 emergency shelter beds for homeless single adults, families, and unaccompanied youth, designed to meet the housing and supportive services needs of these homeless residents; and

WHEREAS, localities customarily work in coordination with police agency resources and local social service providers to conduct outreach to the homeless and to facilitate their transfer to sheltered locations; and

WHEREAS, the State will assist local social services districts if they are lacking facilities, resources or expertise; and

WHEREAS, the State will be imminently commencing and mandating that local social service districts establish comprehensive regional housing and supportive service networks designed to meet the diverse needs of each subgroup within the homeless population; and

NOW, THEREFORE, I, ANDREW M. CUOMO, Governor of the State of New York, by virtue of the authority vested in me by the Constitution of the State of New York, Sections 28 and 29 of Article 2-B of the Executive Law, and consistent with the Laws of the State of New York, including the Mental Hygiene Law, and the judicial interpretations of those laws, do hereby issue this Executive Order to mitigate the effects of such inclement winter weather and the resulting impacts of such weather on individuals experiencing homelessness;

see Homeless on page 40

Governor Andrew M. Cuomo

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PAGE 32 BEHAVIORAL HEALTH NEWS ~ SPRING 2016
visit our website: www.mhnews.org

Behavioral Health News – Spring 2016
visit our website: www.mhnews.org
By Amy Sheyer
AVP, External Relations, Beacon

As we look to the new year and the resolutions we can make to improve our lives and the lives of others, Beacon Health Options (Beacon) urges you to resolve to break the silence and stamp out the stigma around mental illnesses. Talk about it; your story could change a life.

Today, Beacon, the nation’s premier behavioral health management company, will ask New Yorkers and those visiting the “Big Apple” to make mental health awareness their 2016 New Year’s resolution. A 23-story digital billboard in New York City’s Times Square will remind them about the importance of talking about mental illness as a means to stamp out stigma.

According to the National Institute of Mental Health, one in five U.S. adults will be affected by a mental illness in a given year, approximately 43.8 million Americans. Factoring in family, friends and colleagues, all of us are affected by mental illness in some way. Unfortunately, the reality is that approximately 30 percent of people living with mental illness say they choose not to seek treatment due to fear of judgment. The good news is that mental illness is treatable.

“You wouldn’t necessarily know the high prevalence of mental illness in the U.S. because we rarely talk about mental health in public,” said Dr. Jorge Petit, a psychiatrist and Beacon Senior Vice President, National Client Partnerships – New York Region. “Like diabetes, heart disease or high blood pressure, mental illness is a medical condition that requires care; yet because of the stigma that a mental illness diagnosis carries, we have made it something that is easier to hide than to seek treatment. And that needs to change.”

In 2013, ValueOptions, before it merged with Beacon Health Strategies to become Beacon Health Options, took its first step to do just that when the company launched its Stamp Out Stigma initiative. Now spearheaded by the Association for Behavioral Health and Wellness, in which Beacon is a member, the initiative continues work to reduce the stigma surrounding mental illness and substance use disorders. This campaign challenges each of us to transform the dialogue on mental health and substance use disorder from a whisper to a conversation.

More recently, New York City Mayor Bill de Blasio and First Lady Chirlane McCray launched ThriveNYC: A Mental Health Roadmap for All, an action plan to guide the city toward a more effective and holistic system to support the mental well-being of New Yorkers. One of the program’s principles is to change the culture by making mental health everybody’s business and promoting open conversation about it.

What can you do in 2016 to help bring mental illness out behind closed doors and into the public space?

Learn the facts about mental illness. Remind others that it is not the result of personal weakness, lack of character or poor upbringing. Mental illness is a disease just like diabetes, asthma and high blood pressure. It is treatable. See more at: nami.org/stigmasfree.

Listen to someone with an open mind and without judgment. It can be one of the most powerful ways to support a friend, family member or colleague who has a mental illness. Visit naminyc.iwilllisten.org/how-to-listen/ for more information.

Sign up for a Mental Health First Aid course and learn the risk factors and warning signs of mental health and substance use problems. The course also teaches a five-step action plan to help people get the care they need in their community. Visit mentalhealthfirstaid.org.

Take the pledge to stamp out stigma and discover what you can do to recognize, educate and reduce stigma at stampoutstigma.com/pledge.

Supporting Peer Specialists

By Thomas R. Grinley, Program Planner Office of Consumer and Family Affairs NH Bureau of Behavioral Health

An increasingly common workforce issue is preparing “traditional” providers for working beside peer providers, that is, individuals with the lived experience of mental health issues. SAMHSA (Substance Abuse and Mental Health Services Administration) defines a peer provider as “a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience” (SAMHSA, 2013). The use of peer specialists in different roles and different settings has been growing steadily especially since 2001 when Medicaid made peer services billable under Medicaid rules (Daniels, Grant, Filson, Powell, Fricks, and Goodale, 2010).

To be sure, the existence of peer providers predates, by far, the 2007 CMS memo that laid out the Medicaid billing rules (Smith, 2007) and we saw a rapid expansion of peer specialist services. However, until this point the services provided had been primarily volunteer and outside the realm of “traditional” services. Now we were seeing the professionalization of peer providers within the traditional system of services (Chapman, Blash, and Chan, 2015). As Chapman, Blash and Chan (2015) also noted, stigma continues to be an issue impacting the hiring and acceptance of peer workers in traditional treatment programs. However, properly leveraging the lived experience of peers will help define their role in the program and assist with the integration of peers onto the treatment team (Resources for Integrated Care, 2015a).

The burden is necessarily on the mental health program to create an environment which aids the integration of peer providers into the workforce. The most common barrier to the use of peer specialists was the acceptance of the positions within traditional mental health centers (Daniels, Grant, Filson, Powell, Fricks & Goodale, 2010). In 2009 at the Pillars of Peer Support Services Summit, one of the pillars that was identified was “a Comprehensive Stakeholders Training Program that communicates the role and responsibilities of Certified Peer Specialists and the concepts of recovery and whole health wellness to traditional, non-peer staff (peer specialist supervisors, administration, management and direct care staff) with whom the Certified Peer Specialists are working” (Daniels, Grant, Filson, Powell, Fricks, and Goodale, 2010).

The call for training recognizes acceptance as the most significant barrier to the peer specialist workforce.

The organization intending to hire peer specialists must also have a strong philosophy of recovery without which may not have the “attitudinal and structural supports to successfully employ peers/coaches in their workplace” (SAMHSA, 2012). These strong principles of recovery are essential for integration of peer supports into the service array. Likewise, a strong program commitment is necessary for the transformation of service delivery to include a peer support component.

At the fourth annual Pillars of Peer Support conference three years later, there was still a call for “creating recovery cultures that support peer specialists” (Daniels, Tunner, Bergeson, Ashenden, Fricks, Powell, 2013). At the sixth annual conference two years later, conference participants began prescribing supervisory roles for the integration of peer specialists into the workforce. The conference monograph found “A key element of peer specialist supervision is to create a supportive and stimulating environment where the job role and expectations of the peer specialist are open to collaborative discussion” and that “The peer specialist’s supervisor should also be an advocate and should convey the importance of the peer specialist’s roles with human resources and others in the organization.” (Daniels, Tunner, Powell, Fricks, Ashenden, 2015).

As we have said, the burden is necessarily on the mental health program to create an environment which aids the integration of peer providers into the workforce. The Dimensions: Peer Support Program Toolkit (Morris, Banning, Mummy & Morris, 2015) organization assessment makes it clear the responsibility falls to the mental health program with questions such as: see Supporting on page 37.
Preparing from page 6
distance learning technology for a hybrid format. Each module is crafted to be a stand-alone experience and therefore results in a completion certificate within the respective topic area.

Finally, recognizing the need professionals have for career advancement, students who complete any five (5) modules in any sequence within any time frame are awarded an Advanced Certificate in Integrated Primary and Behavioral Healthcare signifying the extensive training that students have undertaken. Each module is recognized by the New York State Department of Education for the award of CEU credits as noted below. Table 1 below provides topic descriptions of each module.

Measuring Training Outcome
Since its inception two years ago, the Integrated Primary and Behavioral Healthcare certificate program has had 122 students participate and complete one or more of the offered modules, while 55 students have since received advanced certificates having completed a total of 5 modules. Participants were from the fields of social work, law, nursing, medicine, peer advocates and para-professionals. They represented upper and mid-management as well as direct service staff.

Measuring training outcomes is always a challenging undertaking. The purpose of training is not only to communicate new knowledge but to also teach new skills that can be applied within practice settings. Measuring skill acquisition is one issue but the more important aspect of training is whether new knowledge and skills are applied in work settings.

In an attempt to measure outcomes, students were asked to develop implementation plans utilizing aspects of principles and skills contained within each respective module. These were reviewed and feedback was provided as necessary. In addition, a specialized self-report evaluation has been developed to help understand students’ motivation to change at the conclusion of each module. The data contained in table 2 and below represent only a sample of the data collected and is representative of two modules. It reflects the level of engagement and enthusiasm of the group who thus far has taken the training.

Students were asked to complete an online evaluation at the commencement of each module. Some questions were answered using a Likert scale ranging from Strongly Disagree (1) to Strongly Agree (5), while other questions were open-ended in an effort to gather qualitative data about each student’s individual experience.

Table 2 below reflects data from the first year of the program and is limited to the first several modules. This data reflects the high level of student satisfaction with the training and content. Perhaps as important, Table 3 below, also from the same cohort, reflects an equally high level of desire to change practice within the workplace, however it appeared that work place support is lagging somewhat behind employee motivation toward change.

Concluding Comments
Health care transformation brought on by the ACA is complex, multidimensional and spans the entire health care enterprise. Delivery systems, payment methodologies, health insurance operational protocols, evidenced based treatment, wellness self-management designs and clinical research focus are all in motion. The workforce must absorb these new movements by first learning the information necessary for implementation followed by engagement in practice change.

The purpose of this brief report was to describe one approach to re-training the workforce that several major Universities are pursuing in various forms. Alternatively, there are national conferences, web based learning opportunities, and stand-alone workshops that are all offering various renditions of training in Integrated Primary and Behavioral Health Care, all of which have a role to play in re-training the workforce. Regardless of training venue, training in this area needs to include practice exercises that will allow participants to leave with new knowledge and skills that can be reinforced back at the workplace. Those trained in Integrated Primary and Behavioral Health Care can serve as leaders within their own organizations providing practice change sustainability within this rapidly changing health care environment.

Peter C. Campanelli is a Senior Scholar, Sr. Research Scientist, and Adjunct Professor within the McSilver Institute, NYU Silver School of Social Work; Kyle O’Brien is a Ph.D. student at NYU’s Silver School of Social Work and a Research Fellow at McSilver Institute; Dottie Lebron is a research scientist and community specialist at the McSilver Institute; Joseph Cerniglia is a MSW student community specialist at the McSilver Institute, Sr. Research Scientist, and Adjunct Professor within the McSilver Institute, and the Importance of Integration. Journal of Law, Medicine, & Ethics, 39(3), 317-327

References


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<td>Integrating Health, Mental Health, and Substance Abuse Services</td>
</tr>
<tr>
<td>Unintended Consequences</td>
<td>Improving Population Health and Disease Prevention</td>
</tr>
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<table>
<thead>
<tr>
<th>Approved CEUs for Social Work**</th>
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<tbody>
<tr>
<td>10 CEUs’</td>
</tr>
<tr>
<td>20 CEUs’</td>
</tr>
<tr>
<td>30 CEUs’</td>
</tr>
</tbody>
</table>

*Advisement available Fall 2015
**Approved by NYSDOE Modules 1-6

Table 2

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total Responses</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The readings, lectures, and group discussions were relevant and helpful toward understanding the course objectives.</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>26</td>
<td>27</td>
<td>55</td>
<td>4.45</td>
</tr>
<tr>
<td>3. I believe this certificate program is necessary for ensuring the use of best practices at my workplace during the implementation of the Affordable Care Act.</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>17</td>
<td>34</td>
<td>55</td>
<td>4.53</td>
</tr>
<tr>
<td>5. I am satisfied with the training I received in this module.</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>24</td>
<td>28</td>
<td>55</td>
<td>4.45</td>
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Table 3

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<th>Disagree</th>
<th>Neither</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total Responses</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have a desire to change workplace policy, procedures, or applied skills having now participated in this program.</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>23</td>
<td>25</td>
<td>53</td>
<td>4.62</td>
</tr>
<tr>
<td>2. I have the necessary knowledge and skills to lead and/or manage at my workplace.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>30</td>
<td>20</td>
<td>53</td>
<td>4.30</td>
</tr>
<tr>
<td>3. I have the proper amount of support at my agency to implement the attitudes, knowledge, and skills I have acquired from participating in this program.</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>28</td>
<td>13</td>
<td>53</td>
<td>3.87</td>
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<tr>
<td>4. I intend to actively participate in changes at my workplace related to integrated health and behavioral health.</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>22</td>
<td>29</td>
<td>53</td>
<td>4.51</td>
</tr>
<tr>
<td>5. I am implementing changes in my workplace using the knowledge I learned in this program.</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>30</td>
<td>19</td>
<td>53</td>
<td>4.38</td>
</tr>
</tbody>
</table>
Co-Occurring from page 29

professional standards and through promoting ongoing professional and program development.

A NADD Accreditation survey evaluates a program on the basis of eighteen competency modules:

- Medication Reconciliation
- Holistic Bio-Psycho-Social Approach
- Database/Outcome measures
- Protocols for Assessments
- Treatment/Habilitation Plans
- Basic Health Care
- Interdisciplinary Team
- Training / staff and family
- Crisis Prevention and Intervention
- Cultural Competency-Family Values
- Trauma
- Quality Assurance/Incident Management
- Evidence-Based Treatment Practices
- Ethics, Rights, Responsibilities
- Interagency and Cross-Systems Collaborations
- Long Term Living – Service Coordination
- Advocacy and Rights Health Informatics (Technology)

(Note: Only the standards that are applicable to the program will be evaluated.)

One way that NADD Accreditation differs from almost all other accreditation programs is the inclusion of a consultation component. Through their expertise, NADD examiners are not only able to identify areas that are in need of improvement, but they are also able to offer concrete suggestions about how to improve the program. The consultation component takes place on site during the course of the survey.

Competency-Based Clinical Certification Program

The NADD Competency-Based Clinical Certification was developed to improve the quality and effectiveness of services provided to individuals with a dual diagnosis through the development of competency-based professional standards and through promoting ongoing professional development. Certification attests to the clinician’s competency in providing services to individuals with a dual diagnosis.

NADD has identified five competency areas that applicants for Clinical Certification must demonstrate mastery of:

- Positive Behavior Supports and Effective Environment
- Psychotherapy
- Psychopharmacology
- Assessment of Medical Conditions
- Assessment

In order to be considered for Clinical Certification, an applicant must meet certain pre-requirements. They must be licensed to practice in a state or province or recognized as an Applied Behavior Analyst, and they must have five years experience in support of persons with intellectual disabilities and mental health issues. They are required to submit three letters of reference.

Applicants are required to submit a five page work sample of a case that demonstrates clinical work with a person who has a dual diagnosis. The work sample should include formulation/conceptualization of clinical problem(s), format for therapy intervention, landmark events or salient issues that arose during the course of treatment and how these were addressed within treatment, reflection on issues within therapy and/or ethical concerns and/or issues relevant to cultural competency, and how the clinical approach was informed by an understanding of intellectual disability or dual diagnosis.

The final aspect of the certification process is a telephone-based interview/exam. Prior to the interview, the applicant is presented with a case vignette approximately about which he or she will be asked to verbally offer his/her thoughts and reflections (i.e., provide a case formulation and treatment plan).

Clinicians who receive NADD Clinical Certification are entitled to use “NADD-C” as a credential.

The NADD-CC is being recognized by a wider and wider variety of different entities as a unique specialty, and we anticipate broader recognition as time passes. Individual municipalities such as the City of Philadelphia recognize the NADD-CC, giving specific preference in a Request For Proposals. Some third party payers, including managed care entities, recognize NADD-CC.

Individual states, such as MN and NJ, recognize NADD-CC and are in the process of adopting NADD-CC into service qualifications and job class specifications.

Competency-Based Dual Diagnosis Specialist Certification

The NADD Competency-Based Dual Diagnosis Specialist Certification Program is designed for specialists in the field of dual diagnosis who deliver, manage, train and/or supervise services for persons with intellectual/developmental disabilities and mental health needs. Staff working in units of county, state or provincial government, QIDPs, RN’s, LPN’s, program directors, program supervisors, case/care managers, program specialists, supports coordinators, peer specialists, trainers, and others are examples of roles that can apply for this certification.

A specialist seeking certification is required to demonstrate mastery of the following six competency areas:

1. Bio-psycho-social approach
2. Application of emerging best practices
3. Knowledge of therapeutic constructs
4. Respectful and effective communication
5. Knowledge of dual role service delivery & fiduciary responsibilities
6. Ability to apply administrative critical thinking

In general, DSPs spend more time with the person with IDD/MI than any other professional. The competence of the DSP can make a big difference in the quality of life for people. DSPs are often the ones charged with supporting skill building. They help the person engage in recommended therapies on a day-to-day basis. This work requires an advanced level of skill and knowledge to do well. However, there is little available to guide DSPs and others in identifying the specific competencies a DSP should have for this work. As a result, many DSPs are under-qualified. Too often, they lack the support and training to do well. This lack of standards can make finding, hiring, training, and retaining qualified DSPs difficult. As a result, many people with IDD/MI do not have adequate daily support.

NADD identified five competency areas that the DSP applicant must demonstrate competency in:

1. Assessment and Observation
2. Behavior Support
3. Crisis Prevention and Intervention

see Co-Occurring on page 40

Beacon from page 9

Dr. Petit earned his medical degree from University of Buenos Aires and completed his psychiatry internship and residency at the Mount Sinai Hospital School of Medicine. Additionally, he completed a public psychiatry fellowship at Columbia Presbyterian-New York State Psychiatric Institute.

About Beacon Health Options

Beacon Health Options is a health improvement company that serves 47 million individuals across all 50 states and the United Kingdom. On behalf of employers, health plans and government agencies, we manage innovative programs and solutions that directly address the challenges our behavioral health care systems face today. Beacon is a national leader in the fields of mental and emotional well-being, addiction, recovery and resilience, employee assistance, and well-being. We help people make the difficult life changes needed to be healthier and more productive. Partnering with a network of providers nationwide, we help individuals live their lives to the fullest potential.

For more information, visit www.beaconhealthoptions.com.

Disorder from page 9

Based on the results of the study, the majority of people with drug use disorder never receive any form of treatment. About 14 percent of people who had drug use disorder in the past year and about 25 percent of people who had ever had drug use disorder received care. Even among people with moderate-to-severe drug use disorder, less than 20 percent of those with past-year drug use disorder and less than one-third of those with lifetime drug use disorder received treatment.

Treatment rates for alcohol use disorder are similarly low. Earlier this year, Dr. Grant's group found that nearly one-third of adults in the United States have alcohol use disorder at some time in their lives, but only about 20 percent receive treatment www.niaaa.nih.gov/news-events/news-releases/niaa-study-finds-alcohol-use-disorder-increased-

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Mental Health Is About All of Us!

see Co-Occurring on page 40

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○ treatment
○ employment and housing services
○ care management
○ early intervention for first episode of psychosis

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demonstrating the ability to use electronic medical records; and tracking and reporting outcomes.

In recognition of the need to support the healthcare staff in the face of these broad-brush changes, the New York State Department of Health has funded a project that directly targets the healthcare workforce through their Health Workforce Retraining Initiative (HWRI). As the entire healthcare system is undergoing change, HWRI is intended to support the workforce to learn the new skills required for them to retain and thrive in their positions.

In order to support the newly created Care Management workforce, through this grant, the New York Association of Psychiatric Rehabilitation Services (NYAPRS) developed the Care Management Training Initiative (CMTI) for Care Managers and their supervisors across New York State. Over the course of 4 years, NYAPRS has developed two CMTI trainings that have been provided to over 900 Care Management staff. Both training series were designed to enhance care managers’ skill sets so that despite the massive changes to our system, they can remain a successful workforce and continue to assist the people they work with to achieve and maintain wellness.

The first phase of the training consisted of 10 webinars and a series of face-to-face trainings, and was successfully completed in 2013 with over 500 staff completing the training. The second phase of the training is currently underway and will be completed in March 2016. The final webinar focused on the 253 trainees, however, the need is so great that over 700 care managers have enrolled in the current training project.

NYAPRS collaborated with four organizations to implement these trainings: the NY Care Coordination Program, the Center for Practice Innovations, the NYS Council for Community Behavioral Health, and Tech Leaders. Over the course of 15 months, the training provides web-based learning for all staff with additional components specifically for the supervisors that included a telephonic learning collaborative and in-person learning sessions. By creating these additional supports for the supervisors, the training teaches supervisory skills specific to the content covered in the webinars. The intent is to build the supervisor’s skill set so that they can support their staff as they implement what they have learned.

Topics include: Outreach, Engagement and Retention; Understanding Complex Needs; Navigating Complex Systems; Effective Outcomes Measurement and Management; and Workload Management and Using Technology to Enhance Productivity.

The efforts of the training collaborative are helping to support the framework for these web of care and offer the resources for care managers to achieve the promise of the Triple Aim. For the participants of care, the training will assure that the staff they work with will understand and negotiate all the systems of care that make up the complex web of our health system. Hopefully, with that added knowledge, recovery and wellness will prevail as the valued outcome.

Ruth Colón-Wagner of NYAPRS can be contacted via email at ruthw@nyaprs.org.

Statewide from page 11

Aging from page 11

Living With Disability: Obviously, older adults are more likely to experience disabilities than younger people. But this is far from the end of their potential to get satisfaction out of life.

In the field of psychiatric rehabilitation, a concept of recovery has emerged that does not mean that people with long-term psychiatric disabilities eventually get over their mental illnesses fully. Some do; but many continue to experience the symptoms and psychological struggles of severe, long-term mental disorders. “Recovery” for them means that they can nevertheless discover ways of living that they find satisfying and meaningful.

Geriatric behavioral health professionals need a similar concept for people who develop disabilities as they age, including those who develop dementia.

Successful Aging: “Successful aging” is one such concept. Recent literature on this concept borrows from the concept of recovery and distinguishes between objective and subjective successful aging. Emphasis is thus placed on personal successes that people have gained over the years, and on the subjective experience of the positive feelings that they have about their lives.

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Knowledge from page 28

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As MCTAC transitions into the rest of states, and children’s implementation the authors encourage providers to familiarize themselves with our tools and previous offerings. All of these offerings and tools will be updated for the upstate and children’s roll outs. Also, please take advantage of MCTAC.info@nyu.edu to share any suggestions for needed technical assistance.

Daniel Ferris, MPA is the Assistant Director, Policy and External Affairs within the McSilver Institute for Poverty Policy and Research, NYU School of Social Work. Meagan Baier, LMSW is a Policy and Research, NYU School of Social Work. They have the unique requirement to provide tensile strength and yet be immensely flexible.

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**Supporting from page 33**

- Is your leadership team in support of implementing a peer support program?
- Is a peer support program consistent with your organization’s mission and values?
- Does your organization have identified champions of peer support?
- Do the benefits of implementing a peer support program at your organization currently outweigh the perceived barriers?

Support from leadership and identification of peer support champions will both be crucial to paving the way for successful integration of peer specialists to the workforce. Typical concerns include whether peer specialists may relapse, whether they have the requisite skills and experience, and a perceived risk that peer specialists may supplant other team clinicians (Morris, Banning, Mumby & Morris, 2015). Only leadership from the top can impart the clear message that the organization is fully committed to integrating peer specialists and receiving the expected benefits of doing so. Only then can the champions smooth the path for full integration.

**Tips to Reduce Negative Attitudes Faced by Peer Support Staff** (Resources for Integrated Care, 2015b) also made clear the expectations of the mental health program with its key considerations:
- Recognize that people can be both clients and providers
- Identify stigma in your organization
- Prepare your organization
- Develop a plan to train and educate peer support staff and supervisors

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**Roadmap from page 8**

Taken together, these principles outline a public health approach to mental wellness that charts a path toward a healthier and happier future for all New Yorkers. ThriveNYC focuses on promoting mental health, preventing illness, and detecting problems early, in addition to treating mental illness.

Several approaches have dramatically improved public health issues. For example, through a combination of policy bans on smoking, broad public communications, increased federal, state and local excise taxes and increased access to treatment tools, New York City cut the adult smoking rate by 35 percent in about a decade. The youth rate fell even more – by 52 percent.

“If you look at how mental illness has been addressed over the years, you see a lot of broken promises,” said Mayor Bill de Blasio. “You don’t see a concerted, holistic effort to help people be well and stay well. The people of NYC need something different, something like ThriveNYC. It will take years to address the problem the way it should be addressed. But we need to start now, to need to start aggressively. The people of NYC deserve nothing less.”

“We want New York City to be a place where people can live their lives to the fullest,” said First Lady Chirlane McCray. “ThriveNYC is about more services, better services and easier access to services. It’s a plan of action that shows us how to treat mental illness — and also promote mental health.”

“Mental illness truly impacts the lives of every New Yorker — our quality of life, our health and our economy,” said Deputy Mayor for Strategic Policy Initiatives Richard Buery. “New York City can and will ensure that all New Yorkers have access to the services and treatment they need to feel good and live healthier. ThriveNYC is a plan of action to guide us towards a more holistic public health system that prevents, detects and treats mental illness.”

“Like much of the United States, New York City is facing a crisis when it comes to mental health. Mental illness and substance use disorders touch every family, the health care system and our economy,” said Deputy Mayor for Health and Homeless Services, Arlene W. Thane. “New York City is facing a crisis when it comes to mental health. Mental illness and substance use disorders touch every family, the health care system and our economy.”

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**References**


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Awards from page 4

More on our honorees...

Peter C. Campanelli, PsyD

Dr. Campanelli founded the Institute for Community Living in 1986 as part of his doctoral dissertation project, and served as President and CEO until 2012. Utilizing his ICL and partner Agencies developed a diabetes management protocol for seriously mentally ill people along with the first community based health home under the chronic Illness Management Program (CIPD). ICL healthcare integration efforts also led it to develop its own health care clinic which it后来 evolved into a specialty federally qualified health center (FQHC). It has served as Board Chair of The Association of Community Living and Managed Care Innovations, as well as President of the Coalition of Voluntary Mental Health Agencies' Board of Directors. He also served on the Board of the National Council on Community Behavioral Healthcare, and is a past Chairman of the Mental Health News, Inc. Board of Directors.

Dr. Campanelli holds a Doctorate in Clinical Psychology from Rutgers University, Graduate School of Applied and Professional Psychology, and is a past recipient of the university’s Peterson Prize for Community Service. He is also a past recipient of the Visionary Leadership Award from the National Council of Community Behavioral Health, and the Congressional Community Corporate Partnership Award from Hon. Edolphus Towns. His work has twice been recognized with the Gold Medal Award from the Hospital and Community Psychiatry Division of the American Psychiatric Association.

John J. Coppola, MSW

Mr. Coppola is a Past-President of the State Associations of Addiction Services, the national association of state associations that represented substance use disorders services providers and which recently merged into the National Council for Behavioral Health. John has served on numerous national advisory committees, including the SAMHSA/CSAT Partnership for Recovery, the CSAT Recovery Month Advisory Committee, and the National Council of State Legislators Addictions Committee. He has also served and is on a number of regional and statewide advisory committees, including NYS Governor Andrew Cuomo’s Medicaid Redesign Team Behavioral Health Work Group, former NYS Governor David Paterson’s Commission on Juvenile Justice Reform, the Northeast Addictions Technology Transfer Center Advisory Committee, Council on Accreditation, and numerous NYS Office of Alcoholism and Substances Abuse Services workgroups. John also served in an advisory role with the Office of National Drug Control Policy.

Prior to becoming Executive Director of ASAP, Mr. Coppola worked for Catholic Charities of the Diocese of Albany from 1981 through 1996, serving most recently as the Executive Director of Montgomery County Catholic Charities. During his tenure at Catholic Charities, Mr. Coppola served as Chairperson of the Catholic Charities USA Alcoholism and Substance Abuse Committee and as Chairperson of the NYS Catholic Conference Alcoholism and Substance Abuse Committee.

Mr. Coppola received his Master’s Degree in Social Work from the State University of New York at Albany and his Bachelor of Arts in Psychology from Dominican College.

Addiction from page 30

and certification in addiction.

Historically, physicians have been eligible to take the exam to become certified in addiction medicine if they had an unrestricted medical license, were board certified or board eligible in a primary specialty, documented 1 year of practice with patients with substance use disorders, and completed 50 hours of continuing medical education in the field of addiction. More recently, individuals can also become eligible through the completion of an ABAM accredited addiction medicine fellowship program, and it is likely that fellowship training will become a required qualification for certification in addiction medicine within the next several years.

Formal fellowship training in addiction medicine is a groundbreaking step towards increasing the number of addiction physicians and closing the treatment gap. The ABAM Foundation defined required competencies for this training in 2010 and the first ten fellowship programs were approved for accreditation. These programs accept physicians that have trained in a wide range of medical specialties, and training consists of exposure to substance abuse treatment in the inpatient and outpatient settings, consultation-liaison services, and continuity care for individuals with substance use disorders. Today, there are 39 fellowship programs in the US and Canada, and ABAM has set a goal of 65 fellowships by 2020.

In the newly established Fellowship in Addiction Medicine at the Institute for Family Health, fellows will have the opportunity to provide substance abuse treatment in an integrated care model.

Integrated treatment, in which substance abuse treatment (and often behavioral health treatment) is provided in collaboration with primary care services at the same location, allow individuals to receive treatment from a team of treatment providers and increases access to care. Further, integrated treatment models may reduce the stigma that can be associated with seeking substance abuse treatment by providing treatment from clinicians with whom the patient has already developed a therapeutic relationship in a setting that is already familiar to the individual.

Providing comprehensive medical and substance abuse services also enhances recovery. Research has shown that individuals with substance abuse related medical conditions who access primary care services are three times more likely to achieve remission over 5 years and are up to 30% less likely to require hospitalization (Weisner, C, Mertens, J, Parthasarathy, S, Moore, C, and Lu, Y. (2001). Integrating Primary Medical Care with Addiction Medicine. Journal of the American Medical Association, 286(14):1715-1723. doi:10.1001/jama.286.14.1715). Integrated treatment is ideal for meeting the comprehensive needs of individuals with substance use disorders.

The growth of addiction medicine promotes an integrated model of health care and moves to closing the treatment gap. Addiction medicine training expands the workforce of specialist physicians to include a broad array of medical specialties and allows for treatment of a more diverse population in a greater number of clinical settings.

Consumer from page 14

being encouraging in places where care meets the mark and beyond.

Supervisors must believe that the culture of their workplace is supportive of their efforts, that the road they lay out before staff and consumers is a road that works within an agency’s guidelines and ideology. Supervision is where the belief of success becomes part of an agency’s operational procedure. In addition to individual supervision provided to all staff, at ICL, we use such resources as Tip of the Week, which brings thoughtful suggestions on how to approach different consumer problems with compassion. Our month-to-month and internal monthly crisis teams work together to bring integrated care to the neighborhoods where consumers live. When new consumers are coming to an ICL facility, senior clinicians weigh in on high-risk behaviors, comorbidities, histories of aggression and violence, and more through our SARC (Special Admissions Review Committee) team. When staff feels it has exhausted all other interventions, a Clinical Risk Consultation Team (CRCT) can be gathered in which senior staff meets with the consumer and the entire treatment team to formulate a safe and effective care plan.

So we are learning that the best consumer outcomes come from a team approach that starts during individual supervision. It is the agency’s leadership that must support staff who, in turn, help consumers realize that their successes are in a setting where they do get better and where they achieve meaningful lives and true community integration. Effective supervision is an essential component in helping this come to fruition.
treatment settings for three reasons:

1. Some out-of-network facilities may not be able to honor an insurance plan’s treatment guidelines. As a result, patients may not be covered for certain services and would have to pay out of pocket.

2. Close analysis of claims from some treatment centers indicates questionable practices in treatment protocols and in billing patients, families and their insurance companies. A prime area of concern is drug screening through laboratory tests. These tests are often administered inappropriately and far more frequently than necessary, and are billed at rates well beyond the usual and customary charges.

3. Typically, after release from an out-of-network facility, patients return home without a support system. This may trigger a relapse, followed by readmission to another treatment center. Receiving treatment at a facility close to home, however, facilitates communication and the availability of peer support network facilities which people are born, grow, live, work in, and receive care in. This is critically important to helping a consumer move towards recovery. A basic understanding of common terms, an ability to communicate effectively with each of the different service systems, and an ability to help clients navigate those systems is a critical and necessary skill.

New Jersey from page 31

weekly engagement (45 classes), promot- ing growth in theoretical foundations and clinical skills for those just entering the field of addictions, as well as for those who had been employed in the field for some time but lack formal education or training. There is also a marked improvement in the understanding of the nature and development of substance use disorders for credentialed social work and mental health clinicians with little experience treating this population.

This opportunity supported professionals like Elizabeth, LPC, LCADC with Masters in Mental Health Counseling, who gradu- ated from ATWD and now works as a supervisor at Jersey City Medical Center. “Knowing the dynamic layers of mental health care, in regards to substance abuse I came to understand that this emmeshed co- occurring population would require more education on my part to obtain employment and provide competent clinical care.”

What Employers Can Do

Educate: Young adults and/or their families typically select treatment centers in the heat of a crisis. They may not be equipped to research questions or receive any services in the past year. When they do seek treatment, it sometimes falls well short of evid- ence-based practices. Employers should advocate for more evidence based practices within their disability coverage framework and the availability of peer support net- works which support long-term recovery.

Of course, it will take action from every- one with a stake in this issue: employers, health plans and providers — to create better systems for supporting young adults trying to recover from mental illness and/or SUD.

Optum does not recommend or endorse any treatment or medications, specific or otherwise. The information provided is for educational purposes only and is not meant to provide medical advice or otherwise replace professional advice. Consult with your clinician, physician or mental health care provider for specific health care needs. Treatment with their health plans — should implement drug screening and reimbursement policies that follow the recommended guidelines of the Centers for Medicare and Medicaid Services.

Advocate: Two-thirds of young adults with mental illness and/or substance use disorder did not receive any services in the past year. When they do seek treatment, it sometimes falls well short of evidence-based practices. Employers should advocate for more evidence based practices within their disability coverage framework and the availability of peer support networks which support long-term recovery.

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pharmacies with fistfuls of prescriptions and stock their medicine cabinets with droves of agents designed to target primary symptoms, secondary side effects and tertiary complaints that would be more effectively remedied through changes in lifestyle or environment. The conventional approach, of course, is one that has been utilized. Or, one might say, that has been prescribed for the treatment of schizophrenia, diabetes, asthma, hypertension and hypercholesterolemia. If we could only understand the potential contradictions or long-term effects of his specific regimen. He and his treatment providers can simply learn from his experience and consider the experience of others who have held a fervent belief in the safety of their medications because they carried the imprimatur of their manufacturer's. Tardive dyskinesia, Metabolic syndrome, and the like are often the result of the deleterious effects. Nervousness, malaise, and many others constitute the sordid legacy of a longstanding approach to the treatment of behavioral health and wellness. It gives secondary consideration to clinical diagnoses, as these are rapidly evolving and culturally effects of trauma and its repercussions with family and friends, and meaningful activity in the social, vocational and educational realms will address the 90% of the health. A workforce that can realize the potential to support this workforce and there is promising evidence that this is beginning to occur. Many states, including New York, have pursued waivers of federal Medicaid regulations that permit them to apply for Medicaid and the Centers for Medicare and Medicaid Services (CMS), the federal agency charged with oversight of the Medicaid program, recently issued guidance that suggests it is time that health care professionals but in proper proportion to support this workforce and there is promising evidence that this is beginning to occur. The author may be reached via phone (914) 428-2928 or by email at abrody@searchforchange.org.

Homeless from page 32

FURTHER, I direct all local social service districts, police agencies including the New York State Police, and state agencies to take all necessary steps to identify individuals reasonably believed to be homeless and unwilling or unable to obtain shelter and necessary for safe housing in inclement winter weather, and move such individuals to the appropriate sheltered facilities;

FURTHER, I direct all local social service districts to take all necessary steps to extend shelter hours, to allow individuals who are homeless to remain indoors, to instruct homeless service outreach workers to work with other relevant personnel and to work with local police in response to the involuntary transport of at-risk individuals who refuse to go inside and who appear to be at-risk for cold related injuries to appropriate facilities for assessment consistent with the provisions of section 9.41 of the Mental Hygiene Law, and to work in coordination with the State Police and all police agencies to ensure that homeless individuals receive assistance as needed to protect the public health and safety and at all times consistent with the State's Constitution and existing statutes;

FURTHER, I direct all local social service districts to comply with their obligations to ensure that facilities used for temporary housing assistance placements are safe, clean, well maintained and supervised and fully compliant with existing state and local laws, regulations, administrative directives, and guidelines; and

FURTHER, this order shall take effect on January 5, 2016 and supersede all local laws, as well as any local directives, guidance, or policies to the contrary.

GIVEN under my hand and the Privy Seal of the State in the City of Albany this third day of January in the year two thousand sixteen.

By The Governor
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