

## Spotlight on Research: An Interview with Jeffrey Borenstein, MD President and CEO of the Brain & Behavior Research Foundation

By Ira Minot, LMSW, Publisher  
Behavioral Health News

**W**hat 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 grants support 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



**Jeffrey Borenstein, MD**

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.

The Young Investigator research grant program was initiated in 1987 to help researchers launch careers in neuroscience and psychiatry. This unique program is intended to facilitate innovative research opportunities and supports basic, translational and clinical researchers and helps expedite the gathering of crucial pilot data necessary for future funding. The Foundation's Independent Investigator research grant program was initiated in 1995 to support mid-career scientists during the critical period between initiation of research and receipt of sustained funding and our Distinguished Investigator research grant program was initiated in 1988 to enable outstanding scientists to pursue new, cutting-edge ideas with the greatest potential for breakthroughs.

What kind of research do you support? BBRF supports innovative research studies that offer the potential for breakthrough discoveries. These discoveries are changing what it means to live with mental illness.

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

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## We Need to Do More Than Just Talk About Mental Illness

By Dr. Herbert Pardes  
Reprinted from The Hill

**T**here 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



**Dr. Herbert Pardes**

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.

It is virtually impossible to calculate the human cost of these tragedies, but one study found that after factoring in under-reporting, suicide and suicide attempts in 2013 cost an estimated \$93.5 billion nationally, primarily in lost productivity.

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

see Do More on page 37



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# The Brain & Behavior Research Foundation: A Personal Perspective

By Ira Minot, LMSW  
 Founder and Publisher  
 Behavioral Health News

**T**he Brain & Behavior Research Foundation (BBRF) is unraveling the many mysteries of mental illness, autism spectrum disorders, and many other diseases and disorders of the brain. I would like to thank Dr. Jeffery Borenstein and his team at BBRF for their help in bringing our salute to their vital scientific research to the readers of *Behavioral Health News*.

I was inspired to write this personal perspective by two things: BBRF's article about Dr. Lisa Pan and her patient Bruce on the following page, and by my personal recollections of Constance and Stephen Lieber, the driving force behind the National Alliance on Schizophrenia and Depression (NARSAD).

Following my own experience with treatment-resistant depression which began in my late 30's, I started the precursor to this publication which was then called *Mental Health News*.

I was getting back on my feet in 1998 when I had the idea to take my experience battling depression into creating a publication to educate individuals and families struggling with mental illness about the latest treatments and the organizations that were in the community to help them. Since I was rebuilding my life from scratch, I decided to dive right into it.

I went out and met with many mental health organizations and many of the leaders of the mental health community in New York State to get their advice and participation in launching the first issue of *Mental Health News*. One of the first people I met along the way was Constance Lieber the President of NARSAD. I called her on the phone and told her about my new project and she graciously invited me over to her home just minutes from where I was living in my supported-housing apartment in the neighboring village.

I told her about my journey through the depths of depression and how I wanted to help others who were traveling the same path. She immediately understood. Before leaving, I asked her if she would help me by featuring a column in *Mental Health News* about NARSAD. She readily accepted the idea and did so for a number of years.

Constance Lieber was an inspiration and a mentor to me during the early days of *Mental Health News*. I would often call her and ask her advice on an article I had received or if an organization that wished to be included in an issue was known to be a trusted representative of the mental health community. She would always give me sound advice. In addition she would always go on to give me a list of five or more other people I should reach out to in order to create an issue that was a great success. I will never forget her.

A Tribute to Constance and Stephen Lieber  
 As Reported in the New York Times

Constance Lieber transformed her family's experience with significant mental illness into a life suffused with meaning, purpose, and extraordinary effectiveness.



Ira Minot, LMSW

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 her husband 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 the Johns Hopkins University, to integrate new discoveries in developmental neurobiology and genetics in order to achieve clinical advances 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 Brooklyn College. She 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.

Dr. Lisa Pan's Research on  
 Metabolite Replacement Therapy

In addition to the other wonderful BBRF articles in this issue, I urge everyone to read the article about Dr. Lisa Pan, her 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.

How Depression Can Get So Bad  
 You Can No Longer Function Anymore

As Dr. Pan's article states: "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."

The account of Bruce's battle with major depression was very similar to my own and I am sure, countless others who have experienced it. But what does it really feel like on a day to day, month to month and year to year basis?

A person's history before their illness, and the financial resources and family support system they may or not have is important. However, being that seriously ill can feel like your whole life has fallen into a dark pit that is so deep you cannot escape back to reality.

In Bruce's case "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." In my case, I had earned a BA in Psychology and a Masters Degree in Social Work. At age 35, I was married and the happy father of my son David. Then, something happened that changed everything. The world to me started to become gray then black as a major depression took hold of me. People around me couldn't understand my predicament—it was horribly frightening.

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. This lack of understanding and discussions 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 form 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 *Behavioral Health News* can continue to follow the advancements and breakthroughs uncovered by the BBRF and bring them to the attention to our many online and hard-copy readers.

# Relief from Decades of Treatment-Resistant Depression Comes with Metabolite Replacement Therapy Trial

By Fatima Bhojani  
Freelance Writer for the Brain & Behavior Research Foundation (BBRF)

**B**ruce had tried everything. And yet, for three decades, he could not find any 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 tremendous struggle," Bruce recalls.

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.

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 he was 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.



Dr. Lisa Pan and Bruce

Out of desperation and out of options, and recalling research from the 1980s that linked low levels of the neurotransmitter serotonin to suicide, Dr. Pan asked colleagues at the University of Pittsburgh, Dr. David Finegold, a professor of human genetics, and Dr. Jerry Vockley, a biochemical geneticist, if they could glean any clues by examining the young man's neurotransmitter profile. Our metabolism is responsible for manufacturing message-carrying chemicals called neurotransmitters, like serotonin and dopamine and norepinephrine, which help regulate our mood.

After running an extensive neurologic panel by analyzing the young man's cerebrospinal fluid (CSF), her colleagues found he was missing small molecules of tetrahydrobiopterin, or BH4, which helps synthesize neurotransmitters. The young man was given a synthetic BH4 replacement. Within weeks his symptoms greatly improved. The young man went off to college and was able to turn his life around.

Dr. Pan began analyzing the cerebrospinal fluid of other patients with treatment-refractory, life-threatening depression. The next three patients she tested all showed low levels of folate, an essential metabolite, in their cerebrospinal fluid, even though the levels in their blood were normal. After being treated with folic acid over a period of weeks, these patients began to show improvement.

Encouraged by these results, Dr. Pan, through her 2012 Young Investigator Grant from BBRF, conducted a small pilot study, the results of which were published in the American Journal of Psychiatry in August 2016.

Beginning in 2014, Dr. Pan and her team evaluated 33 patients with treatment-

refractory depression. They found that 21 patients had metabolite abnormalities, with the majority suffering from cerebral folate deficiency.

Once treated, most patients showed a reduction in suicidal ideation and an improvement in their symptoms. In some cases, their depression disappeared altogether.

"The thing that is really exciting about these findings is that they suggest that we may have underlying metabolic abnormalities that are contributing to psychiatric illness, particularly depression," says Dr. Pan.

Dr. Pan's best theory is that in most cases these patients' bodies cannot make the neurotransmitters the same way other people can. That would also explain why they don't respond to traditional psychiatric medications.

A common class of depression medications, called selective serotonin reuptake inhibitors (SSRIs), blocks the "re-uptake" of serotonin, which means that they stop neurons from reabsorbing serotonin after it has been released into the gap, or synapse, that separates communicating cells. However, if the body does not create enough serotonin to begin with, there is no "re-uptake" to block, she suggests.

Dr. Pan and her team are trying to fully understand the physiology behind the results to comprehend "why we are finding what we are finding," she says.

She has so far expanded her study to 140 participants. To qualify for the study, patients must have had three maximum dose anti-depressant trials for at least six weeks. However, Dr. Pan points out that most participants have undergone more treatments than that.

"Many have had multiple treatments trials, and so much therapy that they can almost teach it. Quite a few had suicidal behavior and ideation," she says. "This is a chronically ill population, who is at risk for death. Their life is very hard. I admire these people more than anyone because they really fight every day."

Last fall, Bruce joined the study. "Dr. Pan's staff have been incredibly engaging, and involved to a depth I have never experienced in the medical community," he remembers.

An analysis of Bruce's CSF revealed that he too, like the suicidal teenager earlier, had drastically low levels of BH4. He began oral BH4 replacement therapy in late April 2017. Within a few days, he knew "something was happening." Tackling his monthly bills had usually taken him a painfully long time, but by the first of May he was able to get them done in 15 minutes.

As time went on, the improvements kept coming. Before he had spent his whole day managing his condition, but now Bruce found free-time in his day to actually "live."

Almost two months into his treatment, Bruce cooked a barbecue dinner from scratch for his extended family on Father's Day, after he spent five hours working on his car. This would have been impossible before he started treatment.

"I did not need one moment of time to manage my illness," Bruce recalls.

Bruce's cognitive functioning and willpower have improved so much that he is now contemplating a return to the professional scientific community.

This is "a remarkable contrast" to his life before, he says.

Bruce was one of the study participants who showed immediate and drastic improvement. Dr. Pan remembers Bruce as a very "slowed down" person.

"He moved slowly, spoke slowly. And now we have a very energetic and excited person, who is motivated," she says.

In her larger sample of patients, Dr. Pan's initial findings stand. More than 50 percent of those tested have a treatable metabolic disorder.

So far, Dr. Pan's team has found seven disorders, most commonly cerebral folate deficiency and BH4 deficiency. There are also patients for whom the team has yet to find a known metabolic disorder.

The study requires patients to come back for a follow-up visit six months after beginning treatment, and Dr. Pan says most are showing improvements in their symptoms.

"We see everything from a really startling change (such as with Bruce) which is very impressive, to a gradual improvement over time," says Dr. Pan.

Every day, Dr. Pan receives calls and emails from fraught patients and family members across the country.

"I really hope that Dr. Pan's diagnostic technology is made available to as many doctors throughout the U.S. and the world, because depression is a true biological, medical condition that can be diagnosed under a microscope," says Bruce. "It is not a moral or character flaw."

Depression by itself is difficult, if not disabling. "But to have a depression that has been going on for years, or even decades, without any relief is an incredible burden to bear," says Dr. Pan.

And Dr. Pan's research could change the way we treat those who bear that burden.

"The promise of that, even though it's very early, is very exciting," says Dr. Pan.

## 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 significant breakthroughs. They 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 sources. 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 more than \$3.8 billion 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 totality of their work showcases progress and advances in psychiatric diagnostic tools, treatments, and technologies.

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# Parenting: Diagnosing and Treating Anxiety Disorders in Children and Adolescents

**By Fatima Bhojani**  
Freelance Writer for the Brain & Behavior Research Foundation (BBRF)

**An interview with Francis S. Lee, MD, PhD, Weill Cornell Medical College, BBRF Scientific Council Member, 2010 Independent Investigator 2005, 2002 Young Investigator**

**D**r. Francis Lee, is the Mortimer D. Sackler Professor and Vice Chair for Research in the Department of Psychiatry at Weill Cornell Medical College, and an attending psychiatrist at NewYork-Presbyterian Hospital. He is also the Co-Research Director of the Youth Anxiety Center at NewYork-Presbyterian Hospital. His research focuses on leveraging molecular neuroscience tools to improve our understanding of anxiety disorders. His current research has centered on factors that influence the plasticity of the brain – its ability to change in response to experiences, both good and bad. Dr. Lee additionally sees patients with a focus on anxiety disorders.

*Over 20 percent of adolescents have anxiety disorders. How does this compare with other mental health issues?*

Anxiety disorders are the most common psychiatric disorder in children and adolescents. Studies differ, but most suggest between 15 percent and 30 percent of youth will 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 about 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 will all 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 something more there.

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

Feeling 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



**Francis S. Lee, MD, PhD**

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 parents 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, interfering with the child and family's functioning.

In later childhood, generalized anxiety is characterized by frequent worry about many things, including school, friends, family members, world events, health, and safety. Obsessive compulsive disorder has specifically to do with intrusive, unwanted obsessive thoughts or urges that cause distress and anxiety, and associated compulsions, habits, or behaviors that temporarily relieve the anxiety but cause other impairments in daily life.

Social anxiety disorder is 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 low 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 underdiagnosis of this disorder.

If the child has had symptoms during childhood, his or her chances of also 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 treated, 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 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 family members] 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 diagnosed is referred to as 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 anxiety 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 touching something "germy," speaking in public, or purposely practicing another feared experience.

This is why it's so helpful to see a professional, because there are certain things that 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

*see Parenting on page 34*

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—*Barbara Toll, Foundation Board Member*

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# Testing a Simple Strategy to Prevent Schizophrenia via Dietary Supplements

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

At 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 inhibition—specifically, its role 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 newborn children from developing schizophrenia—one of the great objectives in all medical research.

The strategy involves providing expecting 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, however. "The brain is settling 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—but you also install a new operating system. In the early brain, each operating



Robert Freedman, MD

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 concluded 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 quiets down just 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  $\alpha 7$  receptors.

CHRNA7 is the 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, meaning they do not make enough  $\alpha 7$  receptors.

In adults,  $\alpha 7$  receptors are activated by a neurotransmitter called acetylcholine. In related research, Dr. Freedman and colleagues have been testing drugs that stimulate the  $\alpha 7$  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 that one 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 giving expectant 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 moms who later go on to develop schizophrenia, already have recognizable differences from babies who don't carry that risk," says Dr. Robert Freedman. The problem, he notes, is that detecting these differences in the first years of life is not predictive of schizophrenia. All who develop the illness have biological differences from the beginning; but many infants with these differences don't go on to become ill.

By the time of the first definitive diagnostic 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 decided 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 cases."

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 fetus. They noted that this supplementation would bring the choline level up to levels others had measured in the amniotic fluid of healthy mothers. The team also drew heavily on medicine's past success with another kind of prenatal supplementation—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, ideally begun before conception and continued throughout the perinatal period, especially in women with poor diets, is accepted practice in the U.S. and worldwide.

Dr. Freedman, with critical help from Camille Hoffman, M.D., an assistant professor of maternal-fetal medicine, and Randal Ross, M.D., a professor of child psychiatry, both at the University of Colorado School of Medicine, took a parallel approach with choline. Led by Dr. Hoffman, 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 supplements during pregnancy to increase the nutrient's level in the amniotic fluid would enhance the development of inhibition 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 two 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 scientists call a "surrogate marker" of a deficiency 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 expecting mother.)

The study showed, too, that choline supplements even benefitted the infants of

see Supplements on page 34

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# Treating Psychosis Patients Early and Comprehensively Has Resulted in Improved Outcomes

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

An interview with Patrick McGorry, MD, PhD, FRCP, FRANZCP, Professor of Youth Mental Health, University of Melbourne, Australia; Executive Director, Orygen, the National Centre of Excellence in Youth Mental Health; 2015 Lieber Prizewinner; 1998 Distinguished Investigator

**A** new approach to treating schizophrenia is based on a revamping of the way patients are treated, and when they are treated, relative to the onset of the illness.

Spearheading 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 have “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 former involves significant moderation or disappearance of symptoms; the latter signifies the ability to function in society, in a job, for instance). This was their status 18 months after receiving treatment for a first episode of psychosis, in centers for youth that Dr. McGorry and colleagues established to deliver this care, which stress a comprehensive approach including social and vocational rehabilitation.

In order to detect and intervene early in young people who are at high risk of psychosis, have just had a first episode of psychosis, or have begun to experience 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 early intervention might change the course of schizophrenia, especially in light of the pervasive traditional view of the illness which stresses its incurability. “It started back in 1984, when I was still a trainee psychiatrist,” he said. “I had the opportunity, when I moved to Melbourne, to set up a research unit for schizophrenia, which was a new thing in those days in Australia. We didn’t have any research units focusing on that illness.”



Patrick McGorry, MD, PhD

He and his colleagues decided to focus on first-episode psychosis patients. Since psychosis occurs in several illnesses (including bipolar disorder and depression, although in a much smaller fraction of cases than in schizophrenia) this meant the focus was on “the psychotic 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 pretty 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 moment 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 so much harm being done to patients.”

As time passed, he noticed a fourth theme. In his view, patients “were being given 10 to 20 times as much antipsychotic medication as they really needed to get better.” At the same time, there was no real psychosocial treatment being offered. These observations provided the impetus for all that has followed in Dr. McGorry’s career. “We decided to try to turn all of this around – to basically challenge the idea that these people couldn’t get better.”

The new approach began with a deci-

sion “to try to limit the harm by using very low doses of medication,” but was accompanied by efforts to address the developmental and family 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 in a part of Royal Park Hospital, 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 this distress needs to be attended to.

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; then you treat the patient 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 they are not maintained,” he said.

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 population, and nothing that was geared 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 are now over 110 such centers – called “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 invited Dr. McGorry to help them design 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 immediately after 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 ‘silos.’ 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 a need for care – they were distressed, their functioning was definitely suffering.”

Critics have charged that this approach can lead to over-diagnosis and overtreatment. “It’s just the reverse,” Dr. McGorry insists. “We’re trying to provide care where it’s clearly needed, even when the patients have not reached the threshold to qualify for one of those more traditional diagnoses like 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 already has 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 is not begun at the very beginning of the disease process. This is the best time to intervene.

see *Improved Outcomes* on page 34

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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



**Arlene González-Sánchez**

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 Olfson, 2017), OASAS has developed a monitoring tool for tracking our treatment system progress in addressing the needs of those afflicted 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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# What's New and Promising from the New York State Office of Mental Health Psychiatric Research Institutes

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

**T**he NYS Office of Mental Health (OMH) operates two institutes, making our psychiatric research enterprise among 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 the Chief Medical Officer 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, scientists, 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 biotech funding to support research ranging from molecular neuroscience to mental health services and policy in many brain disorders and patient populations.

PI's mission is to better understand how the brain works, what causes both normal and abnormal human behavior, how we can improve psychiatric treatment, and implement programs and models of care that will best serve individuals and communities. Some highlights of the current research at PI are summarized as follows.

**Research on Anxiety, Mood, Eating, and Related Disorders.** PI researchers are advancing the understanding of and treatments for conditions such as anorexia nervosa, social anxiety disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), neuroinflammatory disorders (including tic-born infections such as Lyme disease and chronic fatigue syndrome) and somatic conditions (such as illness anxiety and conversion disorders). Over 40 faculty researchers in this area are conducting 24 different funded research studies.

We are using state-of-the-art neuroimaging (including functional MRI) to better understand how the brain functions in individuals with anxiety disorders, OCD, PTSD, and chronic pain. By learning about how these disorders affect the actual functioning of the brain, our researchers seek to discover innovative ways to treat those ill with these conditions.



**Dr. Ann Sullivan**

In addition, the PI Eating Disorders Clinic provides outpatient and inpatient research and treatment program focused on the underlying mechanisms of anorexia nervosa and bulimia. Likewise, the Depression Evaluation Service, an outpatient research clinic, conducts studies on the causes of and treatment for depression for those who have failed conventional care.

The New York State Center of Excellence for Cultural Competence conducts research that improves the quality and cultural competence of mental health services 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, what 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.

**Psychotic 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 build 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 in real practice, 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 regions of the country.

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-affective 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 at all 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 HIV and 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 *Mental Health Data Science*, to ensure that our researchers use the latest methods for data analysis.

It is no overstatement to say that the PI research enterprise is broad, deep and innovative. Its work is among the best in

this country and the world. And PI, is but one of the two OMH research institutes.

**The Nathan Kline Institute** was established in 1952. It is in New York's Hudson Valley, less than an hour from Manhattan, on the campus of the OMH's Rockland Psychiatric Center. NKI is affiliated with the NYU, Langone School of Medicine.

In 2015, NKI was rated among the top one percent of international research institutes. This ranking, which we are proud to convey, is based on the impact of its scientific publications - the national and international journal reports by its remarkable scientific investigators. Moreover, three NKI investigators are among the top one percent of the most highly cited scientific authors in the world.

The NKI's *Center for Dementia Research (CDR)* has received more than \$25 million in federal awards in the past year, alone. It is principally funded by the National Institutes of Health, including the highly prestigious Program Project Grant.

The Center's work has special promise for understanding the causes and of developing novel therapies for Alzheimer's Disease (AD). Discoveries by CDR scientists have stimulated research world-wide, revealing promising new targets for drug development to slow or prevent AD.

The *Center for Brain Imaging and Neuromodulation* explores the functioning of our brains. Their work uses highly sophisticated neuroimaging and electrophysiology techniques combined with new methods drawn from basic neuroscience. Their aim is to identify brain circuit dysfunction in psychiatric illness, and thus pursue and develop new treatments for mental and addictive disorders.

The federally-funded *NKI/Rockland Project* has NKI scientists performing non-invasive, brain scans in over 1000 members of the Rockland community. Their work has produced more than 200 published scientific articles reporting on healthy brain development over the lifespan. This research serves as a leading guide, nationally and internationally, for understanding the developmental origins of psychiatric illness.

Investigators in NKI's *Social Solutions and Services Research Division* recently received a large federal grant to support their studies of the impact of social determinants of health (i.e., racial discrimination and socioeconomic disadvantage) on psychiatric and physical health. Their work involves a long-term study of individuals who were first enrolled 30 years ago in New York City. This particular project combines clinical and social science interviews with biological and behavioral measures of stress to examine how adverse life experiences affect health over time.

**The Emotional Brain Institute**, studies the development of anxiety disorders, particularly the impact of early life experiences in animals and humans. The team of highly innovative investigators at NKI are now exploring emotional development, the impact of early maternal

# 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



Michael B. Friedman, LMSW

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<sup>1,2</sup>—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<sup>3</sup>—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

because there have been particularly dramatic reductions in death rates due to cancer and heart disease. Why, then is life expectancy decreasing?

According to Case and Deaton declining life expectancy is due to a vast increase in deaths due to drug overdoses, suicide, and alcohol-related disease among working age, white, non-Hispanic people who have a high school education or less. Taken together these “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.

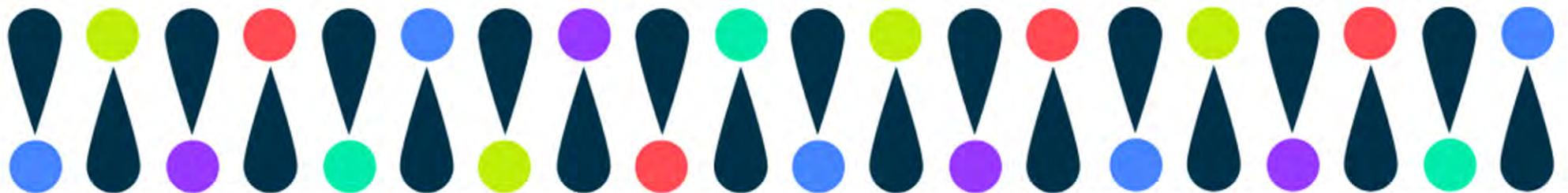
Case and Deaton cite data that indicate that illness and disability (“morbidity”) are also on the rise in the working age population with high mortality. Self-reports on health surveys indicate that they perceive themselves as in poorer health, in more pain, with more limits on activities of daily living, 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 20<sup>th</sup> century. But there has been a significant change in the population most at risk of suicide. Early in this

*see Trends on page 36*



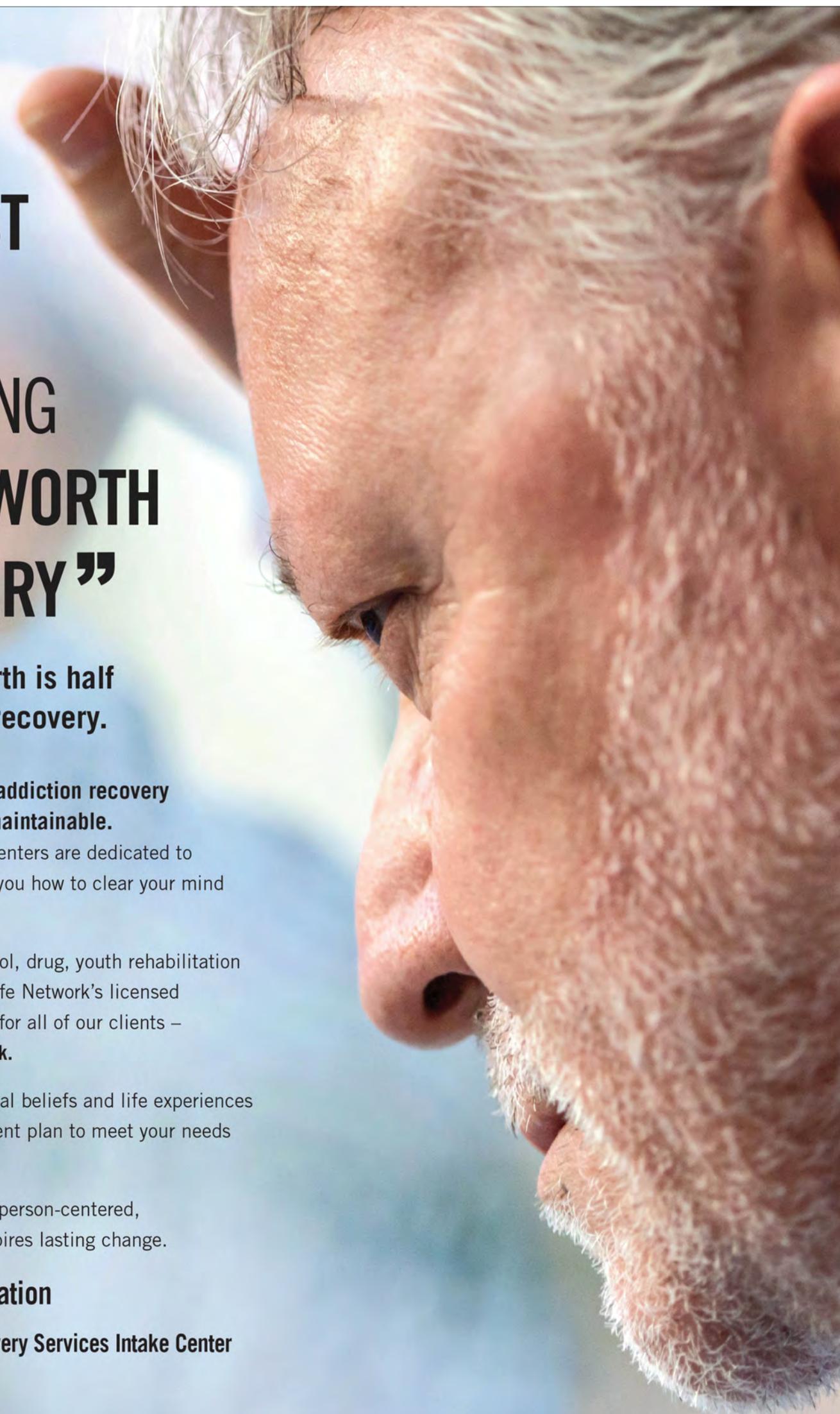
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## Consumer Perspectives



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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

**T**his 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 involvements 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.

**T**his 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. These treatments outperformed 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 treatment for PTSD can be significantly improved by psychotherapeutic approaches alone. Regarding pharmacotherapy, the APA guidelines state that selec-



Amy Joscelyne, PhD

tive 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; Pagni 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.

Furthermore, other neuroimaging stud-



Erin M. Falconer, PhD

ies have shown a relationship between an individual's successful response to exposure-based CBT and frontal brain circuitry responsible for fear processing (Falconer et al., 2008; Bryant et al., 2008).

While these studies provide encouraging evidence for trauma-focused therapy,

not all individuals who may benefit from treatment are able to access it. Barriers to treatment include the unavailability of appropriate services, high costs, and lack of transportation to access services.

Moreover, one of 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 PHDA 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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# Permanent Supportive Housing: The State of the Research

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

Researchers have 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 emerge. 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 and to administer 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 an 18-month survey period (Sadowski et al., 2009).

Other investigators offered a qualified endorsement of these findings through a comprehensive review and meta-analysis



Ashley Brody, MPA, CPRP

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 (Toros & 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 tradeoff between

"sensitivity" and "specificity." That is, modeling aims to maximize the percentage of "true positives" (i.e., those who fulfill modeling criteria) and to minimize the percentage of "false positives" (i.e., those who fail to fulfill modeling criteria but are erroneously included in the former category due to natural variations in the data that inform the predictive algorithm). The model developed by these authors achieved a very strong "Concordance Statistic" (C-statistic) of .83. (C-statistics higher than .7 suggest considerable predictive power.) The potential value of predictive modeling becomes clear when considered against the economic toll of chronic homelessness among the most vulnerable individuals. One study of a chronically homeless population in northern California determined only 10% of its population incurred 61% of health and social service costs (Economic Roundtable, 2015). Another study found 20% of shelter users consumed the largest share of health, social and criminal justice services at a similarly exorbitant cost (Ly & Latimer, 2015). In 2012, the New York State Medicaid Redesign Team (MRT) instituted numerous reforms within its Medicaid program, many of which entailed the identification of individuals who incurred the greatest costs and for whom PSH and other community-based interventions would produce favorable outcomes. MRT reforms have been largely successful in reducing expenditures among

the most costly cohort of Medicaid recipients, but these reforms would surely have benefitted 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.

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# A Virtual Pathway to Technology-Assisted Care Models: Keeping Up with New Technology in Behavioral Health Care

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 cur-



**Jorge R. Petit, MD**

rent 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



**Barry Granek, LMHC**

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 provid-

ers 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

*see Technology on page 36*



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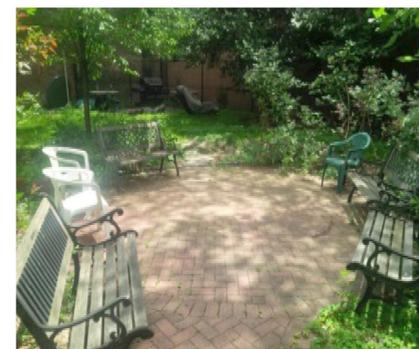


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## Social Isolation: A Solution-Focused Approach

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

**D**oris 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 natural 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 seek 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 Supported 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



Elisa Chow, PhD

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 confused at the time 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 hopelessness. 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 underlying 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 discussions I recognized they were important to Doris so we continued to pursue them. Studies have shown that religion or spirituality are effective in helping individuals cope with major life stressors such as illness, divorce, or mental illness (Harvey & Silverman, *Journal of Cross Cultural Gerontology*, 2007). Religious or spiritual beliefs can provide a sense of meaning and connectedness especially to individuals



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. Recently he was hospitalized and referred to a CR/SRO as he found himself homeless 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 siblings. 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 primary 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 evidence 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 vacil-

lated between feelings of guilt and admiration. At times it seemed as if the roles were being reversed. Clearly Vincent parents were quite worried about him and his lack of fundamental life skills. Moreover, there were clear signs that Vincent’s parents adored him and fostered a type of co-dependency that may have in fact prevented 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 counseling. At age 20, Vincent reported to Theresa that he was hearing voices coming from the television and that he felt scared leaving the home. He was hospitalized in his early 20s and prescribed medications 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 connectedness. Today, health care professionals often refer to these factors as social determinants of health and it’s noteworthy to highlight components that contribute to positive outcomes.

- Collaborative partnerships such as Health Home Care Coordination, regular communication with housing providers, on-going dialogues with both behavioral health and primary care professionals, and discussions with natural supports such as friends, families, clergies/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 conditions. Moreover, it is recommended when considering review of risk, that staff maintain an integrated health lens.

Social isolation is different from loneliness although they are intricately linked. Social isolation is defined by the level of social connections such as small social networks, infrequent social interaction,

*see Social Isolation on page 38*

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# The NYSPA Report: From the President's Desk

By Jeffrey Borenstein, MD  
President, New York State  
Psychiatric Association (NYSPA)

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



New York State Capitol - Albany New York

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 infor-

mation 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 (VMHPCTI), 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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## Cyberbullying Studied at Four Winds

By Staff Writer  
Behavioral Health News

While experiences of victimization are more common in clinical populations, and adolescent psychiatric patients have often been the objects of various forms of bullying, there is reason to believe that bullying via the internet may be particularly harmful for contemporary youths. The nature of internet and social media communications and the high value placed on these sources of information by teens may increase their power, while their broad reach and the anonym-

ity of those who use them to hurt others may serve to aggravate the harm that they do. Therefore, it is important to understand the role that cyberbullying may play in the lives of those adolescents who seek mental health care.

At the annual convention of the American Psychiatric Association in May 2017, the Four Winds research team, led by David L. Pogge, Ph.D., Director of Psychology and Research, in partnership with investigators from the University of Miami Miller School of Medicine and Fairleigh Dickinson University, presented a study entitled "Cyberbullying and

*see Cyberbullying on page 37*

**Cyberbullying and Adolescent Mental Health:  
A Study of Adolescents on an Acute Inpatient Psychiatric Unit**  
Samantha B. Saltz, MD<sup>1</sup>; Maria Rozon<sup>2</sup>; Nicole A. Mavrides, MD<sup>1</sup>; David L. Pogge<sup>2,3</sup>, PhD; Philip D. Harvey, PhD<sup>1</sup>  
<sup>1</sup>University of Miami Miller School of Medicine, <sup>2</sup>Fairleigh Dickinson University, <sup>3</sup>Four Winds Hospital

<p><b>Background:</b> Cyberbullying has received wide media attention and appears to be linked to adverse consequences to victims with multiple suicides reported. In a previous study we found that cyberbullying was a common experience among adolescent psychiatric patients. In this study we examined victimization by cyberbullying among adolescent psychiatric inpatients and related it to social media usage and histories of adverse early life experience.</p>	<p><b>Percentage of Patients Engaged in Social Media</b></p>	<p><b>Mean T-Score for TSSC Scales and Subscales</b></p>	<p><b>Conclusion:</b> These findings suggest that cyberbullying can lead to significant mental health impairments compared to other adolescents treated in an inpatient psychiatric ward. Considering that adolescents who are admitted to these facilities likely have higher depression and anger symptoms at baseline than adolescents living in the community, we suggest that cyberbullying may exacerbate their existing mental health issues. It was interesting that forms of abuse and neglect besides emotional abuse were not associated with cyberbullying. This is consistent with the fact that abuse via social media can generally only be through emotional measures. We also found that the majority of adolescents did not engage in bullying, but victims were active on social media. This suggests that adolescent education regarding healthy use of technology needs to be provided. Further, additional research needs to determine the role of extensive social media use in mental health problems of adolescents who are not abused, but may otherwise be affected by social media access.</p>
<p><b>Methods:</b> After approval from University of Miami's IRB, we collected data on the prevalence of social media utilization and cyberbullying victimization on adolescent psychiatric inpatients between the ages of 13 and 16 at Four Winds Hospital in Katonah, New York. 50 adolescents on the inpatient unit between September 2015 and November 2016 who met criteria completed two surveys assessing childhood trauma: the Trauma Symptom Checklist for Children and the Childhood Trauma Questionnaire. In addition, adolescents were asked to complete a cyberbullying questionnaire. The prevalence of cyberbullying was examined and related to social media usage and histories of childhood trauma, as well as the number of social media contacts.</p>	<p><b>Total Mean T-Score for Those Exposed to Abuse</b></p>	<p><b>Results:</b> 20% (10/50) of participants had been victimized by cyberbullying, while only 3 admitted to engaging in cyberbullying. Access to social media networking sites and engagement in internet based communication was common, with most participants engaging on a daily basis or more frequently in at least one social media activity (Facebook 54%, chat rooms 33%, Instagram 53%, Twitter 30%). Victims reported that several forms of media were being utilized (Facebook 6/10, chat rooms 3/10, Instagram 6/10, Twitter 4/10), except e-mailing (E-mail 0/10). Cyberbullying was associated with higher depression scores (p=0.024), anger scores (p=0.016), and dissociation symptoms (p=0.044). It was found that those who were cyberbullied had lower underreporting scores (p=0.003) and therefore their results appear to be more valid. We also found that a history of emotional abuse was significantly associated with being the victim of cyberbullying (p=0.013), but the other 4 types of early life trauma (Physical and sexual abuse, physical and emotional neglect) were not.</p>	<p><b>Key Points:</b></p> <ul style="list-style-type: none"> <li>• 66.3% of subjects had access to a cell phone</li> <li>• 3/50 admitted to being a perpetrator &amp; 10/50 admitted to being a victim of cyberbullying</li> <li>• Those who were previous victims of emotional abuse were more likely to be cyberbullied</li> <li>• Victims of cyberbullying reported more depression, anger and dissociation symptoms</li> <li>• Research is needed to address the effects of social media on adolescent mental health</li> </ul>
<p><b>Four Winds:</b> Four Winds Hospital has the largest inpatient service for children and adolescents in the greater New York metropolitan area and it has been the site of more than 100 empirical studies looking at issues related to psychopathology and psychiatric treatment of children and adolescents. Because of the large and diverse population of adolescents treated in this setting, it is believed that this would be an ideal site for research addressing the foregoing issues.</p>			<p><b>References:</b> 1. Xantus A, Saltz SB, Shaw A (2015). The Relationship between Social Media Bullying and the Adolescent's Self Report of Emotional Health: A Study of Urban Youth on an Acute Inpatient Psychiatric Unit. J Depress Anxiety 4:186. doi:10.4172/2167-1044.1000186</p>



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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 be-



**Timothy C. Peck, MD, CEO and Co-founder, Call9; Matt Loper, Co-founder and CEO, Wellth; Jorge R. Petit, MD, President and CEO, CBC and David Sandman, PhD, President and CEO, New York State Health Foundation**

havioral 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 was especially gratifying.

Petit stated, "CBC wishes all the awardees our heartfelt congratulations and a special thank you to the Heritage Provider Network and Crain's New York Business for honoring us with this award. As a not-for-profit, behavioral health organization, it is truly heartening to be considered among such amazing organizations and having a spotlight shine on the work we 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 those "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



**Andrew Malekoff**

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 "Damning." In a bipartisan effort, Kaminsky 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 Gov. Cuomo, requesting the same.

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 has 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](http://www.northshorechildguidance.org). To read more about Project Access go to: [www.northshorechildguidance.org/wp-content/uploads/2017/12/north-shore-project-access.pdf](http://www.northshorechildguidance.org/wp-content/uploads/2017/12/north-shore-project-access.pdf)*

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# Unique People Services Opens Lynn's Place: Agency's First Mixed Income Affordable Housing Development

By Staff Writer  
Behavioral Health News

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



**Yvette B. Andre, Executive Director of Unique People Services Cuts the Ribbon as Dignitaries and Supporters Celebrate the Event**

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

*see Affordable Housing on page 37*



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## 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



Debra Pantin

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



Kathleen Riddle

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 OASAS 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. It is 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



**MHNE Board. Front Row: Josh Rubin, Rachel Fernbach, Debra Pantin, Constance Brown-Bellamy. Back Row: David Minot Jonathan Edwards, Yvette Brissett-André, Alan Trager, Barry Perlman, Peter Beitchman, Ira Minot. Not shown: Jorge Petit and Kimberly Williams**

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 non-profit governance and operation will be an asset to the organization during our period of growth and change over the next few years, as will her 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.”

# Tino Hernandez Departs as Head of Samaritan Daytop Village Project Renewal's Mitchell Netburn to Succeed Him

By Staff Writer  
Behavioral Health News

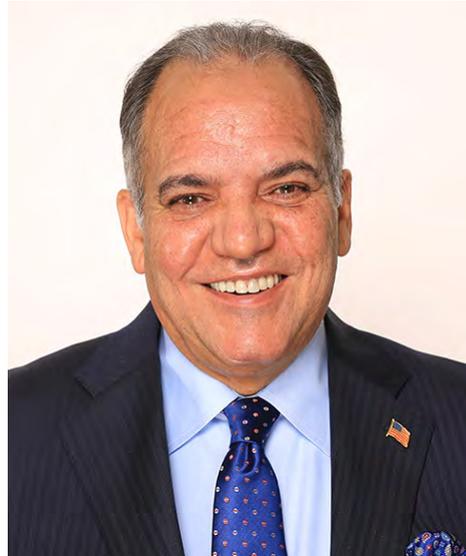
It was recently announced that Tino Hernandez will step down as President and CEO of Samaritan Daytop Village this summer.

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



**Tino Hernandez**

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



**Mitchell Netburn**

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 sub-

stance 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

see *Transition* on page 34

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## Coalition Appoints Lippman as Interim President and CEO

By Staff Writer  
Behavioral Health News

**O**n 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 commu-



**Jason Lippman**

nity, 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

**W**estchester 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



**Seth Diamond**

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](http://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.



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# 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 nal-

axone 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 too few studies to provide validity to this relatively new view.

*The monoamine hypothesis* suggests 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 have 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

*see Exercise on page 37*



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### Parenting from page 6

ultimately the bedrock of this kind of behavioral treatment. These treatments usually last 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 [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 not enable 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 while these are still plastic. These manifestations - they could be symptoms, behaviors, genetic predispositions, or, in the period just ahead, biomarkers - combine in a person to generate what he calls "microphenotypes." By this he means that youth who may ultimately receive a wide range of diagnoses may have some of these individual components 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 out of every three 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 vital to get these vulnerable and suffering young people into care, and to stay with them. But we have not yet built the rest of the house, involving more specializations, for the later stages of illness."

He believes one reason the clinics have succeeded so far is that "they are stigma-free. And they are popular because people don't worry about all the arcane debates

*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: you go to a pediatrician, 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. The young adult has outgrown pediatric 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 who are going to college have a diagnosable anxiety disorder, and the mental health services at colleges are usually not equipped to handle the large number of cases.

*If my child is 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 team. It might be possible to maintain 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.

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 barriers, including financial ones. Young people just come in and talk to someone.

"We scale up the intensity of our response according to the needs the person has. Not just narrow medical needs. Medication can be part of it, but we're also helping them get a job or finish their education or deal with substance abuse or relationships. These are young people in transition, trying to master developmental tasks, like identity. Many have sexual orientation issues. So it's very holistic. We embed our psychiatric expertise within that kind of needs-based framework. Within that structure, we conduct [National Institute of Mental Health] NIMH-level research," which has resulted in many publications and the start of a new journal to address this emerging field: *Early Intervention in Psychiatry*, published by John Wiley & Sons since 2007.

The RAISE clinical trial in the U.S., in which many researchers supported by the Foundation have participated, has pointed to the vital importance of treating psychosis early and comprehensively, in care that is integrated. The RAISE study (Recovery After an Initial Schizophrenia Episode), along with nine other clinical trials, now shows that specialized first-episode programs produce better medium-term results, Dr. McGorry says. He adds: "They clearly have a much more potent effect if the delay in accessing treatment is not too long. Beyond a year or so of delay, they don't seem to be able to reverse the im-

### 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 2015, Dr. Freedman's team reported follow-up results when infants in the original trial reached 40 months of age—the time when behavioral patterns become settled and incipient problems are discernible.

"Children who will 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 atten-

### Transition from page 31

Mr. Netburn's leadership Project Renewal has become universally recognized as a premier agency for its respectful, compassionate, innovative and results oriented approach to serving homeless individuals and families, and those with mental health issues and substance use disorders.

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

*About Samaritan Daytop Village.* For more than 50 years, Samaritan Daytop

tion 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 problems and less social withdrawal compared with children in the placebo group. It is of course impossible to know the "final" outcome of this experiment until the children reach their 20s. 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 and permanent housing assistance, and services for seniors. Annually, Samaritan Village serves over 28,000 people at more than 50 facilities throughout New York City, Long Island and upstate New York.

pact of the illness so well, which makes perfect sense clinically."

To Dr. McGorry, the RAISE results echo findings from his years of research dating back to the 1990s with first-episode patients. "If you do things properly for first-episode patients, from the earliest point of the illness - and the earlier the better, we have evidence of this - the better the outcome is liable to be. Our research shows that the best results come from identifying the patient in the first three months of development of sustained psychosis to really make a difference with early treatment programs like ours. So the timing (as well as specialized first-episode psychosis care) is very, very important. In 2012, the TIPS study (TIPS is an acronym for early detection and treatment) in Norway also showed in a population of 174 patients, 101 of whom received early treatment for first-episode psychosis, that if treatment delay is reduced to a few weeks, recovery rates are 'significantly' better 10 years later. And new research shows that you have to safeguard and build on those gains and not consign patients back to revolving-door care in traditional psychiatric services."

Data from the headspace clinics also support the importance of engaging and following up with so-called ultra-high risk individuals, those with genetic and behavioral warning signs that mark what doctors call the prodrome, the period leading to a psychotic episode. Only one person in three in this high-risk group progresses to psychosis. In a certain number of these people, Dr. McGorry hypothesizes, the condition may resemble - surprisingly - asthma. "Certain young people may have a [biological] vulnerability, which they may grow out of," he says. Others may progress to psy-

chosis, but if treated comprehensively in the very earliest stages, the damage may be limited and the impact of the illness either attenuated or perhaps postponed for some number of years.

This evidence seems to suggest there is a "critical period," says Dr. McGorry, which describes this first period of psychotic illness. "I've worked in the same place for 30 years," he says. "So I've looked after patients for very long periods of time." In his experience, young patients, when treated comprehensively and consistently followed up, improve over time, so the prognosis is better and more malleable than people have realized. Some fraction of patients, perhaps one in five, clearly deteriorate, he acknowledges. "These are the patients we have not learned how to help yet." Some young people at high risk of psychotic disorder seem to outgrow their vulnerability, while others do not. In some ways this pattern is reminiscent of childhood asthma, he says. Some of the latter become chronic patients, for reasons still not clear. Dr. McGorry suspects some portion of chronicity and the premature mortality that flows from physical illness and suicide "is built in by neglect, drugs, or just inactivity, as well as unemployment, social deprivation and poverty." One clear objective of the headspace clinics and the kind of early intervention he has inspired others to try to provide is "to prevent a lot of those co-morbidities, as best as we are able, given our resources."

He concludes: "There's a tremendous amount that can be done, if only the society and governments would actually commit the amounts of money and support for clinical care systems that are appropriate, and also to medical research, just as they do for cancer and HIV."

# 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

It 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 aspects of social cognition and perception within an individual with ASD. This approach allows for the evaluation of social patterns and profiles which differ within and between people. Utilizing such an approach has allowed us to begin answering important questions about which unique factors give rise to social challenges for a specific person, as well as which areas may not be impacted for that same person. In doing so, we can begin to tailor our interventions to more precisely address those issues which matter most for a given individual.

A key example of a project that aims to identify patterns and profiles of social perception and cognition is the SCTL’s study of the SELWeb program. Conducted in collaboration with colleagues at the Rush NeuroBehavioral Center (NBC), this study examines an interactive web-based tool set called SELWeb, which uses a series of game-like activities to examine each of the following discrete aspects of social cognition:

- Non-verbal awareness - the perception and processing of gestures, facial expression and body language.
- Social perspective taking (theory of mind)- the ability to guess or infer what another person may think about a social situation or interaction.
- Social reasoning - the ability to understand, interpret and make decisions based on social information and context.
- Emotion regulation- the ability to appro-



Erin Libsack, BA



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Matthew D. Lerner, PhD

propriately monitor and control one’s emotions in social situations.

The original SELWeb games were developed by our colleagues at Rush NBC with the goal of assessing these four facets of social emotional learning (SEL; McKown et al., 2013). After initial development, the tasks were pooled together, standardized, and tested across two studies which collectively involved approximately 9,500 school-age TD children and evaluated whether the SELWeb tasks indeed measure the specific aspects of social cognition they were designed to assess (McKown et al., 2015). Results showed that the SELWeb games do successfully measure their targeted domains of social cognition, are comparable across domains of social cognition, are consistent for each child over a six-month period, and can be administered in a variety of ways and settings.

With support from the Simons Foundation, we examined SELWeb further in a sample of 60 children with ASD. In addition to finding that SELweb seems to measure the same social cognitive abilities typically assessed using longer and more demanding assessment tools, we found that performance on the SELWeb games was closely associated with parent and clinician ratings of various aspects of social abilities. On average, individuals with ASD show impairments in most (but not all!) SELWeb domains. However, we found dramatic differences within and between children, with some exhibiting a pattern of strengths and challenges in certain domains (e.g., strong ability to read emotions but poor ability to plan social responses), and other exhibiting an entirely different pattern. Thus, SELWeb can be utilized to elucidate unique profiles of strengths and weaknesses in social cognition abilities that vary between individual children. However, to really understand the diversity of ways

children with (and without) ASD understand social information, we must search deeper. Specifically, we must examine how the brain goes about processing social information – in real time.

Electroencephalography, or EEG, is a safe, non-invasive, and cost-effective method of measuring the electrical activity of the brain while the brain is processing information, features which make EEG an ideal tool for pinpointing the exact point in time when differences in social processing occur. One way of doing this is to use event related potentials (ERPs). ERPs represent specific neural responses to a specific event. For instance, 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 ex-

tend 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 will also 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.

### Trends from page 14

century it was adults over 65. Now it is working age adults.

In her remarkable work, Julie Phillips has tracked suicide rates by age, historical period, and generation from 1940 on. Her work indicates that the elder boom generation is at higher risk for suicide than previous generations and that the risk is greater among the younger members of the elder boom generation than among those who are already old. Her conclusion is that the cohort of working age adults who will become old in 10 to 20 years is likely to have higher suicide rates than those who are currently old.

Why? Like Case and Deaton, Phillips uses a Durkheimian perspective to try to understand rising suicide rates. There are, she believes, weaker connections between individuals and their society due to such factors as increased mobility and separation from extended family, increased divorce rates, increased loneliness, decreased civic participation, unstable employment, decreased religiosity, and more.\*\*

Has there also been an increase in mental illness? Given the close connection between mental illness and suicide, that seems likely.

#### Implications for Geriatric Mental Health Policy

It has been clear for many years that the projected growth of people 65 and older<sup>4</sup> 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 counterintui-

tive 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 does not go beyond high school is not. That population may have growing needs for medical, behavioral, and social services as they become old.

What can be done? In part the answer is more and better services\*\*\*\*, 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; lost sources 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 20<sup>th</sup> century

called the “promise of American life”.<sup>7</sup>

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 division in America today. I'm skeptical, but still hopeful.

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\* Case and Deaton speculate why death rates have continued to decline for black and Hispanic populations despite the ongoing travails 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 whites because they had 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 more related to local circumstances than to broad social changes.<sup>5</sup>

\*\*\*\* 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.<sup>6</sup> 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 has 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. PH 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.

One PH staff remarked “For my own clinical work, it's been monumental to break out of traditional phone calls. Not to mention, this is how most of us communicate in 2018. It makes my job a lot more convenient, authentic, and genuine.” “I have seen great benefits for the individuals on our team with secure text messaging... it has really helped build relationships.” another PH clinician stated.

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 talking on the phone but texting 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.”

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 is a good starting point to help increase awareness of the benefits of medication adherence.”

In one instance, PH was serving Malcom, who was prescribed 12 oral medications to be taken three times a day. Malcom had reported past challenges with medication adherence and concerns about forgetting to take them on time. For three months, the PH nurse assisted with medication management using the dispenser machine. The machine alerted Malcom to take notice of the prescribed times, increasing awareness and adherence. Practicing this routine led Malcom 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 service delivery staff should 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 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.

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**Interview from page 5**

What kind of advancements have BBRF researchers found as a result of funding? Advancements funded by our grants continue to define the leading edge of all research in the mental health field. Examples include the use of Clozaril 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 26<sup>th</sup> 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 brain and behavior research. 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 shedding light on common psychiatric conditions through inspiring personal stories and experts sharing cutting edge information on treatment. 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](http://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 and 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.

**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. Roy Blunt (R-Mo.) and Debbie Stabenow (D-Mich.), and Reps. Leonard Lance (R-N.J.) and Doris Matsui (D-Calif.) introduced the Excellence in Mental Health and Addiction Treatment Expansion Act, a small (two-year, eight-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 financing, including grants, loans and tax credits, came from NYC Department of Housing Preservation and Development, NYC Resolution A funds, Capital One Bank, CSH, and the Community Preservation Corporation. Hudson Housing Capital is the syndicator for the tax credits. The architect is Tony Shitemi of Urban Architectural Initiatives and the contractor is Procida Construction Corp. Robert Sanborn of Robert Sanborn Development is the housing consultant.

About Unique People Services.

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 is executive vice chairman of the New York-Presbyterian Hospital Board, and President of the Brain & Behavior Research Foundation's Scientific Council.

Credits: *The Hill* - 12/10/17, <http://thehill.com/opinion/healthcare/364166-we-need-to-do-more-than-just-talk-about-mental-illness>.

Unique People Services, Inc. (UPS) is a New York-based nonprofit 501(c) 3 that provides supportive housing and medical case 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' home, living in well-appointed residences where they receive meals and support services to help them achieve the highest possible levels of independent living and community inclusion. The transitional, long-term and permanent housing UPS provides has also become a safe haven for many formerly homeless individuals.

For more information about UPS, visit [www.uniquepeopleservices.org](http://www.uniquepeopleservices.org).

**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 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 similar to 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 show that exercise not only alleviates 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 non-medical prescription, exercise.

You can reach Dr. Motta by email at [Robert.W.Motta@hofstra.edu](mailto:Robert.W.Motta@hofstra.edu).

**Cyberbullying from page 26**

Adolescent Mental Health: A Study of Adolescents on an Acute Inpatient Psychiatric Unit." This study suggests that cyberbullying does indeed have a significant impact on the mental health of adolescents.

The study followed upon earlier work by members of the research team, who had found that cyberbullying was a common experience among adolescent psychiatric patients. In the follow-up study, a total of 50 adolescent inpatients (13-16 years of age) agreed to complete surveys regarding childhood trauma, emotional and trauma-related symptoms, and experiences of cyberbullying. Three of the 50 participants acknowledged that they had cyberbullied others and 10 reported having been the victims of cyberbullying. Participants who reported experiencing previous emotional abuse were more likely to report having been cyberbullied. The victims of cyberbullying reported more depression, anger and dissociation than the nonbullied patients.

These findings further document the prevalence of this phenomenon in mental health settings and raise the possibility that cyberbullying may cause or exacerbate emotional problems. They also suggest that those teens who have previously been victimized—particularly those who report having been emotionally abused in the past—may be 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.

References: Saltz, SB, Rozon, M, Mavrides, NA, Pogge, DL, Harvey, PD (2017, May). *Cyberbullying and adolescent mental health: A study of adolescents on an acute inpatient psychiatric unit*. Poster presented at the 2017 Annual Meeting-American Psychiatric Association, San Diego, California.



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## 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 & Stephenson, Perspectives on Psychological Science, 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.

### *Outreach from page 30*

Health Center (FQHC) with care coordination services. Ms. Pantin’s leadership role extends beyond the provider level, as she maintains active executive roles on key boards and coalitions for the field, among them, the New York State Alcoholism and Substance Abuse Providers (ASAP), and Mental Health News Education, Inc., publishers of *Behavioral Health News*.

Prior to joining VIP Community Services

in 2013, Ms. Pantin served as COO of Palladia, Inc. (formerly Project Return) where she spent 25 years directing program and operational services serving 26,000 clients annually. Debra earned her Master’s Degree in Social Work from the Hunter College School of Social Work and her Master’s of Science in Management and Health Care Management from the University of Rochester’s Simon Business School. She earned her Bachelor of Arts from SUNY College at Purchase, New York.

### *OMH from page 13*

contact, sleep, and methods of coping with anxiety.

In addition to the well-established NKI clinical research programs in schizophrenia and mood disorders, there are new programs in Obsessive Compulsive Disorder and Suicide. This

work has received funding to develop novel, human biomarkers to guide optimal, clinical strategies for the biological and psychosocial treatments of these conditions.

It is a great privilege to be involved with these two extraordinary research institutes. The future for discovery has never been greater.

### *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 question 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.

### Quality Improvement

To achieve our reform goals for New York, OASAS is encouraging providers to become learning systems of care. Metrics alone are not sufficient for creating a performance driven system. Organizations need to have the capacity and protocols for improving clinical practice in response to feedback from measures. OASAS together with the Center on Addiction will be providing technical assistance for providers to develop this capacity for clinical practice change. The methods are drawn from those used in other industries for improving quality.

### *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:US 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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# Deadline Calendar and Ad Size Specifications

### Deadline Dates

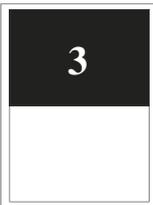
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**Winter Issue - January 8, 2019**  
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**Summer Issue - July 1, 2019**



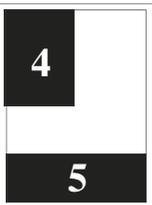
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2  
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3  
Half Horizontal  
\$750



4  
5  
Quarter V & H  
\$500



6  
7  
Eighth V & H  
\$300

### Ad Sizes - In Inches

	Width	Height
Full Page (1)	10.4	12.8
Half Vertical (2)	5.1	12.8
Half Horizontal (3)	10.4	6.4
Quarter Vertical (4)	5.1	6.4
Quarter Horizontal (5)	10.4	3.1
Eighth Vertical (6)	5.1	3.1
Eighth Horizontal (7)	10.4	1.5
Business Card (not shown)	5.1	1.5

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