By Dr. Herbert Pardes

Investigator Grantees, 80 Independent

What does the Brain & Behavior Research Foundation do? The Brain & Behavior Research Foundation is the largest non-governmental funder of mental health research grants in the world. The Foundation funds the most innovative ideas in psychiatry and neuroscience to better understand the causes and develop new ways to effectively treat brain and behavior disorders. These disorders include depression, bipolar disorder, schizophrenia, autism, ADHD, anxiety, borderline personality disorder, obsessive-compulsive disorder, addiction and post-traumatic stress disorder. BBRF supports a broad range of the best ideas in brain research and our grantees have taken substantial steps forward on the path to developing new treatments and finding cures for mental illness.

What kind of grants do you fund? BBRF supports approximately 400 Young Investigator Grantees, 80 Independent Investigator Grantees and 15 Distinguished Investigator Grantees each year. These grants enable these outstanding scientists to pursue new, cutting-edge ideas to answer important questions or help identify new potentially game-changing targets for treatments.

Our Grants support a broad range of the best ideas in brain research. Funding for our grants is focused on four priority areas to better understand and treat mental illness, aiming toward prevention and ultimately cures. These areas include: Basic Research to understand what happens in the brain to cause mental illness; New Technologies to advance or create new ways of studying and understanding the brain; Diagnostic Tools and Early Intervention to recognize early signs of mental illness and treat as early as possible; and Next Generation Therapies to reduce symptoms of mental illness and ultimately cure and prevent brain and behavior disorders.

Who selects your grantees? All Foundation Grant projects are selected by the 176 members of our all-volunteer Scientific Council which is led by Dr. Herbert Pardes and comprised of leading neuroscientists across disciplines in brain and behavior research. The Scientific Council includes two Nobel Laureates and four former and the current director of the

We Need to Do More Than Just Talk About Mental Illness

By Dr. Herbert Pardes

Reprinted from The Hill

There was a time when no one talked about mental illness. But, today, every tragic shooting is accompanied by calls for greater access to mental health treatment. The wheels of legislation turn slowly, but mental illness is a public health crisis that requires immediate attention to improve access to care, raise awareness, and fund mental health research. In order to move the needle, we need real bipartisan leadership.

First, we have to separate facts from fiction. While many people erroneously believe that mental illness has a direct correlation to violence, the vast majority of people with mental illness are not violent. However, mental illness is a strong risk factor for suicide, accounting for 62 percent of all firearm deaths in the United States.

In fact, suicide has risen to the highest levels in more than 30 years. It is now the 10th leading cause of death among American adults and the second leading cause of death for young people ages 10 to 24. Suicide rates have risen for every age group, except older adults, and a recent study in the British Medical Journal found that incidents of self-harm among girls aged 13 to 16 increased by 68 percent over a four year period. We also continue to see an increase in psychiatric illnesses among veterans.

Psychiatric illness has also become one of the major conditions affecting the health of the world population. We are seeing a growing number of people suffering from anxiety and depression with other serious medical conditions or comorbidities. The rising death toll from alcohol and opiate abuse has decimated families and entire communities.

Millions of people with serious mental illnesses, such as schizophrenia and bipolar disorder, go untreated due to a persistent lack of psychiatrists and hospital beds. In many cases, people become homeless or incarcerated; our prison system has become the nation’s largest caretaker of the mentally ill.

These issues are not someone else’s problem. Mental illness affects one in five people, so it is quite likely that every single member of the House or Senate has a spouse, a child, a relative, or a friend who has been touched by mental illness.

Over the years, few major figures have had the clout to successfully press for mental health parity. There are, however, some advocates who stand out as important voices in the call for greater attention and support for programs for the mentally ill.

One example was the late Sen. Pete Domenici (R-N.M.), who took a leadership role in convincing Sen. Warren Rudman (R-N.H.) to recognize the issues of psychiatric patients, support mental health programs, and offer greater equity for those with psychiatric illness. As the father of a child with schizophrenia, Senator Domenici knew the issues first hand.

Rep. Tim Murphy (D-Conn.) made some progress through the Helping Families in Mental Health Crisis Act. With his departure from Congress, we are sorely in need of new champions for the mentally ill.

See Do More on page 37
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“Changes in Our Children’s System of Care”
Deadline: January 8, 2019

Spring 2019 Issue:
“Caring for Older Adults: Challenges and Solutions”
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The Brain & Behavior Research Foundation: A Personal Perspective

By Ira Minot, LMSW
Founder and Publisher
Behavioral Health News

Few people could imagine the breadth and depth of her interests, ranging from the most creative modern art to inspiring architecture, exhilarating music, and insightful studies of neuroscience and human behavior. Guided by her compassion, dedication, and curiosity—as well as her personal relationships with scores of leading psychiatrists and neuroscientists—Constance informally advised thousands of parents who were desperately seeking better treatments and cures for their mentally ill children. During their sixty-five-year marriage, Constance and Stephen A. Lieber shared enduring love and intense intellectual insights to transform the field of basic and clinical research into the origins of schizophrenia and other mental illnesses.

Since 1980, Constance and Steve have been among the leading public advocates and philanthropic supporters of schizophrenia and depression research in the US and around the globe. Their efforts included the creation of significant clinical and scientific institutions to support emerging discoveries in the fields of biological psychiatry and patient services.

For over twenty-five years, they gave exemplary leadership to the Brain & Behavior Research Foundation (formerly NARSAD), the world’s largest private funder of mental health research. Constance served as President from 1989 to 2007. In 2014, their activities were honored by the American Psychiatric Association with a Special Presidential Commendation, stating “Constance and Steve have provided unwavering moral and material support to unravel the mysteries of the brain, and to better understand and treat mental illness.”

In 1987, the Liebers established an annual award for outstanding achievements in schizophrenia research. To date, two Lieber Prize winners have gone on to win Nobel Prizes. At Columbia University, they founded two centers of excellence—the Lieber Recovery and Rehabilitation Clinic for Psychotic Disorders and the Lieber Schizophrenic Clinic. At Williams College, they were the founders of the undergraduate neuroscience program.

In 2011, they created the Lieber Institute for Brain Development, affiliated with Johns Hopkins University, to integrate new discoveries in developmental neurobiology and genetics in order to achieve chloride channels that can change lives. Constance was a graduate of Brooklyn College and attended Columbia University for her post-graduate studies. She received honorary doctorates from Williams College and received over two dozen awards to recognize her outstanding leadership, including: the Brooke Astor Award for Outstanding Contribution to the Advancement of Science, the Women in Science Award from The Rockefeller University, the Distinguished Service Award from the Yale University’s Department of Psychiatry, and the Humanitarian Award from the Society of Biological Psychiatry.

The account of Bruce’s battle with depression, as told by Dr. Lisa Pan's patient Bruce, about the breakthroughs she and her colleagues are having using “Metabolite Replacement Therapy,” a treatment which shows great promise for those with untreatable depression. Their scientific research, supported by the BBRF, in finding a connection between the body’s metabolism and depression, is complex and awe inspiring, and the personal vignette about Dr. Pan’s patient Bruce was something I can personally relate to.

On Becoming a Professional Appointment Keeper Seeking a Way Out

Twenty years ago when I was in the midst of having this major breakdown (as it is commonly called), I began searching for an answer to what was happening and desperately tried to find a physician or a therapist who could help me find my way back to my normal self. It took years of going to appointments, trying a multitude of medications with their many side-effects, experiencing the stigma and shame of having a mental illness, being hospitalized when in total despair, losing jobs due to recurring episodes, and attending outpatient programs to assist me in becoming normal again. It was a long and difficult journey.

Stigma, ECT, Supportive Housing, and Rebuilding Your Life Through Recovery

Stigma is not something that can be understood in the laboratory. It’s people’s lack of understanding about an illness or another person’s disability. Only by continued education across the nation, can we ever hope to have a more informed society. The stigma surrounding it was clearly evident in the recent surge of celebrity suicides reported in the media. Why weren’t the early warning signs heeded?

In Bruce’s case he was given ECT and it did not help him. According to the Mayo Clinic’s website, ECT often works when the full course of treatment is completed, but it may not work for everyone. Much of the stigma attached to ECT is based on the way it was administered many years ago, but it is much safer today especially when medications and other forms of therapy have failed to help individuals with severe depression get better.

Nobody simply jumps out of their illness and back into normalcy without some kind of recovery. In most cases it takes time and deliberate effort on the part of the individual. Many recovery programs and drop-in centers run by consumers are available in most communities. They are a great help in the healing process. Housing programs that help people recovering from mental illness and other conditions are another essential part of the recovery process.

Receiving supportive housing during one’s recovery is one of the most important components to getting better.

BBRF Scientists: Offering a New Future to Treating Illness

Is the next scientific breakthrough for people suffering with depression, anxiety, addiction, attention-deficit hyperactivity disorder, autism, bipolar disorder, eating disorders, obsessive-compulsive disorder, post-traumatic stress disorder and schizophrenia only moments away? It may be, thanks to the funding and support of the Brain & Behavior Research Foundation. Their scientists are investigating the causes and cures of illnesses every day. This is the future and we are seeing it now! It is my hope that the publication Behavioral Health News can continue to follow the advancements and breakthroughs uncovered by the BBRF and bring them to the attention of our many online and hard-copy readers.
Bruce had tried everything. And yet, for three decades, he could not find relief from his debilitating depression and suicidal thoughts. Twenty medications. Electroconvulsive therapy. Countless hours of counseling and cognitive behavioral therapy. Nothing had worked.

Of the 15 million American adults diagnosed with major depression, 15 percent do not respond to any available treatments. They, like Bruce, have treatment-refractory depression. In many cases the illness poses significant risk of suicide.

Bruce’s symptoms began early in his teens. As time went on, they became worse, slowly consuming all aspects of his life. He went from being a high-functioning professional, designing and repairing submarines for the Department of Defense, to someone who could barely muster enough willpower and cognitive capacity to shower, eat, and show up for work. “But even this was becoming a treacherous struggle,” Bruce recalls.

By the time Bruce turned 35, in 2000, his depression became so debilitating that he lost the ability to function day-to-day, and had to resign from his job. The realization that his life was not once successful and independent, but now on the verge of assisted living, caused him great anguish. “How could that possibly be? With my career accomplishments, how could I now lack the capacity to even minimally function?” Bruce wondered.

Bruce turned into a “professional appointment keeper.” His entire day was spent keeping up with doctor’s appointments and managing his symptoms and the side effects from his medications.

Last year, at age 51, Bruce’s current doctor referred him to Dr. Lisa Pan, who was leading research that offered great promise for those with untreatable depression.

Dr. Pan, a 2012 Brain & Behavior Research Foundation Young Investigator Grantee, had long worked with teens at risk for suicide. It was one such young person, under her care at the STAR (Services for Teens At Risk) Center at the University of Pittsburgh Medical Center’s Western Psychiatric Institute, that led her to draw a connection between metabolism and depression.

For years, Dr. Pan struggled to treat a teenager with debilitating, persistent depression, suicidal thoughts, and a history of multiple near-lethal suicide attempts.}

Interview from page 1

National Institute of Mental Health. These men and women are uniquely qualified to identify new research projects that may be unproven but offer potential for significantly different impact. The goal of the Young Investigator Grant is to select the most promising ideas in which to invest, whether proposed by budding early career neuroscientists or by established scientists seeking to explore new paths.

To date, how many grantees have you funded? We started with 10 grants in 1987 totaling $250,000. By the end of 2017 we had awarded more than $380 million to more than 4,500 grantees in the U.S. and 34 other countries. Over the past 30 years we have helped psychiatry and neuroscience advance significantly and have established great momentum in the field.

What have BBRF grantees achieved? Typically BBRF grants lead to additional funding from government, universities and industry. A survey of our grantees revealed that Foundation grants increased a researchers’ ability to secure additional grant support. So the $380 million in grants awarded to date has resulted in additional brain research funding for these scientists. In fact, a recent RAND Europe analysis of the global mental health research funding landscape found that we are the top non-governmental funder cited in published articles and virtually every scientific journal in psychiatry, neuroscience, molecular biology, and genetics includes articles on the research achievements of BBRF grantees. Highlights of our grantees are many and the quality of their work showcases progress and advances in psychiatric diagnostic tools, treatments, and technologies.

see Interview on page 37
And yet you say that anxiety disorders in adults is about seven percent, such as ADHD (eight to 10 percent), or depression in early- to mid-adolescence. Studies differ, but most suggest between 15 percent and 30 percent of adolescents have an anxiety disorder before age 18. This is more than other common childhood and adolescent conditions, such as ADHD (eight to 10 percent), or depression (10 to 20 percent). The prevalence of anxiety disorders in adults is around 30 percent, and the prevalence of depression in adults is about seven percent. Schizophrenia is one percent. Bipolar disorder is around three percent.

And yet you say that anxiety disorders are under-recognized and misdiagnosed in young people. Why?

Anxiety disorders are under-recognized because everyone, children and adults alike, experience anxiety. In children, for example, it is normal to be anxious before an exam or on the first day of school. Your child comes to you and says they are anxious. You yourself are anxious at times, so you don’t recognize the difference in degree. Your hope is that this is due to an adjustment to routine, for example going to a new school. You figure this all will go away on its own.

Anxiety is also frequently misdiagnosed because of the way it manifests sometimes as a bodily symptom, like a stomach ache. If a child has chronic stomach aches, they might refuse to go to school. This could be a tip off that there may be a deeper issue.

Compared to the anxiety that any young person normally feels, how does anxiety in a young person with an anxiety disorder differ?

Anxiety is constant and anxious about a few things some of the time, like giving a speech or taking a test, is in itself not a disorder. An anxiety disorder is a condition in which there is a significant distress and functional impairment. When a child’s severe distress or avoidance of anxiety-provoking situations gets in the way of the child’s day-to-day life, and/or the family’s daily life, then the anxiety has likely crossed a threshold that would warrant a professional assessment and intervention. An obvious warning sign would be if your son or daughter refuses to go to school. This is probably one of the most severe manifestations. Other warning signs would be if your child does not seem to spend much time outside his or her room, or does not seem to want to interact or be part of various activities. Anxiety is a normal emotion to have. It’s when it gets to an extreme level that you should start keeping track, like when you see your child avoiding things that other children are not avoiding, like going to parties, hanging out with friends, or joining school activities, clubs, or team sports.

Is avoidance the main symptom parents would see?

There are a panoply of symptoms. Anxiety is also associated with frequent worry or reassurance-seeking, chronic irritability, difficulty sleeping, and anxiety-related physical symptoms, which for some youth can progress to a panic attack (a brief period of intense fear and inability to act).

What should parents do if they think their child might have an anxiety disorder? Who should they consult first?

There are very good national organizations such as the Anxiety and Depression Association of America (ADAA), the Association for Behavioral and Cognitive Therapies, and the National Institute of Mental Health (NIMH), as well as our organization, the NewYork-Presbyterian Youth Anxiety Center, all of whose websites provide a very detailed description of each type of anxiety disorder, as well as information on the recommended evidence-based treatment options, and often links to well-trained providers in your geographic area. Looking at those websites should be step one. Step two would be to meet with your child’s primary care doctor, and get a referral to a psychologist or psychiatrist for an assessment.

If you start to have a sense that there seem to be greater levels of fear-related symptoms as well as avoidance behavior, then you want to see a professional to get a sense of whether the anxiety warrants a diagnosis and treatment.

What we have learned, from both clinical experience and from research, is that these disorders don’t go away on their own. They need to be treated.

Tell us about the different types of anxiety disorders and the different treatments for them.

The first anxiety disorders we tend to see in youth are separation anxiety disorder, a fear of being separated from one’s par-ents or safety figure, or a specific phobia, for example fear of the dark, heights, animals, insects, getting sick, etc. Many youth have these fears to a certain extent, but for some it becomes extreme, interferes with the child and family’s functioning.

In later childhood, generalized anxiety is characterized by frequent worry about many things, and associated irritability, or even a persistent stomach ache, or even a persistent stomach ache. Obsessive compulsive disorder has specifically to do with intrusive, unwanted obsessions or urges that cause anxiety, and anxiety-related symptoms such as compulsions, habits, or behaviors that temporarily relieve the anxiety but cause other impairments in daily life.

Specific phobias are more common in adolescence and is focused more on anxiety symptoms related to social events, meeting new people, or public speaking. Panic disorder is typically not seen until later adolescence, but includes out-of-the-blue panic attacks and invokes fear and avoidance of situations that might cause a panic attack.

Is there a reason why anxiety peaks early in life?

Anxiety disorders seem to peak at two main times: during childhood (between five and seven years of age), and during adolescence. There is definitely a cohort of patients who have anxiety disorders in childhood, which corresponds to when they have to leave the house and go to school. This environmental change seems to trigger these symptoms. The second wave of anxiety in early- to mid-adolescence is harder to understand. There is still great debate amongst psychiatrists and epidemiologists whether there is a second wave, or whether these adolescents have had lower levels of anxiety all along throughout childhood, and it is only now finally getting to the attention of a care provider.

As I said, there is a significant under-diagnosis of this disorder.

If the child has had symptoms during childhood, his or her anxiety might continue and being diagnosed with depression and substance use disorders during adolescence also increase. This is one of the main reasons why diagnosing and treating anxiety early is so important. If not done, these disorders build upon themselves. If parents notice a significant level of anxiety, irritability, or even a persistent stomach ache, or some other type of symptom, they should not ignore it.

If an anxiety disorder is allowed to linger for, say, five years from onset, not only do the symptoms get worse, but you then have a child who has a very limited world, in which they have been avoiding things. At that point, you’re starting treatment at a different point than you might have if you started five years earlier and it’s more difficult to treat.

Does anxiety disorder run in families?

Just as with many other psychiatric disorders, there is high heritability. But heritability is difficult to explain, because it’s not like getting a diagnosis of Huntington’s disease, where there is a genetic test and if you have the gene, you have the illness. Heritability for anxiety disorders, like any psychiatric disorder, just means that there is a higher chance of having an anxiety disorder if it runs in your family. Parents who have anxiety themselves may also model or reinforce anxious or avoidant coping with their children, which can send an unhelpful message to a child who is genetically predisposed to anxiety.

Can factors in the environment, such as trauma, trigger anxiety disorders?

When you try to do a natural history intake [asking patients and their families about the course of what environmental factors, or other circumstances caused or contributed to the disorder, it’s very difficult to pin down [the cause]. There is a biological component, including genetics, which we don’t understand, which obviously interacts with the environment. There is nothing that suggests there is something in the environment itself that causes an anxiety disorder. There is no direct correspondence with, for example, the way the child was reared — except for significant trauma. But in such a case, that anxiety disorder when included is retrofitted into a post-traumatic stress disorder, since it is the result of an earlier trauma or chronic acute stress.

What are the therapeutic options?

All of these disorders are amenable to the same type of therapy, called cognitive behavioral therapy (CBT). The patient meets with a therapist, usually on a weekly basis, and gets exposed in a controlled environment to things that make them anxious. The point of the treatment is to ensure that adolescents will be able to confront their anxieties and work through them using adaptive coping strategies. The goal is to experience the anxiety and learn that the feeling can be tolerated and managed, and will likely get better the more the adolescent confronts the experience instead of avoiding it. Thus, therapy may consist of going to a nearby Starbucks, or some other public place, and interacting with strangers, or having someone call you, or anything sounding scary, to be practiced in public, or purposely practicing another feared experience.

This is why it’s so helpful to see a professional, because there are certain things they do that may seem a little bit counterintuitive — like having a socially anxious person go into a crowded place where they have to interact. But this is
UNITING DONORS WITH SCIENTISTS

“My brother first exhibited symptoms of schizophrenia in 1960 at age 17. When we were able to support psychiatric research as a family, we found the Brain & Behavior Research Foundation. I became a Research Partner because the satisfaction of enabling a Young Investigator’s work to unlock the pathways to understanding the sources of psychiatric illness is incredibly satisfying. Now I support three Young Investigators each year. My brother knew that whatever science discovered, it would be too late for him, but he wanted to know that others could avoid the illness that had ruined his life. I donate to honor his wish.”

—Barbara Toll, Foundation Board Member

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By Peter Tarr, PhD
Freelance Writer for the Brain & Behavior Research Foundation (BBRF)

An interview with Robert Freedman, MD, Chair of Psychiatry, University of Colorado; Editor-in-Chief, The American Journal of Psychiatry, and Member of the Foundation’s Scientific Council.

2015 Lieber Prize for Outstanding Schizophrenia Research; 2006, 1999 Distinguished Investigator

Testing a Simple Strategy to Prevent Schizophrenia via Dietary Supplements

A t what point do the fruits of basic research—the hard-won bits and pieces of knowledge about brain function that the Foundation’s grants generate—result in the development of new treatments? There’s an exciting example now emerging in the laboratory run by Robert Freedman, MD.

Dr. Freedman, Chair of Psychiatry at the University of Colorado, editor in chief of The American Journal of Psychiatry, and a member of the Foundation’s Scientific Council since 2001, has been on a long journey that began in medical school at Harvard in the late 1960s.

The winner of the 2015 Lieber Prize for Outstanding Schizophrenia Research and twice (2006, 1999) a Distinguished Investigator, Dr. Freedman has been on the trail of what neuroscientists call inhibitory nerve cells that become vital in schizophrenia. Inhibition refers to the brain’s ability to dial down the strength of signals being exchanged among excitatory nerve cells. In schizophrenia, evidence suggests that an insufficiency in inhibition leads to hyperactivity in key areas involved in cognition and emotional processing.

Much of what Dr. Freedman and his colleagues have learned over decades has been translated into a simple and safe preventive strategy to bolster inhibition in the fetal brain, and thereby lessen the risk and perhaps actually prevent some newborns from developing schizophrenia—one of the great objectives in all medical research.

The strategy involves providing expectant mothers with supplements of choline, an essential nutrient that plays an outsized role in the fetal brain while it is developing in the womb. The fetal brain is hyperactive as it assembles itself. “It just fires up all of its nerve cells, no inhibition whatsoever,” Dr. Freedman says. “Of the 20,000 genes we humans have, more are devoted to building the brain than anything else. And most of them are most active—about tenfold more—before birth compared with after.”

Just before birth all this activity needs to quiet down, how-ever. “The brain is subsiding down,” Dr. Freedman explains. “This turns out to be the final step right before delivery, the last of five or six distinct steps which correspond with major changes in brain organization.” In each step, he says, “you not only get more memory and more function—as you do each time you upgrade your computer—you but also install a new operating system. In the early brain, each operating system is installed by the one that came before it.”

Dr. Freedman’s research focuses on one of the earliest operating systems, which unlike the others that follow it, “hangs around to do the very last installation.” This final step in the pre-birth developmental program makes normal inhibition possible.

Evidence shows that in infants who go on to develop schizophrenia, the brain’s inhibitory system does not establish itself as robustly as it should. The results are evident to those who treat and spend time with patients, including Dr. Freedman, still an active clinician.

“You may hear a patient say, ‘I vaguely overheard someone talking and I con- cluded they were talking about me, and that they were saying bad things.’ There is often a hyper-sensitivity to sound. When you investigate, the sound is really there, but misinterpreted. You or I would probably ignore it as noise, if we did hear it. We might say, ‘This is a noisy apartment.’ But we wouldn’t say, ‘And they’re talking about me.’”

A hypersensitivity to sensory information, accompanied by difficulty discriminating the nature or emotional salience of the information, is characteristic in schizophrenia. It can be traced biologically, at least in part, to a deficiency in inhibition. There is too much excitation, not enough inhibition—as, indeed, Dr. Freedman and colleagues showed in a schizophrenia study of the brain’s hippocampus, a vital center for emotional processing. Even in its “resting state,” this part of the brain is hyperactive in people with schizophrenia, the study showed.

Several converging lines of evidence have pointed Dr. Freedman to a gene called CHRNA7 (pronounced “CHUR-na 7”). Very active early in development, the gene quenches just down before birth to a low activity level that continues into adulthood. This is the gene, it turns out, that encodes receptors on nerve cells that become vital at the end of gestation, in the emergence of neural inhibition. The receptors are called alpha-7 nicotinic receptors, or a7 receptors.

CHRNA7 is a gene whose expression is most significantly decreased in the brains of people who have had schizophrenia (as measured in postmortem brain analysis). Genetic studies have also shown that a subset of schizophrenia patients have genomes in which the area on chromosome 15 containing CHRNA7 is deleted. They noted that they make enough α7 receptors.

In adults, a7 receptors are activated by a neurotransmitter called acetylcholine. In related research, Dr. Freedman and colleagues have been testing drugs that stimulate the α7 receptor in adults with schizophrenia—who, presumably, have had insufficient inhibitory activity from the time near birth when the system is first activated.

In the fetus, it is choline in the mother’s amniotic fluid that activates these receptors. Choline is needed throughout pregnancy in considerable amounts for various purposes, not only to prepare the brain’s inhibitory system but also to build the walls of cells throughout the body. Studies show whether giving expectant mother in five does not get enough choline in her diet. While meat and eggs are rich sources of the nutrient, which is also found in many other foods, poor diets do not supply nearly enough.

These facts led Dr. Freedman and colleagues to an experiment that has taken the last nine years to complete. They wanted to know whether increasing mothers extra choline in the second and third trimesters might help their children develop more robust inhibitory capacity. [The accompanying story explains how they conducted the experiment and showed that it works.]

“The larger story is that we’ve gone from learning ways in which the nervous system doesn’t work in schizophrenia to actually doing something to prevent it from happening,” says Dr. Freedman.

“This is the first group of children that we can point to and say, yes, we can treat earlier and do it effectively.”

Choline Supplementation in Mothers Has Yielded Positive Results in Children

“We know that babies born to moms who have schizophrenia, as well as babies from other mothers who later go on to de-velop schizophrenia, already have recogniz-able differences from babies who don’t carry that risk,” says Dr. Robert Freed- man. The problem, he notes, is that de-tecting these differences in the first years of life is not predictive of schizophrenia. All who develop the illness have biologi- cal differences from the beginning; but many infants with these differences don’t go on to become ill.

Freedman decided to focus on reversing the first definitive diag-nostic symptoms—typically, a first “psychotic break,” in the late teens or early 20s—it is already too late to prevent schizophrenia from occurring. Hence, Dr. Freedman’s strategy is to focus on reversing or blunting the first step in the multi-step process toward disease onset. “We thought that if we could bolster the brain’s inhibitory system even before a child is born, then perhaps we could lessen the risk that the other biological steps toward the illness would occur. We might even prevent the illness in some.”

His team demonstrated, first in rodents and then in people, that supplying choline in high doses to expectant mothers would suffice to activate the inhibitory system in the developing brain. They noted that the choline supplementation would bring the choline level up to levels others had measured in the amniotic fluid of healthy mothers. The team also heavily on medicine’s past success with another kind of prenatal supple-mentation—that of folic acid, another vital nutrient that expectant moms must have lest their infants suffer from neural tube defects and a variety of associated birth defects. Folic acid fortification, ide- ally begun before conception and con-tinued throughout the perinatal period, espe-cially in women with poor diets, is ac-cordingly recommended in the U.S. and worldwide.

Dr. Freedman, with critical help from Camille Hoffman, M.D., an assistant pro-fessor of maternal-fetal medicine, and Randal Ross, M.D., a professor of child psychiatry, both at the University of Colo-rado School of Medicine, took a parallel approach with choline. Led by Dr. Hoff-man, who was awarded the Foundation’s Sidney R. Baer Jr. Prize in 2015, the team recruited 100 healthy women from the Denver area. In a double-blind trial they tested whether giving choline supple-ments during pregnancy might stimulate the nutrient’s level in the amniotic fluid would enhance the development of inhibi-tion in the fetal brain’s cerebral cortex. The supplements (twice normal dietary levels) were given by pill, twice a day throughout the second and third trimesters, and then to mother and newborn through the third postnatal month.

Happily, there were no adverse effects in maternal health, delivery, birth or infant development. But did the supplements make any difference? Dr. Freedman’s team gave the newborns a crucial test after five weeks. Each child was exposed to identical sounds—a succession of clicks. The team measured the activity of the brain during this test. A baby or adult with normal inhibition responds much less robustly to the second sound, which is filtered out as comparatively insignificant. A sharp response to the second sound is what scien-tists call a “surrogate marker” of a defici-ency in inhibition.

This marker, called the P50 response, indicated normal inhibition in 76 percent of the infants whose mothers had been given choline supplements. In babies whose mothers received placebo instead of extra choline, only 43 percent had normal inhibition. That figure would likely have been lower if every mother in the trial, regardless of her treatment, had not received special instructions from visiting nurses to eat a diet rich in choline. (The aim was to compare choline supplementation with normal, not subpar, choline intake by the mother.)

The study showed, too, that choline supplements even benefitted the infants of see Supplements on page 34
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A new approach to treating schizophrenia is based on a revamping of the way patients are treated, relative to the onset of the illness. Spearheaded much of the new and more optimistic research on treating schizophrenia is an Australian doctor, Patrick McGorry. In 2015, the Foundation awarded its prestigious Lieber Prize for Outstanding Achievement in Schizophrenia Research to Dr. McGorry for efforts that has shifted the therapeutic paradigm for schizophrenia to early detection and intervention in young people.

Early intervention has resulted in some eye-opening results in Dr. McGorry’s research that have given hope to many. To cite one example, in a trial involving 661 patients with first-episode psychosis, published last September in Social Psychiatry and Psychiatric Epidemiology, Dr. McGorry and colleagues reported that 63 percent reached “symptomatic remission” and 44 percent reached “functional remission.” The latter signifies the ability to continue their illness, which was a new thing in the 1980s, and his efforts and political acumen have resulted in the creation in his city and in other nations in the intervening years, of mental health centers nationwide. These observations provided the impetus for mental health care geared to young people that might be considered revolutionary.

In order to detect and intervene early in young people who are at high risk of psychosis, or have begun to experience psychotic symptoms associated with schizophrenia, there needs to be a system of care that is ready to receive them, and that young people know about and are not afraid to access. In a nutshell, this has been the focus of Dr. McGorry’s work and a cause he has been laser-focused on since the 1980s, and his efforts and political acumen have resulted in the creation in his native Australia of a system of mental health care geared to young people that might be considered revolutionary.

We asked him how he came to the idea that psychosis occurs in several illness (including bipolar disorder and depression), although in a much smaller fraction of cases than in schizophrenia) that this meant the focus was on “the psychotich break,” but not the specific diagnosis of the individual. This would be an important aspect of the model that would emerge from his experimental treatment program.

“We noticed three things quickly,” Dr. McGorry recalls. “First, our first-episode patients were young — teenagers or young adults, in the majority of cases. Second, they had long delays in getting treatment. It was usually something like a suicide attempt or an aggressive incident or some other kind of crisis that propelled them into treatment — often under traumatic and draconian circumstances, with police and handcuffs, coercive measures, involuntary treatment. The third thing we noticed was that they were terrified, because they were being brought into a mental hospital surrounded by people who were middle-aged, with the most severe, disabling illnesses. And psychiatrists were telling them things like, ‘this is a terrible, devastating illness; you’ll never get better; your life will now be very different.’”

At this early stage in his career, Dr. McGorry was stopped in his tracks. “All of those things were absolutely shocking to me — that such things could be happening! I had decided to train in psychiatry because I wanted to do something positive. And yet, I saw that there was too much harm being done to patients.”

As time passed, he noticed a fourth theme. In his view, patients “were being given too to limit the harm by using very low doses of medication,” but was accompanied by efforts to address the developmental and social needs of patients, which were quite different from the needs of middle-aged chronic patients” receiving care in the hospital, he says.

At this early stage, the program was being run as a pilot at a chronic-care mental hospital in Melbourne. “But after a while we realized we needed to be based in the community, and using the hospital as a kind of backup system, rather than the other way around,” Dr. McGorry says. The result of moving into the community, to treat young people where they lived, led to the development of a program called EPICC, which was extensively described in papers published by McGorry and colleagues in the 1990s. A major success that has been adopted in other nations in the intervening years, EPICC begins with the premise that psychosis causes acute distress in young people experiencing it for the first time, as well as among their family and friends, and that treatment needs to be as consistently and intensively as you can, or as is necessary, according to disease stage, until the patient gets better or dies. That has saved a lot of lives. It’s also lengthened the lives of many people who would have died more quickly. In other words, cancer treatment is disease-modifying. Whereas, in the way that serious psychiatric illness is treated, there is often revolving-door neglect.”

Patients who lack insurance or the means to get first-rate care must access the public health system, where typically they “are patched up, episode to episode, but not maintained,” he explains.

In retrospect, Dr. McGorry says, “what we have been trying to do is apply principles established in the care of heart disease and cancer, to psychiatry. Once we ‘found’ our patients, we didn’t discard them after initial treatments. Can you imagine doing that in cancer? With cancer, there’s a premium on early diagnosis; that you treat needs to be an consistently and intensively as you can, or as is necessary, according to disease stage, until the patient gets better or dies. That has saved a lot of lives. It’s also lengthened the lives of many people who would have died more quickly. In other words, cancer treatment is disease-modifying. Whereas, in the way that serious psychiatric illness is treated, there is often revolving-door neglect.”

This situation, acknowledges Dr. McGorry, has a great deal to do with the failure of governments to effectively replace chronic long-term care in psychiatric hospitals with an effective community mental health system. Australia had very poor resources with which to deal with the psychiatric problems of the general public, that was growing, he said. “It was just too easy to find and treat people in their late adolescence and early adulthood, the time in life when so many mental illnesses begin to manifest.”

He has since received backing from various sectors, including Australia’s national government, to establish youth mental health centers nationwide. There has been too much change in the meaning of “headspace” clinics — and more are on the way. There is no publicly backed equivalent in the United States, although various localities in the U.S. and Europe have taken their patients, and even healthier systems along the lines of the headspace centers he has established back home.

“I think what our experiment has shown is that when we do for first-episode psychosis patients what is done for those with serious physical illnesses, you get similar results,” he says. “We’ve shown this not only with early intervention for psychosis, but also in extending this idea to a broader youth mental-health paradigm, one that applies to all the emerging disorders in teenagers and young adults.”

Making Recovery Possible: Treatment That Begins Before Diagnosis

In their still-growing Australian network of over 110 “headspace” clinics for youth mental health, Dr. Patrick McGorry and his colleagues are putting into practice ideas at the cutting edge of psychiatry, ideas that he hopes will eventually replace “flawed conceptions from the age of steam.” This means two things above all, Dr. McGorry said last year in remarks written to help commemorate the 30th anniversary of the Foundation. One is shifting the focus to early diagnosis; the other, which is related, involves beginning treatment during the earliest stages of illness, and even before a diagnosis is possible to make, in many cases. This shift in focus “has shown that the course of illness is plastic and can be greatly improved if timely, evidence-based care is provided,” Dr. McGorry said.

One thing he and his colleagues have learned in their headspace clinics is that treatment is most effective when it is begun early, even before a troubled youth enters the clinic. The treatment he is talking about usually begins before a diagnosis is determined. This has a profound implication: in Dr. McGorry’s view, the diagnostic categories that we are familiar with are often not even needed to begin helping a young person at high risk for mental illness or in the first stages of illness, no matter what the diagnosis might turn out to be.

“We have a staging model for care that has been very important. Some people have tried to develop such models based on the traditional diagnostic ‘ulots.' But those, we find, miss the whole point of staging, at least in the period when an illness is just beginning to emerge,” he says. “We found consistently that our patients had for care — they were distressed, their functioning was definitely suffering.”

Critics have charged that this approach can lead to over-diagnosis and overtreatment, and to the brain and to the person — to proper treatment for those with schizophrenia or bipolar disorder, which can take years to become clear enough to actually make the diagnosis. And by that time, in our experience, the person has already been in need of care for months or years.” Perhaps the most valuable insight to emerge from his clinical experience is that damage is done — to the brain and to the person — if proper treatment for those with schizophrenia or bipolar disorder is delayed for years. This is the best time to intervene.

see Improved Outcomes on page 34
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**Lifting the Veil on Neurons that Assign Good or Bad Associations to our Environment**
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**Kay M. Tye, Ph.D.**
Massachusetts Institute of Technology

**Bright Light Therapy for Mood Disorders including Bipolar Depression**
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**Dorothy Sit, M.D.**
Northwestern University

**Nicotine Receptors in the Brain: Implications for Addiction and Depression**
Tuesday, October 9th, 2:00PM EST

**Marina Picciotto, Ph.D.**
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**Pathways to New Treatments in Autism Spectrum Disorder**
Tuesday, November 13th, 2:00PM EST

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**Neuroimaging Inflammation in Depression and Obsessive Compulsive Disorder**
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A Performance Driven System of Care at NYS’s OASAS

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

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) envisions a performance-driven system of care, one that is adaptable to the changing needs of individuals with substance use disorder (SUD) and their families. A learning system that is integrated with healthcare, person-centered, utilizes the best addiction technology available and can prove its benefits to patients. This will require us to be able to track outcomes at an individual, program, network and system level so that we can target interventions and resources. In this article, I will give an overview of several of these projects with a broad update on each and the overall research plan.

LOCADTR

OASAS and the Center on Addiction worked extensively with the providers and payers to develop the LOCADTR 3.0 application. The LOCADTR is an algorithm for determining a recommendation for level of care for individuals in need of treatment based on a clinical assessment of current risks associated with use and the resources available to the individual in her or his community. The collective wisdom of everyone who participated in workgroups and testing of the tool has helped us to make a practical clinical tool that will have tremendous potential to inform policy, identify service gaps and identify factors impacting outcomes. To date we have a data base of over 830,000 completed LOCADTR assessments. We can connect 80% of individuals who had a LOCADTR to data in our statewide registry of treatment episodes (Client Data System) so we can study system performance, including capacity gaps in service needs and patient outcomes.

We recently published an article in The Journal of Behavioral Health Services and Research describing the development of the tool and its reliability. The paper was comprised of two studies: one in which 139 clinicians were tested for interrater reliability and the second study looked at the characteristics of system overrides to the initial LOCADTR recommendation. In the first study, we found acceptable interrater reliability (IRR = 0.57-0.59) in the administration of the LOCADTR. In the second study of nearly 390,000 LOCADTR administrations we found that clinicians changed the clinical algorithm determination in only 10% of the administrations. We will continue to study the LOCADTR data and make adjustments to the tool and/or our system of care informed by our analyses.

This year we rolled out a concurrent review tool to complement the LOCADTR using the same process with providers and payers to develop the tool. The concurrent review includes questions to determine the appropriateness of continued stay in the current level of care as well as guide clinicians through a process of documenting provision of care in accordance with the clinical practice guidelines.

The LOCADTR and Continuing Review tools provide a rich trove of data for examining treatment system gaps as well as performance. They provide data on an individual level that include: SUD symptoms, primary substance of focus, risks including medical and psychiatric, hazardous use patterns, interpersonal and intrapersonal patterns that interfere with recovery goals, and social, interpersonal, community and personal resources available to support recovery goals. Together with the admission and discharge information gathered, that includes data on admission and discharge disposition, criminal justice, mental health, medical, substance use and employment, we will be able to identify correlations between factors that relate to successful engagement and outcomes and support, and modify algorithms within the tool.

VBP Metrics

Our team at OASAS has been working closely with the Department of Health to establish a practical yet adequate set of metrics that will be included in forthcoming value-based purchasing (VBP) contracts. Metrics for VBP need to fit certain criteria: feasibility, parsimony, consistency with other healthcare metrics, and clinical meaningfulness. The challenge we face is that there are few national measures of effectiveness or quality of substance use treatment that have been validated. Given the current changes in the health care delivery system and the crisis facing the state due to the opioid crisis, we recognized the urgent need to develop and implement metrics. OASAS and the Center on Addiction worked with the Medicaid Clinical Advisory Group, Managed Care Plans, Providers and the Department of Health to more fully develop and implement several measures to support Value Based Purchasing arrangements. Some of these new measures assess whether patients continue in care after inpatient discharge, use of FDA approved medications, and retention in care. OASAS expects to extend their use to monitoring provider performance across payers. These measures have support in the literature and are process indicators that are correlated with outcomes. We recognize that work in this area is still very early and that metrics that are more focused on actual outcomes associated with treatment are needed.

Opioid Treatment CASCADE

Drawing from our work on VBP metrics and inspired by an article published by Williams and colleagues “To Battle the Opioid Overdose Epidemic, Deploy The ‘Cascade of Care’ Model” (Arthur Williams, Edward Nunes, Mark Olson, 2017), OASAS has developed a monitoring tool for tracking our treatment system progress in addressing the needs of those affected by opioid use disorders. The tool is based on a similar one that was developed for addressing the HIV/AIDS epidemic. The management tool shows performance on treatment indicators across different components of effective interventions, from identification of the disorder to retention in care for six months or longer. We will be able to use this tool to highlight gaps in care as well as track progress over time and for different regions and subgroups of people.

Treatment Progress Assessment Tool

The measures workgroup recommended that SUD treatment needed a tool to measure treatment progress that could inform clinical decision making, and also to establish a baseline and subsequent scores to measure individual and program level performance in treatment improvement. There is no Hemoglobin A1C measure for substance use. A toxicology report can determine if someone has used substances within a few days to weeks, individuals can report perception of care but we lack a practical, quick measure of response to treatment that is sensitive enough to capture changes that are indicative of progress.

see OASAS on page 38

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By Ann Marie Sullivan, MD
Commissioner
NYS Office of Mental Health

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he NYS Office of Mental Health (OMH) operates two institutes, making our psychiatric research program one of the largest in the country. We are proud of the work underway at the institutes, knowing that their continued clinical advances will improve the lives of New Yorkers, as well as people throughout this country and the world.

The OMH Institutes are the NYS Psychiatric Institute (PI), affiliated with Columbia, and the Nathan Kline Institute (NKI), affiliated with the NYU Langone School of Medicine. Dr. Jeffrey Lieberman directs PI and Dr. Donald Goff directs NKI. Both institutes report to the Office of Commissioner of OMH. Here are some highlights from each.

NYSPI
PI began as the New York State Pathological Institute in 1896. Since 1925, OMH has worked with Columbia University in an historic, public academic partnership. Psychiatrists, psychologists, social workers and nurses work closely together to conduct both basic and clinical research designed to better comprehend mental disease from the molecular level to the societal implications of mental disorders.

PI is an internationally recognized leader in psychiatric research, with 180 researchers who successfully competed last year for $119 million in federal government, foundation, pharmaceutical and other non-governmental sources to help reduce health and health care disparities in New York State and nationwide. We focus on six research initiatives: integration of physical and mental health services, access to language interpreters, culturally competent engagement, suicide prevention, mental health policy and social determinants of mental health, and first-episode psychosis.

Substance Use Disorders Research. PI is developing and disseminating innovative treatments for those suffering from substance use disorders. We are also working to combat the stigma of these conditions as well as training the next generation of addiction investigators and clinicians.

Researchers in this area are at the forefront of confronting the current opioid crisis. This includes: evaluating the abuse potential of novel pain medications (such as kappa opioid partial agonists and substance P antagonists), studying how an individual’s genetic make-up can be used to improve treatment outcomes, and partnering in national efforts to ensure that evidence-based interventions, which actually works for people with substance use disorders, are delivered to individuals and their families, across New York and throughout the country.

MIND Research Program
Molecular Imaging and Neuropathology
MIND applies neuroimaging to study how brain dysfunction can lead to mood disorders and suicidal behavior. MIND also leads the Silvio O. Conte Center for Suicide Prevention, the only such federally-funded suicide research center in the country. Its mission is to investigate the neurobiology of mood disorders and suicide risk, and development preventive strategies.

Psychiatric Disorders. The mission of this program is to advance our understanding of the causes, natural history, underlying pathology and treatment of schizophrenia and related psychotic disorders. One aspect of this research is to develop measures of violence potential for people with incipient psychotic disorders, including an instrument for violence assessment and a biomarker indicative of imminent potential for violence. In addition, this research seeks to align scientific investigation with the needs of public mental health programs and initiatives, as well as building research into the education programs and clinical services of the department and the OMH system of care.

Currently funded research in Psychotic Disorders is supported by 38 grants or contracts, including 24 NIH awards. The Center for Practice Innovation (CPI) provides extensive educational and training on evidence-based practices, what works for real-life settings, how to deliver it, and how to continuously improve services. The success of CPI is evident in that its work is being used in many other research programs.

CPI also oversees OnTrackNY, a 21-site program that is a national leader in the delivery of coordinated specialty care for individuals within two years of the onset of non-acute psychosis.

The Global Mental Health Program (GMHP) aims to reduce the burden of mental illness in under-resourced communities throughout the world. GMHP works closely with the World Health Organization (WHO) in conducting field studies and technical consultation to update the International Classification of Diseases (ICD), the diagnostic system used by all WHO member nations to capture public health data and set national health and mental health policies.

Last but not least, at PI is the new, groundbreaking, NIMH-sponsored center, “Optimizing and Personalizing interventions for people with schizophrenia Across the Lifespan” (OPAL). The OPAL Center will create an infrastructure to enable research that tests ways to accelerate the development and use, in real clinical settings, of effective, individualized treatments for schizophrenia.

In addition to the research areas described above, PI’s other research programs include: Neuroscience, to study how the brain works; Child and Adolescent Psychiatry, to advance child mental health; Epidemiology & Population Science, to identify what puts us at risk for mental illness; Gender, Sexuality and Health, to serve LGBT communities; Brain Aging and Mental Health, to study how age impacts mental health; Behavioral & Psychosomatic Medicine, to determine how medical illness affects our mental health; and Huntington’s Disease and Synucleinopathies, to understand the phenotypes of these diseases.

OMH on page 38
Deaths of Despair: Social Research Suggests Troubling Trends for the Next Generation of Older Adults

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

Recent social research suggests that the next generation of older adults may be more troubled than the current and previous generations. This, of course, is counterintuitive. 70 is the new 50, we say; 80 the new 60. We are living longer, and we are healthier, right?

Yes, but will the next generation be like this generation?

Anne Case and Angus Deaton—sociologists at Princeton University—and others writing about “deaths of despair” are predicting a significant increase in illness and disability in the next generation. Pursuing a totally different line of research, Julie Phillips—a sociologist at Rutgers University—is predicting a rise in suicide rates among future elder boomers.

Deaths of Despair

Case and Deaton’s research focuses on the fact that life expectancy in the United States has declined in the past few years, reversing a trend of longer life over several decades. This change is particularly surprising because death rates among older adults have continued to decline and

“deaths of despair,” as they have come to be called, are now the 5th leading cause of death in the United States.

It is tempting to believe that this is an historical blip due to the recession of 2007 and the years it has taken for economic recovery. But, Case and Deaton note, increasing death rates are unique to the United States. Other developed countries, which also were deeply affected by the recession, have continued to see death rates decline.

What is different in the United States?

Case and Deaton’s analysis focuses on “cumulative disadvantage” including the decline of job opportunities and stability for people with low education, declining rates of marriage due both to cultural changes and struggles with the economics of family life, declining connections with religion as a source of meaning, and more. In short, Case and Deaton see a kind of Durkheimian connection between rates of death and a lost sense of hopeful connection that white*, working class people have historically had with the American society.**

Issues For The Next Generation of Older Adults

But what does a rise in death rates among working age whites have to do with projections of increased illness and disability in the next generation of older adults? After all, those who have died will not become older.

Case and Deaton cite data that indicate that illness and disability (“morbidity”) are also on the rise in the working age population with high mortality. Self-reports on health surveys indicate that they perceive themselves in poorer health, in more pain, with more limits on activities of daily living, and with more emotional distress than in the past.

In addition, deaths due to overdoses, suicides, and alcohol related diseases are almost certainly just the tip of the iceberg. Many more people are addicted to drugs than who die from accidental overdoses. Many more people attempt suicide than complete it. And alcohol related diseases can persist well into old age. Epidemiological data already indicate increasing use, misuse, and abuse of alcohol and drugs among older adults.

Suicide

In general, suicide rates have been increasing in the United States since the end of the 20th century. But there has been a significant change in the population most at risk of suicide. Early in this

see Trends on page 36
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Consumer Perspectives: The Right Research

By Mike, Jamise, Janine, Michelle, Faith, Maya, Tanisha, Lisa K., Lisa M., and Robert, Tyler, S:US Consumers

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

Among the eleven of us who gathered together to discuss the topic of research in behavioral health from our perspectives, a few common experiences were shared. Our group included individuals of many different backgrounds, but most of us had been impacted by substance use addiction and mental illness. Most of us are currently living in an S:US residential treatment program or supported housing. While our understandings and involvement with research have varied, some telling themes emerged from our discussion about this topic.

A few of us shared that we had been involved in studies of various kinds – from sleep studies, to obesity studies, to smoking studies, to those that went further into our substance use and mental health histories. While some of us had heard of behavioral health research studies, most of us had not participated, and some of us were not aware that there was research into behavioral health, or what that even looked like. One of us recently participated in an NYU study meant to prepare people for outpatient treatment, which delved deeper into their family history of mental illness and substance use by exploring areas that were not discussed during standard counseling.

For those of us that had participated in research we had been motivated to participate as supplements to our own treatment, because we felt it would be beneficial to our own recovery and stability. As one of us stated, “I figured out that I couldn’t do it by myself, and I was putting myself in a place where I could have people around me that shared the same issues and get options from them that I didn’t already explore.” And, from our discussion, it seems that participation in research can provide benefits in addition to any positive outcomes of the studies themselves. One of us stated that participation, “was informative. It made me think outside of the box, provided me with more resources and options. Even if I didn’t feel that what they provided to me was what I needed, they always provided referrals so I could seek it elsewhere if I needed help.”

Even for those of us who have never participated in formal research studies ourselves, our discussion uncovered the ways that research, particularly in the field of substance use treatment, can potentially have real impacts on how services are delivered. This was most evident to those of us who have received services over several decades and have witnessed changes in how substance use treatment is delivered. One of us currently in substance use treatment pointed out how, years ago, a program they participated in had drinking privileges at the end of the week, permitted because at the time alcohol was not considered as harmful as the other drugs being used. But research and treatment experiences of people like us have since changed this approach. Treatment programs at that time also seemed to be harsher, based on the idea that, “If we knock you down to the ground, then we can build you up,” a contrast to the more support-based, person-centered services that are more common today, thanks again to changes in how service providers and researchers understand recovery. These shifts in service and treatment models are presumably the result of research and study over the last few decades, and have a profound impact on the lives of those in recovery.

As our discussion moved to this topic – the tangible impact that research can have on the way services are delivered – we began discussing areas we are curious about or feel would be helpful in our recovery. Although our conversation often focused on service needs as opposed to specific research areas, our discussion revealed that it is important to many of us that researchers listen and acknowledge treatment needs that are important to us. One area that had nearly unanimous favor among us was the idea of including a family intervention model in our treatment.

see The Right Research on page 38
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Treatment Recommendations for Post-Traumatic Stress Disorder: Lessons from Neuroimaging

By Amy Joscelyne, PhD, Medical Affairs Consultant; and Erin M. Falconer, PhD, Associate Director, Medical Affairs ODH, Inc.

This paper reviews current treatment recommendations for post-traumatic stress disorder (PTSD). We focus in particular on therapeutic interventions and how neuroimaging studies have informed treatment options.

PTSD can develop after exposure to potentially traumatic events such as assault, combat, disasters, and accidents. While approximately half the U.S. population will experience at least one potentially traumatic event in their lives, PTSD prevalence for American adults is estimated at 6.8 percent across the lifetime (Kessler et al., 2005a), and 3.5 percent over the past year (Kessler et al., 2005b).

Rates are much higher in certain populations such as combat veterans and refugees, with trauma exposure among veterans linked to alarmingly high suicide rates. In 2014, an average of 20 veterans died by suicide each day, accounting for 18 percent of all deaths by suicide in the U.S., despite only accounting for 8.5 percent of the population (U.S. Dept. of Veterans Affairs, 2016).

Individuals with PTSD may experience distressing memories of the event, heightened startle reactions, avoidance of certain situations, and sleep and concentration difficulties that can impair daily functioning. In light of the pervasive effects of trauma, further research is needed to help improve available treatment options.

Last year, the American Psychological Association released empirically-derived treatment guidelines for PTSD (APA, 2017), which strongly recommended the use of cognitive behavioral therapy (CBT) for PTSD; in particular, cognitive processing therapy (CPT), cognitive therapy (CT), and prolonged exposure (PE). Cognitive therapy focuses on modifying and replacing maladaptive thoughts, beliefs and expectations. CPT and PE involve processing trauma memories by going over, or exposing, the trauma narrative to enhance the individual’s ability to tolerate, rather than avoid, trauma memories.

Dysfunctional cognitions are often identified through this process as targets for intervention. The treatments outperform waitlist and treatment-as-usual in various randomized controlled trials of military-related PTSD (Steenkamp, 2015), with 49 – 70 percent of participants receiving CPT or PE experiencing clinically meaningful symptom improvement. However, approximately two-thirds of these individuals retained their diagnosis of PTSD even after treatment. It is possible that improvements would have been greater in civilian populations, given that combat veterans typically experience multiple traumas following deployments.

Current evidence indicates that the treatment for PTSD can be significantly improved by psychotherapeutic approaches alone. Regarding pharmacotherapy, the APA guidelines state that selective serotonin reuptake inhibitors (SSRIs) may be used. However, the U.S. Department of Veterans Affairs cautions that medications do not treat the underlying cause of PTSD symptomatology (U.S. Veteran’s Affairs, 2018) and therefore, psychotherapeutic interventions should be offered as first line treatment.

Neuroimaging studies provide one important avenue for improving PTSD interventions. To date, these studies suggest that psychological trauma leads to dysregulation of fear processing circuitry in the brain, as well as changes in brain structure (Erickson et al., 2014; Pagani and Cavallo, 2014). Clinicians may need training to understand, and be able to deliver, validated treatments that prevent or reverse these alterations in brain function.

Neuroimaging research on PTSD has mostly focused on circuits that are thought to be important for fear learning and extinction, including the ventromedial prefrontal cortex (PFC), which has an inhibitory influence on the amygdala, a brain structure associated with emotional control in the fear processing network. Taken together, these areas are important in fear learning and extinction, as well as the hippocampus which is important in declarative memory (Erickson et al., 2014).

Importantly, neuroimaging studies have shown that successful exposure-based cognitive behavioral therapy can impact the neurophysiology of PTSD (Felmingham et al, 2007). In other words, successful CBT treatment not only can reduce PTSD symptoms, but also may improve the brain’s ability to regulate fear processing as evidenced by changes in neural fear processing networks. It is critical to understand that successfully treating PTSD using psychotherapeutic approaches can clearly impact the physiology in the brain that underlies PTSD symptoms. To our knowledge, there is no such similar evidence supporting neural change with medication (SSRI) treatment in PTSD patients.

Moreover, the largest obstacles to treatment is the stigma surrounding mental health issues. This may be particularly true for certain populations such as military veterans. Innovative research is attempting to overcome this challenge by exploring other avenues for the collection of trauma-related data. For instance, one study found that service members disclose their PTSD symptoms more fully when they anonymously answer Post-Deployment Health Assessment (PDHA) questionnaires, compared to the official PDHA administered by the military which is tied to their identity (Lucas et al., 2017). This study also examined the use of automated virtual reality humans that interview people about their symptoms and found that active-duty service members reported more symptoms to a virtual human interviewer, compared to an anonymized PDHA.

In summary, while promising and somewhat effective treatments for PTSD do exist, these interventions may benefit from ongoing innovations made possible by advances in neuroimaging and technology-supported approaches to managing PTSD.
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Permanenr Supportive Housing: The State of the Research

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

Researc her compiled a host of methods at their disposal with which to assess the efficacy of service interventions and to establish the foundations on which evidenced-based practices are based. Some of these methods, such as the randomized Controlled Trial (RCT) (arguably the most potent of instruments in the empiricist’s toolbox), have rarely been applied outside the rarefied realm of medical research and were heretofore unavailable to practitioners within the social sciences. In recent years, however, more robust and rigorous analyses of social service interventions have emerged in the research literature. These provide stakeholders with the information needed to render objective appraisals of publicly-funded programs and to direct scarce resources accordingly. Permanent Supportive Housing (PSH) is one of many targets of increasingly sophisticated investigations within the realm of social services, as it is presumed to hold great promise for many of society’s most vulnerable individuals. A survey of research to date suggests this presumption is largely correct, although additional studies are needed to elucidate the mechanisms through which PSH exerts its salutary effects and to identify the populations for whom it may provide the greatest benefit.

It is generally impractical, and often unethical, to apply RCTs or similarly rigorous analyses to interventions that affect human subjects in natural settings, as subjects assigned to “control” groups in RCTs are necessarily denied potentially beneficial interventions available to “treatment” group participants. Nevertheless, some researchers have managed to overcome this challenge through the use of Randomized Controlled Trials (RCTs) of PSH through which subjects were assigned to “treatment” groups (i.e., placement in PSH with associated support services) or “usual care” groups (i.e., placement in other temporary or transitional residential settings as are customarily available to homeless and vulnerable persons). One study examined a sample of 405 homeless individuals, 201 of whom were assigned to a treatment group and 204 of whom were assigned to a control group, in order to determine the impact of PSH on treatment group members’ utilization of inpatient hospital and emergency department services (Sadowski et al., 2009). These researchers applied a variety of controls characteristic of RCTs and necessary to mitigate the impact of potentially confounding variables. For instance, subjects were randomly assigned to treatment and control groups, practitioners associated with the project remained “blind” to subjects’ group designations and a variety of demographic variables were evaluated in order to ensure relative uniformity among groups.

This study found the provision of PSH and support services resulted in fewer hospital days and emergency department visits among its recipients during a 12-month survey period (Sadowski et al., 2009). Other investigators offered a qualified endorsement of these findings through a comprehensive review and meta-analysis of the research literature, but they suggest more rigorous examinations are needed to bolster the evidence base for PSH (Rog et al., 2014). These authors cited certain deficiencies in the literature due to methodological limitations associated with naturalistic observation (a mode of investigation commonly used in the social sciences that cannot control for potentially confounding variables as rigorously as RCT or other “laboratory-based” approaches). The authors cited additional concerns about the current state of research on PSH, including inconsistencies in the operational definitions of housing models and their associated service interventions, small sample sizes and ill-defined subject selection criteria, among others. These factors compromise the validity of any conclusions that may be drawn and suggest a need for greater methodological rigor. These deficiencies notwithstanding, the authors concluded a “moderate” level of evidence indicates PSH promotes housing stability and reduces homelessness among its recipients. These findings were consistent among studies they surveyed irrespective of sampling and procedural variations and other methodological differences (Rog et al., 2014).

Another team of investigators employed a sophisticated epidemiological analysis in the development of a predictive modeling tool designed to boost the efficiency with which PSH services are provided (Toro & Flaming, 2018). These authors acknowledge the prevalence of homelessness among individuals with disabilities and a paucity of PSH resources available to them, and they suggest predictive modeling would enable stakeholders to identify individuals for whom PSH might provide the greatest benefit and to allocate scarce resources accordingly. They surveyed demographic data and health and social service utilization records for 57,259 individuals during a two-year period and developed an algorithm that identified 1,000 members of this cohort for whom health and social service expenditures would be greatest in the following year. Inasmuch as predictive modeling is inexact its application invariably entails a trade-off between the most costly cohort of Medicaid recipients, but these reforms would surely have benefited from sophisticated predictive modeling technologies that accurately identify the subsets of chronically homeless individuals that incur the greatest costs.

As a variety of transformative efforts presently underway aim to replace fee-for-service reimbursement systems with value-based alternatives, payers, policymakers and other stakeholders will seek sophisticated technologies with which to allocate scarce resources to those for whom the need (and potential savings) is greatest. The tools of the empiricists’ trade, including systematic observation, experimentation and predictive modeling, will surely prove invaluable to this endeavor. We should expect them to play an increasingly prominent role in cultivating the evidence basis for PSH and other social service interventions.

Located in Valhalla, New York, Search for Change is dedicated to improving the quality of life and increasing the self-sufficiency of individuals with emotional, social, and economic barriers. We teach the skills needed to choose, obtain and maintain desirable housing, meaningful employment, higher education and productive relationships with family and friends. Our programs and services are focused on individual choices, needs, interests and abilities. The author may be reached at (914) 428-5600 (9228) or by email at abrody@searchforchange.org.

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

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By Jorge R. Petit, MD, President and CEO, and Barry Granek, LMHC, Senior Director, Pathway Home Coordinated Behavioral Care

Community-based behavioral health organizations and the individuals they serve would benefit from embracing new media and digital technologies. Technology-assisted care allows providers an additional set of tools to supplement engagement and establish more meaningful lines of communication. With the expansion of audio, video, mobile and other digital devices and/or multimedia programs, we are seeing this technology shift in all sectors of healthcare, including behavioral health. Organizational tools, apps and communication systems that utilize innovative technology allow healthcare workers to be better attuned to customer needs, with increased information and in real time; boosting patient engagement, leveraging support systems and providing critical cost and time saving advantages.

The rising need for services for those with Serious Mental Illnesses (SMI) that is accessible, less expensive, and more effective, highlights the needs for more intensive and innovative communications strategies to change health behaviors and manage chronic conditions, than our current system of weekly/monthly visits permit. Utilizing novel and innovative technology may be the only solution to reach more people. These resources can allow healthcare workers to reduce the reaction time and distance, enabling the human touch when otherwise unavailable. These tools are not meant to replace face to face visits, rather supplement, enhance, and offer added choice in how one elects to engage with their healthcare providers. These technologies can better address treatment gaps, facilitating access and linkages to needed services, overcome geographic and transportation barriers, foster engagement by enabling anonymity as well as decreasing stigma about accessing behavioral health services. For providers there is a growing body of evidence that these technologies offer more real-time access to critical information about the patients, makes managing caseloads more efficient and effective and potentially freeing clinician time to better address patients with more intensive needs.

Coordinated Behavioral Care’s Pathway Home (PH) Program draws on creative approaches to deliver community-based care, including advances in technology-assisted care. PH has started using texting, videoconferencing, ridesharing, and other mobile tools to support treatment adherence and to prepare staff for the changing realities of a more technologically integrated exchange between the individuals we serve and providers.

For the PH teams, meeting with individuals frequently and on an as needed basis is essential to ensure improved connectivity and ultimately engagement in services with consequent improved health outcomes. It is not uncommon for individuals in a PH Team to receive multiple weekly and at times daily visits. PH staff use phone calls or other means of communication to supplement and offer support in between more traditional visits. Nevertheless, there can remain large gaps of time between contacts where urgent matters can arise or even a small gesture of...
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Doris has been living in her studio apartment in the Crown Heights section of Brooklyn for the past 15 years. She obtained this apartment after finding herself homeless following the breakup of her marriage and other stressors she was experiencing. Doris is quite humble as she describes how her agency has supported her in so many ways. Yet today, she finds herself feeling anxious and worried about her future. Doris reports her third-floor walk-up studio is adorned with lovely family memorabilia which include pictures of her mother and two children, Thomas, 31, and Mary, 27. She reports not knowing her maternal father, and has one sister, Margaret whom she speaks to every now and then. Doris is 54 years old and has had various jobs throughout her life and was in a committed marriage for 12 years. Doris reported her husband cheated on her which caused her to go into a “dark place”. She said that she started drinking at the time and found herself unable to manage her finances and was eventually evicted. Sadly, she told me that her children blamed her for the family break up.

Her apartment is under the auspices of a large social service agency that houses individuals with a wide range of needs including many with a diagnosis of serious mental illness. Doris reports her apartment feels homey. She takes great pride in her ability to cook and says she enjoys sewing and her cat, Leo. Doris explains that her sister always encouraged her to go to counseling because her sister noticed some changes in Doris’s behavior. Truth be told, Doris admitted that she was becoming increasingly sad and that she started self-medicating with alcohol. Doris enjoys her visits with her Supportive Housing Case Manager. She described him as caring and that while she was initially reluctant to open up, she found herself having very few people in her life with whom she can connect with. Distrust of various systems can compromise a person’s sense of control, choice and efficacy and lead to poor health outcomes. For Doris to feel socially connected, the experiences must be accompanied with a sense of stability, safety and trust.

Doris’s Case Manager began to encourage her to seek counseling after noticing her sluggish behavior. According to her Case Manager, Doris often appeared morose and detached and this concerned him. Since she started coming to see me for psychotherapy she admitted she spends much of the time in her apartment alone. She admitted that she hadn’t spoken to her children in many years. Her youngest son, Thomas, has been incarcerated for the past six years on a drug conviction and her daughter, Mary, recently got married and moved to another state. She shared with me that she has been estranged from her daughter for many years and says there are many reasons for this. Many of our sessions together focused on how Doris felt her husband was emotionally unavailable. She said that they were rarely intimate with each other. Doris felt conflicted at the idea of married and devoid of social connectedness. Mutuality is important for a healthy relationship. These factors enable social connections to develop and help to offset negative health outcomes. She also said that her relationships with her children became increasingly strained as she felt a sense of malaise and emptiness. After obtaining this family history, I felt it was important to focus on Doris’s strengths and interests. Doris shared that she used to love going to church services but that she now finds the commute increasingly difficult. Together we have explored finding a closer church but Doris expressed ambivalence and increased helplessness. As people age, their social support networks often become smaller and their social ties lessen.

It should be noted that when obtaining her history, Doris shared that she was hospitalized twice; once after she lost her job in her 40s and shortly after her marriage ended. She said that she could not get out of bed after this loss and that she felt increasingly paralyzed. While she was given medication at the time, she admitted she did not take it because it conflicted with some of her religious beliefs. Doris did say she soon began to feel better through worship and eventually obtained a part-time clerical position. Doris and I agreed that her religious and spiritual activities were clearly important to her and we began to examine some of the underly- ing causes of her sadness and what we would later classify as depression. Doris admitted her mother was a heavy drinker and her home environment was often volatile. Doris would often hide in her room growing up and found great solace reading scripture. There were times where Doris even talked about certain passages of the bible that gave her comfort. While I initially felt ambivalent having such dis- cussions I recognized they were important to Doris so we continued to pursue them. Studies have shown that religion or spiri- tuality are effective in helping individuals cope with major life stressors such as ill- ness, divorce, or mental illness (Harvey & Silverman, Journal of Cross Cultural Ger- ontology, 2007). Religious or spiritual be- liefs can provide a sense of meaning and connectedness especially to individuals

Social Isolation: A Solution-Focused Approach

By Elisa Chow, PhD, Director, Innovations, Outcomes Evaluation; and David Kamnitzer, LCSW-R, Chief Clinical Officer/Senior Vice President ICL

Elisa Chow, PhD

David Kamnitzer, LCSW-R

with the least amount of resources who are encountering difficult life circumstances.

Vincent is a 62-year-old male living in the Williamsbridge section of the Bronx. Recent studies have categorized and referred to a CR/SRO as he found himself home- less with no support. Vincent lived with his parents, Joseph, 86, and Maria, 84 until their death. Vincent was never married, but takes great pride in talking about working in his family restaurant for over 50 years. He completed 10th grade. He said he found it hard to concentrate in the classroom and remembers getting into trouble often.

He reported that he felt great joy in joining his three siblings who also worked in the family business. It should be noted that Vincent is the youngest of four sib- lings. His two brothers, Angelo and John, are both married and each have children and grandchildren of their own. His sister, Theresa, is also married with children. Vincent talks about his relationships with his nuclear family with a sense of longing. While he reports they spend Christmas and Easter together he admitted that it is difficult to visit them due to his complex medical issues and what he now calls being labeled as the “crazy one”. He reported having diabetes, hypertension, and obesity. Vincent spoke quite openly about being over 400 pounds but never saw this as a problem. Eventually it was at the recommendation and urging of his pri- mary care physician and Case Manager that Vincent decided to see me. Vincent reported his doctor felt his obesity may be tied to some underlying issues. Health effects impacted by social isolation have been known for some time. Recent evi- dence indicates that there is an association between a lack of social connectedness, obesity and diabetes (Nonogaki, Nozue & Oka, Endocrinology, 2007)

During our initial sessions together, Vincent said that he was often bullied in school and never had many friends. While he did admit to feeling different from others, he never felt he had a problem. After school he would immediately go to his family’s restaurant. There he would be smothered with attention by his “Nona” who would have an abundance of food waiting. He said that it was a joyous time being in the restaurant and that school was never a priority. Taking care of Vincent’s parents was also something that he spoke a lot about in our sessions. Vincent vacillated between feelings of guilt and admira- ration. At times it seemed as if the roles were being reversed. Clearly Vincent par- ents were quite worried about him and his lack of fundamental life skills. Moreover, there were clear indications that Vincent’s parents adored him and fostered a type of co- dependency that may have in fact pre- vented Vincent from moving forward. He wondered why most of his siblings were rarely available. At times Vincent said he felt tired after being in the restaurant. He did admit that his sister Theresa was his favorite sibling and it was she who first recommended that Vincent seek counsel- ing. At age 20, Vincent reported to Theresa that he was hearing voices coming from the television and that he felt scared leaving home. He was hospital- ized in his early 20s and prescribed medica- tions for what was eventually labeled as paranoid schizophrenia.

My work with Doris and Vincent was similar in that they were both interested in attaining goals related to their housing, integrated health and social connected- ness. Today, health care professionals often refer to these factors as social determi- nants of health and it’s noteworthy to highlight components that contribute to positive outcomes.

• Collaborative partnerships such as Health Home Care Coordination, regular commu- nication with housing providers, on-going dialogues with both behavioral health and primary care professionals, and discus- sions with natural supports such as friends, families, clergy/spiritual leaders.

• HCBS (Home and Community-Based Services cover a myriad of skills development, activities that can benefit the overall health and well-being of people served. These include Community Support and Treatment, Peer Support Services, and Habilitation Services.

• Therapy Models – there are a number of effective treatment interventions that may assist with social isolation. As discussed in the aforementioned vignettes, one may consider a strengths-based approach to treatment, wellness self-management, family systems psychotherapy, and grief/ bereavement counseling.

Social isolation is a growing concern in today’s society and it is noteworthy that people with a diagnosis of serious mental illness often die 25 years earlier than the general population. At ICL, this has played a significant role in the way we approach care. Social isolation or having few social contacts has significant health implications on one’s overall health. For example, Case Managers are trained to pay equal attention to both behavioral health symptoms as well as medical condi- tions. Moreover, there is recommended when considering review of risk, that staff maintain an integrated health lens.

Social isolation is different from lone- liness although they are intricately linked. Social isolation is defined by the level of social connections such as social networks, infrequent social interaction,
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The Guidance Center of Brooklyn works specifically with individuals who have experienced their first psychotic break between the ages of 14 and 30. GCB also operates On-Site School Programs that provide mental health treatment by trained clinicians for children in designated public schools. Clinicians work closely with children, parents, and teachers to address behavioral and emotional issues that impact a student’s ability to perform well in school and social situations.

Highland Park Center and Rockaway Parkway Center both offer integrated physical and behavioral health care on-site. HPC and RPC both strive to help consumers gain control of their lives and live to their fullest potential. Both clinics serve everyone from school-age children to seniors with individual, family, and group counseling.

All of ICL’s clinics are staffed by experienced, culturally humble licensed professionals and offer a variety of individualized and recovery-oriented services.
I am excited about this edition of Behavioral Health News, “Spotlight on Research Honoring the Brain & Behavior Research Foundation.” As President and CEO of the Foundation, I have the privilege of working with outstanding scientists and generous donors who are collaborating to develop new treatments, cures and methods of prevention for psychiatric illnesses. I am also honored to begin to serve as President of the New York State Psychiatric Association (NYSPA) and want to share with you some of the reasons why NYSPA plays such an important role for people who live with mental illness.

On a national level, NYSPA serves a significant role in terms of the advocacy work being done by the American Psychiatric Association, including issues related to parity, access to care, and the criminal justice system and mental health. We are also very active in New York State. NYSPA regularly advocates on behalf of our members and their patients with respect to parity enforcement and implementation efforts. NYSPA has been integral in the introduction of the Mental Health and Substance Use Disorder Parity Reporting Compliance bill, legislation that would require the New York State Department of Financial Services to include in its annual Consumer Guide information measuring insurers’ and health plans’ compliance with parity statutes. If enacted, this legislation would represent a valuable step forward in ensuring full enforcement of the parity laws. I am pleased to report that the bill was passed by the New York State Assembly this June and has been delivered to the Senate for its consideration.

NYSPA continues its Veterans Mental Health - Primary Care Training Initiative (VMH-PCTI), a program funded by the New York State Legislature that provides education and training to physicians and other health care professionals on combat-related mental health disorders, including post-traumatic stress disorder, traumatic brain injury, and substance use disorders, as well as information on suicide prevention and military culture. To date, the VMH-PCTI has trained more than 600 primary care physicians and providers on combat-related mental health disorders.

NYSPA continues to advocate for a statutory prohibition on the provision of so-called “Conversion Therapy” to individuals less than 18 years of age. This bill would prohibit a mental health professional from engaging in efforts to change a minor’s sexual orientation and would define any such efforts as professional misconduct that would subject the provider to discipline by the provider’s licensing entity.

We will continue to advocate in support of the mental health of all New Yorkers and always appreciate any suggestions or ideas from you, the readers of this column.
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Coordinated Behavioral Care Wins Prestigious Heritage Healthcare Organizational Leadership Award

By Staff Writer
Behavioral Health News

C oordinated Behavioral Care (CBC) has won the prestigious Heritage Healthcare Organizational Leadership Award at the 3rd Annual Heritage Healthcare Innovation Awards sponsored by Heritage Provider Network and Crain’s New York Business. CBC was among an incredible group of honorees for this award, including Healthfirst, Mount Sinai Hospital System and Essen Health Care.

The event was very well attended and there were some amazing honorees in the different categories. CBC had also been nominated but did not win the Heritage Innovation in Healthcare Delivery Award for their Pathway Home program.

This was an acknowledgment that CBC and the member agencies that make up the Health Home and the IPA are embarking on a transformative path. Being a clinically integrated delivery system that will be able to leverage the full array of community-based services and programs offered within their 50 network providers, whether they be health or behavioral or housing, was recognized as a transformative trend that will close gaps in services and increase access to high quality programs for all New Yorkers.

In accepting the award, CBC President and CEO, Jorge R. Petit, MD, highlighted the importance of not-for-profit, behavioral health organizations in being honored and stressed the importance of having a spotlight shine on the work that these organization’s do day-in and day-out to care for New Yorkers with serious behavioral health conditions.

CBC and its member agencies are continuing to develop needed ambulatory services, improve on the existing service array within the traditional framework and are working closely with the State and payers to envision a new paradigm of behavioral healthcare that promotes value and outcomes.

Depression, Suicide, Discrimination and Parity

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

I n the immediate aftermath of the suicides of Kate Spade and Anthony Bourdain Gov. Cuomo issued a press release about new funding to address the rising rate of suicide.

He stated: “Two high-profile suicides this week put mental illness front and center, but while those names were the ones in the press, every day there are thousands of New Yorkers who struggle with suicidal thoughts, and we must do everything we can to support them. Depression does not discriminate. It affects every part of society and people from all walks of life.”

I applaud the Governor for bringing this matter to light. He stated, “Depression does not discriminate.” Nevertheless, health insurers that do not comply with federal parity law, denying timely access to care, do discriminate. When New York State government does not enforce this law, they aid and abet discrimination against the “thousands of New Yorkers,” who the Governor referred to as these “who struggle with suicidal thoughts”.

The difficulty people have accessing mental health and addiction care is not simply a matter of stigma. It is a matter of discrimination. This is a civil rights issue that an announcement of new funding alone will not solve.

On December 15, 2017, North Shore Child and Family Guidance Center held a press conference at its headquarters in Roslyn Heights and issued the results of a research study – Project Access that we conducted in collaboration with LIU Post Department of Social Work. In this year-long study, hundreds of Long Islanders were surveyed about their experiences attempting to obtain help for mental health and addiction problems. Of the 650 Long Islanders who took part in the survey, almost half said that it was more difficult finding help for mental health or substance abuse problems than finding help for physical illnesses, nearly 40 percent said that their insurance company did not have an adequate number of providers and two-thirds said that their insurance company was not helpful to them in finding a suitable provider for themselves or a loved one.

NY State Senator Todd Kaminsky, who attended the December 15th press conference, stated that the findings were “Dismaying.” In a bipartisan effort, Kaminisky and Senator Elaine Phillips wrote to the Department of Financial Services (DFS) on January 9, 2018 citing the Project Access study and requesting “a thorough investigation to determine why insurance companies are not being held accountable for network adequacy.” Network adequacy is the part of the federal parity law that states that health insurers who cover mental health and addiction care must have an adequate number of providers in their network. Many more people wrote directly to the Governor, speaking their minds. Many more people wrote directly to the Governor, speaking their minds.

Almost five months later Scott Fischer, Executive Deputy Superintendent for Insurance, a division of DFS, responded in writing to the Senators. Fischer wrote: “DFS’s review of the various networks confirmed that each of the insurance companies in Long Island exceeds the standards for mental health and substance use providers, for the purpose of the commercial products sold outside of New York State.”

Translation: There is no problem. There is nothing more to do. This does not square with the results of Project Access. Health insurers and government ignoring federal parity law is discrimination. When it comes to suicide prevention: access delayed, is access denied.

Discrimination deserves a place alongside stigma when the conversation turns to access to care. It’s a matter of civil rights.

Long after the tragic deaths of Kate Spade and Anthony Bourdain fade from the front pages, the lack of compliance and enforcement of federal parity law will persist and the thousands of people that the Governor spoke of in his press release will still be unable to access care.

The North Shore Child & Family Guidance Center provides comprehensive mental health services for children from birth through 24 and their families. To find out more, visit www.northshorechildguidance.org. To read more about Project Access go to: www.northshorechildguidance.org/wp-content/uploads/2017/12/north-shore-project-access.pdf
The grand opening and ribbon cutting ceremony of Lynn’s Place, the much anticipated first affordable mixed-income development created by Unique People Services (UPS) took place on May 11, 2018.

Ann Sullivan, Commissioner of NYS Office of Mental Health, Emily Lehman, Assistant Commissioner of the NYC Department of Housing Preservation and Development, Kristen Miller, Center from Supportive Housing, former NYC City Council Speaker Melissa Mark Viverito and Assemblyman and Vice Chair of the Democratic Party Michael Blake and various community stakeholders were in attendance. A special presentation was also made to key stakeholders as appreciation of their involvement in the project.

“As the Chair of the Committee on Mental Health, Disabilities, and Addiction, I would like to thank Unique People Services for their commitment to supporting individuals with mental health conditions, said Councilperson Diana Ayala. “Mental health has been stigmatized in our communities for generations. This stigma, coupled with lack of resources in underserved neighborhoods, has caused people to go without treatment for far too long. She further stated, “that is why organizations such as Unique People Services are so important.”

Lynn’s Place, named after the organizations founder Lynn Wonsang provides homes for a mix of formerly homeless individuals and low income families. During the event, a Lynn’s Place tenant shared, “I am grateful for the services provided by UPS—I finally have a home, where I can be myself and not worry about the negative stigma and effects of homelessness. I’m happier than I’ve ever been and it’s all because of UPS.”

The sentiment of the day echoed the role collaboration. “Everyone here today is a UPS champion and a true testament that the key to this new day in the history of our organization is collaboration. Collaboration and dedication to the people we serve today and tomorrow” stated Yvette B. Andre, Executive Director of Unique People Services. “This accomplishment would not be possible without the generosity of our partners and stakeholders. All of them are such great examples of what creative collaboration can achieve.”

Unique People Services provides vital resources to a wide range of programs and projects that are effective in the fight to end homelessness. Lynn’s Place is their first affordable mixed-income development and provides safe and affordable housing to individuals from all walks of life with varied circumstances.

Lynn’s Place features 69 units of housing, with 42 units of supportive housing for individuals with a mental illness and 27 units of affordable housing for individuals and families making less than 60% AMI. Lynn’s Place earned LEED for Homes v3 Gold certification from the US Green Building Council, as well as the ENERGY STAR Multifamily High Rise label, demonstrating a commitment to providing efficient, healthy housing that is good for the environment and residents alike. The development
Outreach Appoints Debra Pantin New President and CEO
Kathleen Riddle to Step Down After Almost 40 Years

By Staff Writer
Behavioral Health News

Outreach has announced a change of leadership. After 39 years, Kathleen Riddle, founder, president and CEO of the non-profit substance abuse treatment organization based New York City and Long Island, will retire. Taking over as president and CEO will be Debra Pantin, formerly CEO of VIP Community Services in the Bronx.

During her leadership tenure at Outreach – which began with a Glendale, Queens storefront, three employees and a $60,000 budget – Riddle grew the agency into a nationally recognized organization with eight primary locations, 300 employees and a budget of $24 million, serving more than 4,000 people per year. In addition, she became one of New York State’s leading advocates for alcohol and drug treatment services, primarily through her efforts as a leader in the New York State Association of Alcoholism and Substance Abuse Providers (ASAP) and Therapeutic Communities of Association (TCA) of New York, both for which she served as president for many years and continues to serve on the executive board. She has also served on the board of Treatment Communities of America as an officer.

“Kathy Riddle is an icon in this area of behavioral health,” said Pantin. “It will be a challenge to fill her role at Outreach, but I vow to continue the fight to recognize treatment as critical measure to address the life challenges stemming from addiction and allow people and their families to recover and move on to healthy lives. This is especially important, at a time when opiate abuse is such a widespread problem in New York State and beyond. My challenge will be to fight for more treatment slots, more funding and more recognition for treatment as an alternative to incarceration, which we know is better for families and society as whole.”

Riddle, who will continue to serve Outreach in a part-time, advisory role, worked tirelessly for support for treatment facilities throughout the state. Her vision began more than 40 years ago when she recognized the need for adolescent treatment while working in the New York City school system as a drug counselor. Through her early efforts, Outreach opened the first residential substance abuse facility to serve children as young as 12 years old. She continued on to start niche programs for adolescents (outpatient and residential), women, women with children, and adults. Riddle also helped create the Outreach Training Institute to allow for more Certified Alcohol and Substance Abuse Counselors to enter the treatment workforce, while also providing professional development opportunities to those already in the field. She became a regular in Albany, working with OAAS and legislators to increase recognition for substance abuse treatment. Rallying the construction and real estate industry and trades to assist with the building of treatment facilities in Queens and on Long Island, Outreach continues to grow, with several capital projects underway.

“It is with mixed emotion, joy, pride, sadness and relief that I step back from my lead role at Outreach,” said Riddle. “Serving as the leader of this incredible organization has been the greatest honor of my life. This decision, while difficult for any of us, is made easier by knowing the extraordinary capabilities and commitment of our Boards of Directors, our leadership and staff. If it further aided by the selection of an exceptional leader in the field, Debra Pantin.”

Debra Pantin, MSW, MS, has more than 30 years of experience in the fields of addiction and mental health treatment services, housing and homeless services, and health care, beginning as a practitioner and later as a leader in establishing programs. At VIP, she successfully propelled the organization that provides comprehensive health and behavioral health services in the Bronx toward a model of integrated care. During her tenure, to name a few of her accomplishments, VIP opened a mental health clinic and transformed its health services into a Federally-Qualified see Outreach on page 38

MHNE Announces New Board Officers and Outgoing Members

By Staff Writer
Behavioral Health News

Mental Health News Education (MHNE), publisher of Behavioral Health News and Autism Spectrum News, is pleased to announce the slate of Officers for the 2018-2019 fiscal year. “On behalf of our entire Board, I wish to thank everyone for their continued support and participation,” stated Ira Minot, Executive Director, and publisher of Behavioral Health News.

Debra Pantin, the new President and CEO of Outreach and past Vice-Chair of MHNE, will be the new Chair of the Board of Directors. Outgoing Board Chair Constance Brown-Bellamy, President of Brown-Bell Consulting stated, “I have served on the MHNE Board since 2008 and as Chair for the past two years, and I will continue as an active Member of the Board. It has been a remarkable experience for me to see MHNE grow in its mission of providing a trusted source of behavioral health and autism education to the community.”

Rachel Fernbach, Esq., Deputy Director and Assistant General Counsel for the New York State Psychiatric Association, will succeed Debra Pantin as Vice-Chair of the MHNE Board. David Minot, Associate Director and publisher of Autism Spectrum News stated, “We are so pleased to announce that Rachel Fernbach will step into the Vice-Chair position. Rachel has been on the MHNE Board since 2016. Her expertise in nonprofit governance and operation will be an asset to the organization during our period of growth and change over the next few years, as well as our affiliation with the New York State Psychiatric Association.”

The remaining officers, both of whom will be serving their second terms, include: Yvette Brissett-André, Executive Director of Unique People Services, who will continue to serve as Secretary; and Kimberly Williams, MSW, President of Vibrant Emotional Health (previously the MHA of NYC), who will continue to serve as Treasurer of MHNE. Continuing their vital service as members of the Board are Josh Rubin, Jonathan Edwards, Barry Perlman, Peter Beitchman, and Jorge Petit.

We have two 15-year founding Board Members who will be stepping down from the Board: Alan Trager, who recently retired as Executive Director and CEO of Westchester Jewish Community Services (WJCS) and Peg Moran, a well-known leader of the behavioral health community. Ira Minot stated, “It is with sadness and joy that we say goodbye to dear friends who were mentors to us from the beginning, and welcome new leaders to work with us as MHNE continues to be a cornerstone of education to the communities we serve.”
It was recently announced that Tino Hernandez will step down as President and CEO of Samaritan Daytop Village this summer.

During Mr. Hernandez’ ten-year tenure, he oversaw the merger of Samaritan Village with both Veritas (2013) and Daytop Village (2015), significantly growing the agency’s scope of services. Today, Samaritan Daytop Village remains a pioneer in substance use treatment.

Nationally recognized for its work in substance use treatment, specialized services for veterans, and housing, Samaritan Daytop Village’s continuum of services includes addiction treatment, health care, mental health care, care coordination, recovery services, shelter, transitional and permanent housing assistance and services for veterans and seniors.

Thanks to his leadership, Samaritan Daytop Village’s budget grew from $23 million to approximately $200 million. Annually, Samaritan Daytop Village serves over 28,000 vulnerable New Yorkers at more than 50 facilities throughout New York City, Long Island and upstate New York.

“Under Tino Hernandez’ leadership, Samaritan Daytop Village has been a beacon of hope for New Yorkers struggling with substance use disorders,” said New York State Office of Alcoholism and Substance Abuse Services Commissioner Arlene González-Sánchez. “It has been a pleasure working with Mr. Hernandez, and I look forward to a continued partnership with Samaritan Daytop Village and his successor.”

On Mr. Hernandez’ watch, Samaritan Daytop Village has matured into the place “Where Good Lives,” helping thousands of New Yorkers reclaim their lives every day. Yet ten years ago, when he returned to the agency after a prominent 15-year career in government, the organization faced a changing and challenging health care environment. Mr. Hernandez envisioned ways to transform the agency into a premier service provider and position it for health care reform, working closely with staff, the Board, the Samaritan Daytop Foundation and their partners.

He embarked on a series of strategic initiatives including efforts to strengthen and expand the agency’s mission to encompass services for those battling substance use disorder, homelessness and mental illness, as well as for seniors and veterans in need; rebrand the organization to reflect its expanded services; diversify and deepen funding streams and services to create a comprehensive continuum of care; expand the agency’s housing portfolio consistent with its mission to assist clients; and enhance Samaritan Daytop Village’s commitment to quality care through evidenced-based and best practices linked to research.

Mr. Hernandez said of his departure, “This was a very difficult decision for me and it’s a bit like leaving home again. It has been my privilege to lead this incredible organization and I am extremely proud of all that Samaritan Daytop Village has accomplished to assist New Yorkers in need. I will watch with much excitement, and perhaps with a bit of envy, as under new leadership it continues to grow and improve the quality of life for thousands of New Yorkers.”

Mitchell Netburn, who has served for eight years as President & CEO of Project Renewal, an organization dedicated to ending the cycle of homelessness by empowering individuals and families to renew their lives with health, homes and jobs, has been named Samaritan Daytop Village’s new President and CEO. Under
 Coalition Appoints Lippman as Interim President and CEO

By Staff Writer
Behavioral Health News

On June 1, 2018, the Board of Directors appointed Jason Lippman Interim President & CEO of The Coalition. Jason brings much experience to his new position, through his long association with The Coalition, including most recently serving as its Executive Vice President, and previously as Director of Policy & Advocacy.

“It is truly an honor to serve in this leadership position,” according to Jason. “Thank you to the Board of Directors and membership for having confidence in me to lead The Coalition through this important transformation.”

In the months ahead, Jason’s primary objective will be to refocus and strengthen The Coalition’s advocacy efforts on fostering the sustainability and viability of the community-based behavioral health sector.

As part of this effort, The Coalition will enhance our presence in Albany and to position us as the go-to advocate and resource for our membership, in navigating the many changes now underway in the community behavioral health sector.

The Coalition for Behavioral Health is the umbrella advocacy organization of New York's behavioral health community, representing over 140 non-profit community based behavioral health agencies that serve more than 500,000 clients in the five boroughs of New York City and its environs. Founded in 1972, The Coalition is membership supported along with foundation and government funding for special purpose advocacy, training and technical assistance projects.

Diamond New CEO at Westchester Jewish Community Services

By Staff Writer
Behavioral Health News

Westchester County Jewish Community Services has announced that its Board of Directors has unanimously approved the selection of Seth Diamond as its new CEO. Mr. Diamond will officially assume all duties as CEO on June 25, 2018.

“We are very happy to have Seth join us as the next CEO of WJCS,” said Neil Sandler, President of the WJCS Board of Directors. “He brings a wealth of experience in public service and in helping underserved communities. The Board was very impressed by Seth’s credentials and his proven track record of shaping and implementing strategic plans. In numerous positions, he has worked with multiple stakeholders to ensure programs provide assistance in the most accessible, efficient, and impactful manner possible. We are confident that Seth will lead WJCS to its next level of success.”

Diamond has extensive experience working in New York City government, most recently as Chief Operating Officer of Metroplus, a health insurance company serving a half million New Yorkers. Previous to that, he was Executive Director of the Governor’s Office of Storm Recovery for New York City, Commissioner for the Department of Homeless Services in New York City, Executive Deputy Commissioner of New York City’s Human Resources Administration, and Deputy Commissioner of its Job Center Operations. He holds a J.D. degree from New York University School of Law and a B.A. degree in Political Science and Economics from Brown University.

Diamond will succeed Alan Trager, who has been CEO at WJCS for 20 years and at the organization for 42 years. “I am pleased to pass the baton to Seth Diamond,” said Trager. “I’ve no doubt that with his background, expertise, and values, Seth will build on WJCS’s key strengths that we’ve developed over many decades and continue to expand the organization’s impact in benefitting Westchester residents.”

“I am proud to have the opportunity to lead WJCS, an organization that has had such an important and positive impact on generations of families throughout Westchester,” said Diamond. “I’m deeply committed to WJCS’s mission of providing outstanding and compassionate care to the residents of Westchester County. I am honored to join the dedicated Board, staff, and volunteers to seek new ways to improve lives of every person in need in Westchester.”

Founded in 1943, WJCS (www.wjcs.com) is one of the largest non-sectarian, not-for-profit human services agencies in Westchester. We support 20,000 Westchester residents, of all ages and backgrounds, annually to help them overcome challenges and achieve personal success. Our 88 programs include: mental health treatment, child and youth development initiatives, programs for people with disabilities and autism, homecare, services for older adults, and privately funded programs for the Jewish community.
The Role of Exercise in Alleviating Anxiety, Depression, and PTSD

By Robert Motta, PhD, ABPP
Professor of Psychology, Director
Doctoral Program in School-Community Psychology, Director Child and Family Trauma Institute, Hofstra University

It is well known that exercise results in numerous physical health benefits and it is becoming increasingly realized that it also alleviates psychological distress. The studies are too numerous to mention in a brief article but suffice it to say that exercise—particularly aerobic exercise, has been associated with reductions in anxiety and depression in children, adolescents, adults, and seniors. The impressive impact that exercise has on these psychological states leads to a number of questions, three of which will be addressed here. First, why does this occur? What is the mechanism or mechanisms? Second, what form of exercise and how much is needed to bring these effects about? And finally, given that anxiety and depression are central components of PTSD, could exercise also reduce symptoms of PTSD when used as an adjunct to traditional therapy or as a stand-alone intervention?

Why is Exercise Effective The short answer is that nobody knows for sure but there are a number of hypotheses. A few will be covered here but none of these have been universally accepted:

The thermogenic hypothesis asserts that rising body temperature accounts for the reduction in negative emotional states. The fact that fevers and hot climates don’t seem to have an effect on negative emotion calls this view into question. Also, peripheral elevations in body temperature are not necessarily associated with central-neurological elevations.

The endorphin hypothesis is perhaps the most popular and most widely known. Vigorous exercise is known to stimulate the body to produce an endogenous opioid, beta endorphin, and this has been said to be associated with the “runner’s high.” Two contrary lines of evidence arise. The opiate blocking substance naloxone does not block the runner’s high, and there is little evidence that endorphins cross the blood-brain barrier and therefore it is unlikely that endorphins are having a direct effect on the central nervous system. Perhaps they are a correlate of some other effect of exercise. A more recent alternative to the endorphin hypothesis is the endocannabinoid hypothesis. Again the view is that energetic physical activity produces endogenous substances similar to that found in marijuana and this is what accounts for the positive psychological effects of exercise. There are to few studies to provide validity to this relatively new view.

The endogenous hypothesis asserts that exercise produces increased brain availability of dopamine, serotonin, and norepinephrine. Animal research suggests that this may be the case, but verification in human research is too problematic and ethically challenging to provide support for this view.

Self-efficacy and distraction hypotheses suggest that exercise increases one’s sense of competence to attain goals and may also distract one from ruminating over their problems. Available research does show that exercise is distracting and can make one see themselves as more capable of setting goals but there has been no strong, one-to-one relationships demonstrated between these outcomes and reductions in negative affective states.

What Form of Exercise is Best?

The majority of research studies has been done on, and support, the value of aerobic exercise. This does not mean that anaerobic or resistance exercises are of no value but emphasis on aerobic activity may be due to the fact that it is easier to quantify than anaerobic exercise. For example, many studies state that in order to be considered an aerobic activity one must elevate one’s heart rate to 60 to 80% of its maximum rate. The maximum rate is given by subtracting one’s age from 220.

For this view.
ultimately the bedrock of this kind of behavioral treatment. These treatments usually last between 12 to 16 weeks. This will not only help the child in the moment, but also help them equip themselves on how they can manage their own anxiety going forward, post-treatment.

Medication within the serotonin reuptake inhibitor class, such as fluoxetine or Prozac is an additional option. Usually, one follows a stepped-care model, where you start with psychotherapy, and consider adding medication depending on the severity of symptoms.

What role do parents play in treatment?

The family plays a significant role. Parents have to stay actively involved in the various behavioral measures taken during the treatment, not only during the therapy hour, but also outside the therapy. So, for example, if the child refuses to go to school, the parent has to make sure their child goes to school. The normal impulse is to not subject your child to stressful scenarios. Therapists discuss with parents ways to push their child to confront their anxiety, and help avoid avoidance behavior. Avoidance behavior leads to overdependence on parents. Therapy tries to place the responsibility of growing independence back on the adolescent.

Working with a skilled therapist will always involve not only the parent but also siblings, on how to deal with a situation where one person in the family seems to take up more attention.

**Improved Outcomes from page 10**

Headspace is a primary-care model, McGorry explains. It is not specialized to particular diagnoses, but rather reflects what he considers a 21st-century notion of treating the manifestations of mental ill-health in common. The key point is to address the behaviors or symptoms as soon as they are manifest, and to treat them not only with medications, where appropriate, but importantly, with robust social, family, and developmental support, to the extent possible. This is the formula that has resulted in “symptomatic” recoveries of two first-episode psychosis patients who entered the program within the first 18 months in the headspace clinics. Data on longer-term trajectories are being developed, McGorry says.

The headspace clinics are more like primary-care clinics than mental health centers by design. “We have built an entrance hall, the front rooms of the house that provide care across the lifespan,” says Dr. McGorry. “It is also about providing the child and the family with health care, but not the usual patient, the one in the middle of the ladder.”

He believes one reason the clinics have succeeded so far is that “they stigma-free. And they are popular because people don’t worry about all the arcane debates that we have in psychiatry about diagnostic boundaries, or criteria or labeling. Ordinary people, including politicians in Australia, understand that these young people are in trouble. We’re trying to help them, trying to make it easy for them to seek help. The entry into headspace is soft. We are welcoming; there are no nosological anxiety disorder, and the mental health services at colleges are usually not equipped to handle the large number of cases.”

“Are you going off to college, what kind of support network can I create?”

Start by having a fairly long discussion with their current mental health care provider about the transition and continuity of care with their current provider through Skype or other tele-health methods. Also find out what services are available in the college and the city your child is going to.

### Supplements from page 8

**When someone who has had anxiety symptoms early in life goes to high school or begins college, what can a parent expect?**

If you have an anxiety disorder or depression before the age of 18, we know exactly what to do to your pediatrics, who then refers you to a psychologist or psychiatrist who specializes in children and adolescents. When you turn 18, it’s unclear whom you should see. When you’re young, you may need special care, but is not the typical patient seen in the adult mental health care system. This change occurs when youth are transitioning to college, or another post-high school experience. So, you might have been in a very protected environment at home, possibly seeing a therapist, and then when you go to college, you jump into a new context, possibly hundreds of miles away, with none of the same support systems in place. It’s estimated that over 20 percent of the adolescents are dealing with an anxiety disorder back on the adolescent.

Working with a skilled therapist will always involve not only the parent but also siblings, on how to deal with a situation where one person in the family seems to take up more attention.

Mr. Netburn’s leadership Project Renewal has been universally recognized as a premier agency for its respectfulness in treating the manifestations of mental ill-health while these are still plastic. These are young people in transition and continuity of care with their current provider through Skype or other tele-health methods. Also find out what services are available in the college and the city your child is going to.

**Supplements from page 8**

**Mothers who carried genetic risk factors for schizophrenia, including variants of CHRNA7.** But in mothers carrying these risk factors who received placebo, even the benefit of dietary advice (as opposed to supplementation by pill) during pregnancy did not prevent their children from showing diminished P50 inhibition after birth. In a separate study, Freedman’s team reported and follow-up results when infants in the original trial reached 40 months of age—the time when behavioral patterns become settled and in-sipient problems are discernible.

“Children who go on to develop schizophrenia already have recognizable motor problems in the first year of life,” Dr. Freedman says, “which are not in themselves diagnostic. But by early childhood they also show clear signs of attention difficulties and social withdrawal, effects that we can trace at least partly to deficits in inhibition.”

At 40 months, the team was excited to observe that children of mothers who had received choline supplements had fewer attention deficits and less social withdrawal compared with children in the placebo group. It is of course impossible to know the “final” outcome of this experiment, certainly not the whole picture. Right now, says Dr. Freedman, “what we know is that the babies exposed to supplemental choline as four year-olds are healthier children than if we had not intervened.”

The team will continue to test whether the specific form of choline used in the trial—called phosphatidylcholine—is indeed the best supplement to give. The optimum dose also remains under study.

**Village has been improving the quality of life for New Yorkers facing adversity. We are nationally-recognized for our work in treatment for substance use disorder, specialized services for veterans, and services for homeless individuals and families. Our continuum of services includes health care, mental health care, addiction treatment, care coordination, transitional housing and supportive housing, and services for seniors. Annualy, Samaritan Village serves over 26,000 people at more than 50 facilities throughout New York City, Long Island and upstate New York.**

One clear risk factor who received placebo, even the better the outcome is liable to be. Our echo findings from his years of research and papers show that specialized first-episode programs produce better medium-term results oriented approach to serving homeless individuals and families. It’s estimated that over 20 percent of the adolescents are dealing with an anxiety disorder back on the adolescent.

Working with a skilled therapist will always involve not only the parent but also siblings, on how to deal with a situation where one person in the family seems to take up more attention.

Mr. Netburn will assist with the transition and depart the agency by mid-July 2018.

About Samaritan Daytop Village. For more than 50 years, Samaritan Daytop Village has been improving the quality of life for New Yorkers facing adversity. We are nationally-recognized for our work in treatment for substance use disorder, specialized services for veterans, and services for homeless individuals and families. Our continuum of services includes health care, mental health care, addiction treatment, care coordination, transitional housing and supportive housing, and services for seniors. Annualy, Samaritan Village serves over 26,000 people at more than 50 facilities throughout New York City, Long Island and upstate New York.
Unique Perspectives: Harnessing Multimodal Assessment to Understand How Children with Autism Decode the Social World

By Erin Libsack, BA, and Tessa Clarkson, MA, Graduate Students and Matthew D. Lerner, PhD, Associate Professor, Department of Psychology, Stony Brook University

I t is well-known that children and adolescents with Autism Spectrum Disorder (ASD) see and make sense of the social world differently than their typically-developing (TD) peers. Often less appreciated is that the way the mind and brain give rise to this social perception and cognition is quite complex, with many interlocking abilities being necessary to decode a social scenario and then engage with it (and the people within it). In recent decades, numerous psychological scientists have attempted to map out these various abilities in TD populations (e.g., Crick & Dodge, 1994; Lipton & Nowicki, 2009; Beauchamp & Anderson, 2010). However, the field of ASD research has been slower to appreciate this complexity, often attributing differences in social cognition among individuals with ASD to a single “silver bullet” differentiating factor, such as perspective-taking, emotion recognition, or self-regulation.

In recent years, researchers, including those of us in the Social Competence and Treatment Lab (SCTL) at Stony Brook University, have started to assess various abilities in TS populations (e.g., strong ability to read emotions, familiarity, and stance, when seeing a face, one’s brain first registers the visual input, then identifies it as a face, then begins the process of decoding its emotions, familiarity, and identity. ERPs can be used to differentiate each of these steps.

Through generous support provided by a grant from the Brain & Behavior Research Foundation (BBRF; formerly NARSAD), the SCTL adapted the original SELWeb paradigm to be compatible with simultaneous EEG data collection. Combining these methodologies allows our team to measure brain activity while children complete the SELWeb tasks. This allows us to assess not only whether an individual is experiencing problems (or strengths) in one aspect of social cognition, but when exactly their social processing may be going awry.

For example, it is well known that many individuals with ASD have difficulty accurately identifying emotions in faces. A child’s performance on the non-verbal emotion recognition SELWeb module would show us whether such a broad impairment is present. Our previous ERP research has shown that such challenges in reading emotions among teenagers with ASD can arise from difficulties in orienting to emotional faces, rather than difficulty decoding faces (Lerner et al., 2013). Now, we can extend this type of fine-grained analyses across many aspects of social cognition. For instance, during our social perspective taking game, participants must make sense of what a cartoon character in a short scene thinks or does (e.g., where they will look for a lost mitten that has been moved without their knowledge). Perhaps a child provides an incorrect answer (e.g., looking for the mitten in the place to which it has been moved) – why does she do so? Is it because she cannot hold in mind the idea of the scene? Is it because she cannot understand what the cartoon character thinks? Looking at ERPs recorded during the task can help us answer these questions. Then, when knit together with the ERP responses to all SELWeb tasks, we can get a deeper, more precise picture of how a child is decoding her social world beyond their responses to questions, and across multiple domains - a capability that was not previously achievable.

Thus, support from the BBRF has helped us to begin to unlock a deeper understanding of how children with ASD think about and process their social world than has ever been possible. Tools such as SELWeb are vital for advancing our ability to understand the unique ways that individuals with ASD may differ in how they think about social situations, and how those differences impact social functioning. The addition of EEG introduces the ability to disentangle the various minute processes involved in specific areas of social cognition. This deepens not only our understanding of the science of ASD, but also will provide much more specific targets for the next generation of precision interventions for the core challenges of youth with ASD. At the SCTL, we aim to be among the groups to usher in this next generation. It is with support from organizations like BBRF to us and others that will accelerate its arrival.

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Trends from page 14

It has been clear for many years that the projected growth of people 65 and older (both in absolute numbers (they will double) and as a proportion of the American population (they will outnumber children) will create very tough challenges for the mental health system. The research on “deaths of despair” suggests that the challenges will be even greater than anticipated because the prevalence of emotional distress for older adults may be higher than it has been in the past. As I noted earlier, this is counterintuitive because people seem to be living longer and better. However, this research reveals that, while people with more than a high school education are doing better, the 40% of the American population that did not go beyond high school is not. That population may have growing needs for medical, behavioral, and social services as they become older.

What can be done? In part the answer is to increase age-appropriate, especially for people of lower socio-economic status and especially in localities that have had relatively high death rates. In part the answer is a comprehensive public health campaign to reduce drug and alcohol abuse. In part, the answer is more effective interventions to reduce the incidence of suicide and suicide attempts, including meaningful gun control. And for older adults, plans are needed that anticipate not just a growth in numbers but a growth of morbidity among those who will become old in 10 or 20 years.

Much of this is already on the behavioral health agenda to some extent. Not nearly enough, of course, but at least it’s on the radar screen.

But if Case and Deaton, Phillips, and others are right that deaths of despair reflect widespread disconnection between individuals and their societies, we need to think much more broadly and address the dimensions of the American society that contribute to growing division and alienation. Inequality; job insecurity; social isolation and loneliness; racial, gender, and class divisions; loss of meaning and hope—it is these trends that need to be addressed.

Is this too much for the physical and behavioral health systems? Probably. Perhaps the best we can hope for is continuing to chip away at problems of behavioral health, which sadly are unlikely to diminish and may in fact increase in a nation that appears to have abandoned what progressives at the beginning of the 20th century called the “promise of American life.”

But perhaps health and behavioral health policy makers can begin to think big, not just about ingenious ways to manage care and cost, but also about alienation and despair. That is not going beyond what school is today. I’m skeptical, but still hopeful.

Michael B. Friedman, LMSW is an Adjunct Associate Professor at Columbia University School of Social Work and Chair of the Geriatric Mental Health Alliance of New York. He can be reached at mf395@columbia.edu.

References


* Case and Deaton speculate why death rates have continued to decline for black and Hispanic populations despite the ongoing trials of life as a minority and the entrenched racial divide in America. Perhaps people of color have always had lower expectations and less hope than whites. Perhaps they have lost less than working class people because they have less to begin with. Just speculation, Case and Deaton tell us.

** President Carter referred to this as an American “malaise” and paid a great political price when running against President Reagan’s vision of a great America. President Trump appears to have understood the profound desire of the white working class for a return to the heyday of blue collar jobs that paid a living wage.

*** A very recent study shows enormous differences in deaths due to overdoses, suicides, homicides and alcohol related illnesses from county-to-county in the United States. The authors say that this indicates that so-called “deaths of despair” may be related to local circumstances than to broad social changes.

**** A good example of advocacy for improvements in America’s health and behavioral health systems is a report calling for a “national resilience strategy” to address deaths of despair recently released by The Trust for America’s Health. It emphasizes the need for more and better mental health and substance abuse services, more preventive efforts, improved pain management, etc.

Technology from page 22

support can go a long way to minimize the loneliness that may lead to isolation and decompensation.

To further relationship building and ongoing communication, the PH Teams have started utilizing a mobile messaging application: a secure texting engagement platform providing assistance with reaching clinical goals, through reminders to take medication and attend appointments, as well as texts that educate on healthy living habits. The care delivery staff schedule reminders and health education texts, either preemptively or in real time. The system can also check-in after tasks like appointments, inquiring how it went or if the appointment was made. After-hours, an automatic text responds with directions of who is on-call and how to reach on-call staff, to ensure 24/7 coverage.

As an example, PH used this technology with Luz, a shy 19-year-old who at first was not talkative during in person meetings or over the phone. When Luz started using the application, she would type out answers to questions about her goals and symptoms, in a way never detailed in verbal conversations. As someone who had experienced suicidal ideation and serious attempts and often described feeling “overwhelmed in life,” it was helpful for PH clinician to begin seeing signs and symptoms based on responses through text messages. During a trip out of state, it proved a useful way to keep in touch and check in regularly. She is now well connected to providers, has not returned to hospital or experienced suicidal ideation, volunteers at a pet shop, and returned to school to continue her education.

Luz sums it up best; “Texting is a lot easier for me than calling. I really do not like more and better service text is simpler, quicker, and more likely to get a response from me. If you don’t have time to call someone, you can find a few seconds to reply to a text message.”

In our work, a common theme from hospital and housing staff is medication adherence. For individuals with medication management needs, PH uses electronic medication reminder & dispenser machines as a tool and reminder that addresses adherence. The machine is programmed by a PH nurse and is set to dispense medications at the appropriate time, prompted by the user. Visual and audio alarms continue to sound from the dispenser and are not dismissed until the medication is dispensed. If not dispensed, the PH Team nurse receives a message and can follow up with a call or visit to the individuals setting and address the lack of adherence. One PH nurse noted, “The medication dispensers are a good starting point to help increase awareness of the benefits of medication adherence.”

In one instance, PH was serving Malcolm, who was prescribed 12 oral medications to be taken three times a day. Malcolm had reported past challenges with medication adherence and concerns about forgetting to take them on time. For three years, the PH staff helped to increase medication management using the dispenser machine. The machine alerted Malcolm to take notice of the prescribed times, increasing awareness and adherence. Prac- ticing this routine led Malcolm to no longer rely on the electronic medication and begin to take medication with increased independence, continuing adherence months later at completion of PH services.

In this ever-changing healthcare and technology world, it is imperative for behavioral health community-based agencies to remain relevant with the changing tide of new technology-assisted care. With the ubiquity of Smartphone apps, including hundreds that target mental health and substance use disorders, and inventiveness in technological tools, it is difficult to ignore this trend in healthcare. Individuals in the service delivery system in NYC with psychiatric conditions would benefit from beginning to use these and the services provided by the PH staff could begin to become aware of the various resources that exist.

If we do not embrace the innovation in healthcare and be present to shape it, we will run the risk of it happening without our input. Piloting and testing technological solutions is the only way to assess usefulness, determine ability to support, and elicit buy-in from administrative and direct care staff. Behavioral healthcare professionals can be on the forefront of innovation, we simply need to have the courage to follow the virtual pathway forward.

Barry Granek is the Senior Director of Pathway Home at Coordinated Behavioral Care and can be reached at 917-242-2090 or BGranek@cbcare.org. For more information, visit www.cbcare.org.
Interview from page 5

What kind of advancements have BBRF researchers found as a result of funding? Advancements funded by our grants continue to contribute to the expanding edge of all research in the mental health field. Examples include the use of Clozapril for the treatment of schizophrenia, optogenetics which helps scientists around the world to better understand the brain, transcranial magnetic stimulation for depression and other conditions, deep brain stimulation for treatment resistant depression, the ongoing development of rapid-acting anti-depressants, and as shown on 60 Minutes this past May, magnetic stimulation therapy that can be used to treat depression without causing the memory loss that can happen with ECT.

What kind of public education does the Brain & Behavior Research Foundation do? In addition to funding research, the Foundation spearheads ongoing campaigns to raise awareness and educate the public about research. Free monthly webinars for the lay public, feature conversations with leading scientists on topics that include mechanisms of antidepressant effects, child and adolescent anxiety, understanding the chaos and complexity of borderline personality disorder, addiction as a brain disease, new approaches to treating depression, and the adolescent brain and mood disorder risk. BBRF holds an annual mental health research symposium in New York City in October with complimentary admission so the lay public can hear presentations on the current research happening in the labs of BBRF grantees and prizewinners.

This year’s symposium will be on Friday, October 26th at the Kaufman Music Center in New York City.

We also hold a monthly “Meet the Scientist” webinar series which I moderate where people can learn about the latest research from international experts in the field of mental health. The Foundation also produces the Emmy nominated public television series Healthy Minds which aims to remove the stigma of mental illness, educate the public and offer a message of hope by shining light on common psychiatric conditions through inspiring personal stories and experts sharing cutting edge information. As the Host of Healthy Minds, my goal is to inspire conversations about mental illness, and provide understandable information and resources for viewers.

Information is available on our website, bbrfoundation.org, and on our social media channels which include Facebook, Twitter, Instagram, LinkedIn and YouTube.

How is Brain & Behavior Research Foundation funded? One hundred percent of donor contributions for research are invested in our grants leading to advances that breakthroughs in brain and behavior research. This is made possible by the generous support of two family foundations which cover the Foundation’s operating expenses.

We know that people with mental illness respond to treatment. But in order to help the millions of Americans who are suffering, we need leaders who will come together to raise awareness, ensure access to care, and provide funding for scientists working to find better ways to diagnose, treat and cure mental illness.

Dr. Herbert Pardes, executive vice chairman of the New York-Presbyterian Hospital Board, and President of the Brain & Behavior Research Foundation’s Scientific Council.


Exercise from page 33

220. The result is then multiplied by .6 or .8 to be considered aerobic. The research studies in which I have been involved typically employ brisk walking, jogging, bicycling, etc. approximately three times a week for approximately 30 to 40 minutes, for between six to 10 weeks. This level of aerobic exercise results in significant reductions in anxiety, depression, and (as stated below) PTSD and these results are sustained in follow-up assessments. However, it should be noted that beneficial psychological effects have actually been demonstrated in a single session of exercise.

There are studies, one of which was a doctoral dissertation I supervised, where weight lifting and resistance training three times per week led to reductions in negative affective states. So what form of exercise is best? Perhaps the answer to that question is simply the question of which form of relaxation is best. The answer to both is the type that best suits you and the type you are most likely to continue doing while not becoming bored or discouraged. This is the “best” form of exercise.

Can Exercise Be Useful in Reducing PTSD?

I have been involved in at least five research projects that have used exercise, primarily although not exclusively aerobic exercise, and we have found significant reduction in PTSD. Recent empirical studies support that conclusion. It is possible that because anxiety and depression are so much a part of PTSD, and it is well known that exercise reduces both of these, that this is the reason for its surprising impact on PTSD.

Traumatized individuals are notoriously avoidant of psychologically based interventions and are also reluctant to take psychotropic medication. The extreme anxiety that is elicited in well meaning therapeutic attempts to get the traumatized individual to confront and reprocess their traumatic experiences, results in fleeing from, and avoidance of therapy. For this and other reasons, alternative approaches to traditional forms of psychotherapy are called for. Exercise is clearly of value in this regard as are other approaches such as yoga, mindfulness, acupuncture, wilderness and animal assisted therapies, etc.

If one reviews the available research on the psychological effects of exercise, it is hard not to be impressed. Empirical studies consistently report that exercise not only reduces depression and anxiety, but also ameliorates anxiety, depression, and PTSD but it also enhances self-esteem, improves concentration and memory, improves academic skills and IQ in children, reduces OCD symptoms, enhances perceptions of well-being and many other positive outcomes. Mental health providers probably have no other intervention that has such wide ranging utility as exercise. It is not far fetched to say that exercise is the “magic bullet” for numerous psychological and physical problems. We clinicians can benefit ourselves by taking a dose of our own medical prescription, exercise.

You can reach Dr. Motta by email at Robert.W.Motta@hofstra.edu.

Do More from page 1

ill, humanitarians who care about the broad aspects of mental health and its impact on the community.

It is heartening to see some members of the Senate and Congress step up. In early October, Sens. Ron Blunt (R-Mo.) and Debbie Stabenow (D-Mich.), and Reps. Leonard Lance (R-NJ) and Doris Matsui (D-Calif.) introduced the Excellence in Mental Health and Addiction Treatment Expansion Act, a small (two-year, eight-month) state initiative to expand access to community-based mental health and addiction care.

There are other small steps being taken, but we cannot wait to deal with the escalating mental health crisis in this country.

Affordable Housing from page 29

also includes a community space on the ground floor, a sunken courtyard, and a landscaped back yard.

Residential services are provided through a NY/NY III contract from the NYS Office of Mental Health. Permanent housing is funded through permanent housing financing, including grants, loans and tax credits, came from NYC Department of Housing Preservation and Development, NYC Resolution 42-2005, Capital One Bank, CSH, and the Community Preservation Corporation. Hudson Housing Capital is the syndicator for the tax credits. The architect is Tony Shetini of Urban Architectural Initiatives and the contractor is Procella Construction Corp. Robert Sanborn of Robert Sanborn Development is the housing consultant. About Unique People Services.

Unique People Services, Inc. (UPS) is a New York-based nonprofit 501(c) 3 that provides supportive housing and medical care management services to individuals and families living with mental health challenges, developmental disabilities and HIV/AIDS. The agency operates more than 24 supportive housing programs in the Bronx, Manhattan, Brooklyn, Queens, and Westchester County.

More than 800 New Yorkers call UPS’ homes, Capital One Bank, CSH, and the Community Preservation Corporation. Hudson Housing Capital is the syndicator for the tax credits. The architect is Tony Shetini of Urban Architectural Initiatives and the contractor is Procella Construction Corp. Robert Sanborn of Robert Sanborn Development is the housing consultant.

About Unique People Services.


These findings further document the prevalence of this phenomenon in mental health settings and raise the possibility that cyberbullying may cause or exacerbate mental disorders. They also suggest that those teens who have previously been victimized—particularly those who report having been emotionally abused in the past—may be even more vulnerable to abuse and may suffer exacerbation of their symptoms as a result. In the future, the Four Winds, University of Miami Miller School of Medicine and Fairleigh Dickinson University research team plans to examine the prevalence of cyberbullying in the general population and attempt to identify its impact on teens outside of clinical settings.

Reducing PTSD?

It is not far fetched to say that exercise is the “magic bullet” for numerous psychological and physical problems. We clinicians can benefit ourselves by taking a dose of our own medical prescription, exercise.

You can reach Dr. Motta by email at Robert.W.Motta@hofstra.edu.
Behavioral Health News Theme and Deadline Calendar

Fall 2018 Issue:
“System Transformation: Challenges and Opportunities”
Deadline: October 1, 2018

Winter 2019 Issue:
“Changes in Our Children’s System of Care”
Deadline: January 8, 2019

Spring 2019 Issue:
“Caring for Older Adults: Challenges and Solutions”
Deadline: April 1, 2019

Summer 2019 Issue:
“The Behavioral Health Workforce: On the Front Line of Behavioral Health Care”
Deadline: July 1, 2019

Fall 2019 Issue:
“Models of Integrated Care Across the Healthcare Sector”
Deadline: October 1, 2019

Social Isolation from page 24
and lack of participation in social activities whereas loneliness involves the subjective nature of these social disconnections. Research findings indicate that loneliness and social isolation are similarly bad for one’s health. However social isolation poses more significant health risks and higher likelihood of premature mortality. On average, people who are socially isolated have a 29 percent increased risk of death compared to 26 percent for those who are lonely (Holt-Lunstad, Smith, Baker, Harris & Stephen-son, Perspectives on Psychological Sci-ence, 2015). Of note is the finding that there was no distinction between subjective or objective measures of social isolation when predicting mortality (Holt et al., 2015). A recent study reported findings that socially isolated individuals were on average 30 percent more likely to have a heart attack or stroke compared to individuals who had strong personal relationships (Valtorta, Kanaan, Gilbody, Ronzi & Hanratty, Heart, 2016). Other findings noted higher rates of infection, depression, and cognitive decline (York Cornwell & Waite, Journal of Health and Social Behavior, 2009).

The discussion on social isolation is indeed complex as noted in the cases of Doris and Vincent. In today’s changing health care climate, social service providers must take into account the impact of Managed Care, Value Based Purchasing, and Medicaid Redesign (MRT). Rather than seeing these changes as barriers, we must be proactive and creative around conceptualizing new program models that may ultimately reduce social isolation, improve whole health, and attain better outcomes.

OASAS from page 12

OASAS and the Center have been working with several providers to pilot a tool that we developed focused on eight self-reported measures of SUD. It includes questions related to symptoms such as cravings, use pattern and problems relating to use and questions related to response to the treatment process including hopefulness and bonding with addiction program staff. Initial testing of this tool show promise in the tool’s sensitivity and correlation with other signs of progress including completion of treatment.

The Right Research from page 16

Recognizing that everyone’s family relationships differ, many of us expressed a desire to have some kind of involvement of family or familial relationships in recovery, as a way to rebuild relationships that may have been strained due to substance use or mental illness, and to (as one of us put it), create “less separation and more unity to help with healing.”

Another topic that emerged as an area of interest in the group was the question of why there seem to be fewer women in residential treatment than in previous years. The difference has been noticeable to those of us who have returned to residential treatment after being previously enrolled a few years prior. Many of us appreciate the benefits of co-ed programs, and wonder why there seems to be lower participation for women and if this is a trend that also exists outside of our particular S.U.S. program. Has there been research into the pros and cons of gender segregated or co-ed residential treatment? Others expressed wanting to know whether one’s childhood environment, neighborhood, and household had an impact on recovery. Another topic raised was whether people who have mental illness and are homeless may stay longer in housing if they have the ability to interview their roommates prior to moving in with them. We are impacted by these and many other areas of treatment services, so we feel that service providers should share their knowledge of the research that informs the services we receive.

Ultimately, our discussion group came to appreciate the value of research, and even those of us who had never participated in research studies grew more open to the idea. We did identify several factors that would impact our decision to participate, however. Financial compensation was mentioned as a motivating factor for participation. Many of us also would prefer to know how research studies are monitored. Would we have quick access to help if something were to go wrong over the course of the study? Are there known side effects of whatever experimental treatment or model we would be participating in? Could it have a negative impact on our recovery? Having histories of substance use, many of us expressed hesitation about participating in any studies that would involve experimental medications or substances. Also, information about existing research studies doesn’t seem readily available, or is not usually brought to our attention. Perhaps researchers could do more to seek us out and maybe our providers could let us know about local studies that may be important to us.

Toward the end of our discussion, another point of agreement emerged: we see the value in research and the information found in research studies if the end result could lead to quality services for those impacted by substance use and mental illness. As one of us stated, “I would hope it could help somebody -- if I could just help one person not go through what I’ve put myself through.”
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