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WINTER 2020

ON MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT AND SERVICES

VOL. 7 NO. 3

## Pain and The Nation's Opioid Epidemic: An Interview with Luana Colloca, MD, PhD, MS

By Michael B. Friedman, MSW

The so-called "opioid epidemic" is a far more complex social phenomenon than it appears to be when politicians and pundits propose solutions to it. They work largely from a simplistic and only partially true narrative that lately concludes that the villains are the drug companies that promoted inappropriate and dangerous use of prescription pain killers. In an earlier formulation, doctors were the villains. Both, of course, have been sadly critical contributors to growing addiction and overdose deaths, but they are not nearly the whole of it.

The narrative goes something like this: the increasing drug overdose deaths in the 21<sup>st</sup> century, though mostly not from prescription pain killers, reflect a progression: first from using prescribed opioids for pain or using stolen painkillers to get high; second, becoming addicted; to third, using easily accessible and cheap street heroin (sometimes laced with fentanyl); to fourth, accidental\* overdose deaths (Gladden, O'Donnell, Mattson, & Seth, 2019).



This narrative neglects the facts that (1) many overdose deaths involve the use of multiple drugs—especially alcohol and benzodiazepines (Sun et al., 2017), (2) the growth of overdose deaths over the past few years is almost entirely due to street

fentanyl, (3) many deaths are from adulterated street drugs, (4) it seems likely that the increased demand for drugs—and consequent rise in deaths—is fueled not just by their availability but by unclear social factors that are driving a rising

sense of despair, which has led to increased suicides and alcohol-related deaths as well as increased drug overdoses (Case & Deaton, 2015) and (5) the management of acute and chronic pain remains challenging.

Given the complexity of the opioid epidemic (Dowell, Compton, & Giroir, 2019), solutions need to be a comprehensive combination of interventions including (1) control of the manufacture, distribution, prescription, and illegal sale of drugs, (2) use of preventive interventions at both the community and individual levels, (3) improved access to effective treatment of addiction, including treatment with medications, and (4) more widespread use of life-saving emergency interventions by first responders.

One Component of All This Is  
Effective Pain Management

We are fortunate that Luana Colloca, MD, PhD, MS, an international expert on the neuroscience and treatment of pain, has agreed to talk with us about how the

*see Pain on page 26*

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## New York State Office of Mental Health Using Medication-Assisted Treatment and Other Resources to Fight the Opioid Epidemic

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

**E**very day, more than 130 people die in the United States as a result of opioid overdose. The opioid abuse epidemic has become a national public health crisis with devastating economic, societal and human costs.

People with mental illnesses served in the public mental health system have significant rates of Opioid Use Disorder (OUD). In fact, mental illness is a risk factor for OUD and adverse outcomes, including overdose. And while some patients in the public mental health system with co-occurring OUD may express interest in receiving treatment, they may experience difficulty going to treatment at an additional clinic setting. Evidence shows that integrated treatment, or "one-stop shopping", improves outcomes for people with mental illness and OUD.

Medication-Assisted Treatment (MAT) is the use of FDA-approved medications, such as long-acting naltrexone (Vivitrol), buprenorphine (Suboxone) or methadone, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.



**Dr. Ann Sullivan**

At the NYS Office of Mental Health, our goal is to ensure that people living with mental illness as well as opioid use disorder get the help they need on their road to recovery. We are working with our providers statewide to enhance the capacity of the 486 licensed mental health clinics to respond to the opioid epidemic. Clinics are required to participate in educational webinars and to adopt new best

practices, including:

- Implement and use validated, standardized, opioid-specific screening tools for all new patients at intake.
- Prescribe or dispense naloxone to all individuals with opioid use disorder and others identified as having risk of opioid overdose. Provide education on how to use naloxone to patient, friends, and family.
- Improve referral process for individuals who need more specialized addiction treatment by developing relationships with specialized substance use programs, scheduling appointments within two weeks of identification and following up to make sure appointments were kept.
- Increase the number of buprenorphine-waivered physicians and nurse practitioners on clinic staff.
- Provide MAT induction and maintenance services for OUD at the clinic

We have also made enhancements to PSYCKES, a web-based platform developed by OMH to improve clinical decision-making and quality improvement. PSYCKES allows clinicians to identify their patients with increased opioid over-

dose risk, including those with a history of opioid overdose and those co-prescribed opioids and benzodiazepines. In addition PSYCKES can identify patient history of OUD diagnoses and level of engagement in counseling and medication services.

OMH is also working within its state-operated clinic and residence programs to stock naloxone kits. Non-medical staff such as social workers, mental health therapy aides and psychologists are being trained to become Overdose Prevention Responders so that they can administer potentially-life saving naloxone in an overdose emergency. We are also developing protocols to equip our safety officers to carry naloxone on their person and cars as they patrol our campuses. So far, over two thousand staff members have been trained throughout our residences and clinics.

Another step we have taken to battle to opioid epidemic is to enhance OUD resources and training available through our Center for Practice Innovations (CPI), a collaboration between OMH's New York State Psychiatric Institute and Columbia University to support training and implementation on evidence-based practices statewide.

*see NYSOMH on page 33*

## Peers as an Effective Strategy for Engaging Individuals with Addictions in Recovery

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

**A**s New York expands its Recovery Oriented System of Care (ROSC), the utilization of peers within hospital emergency rooms, addiction treatment, and recovery support providers, has demonstrated tremendous value, and opportunities to achieve enhanced engagement and retention of individuals in need of addiction services and supports. The Centers for Medicare & Medicaid Services (CMS) provided guidance to state Medicaid directors in April 2007 on peers as an evidence-based model of care.

The New York State Office of Addiction Services and Supports (OASAS) identified a Certification Board to develop and administer a process for individuals with lived experience to become Certified Recovery Peer Advocates (CRPAs) to work within its ROSC. Simultaneously, the state received approval from CMS for Medicaid reimbursement for peer services provided by CRPAs working within the OASAS outpatient system of addiction treatment. Today there are now more than 1,300 CRPAs providing peer services throughout the state!

OASAS has developed several innovative, locally based programs that utilize peers within clinical teams to better meet



**Arlene González-Sánchez**

the needs of New Yorkers, wherever they are in their path to recovery. These programs increase access to assessments and referrals; and provide family support while reducing barriers to receiving help. Capitalizing on federal funding related to the nationwide opioid crisis, OASAS developed 20 Centers of Treatment Innovation (COTIs) that provide mobile treatment, telehealth and transportation to bring services directly to individuals that need them.

The COTI providers utilize peer out-

reach and engagement within communities to help link individuals with appropriate levels of care and support. The data OASAS has received to date indicates that more than half of the individuals engaged by peers are subsequently admitted to an OASAS certified treatment.

The anchors for the COTIs are the certified outpatient treatment programs. Many of these COTI providers have also joined with hospital emergency departments to provide CRPAs to engage individuals after an opioid overdose and to provide a warm hand-off to an appropriate level of care. In 2019 OASAS developed a demonstration with 5 hospital emergency departments to provide buprenorphine induction while partnering with outpatient providers for peer services delivered by CRPAs. One of our outpatient COTI providers, CN Guidance & Counseling (CNG) stated that peer services have been a "game changer" for engagement as the peers put a face on early recovery. A participating hospital systems partner, Northwell Health in Long Island, commented:

In 2017 OASAS initiated the development of 21 Peer Engagement Specialists (PES) programs, in response to community feedback received during the Heroin and Opiate Task Force listening tours conducted throughout the state in 2016. The Task Force, co-chaired by me and Lieutenant Governor Kathy Hochul, identified a series of recommendations, one of which was the development of services to

engage individuals that have experienced an opioid overdose. The PES providers link CRPAs with hospital emergency departments to engage individuals and their families and make referrals to appropriate levels of care. The data is striking (see data charts on page 37).

To support the implementation of the peer program agenda OASAS initiated policy and regulatory modifications. In addition to seeking and obtaining Medicaid reimbursement for peer services delivered by CRPAs within outpatient programs, OASAS now authorizes outpatient providers to conduct and bill for pre-admission outreach and engagement; and to conduct and bill for, these services in-community, or outside of the clinic's four walls.

OASAS issued guidance documents on the following topics: scope of practice for peer services; pre-admission and in-community service provision; and documentation and billing guidance. OASAS also developed a bureau focused solely on peer services integration to provide technical assistance with certified outpatient and opioid treatment program (OTP) providers. The availability of technical assistance to help clinical treatment outpatient providers to integrate non-clinical peers or CRPAs is critical given that OASAS modified its outpatient regulations effective March 29, 2019, to require all such outpatient treatment programs and OTPs to provide peer services as part of their

*see Peers on page 37*

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## Lessons Learned: Tools to Treat Opioid Misuse

By Staff Writer  
Behavioral Health News

In the 20 years it took opioids to become the deadliest substance misuse epidemic in American history, the response from the public is overwhelmingly in favor of controlling access to opiates by limiting their use, supporting prevention education and prevention campaigns, and equipping first responders with overdose reversal kits. Treatment, however, is a mystery to most people unless they or a loved one have needed care.

We asked Dr. Peter Provet, President and CEO of Odyssey House, a clinical psychologist who has worked in the addiction field for 30 years, about the increased role intensive residential and out-patient treatment plays in preventing more overdose deaths.

Dr. Provet: the first thing to understand about the opioid misuse crisis is that the lives lost are only the beginning of the devastation.

The collateral damage to our society is stunning. Families, especially children born to parents addicted to opioids who are now dead, in jail, or still using, are the latest tragedy unfolding before our eyes. Meanwhile, the cost to the economy – at least \$631 billion from 2014 to 2018 – keeps going up and up, draining local municipalities from Ohio to New York



**Dr. Peter Provet**

already straining to provide services.

There is no quick fix for people addicted to opioids. Medication-Assisted Treatment that supports behavioral change is an essential way to reduce overdose deaths and help people rebuild their lives.

Yes, it takes time. Yes, people relapse. And, yes, treatment costs money. But compared with the enormous societal costs, broad-based psychosocial treatment is the only way we can save this generation and the one after it.

Has the opioid epidemic changed treatment at Odyssey House?

Dr. Provet: intensive residential treatment with linkages to community-based outpatient, supportive housing, and peer-led recovery services together represent a model we developed over 50 years ago to effectively treat surging heroin abuse in the 1960s to 70s; the cocaine and crack cocaine crisis of the 1980s and 1990s, and; the tragedy of today's opioid epidemic.

During five decades of changing drugs of abuse in America, the Therapeutic Community Rehabilitation Model has evolved to include psychiatric and medical services, Medication-Assisted Treatment, housing, and vocational supports, and individual and family therapy. But underpinning all these elements is a commitment to peer-supported recovery and the development of a network of people who effectively support each other while in treatment and, most critically, when they rejoin society.

This model is still one of the most effective rehabilitation regimens for people who require a broad range of supportive services. Its greatest strength is its flexibility to adapt to different populations, from women with children, to adolescents, and to older single adults all the while supporting each individual's drug-free/medication-assisted treatment goals and preparing them to function independently.

While the opioid crisis has increased awareness of drug addiction and its profound costs, it has not changed the demands on public treatment providers to save and rebuild lives as quickly, and cheaply, as possible. This is despite the fact that many of the people we treat have endured decades of marginalization and disadvantage – on top of chronic substance abuse and mental health disorders.

You talk about the evolution of treatment services. What changes do you want to see?

Dr. Provet: As a treatment provider I have long fought against the stigmatization of addiction in our society. I want people suffering with substance abuse disorders to be seen as just as worthy of compassion and resources as those with other chronic, relapsing disorders from mental illnesses to medical challenges.

To me, the criminalization of addiction and relegation of substance abusers to the prison system and homeless shelters has done a great disservice to young men and women, particularly from minority communities. As we enter a new decade, I hope overdose deaths from prescription opiates will decline and not be replaced by street heroin and/or fentanyl. I also hope as the legalization of marijuana is adopted by more State Legislatures, we

*see Lessons on page 30*



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# Joint Senate Task Force on Opioids, Addiction and Overdose Prevention

## Testimony by Richard Juman, PsyD, NYS Psychological Association

By Richard Juman, PsyD  
New York State Psychological Association Division on Addictions

In 1804, Frederick Sertürner experimented with opium and created something new—morphine—named after the Greek god of sleep and dreams, Morpheus. More than 200 years later, hundreds of thousands of New Yorkers fall asleep at night under the influence of an opioid. Every morning, a few of them don't wake up.

The United States comprises about 4% of the world's population but consumes about 80% of the world opioid supply. So why is it that when we travel abroad, we're not shocked by the number of people we run into who are obviously wracked by pain? The answer is that opioids are not a good solution to chronic pain, in part because of what's known as "opioid-induced hyperalgesia," a paradoxical and tragic phenomenon in which opioids come to make people increasingly sensitive to pain. Two recent studies that focus on the effectiveness of non-opioid pain management highlight how far removed the overprescribing of opioids is from evidence-based practice. The studies, one involving acute pain, the other chronic pain, both found that combinations of acetaminophen and ibuprofen (Tylenol and Advil) were as



**Richard Juman, PsyD**

effective as opioid-based interventions. And there are many other non-pharmacologic interventions for chronic pain whose effectiveness is evidence-based. So opioids are not a good answer to chronic pain, rather, they cause addiction and death. Routinely referring these patients for non-pharmacologic interventions is one of our recommendations.

So it's clear that a sea change must occur in the way that health care providers think about, treat and especially prescribe for pain. The task is really two-fold. First, what should be done for the thousands of New Yorkers who are addicted to opioids—how can we prevent as many of them as possible from adding to the opioid overdose statistics? Second: what can be done to prevent more people from finding themselves in the same situation—people who are showing up in medical offices now, looking for relief but putting themselves at risk for addiction?

### Where Do We Go From Here?

Towards answering these questions, last year the Division on Addictions of the New York State Psychological Association created a White Paper on the Opioid Crisis ([https://cdn.ymaws.com/www.nyspa.org/resource/resmgr/docs/NYSPA\\_White\\_Paper\\_Opioid\\_Epi.pdf](https://cdn.ymaws.com/www.nyspa.org/resource/resmgr/docs/NYSPA_White_Paper_Opioid_Epi.pdf)). It was distributed at the time to all members of the New York State Legislature and has been shared today with all of you. I trust that a careful review of the paper will demonstrate that there are already many programs, interventions and strategies available now that, wisely-deployed, would go a long way towards helping solve the Opioid Crisis. Among many other recommendations, we sup-

port providing evidence-based training about substance misuse and the risks of opioid-based pain medication for medical and mental health professionals, students and the general public. No patient with chronic pain goes to a medical office eager to become addicted to a potentially life-threatening medication. Only when the prescriber and the consumer both understand that the treatment for pain need not include the risks of addiction and death can an adequate response to this aspect of the opioid epidemic be said to be in place. See the full list of White Paper Recommendations at the close of this article.

We support the strengthening of all programs that are designed to prevent new cases of opioid addiction and those that improve access to interventions that keep the already-opioid-dependent alive, such as methadone, buprenorphine, naloxone, clean needles, etc.

But we are never going to solve the opioid crisis until we recognize that addiction is a complex phenomenon that involves biological, social and psychological elements. And complex as addiction is on its own, it often co-occurs with other psychiatric disorders, such as depression and PTSD. So, we can, and should, maintain our focus on improving

see Testimony on page 32



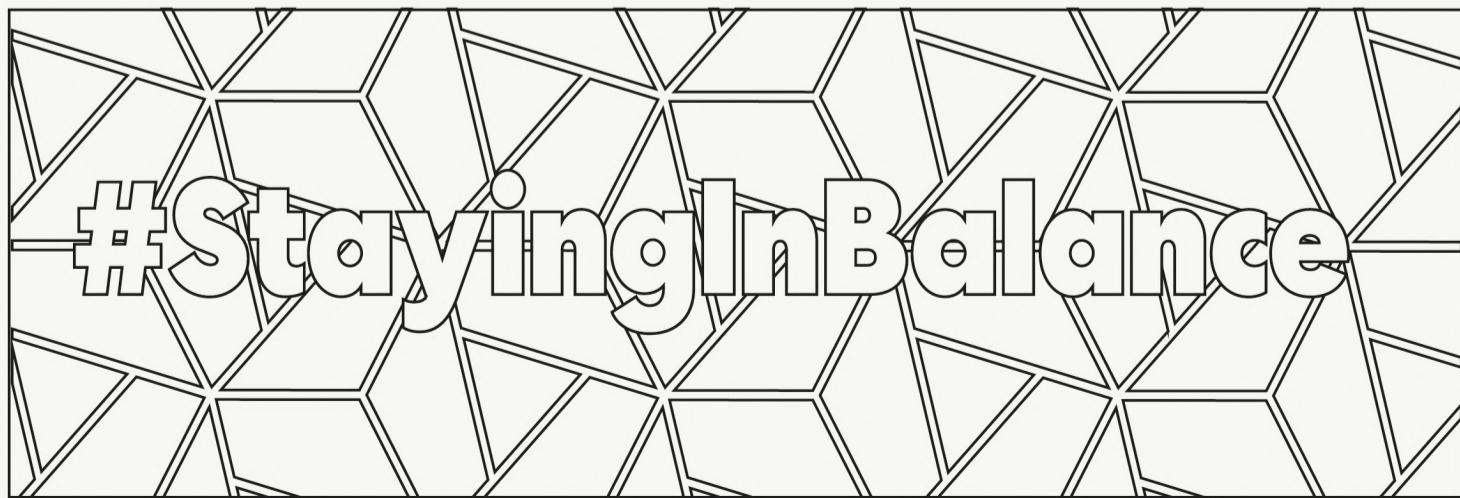
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## CBHS IPA and CBC IPA

# Joint Initiatives to Increase Medication Assisted Treatment (MAT)

**By Jorge R. Petit, MD, President and CEO, CBC and Mark Sasvary, LCSW, Chief Clinical Officer, CBHS**

The New York State Office of Alcoholism and Substance Abuse Services (OASAS), as a recipient of a State Opioid Response Grant (SOR) from the Substance Abuse and Mental Health Services Administration (SAMHSA) put out a grant with the objective of providing funding to provider networks to assess current clinical and program workflows and practices that impact access, engagement, retention, and access to Medication Assisted Treatment (MAT). The grant funding is intended to support programmatic restructuring, implement best practices for the treatment of opioid use disorder (OUD) and achieve fiscal sustainability.

In October 2019, Coordinated Behavioral Health Services (CBHS) and Coordinated Behavioral Care (CBC) Independent Practice Associations (IPA) were awarded funds to develop initiatives that, in collaboration, were synergistic and complementary of the stated mission of the grant described above called the OASAS Behavioral Health Care Collaborative (BHCC) MAT Expansion Award.

CBHS IPA, is comprised of 30 non-profit, community behavioral health (BH) and disability service providers, and 59 affiliates. CBC IPA is a provider-led organization of 50+ community BH agencies across the five boroughs. Both IPAs are dedicated to improving the quality of care for Medicaid beneficiaries with serious mental illness, chronic health conditions and/or substance use disorders.

The region CBHS providers serve continues to struggle with overdose death rates higher than the statewide average. Five out of the seven counties we serve have a death rate higher than the 2018 statewide average, and all counties' death rates either increased or were flat between 2017 and 2018. From 2016-2017, the Hudson Valley region saw an increased overdose death rate in Dutchess, Orange, Sullivan, and Ulster counties. Putnam, Rockland, and Westchester rates stayed flat or decreased. The region has also seen the Opioid Use Disorder (OUD) epidemic shift toward synthetic opioids with such



**Jorge R. Petit, MD**



**Mark Sasvary, LCSW**

deaths increasing 135% from 2016-2017. Since 2017, the region has improved in reducing OUD-related hospitalizations, however, this progress has been inconsistent particularly in Dutchess County where the rate of ED visits for OUD is higher than the statewide average. Sullivan, Ulster, Dutchess, and Orange counties had the four highest rates of OUD deaths, when the rate across the state for counties outside of NYC dropped. Many socioeconomic factors in the region compound this, such as higher than average rates of unemployment, housing insecurity, and individuals skipping medical care due to costs. The region also has significantly higher rates of poor mental health (MH), depressive disorder, and poor physical health.

In NYC, while rates of opioid overdose, related emergency department (ED) visits and hospitalizations in the rest of New York State have outpaced those in New York City (NYC), overdoses in NYC have skyrocketed, with opioid-involved overdose deaths nearly tripling since 2010. In 2018, 892 people in NYC experienced overdoses related to opioid pain relievers, 360 overdosed from heroin, and roughly 25,000 unique clients were admitted to OASAS-certified chemical dependence treatment programs for any opioid. The rate of ED visits for opioid

overdose in NYC was 26.7 per 100,000 residents in 2018 and 25.9 per 100,000 in 2017. The Bronx is a particularly high-need community, with the highest poverty rate (28%) and the highest rate of fatal opioid overdoses (31.9 per 100,000 residents) in NYC. In 2017, 60% of opioid overdose fatalities in the Bronx were among the Latino population, reflecting the borough's highly diverse population and demonstrating the critical need for opioid treatment services that meet the area's language needs. In the Bronx, almost 60% of individuals over the age of five speak a language other than English at home, most frequently Spanish. Central Harlem (21.8 per 100,000) and Washington Heights-Inwood (20.2 per 100,000) also have rates of opioid-related deaths higher than the city average (16.4 per 100,000). East Harlem had the highest rate of opioid overdose death of any NYC neighborhood, increasing from 32.1 per 100,000 in 2017 to 50.4 per 100,000 in 2018. CBC understands its role as a centralized and coordinated provider-led entity in the identification, referral, and outreach/engagement of individuals with OUD. CBC's network includes hundreds of clinics and treatment programs, care coordination, recovery, and social service providers, including 144 SUD treatment programs and 14 OASAS programs, in-

cluding OTPs and CD-OP, available in a wide range of languages.

It is, therefore, a natural partnership for CBC and CBHS to work together on this initiative in a joint manner. Over the next year, CBC and CBHS will develop different but complimentary approaches for improving our network's practices to increase same day access, initiation of Medication Assisted Treatment (MAT), and continuity of care from acute to community settings.

CBHS has developed a program model, CBHS MAT-Paths, that includes multiple treatment paths in order to address the complex needs of the population served and will be packaged for replicability, fidelity, and contracting with managed care plans. CBHS will work with providers to implement this new program across the network and ensure progress is being made to turn the tide on OUD. Each program strategy includes the following key components:

**Implement and Extend Peer Support:** CBHS will utilize peer specialists to engage with and support recipients from in-patient hospitalization and detox to community connection and successful reintegration and participation in treatment. Peers are a primary intervention which improves patient adherence with MAT.

**Expand Referral Resources and Infrastructure:** CBHS has already established infrastructure to support referrals among our network partners and increase referral efficiency and timeliness for our members, clients, and partners. CBHS will facilitate same day access to services and use CBHS as a hub to connect individuals to immediately available treatment services and ensure prompt initiation of MAT.

**Build an innovative MAT-specific bundled payment model for CBHS OUD Providers:** CBHS has entered preliminary discussions with managed care partners to develop a bundled payment arrangement for an episode of treatment for OUD. A bundled payment methodology would impact program sustainability and reward those in our network who can succeed in generating outcomes, including reductions in hospitalizations and mortality rates related to opioid use and improved overall health, wellbeing and quality of life.

*see MAT on page 36*

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# Samaritan Daytop Village and Manatus Development Group Break Ground on “The Richard Pruss Wellness Center” in The Bronx

By Staff Writer  
Behavioral Health News

**S**amaritan Daytop Village and Manatus Development Group broke ground on The Richard Pruss Wellness Center – a “one-stop shop” for behavioral and primary health care in the Mott Haven section of the Bronx on November 13, 2019.

Named in honor of the late Richard Pruss, President Emeritus and former Board Chair of Samaritan Village (later renamed Samaritan Daytop Village), the Center will give Bronx residents convenient access to high-quality fully integrated care. The new Center will transform a vacant lot into a beautiful, modern facility that will provide outpatient treatment for substance use disorder, mental health services, care coordination and a primary health clinic.

With care coordination across different programs, the facility will serve more than 6,000 individuals annually, adding a critical resource center to this low-income, federally designated medically underserved community.

On hand for the groundbreaking were Mitchell Netburn, Samaritan Daytop Village’s President and CEO; Justin Stern, Managing Member, Manatus Development Group LLC; Kathy Riddle, founder



**Mitchell Netburn**

and President and CEO Emeritus of Outreach, who was married to Mr. Pruss for 25 years; New York State Senator Luis Sepúlveda; Commissioner Arlene González-Sánchez, NYS Office of Addiction Services and Supports (OASAS); and dozens of friends and supporters.

Mr. Netburn said, “The Richard Pruss Wellness Center will be a transformative

project. Not only will it change thousands of lives for the better, it will keep jobs in this neighborhood and become an oasis providing critically needed behavioral and primary health care to a community that has long been underserved. By creating this new state-of-the-art facility, consolidating programs and expanding our services, Samaritan Daytop Village will increase the number of individuals we serve each year by up to 30 percent. The Center is a fitting tribute to the legacy of Richard Pruss, a visionary and fierce advocate for people in recovery, who dedicated his career and life’s work to the behavioral health field.”

Pruss, who spent his career at Samaritan, is renowned for his pioneering work helping thousands of individuals confront their addiction and find the road to recovery.

Speaking on behalf of the Pruss family, Ms. Riddle said, “The Richard Pruss Wellness Center is a wonderful tribute to a man who cared for so many individuals in need of treatment and services and helped change the direction of their lives. Richard believed in the unlimited potential of the human spirit and recovery.”

Four Samaritan Daytop Village programs already in the neighborhood will relocate to the new building, keeping more than 180 jobs in the community. The programs, Willis Avenue Opioid

Treatment Program (477-479 Willis Avenue), Independence Outpatient Treatment Program (2776-78 3rd Avenue), New Beginnings Community Counseling Center (2780 3rd Avenue) and Hope Management Program (368 East 148th Street) currently operate in leased, storefront spaces.

Senator Sepulveda said, “It’s an historic day for the south Bronx as we mark the opening of the new Richard Pruss Wellness Center, which promises to be a vibrant hub for health and wellness in the Bronx. Our communities have been systematically & historically medically underserved, contributing to the chronic health challenges that we face and hold us back. I commend Samaritan Daytop Village for their dedication to our community, and it is holistic and community-driven health centers like this one that are the just, equitable, and dignified resources that enable our community to thrive.”

“Comprehensive services, supports and resources in a single location will provide an opportunity for people to access the individualized care they need to rebuild their lives from addiction,” OASAS Commissioner González-Sánchez said. “This groundbreaking is the first step in meeting and supporting the needs of these individuals and their families as well as the

*see Center on page 30*

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## Consumer Perspectives



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## Peers and Recovery: Models for Success

By Angel, Anthony, Barry, Danny, Darrell, Dennis, Desmond, Gary, Jose, Kevin, Michael, Paul, Richard, Robbie, and Stan

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

You have no doubt heard about the opioid epidemic. It has been prevalent in the news, talked about by politicians and their constituents, as well as by the general public. There are also lawsuits filed by various levels of government against opioid distributors and manufacturers. For many, opioids have become synonymous with pain relief.

According to the National Institutes of Health, more than 130 people in the United States die after overdosing on opioids every day. Roughly 21 to 29 percent of patients who are prescribed opioids for chronic pain misuse them. Between 8 and 12 percent develop an opioid use disorder. And an estimated 4 to 6 percent who misuse prescription opioids transition to heroin. In 2017, the U.S. Department of Health and Human Services declared a nationwide public health emergency on opioid use. And while more people are aware, more needs to be done to curb opioid use.

S:US currently supports over 400 individuals with the highest risk for substance use disorders, including opioid abuse. Services include out-patient clinics, residential treatment services and individualized care coordination that focuses on improving the health and wellness of people living with complex healthcare needs.

### Using Methadone and Narcan

Our group came together to initially discuss our experiences with using opioids.

We discovered most of us have used opioids to treat our substance use dependency. One person said he was on methadone for seven years because he needed to detox from heroin. "(Methadone) made me sick. At the local hospital, they gave me Suboxone. This made me feel better. I wasn't sick or did any crime. But then I started experimenting with the dose and then I started to sell my pills for crack money." Suboxone is a partial opioid agonist and is considered somewhat safer and not as strong as methadone.

We also talked about Narcan (Naloxone) that is commonly used to treat a drug overdose. Most of us have been trained on how to use Narcan but only a few of us have actually used it. One of us shared that he used his Narcan training to revive his brother when he overdosed. "I sprayed him (with Narcan). After one minute I tried to revive him. He came to, but then immediately got very angry with me. Because he didn't want to be revived. He also has mental health issues." Another mentioned a similar experience. "I overdosed and

they used Narcan to revive me. I remember becoming aggressive. No one told me that Narcan has those side effects. I think more training is needed more frequently." All of us who have experience using our training agree that even though Narcan has side effects like being sick and aggressive towards others, Narcan saves lives. As one person grimly put it, "I'd rather be sick than dead."

When asked about other types of intervention, we discovered that a few of us use cell phone apps to keep track of our sobriety. One of those apps is called Clean Time, a clean day counter for anyone recovering from alcohol, drugs, smoking, gambling or any other bad habit. It helps to keep track of years, months and days you are sober. One person also makes use of it for his daily meditation, to schedule appointments, and for gratitude prayers. As he put it, "The app motivates me and reminds me of where I'm at."

Very early on in our conversations, the topic switched to other interventions that

*see Success on page 37*

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# Transformations at MHA Westchester: Integrated Services to Address the Opioid Epidemic

**By Rosemarie Spencer, MS, LMSW,  
Senior Director SUD Services; and  
Alison Carroll, LCSW-R, Senior  
VP of Business Development  
MHA of Westchester**

**C**urrent national trends indicate that each year more people die of overdoses—the majority of which involve opioid drugs—than died in the entirety of the Vietnam War, the Korean War, or any armed conflict since the end of World War II. Each day 90 Americans die prematurely from an overdose that involves an opioid. (Rudd et al., 2016b) We are surely facing an epidemic of colossal proportions, yet this is not the first time that the behavioral health field has witnessed an epidemic of opioid deaths. Rather, the question facing us is, what can we do differently this time around? What we do know is that providing fractured services only addressing one piece of an individual's condition has not worked.

Given the profound systemic changes in our health care delivery system, and a keener appreciation of the social determinants of health and a person-centered model of care, behavioral health providers must transition to an integrated treatment model tailored and dedicated to address the complicated life needs of those with co-occurring mental health and substance use disorders, in addition to physical health

needs. Without an integrated, seamless treatment model in place, providers are not on the path of delivering “whole health care” to the individuals they serve. At the Mental Health Association of Westchester (MHA), we are enhancing the provision of integrated services across our diverse array of agency programs. Our focus on whole health encompasses care for behavioral health and physical health conditions that impact the lives of our clients. This focus is reflective of MHA’s philosophy that person-centered treatment is one of self-determination, choice and recovery.

Many factors were behind the push to integrate behavioral health, and the larger physical health systems, including legislative changes that impacted the market. At the federal level, there are three examples of legislation that were passed to support integration: first, the Medicare Improvements for Patients and Providers Act of 2008 eliminated co-pays for outpatient substance use services; second, the Mental Health Parity and Addiction Equity Act of 2008 required that health plan benefits for substance use and mental health services were covered the same as physical health benefits; third, the Patient Protection and Affordable Care Act (ACA) of 2010 increased access to integrated behavioral health services by expanding insurance coverage through Medicaid expansion. These services are part of the ACA’s required Essential Health Benefits

in small employer and individual insurance markets. Specialty care providers, like mental health clinics, were forced to adopt evidence-based therapeutic practices and convert to robust information systems to accommodate the demands for clinical, billing and outcome data from regulators, managed care payers, grantors, etc. This has resulted in a change from volume-based to value-based models. These models require providers to adopt initiatives that result in the improvement of measurable clinical outcomes that demonstrate team-based care provision and coordination. But perhaps the largest factor for the integration of health care, be it mental health, substance use and/or physical health, is that it is the best practice. People are not compartmentalized, and treatment should not be so either. MHA believes that by adopting this approach to treatment of the person as a whole, we will have a better chance of successfully addressing the opioid epidemic this time around.

MHA has approached the transition to integrated care in a staged fashion. During 2018 our agency acquired DSRRIP funds through the Montefiore Hudson Valley Collaborative to provide integrated treatment to those with co-occurring disorders in our Westchester mental health clinics. It allowed us to initiate substance use disorder treatment into our clinics in Yonkers, White Plains and Mt. Kisco. Our mental health clinicians use evidence-based practices, including Cognitive Behavioral Therapy (CBT), Trauma-Focused and Integrative Harm Reduction Psychotherapies, Dialectical Behavior Therapy (DBT) and Motivational Interviewing, and we embed the use of Peer Support Services. We provide a welcoming, caring and safe environment for our clients.

During 2019 we were awarded a SAMHSA Certified Community Behavioral Health Clinic (CCBHC) grant to further enhance and refine our integrated services complement. Given the alarming national statistics that only 1 in 10 individuals receives life-sustaining addiction treatment in the midst of a never-waning opioid tragedy, the CCBHC grant could not have come at a better time. Under the CCBHC grant, enhanced integrated services in our clinics provide expanded accessibility to those with substance use disorders, veterans and their family members, and individuals who are uninsured and underinsured. We provide medication-assisted therapies (MAT) for those with addiction disorders. Our staffing complement has been improved with the addition of Certified Alcoholism and Substance Abuse Counselors (CASACs), mobile clinicians, care managers, family, employment and peer support staff (Certified Recovery Peer Advocates and Certified Peer Specialists). This funding enables us to infuse integrated substance use treatment services not only into our clinics in Westchester County but also into our expanding Rockland clinics. We have applied this philosophy to our other programs such as care management, residential and peer services. In order to continue and further affirm our agency’s commitment to integrated services, we are on the pathway to

establishing an OASAS Article 32 certified substance use disorder clinic in Westchester County.

Lastly, in 2019 MHA was awarded the Statewide Health Care Transformation Grant through the Department of Health. In line with the health care delivery transformation goals New York State has established, we will partner with a health care provider to create a comprehensive health center that provides integrated whole person care including primary health care, mental health care, substance use disorder treatment, dental and specialty care in one setting. Systems of care that are fragmented create obstacles to optimal whole person health. By providing coordinated care that addresses the physical, behavioral and social determinants of health, the individuals we treat benefit in a number of ways: there is better access to care; better engagement in care; better coordination between disciplines of care; an improvement in clinical outcomes; a decrease in stigma as the treatment setting is integrated and normalized; and overall improved client satisfaction.

MHA is infusing integrated care services into other non-traditional care delivery settings. At the Westchester Single Homeless Assessment Center (SHAC) our staff includes CASACs who provide thorough mental health and substance use assessments to single individuals housed through the Department of Social Services (DSS). Referrals are provided to community-based services that address the provision of necessary life supports to facilitate an individual’s return to a healthy and productive life. The Assertive Community Treatment (ACT) team provides treatment, care management, intensive outreach and mobile supports in an individual’s own environment. A multidisciplinary team of behavioral health professionals, including CASACs, addresses mental health, substance use, employment, wellness, family support and nursing needs. Treatment in place is ideally suited for the socially isolated or individuals who are physically or psychologically unable to venture out of their living situations. The Intensive and Sustained Engagement and Treatment (INSET) Program provides mobile supports in the form of integrated interventions as an alternative to traditional care programs and supports. Services are targeted to individuals who are diagnosed with a behavioral health condition, and have histories of multiple hospitalizations, substance use issues and/or criminal justice backgrounds.

It has become clear that in order to combat the opioid epidemic and produce better outcomes for all individuals receiving behavioral health care, we must adopt an integrated system of care. One that not only addresses the condition that is initially presented to us but takes into account all the needs of the person, and does so in a collaborative, strengths-based and person-centered approach.

*For more information about MHA Westchester and its services, please call (914) 345-5900 or visit our website at [www.mhawestchester.org](http://www.mhawestchester.org).*



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# Innovative Management Solutions New York Partners with Arcadia.io to Improve Health Care with Behavioral Health Data

By Staff Writer  
Behavioral Health News

**P**opulation health management leader Arcadia ([www.arcadia.io](http://www.arcadia.io)) announced today a partnership with Innovative Management Solutions (IMSNY) [www.imsnylearning.com](http://www.imsnylearning.com), a joint venture between Coordinated Behavioral Care (CBC) [www.cbcare.org](http://www.cbcare.org), and Coordinated Behavioral Health Services IPA (CBHS) [www.cbhsinc.org](http://www.cbhsinc.org). Through this partnership, IMSNY will be able to better understand and improve the quality of care for New Yorkers with serious mental illness, substance use disorders and/or chronic health conditions, children with serious emotional disturbances, and those impacted by social factors such as poverty, inadequate housing and food shortages.

IMSNY selected Arcadia based on their extensive work across the healthcare continuum over the last decade as well as their leading analytics technology. Arcadia will implement an analytics platform that will allow IMSNY and the 80+ community-based health and human service agencies within its network, comprehensive visibility into the needs of their patient population and support measurement and management of care utilization and quality. Additionally, IMSNY will receive

risk management tools that allow providers at the point of care to identify, prevent, and close care gaps efficiently. Arcadia's platform will enable providers to identify social and economic factors impacting patient health and proactively launch interventions to overcome those obstacles.

"Behavioral health, substance use disorders, and social and economic challenges have a profound impact on physical health," said Arcadia CEO Sean Carroll. "We are proud to enable the important and urgent work of helping behavioral health providers unify their data and networks to better understand and care for individual patients and whole populations."

Arcadia will securely collect, aggregate, and standardize data from IMSNY's New York State network of providers. Through the connection with electronic health record (EHR) systems containing information on 150,000 Medicaid beneficiaries, Arcadia's market-leading population health management platform will offer IMSNY and its network of providers advanced capabilities for risk stratification, predictive analytics, and sharing insight on populations across New York City and the Lower Hudson Valley.

"We are seeing improved outcomes among our patients, but we struggle to adequately analyze, quantify and share

results from our larger populations without a unified data warehouse and analytic functions," said Jorge Petit, MD, president and CEO of CBC. "From the very beginning, Arcadia has been a true partner. We are very excited about identifying relevant and trusted data sources to accurately measure the quality of care for individuals receiving services throughout our IPA network."

"As we move to value-based contracting, timely access to complete and accurate data becomes increasingly important. Data helps us fill gaps in care and avoid duplications. Both of these lead to improved quality for the patients and enhanced value for the payors," said Richard Tuten, Esq., CEO of CBHS.

## About Arcadia

Arcadia.io ([www.arcadia.io](http://www.arcadia.io)) is a population health management company, specializing in data aggregation, analytics, and workflow software for value-based care. Our customers achieve financial success in their risk-sharing contracts through Arcadia's focus on creating the highest quality data asset, pushing expertly derived insights to the point of care, and supporting administrative staff with data when and where they need it with applications including care management

and referral management. Arcadia has off-the-shelf integration technology for more than 40 different physical and behavioral health EHR vendors, powered by machine learning that combs through variations in over 50 million longitudinal patient records across clinical, claims and operational data sources. Arcadia software and outsourced Accountable Care Organizations (ACO) services are trusted by some of the largest risk bearing health systems and health plans in the country to improve the bottom line. Founded in 2002, Arcadia has offices near Boston, Pittsburgh, Chicago, and Seattle. Arcadia was awarded 2019 Best in KLAS for Value Based Care Managed Services.

## About IMSNY

Innovative Management Solutions NY, LLC (IMSNY) is a newly Master Services Organization that will provide health management solutions for the behavioral health sector, with an initial focus on behavioral health Independent Practice Associations (IPA). IMSNY will provide management solutions that are value adds to the provider community starting with the roll-out of the Data Analytic Business Intelligence (DABI) Platform, in

*see Partners on page 37*



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Innovative Management Solutions NY, LLC ("IMSNY"), is a joint venture of Coordinated Behavioral Care (CBC) and Coordinated Behavioral Health Services (CBHS), both organizations are dedicated to improving the quality of care for New Yorkers with serious mental illness, minors with serious emotional disturbances, chronic health conditions, substance use disorders and those individuals that are in need of social determinant of health services.

[www.imsnylearning.com](http://www.imsnylearning.com)  
egrant@imsnylearning.com

## Today's Opioid Addiction and Overdose Epidemic: How We Can Make a Difference

By Jeffrey Selzer, MD  
Medical Director, Committee for Physician Health, Medical Society of the State of New York

The opioid addiction and overdose epidemic that has ravaged America for two decades now has left almost no one untouched. From 1999 to 2017, more than 400,000 people in the United States have died from overdoses related to opioids. According to a poll by the American Psychiatric Association, nearly a third of Americans say they know someone who is or has been addicted to opioids. It has been in the headlines, the subject of Congressional investigations and local town hall meetings, and top-of-mind for healthcare professionals and law enforcement personnel as they work tirelessly to contain it.

The epidemic began with ready availability to prescription opioids, but we've seen it shape-shift as efforts to reduce unnecessary exposure to prescription opioids took effect. Guidelines for the treatment of pain were issued, Prescription Drug Monitoring Programs (PDMPs) were enhanced and promoted, and take-back programs were increased. As a result, the overall national opioid prescribing rate declined from 2012 to 2017, and in 2017, the prescribing rate fell to the lowest it had been in more than 10 years.



**Jeffrey Selzer, MD**

Reducing the supply of prescription opioids, however, did not treat those who had already developed opioid use disorder (OUD). Unfortunately, the black market was ready to supply cheaper heroin and, eventually, synthetic opioids to meet the need for opioids by people afflicted with OUD. Overdose death rates continued to climb into 2017, driven by increases in deaths involving synthetic opioids. Despite the strong evidence of

the effectiveness of medication treatment for OUD, only a third of people who present for treatment of an OUD are offered such medication in our current treatment system.

One of the biggest and most perplexing challenges to addressing the epidemic is reducing the stigma associated with OUD so that more people will seek treatment and more healthcare professionals will be willing to provide it. The yawning treatment gap – in 2018, less than 20% of people with OUD received specialty treatment – is due in part to the historical separation of addiction treatment from mainstream medical care. Stigma and misunderstanding about the disease relegated its treatment to the shadows for decades. Physicians and other healthcare professionals in training did not learn how to help prevent, recognize, or treat OUD, because they would not be expected, or paid, to do so in practice. Raising awareness about the effectiveness of treatment can reduce stigma, embolden patients to seek treatment, motivate clinicians to provide it, and inspire families to demand effective treatment for their loved ones.

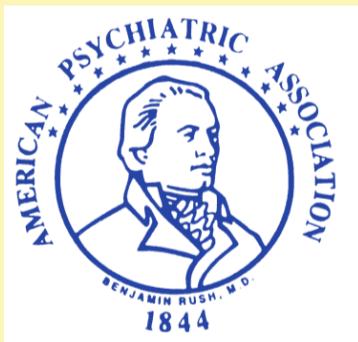
Reducing stigma is necessary but not sufficient to close the treatment gap. We also need to train more healthcare professionals to prevent, recognize, and treat addiction competently and compassionately. According to a recent survey, only 1 in 4 clinicians received training on addic-

tion during their medical education. Less than one-third of emergency medicine, family medicine, women's health or pediatric providers felt "very prepared" to screen, diagnose, provide brief intervention for, or discuss or provide treatment for OUD. Perhaps most troubling, less than half of emergency medicine, family medicine and internal medicine clinicians in that survey believed that OUD is treatable. These insights make it clear that we need to take bold action to equip all of America's healthcare professionals to respond this crisis.

Further, to close the treatment gap and build a sustainable workforce, we also must ensure that there is a sufficient number of highly skilled specialists to lead treatment teams, provide addiction consultation services, oversee treatment programs, train residents and fellows, and directly treat the most complex patients until they are stable enough to be transferred to a trained primary care clinician. There are currently far too few addiction specialist physicians to meet these needs, and too few opportunities for medical students to study and specialize in addiction treatment.

A trained and willing workforce can only be effective if evidence-based addiction treatment services are made available to patients through their health plans.

*see Difference on page 33*



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# The Need for Community-Based Early Intervention for Youth and Young Adults at Early Stages of Substance Use/Abuse

**By Fern Aaron Zagor, LCSW,  
Rosemarie Stazzone, RN,  
Melissa Singer, MS, and  
Basilio Allen, BS**

**T**here is a serious gap in the continuum of services between Prevention and Treatment services for high risk youth and young adults at early stages of substance use. When we speak to these youth what we often hear is, "Prevention, education? I know it all! I could even teach the course!" Or, "Treatment? I'm not addicted! I'm just doing what all my friends are doing. And, I can stop anytime I want to!" So what happens to these adolescents and young adults who are often lost to the system and fall through the gaps? How do we effectively engage them to change their trajectory and prevent addiction and dependence if the current continuum of services does not include Early Use Intervention?

In a 2012 review by Carney and Myers ("Effectiveness of early interventions for substance using adolescents: findings from a systematic review and meta-analysis," *Substance Abuse Treatment, Prevention and Policy* 2012, 7:25 <http://www.substanceabusepolicy.com/content/7/1/25>), only nine evidence based practices were identified. All but one provided limited interventions for the target population, usually one to three individual sessions. In NYS, Teen Intervene, one of the practices mentioned in the review, has been identified to engage youth at this critical time in their spiraling use of alcohol, prescription drugs, opioids, and/or heroin. This model, although effective for some, is limited in that it provides only 3-5 counseling services to high risk youth and then depends on referrals to other resources in the community. However, if there are no appropriate resources, or treatment is not the right intervention at that time, or the youth refuses the referral, there are no viable options. All the models identified by Carney and Myers require that the youth, who hopefully has developed a positive relationship with whom ever was providing the initial counseling, must now start all over again with another community based counselor. We know youth typically have difficulty establishing and maintaining trusting relationships with others. They often do not follow-through with these referrals. These youth are lost to care.

Experience has shown that an approach for effectively engaging this high-risk population is a community based, early intervention model that provides intensive case management supports with wrap around services, an opportunity to develop new and healthy relationships, and a focus on goals that are clearly identified and driven by the youth's vision for the future.

In the aftermath of Hurricane Sandy, The Staten Island Mental Health Society (SIMHS) received funding from the American Red Cross and the Staten Island Foundation to implement an evidence informed, community-based early intervention model, Transition to Independence Process, TIP, (Hewitt Clark, Univer-

sity of South Florida). The targets were high risk youth ages 16-24. Substance use was found to have increased in response to the stressors associated with the Superstorm. In the course of one year, 481 youngsters not connected to any prevention or treatment services were assessed, 86 were engaged in the TIP process and 31 were admitted to either a mental health or substance abuse clinic for treatment.

Hurricane Sandy related funding ended in 2016. Fortunately, in 2018, SIMHS, now a Division of Richmond University Medical Center (RUMC), received funding from NYC DOHMH. South Shore SafeTY.net was launched using the TIP model.

The TIP approach is flexible, positive and life affirming. Unlike most treatment models which focus on problems and weaknesses, TIP is a process that builds on the strengths and interests of each participant and provides trauma-informed person-centered care. South Shore SafeTY.net (SSSN) creates an environment that is free from stigma, developmentally appropriate, and accessible. Youth are engaged in healthy activities, form positive relationships with others, and develop a plan based on their personal goals and dreams. Average stay is 12-18 months.

TIP targets the domains of school, work, peers, and family. Working through the domains and with people in their environment, youth build confidence, find their voice, and develop personal autonomy. The ability for youth to take action and change their past trajectory makes this program unique.

Life Coaches, partnering with Peer Advocates, work with each youth on an intensive and individual basis to help develop and implement a feasible plan to reach personally identified goals. Harnessing available resources, including family members, peers, significant others (school teachers, coaches, etc.), and other community resources/services, the Life Coach builds "virtual" teams focused on helping the youth move towards accomplishing identified goals. Because these teams are "virtual" the stakeholders on each team change according to the needs and goals of the youth.

When ready, youth are engaged in work/study opportunities in fields of interest with a goal toward future employment. The time and effort of each youth is recognized as valuable. Each participant receives a stipend for their work.

One of the most important components of SSSN is the opportunity for healthy socialization. We have found that many of our youth lack good socialization skills, are often vulnerable, and are easy targets for gangs or peers engaged in destructive behaviors. SSSN provides youth with many healthy socialization opportunities for skill development and formation of healthy friendships. Activities have included attending Broadway shows (it's surprising how many have never left the Island, let alone attended a Broadway show), after-school, weekend, and holiday activities, parties, college visiting, and more.

Since the startup of SSSN in January 2018, 33 youth have been engaged, 23 have a history of trauma, 18 have co-

occurring mental health disorders, and more than 50% are employed in work/study and are either completing their high school degree or are enrolled in a college program. All but two are people of color. Providing services that are culturally and linguistically appropriate has been vital to goal attainment. Now established, program numbers are growing.

The evidence of the success of this early use intervention approach is reflected in the stories below (their names have been changed):

Daniel was out of work and school. He had an extensive history of substance use and suicidal ideation. He needed assistance exploring his sexuality and facilitating communication with his divorced parents. Through SSSN, Daniel was able to find his voice. He wants to work in a nursing home and has completed a Certified Nursing Assistant program. Communication with his family improved. He "came out" and began dating and learning how to build healthy relationships. He no longer has suicidal ideation, goes to therapy regularly, and is doing well.

Tony came to the program homeless. He is Autistic and has experienced trauma. He had issues with personal hygiene and healthy eating, and was being bullied. Once enrolled in SSSN, Tony

obtained his GED and was Salutatorian of his class. He began taking better care of himself. He began supportive employment doing janitorial work at the Staten Island Pride Center. He then graduated from the AHRC Cleaning Management Institute completing the Basic Custodial Certification Course. Tony now has a permanent position at the Staten Island Pride Center. He is currently living in a Transitional Independent Living Program.

William came to the program in distress. He had suffered both physical and psychological abuse from his step-father. He was out of work and school. At SSSN, William was helped to find purpose and begin to heal from his past trauma. He began supportive employment at the SSSN site doing janitorial work and graduated at the top of the class from AHRC's Cleaning Management Institute. He completed Basic Custodial Certification and obtained work at Fort Wadsworth in a fulltime union paid position.

April was often left to care for her older sibling's children and was responsible for the upkeep of the home. She was very isolated and lacked confidence. She had no job, was out of school, and smoked marijuana heavily. She is now

*see Intervention on page 30*

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# Mental Health Services and Opioid Use and Dependence: A Non-Sequitur?

By Lloyd I Sederer, MD  
Adjunct Professor, Columbia University  
Mailman School of Public Health

**W**hat does mental health have to do with mitigating the opioid epidemic? Isn't it a problem for substance disorder programs, or addiction doctors?

Well not really, if you consider the rates of opioid use and opioid use disorder (OUD) in patients seen in the community-based, non-profits in NYS providing mental health services. Among Medicaid insured adults about one in three (1/3) people seen in a public mental health clinic in the past year have been prescribed opioids or carry the diagnosis of OUD. That's from Medicaid data, not from screening and detecting opioid use and dependence in these clinical settings, where rates of identification have yet to align with prevalence.

Still, doesn't that mean we need to refer these patients to substance treatment centers and doctors? Also, not really, if we face a couple of facts: First, we already know that when we try to refer a patient with a serious mental illness (SMI) to another program, even to primary care, they just don't go. Like giving a business card to a homeless person on the street. Second, do we really imagine these other programs have any capacity to take on new patients, or if they do the wait time is months if it is to see a physician. In other



**Lloyd I Sederer, MD**

words, the patient before us in a mental health clinic is our patient, substance disorder and all.

The key clinical question then is: how are we going to keep this person alive for the next 6 months, twelve months? By decreasing the risk of drug overdose, and overdose deaths. Which continue to rise in this country.

The greatest life-savers, evidence shows us, is the prescription of Medication Assisted Treatment (MAT) and the

free and abundant dispensation of Naloxone (Narcan – the reversal drug).

We may not have been those physicians who, in the 1990s and early 2000s, inadvertently fostered the opioid epidemic wanting to reduce their patients' pain and buying into the false advertising that opioids were not addicting. But we are the physicians (and prescribing nurses) today who can help end the opioid epidemic and save lives.

The actions psychiatrists and prescribing nurses in mental health offices and settings can take that will save lives are: 1) the prescription of buprenorphine in mental health and primary care settings and 2) the dispensation of naloxone at those same settings (or in conjunction with local health departments).

## Buprenorphine

Buprenorphine can be a critical life-saving medication treatment because those taking it are far less likely to overdose and die, unlike those that are not prescribed this medication.

Despite being released as an FDA approved medication in 2002, the use of buprenorphine (Suboxone and others) today remains limited, especially considering the rising death toll from the opioid epidemic and the safety and effectiveness of this medication.

Buprenorphine is a partial agonist to the opioid receptor (it is simultaneously

a receptor antagonist). As an agonist, this medication binds fiercely to opioid brain receptors thus blocking the uptake of or displacing other opioids, making ingestion of heroin or opioid analgesics by someone with OUD not worth the effort or expense.

It is more difficult to get "high" or overdose on buprenorphine, unless it is mixed with other, non-opioid substances like benzos, alcohol and sedatives. Preparations of buprenorphine have diversified. First there was the sublingual pill, then the dissolvable film, and more recently a monthly subcutaneous injection or a set of four tiny sustained release implants under the skin that can last up to six months.

In past years, street diversion of buprenorphine was limited. More recently, however, this drug has gained greater street value as a type of "insurance" for opioid users in the event they cannot obtain their usual drug supply or want to withdraw or reduce their tolerance. We can this of this use (and diversion) as a form of "harm reduction".

There are concerns, sometimes voiced, about the potential burden and risk of prescribing buprenorphine in mental health offices. There is the required training and DEA waiver, both burdens. There is the prospect of even higher caseloads for doctors and nurses. There is worry about how people in opioid withdrawal

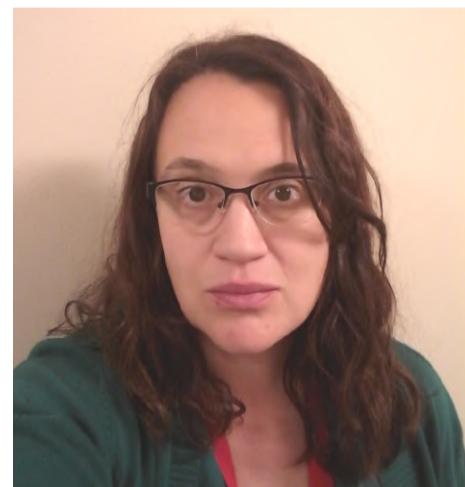
*see Services on page 32*

## Early Findings From a Tri-County Collaborative Approach to Addressing the Opioid Crisis

By Sandra McGinnis, PhD, Senior Research Scientist, and Thomas LaPorte, PhD, Research Scientist Center for Human Services Research, University at Albany

**W**hile the opioid crisis has captured the concern of public health officials and the public, the epidemic is not evenly distributed. Rural communities are especially hard-hit, particularly areas with a large working-class population where dim economic prospects have led to dramatic increases in so-called "deaths of despair" (Case and Deaton, 2017). These communities bear a high share of opioid-related mortality, and also suffer from limited supports to treat addiction and related problems such as mental illness and chronic pain.

In Western New York, a task force of members from the rural counties of Genesee, Wyoming, and Orleans embarked on an initiative to reduce opioid deaths by specifically targeting the potential intervention points around overdose. An opioid overdose presents an opportunity for intervention because the opioid abuse comes to the attention of health care providers, and the individual may be motivated by the emergency to consider seeking treatment. However, this opportunity



**Sandra McGinnis, PhD**

is often unrealized. While the overdose treatment drug Naloxone can reverse an overdose within minutes, Naloxone is not always available. When people in rural areas overdose, emergency responders tend to be further away than in urban or suburban environments; as such, overdose reversal may depend on bystanders who may not have Naloxone or be trained to use it. Second, survivors may decline emergency department (ED) treatment, and if Naloxone is administered by a bystander the survivor may never see a health care provider. Even when transport to a hospital occurs, the survivor may not seek



**Thomas LaPorte, PhD**

addiction treatment. In fact, because Naloxone triggers a painful and unpleasant withdrawal reaction, the first impulse may be to obtain more opioids. Many hospitals have no protocols in place to treat withdrawal or refer to treatment, and many overdose patients are released from the hospital as soon as they are medically cleared and immediately resume opioid use.

The approach taken by the Task Force is multi-pronged and cross-sector, and has sought to involve the public, emergency responders, community hospitals, law enforcement, public health officials, and addiction treatment professionals to increase

the number of people who overdose who 1) receive Naloxone, 2) present at the ED after overdose, and 3) are offered effective treatment, including peer support and opioid replacement therapy to prevent withdrawal, before leaving the hospital. A unique feature of the Task Force initiative is that it is cross-county, allowing the sharing of resources between counties and collaboration between agencies and providers across county lines. The Task Force is supported by a grant from the Greater Rochester Health Foundation.

The project's approach to increasing overdose survival begins with an ambitious plan of community education around Naloxone administration. Providers of Naloxone training throughout the tri-county area participate in a sub-committee on Naloxone and have developed a common curriculum which all have agreed to use. Community members are recruited for trainings, as are emergency medical providers and law enforcement agencies. Family members of people who use opioids, and especially who have survived overdose, are often offered one-on-one informal trainings at the scene of an overdose or at the hospital. Trainings include a distribution of Naloxone kits to participants.

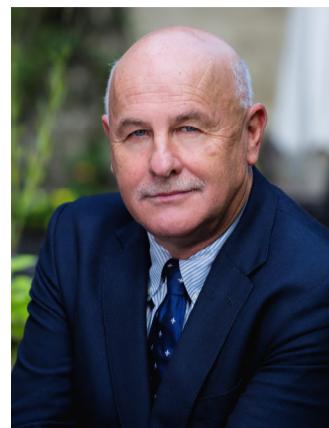
The Naloxone trainings are also used as a vehicle to increase the percentage of

*see Findings on page 38*

## Leaders To Be Honored at Our June 30th Reception in New York City



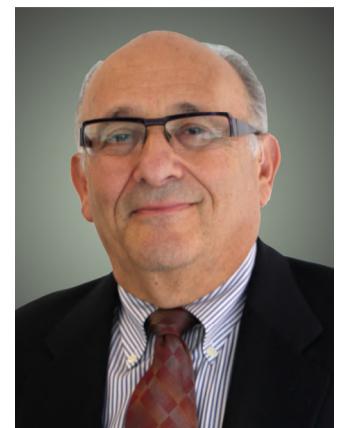
**Marco Damiani**  
Chief Executive Officer  
AHRC New York City  
*Excellence in Autism Award*



**Kenneth Dudek**  
Senior Advisor  
Fountain House  
*Lifetime Achievement Award*



**Allison Sesso**  
Executive Director  
RIP Medical Debt  
*Behavioral Health Advocacy Award*



**Ian Shaffer, MD, MMM, CPE**  
VP and Executive Medical Director  
Healthfirst - Behavioral Health  
*Corporate Leadership Award*

By Staff Writer  
Behavioral Health News

**M**ental Health News Education, Inc. (MHNE), the nonprofit organization that publishes *Autism Spectrum News* and *Behavioral Health News*, will be honoring four outstanding champions of the autism and behavioral health communities at its annual Leadership Awards Reception on June 30, 2020, at the NYU Kimmel Center in NYC from 5:00 pm to 8:00 pm. See pages XX and XX for full registration information.

Debbie Pantin, MSW, MSHCM, President and CEO of Outreach, and MHNE Board Chair, made the announcement stating, "MHNE has selected four prominent leaders from well-known New York organizations who represent some of the very best in the fields of autism and behavioral health. We are honored to pay tribute to them in recognition of their many years of dedicated service to the autism and behavioral health communities."

Ira Minot, Founder and Executive Director of MHNE stated, "We are so pleased to have this opportunity to recognize these champions of the communities MHNE serves. I am also pleased to announce that Anita Appel, LCSW, Senior Health Care Consultant, at Sachs Policy Group, and Matt Loper, CEO, of Wellth, who are both MHNE Board Members, will serve as Event Co-Chairs for our 2020 Leadership Awards Reception."

David Minot, Associate Director of MHNE stated, "Our 2020 Leadership Awards Reception is attended by over 200 recognized leaders from the autism and behavioral health communities who gather to share comradery and network with each other before the summer. This year's event will be an evening to remember, as we pay tribute to our distinguished honorees, their friends, family and colleagues."

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

Marco Damiani  
CEO  
AHRC New York City

Marco joined AHRC New York City with a varied and progressive career in the field of intellectual and developmental disabilities (I/DD), behavioral health and

general healthcare as a clinician, consultant and agency executive. Founded in 1949, AHRC NYC is one of the largest organizations in the nation supporting 20,000 people with I/DD and their families. AHRC NYC has over 5,500 dedicated staff, an annual budget well over \$300 million and provides a broad range of programs, services and supports across the lifecycle. Marco's career began at FEGS as a direct support professional and clinician, shortly after the implementation of the landmark Willowbrook Consent Decree and progressed through the years with positions in New York State government to Executive Vice-President at YAI Network where he led a broad and expansive portfolio of health and behavioral healthcare, research/program evaluation and a large community-based support, information and referral program, to Executive Vice President at Cerebral Palsy Associations of NYS, to his most previous position as CEO of Metro Community Health Centers, a network of 5 Federally-Qualified Health Centers in NYC devoted to supporting patients of all abilities.

In addition to his executive leadership positions, Marco was previously Chair of the Manhattan Developmental Disabilities Council and Chairman of the Alliance for Integrated Care of New York, the first Medicare Accountable Care Organization in the nation focused on individuals with I/DD. Marco is a Mayoral Appointee of the NYC Community Services Board I/DD subcommittee, a Board member of the Inter-Agency Council of I/DD Agencies, New York Disability Advocates and Care Design NY, an I/DD Health Home, and is also an Appointee to the New York University College of Dentistry Dean's Strategic Advisory Council. In recognition of Marco's contribution to the work of its school and to the field of oral health, and for his leadership and advocacy in promoting healthcare innovation models for people with disabilities, the NYU College of Dentistry awarded Marco with the College's highest honor, the Kriger Medal.

Marco earned a BS in Psychology from Manhattan College, a Master's Degree in Developmental Psychology from Columbia University and pursued doctoral studies in Educational Psychology at New York University. He attributes his success to the extraordinary collective work and shared vision of his many colleagues over the years, their enduring commitment to pro-

moting social justice for people with disabilities and his never-ending quest to being more than just a so-so guitar player.

Kenneth Dudek  
Senior Advisor  
Fountain House

A recognized leader in the mental health field, Kenneth J. Dudek has directed Fountain House and the development of clubhouses since 1992. He has pioneered programs that address the housing, employment, educational, and health needs of people living with the most serious forms of mental illness. Kenn retired as President of Fountain House in September 2019 but continues as a Senior Advisor.

During his 27 years of service, Kenn created and implemented a strategic vision that positioned Fountain House as a leader in the global search for cost-effective, humane and successful solutions to the ongoing humanitarian crisis of serious mental illness. Through public-private partnerships, Kenn developed cutting-edge programs that respond to the evolving needs of people with serious mental illness and to changing social trends.

During Kenn's presidency, Fountain House became the first mental health organization to receive the largest and most prestigious recognition of humanitarian efforts, the Hilton Humanitarian Prize. The organization is lauded by academics, researchers, practitioners, psychiatrists, government officials, and others in the mental health field in the US and internationally.

Kenn has never lost touch with his roots as a social worker and established relationships, comradery, and trust with Fountain House members – people living with serious mental illness. Kenn is modest and unassuming but full of passion for the underserved and marginalized. His confidence in the capacity of members has empowered many individuals with serious mental illness to represent the organization and advocate for issues impacting their lives in the broader community.

Kenn's work deserves special recognition because it focuses on the most seriously mentally ill. This differentiates what he does from the majority of mental health programs. Kenn focuses on those who need help the most. Many have no family, no friends, no social network, no housing, and no treatment until they join Fountain House.

Kenn is highly regarded as a dedicated, tireless, leader by the Fountain House Board, staff and members, and within the larger sphere of programs based on the Fountain House model locally here in New York, and globally.

Prior to joining Fountain House, Kenn was Director of Community Support at the Massachusetts Department of Mental Health where he created 25 model clubhouses and many other community-based mental health programs.

Allison Sesso  
Executive Director  
RIP Medical Debt

Allison Sesso has served as the Executive Director of the Human Services Council of New York (HSC) since March 2014 and previously served for many years as the Deputy Executive Director. HSC is an association of 170 nonprofits delivering 90% of human services in New York City.

Under her leadership HSC has pioneered the development of nationally recognized tools designed to illuminate risks associated with government contracts, including an RFP rater and government agency grading system known as GovGrader.

During her tenure at HSC she has led negotiations with government on behalf of the sector and partnered on the development of policy and procedural changes aimed at streamlining the relationship between nonprofits and government. In 2017, Allison led the Citywide "Sustain our Sanctuary Campaign," which successfully pushed for investments in human services contracts totaling over \$300 million to address the non-profit fiscal crisis.

When the largest human services nonprofit in NYC abruptly filed for bankruptcy, she turned tragedy into opportunity by organizing a coalition of experts to evaluate the systemic operational challenges facing human services nonprofits; resulting in a nationally recognized report, New York Nonprofits in the Aftermath of FEGS: A Call to Action, with nine recommendations viewed widely as a roadmap to long-term sustainability of human services nonprofits.

Allison also organized and led a commission of experts focused on social determinants of health and value-based-payment structures that recently completed a highly anticipated report, Integrating Health and

*see Leaders on page 30*



## Annual Leadership Awards Reception

Register online at [www.mhnews.org](http://www.mhnews.org) or complete the form below and mail this page to:

**Mental Health News Education, Inc., 460 Cascade Drive, Effort, PA 18330**

For more information contact Ira Minot, Executive Director at (570) 629-5960 or [iraminot@mhnews.org](mailto:iraminot@mhnews.org)

### Reservations (Registration Deadline: June 9, 2020)

Individual Ticket: \$150       Reserved Table of 10: \$1,500       \$20 Each - Total # Tickets: \_\_\_\_\_

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**Premier: \$1,000**

2 Tickets, Half page journal ad, Premier sponsor listing on website, in journal, at the event, and all promotional materials

**Friend: \$750**

1 Ticket, Quarter page journal ad, Friend sponsor listing on website, in journal, at the event, and all promotional materials

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**Quarter Page: \$ 300 (2.5" x 4") b&w**

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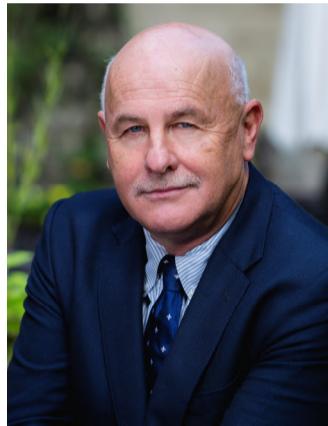
# Annual Leadership Awards Reception

*Celebrating Leaders Making a Difference in People's Lives*

*Please Join Us in Honoring*



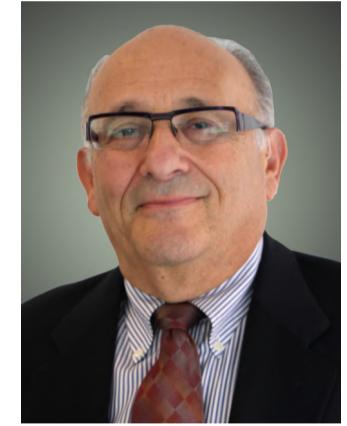
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**Ian Shaffer, MD, MMM, CPE**  
VP and Executive Medical Director  
Healthfirst - Behavioral Health  
*Corporate Leadership Award*

**Tuesday, June 30, 2020**

**5:00 PM - 8:00 PM**

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

**NYU Kimmel Center - Rosenthal Pavilion, 10th Floor  
60 Washington Square South, New York City**

**Online Registration: [www.mhnews.org](http://www.mhnews.org)**

**Journal Ad Deadline: June 1, 2020 Registration Deadline - June 9, 2020**

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](mailto:iraminot@mhnews.org)**

## Taking Care of Our Recovery Professionals

By Christal Montague, MSW, LMHC,  
CASAC, CARC, Chief Strategy Officer,  
Outreach Development Corporation

**D**rug addiction is a disease that needs to be treated and talked about like any other disease. The devastating opioid epidemic that has left no community untouched has only heightened the conversation, as treatment professionals and advocates engage policymakers, researchers and communities-in-need, toward developing targeted solutions to this unprecedented public health crisis. However, solutions aren't clear for employers when their own staff have a substance use disorder history or a personal connection to the crisis, and, increasingly are seeing or hearing about the deaths of clients and former clients, friends and family members, resulting in vicarious trauma. What do we do when our employees struggle with an active substance use issue, whether it be new, or a relapse?

It has been an enduring tradition that providers in the addiction treatment field recruit and employ professionally trained individuals who themselves are in recovery. In recent years, this tradition has also been emphasized through the growing profession of Peer Advocates and Peer Recovery Coaches, whose lived experiences are also viewed as essential assets in engaging, empathizing, and



**Christal Montague, MSW**

working with individuals and families struggling with SUD. Understanding that addiction is a chronic and relapsing disease, what is the best work culture to address an active addiction issue or a relapse? How do agencies manage the unintended consequence of trauma among treatment clinicians? What are the best policies for employers?

Given the dynamic complexities involved, it is no surprise that the behav-

ioral health workforce has been confronting overlapping challenges that include burnout and vicarious trauma, perpetual staff vacancies due to the shortage of qualified and credentialed personnel – a crisis, that leads to further quandaries.

As our employees' responsibilities and required skill sets evolve to meet additional regulatory mandates (integrated care model, person centered care, outcome oriented system of care, ongoing regulations, to name a few), employers face many change challenges. These changes are also compounded with mandated reporting and investigation practices that have emerged in recent years. While intended to protect those whom we are charged with serving, these have promoted a climate in which an allegation has the potential to extraordinarily jeopardize the careers, licenses, and livelihoods of our workforce, while placing equally extraordinary pressures on employers to maintain a work environment that is safe for both clients and staff.

Given the busy competing demands within the field, administrators at times may not have the opportunity to cultivate, coach, and develop employees that may be challenged and hence, miss a valuable opportunity to prevent turnover, at a minimum.

How do we expand and enhance our critically needed workforce? How do we recruit, train, and retain a workforce qualified to effect long-term improvements in the lives of individuals with sub-

stance use disorder? How do we promote wellness and recovery in our staff? To begin, let's consider our own inclinations, human resource approaches, and personnel practices, so that we can contemplate how we may be self-contributing to a weakening workforce, and seek innovative initiatives to turn this around.

As employers, in order to create a safe environment for our workforce to be able to do their best and ensure optimal treatment for clients, it is incumbent upon us to demonstrate that we care about our employees' wellbeing and health. Some may say that we do this by providing health care coverage that staff can participate in, as well as offering time for them to be able to address health needs. These are important and essential, but we can include some additional aspects if we are going to develop and sustain a workforce to address the continuing opioid epidemic, the most pressing public health problem in a generation.

There are several ways in which we can begin to rethink our policies, drug education and counseling programs to keep our employees and workplace safe and productive amid this opioid epidemic:

1. Encourage an environment where employees can disclose opioid (or other substance use) related issues, or risk thereof, without fear of reprisals. We need to be

*see Care on page 33*



### ***Human Development Services of Westchester***

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*Thank You &  
God Bless!*

# A Root Cause of the Opiate Drug Abuse Epidemic

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

**A**n epidemic of opiate abuse and addiction continues to ravage communities throughout the United States. Approximately 183,000 Americans succumbed to opiate overdoses between 1999 and 2015, and countless more have suffered the ancillary effects of addiction that include the loss of employment, shattered relationships, chronic and debilitating health conditions, and encounters with law enforcement officials and the criminal justice system, to cite but a few (U.S. Senate Homeland Security & Governmental Affairs Committee Report, 2018). By some accounts, this scourge is partially responsible for recent decreases in average life expectancy – the first of such decreases recorded in decades (Carroll, 2019). The opiate abuse epidemic is surely not the first of its type nor is it likely to be the last, however. But it is particularly insidious insofar as its origins may be traced to our medical and pharmaceutical industries. Tragically, the industries charged to heal and to promote population health have been repeatedly found culpable in the proliferation of drugs whose use should be limited to select health conditions accompanied by severe and intractable pain.

In his testimony before the U.S. Senate, Dr. Andrew Kolodny, a preeminent authority in addiction medicine, described an unmistakable correlation between a rise in “legitimate” prescriptions for opiate medications and the incidence of addiction and overdose events (Kolodny, 2018). This trend began in the 1990s and rose unabated until quite recently. Dr. Kolodny attributes this to multiple agents including drug company sales representatives, professional societies, hospital and healthcare accreditation organizations such as the Joint Commission (formerly The Joint Commission on Accreditation of Healthcare Organizations), and medical boards, among others. By his account, all were complicit in the reversal of a long-standing tradition that had discouraged the administration of opiate medications in all but the rarest of circumstances.

In 2001, The Joint Commission issued revised standards for the assessment and management of pain that, by many accounts, revolutionized the healthcare establishment’s orientation toward pain and the use of opiate medications for its relief. It would be unfair, however, to attribute the ensuing epidemic of opiate drug abuse and addiction solely to The Joint Commission standards. Several years before they were released, aggressive marketing campaigns by pharmaceutical industry representatives produced an unprecedented increase in opiate drug prescriptions. For instance, Purdue Pharma’s promotion of OxyContin, an opiate-based analgesic, generated a near exponential rise in sales of the drug during the five-year period that preceded the release of The Joint Commission standards (Van Zee, 2009). Purdue’s “success” was not merely a product of astute marketing tac-



**Ashley Brody, MPA, CPRP**

tics, however. It followed a campaign that dissembled and deceived the public and the many healthcare practitioners on which it depends for accurate and reliable information. This campaign repeatedly minimized the risk of iatrogenic addiction, a tactic that led many providers to prescribe the drug more liberally than they would if they possessed a more sober appraisal of its risks. Purdue regularly employed other measures of dubious legality but undisputed efficacy that yielded bloated balance sheets and satisfied shareholders. In these respects, Purdue was not unlike other pharmaceutical companies whose misdeeds have been thoroughly publicized in recent years. A Senate investigation of Insys Therapeutics revealed systematic manipulation of insurers and pharmacy benefit managers that enabled it to circumvent prior authorization procedures designed to limit prescriptions of Subsys, a fentanyl-based product patented by Insys for the treatment of breakthrough cancer pain (U.S. Senate Homeland Security & Governmental Affairs Committee Report, 2018). Insys representatives repeatedly defrauded insurers and pharmacy benefit managers by impersonating healthcare providers or falsely claiming they were operating on providers’ behalf. The McKesson Corporation, Cardinal Health, Janssen Pharmaceuticals (a subsidiary of Johnson & Johnson), and other manufacturers have recently endured heightened scrutiny (and countless legal and civil claims) for their roles in perpetuating this epidemic.

The events of the past 30 years portray a cautionary tale of an unholy alliance between our pharmaceutical industry and medical establishment. This alliance elevates pecuniary interests above clinical considerations and continues to pervade healthcare practices. It has played a particularly sinister role in the opiate abuse epidemic, but its influence is surely not limited to this crisis. It is both embedded in and a byproduct of a capitalist system that necessitates the continual generation of profits for investors, shareholders, and other financial stakeholders. Such a system, when applied to public goods such as healthcare, is bound to produce egre-

gious conflicts of interest and other failures at the expense of our population health. More than 50 years ago, Nobel Laureate Kenneth Arrow offered a detailed explanation of the inapplicability of free markets to healthcare, and the opiate abuse epidemic is merely one manifestation of its misapplication (McKee & Stuckler, 2012). By Arrow’s account, in order for free markets to succeed in this domain they must transform healthcare into a commodity to be regularly sold to prospective buyers irrespective of buyers’ actual needs or resources (Arrow, 1963). For instance, older individuals and those with chronic or comorbid health conditions often have the greatest need for healthcare but few resources with which to purchase it. Thus, as markets cannot profit from the provision of healthcare to our most vulnerable citizens, they must rely on other populations to provide returns on investment. Such *prima facie* evidence of the free market’s failure to meet our population health needs warrants a radical reevaluation of our healthcare financing and delivery systems.

Recent developments suggest the opiate drug abuse epidemic will eventually abate, like the many others that preceded it. The Department of Health (DOH) recently announced opiate overdose

deaths declined 15.9 percent in 2018 compared to 2017 (outside of New York City), the first decrease in 10 years (New York State Department of Health, 2019). This may be attributed to several factors including the increased availability of Medication Assisted Treatment (MAT) for individuals with substance use disorder and the development of additional resources that more readily meet the needs of those in crisis (e.g., open access centers, mobile and telehealth services, etc.). This is welcome news, and it suggests the foregoing measures and others recommended by the New York State Heroin and Opioid Task Force are beginning to produce their desired effects. Nevertheless, this achievement was 10 years in the making and required nothing less than the collective will of the government, healthcare providers, individuals, families, and many other stakeholders. It would be naïve, however, to expect these efforts to continue to persevere in the face of countervailing pressures exerted by actors with seemingly unlimited resources and an economic system that facilitates their exploits.

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## Promoting growth, independence and recovery

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

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### Respite Services

### Career Support Services

### Private Care Management

### Mobile and Transitional Outreach

### 24-Hour Support Staff

- A sample analysis of historical claims data revealed an estimated savings of \$181,828.00 associated with the provision of supportive housing services during a 24-month survey period. These savings were achieved through reduced use of inpatient hospital and emergency department services among clients sampled for analysis.
- Recipients of SFC’s Vocational Rehabilitation services earned a total of \$998,134.30 in wages in 2017. They performed a total of 88,585 hours of work and paid \$228,572.80 in taxes.
- Search for Change’s 2017 employee engagement survey resulted in an overall rating of 4.01 out of 5.

## The Case for Community Recovery Centers

**By Roy Kearse, LCSW, CASAC  
Vice President of Recovery Services  
and Community Partnerships,  
Samaritan Daytop Village**

**A**ccording to the National Institute of Drug Abuse, “Every day, more than 130 people in the United States die after overdosing on opioids.” In 2018 alone, opioids claimed the lives of more than 3,000 New Yorkers, according to the New York State Department of Health.

The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis affecting public health as well as the social and economic welfare of our country. The Center for Disease Control and Prevention estimate that the total “economic burden of prescription opioid misuse alone in the United States is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.”

It should be clear by now to most Americans that we are in a war to preserve the future of our nation against addiction. So, as in any war, a good tactician seeks to employ any weapon in their arsenal that can help guarantee success. Many of the weapons to date used to combat the opioid crisis include prevention, drug free treatment, medically assisted treatment and harm reduction.



**Roy Kearse, LCSW, CASAC**

However, health care professionals are finding that treatment alone—an integral part of the ongoing battle—is not solving the problem. Relapse rates are so high with people who struggle with S.U.D.s (substance use disorders), that the challenge is not only getting people off drugs but keeping them off drugs. As is the case with so many other chronic health conditions, diligence is required to avoid flare-ups and maintain recovery.

Historically the healthcare system has been driven by a notion of “medical necessity” in order for patients to qualify for

treatment and continuing care. Too often, this translates into limited access to post-treatment or aftercare services for S.U.D. patients who no longer have the initially qualifying addiction. But sustained retreat from addiction is an ongoing process. Tools and resources are needed for people to lead sober and productive lives. This is where recovery centers can fill the gap, by offering a nonjudgmental post-treatment support system for sustaining and maintaining recovery.

In many ways, recovery centers are comparable to senior centers. Each model provides for a selection of prosocial services tailored to the needs of a select group of people. A core piece of each model is to offer social networking with a group of peers—people that participants can identify with—and a range of activities that promote healthy living such as positive recreational and educational activities.

At the start of the current opioid crisis, there were very few recovery centers in New York State. Now, thanks to the support of federal and state funding, by the end of 2019 there will be 35 with more expected to open.

Samaritan Daytop Village (SDV), operates two recovery centers in New York City, called Peer Alliance Recovery Centers (PARC). They provide non-clinical support, peer coaching, relapse prevention, recreation, social networking, computer training, vocational assistance and other

community supports designed to help sustain and maintain recovery long term.

SDV’s first PARC, in Jamaica, Queens, has been open for almost three years. Its success led to the opening of a second one this summer in the Mott Haven section of the Bronx, a neighborhood with one of the highest numbers of heroin and fentanyl overdoses.

The results of PARC have been incredible. In addition to serving more than 1,300 clients (1,200 at PARC Queens since 2018 and 145 at PARC Bronx since its opening this summer), over 500 peer recovery coaches have been trained at our facilities, creating a small army of troops who are out there fighting the epidemic. Additionally, over 100 people have been trained by the centers in the use of Narcan, the opioid overdose reversal antidote.

My colleague, Christopher Kelly, a former SDV client now in recovery and working as a Recovery Coach at PARC Bronx, has spoken of the impact that PARC has had on his life. He said, “Every morning, I wake up with exuberance and zeal because at PARC Bronx I help guide and support participants on their recovery journeys. PARC Bronx is an absolutely amazing place and a blessing for all who can use it. As peers, we meet people where they are in their lives. Here, members can come to grow in spirit, career

*see Centers on page 36*

## Opioid Epidemic and Partnerships: Working Together to Solve Problems

**By Jason Lippman  
Founder & Principal  
Jason Lippman Solutions, LLC**

**I**t feels like not a day goes by where the sheer scale of the opioid epidemic is not felt. The epidemic impacts nearly every American through our families, friends, loved ones, co-workers and classmates. According to the Centers for Disease Control (CDC), in 2017:

- On average, 130 Americans died each day from an opioid overdose.
- About 68% (47,600) of the more than 70,200 drug overdose deaths involved opioids.
- The number of overdose deaths involving opioids was 6 times greater than in 1999.

That same year, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 1.7 million people living in the United States suffered from substance use disorders related to prescription opioid pain killers, and 652,000 suffered from a heroin use disorder (these statistics are not mutually exclusive). The CDC also estimates that the prescription opioid misuse alone in the United States costs \$78.5 billion a year (this figure includes the costs of healthcare, lost productivity, addiction treatment



**Jason Lippman**

and criminal justice involvement).

The causes of the opioid epidemic are complex because so many socioeconomic forces came together to fuel the crisis. Marketing by drug companies incentivized using prescription opioids to medicate pain, health insurance companies refused to cover alternative treatments for managing chronic pain, and cut-rate heroin from Mexico and deadly Fentanyl were made easily available on the street for people already addicted and cutoff from prescription pain relievers.

At the same time, individuals living in

vulnerable communities were squeezed out of affordable housing options and let go from stable employment opportunities. On an individual level, biological factors, community and family relations, the exposure to trauma and abuse, can all influence the prevalence of substance use and addiction.

### Working Together

Addiction is a disease that alters brain chemistry and therefore must be treated as a chronic illness. A crisis of this magnitude requires a collective response that treats the whole person in their environment. It needs to be triaged under the rubric of a public health approach that is understanding of the role of recovery in people’s lives.

“Treating the whole person is critical to successful recovery,” says Barbara Johnston, Director of Policy & Advocacy at the Mental Health Association of New Jersey (MHANJ), who spoke about their involvement in a state and national advocacy partnership with the National Council on Alcoholism and Drug Dependence (NCADD), “across the state, MHANJ and NCADD are working together on grassroots advocacy initiatives to raise awareness on co-occurring conditions.”

Facing this problem from all angles, community leaders are working side by side and with wide network of partners, including advocacy groups, primary care, behavioral health and human service pro-

viders, etc., to solve social determinants of health (SDOH) like housing, justice-involved, education, workforce, transportation and food insecurity, and influence public policy.

In 2016, New York State formed the Heroin and Opioid Task Force, comprising of healthcare providers, policy advocates, educators, parents and New Yorkers in recovery. Members of the task force hosted public hearings across the state to better inform their recommendations. Just recently, Governor Andrew Cuomo highlighted the task force’s actions as he announced that for the first time in a decade, the number of opioid deaths declined in New York State.

According to Governor Cuomo’s recent press release ([https://www.governor.ny.gov/news/governor-cuomo-announces-first-reduction-opioid-overdose-deaths-new-york-state-2009?utm\\_source=December+13%2C+2019+Newsletter&utm\\_campaign=December+13%2C+2019&utm\\_medium=email](https://www.governor.ny.gov/news/governor-cuomo-announces-first-reduction-opioid-overdose-deaths-new-york-state-2009?utm_source=December+13%2C+2019+Newsletter&utm_campaign=December+13%2C+2019&utm_medium=email)), since 2016, the state opened nearly 500 new treatment beds, added more than 1,800 opioid treatment program (OTP) slots and made further strides with integrating Medication Assisted Treatment (MAT) services into primary care programs (resulting in nearly 47% increase in patients receiving buprenorphine prescriptions). In addition, New York also expanded the use of recovery centers, youth

*see Partnerships on page 36*

# Pharmacogenomic Testing in Pain Management and Behavioral Health: A Pharmacist Perspective

By Ronnie Moore, PharmD,  
Ludovick Youmbi, PharmD, and  
Angelo O'Neill, MSW  
Allure Specialty Pharmacy

Pain, in its many forms (e.g., nociceptive, neuropathic, inflammatory, etc.), affects upwards of 100 million people in the United States resulting in costs reaching \$600 billion per year.<sup>1</sup> Treatment of pain symptoms through the inappropriate prescribing and use of opioids has fueled an opioid abuse crisis in the United States that continues to be a major public health issue. Over 2 million people across the nation may be suffering from opioid abuse/addiction resulting in annual medical costs of more than \$29 billion.<sup>2</sup> The opioid epidemic requires urgent action. Successfully addressing the crisis will require multiple approaches. One such promising intervention is the use of pharmacogenomics (PGx) to guide the pharmacotherapy of pain.

## Overview of Pharmacogenomics

PGx testing is a diagnostic tool that can be useful in predicting a patient's



**Angelo O'Neill, Dr. Ronnie Moore and Dr. Vick Youmbi**

response to a particular drug. PGx analyzes specific genes that impact drug response via pharmacodynamic and/or pharmacokinetic pathways. Pharmacodynamic pathways are the mechanisms by which the drug acts on the body to produce physiological responses. Pharmacokinetic

pathways are the mechanisms by which the body acts on the drug – absorption, distribution, metabolism, and excretion.

In PGx testing, a patient's genotype (i.e., genetic/hereditary information) is analyzed for variations in genes which affect drug response. Variations in a par-

ticular genes are referred to as alleles. PGx testing identifies a patient's genotype information in regards to specific alleles, and results in a PGx report describes the patient's phenotype (i.e., the observable expression of their genes). For example, CYP2D6 is one of the enzymes that metabolizes many drugs used in pain management such as codeine, tramadol, hydrocodone, and oxymorphone. The gene that codes for CYP2D6 can vary between individuals. The various genotypes of the gene, CYP2D6,a are comprised of combinations of two alleles where each allele may have increased enzyme function, normal enzyme function, or reduced enzyme function. The genotypes, in turn, produce phenotypes described as ultrarapid metabolizers (UM), extensive metabolizers (EM), intermediate metabolizers (IM), or poor metabolizers (PM). The patient's phenotype can then be used to guide pharmacotherapy decisions (Table 1 - Examples of CYP2D6 Genotypes with Corresponding Codeine Metabolizing Phenotypes and Potential Pharmacotherapy Implications (adapted from 3). # The asterisk followed by a number or number/letter combination

see Perspective on page 35

## Constance Brown-Bellamy Appointed to New Position at Inperium

By Staff Writer  
Behavioral Health News

We are pleased to announce that Constance Brown-Bellamy has been hired as the Senior Vice President of External Relations for Inperium Inc. This newly created position will expand Inperium's offerings of affiliated services to include community and government relations expertise. Constance will be based out of New York City and is charged with cultivating relationships with Agencies and other stakeholders to grow and support Inperium of New York Inc.'s Business Development and Affiliation work.

Constance is a seasoned external relations expert with over 15 years of diverse experience and has a proven track record in forging strategic partnerships yielding reciprocal benefits. She possesses a well-

rounded set of experiences in the non-profit, government, university, international and health care industries. Constance commented "I am excited to join an organization that values its partners, and is committed to providing the necessary supports to ensure continuity of care, for some of the most vulnerable among us." Ms. Brown-Bellamy's first day was December 1st.

Inperium, Inc. is a private, nonprofit Pennsylvania corporation exempt from federal income taxes pursuant to IRC 501 (c)(3). Headquartered in Reading, PA, Inperium supports more than a dozen non-profit and for-profit organizations that deliver a broad array of supports and services to people in need. Additional information concerning Inperium may be found on our website: www.inperium.org.

Ms. Brown-Bellamy is a former Board Chair and is a current member of the Mental Health News Education Board of Directors.



**Constance Brown-Bellamy**

Tables 1 & 2 From Above Article			
Genotypes	Phenotype	Potential Pharmacotherapy Implications	
<b>Table # 1</b>			
CYP2D6 *1/*1; *1/*2; *2/*2; *1/*4; *2/*5; *1/*10	Ultrarapid Metabolizer (UM) (~1%-2% of population)	Avoid codeine use due to potential for toxicity	
CYP2D6 *1/*1; *1/*2; *2/*2; *1/*4; *2/*5; *1/*10	Extensive Metabolizer (EM) (~77%-92% of population)	Use age and weight dosage guidelines for codeine	
CYP2D6 *4/*10; 5/41	Intermediate Metabolizer (IM) (~2%-11% of population)	May initiate with age and weight dosage guidelines for codeine; If no response, alternative analgesics may be needed	
CYP2D6 *4/*4; *4/*5; *5/*5; *5/*6	Poor Metabolizer (PM) (~5%-10% of population)	Avoid codeine use due to lack of efficacy	
<b>Table #2</b>			
Comprehensive Gene List	Admira Health	PGx Company B	PGx Company C
Genetic Variants	53 Genes and growing	12 Genes	24 Genes
Drug List	200+	80+	100+
Disease Coverage	Psychiatry, Pain Management, Neurology, Cardiology, Oncology	Psychiatry, folic acid metabolism	Psychiatry

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# Integration of Naloxone Distribution in a Federally Qualified Health Center

**By Maya Nussenzweig, MPH,  
Marva Greer, MPA, Ariel Lindsay  
Jacobs, MPH, Andrea Cole, PhD,  
LCSW, and Thomas McCarry, LMHC,  
Institute for Family Health**

**A**s the opioid epidemic has become a growing public health crisis in New York and the greater United States, it is incumbent upon health care centers to expand our ability to treat those in need. As of one of the largest Federally Qualified Health Centers (FQHC) in New York State, providing integrated primary and behavioral healthcare to more than 100,000 patients each year, regardless of insurance status, the Institute for Family Health has responded to the epidemic in a number of ways. In addition to providing medication assisted treatment with buprenorphine, The Institute is a New York State Opioid Overdose Prevention Program (OOPP), supporting the provision of overdose responder trainings and dispensing naloxone kits to patients and their loved ones, as well as members of our greater communities. This article aims to describe successes and challenges of The Institute for Family Health's efforts to integrate naloxone distribution into care and encourage other organizations to develop similar programs.

In New York state, many health, substance abuse, governmental, and educa-

tional programs, as well as pharmacies, are eligible to become an OOPP. Programs are provided with free naloxone and supplies to distribute within their communities. Through Substance Abuse and Mental Health Services Administration grant funding, The Institute has been able to provide training and technical assistance with organizations interested in becoming their own Opioid Overdose Prevention Programs (OOPP).

Our Program Director noted during an interview, "What stands out most to me about our ability to dispense naloxone is our sheer reach. We have the opportunity to make a great impact. Not only do we see a lot of patients, many of our clinics are serving communities with the highest rates of overdose deaths in NYC and New York State." The overarching goal of the naloxone distribution program is to reduce the rates of fatal overdose by opioids among patients and in our communities.

The Institute has been distributing naloxone as an OOPP for three years throughout our community Health Centers and within their surrounding communities in New York City and the Mid-Hudson valley. Our Program Director highlights, "Over the past 3 years, interest in training and obtaining kits has increased a lot among staff and patients. We have heard many stories of personal experiences, staff and patients being impacted by overdose through loss of family, friends or a patient, and through the news."

When developing our OOPP, the Institute team faced some challenges which we have also been able to overcome. Challenges range from programmatic workflows to identifying and addressing attitudes and perceptions of how overdose prevention fits into care. The first step to establishing a workflow is an organizational wide policy. This policy displays our commitment to overdose prevention and details steps to distributing naloxone. While policy is organizational wide, at the program level, workflows can have some nuances. Over time, we have learned that having a champion at each site has been helpful. Programmatic staff collaborate with champions to ensure adequate supplies, organizing staff trainings, and addressing any challenges that are identified.

Workflows can be a concrete challenge but, understanding attitudes and beliefs around overdose prevention can be a more subtle barrier to successful integration. Our Program Director elucidates, "When we approach distribution as something only for those most at risk of overdose, the tendency is to not give many kits away. Our goal is to move towards offering kits as part of the standard of care. Integrating distribution of kits into patient care allows us the opportunity to provide education and address misconceptions about why someone would want to have a kit, and broaden the understanding of who may be at risk of overdose." Participating in department and clinic staff meetings

has been a helpful forum to provide training to staff as well as supporting open dialogue around questions and concerns related to overdose prevention. In total, 347 Institute for Family Health staff have become trained overdose responders.

Since July 2018, nine individuals have reported successfully responding to an overdose with an Institute dispensed kit, five in New York City and four in the Mid-Hudson Valley. As eight of the overdose responders have been Institute staff either within a health center or the community, there is potential that many more of the kits distributed have been used. While the importance of communicating back when a kit has been used is emphasized during training, although it is likely that does not always happen. These overdose reversals have taken place both at our clinics within the community. Each report of an overdose reversal should be celebrated--it is a profound act to intervene and also provides learning opportunities on how we can improve and increase naloxone distribution. In an effort to ensure access to naloxone kits to those most in need, Institute staff have conducted overdose responder trainings for medical students who provide services at the Institute's free clinics. These clinics capture a particularly important group, as many of the patients are not eligible for insurance and would not be able to receive naloxone for

*see Integration on page 33*

## Pain from page 1

approach to pain management needs to change to effectively manage pain without creating risk of addiction and its consequences. Our conversation about opioids and pain management focused on eight questions.

**Question 1:** Based on your research, are opioids a reasonable medical response to physical pain?

**Dr. Colloca:** The use of opioids for the treatment of pain can put patients at high risk for opioid misuse, abuse, and addiction. They should very rarely be used for chronic pain. And even though they can be useful for acute pain, there are effective and less risky alternatives for some patients. Opioids are often a reasonable treatment of pain associated with terminal illnesses, although some patients prefer not to use them so as to remain as alert as possible as long as possible.

Unfortunately, medical professionals have been trained to use opioids far too frequently. There need to be major changes in the way pain management is approached.

**Question 2:** What changes do you think are necessary?

**Dr. Colloca:** First, the current, virtually universal approach to evaluating pain is fundamentally misleading. Medical practitioners ask patients to rate their pain from 1-10. The result is a highly subjective evaluation of pain that does not capture the complexity of the pain experience



**Michael B. Friedman, MSW**

including interfering with daily activities and creating emotional burdens (Pattullo & Colloca, 2019). For example, one person on the verge of tears because of their pain may rate it a 6 while another will rate it 10. Not very informative.

There are tools for rapid evaluation of pain that are far more useful. (Gordon D. 2015).

Medical and dental practitioners are trained for the most part to use opioids for the immediate and short-term treatment of acute pain. Instead, health care providers should be trained to do a rapid individualized assessment of functional pain and then to select individualized pharmacological and non-pharmacological interventions



**Luana Colloca, MD, PhD, MS**

tions that may or may not involve the use of opioids even for acute pain.

Fortunately, there is a clear trend not to use opioids for the treatment of chronic pain (Dowell et al., 2019; Wood, Simel, & Klimas, 2019). Hundreds of thousands of people are now being tapered off the opioids they may have used for years and are managing pain in other ways.

**Question 3:** Could you say something about the rapid evaluation tools?

**Dr. Colloca:** I do want to emphasize that these evaluations can be done very rapidly, even in the emergency room for peo-

ple who are in very severe pain. The fundamental questions are:

- How bad is the pain? Or in the case of post-surgical pain, how bad will it be? Not a number, but how does or will the patient experience it. Totally intolerable, really hard to take, bad but I can think and communicate.
- How does it affect functioning? There's a functional pain scale that can be rapidly administered to a conscious patient.
- How much does pain interfere with one's life? There's also a tool to capture this.

Of course, it's also important to ask about the patient's experience with managing pain in the past.

The key is to use this basic information to *tailor an individualized plan*. Pain management, that is, needs to become one form of "precision medicine," which increasingly is the hope for vast improvements in treatment for many medical conditions.

**Question 4:** You have said that there are pharmacological and non-pharmacological interventions that can effectively manage pain without the use of opioids. What are the preferable pharmacological interventions?

**Dr. Colloca:** The pharmacological interventions include both prescription and over-the-counter drugs. For example, non-steroidal anti-inflammatory drugs (NSAIDS) can be very effective as can

*see Pain on page 38*

# Opioids and Homelessness in America

By Deborah Werner, MA, PMP  
Senior Program Manager  
Advocates for Human Potential, Inc.

We will present five strategies behavioral health providers can use to help combat the opioid crisis among our national homeless population. Two catastrophic public health issues have become American epidemics: opioids and homelessness. The two are clearly interrelated—opioid use/misuse contributes to homelessness and homelessness exacerbates opioid use/misuse. Both take a tremendous personal toll on individuals, families, and communities. Consider Charlisa and Joe (not their real names):

Charlisa's chronic pain stems from a history of intimate partner violence, and chronic health conditions; now it is coupled with 20 years of addiction to opioids and homelessness. She lost everything, including parental rights. Nights are the worst. She stays in shelters, with boyfriends or acquaintances if they will have her or in shelters or. She's always afraid. The pain rarely stops and never for long.

Joe has been in and out of institutions most of his life. He has been using heroin for 15 years, doing whatever he must to keep the shakes away. He lives in an encampment. Recently the city held a sweep



**Deborah Werner, MA, PMP**

because of a hepatitis outbreak. He lost his sleeping bag and all his belongings, even his few pictures.

Most people experiencing chronic homelessness have multiple vulnerabilities that can lead to and an opioid addiction. Vulnerabilities include significant trauma, serious mental illness, poly-substance use, chronic pain, health conditions, grief, and loss. Substance use disorders and homelessness both result in intensive stigma and discrimination, health problems, criminal justice involvement,

and reduced life expectancy. In fact, in a Boston study, adults aged 25–44 experiencing homelessness were nine times more likely to die from a drug overdose than their housed counterparts (Baggett et al., JAMA Intern Med, 2013).

The United States Interagency Council on Homelessness identified five strategies for addressing the intersection of the opioid crisis and homelessness (2017). Recommendations for behavioral health (BH) providers to help those who are homeless follow each strategy.

1. Assess the prevalence of OUDs and opioid misuse among individuals experiencing homelessness. BH Providers: Assess homelessness and housing instability among your patients/clients. Talk with individuals experiencing homelessness about the types of services they need. Consider advocating for data on homelessness from opioid safety coalition dashboards or mortality review board tools.

2. Develop and implement overdose prevention and response strategies. BH Providers: Provide training, support, and resources to first responders, homeless programs, and outreach workers on a range of overdose prevention and response strategies. Make other harm reduction strategies such as fentanyl testing strips available. Naloxone distribution efforts have been established across the country and are effective at combatting overdose. One exam-

ple of targeted outreach to homeless populations occurs in San Francisco (SF). With approximately 30 percent of overdose deaths occurring in single room occupancy hotels, the SF Department of Public Health is educating residents and plans to make Naloxone rescue boxes readily available (NBC Bay Area, San Francisco to Launch Program to Combat Opioid Overdose Deaths at SRO Hotels, 2019).

3. Strengthen partnerships between housing and health care providers to provide tailored assistance. BH Providers: Collaborate with housing and health care providers to customize assistance to meet the stated and unstated needs of your individuals experiencing homelessness and OUD. One innovative program is the Washington State pilot Peer Pathfinders Program modeled after the Projects for Assistance in Transition from Homelessness (PATH) program and funded by the This program conducts outreach and engagement specifically targeting individuals with OUDs experiencing homelessness linking them with medication-assisted treatment (MAT) services, and navigating systems to help access community resources that facilitate recovery (<https://www.compasshealth.org/services/pathfinder-peer-project>).

4. Improve access to Medication Assisted Treatment (MAT). BH Providers: Access

*see Homeless on page 36*



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# Anti-Racist Organizational Transformation: Questions and Answers

## With Mary Pender Greene, LCSW-R, CGP and Alan Siskind, PhD

By Staff Writer  
Behavioral Health News

**M**ary Pender Greene, LCSW-R, CGP, is a psychotherapist, career/executive coach, trainer, and consultant with a private practice in Midtown Manhattan. She has 20+ years of experience helping individuals, couples, companies, and nonprofits. Mary is the President & CEO of MPG Consulting, a NYC-based consultant group with significant experience in providing capacity building services for organizations of various types and sizes.

Dr. Alan Siskind has enjoyed an extensive and distinguished career in social work, in private practice, and mental health as a clinical practitioner, administrator, consultant, teacher, and author. He is also a senior consultant, an executive coach, and an anti-racist organizational and board consultant for MPG Consulting. Alan's history includes 35+ years of service at The Jewish Board of Family and Children's Services in various leadership roles including Executive Vice President and CEO. Dr. Siskind is Founding Chair of the MHNE Board of Directors, publishers of this newspaper.

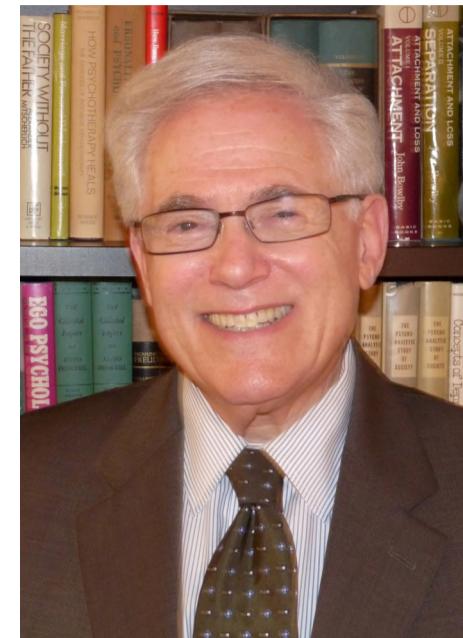
### Q: Why Is Anti-Racist Work Important for Organizations?

A: Institutions are informed by and can be transformed by having a deep understanding of racism and oppression. Racism shapes American institutions historically, culturally, and individually. Internalized racial oppression, power, and privilege can lead to implicit and explicit bias. This is why just diversifying your staff or board is not enough. Organizations and their boards need to engage in meaningful, brave, and authentic conversations across differences, including how to strengthen the organization and begin implementing best practices in the pursuit of an inclusive, fair, and respectful workplace that values all individuals and embraces diversity – with the goal of eliminating barriers to workplace success. This can be accomplished by:

- Creating a common language.
- Learning to recognize white organizational culture and its manifestations.
- Examining the value of relationship building in the workplace and everyday life.
- Describing how socialization produces worldviews that limit our ability to undo racism and other forms of oppression.
- Discussing socialization biases regarding issues of class, wealth, and poverty.
- Examining institutional reasons for poverty focusing on relationships of institutions to poor communities
- Discussing formulations and functions of race, prejudice, power, and racism within historical and present contexts.



Pender Greene, LCSW-R, CGP



Alan Siskind, PhD

- Examining power, privilege, rank, and culture (PPRC), and the impact of their intersections on supervision, management, leadership, and staff relations.
- Describing how individual, institutional, and cultural racism manifest today.
- Discussing how Internalized Racial Oppression develops and operates within individuals and organizations.
- Describing the development of "White" as a race in the U.S. in the context of establishing historical advantages.

### Q: What Are the Goals for Diversity, Equity, and Inclusion (DEI) Training?

A: Organizations often need consultation and training to establish and meet their DEI goals. Below are some possible goals:

- Discussions about race are integrated into management decisions, supervision, and working meetings.
- An anti-racist lens is used in interview and hiring practices, and guides leadership development and decision-making.
- Working with staff and team to use a race lens particularly in understanding and responding to work styles, communication, conflict, and secondary trauma.
- Increased capacity of staff to enter into productive discussions about race, oppression and all isms.
- Specific initiatives around anti-racist organizational change are led by staff from different levels of the institution, and the results of those initiatives are shared across the organization.
- Supporting effective leadership development, team building, and staff development, as well as examining policies and procedures focusing on self-awareness, authenticity, accountability, integrity, efficacy, and growth.

### Q: What Is an Anti-Racist Bystander vs. an Upstander?

A: A Bystander will witness racist behavior in silence and an Upstander will take action. Kitty Genovese was murdered in a New York City street in the presence of 38 witnesses. None of them offered any assistance to Genovese or contacted police. This indicates that personal responsibility in bystander situations cannot be taken for granted. Research shows that behavior in situations of racism is often the same. One study of women's responses to anti-Black racism, anti-Semitism, heterosexism, and sexism found that while 3/4 of participants considered saying something only 40% in fact did so. Another study found that in 44% of incidents of race-based bullying at school, some or all of the bystanders did nothing, with 1/4 encouraging the bullying.

### Q: How Can We Interrupt Bystander Complacency?

A: "Structural Racism. It Stops with Me": A Personal Campaign. The very message of "It Stops with Me" can be regarded as a direct response to bystander complacency. The idea is that we can and should do something when we witness racist incidents. Bystanders do, of course, evaluate the costs and benefits of an intervention. Many can quickly conclude that the potential price of speaking out against racism outweighs the benefits of doing so. However, when bystanders speak out against racism, it can have profound effects. Hearing or seeing an anti-racist upstander can foster more expressions and support of anti-racist behavior. It can also combat some of the conditions of structural racism. Silence may lead people who are against anti-racist work to believe that their attitudes are shared by those around them.

Anti-Racist Upstander action stops the offender from thinking that the community accepts their behavior. Below are possible actions:

- Reporting of racist behavior
- Calling the person "IN"
- Strategizing with your network
- Offering support and comfort to the injured party

As the debate about anti-racism continues, we should make sure we are asking the right questions. It is not, "Do you have a right not to participate?" The questions are rather:

- "What kind of person are you?"
- "What kind of co-worker do you want to be?"
- "What kind of TEAM do you want to LEAD?"
- "What kind of institution do you want to work for?"

### Q: What Keeps People Silent?

A: Part of this work is developing the ability to recognize individual and institutional racism. Often, staff need training and support to develop the skills to intervene. People will only stand up when they believe they are well equipped to act. Things that keep people silent:

- Lack of clarity about the best way to respond
- No confidence or courage to respond appropriately
- Fear of repercussions
- An organizational culture that has not clearly stated their intolerance for institutional racism, racist or oppressive behavior

It is important to understand the psychology of racism. We often assume that motivation behind stereotypes, prejudice of racism, and discrimination is hatred. But not all racism stems from hatred. Most structural racism that I witness through my consultation and coaching isn't because of hate. Rather, it's usually due to: The desire to win; Addiction to power; Competition; The fear of losing influence with the majority group; Greed; and a Desire to maintain political capital

### Q: What Is Political Capital and Why Is It Important?

A: Political Capital in the workplace is the accumulation of resources and power built through relationships, trust, and goodwill, which influence bosses and colleagues. It can be understood as a type of currency used to achieve personal or professional goals. It is often described as a type of credit, or a resource that can be banked, spent or misspent, invested, lost, and saved. Preserving their political capital is truly the core reason of why people do not stand up or speak out when they see an incident in the work environment.

see Q&A on page 33

# WHITE FRAGILITY & RACIAL RESILIENCY: Building Capacity Across the Racial Divide

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**DR. KENNETH V. HARDY, PH.D.**  
**Voicelessness: Dilemmas of Silence,  
Dilemmas of Speaking**

Dr. Hardy is a Professor of Family Therapy at Drexel University and Director of the Eikenberg Institute for Relationships. His clinical work centers on issues including the anatomy of racial rage, learned voicelessness, and the invisible wounds of racial oppression. His talk will explore the phenomenon of oppression-induced Voicelessness among People of Color, and examine the emotional, psychological, and spiritual effects it has on the everyday lives of the racially traumatized. Strategies for reclaiming one's voice will be discussed.



**DR. ROBIN DIANGELO, PH.D.**  
**Nothing to Add: Silence as a Function  
of White Fragility**

Dr. DiAngelo is an antiracist educator, consultant, trainer, and author of *White Fragility: Why It's So Hard For White People to Talk About Racism*. Her talk will address the racially insular social environment of white people in the U.S. and how that builds expectations for racial comfort while at the same time lowering stamina for enduring racial stress, i.e., "White Fragility." She will focus on one particular manifestation of White Fragility: silence in the face of racial injustice, and provide perspectives and skills white people need to build their racial stamina and use the voice their position provides.



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## The Richard Pruss Wellness Center

### *Center from page 12*

community at-large."

Designed by GF5 Architects, the six-story, multi-use state-of-the-art building will incorporate energy-efficient design, enhanced security features, advanced digital infrastructure and upgraded interior and exterior finishes.

Mr. Stern of Manatus Development Group LLC, said, "Manatus Development Group is honored and excited to be building The Richard Pruss Wellness Center for Samaritan Daytop Village. When opened, the facility will be an essential behavior health and primary care center for the Mott Haven community. Working with strong not-for-profits throughout NYC to enhance their missions via real estate development is Manatus' core business model. We could not be happier working with the Samaritan team throughout the process."

Construction is privately funded through market rate borrowing from TD Bank. The development cost of the 84,000 sq. ft. project is expected to be \$35 million.

"This incredible project transforms an underutilized lot into a neighborhood resource for vital health and medical services right in the heart of Mott Haven. The organizations occupying this devel-

opment will be better able to serve vulnerable members of our community, with so many invaluable services integrated into one energy-efficient building that also features state-of-the-art digital infrastructure. Thank you to Samaritan Daytop Village and Manatus Development Group for making this project a reality in our borough," said Bronx Borough President Ruben Diaz Jr.

Commissioner Ann Sullivan, M.D., NYS Office of Mental Health, said, "The Richard Pruss Wellness Center will be an extremely valuable addition to the community and offer Bronx residents access to behavioral health programs as well as primary health care services. The beautiful, state-of-the-art facility will provide Samaritan Daytop Village with the space they need to relocate four successful programs under one roof. I am happy to offer my congratulations and thanks to Samaritan Daytop Village and Manatus Development Group for the great work they do."

Occupancy is expected in the first quarter of 2021. For renderings, please look here.

The Richard Pruss Wellness Center is located on the 500 block of Courtlandt Avenue, at the corner of East 148th Street.

### *Lessons from page 6*

will not see an increase in teenage substance abuse disorders.

For more than 50 years Odyssey House has provided cost-effective, quality treatment services for people with a range of substance abuse disorders from heroin, cocaine, marijuana, and alcohol. Starting in 1967 and continuing right up to today, the reason we have been able to help thousands and thousands of people change their lives for the better is because of the professionalism and dedication of our workforce.

Without counselors, social workers,

administrators, teachers, medical personnel, and facility managers, we would not be able to meet the needs of our population. But this workforce is under stress from increased workloads and a demanding regulatory environment that insists we do more with less.

As treatment steps up to address the opioid crisis that continues to devastate our society, my responsibility and privilege as an industry leader are to retain our professional staff and ensure they have the tools they need to do their jobs and the compensation they deserve as they carry out this essential work.

### *Leaders from page 19*

Human Services: A Blueprint for Partnership and Action, examining the challenges of operationalizing relationships between health and human services providers and offering seven recommendations. She also served on the New York State Department of Health's Social Determinants (SDH) and Community Based Organizations (CBO) Subcommittee helping to formulate recommendations around the integration of CBOs into Medicaid managed care.

Allison has overseen disaster recovery and preparedness efforts on behalf of the nonprofit sector, including coordination with government and was tapped by the Mayor to serve on the Hurricane Sandy Charitable Organizations and Houses of Worship Recovery Task Force and served as its chair. She was also appointed to the OneNYC Commission; responsible for developing a comprehensive plan for a sustainable and resilient city that addresses the profound social, economic, and environmental challenges ahead.

Sesso's past professional experiences include working at a prominent investment bank, at the New York Public Interest Research Group, and as the coordinator of a program for victims of domestic violence and sexual abuse. She holds a Master of Public Administration degree from Baruch/CUNY's School of Public Affairs.

Allison is the Board Chair of the nonprofit Hollaback!, a global movement to end harassment powered by a network of grassroots activists. Additionally, Allison serves on Fund the People's Advisory Council, a national group that aims to encourage investments in the nonprofit workforce as the best way to increase performance and impact across the social sector.

Allison's work on behalf of the human services sector has led City & State to recognize her as number 8 on the Nonprofit Power 50 in 2018, and as one of the 25 most influential leaders in Manhattan in 2017 and New York City's 100 "Most Responsible" in 2016.

Ian Shaffer, MD, MMM, CPE  
VP and Executive Medical Director  
Healthfirst - Behavioral Health

Ian Shaffer, MD, MMM, CPE, is Vice President and Executive Medical Director, Behavioral Health for Healthfirst responsible for behavioral health program management. Prior to this he

### *Intervention from page 17*

working full-time at Stop and Shop and was just accepted into The College of Staten Island. April has declared her major as Early Childhood Education and hopes to run her own preschool one day.

Ira was homeless when he came to the program. He was out of school and work. His girlfriend was 5 months pregnant. Through SSSN, Ira completed NYS Department of State security training. He improved his relationship with his girlfriend and family resulting in moving into the home before the baby was born. He has been linked to the Fatherhood Initiative at United Activities Unlimited and is looking for full-time work. His daughter is healthy and doing well.

was Vice President Behavioral Health Program Design and Research for Health Net Federal Services responsible for behavioral health program design and research with a specific focus on the military and veteran populations and their families. Previously at Health Net, Inc., Shaffer was MHN's Chief Medical Officer, responsible for setting the company's clinical policies and guidelines and ensuring clinical excellence. Dr. Shaffer oversaw MHN's quality improvement and disease management units and was accountable for the coordination and quality assurance of clinical care.

In addition, Dr. Shaffer has overseen quality and outcomes monitoring for the Military & Family Life Consultant Program services and collaborated with his Health Net Federal Services colleagues to ensure optimal care and service delivery for TRICARE beneficiaries.

Prior to joining MHN in 2003, Dr. Shaffer served as executive vice president and chief medical officer of a national managed behavioral health organization, working closely with several Fortune 100 companies. He three times served as chairman of the Association for Behavioral Health and Wellness (ABHW) (formerly the American Managed Behavioral Healthcare Association - AMBHA), and he has also served on several federal government committees, including a three-year term on the National Advisory Committee for the Center for Mental Health Services arm of SAMHSA. He remains involved in national behavioral health policy issues, including parity and autism.

As the President of Behavioral Health Management Solutions, LLC Dr. Shaffer has provided consultation to a variety of startup and ongoing behavioral health programs that have been redesigning to meet the changing needs of health care delivery and reimbursement.

Dr. Shaffer, a Life Fellow of the American Psychiatric Association, is board-certified in psychiatry and addiction medicine, and has received fellowship training in child psychiatry. He received his medical degree from the University of Manitoba and psychiatry and child psychiatry training at the University of Southern California. Dr. Shaffer, a Certified Physician Executive also holds a Master's degree in Medical Management from Tulane University.

All these high-risk youth and young adults would likely have been lost to addiction without intensive, community based, individualized early intervention. This type of early intervention model can be replicated and clearly can make a difference for youth to help reverse the course of their substance use.

Fern Aaron Zagor, LCSW, is Principal, Fern Zagor Consulting LLC, Former CEO, Staten Island Mental Health Society. Rosemarie Stazzone, RN, is COO and CNO, Richmond University Medical Center. Melissa Singer, MS, is Program Manager, SafeTY.net Program, SIMHS/RUMC. Basilio Allen, BS, is Program Coordinator, South Shore SafeTY.net, SIMHS/RUMC.

# CEO Barbara Faron Celebrates 40th Anniversary with Federation of Organizations

By Staff Writer  
Behavioral Health News

**B**arbara Faron, CEO, recently celebrated her 40th anniversary at Federation! When Ms. Faron joined Federation in the late 1970s, it had one office and a handful of employees. The organization was founded in 1972 by an alliance of family advocacy groups and originally focused on supporting the needs of individuals with mental illness.

"The 1970s was a time of transition," Ms. Faron said. "The treatment for mental illness before that point had been to lock patients up and throw away the key. But with the advent of psychotropic drugs, which allowed their condition to become stabilized, many people were released from hospitals, and there were few resources available to them in the community."

Federation ran several programs to support this sector, and around the time that Ms. Faron joined, the organization began to broaden its mission to serve additional vulnerable groups, beginning with seniors. Ms. Faron began her career with Federation as a direct service worker in the Foster Grandparent program, a national program in which Federation became a sponsoring agency and continues to be to this day. In the program, low-income seniors volunteer in schools and daycare centers serving at-risk children.

"The volunteer's role is to work one on one with students who need help focusing on the material," Ms. Faron said. "The seniors receive a modest stipend and the



**Barbara Faron**

role brings additional meaning and purpose to their lives. The teachers are happy to see them, the kids love them and they meet fellow senior volunteers with whom they can create a social network."

Ms. Faron's next role was to launch the Senior Companion program. In this program, individuals with long-term psychiatric histories, many of whom lived in group homes, were recruited and trained to pay social visits to elderly people.

"It was an incredible success," Ms. Faron said, calling both the Foster Grandparent and Senior Companion programs

"strength-based" programs in that they look at people from the point of view of their strengths to provide the support they need to lead satisfying lives and be valued participants in the community.

"From then on, we have used the basic premise of the strength-based perspective to develop all of our programs," said Ms. Faron, who was promoted to CEO in 1986 and has been a catalyst for positive change, guiding Federation to grow and adapt to an ever-changing healthcare system.

"Now, healthcare is at another juncture in which we are rethinking how we provide care in that behavioral health is being integrated into primary care," Ms. Faron said. "Mental health has a very big impact on physical health – they are not separate – and there is a movement to integrate behavioral and physical health."

There is also a major focus in the healthcare system on value-based care, Ms. Faron said. "The right combination of treatment and support required for individuals is being looked at in terms of how to do it at the right price point, with the goal of saving money while improving outcomes," she said.

"It's always a challenge to figure out what will happen next in this ever-changing field," Ms. Faron said. "We are always thinking about what our next step will be in this new world, and how we will integrate our knowledge and experience in the latest iteration."

Reflecting on her 40 years with the organization and how far it has come, Ms. Faron said, "I am incredibly grateful. We have a great team, and for that I am most appreciative – our management team and

all of our staff and direct-care workers are out there every day making it happen."

Ms. Faron enjoys receiving feedback from people that federation has served. "We have a luncheon for senior volunteers, and I remember one woman in particular who came up to me and said, 'Thank you for letting me volunteer,'" Ms. Faron recalled. "She told me that since her husband had died, she had been sitting watching TV all day and feeling isolated, and somehow she heard about the Foster Grandparent program and it changed her whole life – that her life had meaning and purpose again."

Ms. Faron is a Licensed Master Social Worker and a Certified Psychiatric Rehabilitation Practitioner. She holds a Master's Degree in social work from the Stony Brook University School of Social Welfare and has extensive experience in criminal justice, community organizing, aging and mental health. Her memberships include the National Association of Social Workers and the National Alliance for the Mentally Ill. In 2000, she received the second annual "People in Recovery Choice Award" from the Mental Health Association of Suffolk County. Other achievements include: the 2004 Distinguished Alumni Award from the Stony Brook University School of Social Welfare and the 2008 Town of Brookhaven Outstanding Community Service Professionals award. More recently, Ms. Faron was recognized as a Top Female CEO by the Smart CEO Brava Awards, a Top CEO from Long Island Business News, and a Future 50 Award winner for Fastest Growing Company, all in 2016.

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***Services from page 18***

might behave, including their threatening clinicians for prescriptions. These are problems to be mitigated or solved, but not by eluding the needs of the patient we are serving.

*I will not discuss naltrexone (Vivitrol) here, another effective, FDA approved medication, preferring to focus on the two agents that can save the most lives in the next year.*

**Naloxone**

Naloxone is first and foremost a life-saver. EMTs, police and (increasingly) friends and families of people using opioids should have ready access to naloxone nasal spray in the event of an opioid overdose. The nasal spray avoids the “needle barrier”, fears many have about the use of syringes, even auto-injection syringes. Countless lives have already been saved by naloxone.

Naloxone acts immediately and effectively, reversing respiratory arrest and loss of consciousness. It is like the AED (automatic defibrillator) of the world of opioid addiction.

Most states permit pharmacies to dispense naloxone without a prescription. But it can be pricey for individuals and families without insurance or facing a high co-payment (I paid \$40 for a 2-vial package). Having naloxone available at no cost is essential if we are to save more lives in the foreseeable future. No one recovers from opioid addiction if they die from an overdose.

I do not mean to suggest that medications alone are the best approach to treating opioid use disorder. Like any complex and persistent condition, a combination of medication, therapy, motivational approaches, family engagement and mind-body interventions (like exercise, nutrition, yoga, meditation) are more likely to achieve enduring results. That said, buprenorphine and naloxone remain our most

immediate and effective interventions to keep people with OUD alive, so they can live long enough to enter recovery.

Opioid use and dependence are of epidemic proportions in this country. But we have beaten back many an epidemic. Think of smallpox, polio and cholera; of how we have reduced morbidity and mortality from driving deaths and tobacco; and how, with a groundswell of public support, we beat back the AIDS epidemic.

Effective solutions to the opioid epidemic exist. Mental health clinicians need to join in this effort. After all, many people using and dependent on opioids are in our mental health centers day after day – even if we imagine they are not.

*Lloyd I. Sederer, MD, is Adjunct Professor at the Columbia School of Public Health; was for 12 years the Chief Medical Officer for the NYS Office of Mental Health, the nation's largest state mental health agency - and continues there as Distinguished Psychiatrist Advisor; and Contributing Writer for Psychology Today,*

*the NY Journal and Washington Independent Review of Books & the NY Daily News, among other publications. He was Medical Editor for Mental Health for the HuffPost, where over 250 of his posts were published. He has served as Mental Health commissioner for NYC; Medical Director/EVP for McLean Hospital, a Harvard teaching facility; and as Director of Clinical Services for the American Psychiatric Association. He has written hundreds of articles on mental health, the addictions and book, film, TV and theatre reviews, and has published a dozen books.*

*Dr. Sederer is the 2019 recipient of the Doctor of the Year award from The National Council on Behavioral Health. He is a Co-Founder of SessionTogether. He recently created and now directs Columbia Psychiatry Media.*

*His new book, now in paperback, is The Addiction Solution: Treating Our Dependence on Opioids and Other Drugs (Scribner, 2018). Look for his next book in 2020.*

***Testimony from page 8***

prescribing practices, preventing opioid diversion, using I-Stop, etc., but none of these address the root causes and issues that people with Opioid Use Disorders are confronted by. We can't simply enforce our way out of this epidemic, since pharmaceutical companies and prescribers do not control the supply of available opioids. With easy access to heroin, and the widespread presence of Fentanyl in the illegal drug supply, many people may simply turn to alternative opioids that it's now virtually impossible to use without being at risk for overdose death.

We are all now familiar with the term Medication Assisted Treatment, or MAT, often applied to buprenorphine and other addiction-specific medications. But I would ask: What is the Treatment that the Medication is supposedly Assisting? Often, there is none.

The psychological component in addiction is too often overlooked. Evidence for this lies in the frequency of relapse, even after withdrawal has been achieved and even when MAT is in place. There are frequently underlying psychological conditions that the individual is attempting to medicate with a substance; until

that psychological condition is addressed, relapse is a risk. Although no single treatment intervention should be mandatory, effective evidence-based treatment should be offered, including counseling with licensed mental health providers who are substance use experts or licensed substance use disorder programs that include individual, group and family therapies, and include treatment for co-occurring disorders. These are treatments that operate from a person-centered, harm-reducing framework as opposed to treatments that merely operate at the level of the drug itself.

Why not require that health care providers provide referrals to substance use treatment for opioid overdose survivors and patients coming out of emergency department visits, rehabilitation and detoxification facilities? (That's one of our recommendations).

Why not ask prescribers who are checking I-Stop and are concerned about a possible addiction to make a referral to an appropriately trained clinician for an addiction risk assessment? The decision to prescribe or not prescribe is important, but why not take the opportunity to try to address the broader issues presented by a patient who won't get all of the help they

need, whatever the prescriber ultimately decides.

We believe that a solution to the opioid epidemic is attainable. We look forward to working with our colleagues in government, healthcare, education, law enforcement and other arenas to create a comprehensive approach that reduces the frequency of opiate overdose and death in New York State and serves as a model that other states can benefit from.

*Dr. Juman is a Past-President of NYSPA and a member of the NYSPA Division on Addictions Executive Board.*

**NYSPA White Paper Recommendations**

- 1: Provide evidence-based training and education about substance misuse for medical and mental health professionals and students.
- 2: Require prescriber and patient education about the risks of opioid-based pain medications.
- 3: Require health care providers to provide referrals to substance use treatment for opioid overdose survivors and patients coming out of emergency department visits,

rehabilitation and detoxification facilities.

4: Integrate medical, psychological services and social interventions.

5: Offer referrals for non-pharmaceutical, evidence-based interventions for pain management.

6: Address opioid use in individuals in, and transitioning out, of the criminal justice system.

7: Respect the importance of a harm reduction framework for the entire continuum of care.

8: Require health care providers to offer to prescribe buprenorphine, naltrexone and/or naloxone to overdose patients and those coming out of rehabilitation and detox facilities.

9: Provide access to Medication Assisted Treatment to all persons struggling with opioid use disorders, regardless of income or insurance

10: Mandate adequate insurance coverage for evidence-based, non-opioid pain management interventions.

**Contact: Anne G. Katz**

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**NYSOMH from page 4**

In addition to disseminating resources on OUD, CPI launched in 2009 its Focus on Integrated Treatment (FIT) to offer training and implementation supports for providers to enhance their ability to offer integrated treatment. As of October 2019, over 32 thousand people completed more than 376 thousand online integrated treatment education modules. Nearly five thousand people earned CPI's Integrated Mental Health and Addictions Treatment Training Certificate.

Under the leadership of Governor Cuomo, New York has also enacted new laws that prohibit insurers from requiring prior authorization to receive medication-assisted treatment for substance use disorders. Another measure limits patient copayments for outpatient mental health services and substance use disorder treatment to the equivalent cost of a primary care visit.

New York is also fighting the opioid epidemic by ensuring that people have access to treatment services. Last year, Governor Cuomo and members of the

State Legislature created the Community Health Access to Addiction and Mental Healthcare Project (CHAMP) an ombudsman program developed in partnership with the Community Service Society, the New York State Council for Community Behavioral Healthcare, The Legal Aid Society, the Medicare Rights Center, and the Legal Action Center.

CHAMP assists individuals and families in obtaining their legal rights to insurance coverage, helps them to access treatment and services, and resolve complaints regarding denial of health insurance coverage.

OMH is working closely with other state agencies, especially the Office of Addiction Services and Supports and the Department of Health, and with many other stakeholders to provide strategies and resources to help health care providers, communities, and local governments develop practices and policies to help treat opioid addiction and prevent opioid-related overdoses and deaths. Our goal is to ensure that people living with mental illness as well as opioid use disorder get the help they need on their road to recovery.

**Integration from page 26**

free at a pharmacy.

Additional efforts we have seen effective in increasing kit distribution include tabling events in waiting rooms of our health centers, signage around sites, introducing best practice alerts in electronic health records, and participation in com-

munity events such as International Overdose Awareness Day.

If you would like to establish an OOPP at your organization, please visit <https://www.nyoverdose.org/> for more information. Author Contacts: Thomas McCarry ([tmccarry@institute.org](mailto:tmccarry@institute.org)) and Marva Greer ([mgreer@institute.org](mailto:mgreer@institute.org)) to learn more.

**Difference from page 16**

Despite the fact that federal law has mandated coverage of addiction treatment on par with coverage for general medical services for more than a decade, we know that insurers still may not cover or pay for addiction treatment services fairly. Health benefit plans, in both the public and private sectors, should include comprehensive coverage of evidence-based addiction treatment services without arbitrary limits

or unfair utilization controls. When it comes to OUD, it is critical that plans facilitate patient access to medications such as methadone, buprenorphine, and extended-release naltrexone. Too often, utilization management techniques – such as prior authorization – restrict patient access to these life-saving treatments. A delay of just one day is enough time for a patient to relapse, overdose, or suffer other consequences that can adversely affect their treatment outcome.

**Q&A from page 28****Q: How Can Managers and Leaders Learn More About This Topic?**

A: MPG Consulting and NYU Silver School of Social Work are proud to offer a presentation on April 1, 2020: White Fragility and Racial Resiliency: Building Capacity Across the Racial Divide. How Developing Resilience Is for Both People of Color and White People featuring two compelling keynotes:

- Dr. Ken Hardy (Voicelessness: Dilemmas of Silence, Dilemmas of Speaking) will explore the phenomena of Voicelessness and the pervasive impact it has on the lives of People of Color. Dr. Robin DiAngelo (Nothing to Add: Silence as a Function of White Fragility) will explain White Fragility and White Silence as obstacles that prevent racially conscious whites from taking firm and unyielding stances against racial injustice.

- Dr. Hardy asserts that the false choice of either remaining silenced to "survive" or

speaking and being punished often leaves People of Color mired in self-doubt, despair, and rage-masking powerlessness. He will examine the emotional, psychological, and spiritual effects of oppression-induced voicelessness on the everyday lives of the racially traumatized. Strategies for reclaiming one's voice will be discussed. Dr. Hardy's clinical work centers on issues including the anatomy of racial rage, learned voicelessness, and the invisible wounds of racial oppression.

- Dr. Robin DiAngelo asserts that white people in the US live in a racially insular social environment. This insulation builds our expectations for racial comfort while at the same time lowering our stamina for enduring racial stress. This lack of racial stamina is "White Fragility." Those of us who see ourselves as "the choir" can be particularly challenged, for we tend to focus on "evidence of our advancement" rather than reach for humility and continually grapple with how to engage in intentional action. This talk will overview the socialization that leads to White Fragility and focuses on one par-

**Care from page 22**

models for others in our field by using language that de-stigmatizes the disease.

2. Practice a true open-door policy. Many employees fear that as soon as they reveal to their employer that they have a substance use disorder, they face termination. It is important that we find a way to communicate an open-door policy that encourages communication, feedback, and discussion about any matter of importance to an employee, including workplace concerns, questions, or suggestions, and most crucially, the disclosure of personal information, in an environment of trust and safety. Staff must be assured that their health and well-being are of highest importance to us.

3. In organizations utilizing workplace drug testing, reconsider zero tolerance policies as they relate to positive toxicology results. Begin to explore and establish what types of substances are permitted while working: medications for the common cold, anti-nausea, migraine, mood disorder, etc. Consider also eliminating pre-employment drug testing. Some providers have experienced prospective candidates displaying reluctance to take, and/or are unable to pass, pre-employment drug screens, though the medications they use may be appropriately prescribed for verifiable medical or mental health conditions. In lieu of automatic termination on first detection or positive toxicology result of employees, consider instead a policy that provides a second chance by incorpo-

Ultimately, we need comprehensive policy solutions that increase access to evidence-based treatment and bolster the treatment workforce to provide it. Patients, families, and healthcare professionals all have a role to play in advocating for policy changes and resources to rein in the current epidemic of OUD and opioid-related overdose deaths, as well as lay the groundwork for prevention and treatment systems that can more effectively respond to the next addiction-related crisis.

ticular manifestation: silence in the face of racial injustice. Dr. DiAngelo will provide the perspectives and skills needed for white people to build their racial stamina and use the voice this position provides.

**Q: How Can Someone Participate in the Event?**

A: Individual tickets as well as several partnership and sponsor packages will be sold. For more information, contact Kayla Cordero at [mpgconsultingnyc@gmail.com](mailto:mpgconsultingnyc@gmail.com) or (718) 664-4415.

• Single Ticket – \$150

• Equity Seeker – \$1,500 : 10 tickets with Logo placement on digital banners which serve as backdrops at the event

• Anti-Racist Change Agent – \$3,750: 25 tickets with Logo placement on digital banners which serve as backdrops at the event

• Anti-Racist Movement Maker – \$7,500: 50 tickets with Name and logo placement

rating compulsory counseling interventions.

4. Equip all staff, including administration, to recognize the signs of addiction. To be clear, this is not to promote a culture of "snitching" or finger-pointing, but to safely raise concerns. Just as important as it is to cultivate an environment in which employees feel safe to come forward with concerns with personal substance use, equipping all staff to recognize the signs of addiction is paramount for accountability and to also minimize speculation.

5. Engage the services of local employee assistance programs (EAPs) as a benefit for personnel, to whom staff in crisis may be referred. EAPs that offer confidential support for employees and their family members for an array of work-life stressors, including substance concerns, can help staff to access the treatment needed to address presenting or threatening substance use problems.

The opioid epidemic that we continue to confront today remains compounded by a workforce shortage of eligible, committed individuals who want to work in our field. Ongoing discussions about solutions to the opioid crisis for individuals, families, and communities provide an opportunity for providers to look within, consider the extraordinary impact and toll the epidemic demands of our own personnel, and urgently remind ourselves that we shouldn't ignore nor neglect our workforce.

*Dr. Selzer is the Medical Director of Committee for Physician Health, New York's physician health program. He is also the Director of the Northwell Health System's Physician's Resource Network, a confidential counseling program for the health system's practicing physicians, physician trainees, and medical students. Dr. Selzer is the Chair of the New York State Psychiatric Association's Addiction*

*see Difference on page 35*

on digital marketing materials related to the event and with Logo placement on digital banners which serve as backdrops at the event

- Accountability Partner – \$15,000: 100 tickets with Name and logo placement on digital marketing materials related to the event and with Logo placement on digital banners which serve as backdrops at the event

- Continuing Education Credits: This event will offer 3 Continuing Education Credits.

The New York State Education Department recognizes MPG Consulting as an approved provider of continuing education credits for LCSWs, LMSWs, LCATs, LMHCs, LMFTs, and Licensed Psychoanalysts. MPG Consulting is committed to ensuring that organizations serving populations of color are prepared to provide transformative culturally and racially attuned clinical, programmatic, and administrative services. MPG Consulting is certified as an M/WBE.



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**Perspective from page 25**

refers to a specific allele of the gene.).<sup>3</sup>

**Role of Pharmacy**

Pharmacists hold or maintain various roles and responsibilities in the treatment of patients with chronic pain. With the high abuse potential of opioids, pharmacists are well equipped to advise on alternative approaches to pain management. PGx is increasingly becoming an important tool for tailoring pharmacotherapy to patient needs. Pharmacies that offer PGx testing typically provide related PGx clinical services, such as, data interpretation, pharmacotherapy recommendations, patient monitoring, etc. Two of the major clinical areas in which Allure Specialty Pharmacy uses PGx testing are pain management and behavioral health.

**Role of PGx in Pain Management**

A major gene of interest in opioid use is the gene that codes for the CYP2D6 enzyme. In pain management, those drugs of interest include tramadol, codeine, hydrocodone, and oxymorphone. CYP2D6 is responsible for metabolizing codeine to morphine, tramadol to O-desmethyltramadol (a metabolite with 200-fold greater potency), oxycodone to oxymorphone, and hydrocodone to hydromorphone.<sup>3</sup> As described above and in Table 1, the different genotypes of CYP2D6 produce a range of metabolizing phenotypes: UM, EM, IM, or PM. Codeine and, to some extent, other opioids (e.g., tramadol, hydrocodone, and oxycodone) are not recommended for use

in the UM and PM phenotypes, which may account for up to 12% of the population. In the UM phenotype, increased codeine metabolism results in a greater risk of toxicity due to the higher levels of morphine generated. In the PM phenotype, low to no codeine metabolism results in a lack of efficacy.<sup>3</sup> Even in the IM phenotype, which accounts for up to 11% of the population, patients may need to use alternative analgesics. This suggests that knowing a patient's CYP2D6 genotype and corresponding phenotype could be critically important information when considering pharmacotherapy for pain management. A recent paper demonstrated the practical utility of PGx in guiding opioid therapy. Smith, et al, determined that using PGx information to guide pain management resulted in greater improvements in pain control for IM and PM phenotype patients who were originally on codeine or tramadol.<sup>4</sup> At Allure Specialty Pharmacy, we offer PGx testing and have used the results to guide opioid dosing.<sup>5</sup>

**Role of PGx in Behavioral Health:  
Antidepressants**

PGx testing can also be helpful in managing patients with depression. In fact, the FDA requires labeling information, primarily with respect to CYP2D6 and CYP2C19, for a number of psychiatric drugs.<sup>6</sup> The labeling requirements can focus on potential drug interactions or adverse events. For example, CYP2C19 poor metabolizer taking citalopram has an increased risk of QT prolongation.<sup>7</sup> The PGx testing offered by Allure Specialty

Pharmacy includes analysis of CYP2C19 and other enzymes related to antidepressant metabolism. We have successfully used the data to guide antidepressant pharmacotherapy.

**Services Offered – PGx Testing  
Specialty Services for TRD**

At Allure Specialty Pharmacy, we offer PGx testing to aid in pharmacotherapy decisions, particularly for pain management and behavioral health conditions. Allure Specialty Pharmacy has an educational and clinical partnership with Admera Health to provide PGx testing and to offer a pharmacist fellowship program in pharmacogenomics. In comparison to other companies that offer PGx for psychiatric conditions, Admera Health offers an expanded gene-testing panel that covers over 300 drugs used in conditions for psychiatry, pain management, neurology, cardiology, and oncology (Table 2: Comparison of PGx Testing). The pharmacists at Allure Specialty Pharmacy are trained to provide PGx counseling to treat patients holistically.

Allure Specialty Pharmacy has incorporated PGx in treating patients with treatment resistant depression (TRD). Patients with TRD have not responded to two or more antidepressant drugs. Incidence rates for TRD can vary substantially with recent estimates ranging from 13.08 per 100,000 to 120.20 per 100,000.<sup>8</sup> TRD places undue economic and quality of life burden on patients. Olfson et al found that Medicaid patients with TRD have significantly higher annual health care costs compared to patients whose

depression responds to treatment (\$18,982 for TRD patients v \$11,642 for non-TRD patients).<sup>9</sup> Spravato™ (esketamine, Janssen Pharmaceuticals) is a promising new therapy for TRD that is administered nasally under supervision of a healthcare professional in a certified treatment center.<sup>10,11</sup> Allure Specialty Pharmacy is an authorized distributor of Spravato™ and provides clinical consultation to the All Med Medical Group, a certified treatment center in the Bronx, for patients undergoing Spravato™ treatment.

Pharmacists can be valuable partners in the care and treatment of patients with pain or behavioral health conditions. Pharmacists can apply their expertise with current technology (e.g., PGx testing) and/or specialty drugs (e.g., Spravato™) to optimize pharmacotherapy and improve health outcomes in patients.

Allure Specialty Pharmacy is committed to improving the quality of patient lives through innovative customized pharmaceutical treatments and superior customer service. Please visit [www.allurespecialty.com](http://www.allurespecialty.com) for more information. Dr. Ronnie Moore, Dr. Vick Youmbi, and Mr. Angelo O'Neill can be reached at [info@allurespecialty.com](mailto:info@allurespecialty.com).

*Acknowledgements: The authors thank Thomas J. Cook, PhD, RPh, for medical writing and editing assistance.*

*Ronnie Moore, PharmD, is Director of Pharmacogenomics Program; Ludovick Youmbi, PharmD, is Pharmacist-in-Charge; and Angelo O'Neill, MSW; is Director of Business Development, at Allure Specialty Pharmacy.*

*For our full list of references please email [ronnie@allurespecialty.com](mailto:ronnie@allurespecialty.com).*



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*Psychiatry Committee, Secretary of the American Society of Addiction Medicine (ASAM), and Chair of ASAM's Public Policy Committee. He is a Distinguished Fellow of both the American Psychiatric Association and the American Society of Addiction Medicine.*

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***Centers from page 24***

and in life. PARC is there every step of the way without judgment or rejection and holds a special place in my heart."

People in recovery need to know recovery centers offer them safe, neutral zones where they can find the assistance they need to live productive, law abiding lives and contribute to the well-being of their families and their communities.

A long time ago (almost 40 years ago) when I first got into the field of addiction services (fresh out of treatment), I was told that the eventual goal of working in this industry was to put ourselves out of business by eliminating addiction. We may be the only industry intentionally striving for obsolescence. But imagine, if you will, a society in which the scourge of drug addiction is under control or al-

most nonexistent because there is a recovery center in every community catering to the needs of former addicts. The proliferation of recovery centers where people can sustain their recovery would go a long way toward achieving that goal.

*Roy Kearse, LCSW, CASAC is Vice President of Recovery Services and Community Partnerships at Samaritan Daytop Village, where he is leading the agency's efforts to create a recovery-oriented system of care and assist in our broader outreach efforts. Mr. Kearse has more than 35 years of experience in the field of human services, helping develop effective treatment in both substance use disorder and mental health settings. He is the author of "Poems from Recovery," an anthology documenting his forty-year recovery journey published this year by Dorrance Publishing.*

***Homeless from page 27***

to medications is critical to treatment and recovery from OUD. Research shows that medications, even without other interventions, improves outcomes for individuals with OUD (Connock et al., Health Technology Assessment, 2007; National Institute on Drug Abuse, Medications to Treat Opioid Use Disorder, 2018). Encourage Federally Qualified Health Centers (FQHCs) and x-waivered prescribers in your community to serve individuals who are homeless and have complex needs. Work with Health Care for the Homeless Clinics, advocates, and other stakeholders to reduce barriers to accessing OUD medications. For example, low-threshold access to medications, mobile and street medicine programs, or providing inductions at shelters all make it easier for individuals to obtain medications.

A prime example is the California ED Bridge Program, which engages individuals with MAT in emergency rooms (ERs) (<https://www.bridgetotreatment.org/cabridgeprogram>). One ER also distributes a simple business card within the community, and individuals can present the card at the hospital for immediate access to MAT.

Many individuals experiencing homelessness and OUD are involved with the criminal justice system. Rhode Island Department of Corrections has developed a comprehensive intervention. ([http://www.doc.ri.gov/rehabilitative/health/behavioral\\_substance.php](http://www.doc.ri.gov/rehabilitative/health/behavioral_substance.php)). Individuals are screened, assessed, and begin MAT (methadone, buprenorphine, naltrexone) of their choice while incarcerated. Once released, they are immediately connected to a community provider that assists with housing, medications, and peer services.

Health providers provide medications but often rely on behavioral health providers for the skill-building behavioral therapies, psycho-social and recovery supports, case management, and peer supports needed by people experiencing OUD and homelessness. Expert panelists that informed a recent report from the U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation had consensus that sustained recovery for individuals with complex problems requires other supports in addition to housing and MAT (Pfefferle et al., Choice Matters: Housing Models that May Promote Recovery for Individuals and Families Facing Opioid Use Disorder, 2019).

5. Remove barriers to housing. BH Providers: Familiarize yourselves with the shelters, housing counseling, Continuums of Care (CoCs), Coordinated Entry systems, Rapid Rehousing, and homeless service programs in your community. Work with homeless outreach programs and case managers to ensure that housing is addressed and offered to patients who need it.

HUD and its related CoCs have adopted a Housing First approach with significant expansions of available permanent supportive housing for people who experience chronic homelessness. The positive outcomes have been significant; there are more trauma-informed outreach programs available, and barriers to housing have been reduced through low-threshold requirements. Once people are housed, they can better address their health issues (National Academies of Sciences, Engineering, and Medicine, Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness, 2018).

HousingNow in Philadelphia is a dedicated Housing First program for individuals who experience OUD and homelessness. It provides access to permanent housing, case management, and an array of harm reduction and behavioral health services. An FQHC and a pharmacy serve as partners, making MAT as easy to access as possible (<https://pathwaystohousingpa.org/HousingNow>).

Across the nation, an array of recovery housing is available (<https://narronline.org>). These are alcohol- and illicit-drug free shared housing programs with peer support. Many states, including Missouri and Massachusetts, provide vouchers or short-term subsidies to help people access recovery housing, which may be either short-term or permanent housing.

In conclusion, it is key to acknowledge the bi-directional relationship between the opioid and homeless crises. Behavioral health providers can help by working with health and housing providers to remove barriers to hope, health, and home for people and communities. This opens the door to replacing a hopeless cycle with one of promise.

*To learn more about how to help people experiencing homelessness who also have OUD, and state and federal programs for homelessness, please contact Deb Werner at dwerner@ahpnet.com.*

***MAT from page 10***

CBC's goal will be to streamline services by creating capacity for same-day access and provide support for individuals as they transition from acute settings to community-based providers. In order to ensure that providers new to, and those expanding, delivery of MAT services deliver high quality services, CBC will offer a series of Learning Collaboratives (LC), built on the principles of Project ECHO (Extension for Community Healthcare Outcomes) training. These learning sessions will aim to increase the number of providers/prescribers who are proficient in and capable of assisting individuals with OUD/SUD access appropriate interventions, such as MAT.

As a technology innovator, CBC intends to identify and evaluate technology solutions to improve adherence to treatment and access to care for individuals

already in treatment. According to a 2018 meta-analysis of the use of telehealth in Opioid Agonist Therapy (OAT) (of which buprenorphine is one type), "Patients with telehealth-delivered OAT had a retention rate of 50% at one year of treatment compared to 39% for patients with in-person OAT." CBC will review existing technologies and explore the feasibility and cost of using a solution across the network. Providers, including those trained through CBC's LC, will be able to participate in a pilot project that utilizes new Technology Assisted Care (TAC) or telehealth capability.

By joining forces, CBC and CBHS together, will reach over 80 community-based providers across NYC and the Downstate NY region, working to increase access to MAT and greatly enhance a provider's ability to better meet the needs of their clients with OUD/SUD.

**Visit Our Sister Publication*****Autism Spectrum News @ AutismSpectrumNews.org******Partnerships from page 24***

clubhouses, expanded peer services, Centers of Treatment Innovation, mobile treatment, telehealth and 24/7 open access centers. Yet, in marking these milestones and multipronged approach, Governor Cuomo noted that still 1,824 opioid deaths occurred in 2018 (a drop of 15.9% over 2017). There is still much more to accomplish.

In the state of New Jersey, the MATrx Model Concept emerged from the convening of family care physicians, community SUD providers, university-based providers, Federally Qualified Health Centers (FQHCs), ambulatory care clinics, pain and addiction specialists, as well as government subject matter experts. MATrx kicked off earlier this year and offers navigator services across three provider types:

1. Office Based Addiction Treatment (OBAT) providers, which consist of primary care providers including Physician Assistants and Advance Practice Nurses;

2. Premier Providers, like FQHCs, Certified Community Behavioral Health Centers (CCBHCs), Ambulatory Care Providers and Outpatient Treatment Providers); and

3. Centers of Excellence, which are providers contracted by the state to provide training, consultation and peer services, in addition to primary care treatment for complex cases.

As of the fall, 400 providers received MAT and OBAT training and over 1,000 people were served since the launch of MATrx. However, partnering to solve the problems related to the opioid epidemic is not without complications. Stakeholders can hold different opinions on harm reduction versus treatment. Prior authorizations for MAT were eliminated, but formulary preferences and safety edits were left in place. Furthermore, inadequate reimbursement for MAT makes it difficult for providers to hire prescribers and integrate it into their existing services.

Additionally, regulatory barriers impede the one stop community-based model where one could theoretically go to take care of all their primary care and behavioral health needs.

**Solving the Problem**

Government can support multidisciplinary partnerships and create new opportunities for community collaborations to form. In addition, states can implement prescription drug monitoring programs to reign in haphazard prescribing. They can also promote the use of CDC guidelines (<https://www.cdc.gov/drugoverdose/prescribing/guideline.html>) on prescribing opioids for chronic pain. Payers can collaborate with provider networks to improve recovery outcomes, expand evidence-based treatments, improve performance, ease care transitions and support access and adherence to MAT. The shift to value-based care holds potential for tying reimbursement to outcomes. If VBP can make community services fiscally viable, then providers could focus their efforts on recovery and high-quality care for people addicted to opioids.

Working together to solve the opioid epidemic with population health strategies that cut across prevention, intervention, treatment, recovery and enforcement, creates opportunities for pioneering partnerships to form and care collaboratives to become innovation engines. Engaging with internal leadership, we help organizations implement policies that support greater care integration, data-driven approaches and promising practices that are most meaningful for opioid use disorder providers. Through collaborations with statewide partners and payers, and advocating for the resources needed by providers, we can raise awareness and find new solutions to the problems associated with the opioid epidemic that we must confront together.

*Jason Lippman can be reached at jason@solutionsjls.com and you can visit his website at [solutionsjls.com](http://solutionsjls.com).*

**Peers from page 4**

menu of services by January 1, 2020.

An organizational readiness self-assessment tool was disseminated to all outpatient and OTP programs. The tool features embedded links to peer resources, including a Peer Integration Tool-kit, as well as links to all of the above referenced guidance documents.

New York is committed to continuing the integration of peer services. To accomplish this objective OASAS is partnering with the following organizations to train more CRPAs for employment within our ROSC: 1) CRPA Certification Board, the New York Certifica-

tion Board (NYCB); 2) a statewide organization dedicated to developing local recovery community organizations, Friends of Recovery-New York; and 3) the Alliance for Careers in Healthcare (ACH). ACH is partnered with some City University of New York (CUNY) community colleges to develop new CRPA curriculums that provide CRPA training.

The totality of our shared efforts have already demonstrated the power of a peer to engage more individuals in need of addiction and recovery services, and thereby help more families and individuals to achieve wellness on their path to recovery.

**Individuals Engaged by COTI Peers- 5/1/2017 – 10/31/2019**  
**TOTAL- 9,569**

<b>Referred to OASAS-certified treatment program**</b>	<b>75% (7,170) ~</b>
<b>Reported previous treatment and/or recovery services*</b>	<b>72% (6,853)</b>
<b>Of 6,853- 3,827 (56%) were admitted to OASAS certified treatment program***</b>	
<b>Initial Engagement</b>	<b>Number</b>
In community	<b>4,278</b>
ER/hospital discharge	<b>826</b>
Community based organization referral	<b>636</b>
Word of mouth	<b>527</b>
County jail	<b>419</b>
Self-help	<b>183</b>
Inpatient program	<b>143</b>
Marketed materials	<b>25</b>
State parole offices	<b>24</b>
Primary care	<b>20</b>
State Department of Corrections	<b>19</b>
Social media	<b>10</b>
Other	<b>2,459</b>

\*Source- New York State OASAS, COTI data workbooks, 05/01/2017 – 10/31/2019

\*\*Source - New York State OASAS, Data Warehouse, CDS extract of 11/17/2019

<b>OASAS Peer Engagement Specialist Services: October 2017- October 2019</b>		
<b>21 Programs</b>		
<b>Service/ Date</b>	<b>Number</b>	<b>Percentage</b>
<b>Total Individuals Served</b>	<b>20,524</b>	
<b>Individuals Served in an ED</b>	<b>15,867</b>	<b>77.3%</b>
<b>Individuals Served within 3 Hours</b>	<b>17, 375</b>	<b>84.6%</b>
<b>Individuals Referred to Treatment</b>	<b>12,103</b>	<b>58.9%</b>
<b>Individuals Receiving Naloxone Training</b>	<b>7, 575</b>	<b>36.9%</b>
<b>Total Service Plans</b>	<b>12, 510</b>	
<b>Service Plans With Family Member Involvement</b>	<b>3, 231</b>	<b>25.8%</b>

\*Source- New York State OASAS, Recovery Reporting System, County Planning System, 10/1/2017 –10/1/2019

**Partners from page 15**

partnership with Arcadia, to provide easy access analytics for the provider community. IMSNY offers a series of business models that are IPA-centric alternative for Behavioral Health Networks to leverage shared resources and costs savings as opposed to “starting from scratch”. IMSNY provides networks with limited resources, affordable group-purchased administrative services. IMSNY continues to explore other potential services coming online, as needed, to meet the sector’s demands.

About CBC

Coordinated Behavioral Care (CBC)

is a behavioral health provider led, not-for-profit organization dedicated to improving the quality of care for New Yorkers with serious mental illness, chronic health conditions and/or substance use disorders. CBC brings together over 50 community-based health and human services organizations which provide access to quality treatment, housing, employment, and other needed services. CBC operates a Health Home that provides care coordination services to tens of thousands of New Yorkers of all ages, with 50+ community-based care management agencies located in all five boroughs. CBC also operates an Independent Practice Association (IPA) including a citywide network of New York

**Success from page 13**

work. We found that the more we talked, the more we realized that we have a lot of things in common. Collectively, we have substance use challenges and have lived through incarceration and periods of homelessness. Some of us also battle with mental health issues. Having access to mental health services at the same site where we get treatment services is crucial, because we are more inclined to participate when it is convenient and easily accessible.

Our experiences tell us that treatment works when coupled with individual and group counseling sessions, other forms of therapy, and attending group meetings. Some of us work one on one with a therapist. They meet us where we’re at. We set goals for ourselves and our therapist helps us achieve those goals and makes us accountable if we slip up. One of us said, “It’s personal. I talk about my issues and feel more comfortable.” Another said, “I’ve been shot at and I have PTSD. Talk therapy makes me feel better versus taking meds. Pills make me sick. I also do art therapy and breathing techniques. My therapist is great! It’s eye opening for me because she lets me know that I have to give myself a chance and that she has my back.” A third person shared, “Let’s have more meetings, like 3-4 times a week. NA works for me. When I stay connected and go to meetings, I stay clean.” A new S:US participant also shared with us his journey: “This is my first time at S:US. The staff welcomed me with open arms. There is no coddling. I’m 45 days clean and that’s never happened before. The counselors here genuinely care, they keep me going. I also met new friends who are serious about their recovery.”

**Other Services to Help  
With Our Journey to Recovery**

A lot of us are homeless or have had periods of homelessness. We want access to affordable housing with after care services a few times a week in neighbor-

hoods where there are no drugs around. Physical exercise also helps. One person said, “I work out regularly. Physical activity is important to get the mind right.” Another person also mentioned, “Since we have a lot of down time, we should aim to better ourselves by taking vocational courses, doing arts and crafts, taking computer classes, learning about home economics and how to keep a home.” When one person exclaimed, “I want to learn how to live right again and how to maintain it,” the rest of us nodded our heads in agreement.

Finding gainful employment is also important in feeling whole again. A few of us have had success with getting a job at S:US. One person quipped, “I am clean and sober, which I need to be to find employment. I became a certified Residential Aide at S:US.” Another shared that he works as a farming assistant in one of S:US’ urban farms. “The job helps with my self-esteem and it motivates me. I like my job.” While some of our experiences in finding a job are varied, what they have in common is the importance of the support and resources made available to us through organizations like S:US, and programs designed specifically for our needs.

As we finished our focus group, we began to feel both a sense of camaraderie and accomplishment. Our experiences bond us. Another thing that bonds us is our appreciation for S:US. The staff is warm, caring and sensitive to our issues. They are experienced professionals and show interest in our lives. One person shared, “S:US attends to my problems. Because S:US cares, I want to be clean. They have my best interest at heart.” Another said, “I love S:US – the people, the staff, the clients. I feel I belong here. They can relate with me. I’ve been clean for two years and this place saved my life.” Another person said it best: “S:US is like a family. I look forward to coming here, to be around my family motivates me to be a better person. While we might miss our real families, this right here with S:US – this is our family now.”

## If You Are Feeling Hopeless

### Call the National Suicide Prevention Hotline

**1-800-273-8255**

State-licensed primary care, mental health and substance use treatment services, thousands of units of supportive housing, primary medical, recovery and support services, and assistance with concrete needs such as food, employment and housing. Among CBC’s Innovative Programs is the Pathway Home™, offering care transition services during the transition back to the community following discharge from an institutional setting.

#### About CBHS

Coordinated Behavioral Health Services (CBHS) is a for-profit organization dedicated to improving the quality of care

for the residents of the Lower Hudson Valley with serious mental illness, chronic health conditions and/or substance use disorders. CBHS brings together 31 community-based health and human services organizations which provide access to quality treatment, housing, employment and other needed services. CBHS operates as an Independent Practice Association (IPA) including network of mental health, substance use treatment services, thousands of units of supportive housing, recovery and support services, and assistance with concrete needs such as food, employment and housing. CBHS operates in the Counties of Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester.

**Pain from page 26**

Tylenol and other pain relievers that are not anti-inflammatory drugs. As with all drugs, of course, there are potential side-effects of NSAIDS and other pain relievers that need to be watched carefully.

Also, it is very important to keep in mind that *emotions play a very important role in a patient's experience of pain*. For example, anxiety about how bad pain will be makes the experience of pain worse. Emotional aspects of pain can be assessed by using the specifiers from the recent International Classification of Diseases (ICD-11) for pain (Treede et al., 2019).

Drugs that reduce anxiety can be helpful to some patients. Of course, all of these drugs need to be used with care. Benzodiazepines combined with opioids, for example, are a major contributor to drug overdose deaths. Anti-depressants and beta-blockers can have distressing side effects.

*Most important, again, is to tailor the choice of medications to the patient's experience.*

Question 5: You have mentioned tailoring twice now. Could you say a bit more about why it is important to individualize pain management?

Dr. Colloca: There are a number of different types and causes of physical pain. Neuropathic pain, for example, is different from acute pain, and it responds to different forms of treatment (Gladden et al., 2019). In addition, pain may be due to trauma, such as broken bones, to surgery, to arthritis, cancer, diabetes, neurological damage, spinal conditions, shingles, etc.

It is critical to understand the type and source of pain in devising a chronic pain management plan. There are a number of medications, such as Gabapentin and some anti-depressants that are frequently

prescribed instead of opioids. They are effective for some types and causes of pain but not for others (Colloca et al., 2017). And some patients are troubled by side-effects such as sleepiness and sexual dysfunction. Again, individualized choices based on a good evaluation are the key to effective pain management.

Question 6: You have said that there are non-pharmacological interventions that can be helpful. What are they?

Dr. Colloca: Non-pharmacological interventions can be useful both alone and in combination with pharmacological interventions (Garland et al., 2019). They include exercise, acupuncture, physical therapy, etc. on the physical side and counseling on the psychological side.

It is critical to understand that the experience of pain is not caused exclusively by physical conditions. Attitudes towards pain, optimism about life, engagement in pleasurable and meaningful activities and relationships, all have an impact on the experience of pain. Counseling of various kinds can help people to overcome demoralization (Friedman and Nestadt, 2013) about their physical condition and can help them to be as active and involved as their physical condition permits.

Again, tailoring is key. And *tailoring needs to address the psychological, social, and spiritual dimensions of a person's life as well as the physical sources of pain.*

Question 7: Over the past couple of years concerns have been raised—by me among many others—that changing practices regarding the use of opioids may result in some people not getting the pain relief they need. Do you think that opioids should be used for some people who otherwise experience unrelenting pain?

Dr. Colloca: There is no doubt that for

some people opioids are necessary to treat pain effectively. There is also no doubt that they are over-used. It's also interesting that some people with terrible pain choose not to take opioids because they don't like the effect that it has on their cognitive capacity and perception of reality.

So, yes, sometimes opioids are the treatment of choice, but pursuant to a pain management plan that is—to say it again—tailored to the individual.

Question 8: This has been quite fascinating. I'd like to conclude by asking you what changes in health and behavioral health policy are important to move to a more informed and precise practice with regard to pain management without reliance on opioids.

Dr. Colloca: There are a number of key changes that are needed.

- Policy makers need to understand that the opioid epidemic is a complex, multi-dimensional problem that needs a multi-dimensional response.

- Regulations, standards, and practice guides should emphasize prevention of opioid addiction by using opioids only rarely and in accordance with an individualized pain management plan. The expectation should be that pain—other than the pain associated with terminal conditions—should be treated without opioids.

- Effective pain management requires multi-disciplinary interventions. The move to comprehensive delivery systems that include physical, behavioral, and dental care can contribute to improved pain management.

- The goal should be for pain management to become part of the enterprise of precision medicine—personalized, tai-

lored treatment.

- Training and education of clinicians—medical, behavioral, and dental—needs to change, emphasizing meaningful evaluation and tailored multi-dimensional pain management interventions. This will depend on more effective translation of research into practice. There needs to be more funding for this to take place.

Finally, pain management remains a great challenge. We researchers are far from having all the answers we need to be able to fully tailor effective interventions. More research will be absolutely essential to ultimately be able to manage pain without causing addiction or other unfortunate outcomes. NIH's billion-dollar investment this year is a great first step. It will need to continue.

Thank you Dr. Colloca. Your comments have been illuminating and have created a challenge for all of us in the field of behavioral health as well as for medical and dental personnel.

*Luana Colloca, MD, PhD, MS is an NIH-funded associate professor at the University of Maryland and an honorary professor at the University of Sydney School of Psychology.*

*Michael B. Friedman, MSW was an Adjunct Associate Professor at Columbia University School of Social Work until he moved to Baltimore to be closer to his very special grandchildren. He can be reached at mbfriedman@aol.com.*

\* Some of these overdose deaths are probably purposeful. Research is now going on to try to identify those that are suicide.

For a full list of references found in this article, please contact Michael Friedman at mbfriedman@aol.com.

**Findings from page 18**

overdose survivors who are transported to a hospital ED. The common curriculum adopted by all trainers in the tri-county area includes a module emphasizing the importance of transport and medical follow-up and offering strategies to help encourage survivors to go to the ED. The Task Force has produced a 3-minute video on this topic and has incorporated it into the curriculum as of August 2019.

The third part of the Task Force initiative is centered on enhancing the capacity of hospitals to effectively care for overdose survivors. The Task Force worked with the three community hospitals in the region to implement a screening protocol for opioid use disorder (OUD) at ED triage and a three-pronged approach for the treatment of OUD in the ED. This approach includes contacting a Peer Recovery Advocate (Peer) to meet with the patient in the ED; providing the patient with a dose of buprenorphine for withdrawal symptoms and – if necessary – a bridge prescription of buprenorphine until the patient is able to be seen by a medication-assisted treatment provider; and encouraging Naloxone education and distribution to the patient and/or their support person by either contacting a Peer or providing a prescription for

Naloxone that can be filled at a community pharmacy that offers subsidized Naloxone.

In addition to these targeted interventions, the Task Force developed a number of resources on addiction and recovery that are available to the community, including a web site, a call line staffed by Peers, and an ongoing slate of community events.

**Preliminary Findings**

This is a three-year initiative which concluded its first year in April 2019. The Center for Human Services Research (CHSR) at the University at Albany was contracted by the Greater Rochester Health Foundation as an external evaluator for the three years of the project. Preliminary findings by CHSR were as follows.

The Task Force made great progress on their objectives during the first year. One of the greatest achievements was the robust implementation of the organized Naloxone training program. Nearly 1,200 individuals were trained in the three-county area in only a year's time. Given an estimated population of only 110,859 adults in 2018, this equates to a striking 1 out of every 100 adults trained to use Naloxone. Early evidence from an evaluation of the training suggests the training has been effective in improving knowl-

edge of key concepts (e.g., what to do first when you notice someone has overdosed) and increased behavioral intentions to administer Naloxone.

Another impressive achievement is that the Task Force has secured cooperation of all three local hospitals to adopt and implement protocols around the identification and intervention with ED patients who use opioids. The hospitals have added screening questions to their triage procedures to identify such patients, and with positive screens triggering the deployment of a Peer/Recovery Coach.

Events organized by the Task Force throughout the project year reached 896 community members and use of the call line for opioid information and referral has been steadily increasing from 6 calls in the first month to a cumulative total of 177 by the end of the project year. The project website, launched in March, logged 144 users in the first month. This brings the total count of community member contacts to 1,217 for the project year, not including attendance at the Naloxone trainings.

Opioid deaths in the region have decreased by 5% since the previous calendar year. However, this is consistent with decreases seen at the national level, and it is premature to conclude that this was a direct result of the Task Force's work.

Also, most of this was driven by a decrease in Genesee County, and small numbers make it difficult to discern whether this is a real trend. The death rate in Orleans County increased by 71%, which could reflect random year-to-year fluctuation in the data, but which bears further monitoring.

**Conclusion**

It is still early in the project to begin measuring outcomes, but early data show a promising start. Most of the stated objectives are on track, and systems are in place to capture key data points for evaluation. The work of the Task Force represents a systemic approach to the problem of opioid death by expanding potential intervention points across multiple systems (community members, families, first responders, hospitals, treatment providers, etc.) and raising community awareness about those potential intervention points.

The Center for Human Services Research (CHSR), located at the University at Albany, has over 25 years of experience conducting evaluation research, designing information systems and informing program and policy development for a broad range of agencies serving vulnerable populations.

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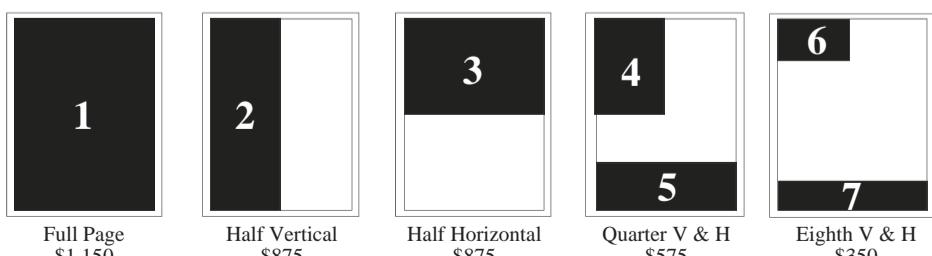
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