The Behavioral Health Workforce Crisis: Past, Present, and Future

By Michael B. Friedman, MSW

First on the list of topics for this issue of Behavioral Health News was “The Workforce Crisis Today.” That’s interesting because the workforce “crisis” is anything but new.

For example, when I first entered this field during the height of deinstitutionalization in New York—the early 1970s—there was a vast shortage of English-speaking psychiatrists in the state hospital system. Having the proper credentials was good enough at the time. Never mind being able to communicate with one’s patients; there was paperwork to be signed.

Fortunately, progress has been made. The problem now is finding psychiatrists who speak languages other than English and who have real clinical and cultural competence, especially regarding kids and older adults.

Of course, it was even worse in the years before deinstitutionalization. Staff–patient ratios in state hospitals were often 1 staff to 8 patients. And the quality of the staff—the attendants and others—was often abysmal. Some were lovely, caring people, no doubt, but some were abusive in the extreme and clinically incompetent. Now a minimum is more like two staff per patient. And abuse, especially the officially sanctioned abuse of the old days such as harsh restraint and punitive seclusion, has been significantly reduced if not eliminated. Much better.

How did they manage in the old days? The patients did much of the work. They cleaned the hospitals, cut lawns, cooked meals, chauffeured the hospital directors, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

So, to say it again, a mental health workforce crisis is not new. And since the beginning of the community mental health movement, many somewhat successful efforts have been made to address both the shortage of mental health personnel and their limited clinical, cultural, and—I would add—generational competence. These efforts fall into three broad categories—education and training, recruitment, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

For example, when I first entered this field during the height of deinstitutionalization in New York—the early 1970s—there was a vast shortage of English-speaking psychiatrists in the state hospital system. Having the proper credentials was good enough at the time. Never mind being able to communicate with one’s patients; there was paperwork to be signed.

Fortunately, progress has been made. The problem now is finding psychiatrists who speak languages other than English and who have real clinical and cultural competence, especially regarding kids and older adults.

Of course, it was even worse in the years before deinstitutionalization. Staff–patient ratios in state hospitals were often 1 staff to 8 patients. And the quality of the staff—the attendants and others—was often abysmal. Some were lovely, caring people, no doubt, but some were abusive in the extreme and clinically incompetent. Now a minimum is more like two staff per patient. And abuse, especially the officially sanctioned abuse of the old days such as harsh restraint and punitive seclusion, has been significantly reduced if not eliminated. Much better.

How did they manage in the old days? The patients did much of the work. They cleaned the hospitals, cut lawns, cooked meals, chauffeured the hospital directors, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

So, to say it again, a mental health workforce crisis is not new. And since the beginning of the community mental health movement, many somewhat successful efforts have been made to address both the shortage of mental health personnel and their limited clinical, cultural, and—I would add—generational competence. These efforts fall into three broad categories—education and training, recruitment, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

The Behavioral Health Workforce Crisis: Past, Present, and Future

By Michael B. Friedman, MSW

First on the list of topics for this issue of Behavioral Health News was “The Workforce Crisis Today.” That’s interesting because the workforce “crisis” is anything but new.

For example, when I first entered this field during the height of deinstitutionalization in New York—the early 1970s—there was a vast shortage of English-speaking psychiatrists in the state hospital system. Having the proper credentials was good enough at the time. Never mind being able to communicate with one’s patients; there was paperwork to be signed.

Fortunately, progress has been made. The problem now is finding psychiatrists who speak languages other than English and who have real clinical and cultural competence, especially regarding kids and older adults.

Of course, it was even worse in the years before deinstitutionalization. Staff–patient ratios in state hospitals were often 1 staff to 8 patients. And the quality of the staff—the attendants and others—was often abysmal. Some were lovely, caring people, no doubt, but some were abusive in the extreme and clinically incompetent. Now a minimum is more like two staff per patient. And abuse, especially the officially sanctioned abuse of the old days such as harsh restraint and punitive seclusion, has been significantly reduced if not eliminated. Much better.

How did they manage in the old days? The patients did much of the work. They cleaned the hospitals, cut lawns, cooked meals, chauffeured the hospital directors, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

So, to say it again, a mental health workforce crisis is not new. And since the beginning of the community mental health movement, many somewhat successful efforts have been made to address both the shortage of mental health personnel and their limited clinical, cultural, and—I would add—generational competence. These efforts fall into three broad categories—education and training, recruitment, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

The Behavioral Health Workforce Crisis: Past, Present, and Future

By Michael B. Friedman, MSW

First on the list of topics for this issue of Behavioral Health News was “The Workforce Crisis Today.” That’s interesting because the workforce “crisis” is anything but new.

For example, when I first entered this field during the height of deinstitutionalization in New York—the early 1970s—there was a vast shortage of English-speaking psychiatrists in the state hospital system. Having the proper credentials was good enough at the time. Never mind being able to communicate with one’s patients; there was paperwork to be signed.

Fortunately, progress has been made. The problem now is finding psychiatrists who speak languages other than English and who have real clinical and cultural competence, especially regarding kids and older adults.

Of course, it was even worse in the years before deinstitutionalization. Staff–patient ratios in state hospitals were often 1 staff to 8 patients. And the quality of the staff—the attendants and others—was often abysmal. Some were lovely, caring people, no doubt, but some were abusive in the extreme and clinically incompetent. Now a minimum is more like two staff per patient. And abuse, especially the officially sanctioned abuse of the old days such as harsh restraint and punitive seclusion, has been significantly reduced if not eliminated. Much better.

How did they manage in the old days? The patients did much of the work. They cleaned the hospitals, cut lawns, cooked meals, chauffeured the hospital directors, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

So, to say it again, a mental health workforce crisis is not new. And since the beginning of the community mental health movement, many somewhat successful efforts have been made to address both the shortage of mental health personnel and their limited clinical, cultural, and—I would add—generational competence. These efforts fall into three broad categories—education and training, recruitment, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

The Behavioral Health Workforce Crisis: Past, Present, and Future

By Michael B. Friedman, MSW

First on the list of topics for this issue of Behavioral Health News was “The Workforce Crisis Today.” That’s interesting because the workforce “crisis” is anything but new.

For example, when I first entered this field during the height of deinstitutionalization in New York—the early 1970s—there was a vast shortage of English-speaking psychiatrists in the state hospital system. Having the proper credentials was good enough at the time. Never mind being able to communicate with one’s patients; there was paperwork to be signed.

Fortunately, progress has been made. The problem now is finding psychiatrists who speak languages other than English and who have real clinical and cultural competence, especially regarding kids and older adults.

Of course, it was even worse in the years before deinstitutionalization. Staff–patient ratios in state hospitals were often 1 staff to 8 patients. And the quality of the staff—the attendants and others—was often abysmal. Some were lovely, caring people, no doubt, but some were abusive in the extreme and clinically incompetent. Now a minimum is more like two staff per patient. And abuse, especially the officially sanctioned abuse of the old days such as harsh restraint and punitive seclusion, has been significantly reduced if not eliminated. Much better.

How did they manage in the old days? The patients did much of the work. They cleaned the hospitals, cut lawns, cooked meals, chauffeured the hospital directors, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

So, to say it again, a mental health workforce crisis is not new. And since the beginning of the community mental health movement, many somewhat successful efforts have been made to address both the shortage of mental health personnel and their limited clinical, cultural, and—I would add—generational competence. These efforts fall into three broad categories—education and training, recruitment, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.
Behavioral Health News

Honor Roll of Sponsors

Gold Sponsor

ICL
WellLife Network

Silver Sponsor

Services for the UnderServed

Behavioral Health News Sponsorship Opportunities

Platinum Sponsor: $6,000

- One Full Page advertisement and article space in four quarterly issues
- Logo with link on Sponsors Page and free website postings of special events
- 100 copies of each issue for distribution to clients, staff, board members, and satellite programs

Gold Sponsor: $4,000

- One Half Page advertisement and article space in four quarterly issues
- Logo with link on Sponsors Page and free website postings of special events
- 100 copies of each issue for distribution to clients, staff, board members, and satellite programs

Silver Sponsor: $2,500

- One Quarter Page advertisement and article space in four quarterly issues
- Logo with link on Sponsors Page and free website postings of special events
- 50 copies of each issue for distribution to clients, staff, board members, and satellite programs

Bronze Sponsor: $1,500

- One Eighth Page advertisement and article space in four quarterly issues
- Logo with link on Sponsors Page and free website postings of special events
- 25 copies of each issue for distribution to clients, staff, board members, and satellite programs

Advisor Sponsor: $500

Friend Sponsor: $250

All Sponsors will receive recognition listing in print on the honor roll page in Behavioral Health News as well as on the publication’s website

To Discuss our Sponsorship Opportunities Please Contact

Ira H. Minot, LMSW, Executive Director
Mental Health News Education, Inc.
460 Cascade Drive, Effort, Pennsylvania 18330

E-mail: iraminot@mhnews.org Phone: (570) 629-5960
Table of Contents: Caring for Older Adults

1 The Behavioral Health Workforce Crisis
1 Leaders Honored at MHNE Annual Awards Reception
4 New Mental Health Parity Laws in New York State
5 Strengthening the Addiction Workforce and Beyond
6 Parity’s Impact on the Behavioral Health Workforce
8 Self-Care is Essential to Well-being at Work
10 Millennials in the Workplace: Investing in a Generation
12 An Effective Work Force Drives Integrated Care
14 A Dedicated but Neglected Workforce: A Call for Change
15 Peers in the Workforce: Reversing Misconceptions
16 Licensed Practical Nurses: Furthering Integrated Health
17 Behavioral Health Care: How Far We’ve Come in 15 Years
18 Addressing the Human Services Workforce Crisis
19 Primary Care Integration: Alternative Workforce Strategies
20 Staff Development at the MHA of Westchester
21 Needs-Based Toolkit for Peer Workforce Integration
21 Jason Lippman Joins Beacon
21 MHNE 20th Anniversary Retrospective
22 Peers: An Essential Component to the Workforce
22 Workplace Stress and Compassion Satisfaction
23 CBC-Pathway Home Wins 2019 Heritage Award
23 Housing Workforce Left Short in State Budget
24 New Management Services Organization for Providers
24 Perceptions of Telephone-Delivered Mental Health Services
25 Meeting the Workforce Challenge at Outreach
25 Adding Recovery Professionals to the Continuum of Care
26 The Impact of Youth Peer Advocates: Early Findings
26 The Center for Practice Innovations
27 CRPA and CHW Training and Workforce Transformation
27 Determinants of Health and Peer Advocates Training
28 Rural Workforce Development: Critical Challenges
28 CoveCare Center Hosts 2nd Annual LGBTQ+ Pride Event
29 Investing in the Integrated Care Workforce
29 Creating a Family Peer Support and Services Workforce

Behavioral Health News
Theme and Deadline Calendar

Fall 2019 Issue:
“Models of Integrated Care”
Deadline: September 16, 2019

Winter 2020 Issue:
“Addressing the Nation’s Opioid Epidemic”
Deadline: December 23, 2019

Spring 2020 Issue:
“Housing: An Essential Element of Recovery”
Deadline: March 18, 2020

Summer 2020 Issue:
“The Suicide Crisis in America”
Deadline: June 17, 2020

To Submit an Article or Advertisement
Call: (570) 629-5960 Email: iraminot@mhnews.org
Visit Behavioral Health News: www.mhnews.org
New Mental Health Parity Laws in New York State

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

About one in five New Yorkers require behavioral health services, but many do not receive treatment because of a lack of access to insurance coverage. More than 10 years ago, the federal Mental Health Parity and Addiction Equity Act required large group health plans that provide mental health coverage to do so at levels comparable with medical services.

And yet national studies continue to reveal significant challenges with accessing behavioral health services for individuals and families even if they have comprehensive health insurance coverage. Individuals and families often experience higher out-of-pocket use, lower reimbursement and restrictions on coverage for needed behavioral health services including mental health services and treatment for addiction.

Fortunately, Governor Andrew Cuomo included critical parity and insurance reforms in his 2019 Justice Agenda, and these new laws and regulations will help guarantee access to mental health care for all New Yorkers. These laws require that insurers apply the same standards for access to mental health and addiction treatment services as they do to medical and surgical care. Some of the strongest and most effective in the nation, these laws will offer additional protections to individuals in need of mental health services and will provide them with help if they feel these laws are not being followed. We now have a clear blueprint to ensure real parity!

Community Health Access to Addiction and Mental Healthcare Project (CHAMP)

In order to help all New Yorkers access insurance coverage for substance use disorders and mental health services, Governor Cuomo and members of the State Legislature created the Community Health Access to Addiction and Mental Healthcare Project (CHAMP).

Health Access to Addiction and Mental Healthcare Project (CHAMP)

CHAMP, an ombudsman program developed in partnership with the Community Service Society, the New York State Council for Community Behavioral Healthcare, The Legal Aid Society, the Medicare Rights Center, and the Legal Action Center, will assist individuals and families in obtaining their legal rights to insurance coverage, helping them to access treatment and services, and resolving complaints regarding denial of health insurance coverage.

The program can help participants by: Listening to their concerns and complaints; Educating participants about their insurance rights; Empowering participants to advocate for themselves and work successfully with treatment providers to address insurance concerns; Helping to address barriers to treatment they need, including medication; and Getting the most from their insurance coverage for substance use disorder and mental health services.

Helpline representatives may be able to resolve concerns immediately, or will enlist the expertise of dedicated CHAMP legal, substance use disorder, or mental health specialists to address the issue. Participants can be assured of timely, respectful, and culturally sensitive assistance with concerns regarding: Access to treatment; Denial of services; Access to medication; Parity/coverage discrimination issues; System navigation; Medical benefits; Enrollment referral; and Legal assistance for insurance appeals.

Consumers and providers can get help from CHAMP by calling the new helpline number (888-614-5400) or by writing to ombuds@oasas.ny.gov.

Additional New Parity Laws and Regulations

Under Governor Cuomo’s leadership, New York has enacted additional tough new laws and regulations that will: Prohibit prior authorization for minors entering inpatient psychiatric treatment and prohibit concurrent utilization review during the initial 14 days of treatment; Prohibit insurers from requiring prior authorization to receive medication-assisted treatment (MAT) for substance use disorders (SUDs) and extending the time period for concurrent review for inpatient and outpatient addiction treatment; Require insurers’ medical necessity criteria for mental health services be reviewed and approved by the Office of Mental Health; Limit patient co-payments for outpatient mental health services and SUD treatment to the equivalent cost of a primary care visit and limiting co-payments for outpatient SUD treatment to one per day; Require network adequacy that provides for timely access to providers; and Codify key parity standards in State law for both MH and SUD benefits.

Governor Cuomo also signed the Mental Health and Substance Use Disorder Parity Reporting Act (Chapter 455; Laws of 2018), which requires health plans to submit key data to the Department of Financial Services (DFS) to ensure compliance with State and Federal Parity Laws. DFS will post this information on its public website, allowing consumers and healthcare providers to determine how well insurers comply with the Parity Act.

This builds upon last year’s implementation by DFS of a new regulation that required insurers to include in their policies a process for insureds, their designees or prescribers to request a review of a decision that a medication for detoxification or maintenance treatment of a substance use disorder drug is not covered by the policy.

Under that regulation, every insurer that provides hospital, surgical, or medical expense coverage and also provides coverage for medication for the detoxification or maintenance treatment of a substance use disorder must include in the policy processes that allow an insured, the insured’s designee, or the insured’s prescribing physician to request a formulary exception and gain access to clinically appropriate medication for the detoxification or maintenance treatment of a substance use disorder not otherwise covered by the policy.

Insurers must make determinations on standard exception requests and notify the insured, or the insured’s designee, and the insured’s prescriber no later than 72 hours after the request. It also required insurers to have a process for expedited formulary exception requests based on exigent circumstances and make determination and notification no later than 24 hours after such requests.

New York has been a leader in advancing parity during the past decade, with early passage of Timothy’s Law, protections for the integration of behavioral health services into Medicaid managed care and reforms to address the opioid epidemic. This package of new laws will help to improve access to insurance coverage for substance use disorder and mental health services and will help eliminate barriers, increase accountability among insurers and health plans, and ensure that New Yorkers receive all the benefits they are entitled to.

SAVE THE DATE for the 4th Annual NYS Suicide Prevention Conference

SEPTMBER 18 & 19, 2019
DESMOND HOTEL AND CONFERENCE CENTER, ALBANY, NY

The 2019 New York State Suicide Prevention Conference will showcase the work being done across the state in a variety of settings, including community, schools, clinical, and academic.

The event will feature presentations highlighting recent developments in suicide prevention, including working with diverse populations, community coalitions, schools and college campuses, health systems, and advancements in surveillance data.

Other highlights include remarks by OMH Commissioner Dr. Ann Sullivan, presentations by the New York State Suicide Prevention Council and the Governor’s Suicide Prevention Task Force, a networking session, a poster session and display of the American Foundation for Suicide Prevention quilt.

For information, visit: www.nyssuicidepreventionconference.org
Many employers have already found the benefit of hiring recovering people into their workforce and the Recovery Tax credits will be used to attract those instances. Recovering individuals are not only dependable, reliable and hard-working employees but they can also have a positive impact on their colleagues who may be suffering from addiction themselves or are struggling with a family member or loved one who is addicted. The Recovery Tax Credit program makes recovering individuals even more attractive to employers and helps reduce the stigma that has plagued those recovering from addiction. It is an investment in the recovery capital that individuals have built through their recovery and it will go a long way to reaching others in workplaces that are struggling with addiction.

OASAS also ensures that staff working in the continuum of prevention, treatment and recovery services are competent in delivering addiction service by providing credentialing for SUD and gambling prevention and treatment professionals. OASAS also provides training for other medical and behavioral health professionals working in our system. Currently, no other NYS licenses/certifications require addiction competencies as part of their required pre-service coursework or examinations. Many professionals voluntarily seek out elective coursework during their pre-service education and may obtain addiction credentials/certifications in the course or their career, but addiction competencies are not part of obtaining a medical or behavioral health license in NYS, which is why OASAS must continue to credential addiction professionals and require additional addiction training for those working in our services.

Prevention staffing guidelines require all Prevention Directors and a percentage of staff to have either an OASAS prevention credential or a related certification (i.e., Teaching, Health Education, Social Work) along with SUD prevention specific coursework and experience. OASAS also requires that all new Prevention Specialists complete a Substance Abuse Prevention Skills Training (SAPST) course within their first year of employment in an OASAS funded Prevention Program. The SAPST is a blended learning course consisting of a 5-hour online course and a 4-day face to face course. The course was developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to give Prevention Specialists a foundational training in the SUD prevention framework.

Treatment staffing requires a multi-disciplinary team format. Most levels of care require a Medical Director with a DATA 2000 Waiver, which allows them to dispense addiction medications. Many programs also employ Nurse Practitioners and Physician Assistants with DATA 2000 waivers to extend their ability to provide addiction medications for their patients/clients. Nursing staff are also a required component of many levels of care. Additionally, programs include Credentialled Alcoholism and Substance Abuse Counselors (CASACs) and other licensed, Social Workers, Mental Health Counselors and/or Marriage and Family Therapists. Many programs also employ vocational counselors, and some have recreation therapists.

In 2018, OASAS implemented a SUD Counselor Scope of Practice which outlines a career ladder for SUD Counselors and indicates which clinical skills each level can perform and what level of supervision is required for each level. All Supervisors must at a minimum have a national credential or state licensure and a bachelor’s or master’s degree. Supervisors must also complete a 30 Hour Clinical Supervision course to be at the Advanced or Master Level and to supervise clinical staff. Additionally, all staff are required to complete training in Medication Assisted Treatment/Recovery, SUD Ethics, SUD Confidentiality and other addiction coursework as a minimum requirement for their orientation. All programs are required to document that staff meet and maintain their credentials and complete the orientation coursework. OASAS also offers, at least monthly, free, online training on pertinent addiction topics which includes a year long series on Ethics which can be accessed at: https://www.oasas.ny.gov/testportal/ LTcourses.cfm. Additionally, free regional trainings are offered throughout the state and can be found at: https://www.oasas.ny.gov/ workforce/training/oasastraining.cfm.

Along with treatment services, recovery services have expanded throughout the state. Community based recovery services are now available in all regions and in many communities across NYS. The Peer Workforce are the newest members of the SUD workforce. In 2013, OASAS approved the New York Certification Board (NYCB), a subsidiary of the New York Alcoholism and Substance Abuse Providers (ASAP), to certify Certified Recovery Peer Advocates (CRPAs). Since then more than 1,100 CRPAs have been certified and may now perform Peer Services in OASAS outpatient clinics and those services can be reimbursed by Medicaid and Managed Medicaid.

see Addiction Workforce on page 38
Mental Health Parity and Its Impact on the Behavioral Health Workforce

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

In 2006, New York enacted a parity mandate in the form of Timothy’s Law, which requires group health plans to provide 30 inpatient days and 20 outpatient days for most mental health diagnoses and requires large plans to provide full coverage for certain biologically based illnesses. Several years later, Congress enacted the federal Mental Health Parity and Addiction Equity Act, which expanded Timothy’s Law into a full parity benefit. Despite these hard-won legislative successes, full implementation and enforcement of parity requirements has yet to be achieved and challenges remain, particularly in the context of parity in reimbursement and parity in utilization review. These areas often have a significant impact on the behavioral health workforce and their ability to receive adequate reimbursement for the essential care and treatment they provide to patients in need.

This article will address some recent legislative and litigation-related successes in New York and in other jurisdictions as well as additional advocacy work that is still needed in the parity arena.

Behavioral Health Insurance Parity Reforms

One recent success involves the 2019-20 New York State Budget, which included a comprehensive overhaul of the New York Insurance Law seeking to eliminate discrimination in coverage of care and treatment for mental health conditions, substance use disorders and autism spectrum disorders. These new provisions, called Behavioral Health Insurance Parity Reforms (BHPR), apply to all health insurance and health benefit plans offered in New York State, including individual plans, group plans and HMOs.

The following are some of the key provisions of the BHPR:

- Coverage for all mental health conditions, substance use disorders and autism spectrum disorders, as defined in the most recent edition of DSM or ICD;
- Prohibits preauthorization and concurrent review of substance use disorder services during the initial 28 days of inpatient and outpatient treatment;
- Prohibits preauthorization and concurrent review of psychiatric inpatient services for persons under the age of 18 for the first 14 days;
- Prohibits prior authorization for formulaic forms of prescribed medications for treatment of substance use disorders;
- Medical necessity criteria must be made available to insureds, prospective insureds, or in-network providers upon request;
- Prohibits taking any adverse action in retaliation against a provider filing a complaint, making a report, or commenting to a government body regarding policies and practices that violate the law;
- Requires insurers and health plans to post additional information regarding their in-network providers of mental health and substance use disorder services, including whether the provider is accepting new patients as well as the provider’s affiliations with participating facilities certified or authorized by OMH or OASAS; and
- Provides additional funding resources for staffing at DFS and DOH to handle oversight and enforcement of parity.

Self-insured plans are not subject to these new provisions, but remain subject to the federal parity law and regulations. The BHPR provisions take effect January 1, 2020 and apply to all policies issued, renewed, modified or altered after that date.

Landmark Mental Health Ruling in Class Action Suit

A second success in the fight for full implementation of the parity statutes took place earlier this year, when the U.S. District Court for the Northern District of California held that United Behavioral Health (UBH) illegally denied coverage of mental health and substance use disorder treatment by relying on flawed medical necessity criteria (Wit v. United Behavioral Health, Findings of Fact and Conclusions of Law, Case No. 14-cv-02346-JCS, (N.D. Cal. Mar. 5, 2019), ECF No. 418). The Court found that UBH was liable under ERISA for developing restrictive medical necessity criteria that deviated from generally accepted standards, resulting in systematic denials of outpatient, intensive outpatient and residential treatment. Although UBH has indicated publicly that it plans to appeal the decision, this is an important breakthrough because the Court acknowledged that UBH’s utilization review activities appear designed to limit coverage and therefore reduce access to necessary behavioral health care and treatment. Although the class action suit did not address parity issues, targeting the treatment of mental illness for medical necessity reviews constitutes a pattern and practice of impermissible discrimination that may also violate the federal Mental Health Parity and Addiction Equity Act.

In the 106-page decision, the Judge noted: “...in every version of the Guidelines in the class period, and at every level of care that is at issue in this case, there is an excessive emphasis on addressing acute symptoms and stabilizing crises while ignoring the effective treatment of members’ underlying conditions.” He further noted that UBH’s guidelines appear to be aimed at reducing costs rather than fiduciary duties owed to beneficiaries and reflected “a ‘utilization management’ model that keeps benefit expenses down by placing a heavy emphasis on crisis stabilization and an insufficient emphasis on the effective treatment of co-occurring and chronic conditions.”

Evaluation and Management Claims

On the other hand, there remain significant issues with reimbursement for behavioral health services that directly impact providers and must be addressed. Recently, two NYSPA members received denials of evaluation and management (E/M) codes by a commercial carrier in connection with combination psychotherapy claims. During the course of a post-payment documentation audit, the carrier took the position that “the use of...
Join the Best Team in New York State

WellLife Network’s culture of caring, commitment and extraordinary generosity towards its employees and the communities it serves makes it a first choice among professionals looking for a rewarding career in the Healthcare and Social Services field.

APPLY NOW AT:  www.WellLifeNetwork.org/Careers
or CALL: 718.559.0516

WellLife Network Executive Offices 142-02 20th Avenue, Flushing, NY 11357

America’s Best in-State Employers have been identified based on an independent survey by Forbes Media, LLC from a vast sample of 80,000 U.S. employees working for companies employing at least 500 in their U.S. operations. WellLife Network was selected from thousands of companies located in New York State and was evaluated in the category of Healthcare & Social Services.
Self-Care is Essential to Well-being at Work

By Lisa Furst, LMSW, MPH
Assistant Vice President, Center for Policy, Advocacy and Education, Vibrant Emotional Health

By now, “self-care” and “workplace wellness” aren’t novel concepts. It would be difficult not to find myriad references to both in the popular and professional press. Many organizations, including in the private sector, healthcare and government have embraced employee wellness programs, seeking to improve staff health, morale and productivity. But could well-being - or lack thereof - in the workplace actually be a public health issue? The World Health Organization thinks it is, reporting in May 2019 that burnout is a “syndrome” that is the direct result of “chronic workplace stress that has not been successfully managed (World Health Organization 2019, Burnout an “occupational phenomenon”: international classification of diseases. https://www.who.int/mental_health/evidence/burnout/en/ Accessed June 12, 2019).” The implications of this are significant for the behavioral health workforce, which works to address both the ongoing needs and emergent crises of some of the most vulnerable populations in New York State and is subject to significant workplace stress.

Workplace stress can be understood as harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the employee (National Institutes of Safety and Health 2007, Workplace Stress. https://blogs.cdc.gov/niosh-science-blog/2007/12/03/stress/ Accessed June 12, 2019). But what makes working in behavioral health stressful? While clinical practice, direct care and program administration all provide their share of stressors, many people in our sector would point to persistent systemic and organizational factors that induce or exacerbate workplace stress. These are numerous, but some of the most significant include: (1) Heavy workloads or caseloads with demanding documentation requirements; (2) Inadequate funding, leading to staff shortages and salaries that do not meet the cost of living; (3) More work than can be accomplished during a regular shift or work day; (4) Not having adequate supervision to support best practices and to address the effects of regular exposure to learning about the traumatic experiences of those we serve. So, what can behavioral health organizations do to promote wellness for its workforce?

Workplace wellness, while often conceptualized as something individual employees engage in on their own, starts with an organization’s commitment to creating a culture in which staff feel respected, engaged, and supported so that they can provide high quality services to consumers. There are many ways to develop an organizational culture of wellness. Some examples of steps that organizations can take to foster employee well-being include:

Create a Listening Environment: Have regular staff meetings; Ensure staff have consistent supervision time to discuss their work; Engage staff in conversations about their work and organizational operations and put their suggestions into practice, wherever possible.

Foster a Culture of Acknowledgement: Celebrate staff successes— and not just the large ones; Reward excellent performance; and Explicitly recognize how central staff are to achieving organizational goals.

Encourage Movement: Create and promote opportunities for exercise, such as group lunchtime walks; Engage local resources, like gyms or health clubs, to provide reduced memberships for staff; and Organize lunch-and-learn sessions to teach chair yoga, stretching, and breathing exercises that can be done at work.

Ensure a Healthy Workspace: Find ways to reduce environmental stressors, such as noise pollution, inadequate or harsh lighting, and outdated equipment that is difficult to operate; Develop a workplace safety plan to help staff defuse consumer crises and address emergencies that threaten to disrupt program operations – and make sure that everyone knows how to enact those plans; and Promote existing resources to which employees can turn for help when dealing with emotional distress, and encourage staff to use them where indicated.

And what can we in the behavioral health workforce do to take care of ourselves while we’re at work?

First, it’s important for us to acknowledge that taking care of ourselves is critically important when the primary focus of our job is to care for others. While some of the workplace stressors we experience are common across various sectors – tight deadlines, for instance – the behavioral...
Join the family

MHS is the proud publisher of the Conners family of solutions for thirty years and trusted deliverer of quality online and digital experiences.

Trust in the Conners family to provide:

- **Easy online assessment** that includes scoring and three detailed, visual report options at no additional cost
- **Improve the impact of your intervention** and treatment strategies by identifying specific challenge areas to work on
- **Reliable instruments** developed with highly representative normative samples and strong psychometric properties
Millennials are now the largest age demographic in the country and the fastest growing cohort in the workforce. Based on U.S. Bureau of Labor statistics, it is projected that by the end of next year millennials will make up 47 percent of the employees in the workplace, and five years later they will exceed 75 percent of the entire workforce. Given these statistics, it benefits organizations to tap into what motivates and appeals to this demographic in order to attract and retain the best talent.

Workplace trends and research on the millennial generation (generally categorized as born between 1981 and 1996), find that one of the most important characteristics for this age group is that they are primed to do well by doing good. Almost 70 percent say that giving back, being civically engaged, having opportunities for social impact, and making a difference are their priorities.

Purpose Over Paycheck

They don’t just work for a paycheck, they work for a purpose. That millennials are driven to be socially engaged is good news for behavioral health care providers. When we asked our millennial staff members why they chose to work for Odyssey House, their responses were on target with workplace trends for their generation. When accounts payable specialist Wendolin Pantaleon graduated from college with a BA in Accounting, she hoped to work for an organization where she could make a “meaningful impact in her community.” She would pass by Odyssey House facilities in the South Bronx on her way home from college and was interested in pursuing opportunities to give back in her neighborhood. For Wendolin, presented with a choice of potential employers, she chose an organization with a reputation for investing in local services and investing in its workforce.

Other trends show the millennial employee is very interested in feedback on his or her performance. Millennials have received adult feedback throughout their earlier years. They’ve often had close involvement from parents in their education and individual support and encouragement from teachers and mentors at school. The contrast can be jarring when they arrive at their first professional position and suddenly only get traditional semi-annual or annual reviews. For them it’s too infrequent, they crave feedback, good and bad.

At Odyssey House we have supervision schedules where employees are given feedback on a consistent basis. They receive formal supervision up to twice a month, depending on their job title, and more than that if necessary. Along with tuition reimbursement allowances, employees who are pursuing further education, advanced degrees, certifications or licenses receive additional structured supervision from a certified instructor.

Teamwork and Engagement

Another key workplace expectation for this generation is an emphasis on teamwork. Many millennials have grown up under parenting styles that supported empowerment, where the kids were included in family decision-making. Now, as they enter the early stages of their careers, millennial employees look for employment with organizations that foster an employee-driven decision-making process. Not only do they want to share responsibility and decision-making, they want to discuss their ideas and be taken seriously as problem solvers.

When Elizabeth Gary found out Odyssey House was looking for social workers to work with pregnant women and mothers with infants at its newly renovated Family Center on Ward’s Island, she was excited to be a part of a family-focused service. For her, the Healthy Mothers, Healthy Families program that brings extended family members into the recovery process and provides young mothers with continuity of care after completion of residential treatment was a therapeutic approach that made sense and inspired her to apply to an organization that she says “has progressive programs where what I do has a meaningful impact and makes a difference every day.”

Adding to the sense of purpose she derives from her work with families, Elizabeth said she is further motivated by having a voice in the creation of the program. “Everyone asks me my opinion, and it’s really great to be encouraged to have input.”

Are you looking for an opportunity to make a difference?

Work for Odyssey House!

Odyssey House is a dynamic, rapidly expanding organization offering a range of full-time, part-time and weekend opportunities within the human services field. Our employees earn competitive salaries and a full spectrum of benefits, including health, dental and vision insurance, tuition reimbursement, and generous paid time off.

View current job listings at LinkedIn. If one of the opportunities matches your skills and experience, apply online or email your résumé and a cover letter to jobs@odysseyhousenyc.org.

Odyssey House
Where recovery gets real

212.361.1600 / odysseyhousenyc.org
Children and adolescents are treated in distinct, age-appropriate programs with the treatment milieu focused on each age group’s developmental issues. Each unit, led by a multi-disciplinary clinical team, mirrors a school setting that promotes shared competencies and encourages bonding. Family/caregivers are a primary focus within all age groups and we encourage their active participation.
The behavioral health sector has been in the throes of a generational change over the past decade, one that has challenged the very way we offer treatment, organize operations and receive funding for our services. Our agencies have worked hard to adapt to these changes while maintaining the strongest commitment to the people we serve and the quality of their care.

Among the most significant challenges has been in preparing our workforce for the shift to integrated care. Fortunately, ICL had long understood the importance of treating both the physical and mental health needs of an individual as well as the impact of their total life experience – the social determinants of health. As far back as 2011, our agency was awarded a SAMHSA grant to support a “whole health” perspective that addressed the critical importance of person-centered care.

One of the most significant challenges of the shift to integrated care has been how to help staff incorporate this approach into their work to best serve clients. ICL recognized that this whole health perspective required a completely new way of looking at practice. In 2013, when David Woodlock became ICL CEO, he brought with him a longstanding commitment to integrated care that was central to his plans for the agency. While integrated, person-centered care had already begun to be practiced at ICL, under his leadership, the agency moved toward more formalized training by identifying four pillars of care – otherwise known as TRIP – care that was trauma-informed, person-centered, integrated and recovery-oriented. This became the centerpiece of training and ongoing education at ICL and would come to be shared with staff at all levels – from social workers to fee clerks, from case managers to office managers.

Understanding Social Determinants of Health

This new paradigm in care has meant reshaping ICL services through an integrated care lens and giving staff a deeper understanding of who they are serving – people in poverty, in distressed, under-served and highly diverse communities and the multiplicity of factors affecting their lives – the Social Determinant of Health. What sets apart ICL is that in our widely varying programs, all staff are now trained to address medical issues with clients. Workers helping people with serious mental illness now ask about their diet, how their blood pressure is, if they are taking insulin for diabetes. We encourage and track our clients getting flu shots and having ‘her’ A1c tested. Among the many tools we offer staff is a Healthy Living Workbook with tools and tips for assessing and improving health status of all clients.

For the past decade, we have been writing and discussing individuals with “co-morbidities” – who have both a psychiatric illness and a medical diagnosis such as diabetes, asthma or high blood pressure. In the process of building a more whole health approach to care, we’ve sought to break the cycle of emergency room usage and hospitalizations for both physical and mental health reasons. Driving our work is the staggering statistic that individuals with serious mental illness die 25 years earlier than the general population. Part of SAMHSA’s mission has been to urge providers to think about integrated care by incorporating Wellness Self-Management throughout all areas of programming and over the past ten years there has clearly been a positive shift in this direction.

At ICL, our outcomes are measured through twice yearly surveys – and the results have been consistently impressive. In 2018, for example, 98% of client say they feel more in control of their lives and more connected to family and community. Once again, SAMHSA recognized our work in 2017 when they selected ICL as only one of three agencies from around the country with their Wellness Award for improving health outcomes for clients with serious health challenges.

At the core of our shift to a more integrated care model is our commitment to and respect for our dedicated staff, who are always poised to learning and advancing new ideas. As a result of the intensive training we offer throughout the year, staff at all levels are developing and refining new treatment tools. Whether an inpatient setting or outpatient clinic, whether delivering services in the home, in a shelter or providing street outreach, ICL staff have become increasingly skilled at addressing both the emotional and physical needs of the people they work with.

All of this represents a major shift for staff, particularly people trained in behavioral health, where assessments were historically focused on past psychiatric hospitalizations, substance use history and other psychosocial stressors. While this remains critically important information in care planning, we understood it was simply not enough. We came to understand the need to “know all the facts” of a person’s life, including their physical health status.

Bringing the Whole Health Model to the Next Level

ICL’s embracing of an integrated care model took on even greater significance with the opening last Fall of our East New York Health Hub. After years of planning with community partners and funders and builders, ICL opened a spectacular 43,000 square foot center designed with the health of the community top of mind. A number of critical ICL programs including Family Resource Center, PROS, ACT teams and our Highland Park Clinic, moved into the space. But the Hub is far more than about co-location. It is about giving access for the people of East New York to the finest health and behavioral health services.

Our innovative health care partner in the Hub is Community Healthcare Network (CHN), a highly regarded organization that operates 13 Qualified Health Centers (QHCs) around the city and shares our vision for maximizing care that addresses all aspects of a person’s life. While our two organizations operate under very distinct and sometimes contradictory regulations and have different cultures, from the beginning we have had an open dialogue and were open to learning from each other as we fine-tune the workings of the Hub. One of the principles we’ve both adopted is the understanding that people coming to the Hub are not a client of CHN or ICL — they are being served at the Hub; together we ensure people get the best and most integrated care possible.

Accomplishing true service integration at the Hub is not easy but the Altman Foundation and New York Community Trust are generously supporting our development of shared policies, procedures and workflows to standardize provision of care. Through this comprehensive service and information coordination between our organizations is critical for us to reach the best possible outcomes for the people we serve.

ICL and CHN staff meet regularly to address concerns and challenges; they also socialize and celebrate holidays, reflecting the importance of relationship-building that is at the heart of good practice.

Because in the end, good practice is still what drives us, especially in the face of major changes in the health care system. We continue to be guided by the roots of social work education and clinical practice and their emphasis on relationship-building, engagement and establishment of trust as rudimentary tenets in building rapport with individuals seeking services. In addition to adapting new tools and approaches, those working in direct care must still learn the fundamental skills of empathy, compassion, employ unconditional regard, demonstrate respect for cultural differences, and pay close attention to social justice, oppression and marginalized communities.

Ultimately the success of the paradigm shift in integrated care rests on our respect for our clients and the experiences that have affected them throughout their lives. This is the necessary first step to real recovery.

So while we’ve been at work rethinking how we provide services and want to help staff incorporate new approaches into their work, we have not lost sight of our core values and our mission that people get better with us. Our health care system is in constant evolution – we are confident that the work we are doing at ICL will continue to move the needle on health care that improves lives. Our staff are fully dedicated to be part of this incredibly important moment in history and to providing meaningful and impactful care to people in the 21st century — care that changes lives.
Join the Team!

Working at the Institute for Community Living is much more than a job.

Wherever you work at ICL, whatever your job – you’ll have a real and lasting impact on the lives of the 10,000 people we help each year.

With more than 1,200 employees, ICL has a wide range of job opportunities at our health, behavioral health, residential and family and child service programs in location across the five boroughs.

People get better with us! Join the team that makes that possible.

http://www.iclinc.org  |  (212)-385-3030 ext. 13015
A Dedicated but Neglected Workforce: A Clarion Call for Change

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

The social service agencies on which vulnerable New Yorkers depend rely heavily on the state government for financial support inasmuch as they act as extensions of it in fulfilling many responsibilities that would otherwise be borne by the public sector. Nevertheless, the period following the Great Recession (i.e., 2011 to the present) has been marked by a massive governmental divestment in the private nonprofit human services sector with predictably deleterious effects on many organizations, their dedicated workforces, and the individuals entrusted to their care.

This has occurred despite steady growth in the state economy in recent years and a corresponding increase in inflation-adjusted state disbursements for other sectors and services. For instance, financial aid for public schools has risen at an annual average rate of 4.6% during this period. State Medicaid expenditures have increased by 3.8% per year. By contrast, however, state aid for human services has decreased by 26% between 2011 and 2018 (The New School Center for New York City Affairs, 2019). This bifurcation betrays the deficit inherent in a 2% spending “cap” that has been invoked selectively and led to unforced austerity within some, but clearly not all, industries. This spending cap began in effect since 2012 but applies only to the “state operating funds” component of the annual state budget. Operating funds constitute little more than half of the budget and exclude federal aid and other resources. Furthermore, as illustrated by the foregoing trends, this cap applies to operating funds in the aggregate and not to specific expenditures itemized therein. Spending that exceeds the cap for select programs and services necessitates draconian reductions for others in order to ensure total spending does not exceed statutorily prescribed limits. The human services sector has borne the brunt of this budgetary balancing act.

It is therefore not surprising that nonprofit human services organizations have experienced unprecedented challenges in recruiting and retaining qualified personnel, as rapidly diminishing revenue has rendered them incapable of offering anything more than modest compensation for extraordinarily challenging work. A recent survey of 126 community-based behavioral health service agencies representing 14,499 employees revealed statewide personnel vacancy and turnover rates of 14% and 34%, respectively (Mental Health Association in New York State, Inc., 2019). These rates reflect statewide averages. Vacancy and turnover rates are considerably higher in Downstate regions – Long Island and New York City, in particular. These trends compromise the viability of these organizations and the quality of care afforded to increasingly vulnerable service recipients. Moreover, the decimation of our valued workforce occurs at a most inauspicious time. A deinstitutionalization movement, initiated decades ago and continuing in earnest, aims to support vulnerable individuals in integrated, community-based settings. Mindful of the “least restrictive” alternatives to institutionalization, the laudable philosophical and financial underpinnings of this movement notwithstanding, its success is contingent on robust investment in the community-based health and social services infrastructure. That is, individuals emerging from hospitals, nursing homes, adult homes and similarly restrictive settings frequently manifest complex and comorbid health conditions and associated life challenges for which intensive and comprehensive support services are necessary lest they falter in the transition to community-based care. Their right to reside in less restrictive settings is surely beyond question, and it now bears the imprimatur of the United States Supreme Court in the L.C. codified in law individuals’ right to community integration and led to the establishment of a statewide Olmstead Implementation Plan that informs many public policy proposals. For this and many other reasons, our community-based system of care warrants an infusion of additional resources with which to meet the needs of formerly institutionalized individuals.

The opposite has occurred, however, and recent initiatives continue to give the nonprofit human services sector short shrift. For example, the Health Care Efficiency and Affordability Law for New Yorkers (HEAL-NY), legislation that authorized substantial investments in facility and information technology enhancements for health and social service organizations, allocated only 1.4% of $8.47 billion to community-based organizations (New York State Council for Community Behavioral Healthcare, 2019). Such a meager investment stands in stark contrast and diametric opposition to these initiatives’ intended aims and requirements for success.

The most recent example of the state’s continuing neglect of the nonprofit social services sector is its deferral of a statutory Cost of Living Adjustment (COLA) for its workforce. This workforce, already grossly underpaid in comparison to those in the public and private sectors, relies on modest increases to mitigate the adverse effects of inflation and other economic stressors. Yet the state has approved this COLA for only two of the past ten years, exasperating the state’s targeted adjustments for select personnel at the exclusion of others. This has enabled the state to “save” approximately $700 million during this period. This is roughly equivalent to a rounding error in an annual state budget of $175 billion borne on the backs and bank accounts of its most underpaid personnel. It has surely exacerbated the crises in recruitment and retention described above. It has also led many poorly paid professionals to rely on some of the same publicly funded benefit and entitlement programs on which their clients depend. Approximately one-third (32%) of low-wage workers, many of whom are employed in community-based social services agencies, access one or more public assistance programs (Jacobs, Perry, & MacGillivary, 2016). Thus, the state’s inattention to the needs of its social services employees is not merely inimical to its stated objective to replace institutional care with efficient and effective community-based alternatives. It is costly.

Ashley Brody, MPA, CPRP

Peace of mind, independence, and recovery

Search for Change, Inc. has been rebuiding lives and strengthening communities for more than 40 years, and it continues to be a leader in the field of recovery. Services provided are integrated, person-centered and fully aligned with the Tri-Aim of healthcare reform and other initiatives that improve quality, promote successful outcomes and reduce costs.

- Residential Services
- Private Care Management
- Respite Services
- Mobile and Transitional Outreach
- Career Support Services
- 24-Hour Support Staff

- A sample analysis of historical claims data revealed an estimated savings of $181,829.00 associated with the provision of supportive housing services during a 24-month survey period. These savings were achieved through reduced use of inpatient hospital and emergency department services among clients sampled for analysis.

- Recipients of SFC’s Vocational Rehabilitation services earned a total of $986,134.30 in wages in 2017. They performed a total of 88,555 hours of work and paid $228,572.80 in taxes.

- Search for Change’s 2017 employee engagement survey resulted in an overall rating of 4.01 out of 5.
Peers in the Workforce: Reversing Misconceptions and Succeeding

By Kerry, Andrea, William, Shaneefa, Elfreda, and Joseph

This article is part of a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The authors of this column facilitated a focus group of their peers to inform this writing. The authors are served by Services for the Under-Served (S:US) a New York City-based nonprofit that is committed to giving every New Yorker the tools they can use to lead a life of purpose.

Employment is one of the most essential aspects of a stable, productive, well-rounded life. This is no less true for us, individuals with behavioral health needs with lives impacted by mental health challenges, substance use, and homelessness. But maintaining stable employment can be more difficult and fraught for us. Instability in our lives may have prevented us from working for periods of time, making it harder to find gainful employment now.

We may experience particular obstacles stemming from our individual diagnoses and needs that make certain types of employment difficult. On top of this, we may also be up against stigma from employers and structural barriers.

But, as several of us learned when we gathered to discuss our experiences as part of the ‘behavioral health workforce,’ we are more than capable of thriving in our jobs and building careers. The possible challenges we may face certainly don’t encapsulate our experiences. Here is some of what our conversation revealed.

Support Tailored to Our Needs

Members of our discussion group have been employed consistently from 10 years to 6 months. One of us is currently seeking employment, but has a diverse work history with periods of long-term employment. Our experiences finding a job are varied, but what they have in common is the importance of the support and resources made available to us through organizations like S:US, and programs designed specifically for our needs. For instance, one of our discussion participants found permanent employment through a job fair run by the New York City Office of People with Disabilities and a program that adjusts typical employment testing requirements for people with disabilities. With these two resources, he was able to secure a permanent job with the City. “Prior to that,” he says, “I had been sending out dozens and dozens of resumes and no one was responding.”

Two of us are participating in transitional employment (TE), which we obtained through S:US’ Brooklyn Clubhouse. (The Brooklyn Clubhouse is part of Clubhouse International, an organization that provides opportunities and resources for individuals with mental illness to live healthier, happier lives.) Transitional employment opportunities typically last for 6 to 9 months each, and are secured by the Clubhouse. One of us talked about an exciting TE opportunity with the NYC Mural Arts Project (part of the NYC Department of Health and Mental Hygiene), helping to design and install a mural to raise awareness about mental illness on a wall of a local Brooklyn school. While the Clubhouse encourages members to obtain outside employment on their own as well, it also offers opportunities for Supported Employment and Independent Employment. Under these two employment types, the Clubhouse provides us with varying levels of intervention to support our adjustment to our places of work.

Paying it Forward as Peers

Two participants in our discussion group work as Peer Specialists with S:US. Having gone through their own journey through behavioral health services, whether for substance use recovery or some other need, they received training (with the support of S:US staff), and now serve other individuals with behavioral health needs. Because of their lived experience, peers can provide invaluable knowledge and support that can’t be taught formally.

see Succeeding on page 35
Licensed Practical Nurses: Furthering the Goal of Integrated Health

By W. Andrew Mullane, PhD
Regional Director, WJCS Behavioral Health Services in Southern Westchester County

It is a startling and sad fact that individuals with serious mental health problems on average die earlier than those without mental health issues. An article in JAMA Psychiatry reported that these premature deaths are primarily due to largely preventable conditions, such as high blood pressure, high cholesterol, diabetes, and heart disease. In 2013, the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration reported that one of every three adults with mental illness smokes cigarettes, compared with one in five adults without mental illness. Individuals with substance use disorders are also likely to have a shortened life expectancy. While the reasons for these outcomes are vast, all point to the need to expand efforts to address the inextricable link between physical and behavioral health.

In an effort to help clients live healthier and longer lives as well as support our therapists and psychiatric staff so they are better able to provide the services which they are uniquely qualified to offer, WJCS, the largest community-based provider of licensed outpatient mental health services in New York’s Westchester County, launched a pilot program in 2012. Licensed Practical Nurses (LPNs) were hired to enhance the integration of mental health, substance use, and physical health treatments as well as boost staff efficiency. Seven years later, this program is a well-established, vital, and valued model that validates the benefits of expanding the traditional behavioral workforce to include LPNs.

There are multiple factors that make integrating LPNs into the behavioral health treatment model beneficial. The United States is facing a crisis of profound impact: the shortage of medical doctors, including primary care physicians, psychiatrists, and doctors specializing in addiction. Access to much-needed care is becoming increasingly challenging for consumers as well as for health and mental health organizations who must maximize the efficiency of practitioners. By integrating LPNs into our behavioral health model, WJCS is now able to provide more comprehensive care to a higher volume of clients and is positioned to better meet the needs of our clients and communities in a managed care environment.

The presence of LPNs in our clinics has allowed us to expand our capacity to conduct medically necessary screening of consumers in areas that are known to contribute to long-term negative health outcomes. In addition to our other providers, our LPNs, trained in motivational interviewing, screen clients for tobacco and alcohol use, help clients explore their desire to reduce or end their use of tobacco, and aid clients in obtaining nicotine replacement therapy or medication-assisted treatment, follow up with clients and communicate with their care providers to successfully reduce harmful substance use.

Our LPNs help us to identify clients who are at metabolic risk by tracking PSYCKES data and through regular screening. They ensure that clients obtain the medical lab work necessary to ensure medications prescribed are appropriate for the client’s health profile and to monitor for reactions to medication. LPNs conduct real-time screening of clients for substance use, via breathalyzer or on demand urinalysis, when our psychiatric providers are prescribing controlled substances in order to minimize the risk of adverse medication and substance interactions.

At WJCS, LPNs have been instrumental in helping to identify clients in need of outside care as well as facilitating that care. At intake screenings and at an annual wellness screening, LPNs review client health concerns and actively connect them to medical providers, often going as far as calling to schedule a doctor visit for consumers who are not connected with a primary care physician or who have not had a physical in the last year. Krystle Colon, Supervising LPN at the WJCS Yonkers Family Mental Health Clinic states, “Clients see me as an extension of their care team and if they have some pressing or, perhaps, embarrassing health concern, they will come to me and ask about it. It’s gratifying to see them address health concerns and increase healthy behaviors.”

On occasions when they have identified a grave medical concern, such as unmanaged diabetes or very high blood pressure, LPNs have walked clients over to a medical provider’s office. In each case, the LPN follows up with the client to be sure he or she has received needed care. The LPN also brings these matters to the awareness of the client’s therapist and psychiatric providers.

As a result of LPNs conducting wellness screenings prior to initial therapy appointments, our mental health practitioners are armed with comprehensive health information at the time of the appointment and freed up to focus on the needs of the client. By having LPNs complete prior authorizations of medications, address concerns regarding medications and medication refill requests, and respond to emergent medical concerns, our system of care is better able to respond to client concerns in a timelier fashion and is also able to offer services to more individuals. LPNs have also begun assisting our psychiatric providers with urgent care walk-in hours by prioritizing clients by need, collecting vitals, completing necessary medical tests, and identifying concerns so that the time with the psychiatric provider is optimized.

Challenges to integrating LPNs in our mental health clinics do exist. Most of the services our LPNs provide are not reimbursed through commercial insurance companies. Adding LPNs to our workforce has added a financial cost but it has enabled us to provide high quality integrated care, which can be life-saving. Additionally, integrating LPNs into our workforce in the ways described above requires much thoughtfulness in the development of workflows to ensure all staff are working at the top level of their licensure. WJCS clinicians welcomed the LPNs, after witnessing the full value of such changes to our clients, our communities, and to the providers themselves.

In summary, the addition of LPNs to the behavioral health team at our WJCS Article 31 Community Mental Health Clinics is helping to enhance our capacity to provide the highest quality health services to the consumers and communities we serve. It is our goal that through innovations like those mentioned, we enable clients to live longer, fuller, and healthier lives, reversing the trend of shortened longevity and more negative health outcomes in people who experience mental health issues.

WJCS-Westchester Jewish Community Services provided mental health services to 3,900 individuals in 2018. For more information, please visit wjcs.com or call (914) 761-0600.

Provides Comprehensive Behavioral Health Services

- Dialectical Behavior Therapy
- Trauma Treatment for Child and Adult Survivors of Sexual Abuse and Domestic Violence
- Peer-led Wellness Groups
- Social and Recreational Support Programs and Activities for Adults Recovering from Mental Illness
- School-Based Mental Health Clinics
- Specialized Therapy for People with Intellectual and Developmental Disabilities
- Therapeutic Social Skills for Children, Adolescents, and Adults on the Autism Spectrum
- Psychological, Developmental, and Educational Evaluations
- Intensive Outpatient Services
- Bereavement Services

(914) 761-0600 www.WJCS.com
845 North Broadway, White Plains NY 10603
Behavioral Health Care: How Far We’ve Come in 15 Years

By Linda Rosenberg, MSW
Former President and CEO
National Council for Behavioral Health

Fifteen years goes by in the blink of an eye. This summer I’m stepping down after 15 years as president and CEO of the National Council for Behavioral Health, which is celebrating its 50th anniversary. This is a good time to take stock of where we have been as a field and where we are going.

When I joined the National Council in 2004, some in the behavioral health community spoke of a system in shambles and unfairly pointed fingers at others. But my perspective was from the ground up and I saw a different reality. When I testified before the Institute of Medicine, I described our members as essential community providers, chronically underfunded, struggling to transform lives.

I told them how our members were reimbursed at rates far lower than others that share the safety-net – hospitals, health centers, the Department of Veterans Affairs – creating a workforce crisis and compromising quality. Then, together, we went to work.

We moved health care integration from concept to reality. Today, integrated physical and behavioral health care isn’t the flavor of the month – we know it’s the best way to meet the complex needs of individuals with chronic, co-occurring conditions.

We embraced the science and practice of recovery and of trauma-informed care. Recovery is now the expectation, not the exception, in mental health and substance use treatment. We recognize and are increasingly prepared to respond to the trauma the majority of our patients’ experience. We have stopped asking, “What’s wrong with you?” and started asking, “What happened to you?”

We successfully advocated for parity, for full inclusion of mental illnesses and addictions in the Affordable Care Act, and for creation of Certified Community Behavioral Health Clinics (CCHBCs). CCBHCs are remaking specialty behavioral health care in this country by providing crisis services; integrating physical and behavioral health; delivering medication-assisted therapies; implementing evidence-based practices; partnering with peers; and collaborating with law enforcement, schools, and hospitals. They are working with groups that have special needs, such as veterans, who may not otherwise receive evidence-based services. CCBHCs are hiring new staff, easing the critical shortage of psychiatrists, especially in rural areas.

We don’t pay for cancer treatment with demonstration grants, and we shouldn’t do so for mental illnesses and addictions. Today, lack of access to care has replaced stigma as the leading barrier to a healthier America. We need sustained funding that supports a comprehensive continuum of services, and the Excellence in Mental Health and Addiction Treatment Expansion Act is a good start. The Act extends the CCBHC program, meeting the growing demand for more mental health and addiction treatment capacity and giving more people the opportunity to recover.

The National Council brought Mental Health First Aid to the United States and we have trained 1.7 million people. This means 1.7 million people from all walks of life are now able to initiate a conversation with someone experiencing a mental health or substance use crisis and refer them to community resources and professional help, if needed. We are well on our way to making Mental Health First Aid as common as CPR.

We continue to promote the adoption of technologies that have revolutionized other industries and are now being applied to health care – technologies that support and educate staff, increase treatment capacity and measure outcomes, put patients in charge of their own health, support the office operations vital to effective care, and deliver psychiatric services into our clinics and homes from across the country. We can be both high-tech and high-touch.

Working together, the National Council and its members have done this challenging and rewarding work. But we have much left to do.

Startling figures show that average life expectancy in the United States dropped for the third straight year, driven by increases in overdose deaths and suicides. You are now more likely to die in this country from an opioid overdose than a car accident. Partisan divide over the Affordable Care Act persists and Medicaid is still under assault.

Where do we go from here? To begin with, we need leaders who have a bias toward action, who are fearless but not reckless.

see How Far on page 32

EHR & BILLING SOFTWARE – DESIGNED EXCLUSIVELY FOR NYS OMH AND OASAS AGENCIES

Celebrating 30 years of providing software solutions to the Behavioral Health Community in NYS. Call for a complimentary assessment of your current system and a demonstration of imaServe Web.

We are providing a 30% discount for your first month of service! Join us in this opportunity to utilize a proven winner and get a bonus at the same time. The integrity of our software is vetted by our customers, some with us for 25+ years

Contact: Carla@imasys.com
Visit: www.imasys.com
IMA Systems LLC, 32 Broadway Suite 614 New York, NY 10004 212-722-6677
I

n 2017, the President’s Committee for People with Intellectual Disabilities provided a report (retrieved from https://www.nadsp.org/wp-content/uploads/2018/02/PCPID-2017_-Americas-Direct-Support-Workforce-Crisis-low-res.pdf) to the President of the United States regarding the workforce crisis for direct support professionals (DSP). Specifically, the number of DSPs needed to support individuals with intellectual disabilities (ID) and autism is not sufficient, causing many individuals to waitlisted with no supports (see Table 1 of President’s Committee Letter for detailed information). The key variables of the workforce crisis were identified as high staff turnover, growing demand for services due to population growth, increased survival rate for people with ID, fewer people in the workforce, lack of living wage, insufficient fringe benefits, high stress on the job, insufficient training and preparation, and a lack of professional recognition and status for all DSPs. Some recommendations to address these key variables include wage initiatives, use of technology solutions (e.g., remote monitoring), designation of DSPs as a distinct occupation and career training and credentialing for DSPs. Other entities have also stated concern with the omnipresent workforce crisis and stated similar causal variables and potential remedies (e.g., M. Davis, Pennsylvania Advocacy and Resources for Autism and Intellectual Disability, Letter to Pennsylvania Department of Human Services, 3 April 2018; see also https://www.fixthedspcrisis.com/).

In response to the recommendation of distinct occupation status and training needs for DSPs, some entities have proposed core competencies and credentialing standards for DSPs. The New York State Office for People with Developmental Disabilities, in conjunction with the New York State Talent Development Consortium, has developed some direct support professional core competencies (www.workforcetransformation.org/wp-content/uploads/2017/03/NYS_Core_Competencies_and_NADSP-Code_of_Ethics.pdf). The competencies are presented as seven overarching service goals. The goals are broken into competency areas (e.g., supporting a person’s unique capacities, personality, and potential; demonstrate support for individual choice-making), and competencies are comprised of multiple skills (e.g., communicate directly with individuals; uses person-first language). Although structured in a manner that would lend itself to job training, the competencies are explicitly described as a representation of the “day-to-day work that DSPs perform” and “are not a training program” (see http://www.workforcetransformation.org/nys-dsp-core-competencies-resources/). Adopting the competencies provides a context to define a distinct occupation status and expectations for those employed.

The Behavior Analyst Certification Board (BACB), a nonprofit credentialing corporation, was established to meet the professional credentialing needs of behavior analysts, government and consumers (https://www.bacb.com/about/). The BACB seeks to protect consumers and solve socially significant problems via increased availability of qualified behavior analytic professionals. One credential developed to meet this mission is the Registered Behavior Technician® (RBT®). Registered Behavior Technicians must meet initial minimum competencies and receive ongoing supervision from professionals with additional training credentials (https://www.bacb.com/mbt/). Requiring DSPs to become an RBT® provides training directly related to the job responsibilities, offers a framework to support DSPs’ professional growth and development, recognizes the DSP role as a distinct occupation within a critical service field, and establishes minimum expectations for acting ethically while supporting individuals.

The New York State competencies and the RBT® credential both have different points to consider. The purpose of this publication is not to debate those options. Rather, the intent is to describe how organizations can be actively engaged in addressing the workforce crisis. Specifically, this publication strives to describe a training and professional development program focused on addressing DSP turnover, emphasizing job specific skill development for DSPs, and providing career paths for DSPs.

Training Program Overview

Melmark is a multi-state human service provider with premier private special education schools, residential living, professional development, training, and research centers. Melmark is committed to enhancing the lives of individuals with autism, intellectual and developmental disabilities, and their families by providing exceptional evidence-based and applied behavior analytic services to every individual, every day. Many of Melmark’s more than 1,100 staff members are DSPs. While the educational requirement for this position is typically a high school diploma, some positions require a bachelor’s degree.

see Training on page 37

We’re Looking For a Few Good Employers!

Our Microsoft-Certified Students (Word, Excel, PowerPoint, Outlook)

Need Real-World Job Experience!

Could You Use a Part-Time Volunteer for Six Months?

Please Help Our Students Get On a Solid Career Path As An Intern At Your Company. No Cost. Government-Sponsored.

Call Liz Edgar, CEO
(914) 557-1318 cell

The Center for Career Freedom
One East Post Rd, White Plains, NY 10601
Freecenter.org

40,000 New Yorkers Rely On Mental Health Housing Programs

Visit bringithomens.org to see how YOU can help urge NYS Legislators to provide Better Funding For Better Care for Community-Based Mental Health Housing Programs.

Bringing it Home is a coalition of community-based mental health housing providers, mental health advocates, faith leaders, and consumers and their families, urging New York State to adequately fund community-based housing programs for individuals with psychiatric disabilities. Full recovery and community reintegration depends on stable housing opportunities. Through education and advocacy, Bringing it Home is working to bring better funding for better care to New York.

Registered Behavior Technicians ® must recognize the DSP role as a distinct occupation and receive ongoing supervision from professionals with additional training credentials (https://www.bacb.com/rbt/). Requiring DSPs to meet initial minimum competencies and receive ongoing supervision from professionals with additional training credentials (https://www.bacb.com/mbt/). Requiring DSPs to become an RBT® provides training directly related to the job responsibilities, offers a framework to support DSPs’ professional growth and development, recognizes the DSP role as a distinct occupation within a critical service field, and establishes minimum expectations for acting ethically while supporting individuals.

The New York State competencies and the RBT® credential both have different points to consider. The purpose of this publication is not to debate those options. Rather, the intent is to describe how organizations can be actively engaged in addressing the workforce crisis. Specifically, this publication strives to describe a training and professional development program focused on addressing DSP turnover, emphasizing job specific skill development for DSPs, and providing career paths for DSPs.

Training Program Overview

Melmark is a multi-state human service provider with premier private special education schools, residential living, professional development, training, and research centers. Melmark is committed to enhancing the lives of individuals with autism, intellectual and developmental disabilities, and their families by providing exceptional evidence-based and applied behavior analytic services to every individual, every day. Many of Melmark’s more than 1,100 staff members are DSPs. While the educational requirement for this position is typically a high school diploma, some positions require a bachelor’s degree.

see Training on page 37

We’re Looking For a Few Good Employers!

Our Microsoft-Certified Students (Word, Excel, PowerPoint, Outlook)

Need Real-World Job Experience!

Could You Use a Part-Time Volunteer for Six Months?

Please Help Our Students Get On a Solid Career Path As An Intern At Your Company. No Cost. Government-Sponsored.

Call Liz Edgar, CEO
(914) 557-1318 cell

The Center for Career Freedom
One East Post Rd, White Plains, NY 10601
Freecenter.org

40,000 New Yorkers Rely On Mental Health Housing Programs

Visit bringithomens.org to see how YOU can help urge NYS Legislators to provide Better Funding For Better Care for Community-Based Mental Health Housing Programs.

Bringing it Home is a coalition of community-based mental health housing providers, mental health advocates, faith leaders, and consumers and their families, urging New York State to adequately fund community-based housing programs for individuals with psychiatric disabilities. Full recovery and community reintegration depends on stable housing opportunities. Through education and advocacy, Bringing it Home is working to bring better funding for better care to New York.
Primary Care Integration: Alternative Workforce Strategies for Community-Based Behavioral Health Service Organizations in the Era of Physician Shortages

By Rachael A. Petitti, PhD, LCSW Lecturer, Program Director, Department of Health Administration and Policy, University of New Haven

It has been many years since the surgeon general report declared that vastly poor health outcomes for persons suffering from behavioral health disorders was a public health crisis. Lives filled with long term disability and early mortality caused, in part, by service fragmentation within the U.S. healthcare system. (Parks, J., Svendsen, et al Morbidity and mortality in people with serious mental illness. Technical report of the National Association of State Mental Health Program Directors. 2006.) Among those in the behavioral health field, this report became widely referenced as it conveyed the changing core principles of care; that mental health and primary care integration is a necessary and basic tenet for this population. Despite that call to action, the provision of integrative services may likely continue to be unequal nationwide for community-based, nonprofit, behavioral health providers, in part due to shrinking public funding and the competing high costs of employing primary care physicians.

Rachael A. Petitti, PhD, LCSW

Alternative Models of Care: Primary Care Physicians Shortage, Funding Limitations.

Compounding these service delivery limitations is a growing shortage of primary care physicians. In a study conducted by the AAMC (American Association of Medical Colleges), it is projected that by 2030 there will be a shortfall of between 14,800 and 49,300 primary care physicians. This is largely due to three reasons: the growing U.S. population, which by 2030 is expected to grow 11%, the aging of the “baby boomers,” with the over 65 population expected to grow by 50% by 2030, and the shortage of medical residents interested in pursuing a primary care practice over a lucrative career as a specialist. (Academy of Family Physicians. Family physician, scope, philosophical statement. In AAFP Reference Manual. Leawood, KS: AAFP; 2012.) This year alone, the number of U.S. medical school graduates entering primary care, family medicine, internal medicine, and pediatrics combined totaled 2,730. (Peikes, D. The Comprehensive Primary Care Initiative: Effects on Spending, Quality, Patients, And Physicians. Health Affairs. 2014;37(6).)

This is a significant shortfall that does not even come close to addressing the predicted deficiencies in the primary care provider pool, which is expected to reach 23,640 by the year 2025. On the contrary, according to the Bureau of Labor Statistics Occupational Outlook Handbook, the projected percent of change in employment for nurse practitioners from 2016 to 2026 is up to 31%. Projected growth in physician’s assistants is 37%, resulting in an increased supply for both occupations with higher than average growth rates.

Coupled with this labor force reality is the unequal distribution of funding available to the nonprofit sector to support integrated service delivery models. We know that the largest portion of resources available to this sector came through the Substance Abuse and Mental Health Services Administration (SAMHSA) 2009-2016 Primary and Behavioral Care Integration (PBHCI) Program grant funding which averaged $400,000 per year per organization, renewable for up to 4 years. This program was developed to address community-based service capacity issues, but what remains unclear are the sustainable effects from the service systems’ ability to continue cost-effective primary care models in the era of reduced funding. Consequently, with the limited supply of physicians and existing economic challenges for nonprofit providers, we propose a departure from the traditional model of physician-based primary care. We advocate for the adoption of a universal industry standard that allows for Nurse practitioners or Physician Assistants to be given full regulatory approval by each state to act as the patient’s primary care provider.
Staff Development at the Mental Health Association of Westchester

By Barbara Bernstein, PhD, MPH
Chief Planning Officer
MHA of Westchester

In recent editions of Behavioral Health News, we have written of sweeping transformations in services offered at The Mental Health Association of Westchester (MHA). These transformations require critical staff development - learning new skills and new processes of working. To manage these changes, “owners” of the Change Management Process are essential. Thus, we need owners of training and incorporation of new skills, of integrating new ways of working, of communicating about and keeping large changes on time and on track, as well as evolving infrastructure to support our work.

Change Management Champions: MHA has invested in developing change management leaders and an ongoing Project Management initiative. Meeting regularly with our Project Management team, Program Directors are responsible for keeping identified projects on track. They identify the action steps, the associated timelines and additional support required to move forward. Progress is tracked regularly, highlighting aspects that are moving forward as planned and especially those that require assistance. Examples of significant initiatives that are “project managed” include the expansion and integration of Substance Use Disorder (SUD) services into our clinics and development of a new residential site that integrates affordable housing with supported housing for individuals with behavioral health diagnoses.

Skill Development: Across all of our services, staff have been required to expand and deepen their skill sets. For example, as we incorporate SUD services, clinicians have learned new assessment tools as well as clinical approaches, such as Screening, Brief Intervention and Referral to Treatment (SBIRT), Integrated Harm Reduction, and Dialectical Behavior Therapy (DBT) for SUD. Physicians are now providing Medication Assisted Treatment (MAT). Our Peer Specialist training, which prepares participants for NYS certification through OMH, now includes Certified Recovery Peer Advocates (CRPA) training, enabling them to provide peer support through the lens of substance use as well as preparing them for NYS certification under OASAS. These certifications provide trained Peers with marketable skills and enhance capacity to obtain meaningful paid work. Throughout the agency, interested staff have participated in training to use Narcan to reverse opioid overdose. Care Managers assist individuals who experience complex and chronic medical and/or behavioral health conditions. To do their jobs effectively, Care Managers have required training in medical conditions, medications, and the interaction of multiple health conditions. Effecting change in life is difficult. Whether the change is related to use of substances or alcohol, developing wellness practices or developing new ways of managing life’s stresses, change requires significant personal commitment. To that end, staff across many of our services have been trained in Motivational Interviewing (MI). Beyond our clinic, our expanded Children’s Services and Home and Community Based Services staff are participating in MI. Thus, ongoing training is required to deliver those services.

In addition to training that we organize or that is provided by regulators, we strongly encourage staff to pursue learning in areas of particular interest to them. Staff are encouraged to apply internally for financial support and/or use of work time to hone specific skill sets that support their work. These opportunities are available not only to those who provide direct services, but those who support the work – e.g., those in Finance, Communications, and HR. To support our Licensed Professional Workers and Mental Health Counselors to satisfy their NYS Continuing Education requirement, we deliver on-site courses that enable them to substantially or fully meet that need.

Train-the-Trainer Capacity: Expertise to deliver in-house training enables us to provide training when and as needed, flexibly meeting the needs of staff. In-house training is time and cost efficient and allows us to adapt training to our specific needs. MHA staff include credentialed trainers in, e.g., Suicide Awareness for All (safeTALK), Applied Suicide Intervention Skills Training (ASIST), Motivational Interviewing (MI), SBIRT and CRPA. We are currently developing Train-the-Trainer capacity for Peer Supported Open Dialogue (POD). POD is a fully collaborative model that utilizes a family and peer “social network” model to address acute crises as well as ongoing concerns. To assure that those who have content expertise are also effective trainers, we have developed internal “Train-the-Trainer” preparation that teaches principles of adult learning and facilitation skills.

Leadership Development: As in many agencies, skilled providers are promoted to managerial positions. However, the knowledge and skills of managing program operations, budget, and staff are different than that required to do the work. We have invested in developing the next cohort of leaders in multiple ways. Groups of our middle managers have participated in a formal depth Middle Managers Academy training delivered by The National Council for Behavioral Health. The curriculum, specifically created for the behavioral health field, addresses developing leadership style, mastering key management tasks and responsibilities, managing and motivating employees, teamwork and accountability, as well as managing budgets and financial information. We consolidate these learning through an ongoing peer-led monthly session meeting for managers, which includes focused training delivered by executive staff. The goal of the initiative is to deepen managerial skills and provide peer support through challenging situations. Executive staff have participated in other leadership development programs, including those offered by Nonprofit Westchester and Manhattanville College.

Philosophy: MHA prides itself on maintaining its focus on delivering person-centered care based on principles of shared decision-making. All staff receive training on the philosophical framework within which our services are delivered. At orientation, and then in a more in-depth manner during their first year of employment, all staff participate in training about the principles of person-centered care, trauma informed care and aspects of cultural competence. These sessions are in addition to training required by regulation, including sexual harassment, compliance, and reporting of child abuse and neglect.

Challenges: Developing a well-trained staff and supervising implementation of new knowledge and skills presents numerous challenges. For example, as we expand the array of new services – such as incorporating SUD services into our more traditional mental health services – we must assure that staff are fully trained. Appropriate training programs must be built or identified and purchased. Taking staff away from daily responsibilities is costly; in many cases reducing delivery of billable services while staff participate in training sessions or requiring that services be delivered at other times. Our workflows and supervisory process must support the integration of new skills. At times, on-going scheduled consultation calls are built into the training schedule. The significant time and money dedicated to developing staff capacity is an investment in improved quality of services, greater efficiency of delivery, and ultimately improved outcomes and client satisfaction. High quality training is expensive. In recent years, government attention to workforce development has provided a significant source of financial support, e.g., through DSIRP and other initiatives. Going forward, alternative sources of funding will be required.

As staff size and training requirements grow, tracking training needs presents another challenge. An Excel spreadsheet which once met our needs is now outdated, inefficient and underpowered. Numerous Learning Management Systems are available for purchase. It is critical that we find the system that is the best “fit” for our agency; a task that is still in process.

Historically, we have relied on face-to-face training sessions and highly value the opportunity for in-person conversation. As we have embraced the many advantages of online training, especially appreciating the time flexibility of ‘on-demand’ training, we continue to explore the best hybrid model for our needs. Should staff participate in online training as it suits their schedule and then meet for discussion? Are we better served by participating in a group? Are there some topics that do not require discussion?

Finally, one of the most significant challenges is that of evaluating training. How do we assess that a training module has effectively delivered the essential content? Most importantly, how do we assess the degree to which staff have
Lippman Joins Beacon Health Options

By Staff Writer
Behavioral Health News

Jason Lippman has joined Beacon Health Options as VP, Strategy and Development in the Tri-State/Mid-Atlantic region. In his new role, Mr. Lippman will be responsible for generating new sales growth through customer acquisition, developing strong client relationships and solutions for Beacon to be a valuable business partner to its clients.

Mr. Lippman comes from Beacon from The Coalition for Behavioral Health, where he served as Executive Vice President. Upon rejoining The Coalition in 2016, Lippman played a vital role in providing stability and management of the organization’s operations through two leadership changes and successfully implemented a strategic transition plan as Interim President & CEO. His major accomplishments during the Interim role included: 26% improvement in revenue collections, and 17% rejoin rate of member resignations from the previous year. As EVP, Lippman was instrumental in The Coalition’s resource development activities, securing media coverage from major news outlets and overseeing of public and private sector partnerships.

Prior to Mr. Lippman’s latest tenure at The Coalition, he served on Amida Care’s Senior Management Team as the primary lead for policy and advocacy initiatives. Major accomplishments included: the launching of the agency’s government relations department, improved city and state legislative and regulatory policies for programs impacting people living with HIV/AIDS, mental health and addiction.

see Lippman on page 34

Organizational Needs-Based Toolkit for Peer Workforce Integration

Introduced at NYC Peer Workforce Consortium

By Aviva Cohen, LMSW
Office of Consumer Affairs
NYC Department of Health and Mental Hygiene

Aviva Cohen, LMSW

We then heard the encouraging words of Public Health Dean, Ayman El-Mohandes who highlighted the value of lived experience in decreasing significant health disparities. The kickoff attendees enjoyed hearing from keynote speaker, Joyce Wale, who is the Regional Executive Director for Behavioral Health at United Health Care. Ms. Wale shared her experience and insight about the factors that have increased support of peer services by managed care organizations. The toolkit kickoff sparked new discussions about how the toolkit can generate growth and advance organizations’ efforts to integrate peers within the behavioral health workforce. Attendees brainstormed about opportunities for collaboration and eagerly connected to others with common goals.

Consortium Background

Plans for an organizational toolkit have been a part of the Consortium’s discussion since its onset. The Consortium began in 2016, after ThriveNYC, a citywide initiative to address mental health, held a Workforce Summit. At the Summit, Subject Matter Experts gathered to discuss the needs of the behavioral health workforce in New York City. The Summit’s peer workforce leaders recommended the formation of a centralized leadership body to coordinate peer workforce stakeholder groups and improve understanding of the Peer Specialist and Community Health Worker (CHW) roles. The NYC Peer and Community Health Worker Workforce Consortium was established to serve as that suggested leadership body.

In order to learn more about the workforce and about related programs and practices, the Consortium gathered comprehensive information on the state of the Peer and Community Health Worker Workforce. Using a mixed methods approach, which comprised interviews, surveys, and thematic analyses of materials, the Consortium evaluated active practices and identified the strengths and needs of Peer and CHW roles within the behavioral health workforce of New York City.

About the Needs Based Toolkit

The Needs-Based Toolkit is an online, automated guide with features that create a customized set of resources. The toolkit is designed to automatically adapt its content according to a completed self-assessment. The customized set of resources provided by the toolkit is specific to the needs of each organization, encouraging use of the toolkit as an action-oriented pathway to improved integration.

Based on the information gathered, the Consortium identified areas that impact recruitment and retention of peer workforce stakeholder groups and improve peer workflow processes to help individuals achieve their own goals. Community Health Workers (CHWs) are trusted community members who hold a close understanding of the communities they serve in frontline public health work. The peer movement has faced a long history of stigma, and of under-recognition as valuable sector of the workforce. The recognition of peers’ value has progressed, particularly when influenced by shifts in policy. Since New York State approved Peer Support for Medicaid reimbursement in 2016, Peer Support has seen substantial growth, demonstrating positive outcomes across an expanding variety of service settings. Peer support improves access to, and engagement in, services for individuals experiencing behavioral health challenges. Enthusiasm about new approaches to support and integration was strong throughout the Toolkit Kickoff event.

The event began with a welcome from Dr. Hillary Kunins, Acting Executive Deputy Commissioner for the Division of Mental Hygiene at New York City’s Department of Health and Mental Hygiene. The toolkit kickoff sparked new discussions about how the toolkit can generate growth and advance organizations’ efforts to integrate peers within the behavioral health workforce. Attendees brainstormed about opportunities for collaboration and eagerly connected to others with common goals.

see Toolkit on page 36

20th Anniversary Retrospective

By Staff Writer
Behavioral Health News

According to Ira Minot, LMSW, Founder and Executive Director of Mental Health News Education, Inc., (MHNE) and Publisher of Behavioral Health News, “It seems like only yesterday that my recovery from mental illness led me to create Mental Health News, the predecessor of this publication. Since our beginning in 1999 the past 20 years has been an amazing journey filled with many equally amazing experiences for me. Meeting and working closely with some of the field’s finest community leaders, educators, scientists and advocates has made this 20th Anniversary possible and a brilliant accomplishment for all involved.”

David Minot, BA, Associate Director of MHNE, who joined his father in 2006 to launch Autism Spectrum News, stated, “I am so proud of the vision created by my father in providing vital behavioral health and autism education to the community. Working closely with our dedicated Board of Directors, we are charting a new course for the future which will enable us to utilize the internet and social media to give our readers a richer experience and enhance our vital educational mission.”

see Retrospective on page 34

20th Anniversary Retrospective

By Staff Writer
Behavioral Health News

According to Ira Minot, LMSW, Founder and Executive Director of Mental Health News Education, Inc., (MHNE) and Publisher of Behavioral Health News, “It seems like only yesterday that my recovery from mental illness led me to create Mental Health News, the predecessor of this publication. Since our beginning in 1999 the past 20 years has been an amazing journey filled with many equally amazing experiences for me. Meeting and working closely with some of the field’s finest community leaders, educators, scientists and advocates has made this 20th Anniversary possible and a brilliant accomplishment for all involved.”

David Minot, BA, Associate Director of MHNE, who joined his father in 2006 to launch Autism Spectrum News, stated, “I am so proud of the vision created by my father in providing vital behavioral health and autism education to the community. Working closely with our dedicated Board of Directors, we are charting a new course for the future which will enable us to utilize the internet and social media to give our readers a richer experience and enhance our vital educational mission.”

see Retrospective on page 34
Peers: An Essential Component to the Behavioral Health Workforce

By Barbara Faron, LMSW, CPRP
CEO, Federation of Organizations

What makes a well-rounded behavioral health workforce who can deliver innovative, person-centered services that can affect change for the better? For Federation, the answer is Peer Specialists. Peers have become an integral part of the behavioral health workforce and Federation has been a pioneer in using peers to deliver services.

Peer Support services began to emerge in 1970s with the introduction of self-help recovery and advocacy organizations. Peers were used and accepted in providing substance abuse services well before they achieved acceptance in mental health systems. In 1981, Federation provided peer support was our Senior Companion Program. People with long-term psychiatric hospitalization histories of psychiatric hospitalization working with adult home residents providing friendly visiting, advocacy, and community integration activities. The program provided opportunities for people in recovery to explore vocational goals by volunteering at community sites such as social programs, adult homes, hospitals, outreach programs, food pantries and soup kitchens. Through the principles of peer support and self-help, Companions helped to improve the quality of life for other individuals within the mental health community. Participants received a meal allowance, travel reimbursement; paid vacation, sick and personal days. They also received the job training and support. The demonstrated benefits to both the peer worker and the residents they served spurred the growth of the program and variations on the theme of involving peers in the delivery of services. Through the years since, Federation has been working to integrate peers into all aspects of our workforce—both in positions designated for peers and for all other positions within the agency for which an individual is qualified.

Lessons Learned

What have we learned over the last 35+ years? That peers bring a new perspective to the services we provide. This view has changed the dynamic of service delivery and added another layer of support, communication, and a unique experience for both the peer specialist and the individual they serve. Peers share the experience of living with mental illness or and/or a substance use disorder with the individuals they serve. This shared experience helps form a trusted bond and with that bond comes the attainable goal for recovery.

We’ve learned that peers understand what it is like to live with voices in your head. What it feels like to not have family support or be living on the street. Peers have experienced the side effects of medication and understand what it feels like to lose a job, or a home because of mental illness. Despite all this, they have overcome these challenges to move forward in their recovery. They have progressed, suffered setbacks, and again moved forward. They understand the road to recovery is not a straight line and with each stumbling block comes a chance for learning and growing.

Time and time again, peer services have been shown to be a benefit to the individual subsequently improved the quality of their life. Since the 1980s, Federation has seen amazing success for its members by incorporating peers into every facet of service delivery within the organization. Peers participate in groups, work in our residences, and are deployed with members of our mobile teams. The truth, honesty, experience, and hope that they bring to our members is immeasurable.

In addition to providing hope, support, and trust, peers also advocate on behalf of the client, making sure the services they receive are person-centered and that the individual is involved with decision making regarding their care. This is turn helps the individual learn to advocate on behalf of themselves, bringing them closer to independently managing their own care and taking more control over their own lives.

The benefits to individuals who serve as peers are equally astonishing. For many, this role fulfills a greater purpose and serves as a calling. They are able to use their life experiences, recovery and accomplishments in a way that helps others do the same. On the same note, they are able to be gainfully employed leading to

The Experience of Workplace Stress and Compassion Satisfaction of Licensed Social Workers

By S. Lala A. Straussner, PhD, LCSW
New York University Silver School of Social Work

Employed in fast-paced, often poorly funded agencies and working with clients who have experienced significant traumas, many licensed social workers are believed to experience a high degree of stress. At the same time, many feel emotionally fulfilled by their work and experience “compassion satisfaction,” i.e., deriving pleasure from being able to perform their work effectively, helping others and contributing to the greater good of society. Yet, solid evidence confirming these beliefs is lacking. This paper discusses the findings of a study that examined workplace stress and compassion satisfaction, and workplace environment factors impacting these phenomena among more than 6,000 licensed social workers.

Workplace Stress Among Social Workers

While generalizable research studies on social workers and workplace stress in the USA are limited, a study in England comparing work-related stress among 26 occupations found that “social service workers providing care” were among six occupations with the highest levels of health profession and found that social workers reported the highest level of workplace stress related to “client” dimension; they also were over-represented in their experience of depression. Finally, Stevens and Higgins (Stevens, M. & Higgins, D.J. (2000). The influence of risk and protective factors on burnout experienced by those who work with maltreated children. Child Abuse Review, 11(5), 313-331) found that 100% of their sample of child welfare workers working with maltreated children in Victoria, Australia scored in the high range of emotional exhaustion. There is no question that social workers experience high levels of stress in many different settings.

Compassion Satisfaction Among Social Workers

Despite the greater attention paid to workplace stress, a few international studies noted the considerable satisfaction social workers derive from helping others. For example, in a large study in England, the occupation of social work ranked 17 out of 88 regarding job satisfaction, higher than medical practitioners and nurses (Rose, M. 2003, Good deal, bad deal? Job satisfaction in occupations. Work, Employment and Society, 17(3), 503-530). A Canadian survey of child welfare social workers (Stalker, C.A., Mandell, D., French, K.M., Harvey, C., & Wright, M. (2007). Child welfare workers who are exhausted yet satisfied with their jobs: How do they do it? Child and Family Social Work, 12, (2), 182-191) found that despite high levels of emotional exhaustion, 41% of workers were highly satisfied with their employment and only 10% scored in the low range of job satisfaction. A study of hospice social workers (Pelton, S.B., 2017). Compassion fatigue and compassion satisfaction in hospice social work. Journal of Social Work in End-of-Life and Palliative Care, 13(2-3), 134-150) found that despite the vast majority indicating compassion fatigue, only 20% scored in the low range of compassion satisfaction. The above studies tended to have small sample sizes, and many did not focused exclusively on licensed social workers. Thus the need for our study.

Our Study

While a detailed description of our study (methodology and data analysis) is available elsewhere (see Acknowledgement), we had 6,112 state licensed social workers respond to a 75-item online survey which included questions focusing on their experiences and feelings regarding their work. We used an 8-item Workplace Stress on page 30 see Component on page 33

visit our website: www.mhnews.org
C oordinated Behavioral Care (CBC) is delighted to announce that Mark Graham, CBC’s Vice President of Program Services was awarded the 2019 Heritage Innovation in Healthcare Delivery Award for Pathway Home at the 2019 Heritage Healthcare Innovations Award. Mr. Graham was recognized for his work in designing and implementing CBC’s innovative Pathway Home program, which has over the past four years helped countless New Yorkers with serious mental illness transition back to the community from institutional settings.

Mr. Graham thanked Dr. Richard Merkin—Heritage Provider Network CEO and the ceremony’s presenter—for recognizing Pathway Home as a model of care that has upended the traditional care delivery system and in doing so positively transformed the lives of over 1,500 New Yorkers, while significantly reducing hospital readmissions and cutting costs across health care systems. Mr. Graham stated, “Pathway Home’s approach is a return to quality, client-centered care, early hospital engagement, immediate community needs assessments and spending quality time with participants on discharge to address isolation and social determinants of health. The Pathway Home Teams are supported by the comprehensive community supports that the CBC Network provides, which are an essential ingredient in the success of the Pathway Home model of transitional care.”

At the luncheon yesterday in support of Pathway Home were representatives from S:US and Catholic Charities who partner on these Pathway Home Teams: Joan Sass, LCSW, Sylvia Andreotto, RN, Aleta Glave, LMSW, and Sasha Robinson, MA, LMSW.

Jorge R. Petit, MD commented, “We need to give a lot of thanks to the NYS Office of Mental Health for their commitment and active partnership in what began as a one-year grant-funded pilot program and is now a multi-team operation that serves distinct and diverse populations across the City. In addition, we need to also extend our gratitude to the CBC Board and IPA Network for their dedication to working with the most vulnerable New Yorkers in making an impact on their lives.”

Pathway Home was up against stiff competition from some amazing innovators in the healthcare space; highlighting cutting-edge applications of technology and up-and-comers in the healthcare industry. CBC wishes to congratulate Geoffrey Chaiken, Co-founder and CEO, Blink Health; Daniel Etra, Co-founder and CEO, Rethink Autism; Yiah Rohm, Co-founder and CEO, Cityblock Health and Thomas Tsang, MD, MPH, Co-founder and CEO, Valera Health on their nominations.

Mr. Graham commented on the successful growth of Pathway Home, “It has grown from a small pilot project to 3 teams and now we are at 8 teams across the city and targeting new populations...”

see Award on page 35

Mental Health Housing Workforce Left Short in State Budget

By Jim Mutton, LMSW
Director of NYC Operations
Concern for Independent Living, Inc.

T housands of non-profit employees working in mental health supportive housing programs across the state were left shorthanded again in the 2019-20 State budget this April, despite a year-long advocacy effort with the Bring It Home Campaign (www.bringithomenys.org), a coalition of over 1,000 mental health housing organizations, faith leaders and individuals. A 2.9% Human Service COLA for state funded community programs was deferred for a tenth year and $13 million in hard fought additional funding from the Assembly and Senate to enhance supported housing and SRO programs was removed in final budget negotiations, leaving only a $10 million increase to these programs to help address a cumulative funding shortfall of $162 million. While the $10 million is appreciated, it is not sufficient to solve the crisis that exists in the mental health housing system. The Times Union also reported that millions in funding for agriculture, healthcare, veterans and youth employment programs included in previous state budgets was reduced, shifted to other priorities or eliminated in the first budget since Democrats took over the state Senate.

As the Director of NYC Operations at a 45-year old non-profit which operates numerous mental health supportive housing programs in Brooklyn, the Bronx and on Long Island, I found myself reflecting on how such a momentous effort could go belly up yet again after months of campaigning, hundreds of legislative visits and six weeks of continuous protests in Albany. How could our state government have failed us again, when a mental health supportive housing stock of over 40,000 units now stood with a crumbling infrastructure 40-70% behind the cost of inflation? How could our agency continue to attract a skilled and competent workforce, when direct care positions now paralleled in salary with entry level jobs in the fast food industry or private car-for-hire ridesharing services. How could I turn to our dedicated workforce who work 2-3 jobs to stay afloat and battle cycles of burnout and vicarious trauma week in and week out and convince them to stick with this career and not jump ship to hospital and union jobs? To put it in perspective, the $10 million increase in the state supported housing and SRO budget would translate to about $500 per bed and do little but add a few dollars to the biweekly pay checks of case managers and supervisors.

Despite the budget crisis, the housing pipeline hasn’t slowed down. Quite the reverse. The need has never been greater for supportive housing in our city and state and government funders have released a record number of RFP’s. In the past five years, our agency has almost doubled its housing stock to help thousands of individuals and families find a pathway out of poverty, illness and hardship to successful community reintegration and recovery. We were part of the effort to end chronic homelessness for veterans recovering from mental health and substance use challenges on Long Island and now intend to do the same in NYC.

New capital and operating funding opportunities are needed to address record levels of homelessness and growing institutionalization of mentally ill individuals. In addition, more sensible funding rates to build attractive housing and hopefully re-engage and re-energize a new workforce. However, unless these rates are adjusted for the entire mental health housing workforce, it will not be enough to resolve the longstanding erosion that has taken place over the last 30 years. To quote the Bring It Home Campaign website, “Integration works so much better than institutionalization, we know that. We also know that institutionalization is very expensive...” It’s time to recognize that community reinvestment also means workforce preservation and investment.
Coordinated Behavioral Care (CBC) and Coordinated Behavioral Health Services (CBHS) announced the formation of a Management Services Organization (MSO), Innovative Management Solutions NY (IMSNY) to support New York State’s Behavioral Health provider community. IMSNY’s initial offering is a customized data warehousing and business intelligence solution that is tailored specifically to meet the needs of New York-based Independent Practice Associations (IPAs) of Behavioral Health providers. Plans are already underway to expand IMSNY’s services to include other MSO services, including practice management, credentialing, revenue cycle management, and other administrative support services, as well as to meet the needs of other sectors in New York’s rapidly evolving healthcare ecosystem. “We are thrilled about this collaborative undertaking, as it will provide efficiencies and economies of scale not just for our IPAs, but the for the whole sector,” said CBHS Co-Chair Elizabeth Kadatz, of RSS, “and we think the timing is right for our community to come together to adapt to the changing healthcare landscape.”

By Staff Writer Behavioral Health News

New Management Services Organization Established to Support NY Community Behavioral Health Providers

Coordination is crucial for improving health outcomes for people with chronic health conditions, mental illnesses and substance use disorders. It is even more critical now that four Medicare models demonstrating significant evidence for improving health outcomes for depression and anxiety (Carleton et al., 2018). In our effort to learn about telephonic mental health services, we interviewed mental health clinicians who provide telephonic mental health treatment. We learned that clinicians’ perceptions towards telephone delivered care vary. One clinician commented “I didn’t know what to expect. I wondered if it would be less personable.” Another clinician said “I thought it would be mainly for two specific populations, the elderly or people who are disabled. But also people who might have fear or stigma [towards] counseling or therapy.” Despite these differences, clinicians’ overall perceptions of patients’ acceptability of these services were positive. For the most part, we heard that “generally patients are satisfied”. In one interview, a clinician said “Everyone I spoke to had positive feedback. I always receive a lot of ‘thank you’s and patients are appreciative when I call them and when they receive help from me. It’s been very positive and seeing that it is helping them and that patients are really benefiting from the service.”

Unlike the sparse research in this area, clinicians we interviewed were not reluctant to provide non-in-person services. In fact, they perceived it as a convenient and beneficial modality for getting patients the care they needed, and even enrolling patients that would not have otherwise sought services. This was clear when one clinician said “I feel that when people are in need of better care they should be able to access it and can definitely help and can be as effective” as in-person treatment.” In our interviews with clinicians, they often mentioned the therapeutic alliance with the patient as something that they thought would have to change in order to provide services over the telephone. Several clinicians mentioned having to pay close attention to their voice tone, their word choice, and actively listening to patients for “clues” to build rapport. In adapting to this modality and reinforcing her skills, one clinician said “I experienced a little bit of burnout coming back and I thought it would be harder to build rapport with patients but patients have been able to engage over the phone.” The general consensus from clinicians was that the therapeutic alliance with their patients was not negatively affected in any significant way nor was treatment or quality of care compromised when they delivered care remotely. These comments support what we know from existing research which demonstrates that telephonic services are effective in treating mental health conditions like depression, and other behavioral health conditions (Boyden & Dobel-Ober, 2016; Datto, Thompson, Horowitz, Disbot, & Oslin, 2003; Ekeland, Bowes, & Flottorp, 2010).

Part of clinicians’ acceptance and adoption of telephone delivered mental health services stemmed back to initial training they received. It was clear that clinicians, who struggled using the telephone for other work, needed practice with telephone training. This has implications for clinicians who lack training in telephonic mental health services or who face providing therapy telephonically to patients. This field has maintained that in-person mental health services to patients are the basis for providing care. Yet emerging technological approaches once
Meeting the Workforce Challenge at Outreach

By Debra Pantin
President/CEO Outreach Development Corporation

A s behavioral health care providers, we confront the unrelenting opioid epidemic, in an environment of rapidly evolving reforms in health delivery and payment systems, one theme continues to resonate: the importance of a vital recovery force. It comes as no surprise that compassioning the reality of systems reform, our field is experiencing a number of workforce recruitment and retention challenges.

Across the country, there remains a critical shortage of sufficiently trained and credentialled health workers and clinical professionals to meet the growing population of individuals in need of behavioral health care. Particularly with 200,000 full-treatment plans. A 2016 report published by the Health Resources and Services Administration (HRSA) highlighted worker shortages as a key challenge for meeting the nationwide need for behavioral healthcare. There are over 123 million Americans living in designated Mental Health Professional Shortage Areas (MHPSAs), and the report estimated it would take nearly 6,000 additional health workers to meet these needs.

A January 2019 publication provided by the Mental Health Association in New York State summarized statewide survey results of turnover and vacancy rates among behavioral health providers. New York’s average annual turnover rate was a staggering 34%. In its segmented data, results showed that regions with higher costs of living had higher rates (up to 42%). Rates across the country are comparable and equally concerning. Salary growth and compensation has largely stagnated, a factor that emerges as highly consequential for behavioral health nonprofits. An inevitable consequence of these challenges is the increasing occurrence of worker “burnout” from high caseloads, more demanding and complicated cases.

Outreach’s Own Workforce

At Outreach, our programs directly experience these challenges, especially in our residential treatment programs. Our capacity to provide vital and accessible care to our clients has endured dramatically with the loss or addition of a clinician. With this in mind, we carefully examine and gauge workforce issues, with focus on employing best practices in recruiting and retaining a qualified, motivated, engaged and job-satisfied staff.

We have fortunately been able to, in some ways, go against the tide on some of these trends, specifically on retention. Of almost 200 full-time and part-time staff at Outreach, our turnover rate for 2018 was 18%. While we are not immune to the national trends, we are taking steps to mitigate those challenges.

Salary and benefit packages have been enhanced for non-clinical and clinical staff, effective 12/1/2016. Other organizational improvements include competitive benefit packages, family-friendly policies and programs, and meaningful professional development opportunities.

Employer Engagement at Outreach

Ten years ago, Outreach embarked upon a culture change initiative. We commissioned experienced executive consultants to interview stakeholders key to our mission: our referral sources, board members, and most importantly, our staff. An opportunity was identified to “de-silo” Outreach’s leadership and programs through a major rebranding and internal organizational culture change. The biggest takeaway from this experience was the ability to establish systems to engage and listen to our employees across our programs.

An important initiative undertaken at Outreach was to participate in the Best Companies to Work for in New York program. Created by the NYS Society for Human Resource Management (SHRM), The Business Council and Best Companies Group, the effort recognizes outstanding places of employment by capturing data on employer benefits, HR policies, practices and demographics, and more crucially, employee engagement and satisfaction.

While designation as a ‘best company’ would enhance Outreach’s reputation as an employer, we were especially invested in the results of the anonymous, voluntary satisfaction surveys completed by our employees; the results of which are aggregated by Best Companies’ statisticians for our review, and highlight trends in key areas such as: trust and confidence in the agency’s leadership, professional development and career advancement, pay and

Adding Recovery Professionals to the Continuum of Care

By Ruth Riddick
Community Outreach ASAP New York State

W hat is the purpose of our work, of all the prevention, intervention and therapy, all that merciful medical model and multi-volume DSM? The treatment plans? Aftercare? All this helping apparatus – what’s it for?

Now, the agreed response is that “recovery” is our mutual goal irrespective of our specialization or wherever we engage professionally with substance use disorder. Recovery is the stated goal of interventionists, counselors, addiction doctors and nurse-practitioners, community mutual-aid. Where, then, do we add recovery professionals?

Way back when I completed a reputable program for alcoholism, I remember being issued with a treatment plan, a 12 Step meeting list, and a plethora of good wishes from gifted counselors, many of whom remain personal friends. Clinical staff had done a great job with me, but I still hadn’t the first idea where to find the bus back into the city or the money to pay my rent. To this day – forgive me! – I haven’t read that treatment plan; it’s somewhere in my attic, safely housed by UHaul. Could I have used a recovery coach? Could I ever!

A recovery coach is defined by training pioneers CCAR (the Connecticut Community for Addiction Recovery) as “Anyone interested in promoting recovery by removing barriers and obstacles to recovery and serving as a personal guide and mentor for people seeking or already in recovery.” Barriers? Obstacles? In this model, we’re talking about quotidian life-challenges: couch-surfing might be considered a barrier to recovery, unemployment an obstacle to rebuilding a credit score. Recovery coaches usually have direct personal experience of meeting these challenges in their own lives.

Indeed, Professor Thomasina Borkman at George Mason University wrote about the value of deploying such “peers,” locating non-clinical authority (her word) in a potent mix of “experience” and “expertise” (1976, quoted in William White). In the recovery field, this formulation has come to mean: “Experience coming from a personal history of or exposure to (i) substance use disorder, (ii) the process of change, and (iii) a sustainable life in recovery. Expertise requiring personal knowledge and training.”

Just what is it that recovery coaches do to support the continuum of care? The simplest definition is that we help people build a sustainable life in recovery. And we do it by using our own strengths to support self-efficacy in others. “Our strengths help us be happier, fulfilled, engaged, and energized, achieve our goals, have better relationships, and bounce back faster from setbacks,” writes career coach, Sonya Tinsley.

That is, coaches focus on the recovery goals of the individual (“client” or “participant”) through purposeful conversations; in effect, mini-strategic planning sessions. These conversations are propelled by the agenda-setting question, “How can I help you with your recovery today?” We leverage our own experience to present options and resources, we encourage practical initiatives in support of both micro goals and the individual’s re-covery mission, and, if it’s helpful, we can be something of an accountability buddy.

Most important, we serve as role models for recovery (“this is what recovery means to me”), encouraging individual visions for that sustainable life. What you might refer to as “talk WITHOUT therapy.”

In the field, we call this process “building recovery capital.” CCAR has listed no less than 32 individual lifestyle items under this heading, including housing, employment, education, finances, community. The engagement with a recovery coach will last as long as the individual/client finds value in this capital-building collaboration – or until insurance cuts off the funding, but that’s a different issue!

The National Council for Behavioral Health (2018) has quantified several benefits of introducing recovery professionals into the continuum of care. These benefits include reduced treatment re-admission rates, rapid turnaround following re-admission, decreased hospitalizations, and reduced length of hospital stay, all of which results have positive implications for the bottom line. Even more personal outcomes such as increased recovery capital, community & civic engagement, and realizing personal potential have also been identified. As NCBH’s Tom Hill, formerly of SAMSHA, concludes, “Recovery is an expectation.” What’s not to love?

Traditionally, recovery coaches have been seen as bridging the gap between treatment and a life in the recovery community, the very gap I experienced when

see Care on page 32
The Impact of Youth Peer Advocates: An Early Look at Findings

By Darren Cosgrove, LMSW
Thomas M. LaPorte, PhD and
Margaret Gullick, PhD

The incorporation of peer support in the treatment process for individuals experiencing mental health challenges has been increasing over recent decades (Campbell, 2005). Adults with mental health conditions have pursued roles as facilitators in recovery-based work (Mead, Hilton & Curtis, 2001), and attained roles as peer support providers in diverse settings (Chinman et al., 2008; Gopal, Lee, Harris, Acri, & Munson, 2017). More recently, youth have also filled critical roles as peer support providers, as young people with mental health challenges may relate better to another young person with lived mental health experience. A further development in peer work is the recent inclusion of Youth Peer Advocates (YPAs) in High Fidelity Wrap-around (HFW); Walker, Baird, & Welch, 2004. HFW is an intensive care coordination model for children with complex mental health challenges. The New York State System of Care (NYS SOC) initiative, a pilot study of HFW implementation, encourages YPA involvement in the HFW process. Here, YPAs tend to work one-on-one with youth HFW participants and collaborate with members of the care team, including care givers, case managers, and family peers advocates.

Including YPAs in the HFW process would appear to offer several advantages over HFW as usual. However, research on the impact of youth peers, particularly in HFW, is currently quite limited. This behavioral therapy social skills training, enhancements YPAs can bring to the HFW process, and some potential challenges of involving YPAs in HFW, both theoretically and in preliminary findings from our ongoing evaluation of the NYS SOC initiative. While the research described here is qualitative and exploratory, the findings may provide directions for future efforts to integrate youth peers in HFW.

The Center for Practice Innovations: A Resource for the Behavioral Healthcare Workforce

By Nancy H Covell, PhD, Sapana R. Patel, PhD, Paul J. Margolies, PhD, Helle Thorming, PhD, LCSW, Ilana Nosse, MD and Lisa B. Dixon, MD, MPH
Columbia University and
New York State Psychiatric Institute

The New York State Office of Mental Health (OMH) and the Department of Psychiatry, Columbia University, established the Center for Practice Innovations at Columbia Psychiatry and New York State Psychiatric Institute (CPI) in 2007 to promote the widespread use of evidence-based practices developed for adults throughout NYS. CPI supports the behavioral healthcare workforce by offering free training, with continuing education, and technical assistance to staff working in not for profit behavioral healthcare agencies. By providing this free support to increase staff competence and support implementation of evidence-based practices, CPI also hopes decrease staff burnout and turnover. Additionally, the provision of free continuing education may help lower wage earners keep their licensure and accreditations without incurring additional out-of-pocket expenses.

CPI has six core initiatives: treating co-occurring mental health and substance use disorders (called “Focus on Integrated Treatment” or FIT), assertive community treatment (ACT), supported employment/education via individual placement and support (IPS), wellness self-management (WSM), first episode psychosis (called OnTrackNY), and suicide prevention (SP-TIE). CPI also supports other state training initiatives including Adult-BH Home and Community Based Services, the Uniform Clinical Network Provider training, increasing the use of clozapine, cognitive health, treatment of tobacco use disorder (as part of the FIT initiative), and treatment of obsessive-compulsive disorder.

CPI also offers training in clinical core competencies for the behavioral health workforce including topics like care transitions and care management, cognitive-behavioral therapy, social skills training, cultural competence, engagement and outreach, ethics, evidence-based prescribing, family and community support, group psychotherapy, integrating medical and behavioral health services, working with the LGBTQ community, justice-involved individuals, managing challenging behaviors, motivational interviewing, peer services, person-centered treatment planning, recovery, risk assessment, shared decision making, stage-wise treatment, substance use, and trauma informed care. Staff can also choose curricula that are built around these core competencies (e.g., motivational interviewing) or CPI certificate programs (e.g., violence risk management).

CPI offers both online and in-person training. Working closely with content experts and instructional designers, CPI has developed over 120 highly interactive online modules that use personal recovery stories, clinical vignettes, interactive exercises, and frequent knowledge checks to engage the learner. CPI also offers several regional and on-site agency face-to-face training across different content areas.

While training is necessary, CPI recognizes that it is rarely enough to change practitioners’ daily actions and achieve high quality implementation of the desired practice. For this reason, CPI offers empirically driven technical assistance to supervisors, managers and practitioners focused upon their implementation efforts. This often includes interactive webinars, an online resource library with practical tools (e.g., group manuals and fidelity checklists), consultations (both in person and by telephone), learning collaborative, and monthly conference calls for participants in specific initiatives during which program staff share successes and receive expert consultation from peers and implementation experts on their implementation challenges. Consultations may follow difficulties with licensing reviews or staff turnover or are provided upon request for technical assistance. CPI’s efforts are guided by dissemination and implementation science and embedded within a practice change model that considers the policy, regulatory and financial environment of practice change as well as organization-level factors such as program-practice fit, leadership investment, organizational culture, time and resources available for practice implementation.

To join a learning collaborative, participating programs form implementation workgroups that develop an implementation plan and oversee the work toward the goals of that plan, participate in learning collaborative meetings, and collect and submit performance indicator data. In many cases, these learning collaboratives use fidelity self-assessments to help guide programs through continuous quality improvement projects. This data allows programs to identify challenges in implementation and work with CPI staff to address these challenges. It also allows OMH to identify and support quality improvement efforts.

As of March 31, 2019, 36,040 staff had completed 412,240 online modules. Programs participating in CPI initiatives are geographically dispersed through New York State, reaching 61 of the 62 counties (the remaining county, contained fully within a State Park, is the least populous in NYS).
The phrase social and cultural determinants of health has entered the lexicon of medical and social service providers and is often mentioned alongside health disparities. Since the early 90s, public health researchers have been suggesting that a person’s socioeconomic characteristics, including race, ethnicity, socioeconomic status, gender and age, largely influence one’s health (Link and Phelan, 1995). These characteristics determine our place in the social structure and consequently, the resources or lack thereof to protect and manage our physical and mental health. In addition to resources, cultural beliefs and ideas about our lives and health are also associated with these determinants. Health disparities, systemic differences in health care and health outcomes among populations, have been attributed largely to the interaction between available resources and aspects of one’s culture. The realization that policies, programs and services must also attend to the social and cultural determinants to achieve health equity is now a commonplace to our collective understanding of health. However, best practices for identifying and addressing these determinants remain under discussion and are being evaluated for effectiveness as we aspire to decrease disparities.

The professionalization of the role of youth and family peer advocates: Over the past three decades, there has been a growing appreciation for the role of peer advocates in providing resources, supportive services and enhancing the health of different communities and especially of persons with behavioral health conditions. Peers provide advocacy, empowerment, coaching and services coordination in many clinical settings and in the community, and successfully engage in services socially disenchanted, often stigmatized, groups. Many peer advocates have direct, lived experience in navigating health and social services systems and communicating with service providers and can translate their experiences into skills and insights that help those they serve.

Building on this unique skillset of peers, several statewide trainings and credentialing programs have emerged to support them in the workforce. As a result, peer advocates increasingly are being hired as full-time paid employees, especially in the field of mental health. Under the auspices of Children and Family Treatment and Support Services in the state of New York, services provided by credentialed family and youth peer advocates will become billable under Medicaid, as of July 1, 2019 and January 1, 2020 respectively. Although this recognition of the critical role of peer advocates in providing services has been long overdue, rendering their services billable enhances their integration into the workforce and denotes their professional value in the healthcare system.

A novel component of the Wraparound Training of peer advocates in New York State: The New York State (NYS) Office of Mental Health (OMH) has been training in and implementing Wraparound with providers serving youth with serious emotional disturbances and their families. This training, offered by the Wraparound Training & Implementation Institute of NYS OMH and funded by a SAMHSA Systems of Care expansion grant, creates a framework for comprehensive, holistic and family-driven service delivery. One of the distinctive features of New York State’s Wraparound program is the formation of a provider triad: a care manager, a family peer advocate, and a youth peer advocate. This triad ensures a team approach to services and is designed to effectively weave the skills and perspectives of all three providers aiming to more effectively address the family and youth needs.

As part of this program, the Wraparound Training & Implementation Institute, in partnership with C-CASE (Center for Research on Cultural and Structural Equity in Behavioral Health) at the Nathan Kline Institute, has incorporated a novel and theoretically-guided social and cultural competency training tailored specifically for peers. Guided by the health lifestyle model, peer advocates are trained in using the family story to identify the social and cultural factors that shape a family’s available opportunities to address health-related matters and the health-related choices the make (Cockerham, 2013). This model suggests that the interplay between opportunities and choices generates lasting dispositions or orientations towards health, which include the tendency to access or avoid mental health services, to seek or not seek community supports, or to adhere or not to adhere to recommended treatment. These tendencies are defined as health habits and they influence our health behaviors. Over time, and with repetition of the same behaviors, a health lifestyle is formed.

The training team’s decision to integrate this health habits-driven model into the peer advocates’ training stemmed from the following three advantages. First, the model provides a clear depiction...
Rural Workforce Development: Critical Challenges

By Rachel W. Bush, PhD
Assistant Professor, Psychiatry and Behavioral Sciences,
New York Medical College

The critical challenges that are associated with rural workforce development remain a significant issue in America. We have an obligation to explore the best ways of caring for the underserved rural population. Currently we have a health professions crisis unfolding. The federal government projects a shortage of over 20,000 primary care physicians in rural areas by 2025 (Nelson, et al., 2017).

How can we guarantee that excellent health care is available for everyone? What are the most effective and useful pathways to ensure professional competence and the acquisition of essential resources? We know and continue to be aware of the fact that evidence based rural workforce policy is an enduring challenge (Wilkinson, 2003). Ongoing infrastructure support remains inadequate (Lyle, 2002).

Stigma

Unfortunately, the stigma associated with pursuing behavioral health evaluation and treatment is heightened in small cohesive rural communities. Within this context there are a limited number of mental health professionals to provide essential mental health care. Privacy and confidentiality are always paramount and yet more difficult to insure within the rural context. Miller (2011) has highlighted some of the essential clinical, professional and social challenges of practicing rural medicine. She argues that complicated interpersonal dynamics occur in sparsely populated areas where privacy is hard to come by. Being the sole medical resource for a community potentially can lead to isolation and physician burnout.

Professional Training

Inequities between rural and urban health will grow unless we ameliorate the situation. In 2010 the Patient Protection and Affordable Care Act and other federal legislative fund initiatives were developed to recruit physicians to rural areas and decrease geographic inequities. Mareck (2011) argues that the federal government has been developing programs to increase the desirability for physicians to pursue careers in rural medicine. Area Health Education Centers (AHEC), Federally Qualified Health Centers (FQHC) and the National Health Service Corps (NHSC) have included scholarships requiring rural medical service as a payoff. The goal of providing community driven patient directed comprehensive, culturally competent quality primary care has also been highlighted in the growth of mental health telermedicine. Between 2004-2014 the annual growth rates in this area have reached 45% (Mareck, 2011). In terms of medical education and medical residencies and fellowships, rural training has been quite limited in scope. For example, we know that 99 percent of residences are located in urban and suburban settings.

Demographics

Older patients comprise one half of all hospital admissions in rural settings (Nelson et al., 2017) where older patients in urban settings account for just 37 percent of hospital admissions. This may be explained in part by the fact that older patients in rural communities also suffer from multiple chronic diseases and their primary care physicians often do not have the support of sub-specialists, emergency physicians and hospitalists. It is a vicious cycle that involves primary care physicians struggling with medical breadth, depth and courage to perform medical procedures outside of their comfort zone (Miller, 2011). This, in addition to primary care physicians having limited access to sophisticated medical technology. Treating sicker patients with complex issues in rural settings therefore can be frustrating. Another determinant of health and wellbeing is rural poverty. Rural patients often travel farther for their medical care, struggle with social isolation and the lack of access to affordable nutritious food and medicine (Nelson, et al., 2017).

Patients resistances to obtaining quality care at times can feel insurmountable and are associated with feelings of instability, anxiety and helplessness. In 2004 Worley used the powerful image of rural communities always being one doctor away from a crisis and the ongoing struggle of being without sufficient resources. As a result, locum tenens recruiters have been responsible for filling gaps in medical care in remote regions. These physicians have the professional flexibility to travel and also control the scheduling of work intensity and commitment for brief periods of time. As a result, notwithstanding the fluidity of providers, underserved regions are capable of receiving necessary care.

Professional Benefits

Rural medicine affords a special sense of professional and personal importance for providers. Rural practitioners have the opportunity to develop long term relationships with patients and their families. They frequently are viewed as important community leaders serving multiple important roles. For example, it is not uncommon to be in the position of treating acquaintances, close friends

see Challenges on page 35

CoveCare Center Hosts 2nd Annual LGBTQ+ Pride Event

By Staff Writer
Behavioral Health News

Close to 100 members of the community recently attended CoveCare Center’s 2nd Annual Pride Clinic, learning about topics such as mental health and substance use issues within the LGBTQ+ population; pronouns and gender identity language; the history of the Pride movement; and LGBTQ+ youth. The clinic began with a workshop focused on the use of LGBTQ+ inclusive language led by CoveCare Center’s Diane Lotto, LMSW, CSW-G, Senior Partnership Services Team Leader and Krista Zanfardino, LCSW, Associate Vice President at CoveCare Center. “Diane and I developed this training to educate the community about the importance of understanding the differences between concepts such as gender identity, gender assigned at birth, sexual orientation, and gender expression. The way we talk to and about people goes a long way in making them feel included rather than ignored,” commented Krista.

CoveCare Center would like to thank the Putnam County Department of Health; GLSEN Hudson Valley and Putnam PFLAG (Parents, Families and Friends of Lesbians and Gays); The Loft LGBT Community Center; the Dutchess County Pride Center; and Planned Parenthood for sharing important information and resources with all who attended the clinic. “We had excellent community organizations join us this year. Many people in the LGBTQ+ community can feel left out or alone, and having these other agencies share their information helps individuals who may feel isolated connect with the resources they need,” commented Krista.

CoveCare Center is the only private non-profit agency providing recovery-based mental health and substance use treatment and prevention services in Putnam County, NY. CoveCare Center offers hope and healing to people of all ages through a comprehensive range of services including individual and group counseling, care coordination, family advocacy, parenting education, community outreach, and medication management. CoveCare Center is a member of the Area Health Education Services (AHEC), a non-profit 501 ©(3) membership organization of forward-thinking, community behavioral health and disability service providers in the Hudson Valley. Region whose shared goal is to promote recovery-oriented and outcome-based services designed to ensure high quality and low costs.

For more information about CoveCare Center and its services, please visit www.covecarecenter.org or visit them at www.facebook.com/covecarecenter or call (845) 225-2700.
Investing in the Integrated Care Workforce

By Andrew Philip, PhD, Senior Director, Laura Heath, MD, MPH, NVAM Fellow, and Kristin Potterbusch, MPH, Senior Program Manager, Primary Care Development Corporation

It is no longer a new idea that the mind and body are intrinsically connected; Socrates via Plato, described this around 360 B.C. Yet, we still separate and isolate these aspects of care; treating behavioral health needs like schizophrenia in mental health clinics and physical issues like diabetes in primary care clinics. Although primary care providers increasingly treat common behavioral health issues such as depression and anxiety, they still only reach a fraction of people who need these services and have not historically provided high-quality care for people with these diagnoses (Barkil-Oteo, 2013). Meanwhile, those living with serious mental illnesses (SMI) generally lack adequate primary medical care and are more often seen in behavioral health settings (Olsson et al., 2019). This dichotomy in care fails to address the realities of comorbidities and whole-person needs.

Integrating behavioral health and primary care bi-directionally (providing primary care in behavioral health settings and behavioral health services in primary care clinics) is a powerful and necessary tool to address a wide range of needs both for staff and patients (Skillman et al., 2016). While there is much work to be done to transform our policy and payment systems to support integrated care, a more transparent yet often overlooked necessity is preparing the behavioral health workforce to deliver integrated care. We can equip our staff through three key mechanisms: interprofessional collaboration, clinical competency, and supervision.

Interprofessional Collaboration

Often behavioral health staff have trained in discipline-specific settings (e.g., schools of social work, psychiatric clinics, or psychotherapy settings) and may not be familiar with methods for communicating with and sharing clinical responsibilities across other disciplines. Health organizations can overcome billing, scheduling and infrastructure barriers to integration only to find that a breakdown in communication between team members stalled an entire organization’s integration efforts. A traditionally-trained behavioral health professional may never have written a brief, quickly digestible note germane to primary care setting records, nor be familiar with how to contribute their skill and perspective within a cross-discipline team huddle or curbside consultation. Integrated settings often illuminate differences in staff priorities and goals (e.g., changes measurable by lab results and screening), language (e.g., terms like ‘patients’ vs ‘clients’, ‘primary complaint’ vs ‘patient goal’), and expectations such as metrics and clinical encounters per day.

To sustain buy-in, cooperation, and collaboration between team members, early wins and shared goals should be established. Screening can be one valuable starting point. Whether improving depression screening or screening for colorectal cancer, both behavioral and medical staff can identify opportunities to see Investing on page 30

Creating a Family Peer Support and Services Workforce

By Marleen Litt, LCSW, Yudelca De la Cruz, MSED, Onicka Miller and Veronica Worley JCCA

For the caregiver of a Medicaid-eligible child who has a behavioral diagnosis, or demonstrated loss of a physical health diagnosis, Children & Family Support & Services (CFTSS) provide unprecedented support, advocacy and resources. On July 1, 2019, the fourth CFTSS component, Family Peer Support Services (FPSS) will become reimbursable under Medicaid Managed Care. Many young people stand to meet eligibility and with the emphasis on family support, it is a service that the whole family can benefit from.

This service differs from other CFTSS and Home & Community Based (HCBS) services in that it stabilizes and supports caregivers through a unique model of peer support. FPSS providers must demonstrate that they have “lived experience” navigating multiple systems of care for their children. Among other benefits, a mounting body of research demonstrates that family peer support provides caregivers with a better understanding of their children’s behaviors, increases their engagement in community and health resources, and reduces the rates of missed medical and behavioral health appointments. In addition, it validates the lived, personal experience of FPSS Providers and empowers them to help others. It further increases the pool of qualified service providers for clients, and provides a pathway to meaningful employment for individuals without a formal education in child development or social services. Currently, more than 35 agencies serving New York City have been designated to provide FPSS. However, there are considerable obstacles to the recruitment, on-boarding, supervision of potential FPSS providers, as well as fiscal viability issues for the agencies employing them.

In various shapes and forms, JCCA has provided peer advocacy and support to families for quite some time, and can offer instrumental insight into the challenges of building and maintaining the FPSS workforce. JCCA, a child & family services agency in the New York metropolitan area, has provided home & community based services, foster care, preventive, mental health, and residential treatment for almost 200 years. The staffing pipeline is clear: almost every JCCA program works with motivated, resilient parents/caregivers who successfully navigate child welfare and/or behavioral health systems and emerge “on the other side” with newly developed strengths, skills, and knowledge. They are prime candidates to become advocates. However, their experience can leave parents and caregivers feeling exhausted and drained. Even the most resilient can harbor feelings of anger and resentment and need time to process, heal, and recover.

Credentialed FPSS providers poses another obstacle. Once employed, FPSS provider must be Credentialed Family Peer Advocates. To obtain a provisional credentialing, one must complete a multi-day online Level I training as well as an application with an attestation and two letters of reference. While providers do not need a formal education, this process can be challenging for prospective advocates who may not have recent work experience. For others, a written attestation recounting personal experiences is a deterrent. For Level II, the FPSS worker must obtain 1000 hours of experience before completing the training and submitting a new application; recertification is required as well. These same credentialing qualifications do not exist for other CFTSS services.

Once they begin work, the Family Peer Advocate is expected to share their own experience, yet maintain boundaries. This is a difficult balance. The FPSS provider needs to have ongoing training, regular supervision, and an ability to process therapeutically the impact of vicarious trauma. Yudelca De La Cruz, the director of JCCA’s Family Resource Center and Parent Advocate program, encourages staff to seek outside therapy but finds that individuals, who are often parents with limited spare time, rely on their supervisor to manage both their work performance and their emotions.

Lastly, for employers who maintain a per-diem workforce structure, the multi-day training can make onboarding costly. The credentialing is at no charge, but providers must be compensated for their time even before they provide a billable service. Additionally, the rates for new Family Peer Support & Services are inadequate to sustain full-time staff. State-negotiated FPSS rates are nearly $10 less than the rates for Psychosocial Rehabilitation, a service that can be provided by a high-school educated worker without personal experience, credentialing, or additional training. JCCA and other agencies provide this service using a per-diem workforce, paying workers for the hours they work at a maximum of 20 hours per week—without benefits or vacation time. Turnover is high, as providers leave for opportunities with better wages, more see Creating on page 33
Evidence-based behavioral interventons for insomnia (i.e., cognitive behavorial therapy for insomnia) are now recommended by groups such as the American College of Physicians and the American Academy of Sleep Medicine. It is therefore important that behavioral health providers familiarize themselves with different components impacting a single issue (such as improving rates of colorectal cancer screening). Shared initiatives will provide opporunities for staff to cross-train, improve fluency in behavioral or medical terminology, and build strong communication.

Clinical Competency

The ability to effectively deliver evidence-based clinical interventions can help behavioral health staff feel efficacious in their work and comfortable in their role within the integrated team. For example, individuals living with SMI are highly likely to also experience chronic sleep difficulties (50-80%); Harvard Medical School (2019) described insomnia as a chronic condition that can impact a single issue (such as improving rates of colorectal cancer screening). Shared initiatives will provide opportunities for staff to cross-train, improve fluency in behavioral or medical terminology, and build strong communication.

Evidence-based behavioral interventions for insomnia (i.e., cognitive behavioral therapy for insomnia) are now recommended by groups such as the American College of Physicians and the American Academy of Sleep Medicine. It is therefore important that behavioral health providers familiarize themselves with different components impacting a single issue (such as improving rates of colorectal cancer screening). Shared initiatives will provide opportunities for staff to cross-train, improve fluency in behavioral or medical terminology, and build strong communication.

Visiting our website: www.mhnews.org

Investing from page 29

Jointly improve a single metric or outcome. In these efforts, staff may find ways to reduce downstream processes (such as the case of depression screening), or to learn from one another about risk factors for disease and opportunities to jointly improve outcomes. The most significant factors impacting a single issue (such as improving rates of colorectal cancer screening) are shared. Initiatives will provide opportunities for staff to cross-train, improve fluency in behavioral or medical terminology, and build strong communication.

Clinical Competency

The ability to effectively deliver evidence-based clinical interventions can help behavioral health staff feel efficacious in their work and comfortable in their role within the integrated team. For example, individuals living with SMI are highly likely to also experience chronic sleep difficulties (50-80%); Harvard Medical School (2019) described insomnia as a chronic condition that can impact a single issue (such as improving rates of colorectal cancer screening). Shared initiatives will provide opportunities for staff to cross-train, improve fluency in behavioral or medical terminology, and build strong communication.

Evidence-based behavioral interventions for insomnia (i.e., cognitive behavioral therapy for insomnia) are now recommended by groups such as the American College of Physicians and the American Academy of Sleep Medicine. It is therefore important that behavioral health providers familiarize themselves with different components impacting a single issue (such as improving rates of colorectal cancer screening). Shared initiatives will provide opportunities for staff to cross-train, improve fluency in behavioral or medical terminology, and build strong communication.

Visiting our website: www.mhnews.org
Workforce Crisis from page 1

and de-professionalization (a positive in my view).

Education and Training

I will not say much about education and training. Professional schools, particularly, have increasingly provided education in “evidence-based” practices that probably have better outcomes than intuitive clinical practice. And training programs abound. In New York, for example, social workers—who provide most of the nation’s mental health services—now are required to get continuing education credits. New training is flourishing, much of it on-line, just one example of how new technology can contribute to improved professional—and paraprofessional—quality.

Recruitment

Recruitment, of course, is key to increasing the size of the mental health workforce. And critical to this is HIGHER PAY—especially for “lower level” staff. It is appalling that residential workforce. And critical to this is increasing the size of the mental health workforce.

organizations to fulfill its obligations to people with behavioral health conditions, is sad in the extreme.

But pay is not the only way to attract people to vital jobs. Loan forgiveness, in a nation in which most people go into debt to get an education, is frequently on the recruitment agenda. Unfortunately, it’s on the recruitment agenda for every vital, but not terribly popular, job, creating huge competition for the little money that is made available to help people pay off their loans.

Beyond the money issues, recruitment depends on creating the sense that work in the field of behavioral health opens up a range of professional and career opportunities—that include increasing pay over time, the expectation of promotions to supervisory and management positions if desired, and access to experiences that add value to the work professionals do such as participating in research, attending conferences, publication, etc. Unfortunately, such opportunities often require very high levels of education and jobs devoted less to service than to academics, so they are effectively closed off to the very workers for which the system has a crying need.

In addition, the mental health professions face a problem of social status. I don’t want to overstate this. There are some high-status roles, being a psychotherapist, for example. But psychiatry is apparently a lower status role among physicians, and social work, for sure, doesn’t get the kudos it deserves.

How to increase the social status of behavioral health work is a tough question. I have always thought it would be useful to have positive images in the movies and on TV. But it strikes me that psychiatrists and social workers, among others, are often ridiculed in the popular media. We need far better public relations!

De-professionalization

Finally, the shortage of professional staff has been, and can continue to be, addressed by “unbundling” functions and thus de-professionalizing them. For example, in the medical world in general, there are now nurse practitioners, physician assistants, and administrative staff who have taken over part of the workload of physicians. In psychiatry there has been a vast change since I entered the field 50 years ago. Psychiatrists previously had done—especially case management and dealing with the concrete needs of people having a tough time managing to lead safe and satisfying lives. Whether this was a wise change is still open to debate, but it has unquestionably been a way to provide more service to more people.

Can more functions of psychiatrists and other professionals be unbundled and turned over to other professional or paraprofessional staff? I have no doubt that this is possible. For example, I believe—and this is very controversial—that psychologists, nurses, social workers, and mental health counselors can all be trained to prescribe psychiatric medications and that, with appropriate training, they can be relied on to sign off on treatment plans that now call for psychiatrists.

This would not be a total response to the lack of psychiatrists in many locales in the United States, but it would help.

see Workforce Crisis on page 34

Brown Bell Consulting is a full service Government and Community Relations company. We provide organizations with customizable solutions to meet all of their local, state and federal government relations needs. To find out more about how we can help your organization, please contact us for a personal consultation.

We look forward to working with you.

Constance Y. Brown-Bellamy, MPA
President and CEO - Brown Bell Consulting, LLC
External Relations Specialist
BrownBellConsulting@gmail.com   (202) 486-0495

Delray Beach, Florida
Individuals, Couples and Families
Mental Heath Services
Older Adults - Medicare Provider
Addiction and Recovery Therapy

Mindy Appel, LCSW, ACSW, LMFT
Bank United Building
5300 W. Atlantic Avenue - Suite 408
Delray Beach, Florida 33484
appelmindy@gmail.com    www.mindyappel.com
(561) 926-7858
Parity from page 6

E/M codes should be limited to new patients, patient re-evaluation after a series of treatments, or a significant change in a patient’s condition. This policy is in direct conflict with the conventions of CPT, which provide that psychotherapy may be billed using a combination psychotherapy code, comprised of an E/M code and a psychotherapy add-on code. Psychiatrists regularly provide E/M services in all settings – inpatient and outpatient - and there is no clinical reason why this service cannot be provided at each and every visit. This policy also conflicts with New York Insurance Law 3224-b, which requires insurers (and all health plans) to accept and mitigate price variation for the same service. In addition, it is committed to working with the provider community, government regulators and other stakeholders to ensure adequate and fair reimbursement for the treatment of mental illness and substance use disorders, both for providers and patients alike.

How Far from page 17

Behavioral health executives need to make decisions and respond quickly to changing markets. They need digital dexterity, using data for strategy and change and using technology to reengineer processes and relationships with staff and patients. This requires leaders schooled in the business, not just social work or psychiatry. We wanted to decrease stigma and we need care that is clinically competent. If we don’t, doesn’t that mean that people is bad for your health? We need government policies that pave a pathway out of poverty. What about the terms, “trauma competent,” “culturally competent,” and “military competent” for your health? We need government policies that pave a pathway out of poverty. What about the terms, “trauma competent,” “culturally competent,” and “military competent” for your health? We need government policies that pave a pathway out of poverty.

Utilization Review

NYSPA continues to work to assist its members in connection with the ongoing utilization review activities of insurance carriers. Many NYSPA members report that a variety of health insurance carriers are using medical necessity as the touch of a button. Agencies that are consistently requesting reviews of behavioral health treatment similar to those detailed in the California lawsuit. Often, the medical necessity review will consist of requests for treatment records and/or a phone interview with the provider to permit the carrier to make a determination regarding the medical necessity of services under review.

Conclusion

NYSPA and APA await a response from the carrier on this important issue.

Care from page 25

My treatment program concluded. Increasingly, however, coaches are also being deployed in emergency rooms as part of triage teams. "Recovery coaches support patients admitted as a result of an opioid overdose or other drug or alcohol related crisis," says Phil Valentine, CCAR Executive Director. Speaking to results, Valentine adds, “Coaches have demonstrated effectiveness in linking Emergency Department patients with treatment and community-based recovery resources.”

In truth, recovery coaches can embody the potential of recovery for anyone at any point in the continuum of care from prevention through to a sustainable life in recovery.

Let’s agree to share that strengths-based definition of “recovery”: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” (SAMSHA, 2011). Anything less is not enough.

Ruth Riddick is a Certified Addiction Recovery Coach and a CCAR designated Recovery Coach Professional. She serves as Community Outreach at Alcoholism & Substance Abuse Providers of NYS, as a Coach/Trainer/Mentor at Sobriety Together and as a peer recovery subject matter expert in a variety of settings. She has been honored for her work by Caron Treatment Centers, Crossroads of Maine, and Irish americas magazine.
Participating in evidence-based practice trainings, such as trauma informed care, motivational interviewing, and mapping-enhanced counseling, not only improves delivery of care, but expands the horizons of our staff. The opportunities to participate in professional development trainings has consistently been valued by staff across various ages and disciplines: Outreach observes these opportunities as an important part of their culture that promotes (and allows for) professional development of staff is only one strategy in which Outreach engages its employees, but a critical one that is more infrastructural and available to us than salary increases.

Though Outreach has maintained strides in retaining much of its workforce, we still share in experiencing our field’s workforce crisis. Our field continues to encounter a shortage of qualified health professionals, and just as important, the salaries with which behavioral health workers are paid are not enough to sustain our workforce. To preserve and expand our field’s ability to meet the needs of our communities, as providers, we need to fiercely advocate in union for vital legislative items, such as Costs of Living Adjustments (COLAs) for our workers. It is incumbent upon us to continue to educate policy makers about the levels of the impact of these shortages on the availability and delivery of care, toward enacting legislative and policy initiatives that foster a lasting solution.

### Supervision:
The Family Peer Model must take into consideration training and opportunities for ongoing therapeutic processing. JCCA has found that staff relate positively to supervisors with lived experience. Supervision needs to be on a regular, ongoing basis with opportunities for debrief when needed as soon as possible and regular training on vicarious trauma.

Staff new to work may require more intensive and regular supervision. This is also vital to instill boundaries as they leverage their lived experience without over-sharing. It is notable that longevity, in comparison with other staff of the same level, is much higher if they have a lived experience. Intensive supervision can be noted as a factor.

### Fiscal Viability:
Research has shown that, in order to be a sustainable career option, peer advocates would need to be increased at least $16 per hour. At New York State’s current rate, it is difficult to create many positions or a true career trajectory for FPS providers. On-going government advocacy work aims to address the differential in wages.

A strong, committed workforce is what is needed to be retained, trained and put to work. With so much potential to strengthen and benefit caregivers confronting challenging medical and behavioral diagnoses, the innovative FPSS model requires a collaborative approach to workforce development.

JCCA’s “lived experience” demonstrates how to leverage this exciting opportunity for clients, agencies, and the providers they employ. Marleen Lit, LCSW Assistant Vice President at JCCA with oversight of the CFTSS, HCBS, Parent Advocate & Family Resource Center programs. Contributions by Yudelca De la Cruz, MS.Ed Director of the Family Resource Center & the Parent Advocate program, and Onika Miller & Veronica Worley, Parent Advocate Coordinators in the Parent Advocate program.

### Investing from page 30

- enhancing the recruitment process: this helps develop a pipeline of qualified staff and helps graduate programs see a need to prioritize integrated training.
- creating an integral and necessary investment in transforming our systems of care is investment in the people that deliver this care. By empowering integrated teams to function cohesively, equipping staff with effective tools that facilitate change, and ensuring adequate and meaningful supervision, we have an opportunity improve patient experience, decrease provider burnout, and better address a full range of complex and interwoven health needs. Integration cannot be “won.” It must continually be earned via strategic investments in a skilled workforce as well as policy and regulatory improvements.

The Primary Care Development Corporation is a nationally recognized non-profit providing strategic investment and technical assistance to support and expand health care — primarily in low-income, underinvested communities — to achieve health equity. For more information visit pcdc.org or call (212) 437-3900.
Health from page 27

and understanding of how our tendencies to manage our health in particular ways are shaped by social and cultural determinants. This realization deflates the stigma and blame from a family or youth that chooses to address their behavioral health needs in their own way. This view is also consistent with the Wraparound principles of family voice and choice, cultural (and structural) competency and individualized strategies (Walker, Bruins, VanDenBerg et al. 2004). Second, the model also reveals how the parents’ and caregivers’ health habits contribute to the family’s orientation towards their health, and this can inform the team-based support and services offered to the family. Finally, the health habits model recognizes that there is a lasting effect of one’s long-term opportunities, or lack thereof to address their health. This perspective is invaluable in developing a care plan and supports the Wraparound principles of unconditional, persistent and outcomes-based provision of services.

Components of the Health Habitus Integration training: The Health Habitus Integration training consists of five components: (1) a didactic phase familiarizing trainees with the model and its significance; (2) a practice activity where trainees write about their own health habits; (3) a didactic phase on conducting in-depth interviews designed to elicit the family’s and the youth’s health habits according to the health habits model. (4) A practice activity where trainees organize the information about the family and the youth’s health habits into a note, that can be enriched and revised as peer advocates increase their rapport with and understanding of the family and the youth through multiple meetings; and (5) a discussion phase on potential strategies for integrating the health habits information into the peer advocates’ one-on-one meetings with the family and the youth, but also in the triad’s meeting with the care manager and both peer advocates. The integration of the health habits information in the peer advocates’ interactions with the family, the youth and their team members has the potential to: strengthen the family and the youth’s engagement in care, strengthen self-advocacy and empowerment, contribute to the identification of community and natural supports, and to the development and implementation of a family-centered strengths-based plan. The training is offered by expert facilitators and consists of six hours. Four to five weeks after the day of the training, a one-hour booster session is provided through webinar that focuses on discussing a family’s health habits note and strategies for integrating the information in the note into the peer advocates’ family meetings.

Preliminary evidence on the training utility: Based on baseline and follow-up evaluation surveys, the implementation of the training, a one-hour booster session is provided through webinar that focuses on discussing a family’s health habits note and strategies for integrating the information in the note into the peer advocates’ family meetings.

Workforce Crisis from page 31

Looking Ahead

Prediction is notoriously uncertain and arrogant. But here’s a few stats at how the behavioral health workforce will evolve.

First, there will be continuing unbundling/de-professionalization of roles.

Second, this will include increasing use of peers to provide services hitherto not seen as part of their bailiwick.

Third, technology will be used in increasingly innovative ways, not just to provide communication with traditional providers but also to provide innovations that will be therapeutic in effect and designed to address the social determinants of behavioral health conditions.

And fourth, old people—like me—will increasingly be seen as being able to provide help and not only as people in need of help. We can become a vital part of the mental health workforce both as paid, experienced workers and as volunteers.

Details, of course, need to be filled in. Another time, perhaps.

Michael B. Friedman, MSW has been working in the field of mental health for over 50 years—as a direct practitioner, an administrator, and largely as a mental health advocate. He taught health and mental health policy at Columbia School of Social Work for twenty years. He has just moved to Baltimore to spend more time with his grandchildren, who are, of course, cuter than most. He will also continue writing and will take on new adventures yet to be determined. He can be reached at mbfriedman@aol.com.

Lippman from page 21

substance use disorders, convening of Amida Care’s DSRIP PPS partners to create program efficiencies and meet milestones and goals, as well as collaborating with the CEO to conceptualize a statewide HIV/AIDS Accountable Care Organization (ACO) and strategize on other innovative service delivery models.

To contact Mr. Lippman: email him at jason.lippman@beaconhealthoptions.com, to contact Liz, at liz.tuten@cbhsinc.org, to contact Michael, at michael.friedman@beaconhealthoptions.com, or to contact Mr. Lippman directly at (914) 703-0453, tutenr@cbhsinc.org.

Perceptions from page 24

considered “secondary” or “inferior” are no longer true as a growing number of mental health professionals are extending their reach through these modalities. This is an opportunity for the field to shape practice innovation by developing students’ and mental health professionals’ competence and confidence to effectively deliver telephonic mental health services.

About the authors. Micaela Mercado, PhD, is Director of Research; Virna Little, PhD, is Chief Operating Officer; and Ennie Kim, LCSW, is Director of Training at Concert Health. All correspondences can be directed to Dr. Virna Little at virna@concerthealth.io

References


Lippman from page 21

statewide HIAIDS Accountable Care Organization (ACO) and strategize on other innovative service delivery models.

To contact Mr. Lippman: email him at jason.lippman@beaconhealthoptions.com or mobile number (646) 916-0948.

Perceptions from page 24

considered "secondary" or "inferior" are no longer true as a growing number of mental health professionals are extending their reach through these modalities. This is an opportunity for the field to shape practice innovation by developing students’ and mental health professionals’ competence and confidence to effectively deliver telephonic mental health services.

About the authors. Micaela Mercado, PhD, is Director of Research; Virna Little, PhD, is Chief Operating Officer; and Ennie Kim, LCSW, is Director of Training at Concert Health. All correspondences can be directed to Dr. Virna Little at virna@concerthealth.io

Retrospective from page 21

read by many hundreds of thousands of consumers, family members, and service providers in the autism, behavioral health and substance use disorders communities. Too numerous to mention here, you can find all back issues of both publications on MHNE’s two websites which are posted for all to read.


Experienced Commercial Equipment Finance Provider

Whether your business is looking to purchase IT equipment, software, restaurant equipment, durable medical equipment, transportation or construction equipment, we have you covered. When you choose us for your equipment financing needs, you are assured a smooth process from application through to funding. We handle everything in the process so you can focus on the needs of your business.

✓ A B C credit score qualification ✓ Same day credit decision and funding ✓ $5,000 - $5,000,000 +, with Flexible terms ✓ 80 Years Experience
For the two peers in our discussion group, the opportunity has been life-changing. One spoke about participating in peer training after receiving support from S:US following the death of his mother, when he needed recovery support for alcoholism co-occurring with depression. After completing a free Recovery Peer Advocate Training, he sought out other courses related to recovery services.

“My S:US caseworker sent me to someone to help me revamp my empty resume. I was coming up around two years sober. After discussing it with her colleague on my resume, I got an interview with my current director,” he said. “Every question she asked me I had an answer for, because I was fresh out of school. And the next thing I know, I’m employed for S:US as a Peer Specialist. I haven’t done it in my life. They had to teach me how to use the copier. This was six months ago. Now, I’m handling a case load of 12. I do service plans. I do one-on-ones, I run men’s groups. Before, I couldn’t even turn on the computer!”

Peers provide services that are centered on what the individual wants for themselves and their life, not dictated by the peer or other staff.

“All our notes must reflect a person-centered approach, where the person’s going to tell you what they need. This has changed from the old traditional method of ‘you’re going to do it this way or I’m going to report you to your mandating agency.’ We now meet people where they’re at...It makes me feel so good to know what I could help somebody, because I got helped. It’s paying it forward, it’s amazing. My life just transformed, and S:US really played a big part.”

What We Need to Keep Succeeding

Our group discussed some of the factors that allow us to maintain our employment and be successful once we have been hired. Many of us mentioned needing continued support from our mental health care providers, who can help us build confidence and see things differently in our lives. We also utilize outside resources, VA or other providers, because it can be almost impossible to maintain a job when we aren’t able to manage our health and safety.

“Living at S:US and having a place where people my age feel accepted and it’s safe, has been very helpful,” one of us stated. “That’s what helped me earn my Master’s, being able to just go home and not worry about where you’re going to live and how you’re going to pay the rent. That is very supportive, along with the Wellness Coaches there.”

Another in our group spoke about following a concept used in the field of addiction recovery which focuses on balancing eight dimensions of wellness: emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual.

We also touched on the importance of coping with job stressors. Listening to music, watching favorite TV shows, and knowing when to use our vacation time were all mentioned as important self-care strategies.

As our discussion concluded, a sense of optimism and contentment could be felt in the room. Each of our stories contributed to reversing stigma in the workforce about people with mental health challenges and other disabilities. With our visibility, this can only continue to grow.

In recognition of the impact of workplace stress, particularly on those whose work is primarily to serve others, Vibrant Emotional Health developed a toolkit called Staying in Balance: Healthy Solutions for Managing Workplace Stress. This toolkit is a free, downloadable resource that can be found at https://www.vibrant.org/wp-content/uploads/2018/10/Vibrant_Toolkit_Staying-in-Balance.pdf. It provides resources for organizations to encourage a culture of wellness, and also provides tools that staff members can use to support their self-care.

Two key resources available in the toolkit include: 1) a self-care assessment to identify how well we are taking care of ourselves and where we might choose to increase our self-care activities; and 2) a personalized self-care action plan that helps us identify what we can commit to doing daily, weekly, monthly or as needed to support our own well-being. In addition, a module is devoted to helping supervisors and other organizational leadership understand the elements of establishing a culture of well-being at work, including: 1) key questions to ask when assessing organizational stress; 2) tips for identifying solutions to mitigate the impact of stress; and 3) determining if the implemented solutions are working as intended.

Workplace stressors will always exist. Even in “good times,” the behavioral health workforce is often understaffed and overburdened; in less than good times, the workforce faces demands to do even more with increasingly less. While the vagaries of budget cycles will continue to impact our sector, we still have opportunities to foster wellness at work.

Organizational commitment to employee well-being, coupled with supporting staff in their own self-care efforts, is essential to the continued welfare of our workforce. We know we are capable of innovation and implementing creative solutions to meet challenges; our commitment to our work compels us to make workplace well-being a cornerstone of our sector.

Wealthforce experiences unique stressors that arise from providing care for, among others, those who have experienced psychological trauma or are recovering from mental illness. Self-care is not a “nice extra” for behavioral health professionals; it is an essential skill that we need to leverage for our own health so that we can continue to do our work well and with satisfaction.

Second, we need to understand our own unique responses to workplace stress to address it. We should pay attention to how we are feeling physically, emotionally, and mentally, and so that we can gauge when stress is taking more than a usual toll. For example, we might notice that stress causes us to feel more anxious, have difficulty concentrating, remembering things and getting our work done. We might find ourselves coping in ways that feel good in the short-term, but that have a long-term negative impact on our health, such as eating too much, sleeping too much, or using or overusing alcohol, drugs and cigarettes. We might find ourselfs neglecting others, neglecting our responsibilities and participating the activities we normally enjoy.

In recognition of the impact of workplace stress, particularly on those whose work is primarily to serve others, Vibrant Emotional Health developed a toolkit called Staying in Balance: Healthy Solutions for Managing Workplace Stress. This toolkit is a free, downloadable resource that can be found at https://www.vibrant.org/wp-content/uploads/2018/10/Vibrant_Toolkit_Staying-in-Balance.pdf. It provides resources for organizations to encourage a culture of wellness, and also provides tools that staff members can use to support their self-care.

Two key resources available in the toolkit include: 1) a self-care assessment to identify how well we are taking care of ourselves and where we might choose to increase our self-care activities; and 2) a personalized self-care action plan that helps us identify what we can commit to doing daily, weekly, monthly or as needed to support our own well-being. In addition, a module is devoted to helping supervisors and other organizational leadership understand the elements of establishing a culture of well-being at work, including: 1) key questions to ask when assessing organizational stress; 2) tips for identifying solutions to mitigate the impact of stress; and 3) determining if the implemented solutions are working as intended.

Workplace stressors will always exist. Even in “good times,” the behavioral health workforce is often understaffed and overburdened; in less than good times, the workforce faces demands to do even more with increasingly less. While the vagaries of budget cycles will continue to impact our sector, we still have opportunities to foster wellness at work.

Organizational commitment to employee well-being, coupled with supporting staff in their own self-care efforts, is essential to the continued welfare of our workforce. We know we are capable of innovation and implementing creative solutions to meet challenges; our commitment to our work compels us to make workplace well-being a cornerstone of our sector.

Self Care from page 8

Meaningful work, engagement in decision-making, investment in technology, opportunities for professional advancement through education and training, and flexible schedules are more important to millennials than traditional benefits of job security, a pension, or guaranteed retirement.

For millennials like Elizabeth and Wendolin, making a difference and being engaged in socially-minded services are qualities Odyssey House is proud to value and share with its employees.

Odyssey House helps New Yorkers in need overcome drug and alcohol abuse, improve their physical and mental health, and defeat homelessness. For more information, please visit odysseyhouseinc.org or call 866-888-7880.

In recognition of the impact of workplace stress, particularly on those whose work is primarily to serve others, Vibrant Emotional Health developed a toolkit called Staying in Balance: Healthy Solutions for Managing Workplace Stress. This toolkit is a free, downloadable resource that can be found at https://www.vibrant.org/wp-content/uploads/2018/10/Vibrant_Toolkit_Staying-in-Balance.pdf. It provides resources for organizations to encourage a culture of wellness, and also provides tools that staff members can use to support their self-care.

Two key resources available in the toolkit include: 1) a self-care assessment to identify how well we are taking care of ourselves and where we might choose to increase our self-care activities; and 2) a personalized self-care action plan that helps us identify what we can commit to doing daily, weekly, monthly or as needed to support our own well-being. In addition, a module is devoted to helping supervisors and other organizational leadership understand the elements of establishing a culture of well-being at work, including: 1) key questions to ask when assessing organizational stress; 2) tips for identifying solutions to mitigate the impact of stress; and 3) determining if the implemented solutions are working as intended.

Workplace stressors will always exist. Even in “good times,” the behavioral health workforce is often understaffed and overburdened; in less than good times, the workforce faces demands to do even more with increasingly less. While the vagaries of budget cycles will continue to impact our sector, we still have opportunities to foster wellness at work.

Organizational commitment to employee well-being, coupled with supporting staff in their own self-care efforts, is essential to the continued welfare of our workforce. We know we are capable of innovation and implementing creative solutions to meet challenges; our commitment to our work compels us to make workplace well-being a cornerstone of our sector.

When I was in the depths of depression, it was as if I was standing at a door pushing against it to try and keep the pain from coming. The harder I pushed the weaker I became. One day I finally decided to open the door and let my illness in. That was the day my recovery finally began.”

Ira H. Minot, LMSW, Publisher
Toolkit from page 21

specialists. For example, the roles of peers have often been poorly defined, without clear expectations, which frequently result in confusion of other employees, and assignment of either mundane office work, or, on the flipside, clinical tasks, either of which fall outside the realm of a peer’s role, and fail to draw on the strengths that peers can contribute to an organization and its service recipients.

Other areas that respondents identified as needing improvement included salaries, opportunities for advancement within the peer role, and leadership-oriented training and supervision. The practices that were identified to address these were divided into categories of practice.

Nine areas of practice are included in the assessment of organizational readiness: Recruitment; Attitudes and Beliefs; Diversity and Inclusion; Finances and Sustainability; Role Clarity and Workflows; Career Advancement Opportunities; Supervision; Orientation and On-Boarding; and Program Monitoring and Evaluation.

Benefits of a Customized Toolkit

In this rapidly transforming healthcare environment, the appreciation of person-centered care has advanced, bringing forth a recognition that the needs of service recipients are varied. Particularly when collaborating across disciplines, organizations, too, should receive support and training that is specific to their needs.

The process of employees' collaborative engagement in the self-assessment process embodies the integrative and supportive practices that organizations may aim to strengthen. An organization’s encouragement of a self-assessment process communicates a commitment to the perspectives of its employees, which is a core ingredient in sustaining buy-in in a supportive environment.

When using the toolkit, organizations can also download a PDF summary of their responses with their customized toolkit resources. This record provides a measure to use in identifying domains of practice for improvement, addressing those practices with the help of the selected resources, and later, re-assessing readiness and continuing to monitor progress over time.

Dissemination and Next Steps

The Consortium has extended an offer to provide toolkit-focused guidance to organizations looking to strengthen their recruitment and job placement process as well as the graduate's needs and interests. To support the recruiting and job placement process, CSI developed a new Community Health Worker (CHW) community partners to match graduates to community partners to match graduates to the appropriate employer sites based on current workforce needs, roles and responsibilities, as well aseki. The College of Staten Island works closely with SI PPS, SIPCW, and community partners to match graduates to appropriate employer sites based on current job needs, roles and responsibilities, as well as the graduate’s needs and interests. To support the recruiting and job placement process, CSI has dedicated a Job Developer Staff to identify employers and their needs and prepare students for interactions with those employers. In addition, for CRPAs, the SI PPS with SIPCW has also dedicated a Peer Integration Services Coordinator staff to support partner employers with the recruitment and job placement process as orientation and workflow improvement upon CRPA employment.

Phase 4: Curriculum Refinement with Community Input: The fourth phase involves the collection of critical feedback from both employers and graduates of the training programs to further enhance the training curriculum and job placement process as well as orientation and workflow improvement upon CRPA employment.

As we address these and other challenges, supporting staff through their specific professional development track and providing the highest quality service remains an ongoing priority and commitment at MHA.

Resource from page 26

Learn more about CPI at: www.practiceinnovations.org. If your program has not yet signed up for CPI’s training and resources, complete an application at: https://cume.col.altriques.com/jfc/form/SV_7U1D0ZnSw7yh7y3

For questions related to this article, please contact the author, Nancy Covell at: nancy.covell@nysp.columbia.edu

Transformation from page 27

challenge to address the lack of CHW’s and CRPA was to determine what curriculum/skills were needed by partners and create a common curriculum which partners would accept. A common curriculum would break the old single employer, sitio approach to employee learning and development. The SI PPS in partnership with the College of Staten Island (CSI), Staten Island Partnership for Community Wellness (SIPCW), and other community partners joined forces to develop robust CRPA and CHW training and workforce programs using the four-phase model. The model begins with conducting a current state analysis and needs assessment of the Peer Advocate and CHW workforce. During this phase, SI PPS community partners share information on their projected demand for CRPA and CHW staff. SI PPS with the CSI use this information to develop target goals for each training program including class size, funding, and job placement resources.

Phase 2: Curriculum Development: The second phase involves creating a new curriculum or leveraging an existing curriculum, reviewing and gathering feedback from community partners/employers during structured discussions to develop the training curriculum. Based on real workforce needs and CRPA/CHW roles and responsibilities, community clients and employers share input on expectations of what the training should entail.

Certified Recovery Peer Advocate (CRPA) Training Program: SI PPS and CSI adapted the NYACH and Queensborough Community College curriculum and incorporated additional elements from community partners to establish the CRPA training program. The CRPA training curriculum includes Advocacy, Mentoring/Education, and Recovery/Wellness. Support and Ethical Responsibility as well as other professional and soft skills development. The program’s key objectives for students are to: Learn the standard skills and knowledge needed to succeed in the CRPA role; Receive personalized support from the program’s dedicated student advisor; Prepare to sit for the peer recovery certification exam; Work with the program’s developer to create a resume and prepare for interviews; and Connect with employers on Staten Island.

Community Health Worker (CHW) Certificate Training Program: SI PPS and CSI developed a new Community Health Worker certificate training program which has four tracks. One specific track has a behavioral health focus to train future CHW’s who will work in behavioral health settings and other settings with people living with mental health and/or substance use disorders. The CHW Certificate Training Program provides learners with the skills and knowledge to enter the workforce as a CHW, Advocate, Navigator, Outreach or Resource Coordinator, whether in community-based organizations or in hospitals. The CHW training program’s goals are to: Learn about the chronic physical and behavioral health disorders impacting community members; Help clients make positive changes using Motivational Interviewing skills; Build awareness of the importance of culture in healthcare; and Provide college credit through the study of Anthropology, an effective tool for CHW’s to understand the communities they serve.

Phase 3: Post-Training Job Placement Assistance: The third phase focuses on job placement for students who graduate from the CRPA/CHW training programs. The College of Staten Island works closely with SI PPS, SIPCW, and community partners to match graduates to appropriate employer sites based on current job needs, roles and responsibilities, as well as the graduate’s needs and interests. To support the recruiting and job placement process, CSI has dedicated a Job Developer Staff to identify employers and their needs and prepare students for interactions with those employers. In addition, for CRPAs, the SI PPS with SIPCW has also dedicated a Peer Integration Services Coordinator staff to support partner employers with the recruitment and job placement process as orientation and workflow improvement upon CRPA employment.

As we celebrate the 20th Anniversary of Behavioral Health News

We’d Like to Thank Our Readers, Advertisers and Many Organizations For Their Participation, Support and Dedication to Our Vital Educational Mission

As we address these and other challenges, supporting staff through their specific professional development track and providing the highest quality service remains an ongoing priority and commitment at MHA.

As We Celebrate the 20th Anniversary of Behavioral Health News

We’d Like to Thank Our Readers, Advertisers and Many Organizations For Their Participation, Support and Dedication to Our Vital Educational Mission

As we address these and other challenges, supporting staff through their specific professional development track and providing the highest quality service remains an ongoing priority and commitment at MHA.
Training from page 18

Training Philosophy

Training at Melmark is designed to increase the professional skills of employees, which in turn increases life outcomes for the individuals we support. Melmark trains based upon the principles of competency-based instruction, performance-based instruction (e.g., Brethower, D. & Smalley, K., 1998. Performance-based instruction: Linking training to business results), and behavioral skills training (e.g., Parsons, M. B., Rollyson, J. H., & Reid, D. H., 2012. Evidence-based staff training: a guide for practitioners. Behavior Analysis in Practice, 5, 2-11). Competency-based instruction is utilized throughout trainings and is seen in the form of guided notes, fluency timings, and written exams. Performance-based instruction links training to expected job duties; establishes minimum criteria to demonstrate successful performance of job duties; utilizes performance feedback; and trains via observation, guided practice, and demonstration of mastery (sometimes referred to as “I do, we do, you do”).

The professional development department is responsible for implementing the training model and ensuring all trainings align with the mission and vision of the organization. All members of this department have at least a bachelor’s degree, previous experience supporting individuals with disabilities, and demonstrated competence on all training procedures prior to training. On average, the department conducts 5-15 trainings per week across various programmatic settings, and all training needs are derived from federal, state, and local regulatory requirements; policies and procedures; clinical practice guidelines; and evaluations of the organization and employee performance. The descriptions of Melmark’s training processes can be found below and are fully developed and are being increasingly implemented across all service divisions. These training processes are targeted for full implementation in 2019.

Orientation

All new employees are required to complete a three to four-week orientation. The first week of training provides new employees with foundational knowledge of Melmark and the individuals served. The second week provides employees with a comprehensive overview of applied behavior analysis and how it is implemented. The training topics align with the BACB RBT® Task List (see https://www.bacb.com/rbt/). Employees are provided with an orientation binder containing organizational information, materials to aide in the acquisition of knowledge, and all competency assessments. This aspect of training has been implemented in all state divisions.

On-the-job Training

At the beginning of the third week of orientation, new employees observe colleagues performing job duties and receive department-specific training. Training is competency based and focused on teaching employees the specific skills needed to perform their job. Similar to orientation, each new employee receives an onsite training binder that contains department-specific material and competency assessments. The on-site training supports the first 90 days of employment. This aspect of training has been implemented in at least one state division with plans to implement across all locations.

One-year Plan

To guide new employees’ professional growth during their first year, all staff are provided with a one-year training plan specific to their job. The first 90-180 days of each plan is dedicated to orientation and on-the-job training. The third and fourth quarters emphasize career path development by providing opportunities for professional growth (e.g., cross training for positions that would be a promotion). This aspect of training is currently being rolled out in one state division with plans to implement across all locations.

Professional Development Plans

Professional development plans serve as a planning tool for employee growth and development. This tool prompts supervisors to define professional goals, align goals with internal training and professional development activities, and coordinate goals with external training and professional development activities. Internal activities might involve completing various organizational trainings (e.g., expert speaker presentations), observing new learning job requirements of closely related positions, and receiving mentorship. External activities might include professional conferences, training workshops, and university courses. Melmark offers a tuition reimbursement benefit to create an avenue for employees to further their professional development.

Outcome of Training Program

Previous research has indicated (e.g., Kazemi, E., Shapiro, M., & Kavner, A., 2015. Predictors of intention to turnover in behavior technicians working with individuals with autism spectrum disorder, Research in Autism Spectrum Disorder, 9, 116-129) that link our readers to a community of support. Behavioral Health News provides information, education, advocacy and community resources that encourage these same outcomes.

Shawn P. Quigley PhD, BCBA-D, is Senior Director of Clinical Services and Professional Development; Jennifer Rane MS, BCBA, is Director of Clinical Training; and Lindsay Dunn MA, SPHR, CPHRM, is Senior Director of Human Resources at the PA Division of Melmark.

Behavioral Health News provides information, education, advocacy and community resources that link our readers to a community of support.

Behavioral Health News can provide your organization with a trusted and evidence-based source of behavioral health education.

Call us today at (570) 629-5960 or visit our website at www.mhnews.org

New York State has an opportunity to learn from its partners abroad and to alter a longstanding trajectory of neglect of its social services sector. This would surely be to the benefit of an immensely dedicated and undervalued workforce on which the state depends for the fulfillment of its policy objectives. Most importantly, it would enhance the health and welfare of our population and honor our solemn commitment to the most vulnerable among us.

The author of this article may be reached at abrody@searchforchange.org or (914) 428-5600 (x9228).
FINDINGS FROM PAGE 26

Wraparound process and can help youth advocate for themselves (Lombrowski et al., 2008; Silva et al., 2019). For example, YPAs may guide youth in determining their goals, provide coaching and preparation before team meetings, or help youth articulate their needs in meetings.

Additionally, participation may benefit the YPAs themselves. YPAs may experience a sense of purpose and meaning through their efforts, and develop valuable work experience and skills (Walker et al., 2018). HFW involvement thus provides another opportunity for YPAs to pursue their own recovery: while not a primary goal of HFW, increased wellness for YPAs is both a positive outcome and can make them more effective within HFW.

But peer support services are not without challenges. Adult peers have reported a lack of role clarity and job expectations, as well as feelings of isolation from professional team members (Chinman et al., 2008; Kemp & Henderson, 2012). Hierarchical social structures may also result in less emphasis on peer input versus the opinions of professional team members. These barriers make it difficult for peers to collaborate effectively with other team members, and have the potential to be magnified among YPAs, who are particularly vulnerable to being under-valued or dismissed by providers who prioritize professional views (e.g., Delman & Klodnick, 2017; Walker et al., 2018). In particular, when YPAs’ views about the best course of action conflict with the perspectives of caregivers and other team members, they may be ignored, limiting the ability of YPAs to effectively work with care teams and advocate for the youth participant. Additionally, these negative experiences may hinder the YPA’s own recovery.

PRELIMINARY FINDINGS ON THE IMPACT OF YPAS IN HWF IMPLEMENTATION

As part of our evaluation, we collected interview and survey data from individuals in many roles in HFW, including YPAs, youth participants and caregivers, family peer advocates, and care management agency administrators.

HFW ENHANCEMENTS FROM YPAS: Across roles, participants spoke about how YPAs’ common mental health experiences or similar ages were key drivers in building trust and engaging youth participants in the HFW process. As one caregiver stated, “I adore [YPA] and [YPA] – they’re amazing. They tend to protect your shrinking [ego] of about helping and they listen to both sides – no judgment. I feel I can open up to them about anything.” YPAs further described how common experiences helped encourage trust in the HFW process. One YPA felt that “being able to say I’ve come through it gets more buy-in than I went to school and I know all about it.” Some suggested that YPA’s similar age helped smooth second-generation cultural barriers. One YPA shared, “I’m like them. I have Instagram, snapchat, et cetera. Older people might not have that knowledge or relationship with youth. I’m like an older sibling, easier to relate.” As an YPA noted, “you can’t educate [ sic] that empathy.”

Further, YPAs were able to keep youth perspectives centered. As one YPA noted, her focus is on “...reminding the family about youth; talking to and empowering the youth... Youth know for the first time that these meetings are about the youth. Other systems don’t do that.” A family peer advocate observed, “[Youth] could share experience with YPAs. Share hope. [Youth] face would light up. [Youth] felt heard. [Youth] could share their voice without fear of being disciplined – [YPA] facilitated that.” As such, YPAs were able to coach youth so they could share their opinions, and then reinforce those positions to ensure that the youth’s perspective honored in the HFW process.

These relationships promoted engagement with the HFW process and youth progress. One youth participant related, “I have a good bond with the YPA. That helps. If the YPA didn’t join the program, I don’t know if I’d be doing as well as I am.” Additionally, these negative experiences may hinder the YPA’s own recovery. Sometimes the strongest relationship in the unit is between the YPA and the youth and we rely on that to drive the case forward.” Taken together, these findings suggest that youth articulate their needs in meetings. Input versus the opinions of professional team members are no longer on the sidelines, but are equal contributors. Some YPAs felt their work was unappreciated and that other HFW participants tended to discount their contributions. YPAs felt that YPA care managers were more seriously. YPAs reported that some HFW participants tended to discount them and their input, taking care managers and clinicians more seriously. Care managers also weighed in on role hierarchies, stating that they felt the need to oversee YPAs to ensure they fulfilled tasks.

Interviewees noted that YPAs may struggle with working with youth with complex mental health challenges due to a lack of specialized training. A family peer advocate remembered that an YPA felt, “working with difficult cases can be very intimidating.” Another YPA shared, “There should be more credentialing in place. More than a high school degree –

CONCLUSION

Youth Peer Advocates have the potential to enhance High Fidelity Wraparound by facilitating family trust in the process, elevating youth perspectives, and fostering youth engagement through their lived experiences and relationships with youth. However, YPAs may need enhanced training to meet complex family needs, and avoid being relegated “to the sidelines” within the care team. As such, future HFW instantiations looking to include YPAs should consider the supports needed to maximize their potential value in the HFW process. The Center for Human Services Research at the University at Albany evaluates the New York State System of Care initiative. The Center has over 25 years of experience conducting evaluation research. See more at https://www.albany.edu/chsr/.

Darren Cosgrove, LMSW is a Doctoral Candidate at the University at Albany School of Social Welfare. Thomas M. LaPorte, PhD, is a Research Scientist at the Center for Human Services Research at the University at Albany. Margaret Gallwick, PhD is a Senior Research Scientist at the Center for Human Services Research at the University at Albany.

SHORTAGES FROM PAGE 19

Professional. Historically community-based providers have been contractually obligated to engage a minimum of physician services, limiting alternative solutions to meet the patients’ primary care needs, especially when these other qualified medical providers are often better suited to meet the demands of this population and are much more cost effective. As advocacy leaders and champions of our mission, we have realized the benefits of primary care integration within our industry and advocate alternative solutions to meet the needs of patients and their families. Despite these efforts, many patients still face significant challenges in obtaining necessary care. These challenges include long-standing barriers to integration, financial pressures, and lack of federal funding are now making every provider wary of further decreases in the pool of patient care revenue. Primary care providers will be cautious about losing potential reimbursement to increased mental health services unless they feel they can benefit from the cost savings in the utilization of primary health care. Comparably, the groups that control mental health revenue to protect their own costs, are often more likely to support community-based organizations with more patient-centered, cost-effective models of care coordination that broaden organizational vision and mission to include holistic care. The results of this survey will enable us to analyze funding needs, and the support required for these essential services. Please feel free to take and forward this survey to any of your nationwide nonprofit colleagues. If you have any questions regarding this survey, please contact me directly at rpetti@newhaven.edu or at (203) 479-4704.

DEAR NONPROFIT LEADER,

We are conducting a short survey at The University of New Haven on primary care integration funding within the nonprofit, behavioral health sector. The results of this survey will enable us to analyze funding needs, and the support required for these essential services. Please feel free to take and forward this survey to any of your nationwide nonprofit colleagues. If you have any questions regarding this survey, please contact me directly at rpetti@newhaven.edu or at (203) 479-4704.

Addiction Workforce from page 5

To incentivize CRPAs OASAS provided $500,000 in scholarships over the last 2 years to help them obtain their certifications. There is also a planned increase in the Peer Service reimbursement rates and the number of Peer Services that can be performed in a day has also increased considerably to incentivize the adoption of Peer Services in OASAS outpatient clinics. OASAS provides onsite Peer Integration services for all OASAS providers and have formulated a toolkit which can be found at: https://www.oasas.ny.gov/recognize/peerIntegrationTool.cfm. Additionally, Peer Services are also now a required component in OASAS’ outpatient settings. Only by strengthening the addiction workforce to meet the expanding needs of those suffering from addiction, and finding gainful employment for those recovering from addiction, will we be able to increase the capacity of competent and effective prevention, treatment and recovery services and reduce the stigma of those impacted by addiction.
Advertise Your Programs, Services, and Events for the Behavioral Health Community and Reach Our 160,000 Print and Online Readers
Your Advertisement Will Run in Color in our Online Edition

Subscribe to Behavioral Health News

Yes! I Want to Receive Each Quarterly Issue by Mail

☐ Individual/Family ($60 per year)
☐ Professionals ($75 per year)
☐ Small Group - 25 Copies Each Issue ($225 per year)
☐ Large Group - 50 Copies Each Issue ($450 per year)

Give The Gift of Hope: Order An Extra Gift Subscription for Someone in Need
Name, Title, & Organization: ________________________________
Address: __________________________________________________
__________________________________________________________ Zip: __________
Phone: __________________ E-mail: __________________________

Advertise in Behavioral Health News

☐ Business Card - 4 issues ($600)
☐ Eighth Page (1 issue $350 - 4 issues* $1,050)
☐ Quarter Page (1 issue $575 - 4 issues* $1,725)
☐ Half Page (1 issue $875 - 4 issues* $2,625)
☐ Full Page (1 issue $1,150 - 4 issues* $3,450)
☐ Inside Covers & Back Page (please call)
☐ Special Multi-page Supplements (please call)
☐ Honorary Sponsorship (please call)

* 25% Savings - Book 3 Get 1 Free!

Name & Title: ____________________________________________
Address: ________________________________________________ Zip: __________
Phone: _________________ E-mail: _________________

Mail this form with a Check made out to:
Mental Health News Education, Inc.
460 Cascade Drive
Effort, PA 18330

To pay by credit card visit:
www.mhnews.org/advertise.htm
Phone: (570) 629-5960  E-mail: iraminot@mhnews.org

Contact Us Today! (570) 629-5960 - iraminot@mhnews.org

Deadline Calendar

Fall 2019 Issue - Deadline: September 16, 2019
Winter 2020 Issue - Deadline: December 23, 2019
Spring 2020 Issue - Deadline: March 18, 2020
Summer 2020 Issue - Deadline: June 17, 2020

Ad Sizes - In Inches

<table>
<thead>
<tr>
<th>Ad Size</th>
<th>Width</th>
<th>Height</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Page (1)</td>
<td>10.4</td>
<td>12.8</td>
</tr>
<tr>
<td>Half Vertical (2)</td>
<td>5.1</td>
<td>12.8</td>
</tr>
<tr>
<td>Half Horizontal (3)</td>
<td>10.4</td>
<td>6.4</td>
</tr>
<tr>
<td>Quarter Vertical (4)</td>
<td>5.1</td>
<td>6.4</td>
</tr>
<tr>
<td>Quarter Horizontal (5)</td>
<td>10.4</td>
<td>3.1</td>
</tr>
<tr>
<td>Eighth Vertical (6)</td>
<td>5.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Eighth Horizontal (7)</td>
<td>10.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Business Card (not shown)</td>
<td>5.1</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Phone: (570) 629-5960  E-mail: iraminot@mhnews.org
SAVE THE DATES

40th Annual ACLAIMMH Conference

Featuring NYS Leaders and over 50 Sessions on relevant policy, program, fiscal, HR, and other topics related to NYS mental health providers

November 5 - 8, 2019

The Sagamore Resort
Bolton Landing, NY

For more information, visit aclinys.org