BEHAVIORAL HEALTH NEWS

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ON MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT AND SERVICES

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Changes in Our Children's System of Care

By Kathleen Rivera, LCSW, Senior Vice President of Care Management Services, JCCA, and Amanda Semidey, LCSW, Vice President of Care Coordination Services, CBC

In this important children's issue of *Behavioral Health News*, we wish to address "Caregiver's Challenges: Working with Families in Distress." JCCA is a not-for-profit child welfare agency with a nearly 200-year history of providing comprehensive care to more than a million abused, neglected, and traumatized youth and their families.

As mission-driven non-profit organizations, we know that the profile of the members we serve is not unique; we are aware of "who" we serve and "why" we serve them. Medicaid Redesign, however, offers a unique opportunity to focus on "how" and the "what" of service delivery and overall health outcomes. Children with complex and/or chronic conditions frequently experience fragmented or poorly coordinated care, placing them at a greater risk of hospitalization. Even on an outpatient basis, this cohort often receives unnecessary or redundant assessments, tests, or procedures, as well as conflicting information from multiple providers working in silos. The compounding result is poor clinical outcomes and increased costs. Less visibly, but just as important, these systems leave caregivers in distress, overwhelmed by the healthcare system and more vulnerable to disengaging from all services until the next crisis.

Children with the most serious and complex needs are frequently involved in multiple child-serving systems (e.g., mental health, child welfare, juvenile justice, tracked into special-education at a young age) which is a sentinel indicator for risk of out of home placement. Providers need to assess and address the external and internal factors interfering with a caregiver's ability to remain engaged in services, for and with their children. Caregivers want to meet the needs of their children, but they often struggle with knowing how, when, and where to get help.

The caregiver's voice as well as opportunities to make decisions regarding services and interventions are essential for ongoing family engagement. Successful collaboration between the family and the provider is required when identifying and supporting caregivers' challenges. Caregivers need to trust and believe that providers are on their side and share their vision and goals. Providers become the linchpin to explaining the healthcare landscape, assuring caregivers of strategies that align with their goals, and level-setting expectations for how multiple providers can work seamlessly toward the same Care Plan, thereby allowing a distressed family to experience their Care Team as their partners and advocates.

see Families in Distress on page 12

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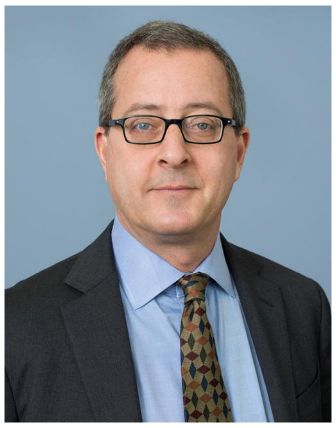

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Table of Contents

Changes in Our Children's System of Care

Editorial Calendar

Behavioral Health News
Upcoming Theme and Deadline Calendar

Spring 2019 Issue:
"Caring for Older Adults"
Deadline: March 18, 2019

Summer 2019 Issue:
"The Behavioral Health Workforce"
Deadline: June 17, 2019

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

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Medicaid Redesign Will Help Children and Families Get the Right Services at the Right Time

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

New York State embarked on a large-scale effort in 2011 to restructure the State's Medicaid program based on recommendations from the Governor-appointed Medicaid Redesign Team (MRT). The MRT was comprised of a wide variety of stakeholders, including State agencies, providers, advocates, consumers and family members, charged with identifying how best to improve health outcomes, garner sustainable cost savings, and yield administrative efficiencies.

The MRT's subcommittees included the Children's Medicaid Redesign Team, focused on guiding and informing the State on the development of children's redesign initiatives, including the transition of behavioral health and other services to managed care, the transition of children in foster care to managed care, and the integration of the delivery of Health Home care management model for children.

The Children's Medicaid Redesign process forged a deep partnership between a variety of the State's child-serving Agencies, including the Department of Health (DOH), the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS), and later, the Office of Persons with Developmental Disabilities (OPWDD).

The guiding ideal behind the Medicaid restructuring was for children and their families to receive the right services, at the right time and in the right amount. To accomplish this, the Children's MRT and the State agencies identified a variety of goals to be achieved through the redesign efforts, including:

- earlier identification of needs of children and families,

- intervening earlier to prevent the onset or progression of behavioral health needs,

- providing services in the most natural and least restrictive setting, and

- maintaining children and youth in their homes and community with adequate services and supports.

Furthermore, as a cross-agency effort, the goal was also to allow for equal access to services regardless of the "door" a child and family used to enter the healthcare system. As a result, the design was predicated on any child in need, regardless of their disability, having access to the same array of services as long as they met the eligibility criteria.

Dr. Ann Sullivan

To effectively improve the continuum of services that can both prevent and address behavioral health conditions, a wider array of services available earlier in a child's developmental trajectory was needed. Therefore, the redesign includes a significant expansion and enhancement of the existing children's behavioral health service continuum that provides the range, flexibility, and capacity to individualize service provision in accordance with the unique needs and preferences of each child, youth, and family.

A large part of the redesign is focused on making services, known to work well, more readily available to a broader population of children. As such, services that once were only accessible through a Home and Community Based Services (HCBS) Waiver for children at risk of hospitalization, were developed as State Plan services for all children eligible for Medicaid. Furthermore, the services were included as a part of Early, Periodic, Screening Diagnostic and Treatment (EPSDT) services, directed to all children under the age of 21 years of age as long as they were in need of the service(s) and met medical necessity. This offers a greater opportunity to achieve the goal of integrated care of behavioral health services with physical health care, and the chance to intervene earlier in the lives of children in a more preventive and proactive way.

NYS established six new children's behavioral health Medicaid State Plan services to benefit children from birth to 21 years of age. The six services, called Children and Family Treatment and Support Services (CFTSS), are for any child identified as having a behavioral health need who meets medical necessity. The aim of CFTSS is to more effectively meet the needs of children, youth and families by not only expanding access but enhancing the array of clinical treatment and rehabilitative supports available for children and youth from infancy through young adulthood. CFTSS are intended to be delivered primarily in nontraditional settings, allowing interventions to take place in the home and other natural community-based locations where children/youth and families live, attend school or engage in services.

The six Children and Family Treatment and Support (CFTSS) services include:

- Other Licensed Practitioner (OLP) - a reimbursement mechanism through EPSDT for clinical services provided by specific categories of Non-Physician Licensed Behavioral Health Practitioners within their scope of practice, for children/youth in need of behavioral health assessment and/or treatment provided in flexible venues, for whom an office based setting may not be effective.

- Crisis Intervention (CI) – mobile response for children/youth experiencing an acute psychological or emotional change which exceeds the abilities and the resources of those involved to effectively resolve it.

- Community Psychiatric Supports & Treatment (CPST) - a comprehensive array of interventions that includes intensive rehabilitative interventions, as well as supports to educate and assist families regarding behavioral health challenges and barriers.

- Psychosocial Rehabilitation Services (PSR) - a skill building service to restore, rehabilitate, and support a child's developmentally appropriate functioning to enhance community integration by assisting the child to develop and apply skills in natural settings.

- Family Peer Support Services (FPSS) - activities and supports provided by NYS Credentialed Family Peer Advocates (FPA) to families for the benefit of a child experiencing mental health challenges in their home and/or community.

- Youth Peer Support and Training (YPST) - activities and supports provided by NYS Credentialed Youth Peer Advocates (YPA) to children who are experiencing mental health challenges in their home, and/or community.

CFTSS may be provided individually or as a coordinated, comprehensive package of treatment and rehabilitative supports, depending upon the unique needs of a child/youth and family, and may compliment the provision of other traditional treatment services the child/youth may be receiving. The service need will vary depending upon the child's age, developmental stage, needs of the family/caregiver, whether the child has an identified behavioral health need and degree of clinical complexity. To promote wellness and recovery particularly for children/youth with multi-system involvement or higher intensity service needs, this expanded array of service options may help prevent the need for more restrictive and intensive levels of care.

The implementation of CFTSS will be according to a planned phased roll out. On January 1, 2019, the first three services will be implemented, including OLP, CPST and PSR. The second phase of the roll out will occur July 1, 2019, at which time FPSS will be implemented. The remaining services of YPST and CI will phase in January 1, 2020.

- Expanding and enhancing the children's behavioral health service array will help us to achieve a number of goals for the children, youth and families of New York State, including: increased capacity and access to care for a broader expanse of children and families;

- Greater flexibility and choice for individualized care unique to the child and family's needs and preferences;

- Increased focus on prevention and early interventions to include infant and early childhood mental health capacity;

- Reduction in traditional barriers to services and the associated stigma through the delivery of services in natural settings; expanded range and scope of services that can be easily increased or decreased in accordance with a child and family's changing needs; and finally,

- The prevention or reduction in the need for restrictive, higher levels of care through the utilization of comprehensive service packages available within the home and community.

By providing this new array of Children and Family Treatment and Support Services, NYS hopes to achieve the guiding ideal behind the Medicaid benefit redesign, for children and their families to receive "the right services, at the right time and in the right amount."

To learn more about NYS Children's Medicaid Redesign, please go to: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/index.htm.

The Changing Landscape of Children's Behavioral Health in New York: Opportunities for Addiction Services

By Arlene González-Sánchez
Commissioner
NYS Office of Alcoholism and
Substance Abuse Services

New York State has been engaged in an effort to re-design its Medicaid program to better meet the needs of the people it covers while managing costs more effectively. The goals have been to increase access, develop new services, improve outcomes and reduce use of expensive hospitalizations. As the State is set to transition children's behavioral health services to Medicaid Managed Care, there are opportunities for addiction service providers to increase access for children, youth and their families. Over the next year, children and youth from birth to age 21, who have a substance use disorder and/or who are impacted by substance use disorders, will have increased access to services in their communities. This access comes from the implementation of the Children and Family Treatment and Support Services (CFTSS), as well as the implementation of in-community services for youth under 21 years of age. Both are occurring as part of the Children's Health and Behavioral Health Transformation.

The CFTSS are authorized under the Early and Periodic Screening and Diagnosis and Treatment benefits. These benefits are an array of Medicaid benefits for children under 21 years of age, which have traditionally focused on children's preventive medical care (i.e. well baby visits, early screenings at designated ages) as well as being rehabilitative in nature. This set of Medicaid State Plan services will allow for specialized community-based services to be accessible before a need for hospitalization occurs. These services offer the addiction field opportunities to expand the reach of prevention services, develop both family and youth peer support, and assist families impacted by youth substance use disorders.


Arlene González-Sánchez

The services will be phased in beginning January 2019 through January 2020. Two exciting opportunities for new services are: Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services. These offer addiction services providers the opportunity to deliver services in community settings where youth normally gather (e.g. pediatric offices and other medical settings, schools, community centers and in the home, as appropriate). These services will also assist New York State in the development of Recovery High Schools and Alternative Peer Support activities for youth.

The addition of Other Licensed Practitioner (OLP) and CPST will allow for further development of Family Centered Treatment services for parents who enter residential services with their children by allowing the children to receive services where they live with their parents. For example, a toddler in care with their mother who needs a developmental assessment or early intervention services, may be able to receive those services in the same place without the need to travel.

The addition of Family Peer Support and Youth Peer Support and Training will allow for expanded peer services for youth and families impacted by youth substance use disorders. This can mean assistance and support in navigating the addiction services as well as other service systems. It can also serve as support for the parent/caregiver navigating how to parent a child in early recovery. These family peer services can be provided in the community, in Recovery Centers, Youth Clubhouses and treatment centers. Beginning January 2020, we will be able to offer Youth Peer Supports, tailored specifically of youth under 21 years of age and delivered by trained peers 18 – 30 years of age. These peer services will allow us to enhance services provided in the Youth Clubhouses, Recovery High Schools and treatment settings.

In addition to the CFTSS services discussed above, OASAS Outpatient providers who treat youth can now provide services in the community through their Part 822 Outpatient Program, which allows for expanded access to services. Over the next year OASAS will be working with these providers to implement Clinical Practice Standards for Adolescents, as a quality improvement tool.

OASAS has been working toward assisting providers in preparing for these changes through several avenues and will continue to do so over the next year. We would like to share some of them with you. Over the last couple of years, we have been working with the NY Certification Board to develop two parenthetic(s) that can be obtained by Certified Peer Recovery Advocates (CPRA) to allow them to deliver either Family Peer Support Services or Youth Peer Services. Information regarding the Family parenthetic will be released in early 2019 and the Youth parenthetic shortly thereafter.

To assist providers in preparing to deliver quality and accessible in-community services, OASAS is working with the Coordinated Care Services Inc. and Center on Addiction to provide a wide range of technical assistance around developing a business case for providing in-community services in a clinically appropriate and accessible manner. This technical assistance will be provided via webinars, regional meetings and one-on-one assistance. This work began in late 2018 and will continue through 2019.

For information on the services discussed in this column as their implication for addiction services, please contact oasas.sm.adolescent.womens.bureau@oasas.ny.gov.

Collaborating to Improve Children's Health Care: The Time is Now

By David Woodlock
Chief Executive Officer
Institute for Community Living (ICL)

In 2015, New York State's Medicaid Redesign Team (MRT) issued a "Roadmap for Medicaid Payment Reform" that laid out a path for dramatic and innovative change in the way the state financed and administered healthcare. Initially, MRT took on a volume-based approach to health care through the introduction of QARR and HEDIS Measures on patient experience and outcomes. Over time, MRT began to reward value, identifying it at the nexus of improved health outcomes and cost.

As a result of the work of the MRT, payers, health systems, IPAs, CBOs and behavioral health providers have come together to better understand root causes, access, engagement and the whole health principles that lead to dramatic shifts in how health care should be delivered. Evidence of these changes can be seen in State Department of Health and hospital investments in housing, the presence of recovery coaches in emergency departments to improve engagement in Medication-Assisted Treatment (MAT), DSRIP Max Series and in projects such as the new ICL/CHN East New York Health Hub offering behavioral and physical health care under one roof through an integrated approach. This work is far from fully scaled but the direction of healthcare for adults in New York is heading in the right direction.

Unfortunately, the MRT has not created the same changes in services to children and youth. MRTs analytics looked at the total cost of care and resulted in a profoundly new understanding of who high-need, high-cost individuals were. This led to the development of new service models and innovative partnerships that incorporate how social determinants of health, traumatic experiences and substance use disorders all play a role in health outcomes. For the adult population, total cost of care is overwhelmingly found in the health and behavioral health sectors. For children and their families this is not so. Children are not just smaller adults. I am convinced that if the same MRT analytic strategy were applied to troubled children and families, one would need to also look at child welfare, juvenile justice, behavioral health and most certainly education. If we want to improve lives today as well as for the next generation, we need the same kind of innovation and system reform that the MRT delivered for adults.


David Woodlock

A Promising Path Forward

I believe there is a path that could be forged right now, like the MRT Roadmap, but focused this time on the unique needs of children and their families. A "Children's Redesign Team" (CRT) could establish a vision and roadmap for achieving value for children and families. This unique and forward-focused plan would bring together stakeholders from relevant, child-facing agencies in New York State to focus NOT on coordinating what each agency is doing or could do individually, but to coalesce around common outcomes that can then be used to drive value for our next generation.

The CRT would start with an understanding of the fact that all children are served by more than one state agency, that no single agency is ever exclusively responsible for the well-being of a child. Any viable plan must consider the interrelatedness of areas like education, juvenile justice, and child welfare with health and behavioral health.

The need for better cross-agency collaboration to improve both the quality and cost (the value) of care might be best understood by looking at school-related Medicaid funding. In FY 2016, almost $262 million in New York Medicaid spending was spent on school-based services. The deep connection between education and health is clear – agencies are often serving the same child, in the same location, separately attending to the same or interrelated issues. The reality is that these child-serving health and education entities, for the most part, have grown and developed wholly independent of each other.

Given this significant interplay between children's education and health needs, it seems only logical that adequately supporting children requires better coordination of services between school settings and care provided elsewhere. There is much we know and many basic tools to get started. We could organize the work using the priorities outlined by the New York State Council on Children and Families "Kids Well-being Indicators Clearinghouse" (KWIC). There the Council identified a common set of measurable indicators to improve child and family outcomes -- "Touchstones" -- that focused on: Economic Security, Physical and Emotional Health, Education, Citizenship, Family, and Community. These areas are integrally related and can form a set of goals and objectives that cut across all service systems to allow organizations with diverse missions to come together to improve conditions for children and families. These Touchstones are useful today to inform the CRT's work of building collaborative services that enhance the lives of children and support families.

Some argue that coordinating care across child-serving agencies is just too great a task, that these agencies are simply not organized to encourage this type of collaboration. This was the argument used against the MRT when it began 5 years ago. The impact on adult health care outcomes tells a different story – one getting closer to value.

Applying the concept of value to the children's system will be difficult, will require a long-term investment and will require perseverance. We can build on the successes and knowledge gained from the Decade of the Child in the 1990s, the Children's Plan, the First 1000 days of Medicaid, Close to Home and Community Schools, to name a few. These actions have made a difference but they have not resulted in a fundamental shift in how we deliver and measure the impact of our collective work.

New York State has proven time and again to be one of the most innovative and forward-thinking states with some of the brightest policy minds and most effective leaders. There is no reason to think that the state cannot apply that same innovative thinking to improving care by better coordinating the work of the agencies serving children.

I am ready to join the effort to make this happen. Are you?

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Championing a Hidden Health Crisis: Childhood Sexual Trauma

By Rebecca Costa, LCSW-R
Vice President, Operations
WellLife Network

The contemporary English writer, Julian Barnes once wrote "Memories of childhood were the dreams that stayed with you after you woke." Sadly so, for many children those memories of childhood are not laced with adjectives such as happy, trusting, innocent, precocious, fresh, sensitive, fanciful, gentle, joyous, and imaginative. Some memories are so traumatic and pervasive that their life experience changes them both emotionally and biologically through their lifespan if no intervention is sought. Childhood sexual abuse occurs at rates so high as to liken it to an epidemic.

- Nearly 70% of all reported sexual assaults in the United States occur to children ages 17 and under. (National Crime Victimization Survey, 2002)

- Youths have higher rates of sexual assault victimization than do adults. In 2000, the rate for youths aged 12 to 17 was 2.3 times higher than for adults. (Sedlak et.al., 2010)

- Child Sexual Assault is widespread, affecting 1 in 5 girls and 1 in 7 boys (Domestic Violence National Hotline, 2018)

The Domestic Violence Hotline reports that in 2018 every 98 seconds, an American is sexually assaulted . . . and every 8 minutes, that victim is a child.

Research (Finlehor, 2012) supports that about 90% of children who are victims of sexual abuse know their abuser. Only 10% of sexually abused children are abused by a stranger. It has been reported that 60% of the children who are victims were abused by people the family trusted.

We know that childhood sexual trauma begins gradually. Months may be spent by the perpetrator 'grooming' their victim with nonsexual hugging and touching, behavior that appears perfectly normal and acceptable. Among many factors, perpetrators may provide the attention or the help children are missing, or they recognize and chose the child who is lonely or has little confidence.

Rebecca Costa, LCSW-R

> *Children are trusting and innocent; they believe that everybody loves them. The Stranger Danger and Good Touch, Bad Touch campaigns are not enough.*

Elizabeth Jeglic, Ph.D, a professor of psychology at the City University of New York Graduate Center, supports that we are targeting the wrong individuals when we teach our children about stranger danger. Teaching our children about consent and that no one should be touching them without their permission is essential. Perpetrators are more likely to be known to the child –meaning family, friends and those they know in their environment, like teachers, clergy and coaches.

Consent is key – children need to understand that they control who can and cannot touch their bodies, and they can leave when a situation feels wrong. Children at different developmental ages communicate their concerns and needs, meaning when bad things happen to them, in different ways. Hence, educating all caregivers, not just parents to be more clearly aware and able to provide a simple message to children that it is okay to talk and there are safe people to talk to is essential. Parents and caregivers will benefit from support in helping to teach children to trust their instincts and how to handle situations that make them feel uncomfortable–like what you do if you are at a friend's house and someone there tries to touch you, or show you inappropriate material. Open communication allowing for roleplay of these types of situations with a child helps to build a comfort and resiliency.

Communicate, communicate; the collective 'we' (parents, caregivers and professionals) need to listen and permit the expression of ideas and feelings even when the child's ideas differ from yours. Listen first and acknowledge the expressed opinions and thoughts. Viewpoints can change, but, mutual respect entitles each to their own. Give undivided attention; let children see that the focus is solely on what they are staying. Keep communication open ended on any subject. Avoid making judgments. To be seen as a confident we need remember, respect brings respect. It is not necessary to approve of all behavior, but it is important to understand the feelings involved. *Back our children up* – when a child decides they don't want to be touched, either in a tickle fight or when they meet an Aunt, 'we' need to respect that.

Impact of Sexual Abuse Surfacing Later in Life

Research supports that disclosure is extremely challenging emotionally and intellectually for a multitude of reasons, one of which is the manipulation and threats of varying degrees by the abuser. The emotional experience of disclosure is mixed, with a percentage of the victims expressing guilt related to the disclosure. In an overview, The Center for Disease Control and Prevention looks at the potential lifetime view of the impact of childhood sexual abuse in these categories; social, emotional and cognitive impairment, adoption of health risk behaviors, disease, disability and social problems and early death.

Childhood sexual abuse, physical abuse, emotional abuse and neglect are associated with adolescent suicidal ideation across community, clinical and high-risk samples, (Miller, A.B., et. Al. 2013.) It is a strong predictor of suicidal ideation into adulthood.

The biological impact, the stronger and more intense an experience of stress from many sources for a child, impacts their brain development. Trauma experiences have a powerfully significant and detrimental impact on the developing brain: they override the impact of normal developmental experiences. Stress when prolonged, severe or recurrent, impairs coping abilities and if too great a child becomes vulnerable to future stress and less capable of benefitting from healthy nurturing supports that might help buffer future stressors or trauma. There is a body of research that supports that changes do occur in the brain and our response to stress. In addition, the study of gene expression, known as epigenetics, is uncovering changes that may affect stress response in the DNA.

We need public education as well as evidenced based treatments for traumatic childhood experiences. Victims' voices, research, clinical studies and practice have helped to develop a more comprehensive understanding of the childhood sexual abuse trauma experience and its effect across an individual's lifespan. How to more effectively address the needs of children in a preventative, nurturing, open manner and approaches in treatment that are effective and successful continues to evolve. We need to champion this health crisis in our homes, communities, schools, etc. so that the dreams and hopes seeded in childhood can be realized by all.

Meeting the Needs of Youth in Transition: Recommendations for Systems Reform

By Ashley Brody, MPA, CPRP
Chief Executive Officer, and Vinny Sceri, Director of Vocational Services
Search for Change, Inc.

Adolescence is commonly defined as a period of transition between childhood and adulthood with distinct physical and psychological challenges that must be successfully navigated en route to maturity. One of these challenges is so deeply embedded in this period of development that it found its way into its definition. The challenge of transition, specifically the passage from one state, stage, subject or place to another, is often accompanied by an emotional and psychological maelstrom that can alter the trajectory of even the most grounded and secure adolescent. When coupled with the enduring effects of trauma, poverty, racism and a host of other impediments to healthy development a transition can raze what little remains of the fractured foundation on which so many of our young adults stand.

The difficulties that attend periods of transition are surely not unique to adolescents, and evidence of their potentially deleterious effects on the health and stability of vulnerable populations abounds. Health and social service providers are now subject to various process and performance measures through which they must affirm the value of their services to their recipients, payers and other key stakeholders, and many of these measures pertain to transitions between care settings (e.g., institutional to community) and interventions that would promote recipients' stability during such transitions. These measures bear the imprimatur of the National Committee for Quality Assurance (NCQA), New York State Department of Health (DOH), Clinical Advisory Groups (CAGs) and a host of other authorities charged with the application of evidenced-based practices within the service delivery process.

Important as these advances are, however, they neglect to address the profoundly disruptive transitions many adolescents encounter as they migrate between systems of care (e.g., child to adult) and navigate myriad (and often incongruent) regulations, eligibility requirements, treatment philosophies, provider competencies, services and resources. In a report on the findings of its Youth Initiative Work Group, the Center for Rehabilitation and Recovery of The Coalition of Behavioral Health Agencies summarized several recommendations for improvement in our systems serving youth, specifically Transition Aged Youth (TAY) (i.e., individuals aged 16-25), that encompass a variety of domains including educational and employment offerings for TAY with special needs (The Coalition of Behavioral Health Agencies, 2007). This is of special interest to the staff of my agency's vocational rehabilitation program inasmuch as it has increased its capacity to serve this population in recent years, and it is poised for continued expansion following implementation of a renewed contract with the office of Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR).

Ashley Brody, MPA, CPRP

Several years ago, Search for Change (SFC) expanded its mission to support young adults with unique educational and vocational rehabilitation needs. Until then, our agency had served adults only (i.e., individuals aged 18 or older) in accordance with its original mandate. We recognized many adolescents would benefit from our offerings, especially as a paucity of services for this population leaves many with few alternatives for meaningful support. We also recognized we would need to cultivate new competencies and a broader understanding of systems serving youth in order to effectively deliver on our new promises. In embracing the challenges and rewards inherent in this process we have witnessed deficiencies in our social service infrastructure that must be addressed lest they fail many of the vulnerable adolescents that depend on it.

Our staff has observed several examples of discontinuity between systems serving children and adults that pose unnecessary obstacles for youth in transition. This is especially disconcerting in view of the prevalence of serious mental illness among this cohort that exacerbates risks associated with transition. Research suggests one in ten children and adolescents experiences a mental health condition severe enough to cause marked functional impairment (National Alliance on Mental Illness, 2001). Exposing such highly vulnerable individuals to poorly coordinated or disjointed support services is certain to compromise their stability and prospects for long-term success. The mere existence of a two-pronged mental health system that serves children on one pole and adults on another suggests a structural discontinuity that impedes service integration and the application of holistic, person- and recovery-oriented supports for those who need it most. The Youth Initiative Work Group urged key stakeholders charged with oversight of child and adult systems to conduct a comprehensive review of their systems' access and eligibility requirements and to align them to the greatest extent possible (The Coalition of Behavioral Health Agencies, 2007). They also urged stakeholders to consider the unique needs of youth in transition between these systems and to expand the array of supports available to support them. The current systems, best characterized as programmatic and bureaucratic "silos," all but ensure disparate approaches to serving youth in transition and enduring deficiencies in coordination and communication that can compromise the health and welfare of individuals entrusted to their care.

Other obstacles cited in The Coalition's report and observed by my agency's vocational rehabilitation staff include differential eligibility criteria for publicly-funded benefits (e.g., Medicaid, Supplemental Security Income, etc.) to which children and adults are subject; an absence of core competencies in child and adolescent development among professionals who primarily serve adults (but must now embrace adolescents and young adults); and a scarcity of social, emotional and residential support services for youth in transition, far too many of whom have experienced poverty, homelessness, abuse, familial strife and other traumatic events. These obstacles notwithstanding, some policymakers and others charged with oversight of youth services have demonstrated a renewed commitment to support this population, especially within the realm of educational and vocational services. The rapid growth and diversification of SFC's TAY service offerings is merely one indication of this promising trend. Our entrée into this arena enabled us to provide fundamental job skills training and support services to young adults who were unable to obtain them within traditional educational settings. We are now engaged in a pilot project that shepherds vulnerable adolescents through transitions between secondary and post-secondary education, periods fraught with stress, uncertainty, heightened vulnerability and associated risk factors. We are poised for continuing diversification of our service offerings under the terms of a new contract that includes a sizable investment in TAY services.

Auspicious as these developments are, they are not without certain challenges. ACCES-VR has experienced an influx of young adults that threatens to overwhelm some of the Vocational Rehabilitation Counselors (VRCs) assigned to process their requests for assistance. Rapidly rising caseloads have led VRCs to rely on their contracted providers to deliver many services formerly within their purview.

see System Reform on page 31

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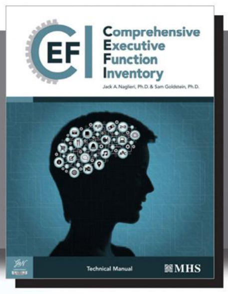

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The Children's Psychiatric Symptom Rating Scale (CPSRS)

By Four Winds Hospital
Katonah, New York

The Children's Psychiatric Symptom Rating Scale (CPSRS) is a tool designed to help investigators capture the judgments of clinicians and use them to improve the quality of patient care. For years Four Winds has used rating scales to capture therapists' judgments regarding the nature and severity of symptoms patients are experiencing both at admission and discharge. This information has made it possible to track the effectiveness of treatment and form a more complete understanding of the problems experienced by people seeking treatment in this setting. However, when Four Winds began treating pre-adolescent children it quickly became clear that existing rating scales, which had been designed with adults in mind, were no longer appropriate.

In response, the Four Winds Hospital Psychological Assessment Service developed a rating scale that targets the problems most often seen in children seeking mental health services. This rating scale was designed so that it could be used by any qualified mental health professional without requiring any additional specialized training. The result was the CPSRS. This user-friendly scale includes explicitly stated definitions of the problems being rated and clearly defined anchor points reflecting the severity of those problems.

At the Annual Meeting of the American Psychiatric Association David L. Pogge, John Stokes, Derek Nagy and Philip D. Harvey presented a poster entitled "Capturing Clinical Judgments of Psychiatric Symptoms in Children: a Brief Scale for Research and Clinical Applications." It summarized a series of studies of the reliability and validity of the CPSRS. To test the inter-rater reliability of the CPSRS, two raters independently rated patients' symptoms on the basis of a review of their chart and a structured interview. The high level of agreement in their ratings confirmed the reliability of this scale when ratings are based on the kind of information typically available to clinicians.

To determine the validity of the CPSRS, ratings by staff clinicians of 200 child inpatients were correlated with other rating scales, information from medical records, and psychological tests. The correlations of the CPSRS with these other variables confirmed its validity. When the validity of the CPSRS was compared to that achieved with common research rating scales that require more extensive and specific training, the CPSRS appeared equally valid for all of the variables examined.

A reliable and valid rating scale is important in measuring the effectiveness of a treatment. Using such a scale offers clinicians the opportunity to quantify their observations and use this information to determine the effectiveness of treatment. This study suggests that the CPSRS is a user-friendly, reliable, and valid rating scale that can be utilized by any appropriately trained mental health professional in clinical or research settings to capture clinical judgments concerning the most common psychiatric symptoms experienced by children.

A Message From Four Winds CEO
Moira Morrissey, Esq.

Four Winds Westchester has been providing high-quality psychiatric care to our community for more than 35 years. Our success is the result of a professional team effort that is focused on each individual patient. We are dedicated to treating the whole person in our therapeutic, cottage-like units.

When asked what distinguishes Four Winds Westchester, my response is simple. It is the compassion and skill of our staff, who work day-to-day to improve the health and well-being of our patients.

As you tour our services and programs, you will learn about our multidisciplinary treatment teams, our innovative programs, our educational events, and our commitment to our patients, employees, volunteers, visitors and community.

We look forward to serving you and your family now and in the future.

Families in Distress from page 1

Providers must foster synergistic relationships with caregivers, creating opportunities toward skill building that engender their independence and reinforcing their resolve to be successful in their child(ren)'s care planning goals. Very often, caregivers struggle to access the tools or resources needed to successfully meet the challenging needs of their child(ren). These challenges are frequently further compounded by limited resources; these social determinants of health can impede their ability to attend or manage the constellation of acute and chronic needs of all family members.

Compounding complex medical and behavioral needs are day-to-day social and economic factors like food insecurity, housing instability, and social isolation (Long et al., 2017). The lack of resources to meet basic needs such as stable housing, education, food security can understandably become the caregiver's primary focus overshadowing their attention and ability to address behavioral health and chronic medical issues. "Powerful drivers of health lie outside the conventional medical care delivery system, so we should not equate investment in clinical care with investment in health. Investment in clinical care may yield smaller improvement in population health than equivalent investment that address social and behavioral determinants" (Adler, et al., 2016). Providers therefore must focus on ameliorating the distress of families with multiple and complex medical and behavioral health needs. Otherwise, providers miss a critical intervention and opportunity to meaningfully engage child(ren) and their caregivers in services or treatment. Addressing these barriers and challenges is fundamental to supporting stability in the community, re-enforcing the Care Plan goals, maintaining continuity of care across multiple providers, and encouraging resilience post-crisis or acute episode. It is within this holistic approach that providers working with distressed caregivers impart hope and foster support.

The integration of these interventions also supports continued caregiver buy-in. Comprehensive approaches focusing on safety, prioritizing social determinants of health, and offering sufficiently nimble interventions to support transitions from inpatient settings back into the community provide both a safety net and a bridge for caregivers during crisis and post-crisis transitions.

This approach can strengthen engagement, serve as the conduit for multiple providers to remain knowledgeable of recent crises, simultaneously assist in managing the crises itself, and improve the child and family's stability. To illustrate, we offer the below brief vignette of a member and caregiver receiving serves from JCCA. Recently, JCCA's Health Home program enrolled the below family into Coordinated Behavioral Care's (CBC) Health Home (HH) Care Management Services.

"Sabrina" is a single mother residing in Brooklyn who is facing a multitude of concerns, including meeting her three children's special needs. She currently has an open case with the Administration for Children Services (ACS), and like many of those served by JCCA, she is experiencing housing instability. Sabrina's 15-year-old daughter was enrolled into CBC's Health Home Serving Children (HHSC) program in June 2018 under the eligibility criteria of a Severe Emotional Disturbance diagnosis. Sabrina's daughter ran away from home for two weeks following a verbal dispute with her mother. Upon return she attempted to engage in self injurious behaviors. As a result, Sabrina called 911 and her daughter was admitted to a Long Island hospital in New York. While in the ambulance, Sabrina called her daughter's JCCA Health Home Care Manager (HHCM). Recognizing the heightened level of stress and the challenges of navigating the health care system, particularly for an overburdened family at a time of crisis, the HHCM met Sabrina at the hospital and stayed with her until well after midnight. While at the hospital, the HHCM helped Sabrina stay updated on her daughter's condition and, once her daughter was admitted to the inpatient unit, ensured that Sabrina understood what would occur during the admission. Because the HHSC consent was in place prior to admission, the HHCM was also able to remain in frequent contact with Sabrina's daughter's pediatrician during her week-long stay. The HHCM successfully secured Sabrina's engagement by being present during the admission, thereby establishing trust and ongoing support. The HHCM also participated in discharge planning, helping the family to better understand the child's aggressive behavior and suicidal ideation as symptoms of her diagnosis. Supporting a safe transition back into the community, the HHCM informed of the adolescent's providers of the recent crisis and need for stabilization. Upon Sabrina's daughter's discharge, the HHCM worked with the community providers to ensure she attended her outpatient mental health appointment following her discharge, supported Sabrina and her daughter's understanding of her medication, reviewed the importance of taking her medication and assisted Sabrina in an appropriate school program enrollment for her daughter.

A coordinated behavioral health system that addresses the gaps between need and care is essential in helping families in distress. "The health home model's whole-person approach—encompassing comprehensive care management and coordination, integration of physical and mental/behavioral care, and links to non-clinical supports—thus has the potential to improve the overall health and quality of life for some of the most vulnerable Medicaid beneficiaries" (U.S. Department of Health & Human Services Assistant Secretary for Planning & Evaluation Office of Disability, 2017).

Community-based care management services under the HHSC model supported JCCA's HHCM in offering targeted and persistent care coordination. This resulted in a greater safety net, a more comprehensive array of service coordination across a delivery system (outpatient behavioral health services, inpatient, shelter, PCP and pharmacy), meeting the goal of better integrated services, improved engagement and health outcomes, and reduced costs. This

see Families in Distress on page 33


Four Winds HOSPITAL
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System Change and Service Providers: Opportunities and Challenges in Addressing Unmet Needs

By Andrea Smyth, MPA
Executive Director, NYS Coalition for Children's Behavioral Health
and Jason Lippman, Executive Vice President, The Coalition for Behavioral Health

In 2011, a priority of New York's Governor Andrew M. Cuomo was Medicaid redesign, with the substantive presence of behavioral health services in both the Medicaid Redesign Team (MRT) and the subsequent Delivery System Reform Incentive Program (DSRIP). The focus was to reduce inpatient hospitalization and the over-reliance of the most expensive users of Medicaid on higher cost and avoidable services. Emerging from the effort was a lone outlier: children's behavioral health services. The Behavioral Health Subcommittee of the MRT prudently decided not to apply the Triple Aim to the children's mental health system and instead, identified that a separate Children's Subcommittee was needed because: *"The children's behavioral health system of care was under-resourced and had insufficient capacity."*

Unlike every other MRT subcommittee, the Children's Subcommittee was tasked in 2011 with expanding the children's mental health service array and reforming delivery to address unmet needs and barriers to access. The redesign was still to include care management for all and conversion of Medicaid fee for services to Medicaid managed care, but the similarities with the adult service MRT efforts ended there.

Jason Lippman

In January 2019, New York will finally implement the recommendations of the MRT Children's Subcommittee for Children's Behavioral Health. The more than 7-year effort turned into a broad reform of the children's system of care and goes beyond the need for more behavioral health services.

The children's behavioral health reforms will:

- Provide interventions earlier for more children by expanding the array of Medicaid services and expanding eligibility for certain services to more children;

- Expand Medicaid spending on children's behavioral health services; and

- Address unmet need by reducing barriers and waiting periods for evaluations and accessing treatment.

The overall redesign effort will also:

- Unify age eligibility across child-serving systems (foster care, mental health, developmental disability and medically fragile) to uniformly be from birth to age 21;

- Offer care management for all eligible children;

- Consolidate 6 existing but different Home and Community Based Waiver (HCBS) programs into a single HCBS array with 11 services; and

- Move exempt populations and Medicaid services to Medicaid managed care.

The overall approach to the children's system redesign was steeping in a long history. New York is home to two of the earliest federal 1915c Waiver program authorized in the United States: the Care-At-Home Waiver program for medically fragile children and the NYS Office of Mental Health's Severely Emotionally Disturbed Waiver program for children who would otherwise need institutional or hospital level care. With a decade's worth of history in caring for high-need, high-risk children in the community, New York's providers were seen as leaders in serving children in the least restrictive environment. Therefore, when identifying which services could best support more children earlier in their illnesses, the MRT Subcommittee took the five most highly rates home and community-based services and proposed they be added to the state plan to be accessed by thousands more children.

Expanding the Array of Medicaid Children's Behavioral Health Services: Three of the six new Child and Family Treatment and Support (CFTS) services will be added to New York's State Plan on January 1, 2019. The new services are under Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit and are available to children/youth under the age of 21 who are Medicaid-eligible

see Unmet Needs on page 34

Community Capacity:
Can We Deliver Better Treatment for Children and Families?

By Andrea Smyth, MPA
Executive Director, NYS Coalition for Children's Behavioral Health

Andrea Smyth, MPA

On October 15, 2011, the Behavioral Health Subcommittee of Governor Andrew M. Cuomo's Medicaid Redesign Team (MRT) gave its final report. For the adult behavioral health system, the report recommended an unprecedented investment into the housing needs of individual's with mental health and substance use disorders. For the children's behavioral health system, there was also an unprecedented recommendation, that being: "*The Children's Behavioral Health System lacks capacity to best serve the needs of the state's children and youth; community-based care should be targeted for planned investments and re-investments. This need for investment must be taken into account.*"

The acknowledgement of lack of capacity is stunning because the status quo of too few services, with slots and caps on the number of youth and families accessing care perpetuated stable government spending and insurance actuarial projections that excluded the Medicaid population. In addition, access to care often relied upon a deficit-based care model, or the need to "fail first" at a lower level of care before accessing intensive services.

However, for over 75 years, there was credible, wide-spread support for the best methods of meeting the behavioral health needs of children.

- In 1941, Anna Freud, the youngest daughter of Sigmund Freud, formed the Hampstead Nursery in London. The nursery served as a psychoanalytic program and home for homeless children. Her experiences at the nursery provided the inspiration for books and findings that emphasized three needs of the growing child: the need for intimate exchange of affection with maternal figure; the need for ample and constant external stimulation of innate potentialities; and the need for unbroken continuity of care.

- In 1984, the Child and Adolescent Service System Program (CASSP) principles were initiated to encourage comprehensive, coordinated and culturally competent mental health services for children, adolescents and their families.

- Between 1995 and 1997 Kaiser Permanente, conducted a landmark Adverse Childhood Experiences Study that found that left untreated, a child's adverse childhood experiences can result in chronic *health* conditions later in life.

Over generations, the debate around strong, family-and-community-focused care has dominated the child emotional development research, child health studies and child welfare policy debates. The recommendations often centered on accessing children's mental health services earlier in a young child's life, but somehow the debate never resulted in expanded capacity.

Therefore, it is extraordinary that less than a decade after the 2011 MRT revelation of the capacity shortcomings in child and family behavioral health care, a January 1, 2019 inauguration of behavioral health expansion and transformation will begin a hopeful new chapter in community capacity. Mechanics and economics aside, a better way to treat children and support families will greet the dawn of the New Year.

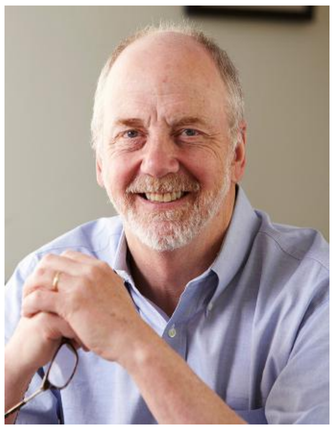
That better way is the addition of Child and Family Treatment and Support (CFTS) services to the New York State Medicaid State Plan under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) child health component of Medicaid. Federal statutes and regulations state that children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that States must cover a broad array of preventive and treatment services. New York's capacity expansion adds children's behavioral health services to join the existing array of health EPSDT entitlement services.

Better Services - Better Delivery Model

At the center of the CFTS service design is the foundation that the treatment goal or valued outcome for families and

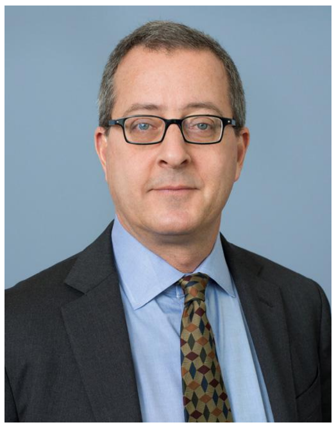
see Community Capacity on page 32

Leaders of the Behavioral Health and Autism Communities To Be Honored at Our May 22nd Reception in New York City



Steve Coe

Daniel Etra and Eran Rosenthal



Peter Provet, PhD

Joyce Wale

By Staff Writer
Behavioral Health News

Mental Health News Education, Inc. (MHNE), the nonprofit organization that publishes *Autism Spectrum News* and *Behavioral Health News*, will be honoring five outstanding champions of the autism and behavioral health community at its annual Leadership Awards Reception on May 22, 2019, at the NYU Kimmel Center in NYC from 5:00 pm to 8:00 pm. See pages 18 and 19 for full registration information.

Debbie Pantin, MSW, MSHCM, President and CEO of Outreach, and MHNE Board Chair, made the announcement stating, "MHNE has selected five outstanding leaders from prominent organizations representing some of the very best in the fields of autism and behavioral health."

Ira Minot, Founder and Executive Director of MHNE stated, "We are indeed honored to have this opportunity to recognize these champions of the communities we serve. We are also pleased to announce that Yvette Brissett-André, Executive Director and CEO of Unique People Services, and MHNE Board member, will serve as Event Chair for our 2019 Leadership Awards Reception."

Proceeds from this event will go towards expanding and developing the nonprofit educational mission of *Autism Spectrum News* and *Behavioral Health News*.

Steve Coe
CEO
Community Access
"Lifetime Achievement Award"

Steve Coe has dedicated his career to advancing the rights of people with mental health concerns. As CEO of Community Access, since 1979, he leads by example, affirmatively hiring people with a lived experience in the mental health system at all levels of the organization.

Under Mr. Coe's leadership Community Access has developed many innovative programs, such as the Howie the Harp peer training academy, the AWARDS EHR (acquired by Foothold Technology), affordable housing for formerly homeless people recovering from mental health concerns and for working families with children, Pet Access adoption service, and New York's first peer-operated crisis respite center that is a cost-effective alternative to hospital care.

The agency currently owns and manages over 1,100 units of affordable and supportive housing at 20 sites and has 590 units in active development and proposals for 700 more.

Steve was one of the first board members of Coalition for the Homeless and the Supportive Housing Network of New York and is former president of the New York Association of Psychiatric Rehabilitation and the NYS Association for Community Living. He chaired two NY/NY Campaigns, led the statewide Campaign for Mental Health Housing, which helped secure financing for thousands of new housing units, and testified before Congress on the "Examining H.R. 2646, the Helping Families in Mental Health Crisis Act" in June 2015.

In 2012, Steve was instrumental in forming a broad coalition calling for increased police training for officers dealing with 'emotionally disturbed persons' 911 calls. As a result of this campaign, the NYPD began Crisis Intervention Team training for 5,000 officers in 2015. In recognition for his efforts, Steve received the 2016 National Council for Behavioral Health Advocate of the Year Award.

Daniel Etra and Eran Rosenthal
CEO and President & COO
Rethink Autism
"Leadership Award"

Mr. Daniel A. Etra currently serves as Co-Founder and Chief Executive Officer of Rethink Autism, Inc. With over two decades of successful international business experience, including 15 years as a serial entrepreneur, Mr. Etra was Co-Founder & CEO of R.E.R. International, a global supplier of printed materials to the retail industry. He was a Consultant at Bain & Company, helping establish their NY office and also served as a Managing Director of Promodex Ltd., an importer and distributor of consumer appliances and industrial equipment in the Middle East. In addition, Mr. Etra served in the Israel Defense Forces and worked at Wasserstein, Perella & Co., specializing in M&A in the fields of healthcare, technology and natural resources.

Mr. Etra has won numerous awards including the Inc. 500 Award, the SmartCEO Future 50 Award, and CEO of the Year from Industry Era and Corporate Vision Magazines. He is also a member of the Young Presidents' Organization (YPO). Mr. Etra has an MBA from Harvard Business School and a BA in Economics from Yale University. Born and raised in New York City, he is active in variety of children's causes and volunteers with organizations such as NY Cares and Memorial Sloan-Kettering Cancer Center.

Mr. Eran Rosenthal currently serves as a Co-Founder and President and COO of Rethink Autism, Inc. Prior to co-founding the Company, Mr. Rosenthal was Co-Founder & President and COO of R.E.R. International, a global supplier of printed materials to the retail industry. Previously, Mr. Rosenthal was Director of Operations at QRS Corp., a public company providing e-commerce solutions to the retail industry. Mr. Rosenthal served in the Israel Defense Forces as a Captain in the Navy. Mr. Rosenthal has an MBA from University of Illinois and a BA in Political Science from Tel Aviv University. Born and raised in Tel Aviv, Israel, he is the father of three children.

Peter Provet, PhD
President and CEO
Odyssey House
"Community Service Award"

Dr. Peter Provet joined Odyssey House as President and CEO in 1999. Previously, Dr. Provet was Vice President and Director of Adolescent Programs and Clinical Support Services at Phoenix House, where he ran the largest adolescent treatment system in the country. He has more than 25 years of clinical experience treating people with addictions and mental illness.

He was awarded a doctorate in Clinical Psychology from Boston University; a Master of Arts in Psychology from City College of New York; and a Bachelor of Science in Mental Health from Tufts University. He is a Licensed Clinical Psychologist and formerly an Assistant Professor of Psychiatry, Albert Einstein College of Medicine.

Peter holds memberships with Treatment Communities of America (TCA); New York Association of Alcoholism & Substance Abuse Providers (ASAP); and serves on the Boards of the Coalition of Behavioral Health Agencies and the National Action Alliance for Suicide Prevention. He has authored several articles and op-eds on substance abuse issues including help for cocaine abusers and their families, guidelines for psychologists in assessing and treating substance abuse, and adapting treatment techniques for special populations. Dr. Provet is an expert spokesperson on substance abuse and health issues. Extensive media commentary includes: letters to the editor and opinion pieces published in major media outlets (The New York Times, USA Today, Newsday, and New York Daily News); national and local television and radio news features and documentaries.

Joyce Wale
Regional Executive Director
United Healthcare
"Corporate Leadership Award"

Joyce Wale began her career in high school, where she started her school's Social Action Committee and volunteered at health and human services organizations. Her dedication led her to obtain both a Bachelor and Master's degree in Social Work, with honors. Ms. Wale worked in child and adolescent behavioral health programs at both the direct clinical services level as well as administration in clinic, residential and day treatment services. With an extensive clinical and administrative program background, she went on to direct a National Institute of Mental Health State Planning grant in New Jersey. Moving up quickly to take over the leadership of the state's Child and Adolescent Mental Health Services while continuing to serve as the Project Manager and Principal Investigator of the multi-year planning grant.

The lack of direct clinical work led Ms. Wale to establish a small clinical private practice. In addition, Ms. Wale taught at the university level and served in various capacities on the Board of Directors for the NJ State Chapter of the Mental Health Association. She served on a variety of legislative and NY State Committees while leading the New York City Health & Hospitals Corporate Behavioral Health Services. Under her leadership was the implementation of AOT, the development of numerous services across the city as well as establishing roles for peer leadership and publishing multiple articles on service delivery. She is a fellow of the New York Academy of Medicine and Vice President of the Board of Directors of the Institute of Behavioral Healthcare Improvement.

Currently Ms. Wale is the Northeast Regional Executive Director for Behavioral Health at United Healthcare Community. In this role she has oversight of the Insurance Company's Health and Recovery Plan, and its Mainstream and Essential Health Plan Behavioral Health Services. Additionally, she oversees the public sector behavior health services in the northeast. She is passionate about including individuals with lived experience in service delivery and administration.

When and Where They Need It: Providing Community-Based Services to Families and Youth for Foundational Wellbeing

By John Orr, LMHC
and Lisa Furst, LMSW, MPH
Vibrant Emotional Health

For community providers serving children and families in New York, there is a contemplative question our work presents to us like an ever-unfolding puzzle – how can we get young people to the services that will support their ability to live their best lives? Many creative strategies have been employed. Some have worked, many haven't, and providers are left to find new solutions that sometimes feel rather limited – despite the rich array of services that New York has to offer.

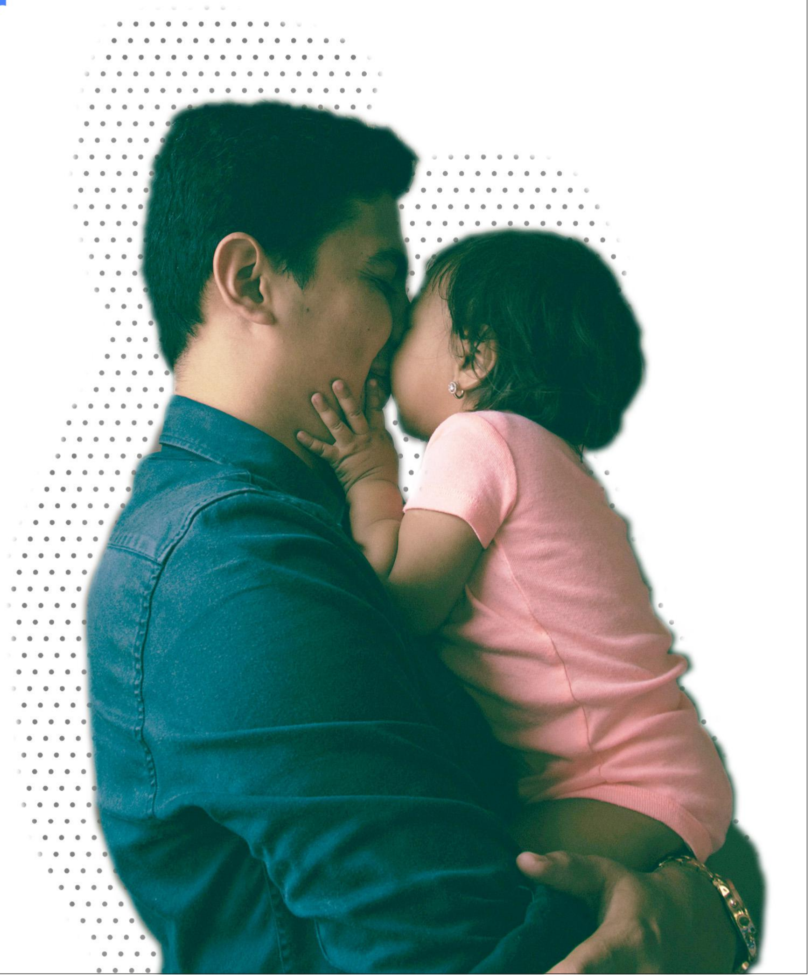
Fortunately, there will soon be an answer to this question that will allow providers to serve youth more effectively. Starting in 2019, young people under 21 years of age who are Medicaid recipients will have access to the new Children & Family Treatment and Support Services (CFTSS), a range of modalities that change the current service model by bringing the help to those in need, in the place of need, when it is needed.

Almost two years ago, we at Vibrant Emotional Health (formerly the Mental Health Association of New York City), expanded our service array to include care management for children and adolescents experiencing chronic conditions and functional limitations. As our program grew, we found ourselves faced with what seemed a disproportionate amount of young people who refused to leave their home. Some hadn't left in weeks, others in months, and at one point, this included 25% of the clients on our roster. It left us wondering if this was a glimpse of a greater issue facing young people and their families, and one that couldn't be easily solved using services provided within currently existing program models.

As we continued to form new relationships with families and community organizations, we found that the number of young people not leaving their homes always remained higher than expected. Recognizing this need, our care managers adapted and found creative ways to be of assistance; yet, a longstanding conversation among team members revolved around the need for more home-based services, specifically psychotherapy and other specialized services that could be dedicated to the specific needs of our client base. CFTSS offers integrated solutions with the roll out of three different services known respectively as: 1) Other Licensed Practitioner; 2) Community Psychiatric Support; and 3) Treatment, and Psychosocial Rehabilitation.

While it is becoming more common for people to consider and recommend counseling/psychotherapy for young people, putting such recommendations into practice proves to be much more challenging. This is set to change with Other Licensed Practitioner (OLP) as psychosocial assessments and psychotherapy are leaving the provider's office in favor of provision within community settings, including the home. One likely benefit of this convenient access to services will be an increase of people served, but in addition, delivering services where and when youth and families need it will also afford providers an opportunity to regain the trust of families who have come to know the frustration of trying to establish and maintain treatment services within the typical constrains of the service system. Long wait times, transportation challenges, and inconvenient times of service have long been factors contributing to parents' and caregivers' stress, and sometimes

see Wellbeing on page 28



MENTAL HEALTH NEWS EDUCATION

Annual Leadership Awards Reception

Register online at www.mhnews.org or complete the form below and mail this page to:
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For more information contact Ira Minot, Executive Director at (570) 629-5960 or iraminot@mhnews.org

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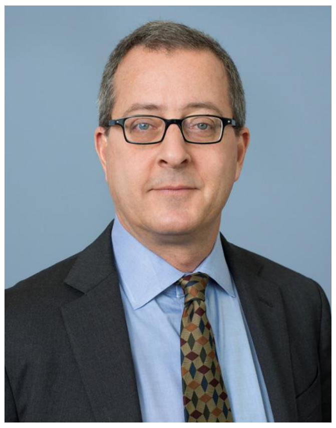

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Wednesday, May 22, 2019

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5:00 pm Networking Reception - 6:00 pm Awards Presentation

NYU Kimmel Center - Rosenthal Pavilion, 10th Floor
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Online Registration: www.mhnews.org

Journal Ad Deadline: April 19, 2019 Registration Deadline - May 3, 2019

Proceeds from this event will go towards expanding and developing the nonprofit educational mission of Autism Spectrum News and Behavioral Health News. With these publications, Mental Health News Education, Inc. aims to reduce stigma, promote awareness and disseminate evidence-based information that serves to improve the lives of individuals with mental illness, substance use disorders and autism spectrum disorders, their families, and the provider community that serves them.

For information contact Ira Minot, Executive Director (570) 629-5960 or iraminot@mhnews.org

Transformations at MHA Westchester: Children's Services

**By Barbara Bernstein, PhD, MPH,
Chief Planning Officer
Deirdre Sferrazza, LMSW,
Vice-President of Children's Services,
and Beth Glauber Ahern, LCSW,
Director, Children's Services,
MHA Westchester**

In a recent edition of *Behavioral Health News*, The Mental Health Association of Westchester wrote of sweeping transformations in process throughout our agency, with a specific focus on services for adults. In this edition, we describe the transformations occurring throughout our services for children and their families. Even as the services – and corresponding workflows and staffing patterns change, our commitment to delivering services tailored to the individual needs of children and their families remains unwavering.

Since its inception in 1946, MHA Westchester has been a pioneer in offering services for children and their families. Originally working with schools, we delivered services for children through the lens of the then-current "Mental Hygiene" movement. Evolving with changes in best practices, our treatment and support services have grown to provide assistance in shelters, families' homes and other community locations of their choice, as well as in our licensed clinics. Working from a strength-based focus, we currently provide clinic and community-based psychotherapy; services to support caregivers' decision-making and parenting skills to maintain family stability, avoid or mitigate crises and avert hospitalizations; and family support services, to name only a few of our many offerings. MHA Westchester is recognized for its work with the most vulnerable of our community's children and families, particularly for the services we provide for those who receive health care through Medicaid funding and those who are otherwise deemed eligible for these services.

At the time of this writing, sweeping changes to New York State's children's services are scheduled to take effect on January 1, 2019 and are expected to be in place by time of publication. Remaining steadfast in our commitment to those we serve, we have spent the last two years investing time and work into preparing for the launch of this new array of services. The philosophy behind these changes resonates with our own – providing a selection of individual services specifically matched to a child's need, rather than a "program." In addition to providing greater relevance and flexibility, changes will also improve access to care. Rather than funneling referrals through a "Single Point of Access" system, referrals will be allowed to come from any source, including pediatricians and schools, as well as self-referral. Notably, services will be available for a wider age range. We will now be able to offer services for children under 5 years of age, offering earlier intervention and mitigating the need for more intensive services at a later age – a practice philosophically aligned with the Mental Hygiene movement of past years and our own values. Assessments and recommendations for specific services will also be accepted from a wide range of professionals, i.e., "licensed practitioners of the healing arts." In addition to licensed behavioral health professionals, this list includes nurses, nurse practitioners, physicians and physician assistants, among others.

Briefly, the Children and Family Treatment and Support Services (CTFSS) that are expected to become effective in the new year offer re-organized and updated versions of existing services, such as our WAIVER and Mobile Mental Health services. New services will include Community Psychiatric Supports and Treatment (CPST); Psychosocial Rehabilitation (PSR); and Other Licensed Practitioner (OLP). These services will be available to Medicaid-eligible children and youth, ages 0 to 21, who have – or are at risk of developing – a behavioral health condition that impacts their functioning.

Preparing for these services has drawn heavily on MHA Westchester's recent transformation work, during which we mapped workflows, established more efficient staffing patterns, emphasized writing collaborative treatment plans that reflect individuals' goals and improved back-office functions such as IT, HR and Finance, which keep services running smoothly.

Preparing for the new services has required dedicated staff to assiduously follow the State's roll-out plans, which have evolved over time with repeated changes in dates and program specifics. In recent months, preparation work has intensified, culminating in bi-weekly meetings among senior staff to achieve a NYS Provider Designation, complete a Managed Care Organizational Self-Assessment and apply for a Critical Access Provider Transition Planning Grant, including completion of a strategic plan. Through it all, we have worked to keep the challenges – and our solutions to them – "behind the scenes," so that children and families who are currently enrolled in services receive uninterrupted care.

Our IT, Finance and HR departments have played a key role in this effort. Among the "behind the scenes" challenges that we have managed is the creation of new staffing patterns, even as State -defined caseload sizes continue to evolve and the dates by which they become effective continue to change. Another impact on staffing arose as we created "firewalls" between those who provide services and our Care Management arm, which may recommend services. The firewall impacts pathways for sharing information within the agency, as well as limits which senior staff may supervise staff who work in the children's services world. Children who currently receive services through our WAIVER program will be transitioned into Health Homes between January 1 and March 31. As our current WAIVER Individualized Care Coordinator staff transition to providing services through the Health Homes, they must learn related regulations and ways of working. During this transitional period, some staff will function in both the current and new worlds simultaneously, demanding great flexibility, patience and exquisite attention to detail. Even as they learn new roles and regulations, they will continue to assure children and their families that they will receive needed services. Great thought and care has been put into the ways we inform families of the changes to the system and re-assure that needed services are not lost or compromised. Later communication will focus on disseminating information about the new services to those who may become referrers, as well as those who will be eligible for services. Informational material has been designed to achieve this.

Proposed changes impact administrative functions as well. Finance and IT staff have dedicated time to creating systems for billing of the new services, including working with payors to update contracts and test new billing codes and systems. Finance, IT, HR and program staff work jointly to assure that appropriately credentialed staff are hired, cleared and trained to provide the new services. Program staff, IT and the team implementing our new Electronic Health Record (EHR) are working together to integrate new documentation forms into our existing EHR as well as our new EHR that will launch in the next months. During this transition, staff will function simultaneously in two worlds with respect to documentation.

While preparing for the new services, we continue to gear up for changes expected in the near future. Recognizing the value of Peer Support, we are especially pleased by the anticipated launch of Family Peer Support on July 1, 2019 and Youth Peer Support in January 2020, which allows us to serve an expanded population.

MHA Westchester has successfully navigated the many sweeping transformations required by New York State over the past years – from clinic re-structuring to the overhaul of Medicaid. We have not only managed these changes – and the challenges that come with them – but have continued to thrive thanks to visionary leadership and Board support; intensive and continuing work to educate ourselves about systems change and effective business practices; re-structuring staff roles and developing new services; and hiring consultants and creating affiliations where appropriate. MHA Westchester continues to grow in size, in community footprint and in scope of services while keeping our eye on what matters most – providing the best services to people when and where they seek them.

Bringing Children, Family Treatment and Support Services to Life

What will CFTSS look like in the life of a child and family? Peter typifies the kinds of challenges our young clients face, and how CFTSS will help children like Peter return to the routines and activities typical of their ages.

see Transformations on page 31

Consumer Perspectives: Advocates, Supporters, Parents

By Therese, Almarie, Cristi, Nora, and Janine

Services for the UnderServed partnered with the National Alliance on Mental Illness – New York City (NAMI-NYC) for this special edition of this column. 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 gathered for a discussion group with their peers to inform this writing.

As parents of children with mental health needs, our knowledge of the children's mental healthcare system has largely been built out of necessity. We are participants in a support group with the National Alliance on Mental Illness (NAMI) – New York City, and can each recall the moment we became introduced to this world – the times we realized that our children needed something more than we could provide as parents. It started with the diagnoses and the early signs: straight-A students refusing to attend school, a child saying things and doing repetitive behaviors that concerned us, or school staff saying our child might have depression. Since then, the experience of finding and maintaining effective care hasn't been easy for any of us or our children. But our involvement, and the help of supportive resources like the National Alliance on Mental Illness, has taught us so much and has strengthened our resolve to continue to be champions for our children and to help empower other parents with what we have learned.

Our discussion brought up some very powerful take-aways. Below are a few of them. Each of the quotes in this piece represents sentiments expressed directly by one of us.

At one time or another, we have all had negative experiences with access and quality of care. Our discussion brought up some real challenges we have had in finding effective care to meet the specific needs of each of our children. Our experiences have exposed us to holes and flaws in the system and with insurance coverage – things that we feel have prevented our children from getting the care they need. While we have certainly experienced successes, we cannot ignore how challenging it has been.

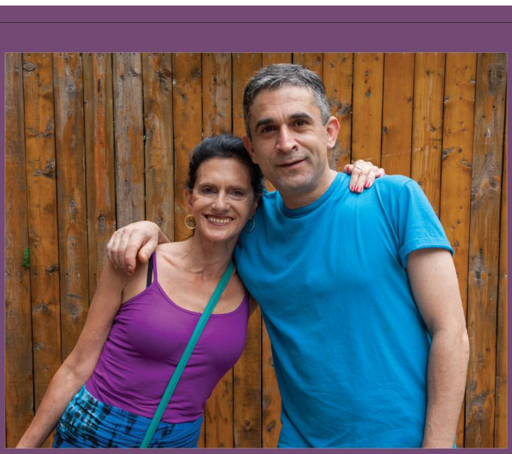
"I knew my child had obsessive compulsive disorder (OCD), so I asked our insurance provider for a therapist. They sent me a list of 5,000 people and more than 50% of the numbers were wrong. A bunch of the other numbers were people who only saw adults. Very few people see kids with OCD. It took two months of me looking every day until I found someone who works with kids, who is an OCD specialist, and had availability. We found care and medication for her. Then she sort of got 'fired' by everyone because she had a downward spiral. She stopped going to school, stopped eating, stopped going to the bathroom. They said she had to be in residential treatment, but our insurance refused to cover it. Our insurance offered me a mentoring service, but when they called me for the first appointment, he had never even heard of OCD."

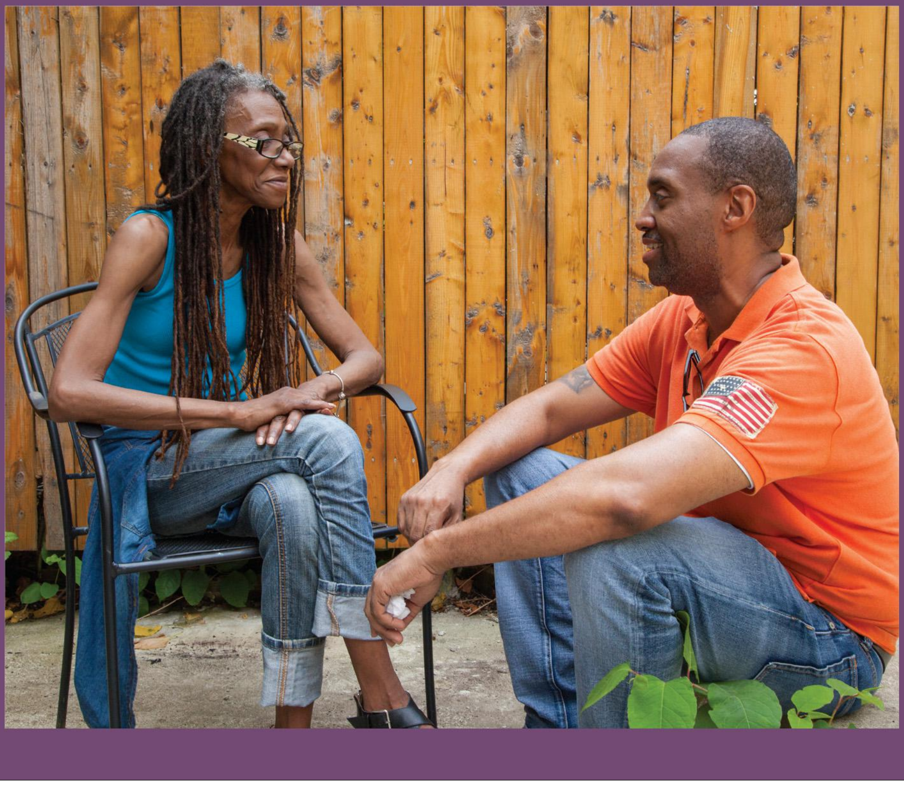
"I think the biggest problem we have in New York is that guidance counselors in the public schools are not really trained to handle mental health. When my son stopped going to school, the guidance counselor had no interest, no wisdom, no insight, no empathy, no nothing. All she offered me was, 'This is not the right school for your son. This is a very rigid school and he cannot keep up.' But he got into the school, so I knew it was not an intellectual problem, it was an emotional problem. But they didn't know how to identify it."

"Psychiatrists are so hard to find. They are not in-network. There was one psychiatrist who called and said, 'I'm sorry, I cannot take your son. He just has so many problems.' And I found out that it's harder to find an adolescent psychiatrist because they have to do two more years of residential training."

We have to advocate fiercely for our children. From navigating what services are covered by insurance, to coordinating

see Consumer Perspectives on page 31





The NYSPA Report: Spotlight on OnTrackNY – New York's First-Episode Psychosis Early Intervention Program

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

OnTrackNY is a coordinated specialty care program for adolescents and young adults who have started experiencing psychotic symptoms. Started in 2013, the program is a joint collaboration of the New York State Office of Mental Health (OMH), the New York State Psychiatric Institute (NYSPI), the Center for Practice Innovations at NYSPI and the Columbia University Department of Psychiatry. OnTrackNY was inspired by the early successes of Recovery After an Initial Schizophrenia Episode (RAISE), a project funded by the National Institute of Mental Health. Studies have found that multidisciplinary early psychosis programs have resulted in reduced hospitalization, increased engagement with treatment, improved quality of life and enhanced symptom reduction, among other positive outcomes.[1]

Rachel A. Fernbach, Esq.

Individuals eligible for the program include adolescents and young adults between the ages of 16 and 30 who have been experiencing psychotic symptoms for at least one week but not more than two years. Participants must have one of the following primary psychotic disorders: Schizophrenia, Schizoaffective disorder, Schizophreniform disorder, other specified schizophrenia spectrum and other psychotic disorders, Unspecified schizophrenia spectrum and other psychotic disorders, or Delusional disorder. Warning signs may include exhibiting unusual thoughts and behaviors, hearing or seeing things that others don't and disorganized thinking.

OnTrackNY service sites are located within existing hospitals and outpatient mental health clinics at more than 20 locations across the State, including locations in Manhattan, Queens, Brooklyn, the Bronx, Staten Island, Long Island, Westchester, Orange County, Albany, Syracuse, Binghamton, Buffalo and Rochester. Each location includes a multidisciplinary team comprised of a team leader, licensed primary clinicians, an outreach and recruitment coordinator, a supported education and employment specialist, a prescriber and a nurse. In addition to their individual clinical and professional backgrounds, team members receive specialized training in differentiating first-episode psychosis from other types of mental illness, suicide prevention and cultural competency, among other topics. Each local team serves between 35 and 45 individuals at a time. Funding for OnTrackNY is provided by OMH and the federal community mental health block grant.

Inpatient psychiatric units generate approximately 40% of referrals to the program and approximately 20% of referrals come from outpatient mental health providers, families and self-referrals. The remainder of referrals come from schools, community organizations and hospital emergency departments.

OnTrackNY provides a comprehensive array of treatment and supportive services including pharmacology, case management, psychotherapy, education and employment services, and health and wellness services. The following is an excerpt from a 2017 article about OnTrackNY published in *Psychiatric Services*, a publication of the American Psychiatric Association that focuses on research, policy and practice issues in the treatment of mental illness:

"Evidence-based psychopharmacology involves prescribing the lowest effective doses of antipsychotics with the fewest possible side effects. An emphasis on health and wellness/primary care coordination addresses cardiometabolic factors associated with antipsychotics by providing education on nutrition and exercise, assessing health with routine lab work and coordinating with other medical professionals. Case management helps individuals and families meet concrete needs (such as health insurance and housing) and connects individuals to outside resources. Cognitive-behavioral-based therapy includes two components. The first is a general supportive approach focusing on engagement and collaborative identification of personal goals. The second focuses on cognitive-behavioral principles to treat symptoms of psychosis and related conditions (such as substance use and trauma). The overarching focus is training in resiliency, illness and wellness management, and coping skills. The delivery of psychotherapy is flexible (for example, provided in groups or individually, in the clinic, or in the community), and the content discussed in sessions is tailored to individual needs and preferences. . . . Peer services were recently added to the model. The peer specialist focuses on building a relationship with participants, enhancing outreach efforts to help them stay connected to the program, connecting them to resources in the community, and empowering them to advocate for themselves and effectively use OnTrackNY services."[2]

A central goal of the program is to help participants avoid re-hospitalization and to maintain connections with family, friends and the local community. Participants are encouraged to establish and work towards individual goals related to school, work and interpersonal relationships. Participation in the program is generally limited to an average of two years, although that period of time may vary according to individual needs and preferences. Family involvement and education is an essential component of the program. Family members are provided with information and tools to better understand and cope with their loved one's illness. Families work closely with participants and the OnTrackNY team to identify and achieve individual clinical and personal goals.

In addition to direct state and federal funding, covered services may be reimbursed by Medicare, Medicaid and/or commercial insurance where available. The OnTrackNY website notes that services are made available to "all referred individuals meeting clinical admission criteria, without wait lists and regardless of insurance status or ability to pay."

"We are only beginning to understand the considerable value of reducing the duration of untreated psychosis and providing hopeful, developmentally appropriate and high-quality care to young people experiencing the onset of psychosis," said Lisa Dixon, M.D., M.P.H., Director of OnTrackNY. "It is a privilege to work with the clinical teams offering the program. The young people and their families are so inspiring. We try to be humble and recognize that we still have much work to do in order to improve the program and ensure it serves everyone."

The OMH 2019 Local Services Plan Guidelines for Mental Hygiene Services further notes: "OMH is seeking to improve early identification and treatment for individuals with psychotic disorders such as schizophrenia through the dissemination of first episode psychosis (FEP) models. The ultimate goal of the FEP initiative is to minimize disability so often associated with schizophrenia and to maximize recovery. New York State's *OnTrackNY* initiative for first episode psychosis interventions has expanded statewide with 22 sites as of year-end 2017, and 700 individuals served in the past year alone."

For more information about OnTrackNY and a list of its locations across New York State, please visit www.ontrackny.org. The OnTrackNY website also provides community resources including videos of personal stories and successes in the program, access to the OnTrackNY blog and monthly newsletter and community social media connections.

References

1. "Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes," Psychiatric Services 69:8, August 2018.

2. "OnTrackNY: The Development of a Coordinated Specialty Care Program for Individuals Experiencing Early Psychosis," Psychiatric Services 68:4, April 2017.

GOVERNOR CUOMO SIGNS PARITY REPORT ACT

NYSPA is pleased to announce that NYS Governor Andrew Cuomo signed the Mental Health & Substance Use Disorder Parity Report Act (A.3694-C) into law on December 21, 2018, an especially symbolic date as it marks the 12th anniversary of the enactment of Timothy's Law, New York's mental health parity mandate.

The enactment of A.3694-C (Chapter 455 of the Laws of 2018) is a huge victory for NYSPA and the broader mental health and substance use disorder (MH/SUD) community as it will compel insurers, health plans, and behavioral health management companies to submit key data and information to the Department of Financial Services for analysis and evaluation of compliance with federal and state parity laws, culminating in the publication of a report posted on the Department's website. This measure will provide much needed accountability and transparency as parity laws are critical to maintaining and enhancing access to care.

In support of this legislation, NYSPA partnered with twenty-five statewide organizations as well as five national organizations, including MSSNY, other medical specialty societies, organized social work and psychology as well as a broad array of consumer and provider representatives of MH/SUD services. This success would not have been possible without the tremendous grassroots support of NYSPA members and members of the partnering organizations that generated letters, calls and tweets in support of the bill.

For more information on the Parity Report Act, please contact Richard Gallo, NYSPA Government Relations Advocate at (518) 465-3545.

Addressing the Growing Problem of School Refusal

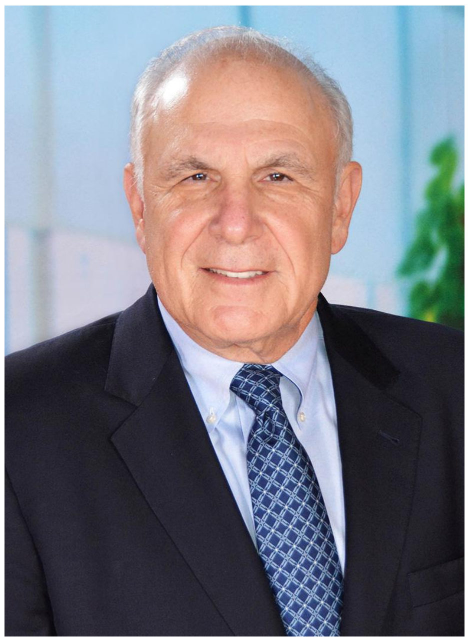
By Howard Savin, PhD,
Jay Cohen, MEd,
Valery Bailey, MPA,
and Katherine Fearon, LCSW,
First Children Services

Anxiety disorders have been plaguing America's children to a significant degree and are now one of the most common behavior health disorders of today's school age children. Anxiety, often in conjunction with depression, is found to be a key determinant of school refusal (historically diagnosed as School Phobia) which is now estimated to affect as much as 5% of all school children. (CDC, Data and Statistics on Children's Mental Health, 2015) Unlike truancy, which is largely a conduct disorder, school refusal encompasses children from kindergarten through high school who may be experiencing mild separation anxiety as well as more severe cases where a student may miss weeks or months of school because of debilitating anxiety or depression. (M. Wimmer, School Refusal: Information for Educators, 2010) There are serious long-term social and educational consequences associated with missing school, and school refusal has become a major concern for children, parents and schools alike. Effective programs are urgently needed to address critical underlying social, emotional and educational issues and serve to facilitate regular school attendance, which is the optimal outcome in most instances. Accordingly, this article describes the components of The Transitions Program at First Children Services and includes an illustrative case study.

Transitions Program Description

The Transitions Program at First Children Services enables parents and caregivers to begin confronting and resolving school refusal in their children. School refusal is addressed by moving home bound students into a center-based instruction team of professionals. The program serves students ranging from middle through high school grade levels. Meeting the mandates of the State core-curriculum, students are offered courses in every academic area, spanning ability levels from moderate to honors. Each of our State certified teachers follows a curriculum which changes our students' lives by nurturing a passion for learning within a therapeutic environment - a model which is designed to foster life-long academic skills, reflection and emotional stability. The program goal for middle school age children is reintroduction of our students to their home school's classroom setting in most cases. For high school age students entering the program, the targeted outcome is often to buoy their social-emotional growth and maximizing academic attainment, while guiding them through high school graduation and beyond.

At present, 25 New Jersey school districts send their students to our Transitions Program. Daily instruction is delivered in small group, limited to no more than six students in a class setting. The comprehensive program includes individual and group counseling, offered by a staff of licensed clinicians. Once enrolled in our program, each of our students is administered the Beck Youth Inventories-Second Edition (BYI-II). The BYI- II are five self-report scales that measure the student's experience of depression, anxiety, anger, disruptive behavior, and self-concept. The results help articulate the social-emotional status of each student, enabling staff clinicians to utilize specific therapeutic interventions while tracking clinical progress over their time in the program and prior to IEP or parent progress conferences. Our clinicians employ contemporary approaches to therapy based on individual needs. Interventions include mindfulness, cognitive-behavioral, and dialectical-behavior therapy. Each student receives a minimum of 40 minutes per week of individual therapy and 45 minutes per week of group counseling sessions. Additionally, our students attend a 45 minute weekly social skills group which employs the evidence-based Skillstreaming curriculum. This facilitates development of interpersonal competencies which enable the re-entry of our students to their sending school districts or to confidently pursue post-secondary education. Our academic and social skills programs, in sum, are crafted to prepare students to function independently in today's complex society.


Howard Savin, PhD

Case Study

This 16-year old High School student had been homeschooled for 3 years prior to placement in our program. At that time, her diagnoses were severe mixed anxiety disorder with severe functional impairments, generalized anxiety disorder, separation anxiety (severe), school phobia and avoidance, somatic preoccupation, and agoraphobia. She was prescribed Zoloft and Intuniv. She was essentially a prisoner in her own home with a severe enmeshment with her mother. Her anxiety surfaced when she was

see School Refusal on page 30

To Improve Adolescent Mental Health We May Need to Address Adverse World Events

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

It appears that the prevalence of mental disorders among adolescents has been increasing. The National Survey of Drug Use and Health (NSDUH) shows an increase in major depressive episodes.[1] A study about children and adolescence who are eligible for SSI by virtue of mental disabilities found an increase in most disorders between 2004 and 2013.[2] And CDC "surveillance during 1994-2011 has shown the prevalence of [mental health] conditions to be increasing."[3]

There is some dispute about whether the apparent rise in prevalence reflects increases in mental illness or in its diagnosis. But the documented rise in adolescent (13-21) suicide rates from 7.8 to 10.1 per 100,000, a 29% increase since the turn of the 21st century,[4] lends credibility to the claim that mental illness has increased.

Why the Increase?

One common speculation is that there has been a decline in mental health services in this century. But that is not the case. The use of mental health services by adolescents has increased.[1] Funding of mental health services has also increased.

Michael B. Friedman, LMSW

Whatever the ups and downs of state mental health funding, the expansion of Medicaid and the requirement to cover behavioral health under the Affordable Care Act have resulted in millions of people getting additional coverage and some increase in service utilization.

So, if there has not been a decline in mental health services, why is the prevalence of mental disorders among adolescents up? Clearly, other forces are at work.

Perhaps it is the factors that are commonly called "social determinants", most notably poverty, violence, and "adverse childhood experiences" (ACEs).

Could be, but in a recent survey conducted by the Harris Poll for the American Psychological Association[5], adolescents themselves gave different and interesting answers.

The survey asked about the mental health of people of different generations—Gen Z (15 -21), Millenials (22-39), Gen X (40-53), Baby Boomers (54-72), and "matures" or older adults (73+).

According to the survey, Gen Z (the adolescents) "are most likely of all generations to report poor mental health and … also significantly more likely to seek professional help for mental health issues." They seem, that is, to experience more distress than older generations, more feelings of depression and anxiety, and to use mental health services to deal with them.

And what are the sources of their distress? The Gen Z'ers themselves point to world events that are making headlines—gun violence; sexual harassment and assault; treatment of immigrants, especially separation of families and deportation; the economy and discouragement about having a secure financial future; housing instability; drug problems in their families; racial discrimination; the current, divisive and vituperative political climate; their skepticism about the future of America; and more.

Clearly, there has been much to fuel concern about the state of America and the world since the beginning of the 21st century—through the administrations of Bush, Obama, and now Trump. The rise of terrorism, the decline of the environment, the possible spread of nuclear weapons, increasing disparity, rising racial tensions, the plight of refugees, and more—all contribute to the gloominess of most of the people I know and to fear for the well-being or even survival of future generations. But do these big social issues contribute to more diagnosable mental illness?

There are reasons to be doubtful. Many people who experience depressive or anxiety disorders grasp for reasons that might explain their unhappiness or fear and often don't come up with accurate explanations. So, Gen Z'ers could be wrong about what's causing stress in their lives.

In addition, distress and mental illness are not one and the same. The Gen Z'ers could be right about their sources of stress, but it could be wrong to assume that a rise in stress is contributing to a rise in mental illness.

And, maybe, as I said at the beginning, prevalence of mental disorders is not on the rise, just its diagnosis. Or maybe it's

see World Events on page 30

Building Workforce Capacity to Support the Mental Health Needs of Young Children and Their Families

By Susan Chinitz, PsyD
Clinical Co-Director, Early Childhood Mental Health Training and Technical Assistance Center (TTAC)

New York City is supporting its youngest children's early development and their families through an innovative training partnership and network, funded by the New York City Department of Health and Mental Hygiene (DOHMH) as part of ThriveNYC.

The Early Childhood Mental Health Network, which launched in 2016, consists of seven Early Childhood Therapeutic Centers (ECTCs), which are embedded within licensed mental health clinics across the city. The ECTCs are responsible for providing psychotherapeutic services for children birth to five years of age and their families, as well as Early Childhood Mental Health Consultation within publically funded early care and education programs serving children under five. A further innovation of the NYC model was the simultaneous development of a Training and Technical Assistance Center (TTAC) as an integral part of the Network, which provides workforce development and ongoing professional support for the staff of the Therapeutic Centers and others who work with young children and their families.

The specialized skill set required to provide psychotherapy to children under 5, and mental health consultation in preschools, as well as the paucity of clinicians who are trained in infant and early childhood mental health, made it critical to develop and provide training support as new clinical services were developed. The target audience for training is the staff of the ECTCs as well as staff in other child serving systems who have become increasingly cognizant of the importance of healthy social emotional development in early childhood. TTAC is a collaborative effort between the New York Center for Child Development, an early childhood service provider, and the McSilver Institute for Poverty, Policy and Research at the NYU Silver School of Social Work, each of which bring different and highly complementary areas of expertise to this effort.

TTAC offers its most intensive training to the staff of the seven Early Childhood Therapeutic Centers. This primarily includes on-going training in evidence-based therapeutic interventions. Based on an early needs assessment of newly hired staff in the Therapeutic Centers, as well as on knowledge of the high prevalence of trauma in many communities across the city, Child Parent Psychotherapy (CPP) was selected as the first evidence-based intervention in which clinicians and their supervisors were trained. CPP – a relationally focused, dyadic therapeutic intervention for young children along with a parent or caregiver - is indicated when either the child, the parent or both have been victims of traumatic experiences or have otherwise struggled with relationships disorders. This is an 18-month long training that incorporates the use of didactic sessions and the development of a learning collaborative of clinicians who convene monthly on group supervision calls.

In its second year, and in response to the needs expressed by staff of the ECTCs, training in a second evidence-based intervention – Triple P – a parenting intervention, has been provided.

In addition, staff of the ECTCs has been provided with intensive and ongoing training and support in the provision of Early Childhood Mental Health Consultation using the Georgetown Framework. This, too, has included didactic training sessions supplemented by the use of monthly group supervision calls.

Throughout its first two years, the TTAC has enhanced its training efforts by inviting experts in trauma and other practice areas to address the clinicians working in the ECTCs as well as the larger community of professionals who work with young children. Drs. Alicia Lieberman and Chandra Ghosh Ippen, international experts in trauma in infancy and early childhood, spoke to a large, interdisciplinary audience about the impact of trauma on very young children as well as best practice principles of therapeutic intervention and community support. Dr. Marie Anzalone, a nationally known occupational therapist and author, provided training in sensory processing disorders, which often underlie children's behavior problems at home and in school, to a large citywide audience of clinicians, preschool teachers and developmental therapists.

Clinicians from the ECTCs, as well as many clinicians working in other licensed mental health centers, attended a two-day training provided by ZERO TO THREE on the Diagnostic Classification for Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). This newly revised edition includes the latest conceptualizations on early onset mental health, developmental, and relational disorders, and also informs a developmentally, contextually and culturally attuned approach to clinical assessment and diagnosis of young children.

Given the pressures on clinics to be financially solvent, several half-day workshops have been offered by the McSilver Institute staff on the topic of business sustainability.

A significant feature, and asset, of the TTAC is its capacity to be flexible in its

see Workforce Capacity on page 28

Essentials for Working with Teenagers in Groups

By Andrew Malekoff
Executive Director, North Shore
Child & Family Guidance Center

Andrew Malekoff

As we transition into a changing system of care, it is essential that we do not lose sight of fundamental practice skills such as tuning-in, engaging and contracting with teens and their families. Nowhere is this more critical than working with teens in groups.

Group work cannot simply be a means of herding teens together to maximize revenue. If our work with teens in groups is to qualify as value based, it must be implemented from a solid foundation. Following are seven principles that provide a strengths-based foundation for working with adolescents in groups.

Principle I: Form Groups Based on Members' Felt Needs and Wants, Not Diagnoses: Groups must not be formed on the basis of a diagnosis or label. Groups should be formed on the basis of felt needs and wants that the group is being formed to address. Felt needs are different from ascribed labels. Understanding members' felt needs is where we begin in group work. Such a simple concept, yet so foreign to so many.

Principle 2: Structure Groups to Welcome the Whole Person, Not Just the Troubled Parts: Group workers must learn to structure groups to welcome the whole person and not just the troubled, hurt, or broken parts. There is much talk these days about strengths and wellness. This is hardly a new and revolutionary concept, but it has been neglected for too long. Good group work practice has been paying attention to people's strengths and assets since the days of the original settlement houses more than 120 years ago, mostly without any fanfare.

Principle 3: Integrate Verbal and Nonverbal Activities: Competent group work requires the use of verbal and nonverbal activities. Group work practitioners must, for once and for all, learn to relax and to abandon the strange and bizarre belief that the only successful group is one that consists of people who sit still and speak politely and insightfully.

Principle 4: Develop Alliances with Relevant People in Group Members' Lives: Group workers involved with youths must understand that anxious and angry parents, teachers, and school administrators are not our enemies and that we must collaborate with them and form stable alliances with them if we are to be successful with their children. We must learn to embrace their frustration and anxiety rather than become defensive and rejecting. Alliances are needed with relevant others who are deeply invested in the plight of our group members.

Principle 5: Decentralize Authority and Turn Control Over to Group Members: Group workers need to understand that losing control is not what you want to get away from; it's what you want to get to. What this means is that when control is turned over to the group, and when the group worker gives up his or her centrality in the group, then mutual aid can follow, and members can then find expression for what they have to offer, something valuable to contribute to the group. Encouraging "what they have to offer"—that is the kind of group work we need to practice; that's what real empowerment is all about.

Principle 6: Maintain a Dual Focus on Individual Change and Social Reform: Group workers must stay tuned in to the near things of individual need and the far things of social reform. Group workers must help group members to become active participants in community affairs, so that they might make a difference, might change the world one day where others have failed. A good group can be a great start for this kind of consciousness development and action.

Principle 7: Understand and Respect Group Development as a Key to Promoting Change: Each good group has a life of its own, each one with a unique personality—what group workers refer to as a culture. All those working with groups must learn to value the developmental life of a group. A greater understanding of and respect for group development, amidst the noise and movement and excitement of a typical kids' group, can lead to a feeling of greater confidence in the group worker—confidence to move ahead and to hang in there and not bail out, as too many an adult already has.

The strengths-based principles summarized above are overlapping and interrelated. They call for group workers to consider the felt needs of group members, recognize and activate what group members have to offer, use a variety of

see Groups on page 31

To Help Transition Age Youth and Young Adults Succeed: Focus on Their Education

By Evelyn Frankford, MSW
Independent Consultant

While transition age youth and young adults ages 16 to 25 with serious mental health conditions (TAYYA) face many challenges and risk factors, not graduating from high school is possibly the single biggest one, predictive of multiple future problems including unemployment, homelessness, and incarceration, and of foreclosed opportunities to live a satisfying life in the community, something most young adults want.

Dimensions of the Problem

More than 50% of students aged 14 or older with a mental health condition drop out of high school, which is the highest dropout rate of any disability group. Such students also experience low grade point averages, poor attendance, and the highest expulsion/suspension rates among all students with disabilities.[1] Disruptions in relationships and social isolation result from and contribute to these problems.

Examining data from the National Longitudinal Transition Study about the lives of high school youth with disabilities, researchers confirmed these poor indicators: They found that students with a primary disability category of emotional disturbance (ED) demonstrated a pattern of "disconnectedness from school, academic failure, poor social adjustment, and criminal justice system involvement."[2]

Researchers carrying out a large longitudinal study of adolescent offenders found that having a mental health disorder is not independently linked to poor employment outcomes; rather, lack of educational achievement, specifically lack of a high school diploma, carries the weight.[3]

Student mobility is a barrier to education: the more often the student moves, as many TAYYA do, whether because of placement decisions or changes in residence, the more difficult her/his academic and social situation becomes. In Massachusetts in 2009, students who attended only one public high school graduated at a rate of 85.9% while students who attended three schools graduated at a rate of 39.8% and those who attended four schools graduated at a rate of 24.9%.[4] Other factors that disrupt schooling for TAYYA include:

- Functional limitations that impact educational performance such as sustaining concentration, screening out stimuli, maintaining stamina, handling time pressure, interacting with others, and test anxiety[5]
- Returning to school after an absence for a mental health or substance use disorder, during which the student will have missed academic work and been disconnected from social networks
- School disciplinary practices that result in disproportionate suspensions and expulsions for students with a mental illness

What is to be Done?

Mental health providers that want to promote good outcomes in teen patients with serious mental health conditions are in a strategic position to use emerging best practices to work with youth on strategies that help them attend school regularly, stay in school through graduation, and access vocational resources to reach a desired work life.

see Education on page 30

Identifying and Managing Anxiety and Worry In Children and Adolescents

By Debra G. Salzman, PhD
Clinical Psychologist
Behavior Therapy Associates, P.A.

Many children and adolescents struggle with anxiety and worry. According to the National Institute of Mental Health (NIMH), based upon the National Comorbidity Survey-Adolescent Supplement, 31.9% of adolescents aged 13-18 were identified as having an anxiety disorder with 8.3% of those individuals having severe impairment (Merikangas, K.R., et al., 2010). According to this study, the median age of onset for all anxiety disorders was six years of age. These prevalence rates highlight the importance of addressing anxiety among our youth.

Additionally, recognizing the early age of onset, it becomes important to address childhood anxiety early in the child's life to prevent years of struggling with anxiety and worry. Adults often believe anxiety in childhood will abate over time. Although this can be the case, it is apparent that these anxious kids, became anxious adolescents who may become anxious adults. In the National Comorbidity Study Replication, 19.1% of U.S. adults had an anxiety disorder over the past year and 31.1% of U.S. adults have experienced an anxiety disorder in their lifetime (Kessler, R.C., et al., 2005).

A common mistake made when discussing anxiety is thinking that all anxiety is alike. The type of anxiety disorder an individual is diagnosed with is very important in helping to determine the course of treatment. The first step toward helping a child struggling with anxiety is assessing the type of anxiety the child is experiencing. A child having difficulty going to school may have difficulty for a variety of reasons. School avoidance can be a presenting problem associated with symptoms of Separation Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorder with Agoraphobia, Social Anxiety Disorder or a Specific Phobia such as Emetophobia (fear of vomiting), to name just a few.

The treatment approach for each of the above disorders will be vastly different. Important components of the assessment process include asking questions about: triggers for anxiety, places the child / adolescent avoids, places the child / adolescent can go without anxiety, behaviors the child / adolescent exhibits in a variety of settings with and without their parents, ritualistic behaviors, social relationships, and the child's / adolescent's strengths and weaknesses.

Asking questions of parents as well as the child or adolescent is essential since parents may fail to recognize symptoms that may be due to anxiety. Also, the child or adolescent may be embarrassed to discuss their anxiety, although individuals who are anxious often are very willing to share their fears in a safe, supportive, nonjudgmental environment.

It is beyond the scope of this article to provide a comprehensive overview of the diagnostic criteria for the various anxiety disorders. However, it is important to understand the distinguishing features among these disorders (Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-V), 2013):

- The essential feature of Separation Anxiety Disorder is excessive fear or anxiety concerning separation from home or attachment figures.

- In Specific Phobia, the fear or anxiety is regarding a particular situation or object.

- Social Anxiety Disorder is marked by an intense fear or anxiety of social situations in which the individual may be exposed to possible scrutiny by others.

- Panic Disorder with Agoraphobia is marked by fear or anxiety of having a panic attack and fear of going places due to this fear.

- Generalized Anxiety Disorder occurs when an individual experiences excessive anxiety and worry about a number of events and has difficulty controlling the worry.

- Obsessive Compulsive Disorder requires the presence of obsessions/compulsions which are time consuming (more than an hour a day) or cause marked impairment or distress.

Helping individuals manage their anxiety and worry involves many components, the first involving educating families about anxiety. Most individuals would like their anxiety to "disappear". Taking this approach sets the individual up for failure. Understanding the importance of anxiety and how anxiety is adaptive helps to decrease the level of fear over the symptoms. The body's reaction of fight or flight is meant to protect us from danger. The problem becomes when innocuous events trigger that fight or flight reaction. Hearing thunder, going to a birthday party without a parent, having to talk in front of the class, sitting in an auditorium, and riding on the school bus are all common activities that may signify danger to someone with an anxiety disorder. The individual with the anxiety disorder may have a physiological reaction to the thought or object which then leads to an overestimation of danger.

Some very common errors in thinking among individuals struggling with anxiety are overestimation of risk and catastrophizing the outcome. For the above examples, a child/teen may believe thunder will lead to their house catching fire from a lightning strike. Riding on a school bus may lead to someone vomiting. If dropped off at a birthday party, the child may be afraid the parent will never come back. Sitting in an auditorium will cause a panic attack and the child will not be able to get out.

Cognitive behavior therapy teaches the child/teen and family strategies to better manage their anxiety. Possible strategies that are part of a treatment plan based upon the diagnosis include: education, relaxation, and breathing retraining to help reduce the physiological escalation of anxiety; cognitive restructuring (to evaluate the anxious thoughts); gradual exposure to feared situations; exposure to the physical symptoms; and exposure and response prevention.

Gaining the child's/teen's motivation to treatment is paramount. The individual must face their fears in order to overcome their fears. Without motivation, it becomes a war of wills invariably with the child winning. Parents must recognize that if they make their child's life too safe by protecting them from each of their fears (e.g., sleeping in his/her room, letting him/her stay home from school, providing constant reassurance, engaging in compulsions by washing things for him/her, not allowing any guests in the home, etc.) the child/teen may decide that facing his/her fears is not worth the effort. If the child/teen has to feel anxiety, then there may be more willingness to participate in treatment. Additionally, parents and teachers need to recognize how they may be subtly reinforcing the individual's anxiety. Giving extra attention for fear rather than for bravery is just one example of this. Therefore, the adults need to change the attention they provide so that they are reinforcing their child being brave while approaching feared situations.

The most important message to remember is that the goal in life is not to live anxiety free but instead to learn how to not give in to the anxiety. To be able to

see Anxiety and Worry on page 31

Workforce Capacity from page 24

offerings, which are developed based on feedback from the ECTC staff, specific requests from other professional groups, and in response to emerging issues in the field. For example, in response to the presence in NYC this past summer of migrant children separated from their parents at the southern border, TTAC provided trainings to the staff of the organizations that provided legal and social services to these children on early childhood trauma, vicarious trauma and self-care, which were welcomed and very well received by these professionals.

Since its launch in 2016 through November 2018, TTAC has provided training for 205 staff from the DOHMH-funded Therapeutic Centers, 434 staff from other licensed mental health clinics, and more than 978 staff from various child serving organizations, totaling 1,617 unique individuals. Each training is followed by a detailed evaluation completed by participants, which provides feedback and input for new programming for the Network. To date, all trainings have received positive ratings and have been judged useful and effective for the Network's practitioners. TTAC was also instrumental in the development of a series of three webinars on social emotional development in infancy and early childhood that has just been released by the NYC Bureau of Early Intervention, and will be available to thousands of early childhood professionals.

In conclusion, though the field has affirmed the efficacy of early childhood mental health services, there is great need to support the development of a work force that has the training and resources to work effectively with this special population. TTAC builds the capacity and competencies of mental health and early childhood professionals to identify and address the social emotional needs of children birth through five and their families through the continual needs assessment of professionals who work with young children, specialized training in evidence-based interventions and best practice approaches to mental health consultation, and via the development of workshops, webinars and other learning forums on topics related to social emotional development and early childhood mental health. Indication from all assessments suggests that these efforts have been effective and can provide a model for other localities seeking to expand mental health services for very young children.

For additional information, contact Evelyn J. Blanck, LCSW, Director, Early Childhood Mental Health Training and Technical Assistance Center. You can reach her at ejblanck@msn.com, or visit our website at: www.ttacny.org.

Wellbeing from page 17

desperation, when they are already seeking a solution to the taxing experience of caring for youth with special needs. With OLP, young people can receive a psychosocial assessment, treatment planning, and psychotherapy in a location that eliminates some of these initial barriers and stress. It also offers an answer for the isolated youth who would never venture to a clinician's office, as dedicated therapeutic assistance in the home now offers the chance of interrupting the profound seclusion that significantly limits their lives.

Skilled assistance continues with Community Psychiatric Support & Treatment (CPST), a multi-faceted service containing six distinct components: 1) Intensive Interventions (Counseling); 2) Crisis Avoidance (Counseling); 3) Intermediate Term Crisis Management (Counseling); 4) Rehabilitative Psychoeducation; 5) Strengths Based Service Planning; and 6) Rehabilitative Supports. Both a stand-alone service and a compliment to the other CFTSS services, the six components of CPST provide in-depth, dedicated support designed to resolve the concerns that are placing young people at risk for more restrictive levels of care and is designed to keep more families intact. Considering again the challenges of young people isolated in their homes, it seems likely that some will face crises as they attempt to make the shift to broaden their lives outside of the home. CPST can provide dedicated and direct assistance to anticipating, understanding, and overcoming such crises while simultaneously providing psychoeducation that allows the young person to become more informed of the options for living, once obscured, that are available to them.

Even further options for assistance are also available through Psychosocial Rehabilitation (PSR). For young people who have overcome the more significant barriers to wellbeing, or have a level of need that requires assistance but is not in need of the more intensive services above, PSR provides practical and direct skill learning opportunities. Similar to CPST, there are multiple components to PSR that are generally focused upon Personal and Community Competence and include: 1) Social and Interpersonal Skills; 2) Daily Living Skills; and 3) Community Integration. With these services, young people have a much wider range of assistance available to them. They can learn the practical skills that will help ensure their success – be it the management of ADLs to the building of friendships, PSR provides the skills needed to integrate and succeed in our community.

These promising new services offer hope and inspiration, but also come with a shift in practice for many organizations – that of developing partnerships with Managed Care Organizations (MCOs). Per the state's guidance, each of the new services is required to be of medical necessity. Providers may find ample evidence to include in their evaluations and service plans, but many do not yet know how each MCO will approve or deny requests for service. As the new system finds its way toward functionality, anticipation of denials and resubmissions should be a regular business practice. Agencies may be greatly benefit from identifying a staff member who is dedicated to the review and submission of claims and for ensuring effective communicating with MCOs in order to develop programmatic expertise to ensure a significant reduction in denials. While securing such staff members may require initial additional expenditures for organizations, the absence of such staff creates a much higher likelihood for confusion, denials, and the rewriting of service plans by providers who could be of better use serving families and generating revenue. Regardless of the chosen staffing constellation, this shift into managed care is set to be our new norm and agencies have the opportunity to guide their own evolution and success, starting with CFTSS.

With new services, new relationships, and new ways of operating, youth and family providers have a possibility of reinvigorating the ways in which they serve young people. If successfully coordinated, there is a significant opportunity to help young people transcend the common challenges associated with traditional program models by utilizing this more integrative approach. The potential result of this shift is the development of a firsthand understanding of wellbeing that is foundational to long-term success. For some, it may be the first glimpse of wellbeing after many years of struggle; for others, it may be what prevents them from years of struggle that were endured by so many others. No matter the circumstances, these services are definitely needed and could not have come at a better time for New York's youth and families.

John Orr, LMHC, is Program Director, Child and Adolescent Care Coordination, and Lisa Furst, LMSW, MPH, is Assistant Vice President, Center for Policy Advocacy and Education, at Vibrant Emotional Health.

Reference: Children's Health and Behavioral Health Services Transformation Medicaid State Plan Children and Family Treatment and Support Services Provider Manual for Children's Behavioral Health Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services, June 2018.

BEHAVIORAL HEALTH NEWS DESK

Implementing Universal Suicide Risk Screening in Healthcare Settings: Model Could Help Hospitals Better Identify and Aid Youth at Risk for Suicide

By The National Institute of Mental Health (NIMH)

A new report, authored in part by researchers at the National Institute of Mental Health (NIMH), part of the National Institutes of Health, provides guidance on how to implement universal suicide risk screening of youth in medical settings. The report describes a way for hospitals to address the rising suicide rate in a way that is flexible and mindful of limited resources.

In 2016 alone, more than 6,000 youth in the United States under the age of 25 died by suicide, according to the Centers for Disease Control and Prevention . Studies have found that a majority of youth who died by suicide visited a health care provider or medical setting in the month prior to killing themselves. The interactions of these youth with the health care system make medical settings an ideal place for positioning suicide intervention efforts.

“Suicide is a major public health concern and early detection is a critical prevention strategy,” said NIMH Director Joshua A. Gordon, M.D., Ph.D. “Part of NIMH’s suicide prevention research portfolio focuses primarily on testing and implementing effective strategies for identifying individuals at risk of suicide. Results from these research efforts are poised to make a real difference and help save lives.”

In 2007, The Joint Commission (TJC) (https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml) released a National Patient Safety Goal requiring that all behavioral health patients who present to psychiatric and general hospitals be screened for suicide risk. However, upon examining their data, they discovered that over a quarter of hospital suicides occur on non-behavioral health units, and at-risk patients were passing through emergency departments, inpatient medical units, and outpatient clinics undetected. This realization led TJC, in 2016, to recommend that all patients presenting to medical settings be screened for suicide risk.

While good practice, universal screening can present a strain on the resources of hospitals and other health care facilities. The report, published in Psychosomatics, presents a new three-tiered clinical pathway system as a flexible and resource-conscious way to implement universal suicide risk screening within pediatric health care settings. The system was created by an international subcommittee of the Pathways in Clinical Care workgroup from within the Physically Ill Child committee of the American Academy of Child and Adolescent Psychiatry.

The clinical pathway model consists of three main components, the first of which is an initial screen of all youth using the NIMH IRP-created Ask Suicide-Screening Questions (ASQ) tool. The ASQ is the first screening tool developed specifically to detect suicide risk in pediatric medical patients, is available in 14 languages, and takes about 20 seconds to administer. The second tier of screening is the most critical step and calls for a brief suicide safety assessment (BSSA), which takes about 10-15 minutes to administer. This measure is used to classify a person’s risk of suicide (low risk, high risk, or imminent risk) based on survey responses and clinical judgment, guiding the clinician’s decision for next steps. The third tier of screening, if deemed necessary during the BSSA, involves a full comprehensive safety evaluation by a licensed mental health provider. The goal of this assessment is to address safety issues and establish an intervention plan.

Decisions about patient care are made at each of the three assessment stages and are dependent on clinical insight in combination with responses to the surveys.

“Clinicians from across North America came together to address this youth crisis in a feasible, consistent and flexible way that can be adapted to each system where suicidal youth present,” said Maryland Pao, M.D., clinical director of the NIMH Intramural Research Program and an author on the paper.

The clinical pathway model presented in this report is accompanied by a variety of resources to help health care settings implement the outlined model (e.g. the ASQ Toolkit). It is hoped that the clinical pathways model described in this report can be used in health care settings to implement universal screening for youth in an effective manner—a manner that will help identify youth at risk for suicide and save lives.

According to Lisa Horowitz,Ph.D., M.P.H., a clinical scientist in the NIMH Intramural Research Program and an

see Risk for Suicide on page 31

Funding for NYS Opioid Epidemic

By The Office of New York State Governor Andrew M. Cuomo


Photo by Pat Arnow

Governor Andrew M. Cuomo

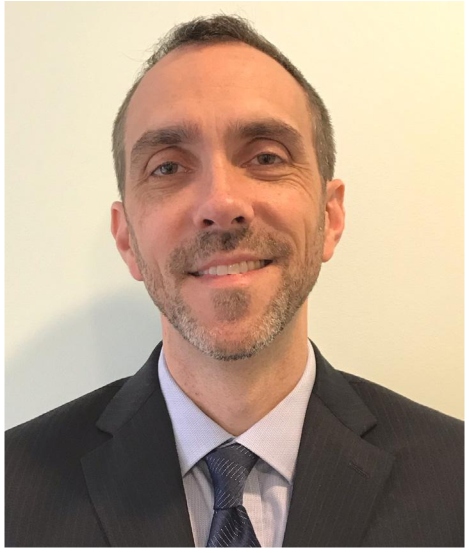
Governor Andrew M. Cuomo announced more than $9 million in federal funding has been secured to expand opioid addiction treatment services across the state. This funding includes $5.7 million to expand access to medication assisted treatment, $2.1 million to develop new recovery centers in areas of high need, and over $1.3 million for specialized treatment and recovery programs. These initiatives are being funded through the State Opioid Response Grant, which is administered by the Substance Abuse and Mental Health Services Administration.

“As the opioid epidemic continues to impact communities across the state, we are as committed as ever to expanding and enhancing programs that provide critical options for treatment," Governor Cuomo said. "We will continue to take aggressive action to combat this crisis and work to ensure these lifesaving services are available to any New Yorker who needs them.”

see Opioid Epidemic on page 32

Toth New CEO at CoveCare Center

By Staff Writer Behavioral Health News



Eric A. Toth

CoveCare Center in Carmel, New York is pleased to announce Eric A. Toth as its next Chief Executive Officer, effective January 2019. Diane E. Russo, current CEO of CoveCare Center, is retiring at the beginning of 2019 after 20 years of dedicated service.

Mr. Toth has spent the past 18 years with Family Services of Westchester (FSW), most recently as the Vice President of Program Operations, a position he has held since 2013. His role at FSW focused on managing, coordinating and developing clinical and community-based programs and projects. With his extensive experience and proven record of dedication to helping those in need, Mr. Toth is well suited to advance CoveCare Center’s mission to partner with individuals, families, and the community to foster hope, wellness, and recovery, and to restore quality of life by addressing mental health needs, substance use, and social and emotional issues.

see New CEO on page 31

World Events from page 24

organic. Or, maybe, as many people seem to think, it's social media and screen time.

A digression here about social media. 55% of Gen Z'ers reported that social media was a primary source of support when they are distressed. They also reported that it could be a source of distress, due to cyber bullying and the like. So, in their experience social media are a mixed bag.

Back to the question of whether world events are contributing to a decline of mental health. Possibly not, but if we use the usual simplistic model of mental illness as the outcome of innate vulnerability and social and psychological stressors, it would make sense that the state of the world is having an impact on the state of mental health—adolescent and adult.

And this would have important implications for mental health policy.

First, it raises doubt about whether increasing the availability of mental health services, improving their quality, promoting integration of service systems—all high on mental health policy agenda—will have a significant positive impact on the prevalence of mental disorders, suicide rates, overdose deaths, and so forth.

I am not suggesting that the elements of the current behavioral health policy agenda should be abandoned. I have been advocating for them for the past 40 years and will continue to do so. And I believe that mental health services can relieve the suffering of many individuals. Whether achieving our goals would result in widespread improvement of adolescent mental health is another question entirely.

Second, the probability that world events have a significant impact on mental health suggests that our current prevention agenda[6] does not go far enough. Again, I am not suggesting that we should abandon this agenda. It's important to mitigate the impact of poverty, violence, and adverse childhood events. It's important to provide support for parents who struggle to do what is right for their kids. It's important to provide early intervention and better education. But it may not be enough.

It may be that child and adolescent mental health advocates need to add **adverse world events** to their list of concerns, not just because the future of humanity may depend on the outcome of these issues, but more narrowly because the mental health of the next generations will fall, or hopefully rise, with the outcome.

Of course, taking on the flaws of the world we live in may be far too much to do. It takes enormous effort to pursue our current agenda. Our successes, and there are quite a few, have been hard won. Some advocates are called "tireless" because they are persistent. Most, I suspect, are in fact tired but dogged.

Nevertheless, long-term improvement of the mental health of our youngest generations may depend on entering the fray to fix the world and ensure that the generations to come will have the life we hope for them.

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School Refusal from page 23

in 6th grade and her grandmother died. Soon after, she had her first panic attack at school. This is when she stopped attending school. Her first visit to our program appeared unsuccessful. The student sat in the car for about an hour before entering the building, only to leave after five minutes. These five-minute visits went on for nearly two weeks before there was a breakthrough. Five minutes then became fifteen minutes. Fifteen minutes led to an hour - then, a half-day. To many, five minutes in class does not seem significant. However, her anxiety, present since the age of 11, affected not only her "refusal" to go school, but every aspect of her life. As a sixteen-year-old, she had never been left alone as she literally clung to her mother. The entire family was in her personal prison with her.

At the Transitions program, each plan is customized to meet a student's needs. In this case, her plan was layered with multiple supports. First, we gave her the tools to navigate overwhelming anxious moments. She was introduced to mindfulness coping strategies that created a path for her to control her emotions. In tandem with the mindfulness approach, the student met every morning with a clinician. The sessions were initially forty minutes and focused on developing and practicing coping skills, deep breathing, and positive affirmations. She was also permitted 5-minute breaks during the day as needed to practice her coping skills when her anxiety became overwhelming.

These sessions, over ensuing months, were faded to once per week morning check-in sessions along with "as needed" sessions for particularly anxious moments. She was also assigned a staff behavior technician to assist her with executive functioning that included hygiene, organization and socialization. She retained the support staff for the following school year.

During the summer of 2018, this student enrolled into a physical education course at her home high school. She was successful in completing her coursework and interacting with other students and teachers. In fact, it was the Transitions Program staff's recommendation that the student be enrolled for several courses at her sending school during the 2018-2019 academic year. Unfortunately, the sending high school was unable to accommodate this student's needs due to scheduling conflicts, so she opted to remain here at the Transitions Program as a full-time enrollee.

This Transitions Program participant is now an outgoing, happy teenager who has learned to manage what once was debilitating anxiety. She now mentors' new students, helping them to manage their catastrophic thoughts and proudly shares her story about starting in the parking lot. Her school attendance has improved to close to eighty percent. Academically, she exceeded the expectation of her sending district and is poised to complete the program in June, 2019. This student, once ridden with severe anxiety, now has friends, goes shopping, and even boasts of sleepovers!

Author credits: Howard Savin, PhD, is Chief Clinical Officer; Jay Cohen, MEd, is Transitions Program Supervisor; Valery Bailey, MPA, is Vice President of Operations; and Katherine Fearon, LCSW, is Transitions Program Social Worker, at First Children Services

For more information about our program, please contact Howard Savin, PhD at hsavin@firstchildrenservices.com or (856) 888-1097. On the internet, our Transitions Program information can be found at www.firstchildrenservices.com.

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. SAMHSA

Education from page 26

The range of possibilities for action is considerable: individual engagement using a positive youth development model to solve problems that push TAYYA out of school; programmatic interventions to re-integrate students into school after an absence; and systems changes to implement a Multi-Tier System of Supports (MTSS) that reduces suspensions and expulsions by improving school climate and reserves intensive clinical services for those most in need.

Interventions that Work

Effective interventions for TAYYA build on positive youth development and person-centered planning that engages the young person around her/his strengths and interests.

Positive youth development is characterized by adaptive or mutually beneficial relationships between an individual and her/his life context, so that the individual contributes to the contacts that support her/him. The clinical element enters the framework when the goal of positive developmental interventions is to restore or enhance developmental processes that have been compromised by high levels of risk and challenge.[6]

Positive youth development approaches are useful for improving TAYYA education outcomes, for example by promoting positive perceptions of school which then leads to better school attendance, which is essential for academic achievement and graduation.[7] The ideal model will use mental health agency staff skills and knowledge of human development to engage a disconnected young person and strengthen their connections with school and long-term vocational goals.

Mental health providers can also collaborate with schools in program development, for example, by introducing mentoring programs that help the young person concentrate and handle pressures.

Providers can create "bridge" programs, such as BRYT (Bridge for Resilient Youth in Transition) developed by the Brookline Center for Community Mental Health for the local high school and now being tested in diverse districts across Massachusetts. BRYT helps students who have been absent due to behavioral health challenges to reintegrate with school. It places mental health staff in the school to provide clinical supports for returning students, academic case management on their behalf with school personnel, and liaison with families for students in both special and general education.[8]

Finally, systems change is an option for assisting TAYYA: Partnerships between schools and community agencies have often created a three-tier model, called a Multi-Tier System of Supports (MTSS) that invests in universal supports for all young people (Tier 1) to improve school climate and modify disciplinary practices that too often result in suspension or expulsion for students with behavioral health challenges. This model reserves Tier 3, the most clinical tier, for the minority of students with more intensive care requirements.

Reinforcing the Imperative to Focus on Education Issues

Serious mental health problems represent the largest burden of disease in young people. Yet, TAYYA between the ages of 16 or 18 and 21 with serious mental health conditions, who may have received services as children, discontinue services – either by dropping out or being forced out. Policy and funding barriers, unpleasant school experiences, lack of attractive treatment models, stigma and a desire to "be done" with mental health services, and poor coordination between mental health services and community institutions such as schools all contribute to this phenomenon.[9]

To reverse the trajectory leading to

see Education on page 34

System Reform from page 10

This, in turn, has required providers to develop new capacities and competencies essential to effectively serve this population. In recent months our vocational rehabilitation staff has undergone comprehensive trainings in benefits advisement, developed procedures and protocols necessary to engage families of youth in transition and explored a menu of new service offerings integral to recipients' attainment of their educational and vocational goals. For instance, the transportation needs of young adults and other vulnerable populations are both critical to their progress and frequently overlooked. We recently established an agreement with one payer whereby transportation will be provided to select recipients who are unable to access it through other means. This elemental service enables many young adults to acquire and to retain positions of employment that would otherwise be inaccessible to them.

As we survey a rapidly changing landscape of health and social services we note many opportunities to strengthen the safety net for youth in transition. Health Homes serving children, an expanded array of Home and Community Based Services and a movement toward value based reimbursement under Medicaid Managed Care are but a few of the transformative initiatives that promise to advance the Triple Aim among this vulnerable population *if properly applied.* It is incumbent on payers, providers, families of service recipients and other stakeholders to remain vigilant lest these initiatives fail to achieve their desired aims and perpetuate the fragmentation that has frustrated our vulnerable youth for much too long.

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Transformations from page 20

Peter lives with his mom and sister. He has always been an anxious child, having had difficulty separating from his parents upon entering preschool. To this day, he worries excessively about what others think of him, changing his clothes multiple times before leaving the house each day, and is uncomfortable when home alone. Earlier this school year, Peter was overwhelmed at the prospect of presenting his science project to the entire class. He put off completing the project, and on the day of the presentation, he told his mom he was not feeling well. She allowed him to stay home from school that day, and he faked illness for the rest of the week. The following Monday, he refused to go to school. One day turned into a week, which turned into a month. Peter has not only missed more than 25 days of school, but he has not played on his travel soccer team and has stopped responding to texts from his friends. His health and family relationships have both suffered as a result of staying home, sleeping during the day and staying up all night.

How will CFTSS address the multiple layers that Peter and his mom need to work through?

- The Other Licensed Practitioner (OLP) staff will help Peter develop skills and strategies to manage difficult feelings when he is anxious and depressed.

- The Community Psychiatric Supports and Treatment (CPST) staff will provide Peter's mom with psychoeducation and equip her with strategies to assist Peter return to school.

- Psychosocial Rehabilitation Services (PSR) staff will work with Peter on regulating his sleep, developing bedtime and morning routines, re-engaging with his peers, and returning to the soccer team.

- Working collaboratively, this network of supports will help Peter succeed as a seventh grade student and beyond.

New CEO from page 29

Speaking on behalf of CoveCare Center's Board of Directors, Board Chairperson Sal Gambino stated, "We are confident that Eric's experience, knowledge, and integrity are a great match for the work, staff, and friends of CoveCare Center. Together we will continue to move forward and spread our vision of a strong, united community where all people are valued, accepted, and empowered to live healthy lives."

"I am honored and excited to join CoveCare Center. The quality of the care provided by this organization is a reflection of the teamwork and values of the staff, the community partners and the Board of Directors. With CoveCare Center's 20 years of experience to build upon, I am eager to join this team, to continue to help those in need and to grow our services to meet the needs of the community," said Mr. Toth.

Mr. Toth holds a Bachelor of Arts degree in Literature from The New School, a Master's Degree in Social Work from Hunter College, and a Master's Degree in Business Administration from New York University's Stern School of Business. He is an adjunct professor at Fordham University's Graduate School of Social Services.

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 Coordinated Behavioral Health Services (CBHS), 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.

Visit www.CoveCareCenter.org or call (845) 225-2700 for more information.

Consumer Perspectives from page 21

communication between providers, to educating staff on our child's particular diagnosis, to calling out stigma among healthcare workers, we do a lot. None of us had any help when our children first needed care, so we were left navigating a complex system of providers, policies, and terminology by ourselves. Some of us have worked double shifts to be able to support our children's healthcare needs. We have paid for out-of-network costs out of pocket. As parents, we will always do everything in our power to ensure that our children get help and services they need to not only be happy, but to thrive in school, graduate, and advance in life as healthfully as possible.

"Your research has to be so extensive and you have to be persistent and really know who to talk to. Otherwise you get lost and there is so much information, you don't even know where to begin. My son's issue is abandonment. And he had gotten close to his social worker. So when they tried to introduce another social worker, I said, 'Is it possible for us to have a meeting where you introduce this social worker to my son so that the transition is better? This is what my son needs.' So you really have to advocate for your kid."

One quality connection can make a world of difference. In spite of the challenges, our discussion revealed that significant successes can come from even one quality provider or relationship. Our children need to trust those they work with and feel respected and validated. These qualities, along with care that is accessible, can be truly life-changing.

"Looking back, what we thought was normal teenage behavior was not. That was when my daughter starting having auditory hallucinations. We found a good therapist. She worked hand-in-hand with her doctor at the time and my daughter felt comfortable. My daughter was so excited because at one point she didn't trust anyone. This therapist was in-tune to my daughter's feelings, and didn't negate what my daughter told her. She also told me to take my daughter back for a proper diagnosis. My daughter was so excited to see her, and there was a change in her behavior. She started wanting to be more sociable with family members."

"My son's guidance counselor, I love her. She is the one that noticed that he was suffering from depression and was talking about suicide. She was the eye-opener. He really liked her, he opened up to her all the time. She recommended a particular hospital, and he got a very good therapist there."

"The mobile crisis team at my local hospital is fantastic. Number one: they come to you. I knew my son would never show up to therapy, but they come to the house three times a week. That is major. And I don't have to be there. I'm working and I can't take off every time they are there. Plus, it's free."

Having a support system sustains us. Everyone in our discussion group is connected to one another through NAMI's parent support group. For us, NAMI and our group here at Services for the Underserved (S:US), have helped ease the stress and isolation we have felt from the struggle of navigating the system and other challenges. We feel comfortable with each other because, in this space, we won't be judged and minimized. The typical stigmas and attitudes we experience out in the world, toward our children and our lives, do not exist.

"I had an 'aha moment' realizing people are going through the same thing as me, who I could speak to and not feel uncomfortable. It's really hard speaking with family or coworkers. No one else understands. That's the reason I'm still with NAMI and volunteering to help other parents. It's hard as a parent, not knowing where to go, who to turn to, how to look for things. Even for my daughter it was like a godsend, because with her diagnosis she has auditory hallucinations and they have a support group for that."

"I wish I had known NAMI when I was first starting out. I was already deep, deep in the problem. I am a volunteer to support other parents. I really wanted to help because I know how painful it is, and when I think about it I get teary-eyed. I hear things from parents that I used to say when I was going through it. You really can't do it without support."

Advocacy, support, and hope help to fortify us, our ability to ensure our children's needs are met, and our resolve to educate and support fellow parents.

Groups from page 25

activities and media to engage and challenge young people in groups, reach out to parents and other relevant people in group members' lives, recognize opportunities for group members to practice social action and citizenship, and become familiar with the developmental path of groups.

Andrew Malekoff is the Executive Director of North Shore Child & Family Guidance Center, which provides comprehensive mental health services for children from birth through 24 and their families. To find out more, visit: www.northshorechildguidance.org. He is the author of Group Work with Adolescents: Principles and Practice (Guilford Press), now in its third edition.

Anxiety and Worry from page 27

live your life doing the things you value rather than avoiding fear. There is hope for families struggling with anxiety and worry that with motivation, effort, the appropriate strategies, and learning new skills, the individual can learn to manage their anxiety and prevent it from interfering in their lives.

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Risk for Suicide from page 29

author on the paper, these pathways make it possible for health care systems to implement suicide risk screening for all patients, in a practical way. This is how researchers and clinicians can partner together to heed the call to action to lower the suicide rate and save young lives.

Community Capacity from page 15

the youth is the desire to get better and lead a productive life. Families want that outcome regardless of which “service system” their child engages through, the child welfare system, the mental health system the DD system or the health system. The design of adding the behavioral health benefits as state plan services is that any child eligible or enrolled in Medicaid can access the services if a licensed professional determines medical necessity, regardless of what other Medicaid services they may need to address other challenges or disabilities.

The “better services” model includes family and youth support as funded services and an essential component of service delivery. Previously, those services were only available to the limited number of children who could access Home and Community Based Services (HCBS) through the state’s Waiver programs with a capped number of slots. Yet, they were rated among the most highly valued by families and children in the Waiver programs.

The “better services” model mirrors the family-friendly HCBS model in other ways too. CFTS Services are authorized to allow services and supports in settings that are preferable and readily accessible to children, youth, and their families. “Community-based care” was never more literal. The intent is that the majority of treatment and supports will be provided “offsite”, or in the home, school, and community. Once consent is provided, the services can be provided at the location that best meets the family needs and supports the restoration of the child’s functioning in a normal setting. For example, if a child’s biggest barrier to fully functioning in school is the lack of ability to establish non-confrontational communication, a community mental health worker can implement psychosocial rehabilitation services at a playground, park or sports team setting. The child learns, develops and practices his/her new skills in the setting where they will be most valuable.

The 6 new CFTS Services’ design will take family-driven and youth-guided services to scale by making them available to all Medicaid eligible children, based on their needs. The first 3 of the CFTS Services that will be implemented on January 1, 2019 are Other Licensed Professional (OLP), Community Psychiatric Treatment and Support (CPST) and Psychosocial Rehabilitation (PSR). These are also modeled after existing HCBS Waiver services. OLP will bring diagnostic, assessment and eligibility determination out of the clinic and doctor’s offices, allow licensed professionals to work to the top of their scope of practice and, hopefully, reduce waiting periods and erase some of the stigma families associate with having to bring their child to mental health outpatient settings. CPST is a service that will allow for reimbursement from counseling and crisis assistance to be provided by appropriately credentialed professionals and also allows for psychoeducation supports to be provided by BA level community health/mental health workers to family members to help them support their child’s treatment plan, medication adherence and to better understand how the services will support their child’s development. PSR is essentially a skill building supportive service provided by an unlicensed community mental health worker who helps the child implement the treatment plan one-goal-at-a-time.

Good Intentions - Great Design
Better Results?

The growing populist belief is that behavioral health care is effective and commonly required. More and more, citizens motivated in part by their own family experiences, speak in favor of service expansion. These families are commonly accepted as the community’s voice about both the importance of behavioral health, and acceptance that the common definition of “health care” includes behavioral health. Policy makers should be aware that there exists something of a mandate to expand community capacity and respond to pervasive child and family need. They should understand that the CFTS services design is good. Most importantly, they should pay careful attention and join in an effort to dictate how the outcomes and results of such a creative expansion of new children’s behavioral health benefits will be measured.

One set of results, based on the Social determinants theory, might require us to wait until a child reaches age 27 (age of full emotional development for males). The Social Determinants Theory, extends the definition of health care beyond the limits of direct medical provision to include macro-factors that affect the health status of an entire population. The World Health Organization’s definition of social determinants is deceptively simple: *The social determinants of health are the conditions in which people are born, grow, live, work, and age. The circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.*

The assumptions that child health will be improved by a nurturing environment for children, better engagement with education, a socially supportive community will not send the insurance actuaries running to the bank to safeguard huge returns on their investment. Likewise, policy makers worried about re-election in 2 years may grow impatient with the slow pace of outcome data. However, the facts remain that early adverse experiences and missing developmental milestones become embedded in biology during the processes of development. The embedded biology forms the basis of the individual’s behavioral and human capital, which affects health throughout life. Only through earlier intervention and treatment can the adverse impacts be balanced with positive coping skills and appropriate development.

The complexity of these challenges may make it difficult for policymakers to remain constant and committed to the relatively slow return-on-investment represented by children’s mental health policy reform. Yet, by determining whether access to quality care is sufficient and whether the community-based design of CFTS services is practical MUST be the second phase of this children’s mental health reform; by securing and sustaining essential care for children. The commitment must last at least as long as a comprehensive review of how managed care organizations react to their new involvement with the “whole child’s” health care costs, now that previously carved out behavioral health costs are factored in and until we determine how the children’s mental health provider community fares in delivering more, high quality but less intensive, community-based services delivered by a mobile community mental health workforce.

Expanding the children’s behavioral services capacity won’t be easy. The positive outcomes may take five or more years to trickle in, but children and families who will benefit will understand immediately that the expansion, the way the new services will be delivered and the positive child development that results are worth the investment. The supporters of the redesign remain steadfastly unified behind the design, which embodies the fact that, children cannot be served alone. When we look at a child, we must never fail to see the two or five or ten caretakers around him, his community, the capability of his school to accommodate his needs and his access to social supports. Families are simply the first and best behavioral health asset that a child can have and the new Child and Family Treatment and Support Services were designed with that fact in mind.

The NYS Coalition for Children’s Behavioral Health website can be found online at: www.cbhny.org

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Opioid Epidemic from page 29

“I have heard firsthand from countless families across the state who have felt the impact of addiction," said Lieutenant Governor Kathy Hochul, Co-Chair of the Heroin and Opioid Task Force."This epidemic is claiming too many lives prematurely, and we refuse to sit on the sidelines and watch it continue. With this investment, New York is reinforcing our steadfast commitment to combat this crisis and help individuals on the road to recovery.”

“This funding is crucial to our efforts to address addiction in communities throughout the state,” New York State Office of Alcoholism and Substance Abuse Services (OASAS) Commissioner Arlene González-Sánchez said. “These projects will build on the nation-leading work that we have already done here in New York, and result in more services, and more lives being saved.” The following initiatives are included in the funding:

- $3.9 million to increase access to services, including hiring or contracting for additional buprenorphine prescribers in the following 26 counties: Cattaraugus, Allegany, Steuben, Chemung, Schuyler, Seneca, Livingston, Wyoming, Orleans, Chenango, Lewis, St. Lawrence, Franklin, Clinton, Essex, Hamilton, Warren, Fulton, Washington, Rensselaer, Albany, Schoharie, Delaware, Putnam, Westchester, and Rockland. Each county will have the flexibility to develop resources and services to address the specific needs within the county. Services can include mobile treatment services, increased use of peers, telehealth, increased prescriber capacity, or other options.

- $2,187,000 is available through a Request for Applications (RFA) for five new addiction recovery centers in high-need areas: Each center will receive $87,500 in start-up funding, and $350,000 in operating funding. RFA will be released for bids on December 4, 2018, and bids will be accepted through January 2, 2019. Interested parties can review the RFA (https://www.oasas.ny.gov/procurements/documents/Recovery-Center-RFA.pdf).

- $1.5 million for OASAS Open Access Centers to hire or contract with buprenorphine prescribers: This action is expected to create access to buprenorphine for at least 1,000 new individuals.

- $600,000 to support increased transportation initiatives: Funds will be allocated to programs who provide transportation services to individuals seeking treatment in their communities. Within this funding, support is provided to Save the Michaels in Western New York for their innovative program which connects and transports New Yorkers who are being diverted by the courts into treatment.

- $300,000 for the REACH (Respectable Equitable Accessible Compassionate Healthcare) primary care practice program: REACH will collaborate with OASAS on the State Opioid Response grant to help support expansion of Medication Assisted Treatment (MAT) in the rural Southern Tier Region of New York. The requested funding will support the cost of MAT for 217 patients for a 12-month period.

- $300,000 for the Specialized Peer Services Program: This program will target individuals who have been released from prison or jail to communities in New York City, and are in need of re-entry services including recovery, substance use disorder, and mental health services, as well as wrap-around services. The peers will offer support to individuals re-entering their communities, including helping them with recovery plans, skill development, and obtaining services.

- $250,000 for a collaboration with the Center on Addiction: Will support the development and testing of a tool that treatment providers can use to assess treatment progress and provide better quality of care for people with opioid use disorders as well as other substance use disorders.

- $200,000 for first responder training on addiction: The Bureau of EMS and Trauma Systems will create classes to train EMS providers in New York State on how to work with individuals experiencing intoxication to opioids or other substances. This program will be developed with Regional Emergency Management Organizations.

New Yorkers struggling with an addiction, or whose loved ones are struggling, can find help and hope by calling the state's toll-free, 24-hour, 7-day-a-week HOPEline at 1-877-8-HOPENY (1-877-846-7369) or by texting HOPENY (Short Code 467369).

Behavioral Health News Upcoming Theme and Deadline Calendar

Spring 2019 Issue:
"Caring for Older Adults"
Deadline: March 18, 2019

Summer 2019 Issue:
"The Behavioral Health Workforce"
Deadline: June 17, 2019

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"
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Families in Distress from page 12

coordination began with establishing rapport with the family during HHSC enrollment, being present and supportive during the crisis and hospital admission, conducting follow up with treatment providers during the hospital stay, participating in the discharge planning, being available during the transition to the community and re-establishing new linkages post hospitalization. As a result of joining with the family to support their needs, the adolescent is currently medication-adherent, receptive to working on her relationship with her mother, in an appropriate school-setting that supports her behavioral needs and is connected to a supportive peer group.

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For more information about CBC's Health Home Serving Children (HHSC) program, contact Amanda Semidey at ASemidey@cbcare.org or visit our website at http://www.cbcare.org.

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Unmet Needs from page 14

and who meet medical necessity criteria. Previously, services similar to the CFTS services were only available to a very limited number of children with very complex needs who were eligible for HCBS services.

The CFTS service implementation will be phased in between Jan 1, 2019 and Jan 1, 2020. The January 1, 2019 changes include the addition of 3 of the 6 new CFTS services: Evaluation and Assessments and Psychotherapy – called Other Licensed Professions; Counseling and Psycho-social education – called Community Psychiatric Support and Treatment; and Skill-building and Rehabilitation – called Psychosocial Rehabilitation. In July 2019, another CFTS service will be added to support caregivers, and engage and strengthen families – called Family Peer Support Services. Later, on January 1, 2019, the last 2 CFTS services will be added to the Medicaid plan: Youth Peer Support and Crisis Intervention.

All six of the new services are intended to improve a child's functioning at home, school and in the community and must be offered where children live, learn and play. The service design is for treatment and support to made available where the child and family can access it easily, as often as necessary and where the behavioral improvement are most necessary.

Designating Providers: The state determined that serving children in the least restrictive environments and with flexible, family-driven care, would not be as familiar to traditional brick and mortar based medical care providers. The designation process focused on the types of providers that were used to going to the children, not having the children come to them. Designation focused on those agencies already familiar with providing home and community-based services and providers with child, youth and family experience as well as clinical, licensed programs. Unlike previous community-based programs, like Early Intervention, individual practitioners will not be eligible for designation. The licensed and unlicensed care-givers will have to be employed by or under contract with a designated agency.

However, this approach to service delivery is not without challenges for service providers. In addition to having to establish regular, scheduled clinical supervision of a nomadic workforce, providers must recruit and retain a workforce able to wrestle with MTA delays or harsh weather conditions in upstate New York. In addition, the productivity of a traveling workforce brings expenses that may not be fully accounted for in the preliminary rates.

The general workforce shortages, a result of robust employment and in the clinical field, insufficient pipeline to meet demand, is a looming challenge.

The Children: All Medicaid eligible children who live in a home or community setting and meet medical necessity criteria and are able to accept flexible, family driven services can receive the CPST services. Medical necessity does require a diagnosis, but the addition of the Other Licensed Profession (OLP) service is intended to allow evaluations and assessments by licensed practitioners of the healing arts that can take place in community settings and be scheduled when family members are available.

Services for kids already receiving Medicaid service but who need additional supports to prevent the need for higher levels of care will also be eligible for the CPST services.

The opportunity to rapidly expand delivery of services to kids with unmet needs is the most exciting aspect of the children's redesign.

Other Redesign Components: In addition to the expansion of community children's behavioral health services, the reform that is planned for 2019 will include moving all youth in the 6 HCBS Waiver programs to Health Home care coordination. The transition from the current Waiver care coordination to Health Home care coordination is complicated and will require the existing HCBS Waiver providers to do a tremendous amount of work before January 18, 2019.

In addition, when the new array of HCBS services come on line in April 2019, the services and the children will be covered by Medicaid managed care. Then in July, the voluntary foster care population moves to Medicaid managed care. This will require Voluntary Foster Care Agencies to be enrolled with MMC plans for the first time. The system changes for the providers are extreme, but the quality results for children and families should be measurable almost immediately if more children access services and are linked into integrated record keeping and utilization can be tracked.

Next Steps and Measuring Success: To achieve the state's vision of higher quality and more affordable care, the continued involvement of the Children's MRT Subcommittee should be a priority throughout implementation. The state must ensure that reforms result in a behavioral health system that dramatically expands access to timely, high quality care, that the care management services meet family needs and that the new HCBS array is sufficient.

General Oversight Recommendations

- Ensure that full funding to implement the new Children and Family Treatment and Support Services and the transition timeline of services to Medicaid managed care are met;• Evaluation whether the proposed reimbursement rates are sufficient to sustain the community-based design of the model and quality of the CFTS services;

- Address the need for expanded workforce resources to build the needed clinical capacity to meet demand and address the significant shortage of qualified clinicians;

- Collect data to assess the children's behavior health implementation and utilization expansion under Medicaid Managed Care; and

- Engage in a robust education and outreach campaign to ensure that pediatricians, family practices, and child- and family-serving agencies are aware of the new community-based options.

Data and Analysis Recommendations: Because most children's mental health and behavioral health services were provided through capped and "slot-limited" programs, the comparison of Medicaid utilization will be an "apples to oranges" comparison for quite a few years. The capped programs are higher cost and fewer children were eligible, but as with any new service, the up-take on the CFTS services may be slow until public awareness pushes demand. Among the greatest challenges to determining the impact of the expansion of children's behavioral health services is a lack of sufficient, comprehensive baseline data on the gap between the number of children who need behavioral health services, and those who actually receive them. Estimates on the gap between capacity and need remain frustratingly sparse, making it difficult to assess the true unmet need within the state. We therefore urge the state agencies involved with the children's transition (Department of Health, Office of Mental Health, Office of People with Developmental Disabilities and Office of Children and Family Services) to collaborate to improve the collection and dissemination of data on children receiving behavioral health services. This effort must include establishing a baseline of children served prior to the transition, the state can better monitor the impact of these large systems changes. The data collection will identify how to best increase access in a strained and under-resourced system.

Workforce Recommendations: There is need for more data on workforce availability. Though we know the workforce shortages are widespread, it is difficult to quantify the extent of the problem without more robust data collection from the state. We support implementing a re-registry survey, requiring reporting and data collection on health care practitioners who seek to have their professional licenses renewed with the State Education Department. A program like this would allow licensed health and mental health care practitioners to report information including the type of setting where the practitioner practices and their geography. This data would help inform the state whether, where, and how behavioral health professionals are practicing, and help with specific health workforce shortages by targeting recruitment programs available through the state to the most under-capacity communities.

In addition, although the MRT initially made recommendations about addressing scope of practice reforms to address the behavioral health workforce shortages, they were never implemented. Moreover, while workforce training and transformation funding was readily made available to hospitals and other institutions, the community health care workforce was not the beneficiary of such investments. Now, with the expansion of children's community services represents the perfect moment to re-establish a MRT Community Workforce Modernization subcommittee to tackle the community health and behavioral health workforce challenges that will ensure capacity expansion is possible.

Looking Ahead

As we ring in the New Year, let us rejoice in the opportunities as well as prepare for the challenges that lie ahead of us, as we strive to guarantee a better quality of care and services for our kids.

To visit the Coalition for Behavioral Health online go to: www.coalitionny.org.

Education from page 30

poor outcomes, states and localities are increasing their focus on building infrastructure and services for TAYYA. Among the central areas of focus must be their education and how the mental health service system can improve education outcomes for this population. Connection with school - vs. disconnection - can mean the difference between a successful life in the community or one bouncing around on society's margins.

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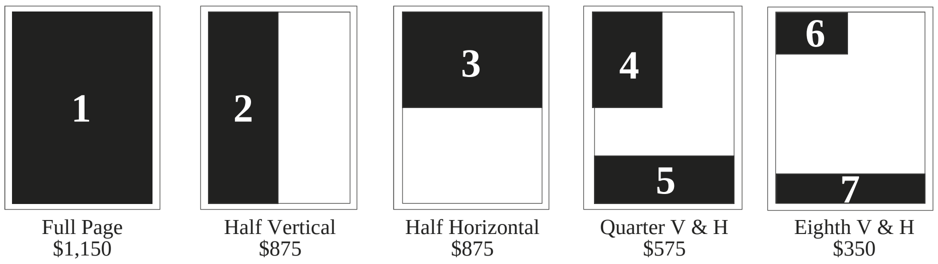

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