

## Serious Mental Illness: History and Challenges Ahead

### Basic Research Has Had a Major Impact on Developing New Treatments for Serious Mental Illnesses

By Peter Tarr, PhD,  
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Depression is the leading cause of disability worldwide, with an estimated \$2 trillion annual economic impact. The cost in terms of human suffering is, of course, incalculable. Each year about 8% of adults—nearly 20 million Americans—experience major depression; 8% of adolescents experience at least one depressive episode; and an estimated 3 million American adults make a suicide plan. Unfortunately, more than 50% of Americans with depression remain untreated. And while many who are treated respond to therapy, at least one-third do not respond or do not have a full response. Non-responders have “treatment-resistant depression” (TRD).

Many of these facts are known to the broad public. Not so well known are the



activities of researchers in this country and around the world who have dedicated their lives to studying the basic biology of the human brain. The purpose of this arti-

cle is to bring some of the more consequential fruits of their labors to light—beginning with new treatments for treatment-resistant major depression.

#### The First Rapid-Acting Antidepressants

In the spring of 2019, the U.S. Food and Drug Administration granted approval for two breakthrough medicines that act rapidly to alleviate symptoms of major depression. Esketamine, a drug administered via a nasal spray, was approved for use in treatment-resistant major depression. Weeks later, brexanolone, administered intravenously, was approved for use in postpartum depression.

Both events are milestones: *Esketamine* is the first antidepressant with a novel mechanism of action to be approved since the FDA’s 1959 approval of imipramine. Esketamine’s beneficial effects have been described as profound and astonishing, often beginning within an hour or two after administration. (Widely prescribed SSRI antidepressants typically take weeks or months to provide relief.) *Brexanolone* is the first medicine ever approved specifically to treat depression that begins just before or in the months

*see Research on page 34*

### Outcome of Schizophrenia in Later Life: Conceptual Changes and Implications for Treatment and Policy

By Carl I. Cohen, MD  
SUNY Downstate  
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In tandem with the greying of the general population, there has been a dramatic increase in the number of older adults with schizophrenia (OAS). Since 2000, there has been a doubling of persons aged 55 and over with schizophrenia and they now comprise about one-fourth of all persons with schizophrenia. Globally, the number of persons with schizophrenia aged 60 and over will double between 2014 and 2050 and will reach 10 million. Nevertheless, only 1% of the schizophrenia literature is devoted to older adults.<sup>1</sup>

Schizophrenia typically arises in the second and third decades of life, and roughly three-quarters of people develop schizophrenia before the age of 40. Although persons with schizophrenia have substantially higher mortality rates than the general population, many more are living into older age. A study in the Netherlands found the prevalence estimates of schizophrenia in the adult population at age 60 was .35%, .14%, and .03% for



early-onset, late-onset (arising between age 40 to 59), and very late-onset schizophrenia (arising at age 60+), respectively; the overall prevalence was of 0.52%. Thus, the ratio of early-onset to late-onset types was 2:1.<sup>2</sup>

An understanding of the various out-

come measures of schizophrenia in later life is critical for developing rational treatment and public policy decisions. Many of our perspectives on the outcome of schizophrenia in later life are based on studies done in the 20th century when people typically spent many years in insti-

tutions. Today, more than 85% of OAS live in various levels of supportive or independent living in the community, 10% reside in nursing homes, and 5% are in hospitals.<sup>1</sup> In this article, I will elaborate on 7 essential points that will provide the reader with an appreciation of the evolution in the conceptualization of outcomes in later life and the implications for care. Many of the findings are based on our longitudinal data collected on community-dwelling persons aged 55 and over with EOS (defined as onset before 45) living in New York City.<sup>1,2</sup>

*Point 1: “Outcome” changes historically because of evolving diagnostic criteria, criteria for outcomes, and social factors.*

Across the 20<sup>th</sup> century, there have been wide swings in the clinical outcomes of persons with schizophrenia. In the early part of the century, favorable outcomes were thought to occur in about one-quarter of patients. In the mid-century, optimism grew, and favorable outcomes were thought to approach one-half of patients; however, favorable outcomes

*see Outcome on page 16*



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Winter 2024 Issue

**The Role of Housing and Employment in the Recovery Process**  
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## Recovery: Realizing Hopes and Dreams

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

**W**e must ensure that individuals living with mental illness have the opportunity to fulfill their hopes and dreams. To do so, all the systems and services we design must support the ability for individuals living with mental illness to thrive in their own community and reach their personal goals. We have to make available opportunities for a full education, employment, social connections, and enriching social life and activities. And we must have available a welcoming continuum of care services that support individuals and families when needed.

Governor Kathy Hochul's historic, \$1 billion plan to strengthen the [State's mental healthcare system](#) provides us with a blueprint as well as the resources to make these goals a reality. From their first experience with mental illness, through navigating their life choices and experiences, each individual needs to be able to learn and thrive and reach their aspirations.

OnTrackNY is a comprehensive program that empowers young people experiencing a first episode of psychosis to understand their experiences and to pursue their goals for school, work, and relationships. The program includes a diverse team of professionals in health, mental health, and peer support. The impact of this program can be illustrated by sharing feedback received by recent recipients.

A young man who we'll call Robert (which is not his real name) experienced a psychotic episode and hid his illness from others because he felt no one would truly understand what he was going through. But when he began to work with the OnTrackNY program, he met a Peer Specialist who took the time to learn about Robert's goals and aspirations as well as the challenges he faced. Through their relationship, Robert realized he "...could live a life that was worthwhile... and I was a person who still mattered." Robert is now working as a Peer Specialist, helping others make their way to recovery.



Ann Sullivan, MD

The program also helped change the life of a young woman who we will call Susan, who was diagnosed with schizophrenia when she was 19 years old, which led to multiple hospitalizations. She did not trust her caregivers and felt the delusions she experienced were reality. OnTrackNY empowered her and put her "at the forefront" of her own care, she said. "Today, I have a lot more hope that I can live a full life even if things are hard. My future is in my control."

In addition to expanding OnTrackNY, Governor Hochul's budget dramatically increases a host of services that enable individuals to thrive in the community. There will be 26 more Certified Community Behavioral Health Clinics (CCBHCs) across the state that provide a full continuum of ambulatory mental health services and outreach, 42 more Assertive Community Treatment (ACT) teams providing community-based care serving an additional 2500 individuals including adults and youth, 50 Critical Time Intervention (CTI) teams to support individuals who may be transitioning from more intensive inpatient or emergency department care, additional INSET (Intensive and Sustained Engagement Teams) teams to pro-

vide peer support for individuals with serious challenges, HBCI (Home Based Crisis Intervention) and ACT Teams for youth and much more!

But all these services can only be effective if someone has a safe place to sleep and live. This Budget adds 3500 units of supportive housing, including housing first and transitional housing, designed to meet individuals with multiple complex issues and provide the supports needed to thrive.

Throughout these services, peer specialists are critical to success. Peer specialists, who play such an important role in OnTrackNY as well as the Safe Options Support (SOS) Teams focusing on individuals who are homeless, and in many other programs, are integral components in the continuum of care. Their influence and importance in the mental healthcare field is crucial for success.

Peer Professionals share their own experiences with mental health challenges, emotional distress, and trauma, as well as their personal recovery. These experiences, combined with their firsthand knowledge of the mental healthcare system, put them in a unique position to offer support and help others on the journey to recovery. Multiple national research studies have shown that peer support, by building trusting relationships, can help reach, engage, and connect with people who may have had difficulty connecting to traditional mental health services.

And while Peer Professionals support others on the path to recovery, they also teach life skills and help people experiencing mental health challenges to lead successful and meaningful lives in the community. Peers understand their clients and the challenges they are facing. They demonstrate that hope and recovery are very real possibilities for people living with mental illness. This strong, positive relationship and encouragement leads to increased collaborative engagement in services, greater life satisfaction, and the reduced need for hospitalization.

The ability to build a strong relationship is at the core of the work being done by the Safe Options Support (SOS) Teams

created last year under the Governor's direction. These teams are working with people who are living with mental illness and are also experiencing homelessness and living on the street and in the NYC subway system.

Individuals living on the street are often very difficult to engage, and the process of building rapport and trust can take time and multiple contacts. The SOS teams, which include licensed clinicians, care managers and peer specialists, help connect the client to treatment and support services, as well as temporary and permanent housing options.

The teams continue to work with their clients as they transition from homelessness to housing, promoting community integration, self-advocacy, and continuity of care by ensuring that the recipient has strong ties to their professional and non-professional support systems during these critical periods.

The ultimate goal of the teams is to help people with serious mental illness who are living on the street through a comprehensive process that may include inpatient treatment, but which ends with the development of self-management skills that lead to housing, employment, recovery, and self-sufficiency.

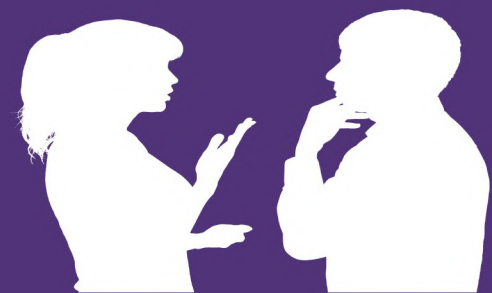
In the months and years ahead, thanks to the budget investments made by Governor Hochul, we will be expanding peer support programs as well as the innovative treatments and services that assist patients and clients along the entire continuum of care. These are the programs that help people with serious mental illness as they transition from inpatient care when needed to outpatient community-based care; programs that help people experiencing homelessness to gain the life skills they need to live successfully in the community; and programs that help people achieve their goals and fulfill their hopes and dreams.

The Governor's mental health plan will enhance the State's mental healthcare system and provide people living with serious mental illness with the services they need live fully in the community, to hold a job, go to school, build relationships and to truly thrive.

# Help change the conversation about mental health.

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# Understanding and Detecting the Signs of Serious Mental Illness and Suicidal Ideation

By Rola Aamar, PhD  
Partner, Behavioral Health Solutions  
Relias

Serious mental illness and suicidal ideation are two of the largest problems in American healthcare today. In fact, while [one-in-five American adults have any mental illness](#), approximately 1 in 20 adults in the U.S. are affected by [serious mental illness](#), or a mental illness that significantly impacts the ability to function in one or more aspects of everyday life. Meanwhile, suicide is the twelfth leading cause of death overall for all populations in the U.S., and the second leading cause of death in children between the ages of 10 and 14. The relationship between death by suicide and unmanaged mental health conditions or low access to mental health services is well documented in recent research. Current research also highlights the continued rise in mental health symptoms and diagnoses among Americans given recent world events. The need to address serious mental health and suicide risk is greater than ever. The relationship between death by suicide and unmanaged mental health conditions or low access to mental health services is well documented in recent research. Current research also highlights the continued rise in mental health symptoms and diagnoses among Americans given recent world events. The need to address serious mental health and suicide risk is greater than ever.

Fortunately, there are steps that can be taken to address the need for greater mental healthcare, specifically screening early and consistently and using screenings as a way to offer the individualized support needed. By learning to screen individuals, behavioral health practitioners can offer help to those affected by mental illness before it becomes overbearing.

In this article, we'll discuss the warning signs of serious mental illness and suicidal ideation that behavioral health staff should know, as well as the basics of mental health screenings and suicide risk assessments that can help healthcare staff in any setting more effectively work with clients struggling with their mental health.

## Setting the Stage: The Causes of Mental Illness

Most serious mental health conditions begin by early adulthood. Research has shown that 50% of lifelong mental illnesses begin by age 14 and that 75% present by age 24. Therefore, this article will be geared toward working with and identifying these conditions among younger individuals. But the lessons from this article can, and should, be applied to people of all ages when the need arises.

There are many factors that contribute to the presence of mental illness. Genetic, experiential, and social factors all contribute to one's mental health. Among younger populations, especially those from historically marginalized groups, [the influence of stigma](#) about mental illness and seeking behavioral healthcare cannot be understated. In fact, research has shown



that those who feel stigmatized are 50% less likely to seek treatment.

This potential reluctance to seek help is one of the big reasons why mental health screenings are so important. By normalizing the screening process, healthcare providers can help mitigate the stigma of talking about mental health symptoms and conditions. For example, a primary care provider might normalize the screening process by asking every patient seen to answer questions about mood in recent weeks. By working with other caregivers and organizations in your area, such as general practitioners, youth groups, and schools, your organization can work with local populations to discover where care gaps exist.

But when your staff members conduct these screenings what should they look for?

## Warning Signs: Know What to Look For

There is a multitude of warning signs for both serious mental illness and suicidal ideation. For behavioral health specialists, it is crucial to learn how to recognize these signs in order to help their clients as well as teach other healthcare professionals how to know when a client is at risk.

Unfortunately, there is no one sign for serious mental illness. Different conditions will present differently. With that said, there are several red flags that behavioral health specialists can look for in order to justify taking further action. While this is not a complete list, [some of the most prominent symptoms](#) of untreated mental health conditions include:

- Changes in sleep or appetite
- Excessive anxiety, fear, or worry
- Frequent feelings of sadness
- Feeling disconnected and/or withdrawing from social behavior
- Changes in behavior or mood

Though the appearance of one or two of these symptoms may not point to serious mental illness, if a patient is exhibit-

ing several of these symptoms further assessments may be warranted. If left untreated, an individual experiencing mental illness may begin to experience suicidal ideations.

There are some similar signs of suicidal ideation and serious mental illness, such as increased feelings of sadness and/or anxiety, and changes in behavior. But there are also definite signs of suicidality that behavioral health specialists need to be aware of. These include:

- Talking about wanting to die, becoming a burden on others, and feelings of guilt or shame.
- Emotional pain so strong it does not seem bearable.
- Planning or researching ways to die.
- Giving away important items, making a will, and/or saying goodbye to family and friends.

If you recognize these signs in your clients, knowing what to do next will prove critical to keeping them safe and helping them heal.

## Conducting Mental Health Screenings and Suicide Risk Assessments

Mental health screenings are an important first step in working with clients who may be experiencing mental illness. By incorporating this tool into your organization's workflow, you can better gauge the conditions that your clients are coping with, as well as the severity of these conditions.

To [conduct these initial screenings](#), you can ask clients to describe their mindset, feelings, and behavior. Through this questionnaire, trained staff members should be able to deduce the mental health condition (if any) that the client is experiencing. It may also be advisable to employ or partner with nurses or physicians who can properly screen for testable conditions such as vitamin deficiencies, thyroid disease, and others that can lead to mental illnesses such as depression.

If you're worried that a client or clients may be experiencing suicidal ideation, a suicide risk assessment would be the next step. To [conduct these assessments](#), use language such as the following:

- "I understand these questions may be uncomfortable to answer. I ask them because I value helping all my clients stay safe."
- "I want to take as much time as you need to talk about these next few questions."
- "It's common for people to think about being better off dead when experiencing tragedy or stress, let's talk about how you're doing."
- "I have these questions for you to answer on this form, but let's talk about them together first."

When conducting these assessments, it's critical to not rush or minimize the assessment in any way. By giving your client your full attention, you'll be better able to determine their risk of suicide and how best to help them move forward.

*Rola Aamar completed her PhD in Marriage and Family Therapy from Texas Tech University, where she focused her clinical research on vulnerable populations and the importance of treatment alliance between patients, the family, and healthcare providers. Aamar was a SAM-HSA Minority Fellowship Program fellow from 2014-2015. She has years of behavioral health clinical experience working with multidisciplinary healthcare teams in primary and specialty treatment where she implemented clinical protocols to address social and relational barriers of care. She is currently a Partner for Behavioral Health Solutions at Relias, bringing her clinical and operational knowledge of integrated care, clinical research, and behavioral healthcare to support client use of population performance data to improve clinical performance and patient health outcomes. In this role, she provides clinically informed, data-driven consulting to clients to promote performance improvement.*

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*see Signs on page 42*



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# Bridging the Leadership Gap

By Mary Pender Greene, LCSW-R, CGP  
President and CEO  
MPG Consulting

Recent research has shown that our collective “mental model” and quest for the conventional white standard for a leader reduces the likelihood that BIPOC will be viewed as suitable for leadership roles. Lack of diversity at the top of organizations has often been attributed to the belief that there are not enough leaders of color in the sector. Our research, data, and personal experiences tells a different story.

We must change the narrative about why there are not more leaders of color in the sector. We need to address how potential leaders of color are “weeded out” on all levels of our institutions based on the deeply held and often unconscious assumptions about race and the perceptions around leadership. We must move away from the presumption that there are not enough qualified individuals who are willing and able to lead. This means looking at the assumptions and structures that guide decision makers. It’s crucial that we turn the mirror inward and become critical lovers of our institutions. This means honestly examining our policies and practices that lead to this leadership gap. Race and race equity can become a top priority in our field when we can begin to talk about how our sector can change its track record on race. We must create the culture shift that is needed to advance the leadership of people of color in the sector.

White institutional culture causes organizations to proclaim that they want diversity and inclusion, yet what they often want is to see difference at the table but not hear or value the lived experience, contributions, or different approaches offered by BIPOC. This failure to accept difference makes it challenging for small numbers of people of color to be authentic, thrive, influence organizational culture or ascend to C-suite levels. Unexamined White favoritism and unimpeded bias and structural racism is a different way of placing a knee on the necks, voices, and contributions of BIPOC along their journey towards leadership. It also nullifies the experience, inspiration, and vision that could be offered by both staff and board members of color.

A leader’s most important role is to set the culture of their organization. Remember that organizational culture is shaped by the worst behavior a leader is willing to tolerate. While workspace diversity is important, culture is equally as important, and often it is not hospitable to people of color in leadership roles. This is the reason why so many BIPOC are overlooked, opt out of leadership paths, or simply leave after a few years. Many who leave claim publicly that it was for a better opportunity, yet privately admit to not feeling valued for who they were and were denied the opportunity to fully contribute.



Mary Pender Greene, LCSW-R, CGP

## Belonging As an Integral Part of DEI Initiatives

Leaders on an anti-racist institutional journey must create an atmosphere of inclusiveness and belonging, which tends to produce an environment of collaboration. Prohibition is not the only way to exclude. There are subtle, yet effective methods that can cause BIPOC to be devalued. Belonging goes beyond the concept of DEI to a feeling of being fully accepted and even treasured by their colleagues and the organization. Belongingness is the sense of psychological and emotional well-being that enables people to perform at their best, feel appreciated, respected, and motivated. They can contribute their unique views and ideas. It is also about representation, being seen, and seeing yourself reflected at the highest levels in an organization, and at the decision table. If BIPOC do not see anyone who looks like them in leadership roles, it is harder for them to feel a sense of trust or Belonging.

## Creating Safe Spaces

Setting an inclusive work culture of Accountability and Belonging is central to the role of a developing anti-racist leader. An effective culture shift requires the engagement of the entire leadership team. As an anti-racist leader, set the tone from the top by evaluating where you are as an organization. Don’t pretend to have a diverse leadership team or board when there are very few BIPOC members. Be aware of who is hired, who gets the plum assignments, who is opting out, who is turning a blind eye, and where the pockets of resistance are. Are some people being treated poorly? Do people feel disconnected? Are people resigning or quiet quitting? Do they feel safe enough to bring their full selves and best selves to work?

Pockets of resistance by staff with positional authority is the greatest threat to an organization’s anti-racist work. Everyone in the organization knows who they are—they are the ones who hold the pow-

er to define what and who is good and valued, and yet they are often permitted to opt out of the anti-racist work. When these pockets of resistance are not held accountable, it allows for unchecked white-body privilege, bias, and structural racism. Keep in mind that BIPOC often suppress their authentic thoughts and feelings to survive in white spaces.

## Being Accountable

It is the anti-racist leader’s role to ensure that anti-racist work is **not elective**. Include every single person working within your organization. Staff with positional power who resist the anti-racist goals especially must be held accountable. When certain staff are allowed to opt out of the anti-racist work, it is another form of favoritism. A leader’s silence will be viewed as a lack of dedication to the anti-racist mission. This inaction is **the #1** threat to an organization’s anti-racist mission because it causes people inside and outside of the organization to distrust the commitment of leadership.

Repeated microaggressions, subtle insults, witnessing white favoritism, and feeling unvalued can consume tremendous energy. The amount of time that BIPOC are forced to spend on addressing these issues, fighting for job survival, and proving themselves repeatedly causes racial trauma and destroys aspirations. This leads to less-than-optimal performance, success, and retention, followed by low morale and burnout. All leaders’ evaluations should stress the ability to recruit, develop, and maintain a diverse team. Supervisory sessions must include consistent conversations about the status of cross-racial relationships.

Take a bold step and request walking meetings with select BIPOC to learn about their experience at the organization and ask if their BIPOC colleagues are thriving. Walking meetings can strengthen interpersonal relationships since walking side by side means the conversation is more peer-to-peer. This can reduce hierarchical status distinctions and tension during discussions. You can also track the hiring, retention, and promotions of BIPOC staff and check for departmental or supervisory patterns regarding turnover or complaints. You must have **zero** tolerance for racist or oppressive behavior.

Success lies in holding yourself and the entire organization accountable for the anti-racist mission, seeing the value of each team member, and eliminating barriers to the contributions of BIPOC staff. You must become racially literate to be able to see, discuss, and interrupt bias and structural racism. Leadership must consistently demonstrate its commitment to the anti-racist process by setting a tone for honest discourse and openly acknowledging tensions. Friction must be acknowledged and resolved swiftly and respectfully. All staff must be helped to accept a degree of uncertainty and discomfort. Upskill current and potential leaders so

they can confidently handle complaints relating to racism and micro-aggressions. The goal is to increase the organization’s tolerance for discomfort.

## Checklist for Creating Systems of Support

1. Increase your racial literacy. Learn to see how oppression, in its many forms, has led to inequity.
2. Listen to the experiences of those most negatively impacted.
3. Think outside of the box when reviewing internal talent to further advance BIPOC leadership.
4. Examine the track record of recruiters; have a conversation about the desire for candidates of color.
5. Ask recruiters about their success in finding and placing candidates of color.
6. Institute training and hiring standards for people who hire C-suite level staff and Boards of Directors since Boards hire executive leadership. Training should include information on racialized attitudes before a search to lay the groundwork to make decisions to address racial bias.
7. Purposefully interact with BIPOC professionals beyond the workspace to develop authentic cross-racial relationships. If you have BIPOC in your life and race is not a part of the conversation, the relationship is shallow and inauthentic. Creating a diverse leadership team and board is directly connected to the diversity of your network, so expand it to include BIPOC. Remaining in a silo of white voices limits your ability to meet BIPOC and to have authentic interactions.
8. Locate, mentor, and support a BIPOC to be your potential replacement and others for C-suite roles.

An anti-racist journey begins with setting the tone from the top and creating an anti-racist organizational development plan starting with leaders, managers, supervisors, and the board. Since attitude change cannot be mandated, leaders often need support in the form of executive coaching and consultation, as anti-racist work is a messy process. Remember that the overrepresented, presences and voices of White bodied individuals at the top of an institution creates an absence of BIPOC leadership in the system.

*MPG Consulting (MPGC) is a consultant group committed to eliminating bias and structural racism while creating a sense of belonging in the workspace. We help organizations develop systems for change to dismantle barriers to success. For more information please visit [www.marypendergreene.com](http://www.marypendergreene.com), and by email at [mary@mpgconsultingnyc.com](mailto:mary@mpgconsultingnyc.com), (212) 245-2510.*





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# The NYSPA Report: Overdose Prevention Centers Keep our People Alive

By Alan T. Rodríguez Penney, MD  
Attending Psychiatrist  
Janian Medical Care



Alan T. Rodríguez Penney, MD

People with opioid use disorder (OUD) have a high prevalence of a serious mental illness (SMI). Nearly 27% of people with an OUD had a co-occurring SMI (Jones and McCance-Katz 2019), which complicates care when access to dual diagnosis treatment is limited. Overdose deaths have steadily increased in the US, with over 100,000 deaths per year in the past two years (Ahmad et al. 2023). Of these, the majority is driven by synthetic opioids other than methadone, with over 70,500 overdose deaths in 2021. This accounts for almost 200 people a day. These deaths are not distributed equally. In 2021, American Indian and Alaska Natives experienced the highest mortality, followed by people who are Black (KFF 2023). Life-saving interventions such as medication assisted treatment (MAT) work. However, very few access care, and 87% of people with opioid use disorder do not receive evidence-based treatment (Krawczyk et al. 2022). Therefore, it is of utmost importance to provide services to keep our people alive until they are ready for change.

Harm reduction reduces the negative consequences associated with substance use. Interventions may include syringe service programs (SSPs), naloxone, fentanyl test strips, overdose prevention centers (also known as supervised injection sites), among others. SSPs have a strong evidence-base for decreasing the incidence of HIV and viral hepatitis infections and increasing the likelihood of abstinence. They are cost-effective, and don't increase illegal drug use or crime (CDC 2023). Naloxone is an opioid antagonist that quickly reverses a life-threatening opioid overdose. It can be given intranasally or intramuscularly. States that enacted laws to increase access to naloxone saw a 14% decrease in opioid

overdose deaths (NIDA 2017). Fentanyl test strips are a relatively new harm reduction intervention and scientific evidence is still being collected to determine their effectiveness (CDPH 2018). Overdose prevention center (OPC) programs, also known as a Supervised Injection Facility (SIF) or a Supervised Injection Site (SIS), allow people who inject drugs (PWID) to use in a supervised setting where staff can intervene if an overdose occurs.

OPCs are new in the United States, with the first center opening in New York City in November 2021. However, these programs have been well-established in other parts of the world. Unofficial OPCs have existed long before and it wasn't until 1986 when Switzerland opened the first recognized OPC (EMCDDA 2004). There are now 120 OPCs operating across 10 countries (Samuels et al. 2022). Studies evaluating outcomes estimate these programs save lives and reduce medical care associated with overdoses (Armbrecht et al. 2021). The first OPC was established in the US by OnPoint NYC, which operates two sites. As of June 2023, they had over 78,000 engagements and intervened 845 times to address overdose symptoms. To date, there has never been an overdose death in an OPC. This harm reduction approach is safe

and effective. However, other US cities have not been able to open OPCs due to legal barriers on the local and federal level. The federal statute 21 USC § 856 of the Controlled Substances Act of 1986 (GovInfo 2023), also known as the "Crack House Statute", deems it illegal for organizations to open a physical space and knowingly allow use of controlled substances. OPCs operate in a legal gray area that makes them vulnerable to legal challenges and prohibit federal funding. This has impeded cities wanting to open an OPC from doing so. Amending the Crack House Statute to include exemptions for organizations providing overdose prevention services would remove a significant barrier to providing life-saving treatment.

We need to keep our most vulnerable people, especially those with co-occurring SMI and OUD, alive and safe until they're able to access treatment. This is a crucial aspect of providing care and it starts before our patients come into our office.

*Alan T. Rodríguez Penney, MD is a Public Psychiatrist working for Janian Medical Care. We provide compassionate medical and psychiatric care to people who are currently or formerly homeless. Alan can be reached at [alan.rodriguez@janianmed.org](mailto:alan.rodriguez@janianmed.org).*

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## Why PROS Works: Achieving Independence and Fulfillment

By Mindy Liss  
Communications Consultant  
Institute for Community Living (ICL)

The deinstitutionalization of the mentally ill in New York State some 50 years ago had a clear goal: To create accessible and adequate housing and support programs to allow people to live independently in the community, to work toward recovery and a full and productive life outside a psychiatric hospital.

While New York's efforts have met with mixed success – housing, in particular, remains a huge challenge – one of the most successful models of service to come out of this era is PROS: Personalized Recovery-Oriented Services. These programs help participants follow “personalized recovery plans” designed to achieve overall wellness by meeting goals such as living independently, education, medication management, and securing employment. PROS programs throughout New York State are grounded in community integration to achieve recovery and overall wellness.

PROS is a critical tool at the Institute for Community Living (ICL) for helping people achieve their recovery goals and move toward independence and a more fulfilling life. The program was built to ensure people are active members of their communities, deal effectively with everyday stresses, reconnect with family, and plan for the future.

A multidisciplinary set of services is



offered by a team of social workers, psychiatrists, nurses, employment peer and entitlements professionals, and creative arts specialists. Sessions focus on relapse prevention, medication management and wellness, nutrition, and social functioning.

Support groups with other participants have always been at the center of the PROS model – they help participants find ways to take control of their lives and meet goals related to education, employment, relationships, and housing.

PROS is housed in ICL's East New York Health Hub – opened in 2018 to offer integrated care where people may come through one program door but find their way to many other resources that help them shore up their path to recovery

and greater health. They benefit from being part of a vibrant community, with access to healthy food from the farmers market food pantry on the first floor, take a yoga class, or get their flu shot.

ICL's whole health model of care has been critical to the people attending PROS. Being housed in the Hub makes it possible for participants to get critical medical care from ICL's partner Community Healthcare Network (CHN), which offers health services and nutrition support. Many PROS participants now get their primary care at CHN – some for the first time in their lives -- as well as the care of specialists to address diabetes, high blood pressure, and other physical health challenges.

Creative arts are integral to the PROS program. In the ICL Hub art room, Dylan is the devoted PROS teaching artist; he leads art classes in a light-filled fully-equipped art room on the main floor of the East New York Health Hub. Even in the most trying periods of the pandemic, PROS artists made their way to the art room at the Hub, where they found comfort and broke their isolation by doing their art and connecting with fellow artists. That's what PROS is all about – helping individuals rebuild by offering the comfort of community and recognizing each person as an individual with goals and aspirations... and great talent.

Over the years, peer support has become more important in PROS programs – learning from people with lived experience has proven to be another critical tool in the PROS arsenal.

The proof is in the outcomes – research has repeatedly demonstrated that participation in PROS leads to a significant decrease in psychiatric hospitalizations – showing that maintaining this type of psychiatric rehabilitation model must include recovery-oriented components as PROS does so effectively.

At ICL, the success of PROS is thanks to participants who come to the program day after day, doing the work to better their health while supporting others on their journey. They are grateful to the very dedicated and compassionate staff who help them day in and day out. Come visit the ICL East New York Health Hub to see what success looks like at PROS.

## Ivor: One Special Story of Perseverance at ICL

By Mindy Liss  
Communications Consultant  
Institute for Community Living (ICL)

There is much to be proud of at ICL PROS – so many have come through the program, and thanks to the support they received and the hard work they put into it, they have overcome major physical and mental health challenges.

One recent story of success is Ivor.

In the early 2000s, Ivor had completed his Associates degree and embarked on a successful career in technology. But he also experienced mental health and anger management challenges. His struggles took hold in unexpected and painful directions - ultimately leading to his incarceration.

On his release, Ivor was determined to turn his life around. He enrolled in Personalized Recovery Oriented Services (PROS), ICL's community-based, whole



Ivor

health program that provides wellness groups, psychotherapy, and medication management out of the ICL East New



Mindy Liss

York Health Hub.

Ivor set his sights on finding stable housing, managing his mental health, re-

integrating into the community, and maintaining his independence. Over the past three years, Ivor has proven that nothing will stop him from achieving his ambitious goals.

Today he regularly participates in groups focused on health, wellness, and financial literacy, which have helped him build skills and confidence. Working closely with his recovery specialist and psychiatrist, Ivor identified and tackled barriers that could hinder his progress. He also reconnected with family, including his sister and aunt. “They are the backbone of my support system,” he shares.

This spring, Ivor moved into ICL's Broadway residence and is living independently. He is also a passionate writer and recently published his first book, which explores spiritual themes. “ICL was a crucial part of the village that helped me get to where I am today,” says Ivor. “I am proud of my own persistence and hard work. I have such a sense of accomplishment.”

*At ICL, the success of PROS is thanks to participants who come to the program day after day, doing the work to better their health while supporting others on their journey.*





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- Compassion
- Integrity
- Accountability
- Quality
- Growth and Mastery

We believe all people should have the opportunity to live healthy and fulfilling lives. We take a trauma-informed approach, meeting the people we serve wherever they are, working together to support them in achieving their goals.

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To learn more go to [www.iclinc.org](http://www.iclinc.org)

To find out how to access our services, call 844-ICL-HOPE.



# WellLife Network's MH Residential Services: Creating Exceptional Living Experiences for Individuals with SMI

By Crystal John  
Vice President  
Behavioral Health Residential Services  
WellLife Network

In today's world, individuals experiencing severe mental illness (SMI) face numerous challenges. Safe and nurturing residential services are crucial components for successful well-being, along with essential support structures necessary for recovery. WellLife Network's highly acclaimed housing programs create exceptional living experiences, helping those struggling with SMI attain independence and live with dignity in the community. This article highlights the pivotal role WellLife plays in providing transformative care and support for individuals with severe mental illness.

As one of the largest regional providers of supportive housing, WellLife operates over 1,175 residential housing beds, offering varying degrees of supervision across Queens, Brooklyn, the Bronx, New York City, and Long Island, including Congregate Housing, Community Residences-Single Room Occupancy (CR/SRO) across Queens and Brooklyn, Supported SRO (SP/SRO) in Brooklyn and the Bronx, Apartment Treatment Programs, Mixed-Use Housing complexes, and over 600 Supportive Housing beds throughout New York City and Long Island.

## An Organization Dedicated to Empowering Individuals

WellLife Network is a New York-based health and human services agency dedicated to empowering individuals and families with diverse needs to realize their full potential. With over 42 years of experience, WellLife has developed a wide range of recovery-based housing options serving over 1,100 people with severe mental illness and formerly homeless individuals across New York City and Long Island. WellLife works with people diagnosed with complex and *severe mental health* conditions, including personality disorder, psychosis, and trauma. Since its inception, supportive housing has provided residents with job placement, family reunification, appointment and medication management, housing accommodations, and other related housing assistance that promotes general health and well-being.

## Compassion Promotes Independence

Through compassionate care and innovative housing programs, the WellLife Network residential team effectively addresses the many challenges individuals with severe mental illness face. The organization's person-centered approach to housing embraces a vast array of alternatives – with ongoing support for those able to live more independently. Case managers re-



Crystal John

ceive backing from peer specialists who provide essential assistance in helping clients address basic daily living activities. By offering diverse residential services supported by specialized staff, the organization fosters progress toward independence and helps cultivate dignity among society's most vulnerable members.

## Serving a Diverse Population with a Broad Range of Services

WellLife's holistic approach tailors residential solutions to individual preferences and strengths. These solutions promote wellness, self-determination, and recovery. A variety of housing options within a diverse client base demonstrates WellLife's commitment to diversity and inclusivity. Reporting an overall success rate of 85%, WellLife serves clients from various ethnic backgrounds – 60% African American, 20% Caucasian, 15% Hispanic, and 5% Asian and other.

The challenging nature of SMI presents barriers to effective housing assistance. Individuals may experience a lack of medication compliance, emotional outbursts, loneliness, severe depression, or indifference to their well-being. To combat these issues, WellLife employs specialized staff with the expertise necessary to encourage engagement and ensure medication compliance. Specialized housing is available for individuals with SMI requiring wheelchair accessibility.

## Innovative Programming Supports Independent Living

Tailored programs and activities encourage residents to engage in meaningful interactions, fostering a supportive social network. Case managers and peers promote medication compliance and psychiatric treatment, while daily living skills training helps develop proficiency in essential tasks like personal hygiene, meal preparation, and household management.

## Mixed-Use Residences Foster Whole-Person Wellness

WellLife Network is implementing a

new model housing program in each of its mixed-use residences that adopts a whole-person approach to wellness. This innovative initiative connects individuals needing additional support, or those living with chronic illnesses, to vital resources, services, and healthcare. The primary goal is to maintain sustainable housing for all residents while fostering overall well-being and stability in their lives.

WellLife's mixed-use residential buildings also provide various recreational activities to nurture community spirit and a sense of belonging among residents. The organization employs a recreational/creative arts specialist who designs engaging experiences for residents and their children. For example, Mother's Day festivities included a special luncheon, hair and face makeovers, and handmade gifts for all attending mothers.

The activities, emphasizing inclusivity, encompass holiday celebrations such as Veterans Day, July 4th, and Thanksgiving, alongside collaborative ventures such as painting uplifting murals in shared spaces. This strategy strengthens community bonds by creating connections and shared experiences for everyone involved. Furthermore, residents regularly participate in field trips to museums, local events, and community attractions. These combined efforts empower residents to lead fulfilling lives while managing their mental health challenges effectively. This innovative initiative connects individuals needing additional support, or those living with chronic illnesses, to vital resources, services, and healthcare.

## A Recovery Story Through Nature

Since 2013, Angelo R. has resided in a WellLife Network-supported housing residence. His struggle with sadness began six decades ago, eventually evolving into depression. Despite this, Angelo excelled in school and pursued a prosperous car dealership business. However, four stressful events in his 40s led to hospitalization and therapy. Post-release, he joined WellLife Network and has been thriving ever since.

Now known as the "Mayor" of his apartment complex, Angelo offers advice and guidance to his neighbors. He embraces positivity through gardening, sharing his bountiful flowers and vegetables with his neighbors. This journey towards healthy living has brought happiness to Angelo and his community.

## A Network of Housing Alternatives

WellLife's range of housing alternatives underscores its commitment to addressing diverse needs within its client base. Its housing portfolio includes:

- **Congregate Housing** offers supervised living arrangements in Queens and Brooklyn for people with men-

tal illness leaving hospital care but not yet prepared for independent living. Along with medication management and access to external rehabilitation and vocational activities, round-the-clock guidance with personal and community living skills is available.

- **Community Residences/Single Room Occupancy (CR/SRO)** delivers a 24/7 supervised living solution in Queens and Long Island, featuring individually inhabited studio apartments complete with efficiency kitchens and private bathrooms.
- **Supported SRO (SP/SRO)** focuses on permanent housing in Brooklyn and the Bronx, providing on-site case management within private studio apartments equipped with efficiency kitchens and bathrooms.
- **Apartment Treatment Programs** bridge the gap between supervised residences and independent living situations by offering residents shared apartment spaces in Brooklyn and Queens. With the aid of Network staff, residents receive guidance on improving their living skills and building community connections.
- **Supported Housing – Scatter Site** promotes community living in shared apartments across Manhattan, Brooklyn, the Bronx, Queens, Nassau, and Suffolk Counties. WellLife Network staff offer living skills training and case management services as required by individual needs.
- **Mixed-Use Housing** includes beautifully appointed studio, one- and two-bedroom apartments for special needs SMI residents, low-income individuals, and families.

WellLife's Residential Services serve as a beacon of hope for individuals struggling with severe mental illness as they navigate the path to long-term recovery. With a compassionate approach to care and innovative housing programs, WellLife Network effectively tackles the numerous challenges faced by those with severe mental illness. These programs are sustained through a strong partnership with The New York State Office of Mental Health and The New York City Department of Health and Mental Hygiene.

Offering a wide range of residential services supported by specialized staff, WellLife Network promotes progress towards independence and nurtures dignity among society's most vulnerable members.

To inquire about referrals to Behavioral Health Residential Programs, contact: BH Residential Intake at 917-757-5686.



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- WLN is a Qualifying Employer for the Public Service Loan Forgiveness (PSLF) Program





# Interview with Arthur Y. Webb for His New Book “Honorable Profession: My Years of Public Service”

By Arthur Y. Webb

Arthur Webb recently published a book titled, *Honorable Profession: My Years in Public Service*. Mr. Webb prepared responses to questions that colleagues and interested readers have asked him about the book. Mr. Webb’s previous book was published in January 2022 titled, *Dangling on a String: The Future of Public Policy for the Field of Intellectual and Developmental Disabilities in New York*. This was featured in *Autism Spectrum News*.

## Why did you write this book?

There are two reasons for writing this book: one is that I wanted to counteract all the negative and hostile rhetoric directed towards public servants; and two, I wanted to provide an insider’s view of what it takes to manage in government.

## Why do you say that public service is an honorable profession?

I was inspired as a young person by President Kennedy when he said: “Ask not what your country can do for you - ask what you can do for your country.” Our country is a young country and still trying to make democracy work for everyone. I entered into public services to strengthen the essential role of government, to shape its responsibilities and to ensure public dollars and resources were used in effective ways. I responded to the call.

## Why do you use the term public servant?

First of all, the use of the term “public servant” is a more positive way of thinking about government employees. While bureaucrat and technocrat are often used but they sometimes carry a negative connotation. To “serve first” was instilled in me early when I was active in a national youth movement as a teenager. When I use the term public servant in this book, it embraces these deep emotions to serve first - be a servant.

## What were your responsibilities over your 18 years in state service?

The book captures the lessons learned



Arthur Y. Webb

over 18 years as a public servant serving in six government agencies, four of which I headed. These agencies were diverse including state corrections, social services, health planning, substance abuse treatment and intellectual and developmental disabilities. Governor Mario Cuomo once referred to me in positive terms in a radio interview that I was a “utility player.” I interpreted this to mean that I could be called upon to undertake any position of responsibility.

## What are the management insights that you talk about?

The book was originally titled “the art of public management.” Management in government is, indeed, an artform. How a manager or leader deals with conflict is at the heart of what it takes to survive and thrive. Conflict is the sharp edge of change. Reform does not come simply without conflict.

Surviving and thriving are not the same thing. Surviving requires cunning, shrewdness, iron will and quick escapes with no trail. Thriving demands vision, leadership, motivation, innovation, principles and courage.

Another powerful insight is that as an executive, your personal and professional ethics are the most important aspect of your management style. It is the thing that peo-

ple will remember. Without a sense of obligation and commitment to people and the truth, the dilemmas of choice are not clear.

A strong sense of the worth of every single person provides the dignity and nobility of government. This is at the core of why government exists.

## As the head of several agencies, what would you say to any new manager?

A public servant has to be ready for the unusual or unexpected from a sudden storm, an oil crisis, a union walkout, a sudden departure of a senior official, or a pandemic. Be ready to adapt and adopt a mindset to manage these sudden circumstances.

The view at the start of the race is very different than the view at the end of the race. The rewards and results are different than you think or expect. Be careful when the thin veneer of rationality is stripped that there is something of substance. This is a moral and political imperative.

## Why do you think “politics is the grease” that keeps government working?

The reality is that we live in a political world where there is give and take, better known as compromise. Also, politics keeps government from totally being technocratic while government maintains stability and continuity. We need both to work effectively to sustain our form of government.

Government is an anchor for democracy that needs constant revitalization, which politics gives us.

## Isn’t your book more like an autobiography?

I honestly struggled at first with the dilemma of being an autobiographer versus being an insider and telling a story. Keep in mind, this book is two books in one. The second half of the book was written 30 years ago and was ready for publication, but I held on to it. This part of the book is more about the art of management while the first half captures some of the stories that illustrate and support the management lessons. Overall, I see the book as storytelling.

## In looking back at your career in public service, what do you see as your

## greatest accomplishments?

While I describe many of the successes and failures in my career in public service, I really think it was my ability to use common sense and willingness to take on some of the major challenges of the times that distinguishes my service. From closing state institutions like Willowbrook State School, or responding to AIDs crisis in the prison system, or expanding services for substance abuse with treatment on demand, and optimizing Medicaid to serve the poor and disabled, were all highlights for me. The truth is I never indulged in broadcasting our successes. I let actions speak louder than words. I seldom look back other than remembering the lessons learned. Nostalgia is not my thing. Indeed, all of this made writing this book that much harder.

## The Times Union in Albany recently published a commentary by you where you wrote that you were optimistic about public service. Why?

The thousands of people I have worked with in the public sector have met the challenges of their jobs with impressive skills and ethics. I remain optimistic about the role of government and the people who work in the public sector as a pillar for the well-being of our society. Our young country has had major swings in attitudes and expectations of government and, in many cases, in violent terms. Why do we tend to come to peace somewhere in the middle? Because at our core is a principled belief in our democracy.

*In a nearly 20-year career with the state of New York, Arthur Y. Webb served as Commissioner of the Office of Mental Retardation and Developmental Disabilities (now the Office for Persons with Developmental Disabilities), Acting Commissioner of the Department of Social Services, Executive Director of the Division of Substance Abuse Services, Director of the Health Planning Commission and Deputy Commissioner of the Department of Correctional Services. He’s the author of the book “Honorable Profession: My Years in Public Service.”*

For more information, visit [arthurwebbgroup.com](http://arthurwebbgroup.com).

## Outcome from page 1

diminished to approximately one-third by the end of the century with the release of DSMIII diagnostic criteria and a social climate that stanching funding for severe psychiatric illness and community safety net supports.<sup>2</sup> A countervailing perspective emerged in the last quarter of the century from 10 long-term studies, mostly from Europe and the United States, that assessed patients between 20 and 37 years after initial evaluation. Nearly all subjects were in middle or later life. These studies found clinical and social recovery to be about 50% for each category.<sup>2</sup> A limitation of these studies was

that they provided a single snapshot of late-life clinical status. However, in the past decade, two longitudinal studies of OAS, predominantly outpatients from the United States and the Netherlands, found rates of persistent clinical remission and persistent social recovery to be about 25% for both categories.<sup>2</sup> Thus, the optimism of the earlier long-term studies must be tempered by these longitudinal data.

*Point 2: A comprehensive view of “outcome” should include symptoms, functionality, a combination of symptoms/functionality (recovery), and successful aging.*

Although clinical remission, which comprises positive (e.g., hallucinations, delusions) and negative (e.g., blunted affect, anhedonia, avolition) symptoms, is an essential outcome variable, the DSM5 recognizes other symptom dimensions such as depression and cognitive impairment. Moreover, functionality is an important outcome variable, especially measures such as community integration. The combination of clinical remission and community integration comprises “clinical recovery.” Subjective measures such as self-perceived quality of life are pivotal variables affecting other outcome measures (see below). Finally, physical well-being, although not a psychiatric category, is espe-

cially important given the higher mortality rates in OAS, e.g., about twice their age peers. Finally, some investigators have been interested in resilience, coping strategies, and other factors that comprise positive mental health or successful aging.

*Point 3. Clinical outcome criteria are largely independent of each other.*

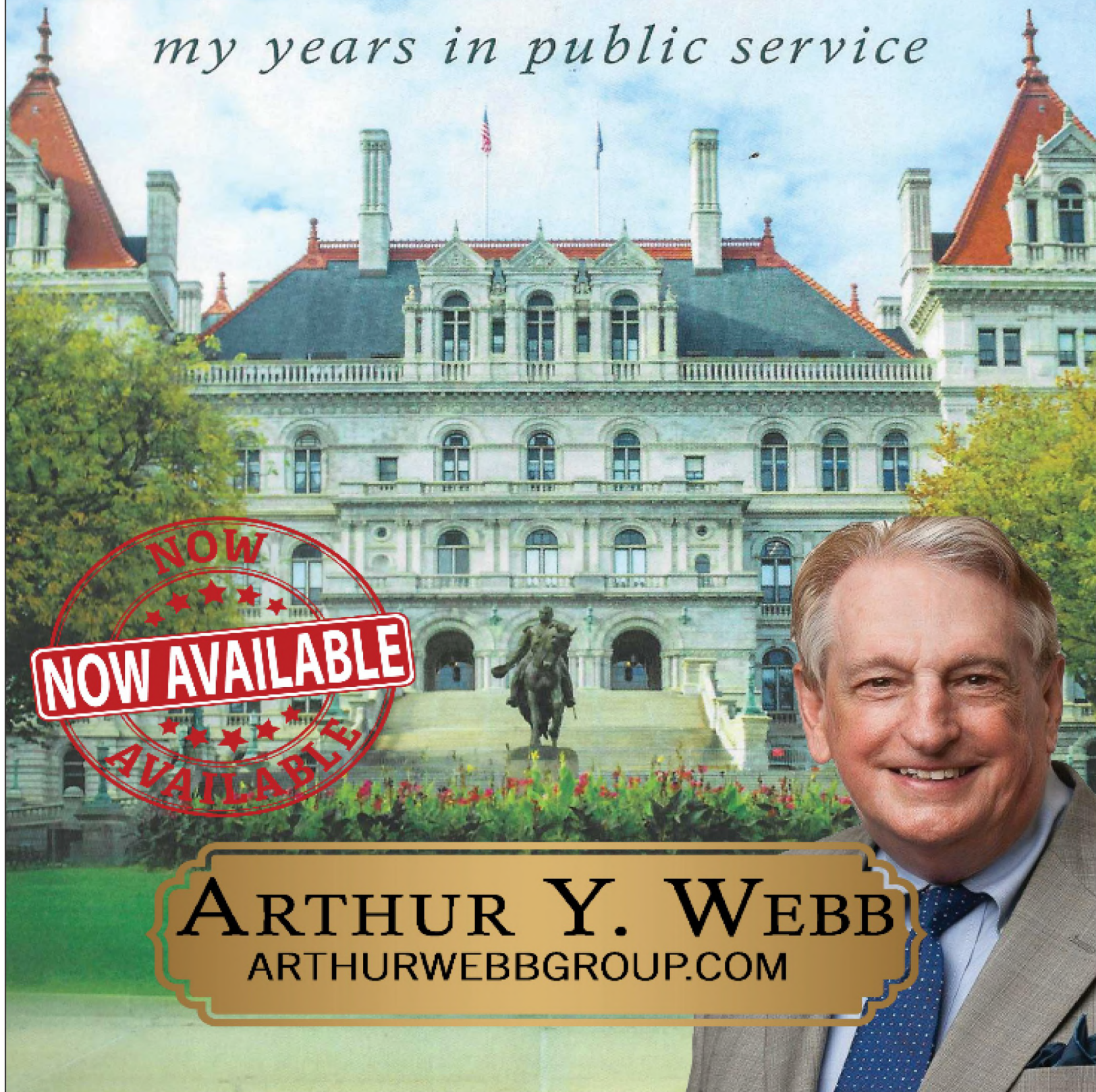
Our research found that the various outcome measures—e.g., clinical remission, community integration, depression, and cognitive functioning—only modestly correlated with each other, and the shared

see *Outcome on page 38*



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*my years in public service*



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- Jeffrey A. Sachs, CEO & Founder of Sachs Policy Group and Former Deputy Secretary for Health and Human Services under New York State Governor Hugh L. Carey

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# Severe, Long-Term Mental Illness: What Does it Take to Live Well?

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

Typical images of people with severe, long-term mental illnesses are misleading. We think of people who, despite mental illness, have lives that they find satisfying and meaningful but of homeless people dressed in rags pushing shopping carts with all their belongings and sleeping on heating grates on city streets or people tormented by angry, domineering voices or people whose depression is so deep that they can't get out of bed in the morning or people who relive terrifying experiences over and over again or people who are also addicted to alcohol or drugs and whose lives have fallen into disarray.

It is true that people with serious, long-lasting mental illness are, by definition, unable to manage in the community without substantial assistance from family, friends, communities, and/or the government. It is also true that they frequently have difficult lives. Their life expectancy is 10-25 years less than the general population in large part because they often have poor health and have limited access to decent health care. They frequently have co-occurring substance use disorders. They often live in poverty and in squalid and sometimes dangerous housing. They frequently experience homeless-



ness at some point in their lives. They are disproportionately among those incarcerated in jails and prisons. They have high rates of suicide. They are mostly unemployed. They often have limited access to the mainstream—even to houses of worship. And so on.

Despite this bleak picture, many people with severe, long-term mental illness have lives that they find satisfying and meaningful and, in that sense, have experienced what has come to be called “recovery.” Notably, some people with serious mental illness are now working as peer specialists, and there are some who

have emerged as advocacy leaders and as managers of mental health organizations.

What does it take for people with SPMI to have satisfying lives in the community? The answer is not difficult, because people with SPMI are first and foremost people, and all people have the same fundamental needs:

- A decent place to live
- Income to pay for food, other necessities, and a bit of fun
- Health and longevity

- Satisfying family and social relationships
- Satisfying and meaningful activities such as work or art or advocacy
- A sense of connection and belonging in a community they value
- Spiritual opportunities.

The survival of people with severe, long-term, disabling mental illnesses, is historically the core responsibility of the American mental health system. From the end of the 18<sup>th</sup> century until the middle of the 20<sup>th</sup> century, this responsibility was met primarily by providing custodial care in state asylums and hospitals. After World War II, a gradual shift began to support this population in the community. There were changes both in mental health policy and, perhaps more importantly, in policy regarding public assistance, which became available to people with psychiatric disabilities early in the 1950s. Reliance on state hospitals peaked in 1955, when at most 1/3 of people with severe, long-term mental illness were in state hospitals. Incremental changes over the past 60 years, especially the development of the Community Support Program (CSP), have resulted in important improvements in the lives of people with psychiatric disabilities. There has been

*see Live on page 39*

## Just Another Day

By Alissa Langevin  
Homemaker

What does mental illness feel like? It feels like drowning, alone and helpless, surrounded by nothing but inky black water, and deafening silence. As an icy chill creeps down your spine, a paralyzing numbness begins to set in. Breathing is very difficult now as you feel a sudden scalding hot sensation burning the inside of your lungs, replacing what little oxygen you had left, leaving behind frigid water instead. Feeling tired now, your eyelids become heavy as you struggle to keep them open. The darkness that had surrounded you this entire time feels different now. All that is visible now is pitch black tunnel devoid of all light. Everyone has a story. A significant moment, or moments, in their lives that would go on to define them as the individual they are today. This is my story and the significant moments that made me the individual I am today.

Growing up, my parents did everything that they could to provide a happy and fulfilling life for my two siblings and me. Although many happy memories were made together over the years, their best efforts sadly were not quite enough. Medical bills and rent, among other expenses, were skyrocketing and debt was creeping in at an alarming rate. As my terminally



ill mother's sickness worsened, my family and I had no choice but to reside in a decrepit apartment complete with drug dealers, prostitutes and a perv next door neighbor and landlord, both with an eye for young girls. By my eleventh birthday, I had seen so much death, following the tragic passings of my mother, brother, and nephew. In the following years I would go on to experience this heartbreak twice more with the passings of my grandmother and my father. By the age of twenty-three, I had lost all of those that once were a big part of my life.

The horror story does not end there, however. To cope with the nagging, unrelenting pain of so many traumatic losses, I ended up finding temporary solace from grief through a revolving door of abusive relationships to fill the soul sucking black hole inside me. Physical, mental, and sexually abusive relationships became the norm, eventually convincing myself that these volatile relationships were the only cure for the otherwise incurable disease festering inside me. As the years passed, I began mixing abusive relationships with excessive drinking. At the time, this so-

called coping mechanism worked wonders at keeping the multitude of repressed memories I had shoved so far down that I was sure they would never find their way back out. Every single one of these misfortunes took a part of me, changing me into a shell of my former self. At this point, I had lost all connection with myself and those closest to me at the time.

Mental illness comes in many different shapes and sizes, by-products of trauma. They affect an individual's mood, thoughts, and behavior. Widely misunderstood and ignored by so many people, mental instability is an all too real horror, plaguing a shocking number of individuals of all ages. Disorders such as these are also known by many different names which in my case are: Attention Deficit Disorder, Anxiety, Depression, Bipolar Disorder, and Borderline Personality Disorder.

As a wife and mother of one, I am in a constant battle with my inner demons who relentlessly torment me, inevitably making me question myself and those around me. Being an easygoing and present member of my family is one of the most challenging obstacles I'm blindly forced to navigate on a day-to-day basis. The absolute most frustrating and baffling part of any day is identifying, recognizing, and expressing not only my thoughts, feelings, and affections but also other peoples as

*see Another Day on page 42*



# The Evolution of the 988 Lifeline: A Year After the Transition

By Tia Dole, PhD  
Chief 988 Lifeline Officer  
Vibrant Emotional Health

**O**n July 16, 2022, the National Suicide Prevention Lifeline announced the transition of the former 1-800-273-TALK (8255) phone number to 988, an easy-to-remember three digit-number for 24/7 crisis care across the United States and its territories.

A year after the transition, the [988 Suicide & Crisis Lifeline \(988 Lifeline\)](#) has seen a significant rise in volume – routing more than 4 million calls, texts and chat messages to crisis centers – highlighting the demand for mental health services.

Data from SAMHSA showed that in May 2023 versus May 2022, calls answered increased by 45%, chats answered increased by 52%, and texts answered increased by 938%. The 988 Lifeline answered 159,040 more contacts (calls, chats, and texts) and significantly improved how quickly contacts were answered.

#### Access to Mental Health Services

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by Vibrant Emotional Health (Vibrant), the 988 Lifeline is critical in being the entry point to a responsive and comprehensive continuum



Tia Dole, PhD

of crisis care nationwide. The 988 Lifeline is a network of more than 200 crisis centers that helps thousands of people overcome daily crises. Anyone experiencing suicidal, substance use and other mental health or emotional crises or distress can reach a trained crisis counselor by calling or texting 988; chat is available at [988lifeline.org](https://988lifeline.org).

On May 3, 2023, Surgeon General Dr. Vivek Murthy released a new Surgeon

General Advisory calling attention to the public health crisis of loneliness, isolation, and lack of connection in our country, and addressing loneliness is critical in order to fully address the mental health crisis in America. Numerous studies have shown that callers feel less suicidal, less depressed, less overwhelmed and more hopeful after speaking with a 988 Lifeline counselor. Counselors are trained to provide confidential emotional support and crisis counseling to people in suicidal crisis or emotional distress and connect them to resources. Too many people experience suicidal crises or mental health-related distress without the support and care they need, but the 988 Lifeline makes it easy for people to contact the line for help. These highly trained crisis counselors – actively listening and providing support throughout the call – help callers work through their feelings without judgment or criticism. They also make sure a caller is safe before they disconnect the line.

#### Looking Forward

Thanks to the federal government’s commitment to addressing the mental health crisis in America, and the \$501.6M provided by Congress for the 988 Lifeline in the [Fiscal Year 2023 Omnibus Appropriations Package](#), the 988 Lifeline has been able to dramatically expand access to comprehensive and lifesaving services,

and advance suicide prevention for all. Part of its ongoing effort to improve our nation’s mental health is to provide care in the most culturally appropriate and affirming ways. Funding is being used to establish outreach, partnerships, and services to historically harmed and excluded populations at higher risk of suicide, including LGBTQI+ youth and young adults, persons from Tribal Nations, Black and Brown communities, and persons with functional disabilities.

Last September, 988 Lifeline introduced a pilot program to allow people to connect with a counselor specifically trained to address issues faced by LGBTQ youth. In November, the state of Washington launched the Native and Strong Lifeline, the first suicide crisis line for American Indians and Alaska Natives, in collaboration with and as part of the national 988 network. Vibrant is working to develop and implement expanded language access services to include Spanish chat and text services and to expand Spanish language centers within the network. Over the past year, the number of centers answering calls in Spanish grew from three to seven.

Finally, Vibrant is also working on developing and implementing a direct 988 Lifeline Video Phone option for deaf or hard-of-hearing American Sign Language users. With this option, people who are

*see 988 on page 42*

## Unlocking HOPE and support with the 988 Suicide & Crisis Lifeline:

Vibrant Emotional Health administers lifechanging services, offering 24/7 support for emotional distress and crisis care, empowering individuals to achieve emotional wellness, anytime, anywhere.



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# Mental Healthcare in America: An Industry on the Mend

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

America's healthcare industry accounts for one fifth of its Gross National Product (GNP) and produces mediocre outcomes at best. Innumerable factors are implicated in this dysfunction, most of which are borne of a capitalist structure designed to maximize profits for its principal agents. This has produced a medical industrial complex continuously in pursuit of lucrative treatments that confer modest benefits at great expense to recipients. Potentially effective interventions that do not deliver pecuniary benefits to investors and other economic stakeholders are often marginalized or disregarded altogether. These failings are particularly harmful to the most vulnerable members of society, including those with serious mental health conditions and other chronic ailments.

In the mid-20<sup>th</sup> Century, Nobel Laureate Kenneth Arrow declared the market economy incompatible with healthcare (Arrow, 1963). He cited information asymmetry as one of several bases for this incompatibility, and ensuing developments in the mental healthcare industry, including the way mental health and its opposite are defined, support Mr. Arrow's assessment. Information asymmetry is evident when one party (e.g., a healthcare



Ashley Brody, MPA, CPRP

provider) possesses more knowledge or information than another (e.g., a healthcare recipient). Although such asymmetries emerge in many human interactions, their prevalence in healthcare transactions operating within a market-based system are particularly insidious insofar as they perpetuate an imbalance of power that often accrues to the economic benefit of healthcare providers and their industry allies. Psychiatry, the branch of medicine through which mental illness

has been defined and treated throughout its history, is uniquely prone to information asymmetry and the exploitative influence of the "free" market.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), the proverbial "Bible" of the psychiatric profession that enumerates the various manifestations of mental illness (e.g., diagnostic categories), was established in 1952 and included approximately one hundred conditions. The number of diagnosable conditions increased significantly through subsequent editions, and its current volume (DSM-5-TR) includes 298. If such an expansion in the array of recognizable conditions signaled a greater understanding of phenomena that existed independently of psychiatry's influence it should rightly be lauded as evidence of scientific progress. There is considerable countervailing evidence, however, to suggest the profession's nosology is a by-product of sociocultural, economic, and political factors. A leading example is the history of "homosexuality" as a "mental illness" that appeared in earlier editions of the DSM but was ultimately removed in accordance with changing social mores. Put differently, "homosexuality" was a "disorder" when it failed to conform to societal norms. The foregoing facts underscore the unique perils of information asymmetry within psychiatry. That is, it is a medical specialty that defines the scope of "normal" or acceptable behavior through classification of socially constructed opposites (i.e., aberrant or abnormal psychological conditions), so it inevitably follows that its recipients either possess less information than its practitioners or what information they do possess is often devalued (at best) or construed as evidence of disordered thought or behavioral processes (i.e., a symptom).

A substantial increase in the volume of conditions to which corresponding treatments may be applied compounds the adverse effects of information asymmetry, especially when viewed in the context of commercially driven advances that entail economic interdependencies among healthcare practitioners, pharmaceutical industry representatives, and other key stakeholders. When the fourth edition of the DSM (DSM-IV) was published in 1994, 57% of the members of a taskforce charged with its development reported financial ties to the pharmaceutical industry. When the DSM-5 was released in 2013, nearly three quarters (72%) of taskforce members reported such ties (Suris et al., 2016). Perhaps not surprisingly, a proliferation of diagnosable conditions that emerged through successive editions of the DSM was accompanied by a commensurate increase in the number of pharmaceutical "treatments" and more aggressive marketing strategies. Between 1997 and 2016, industry marketing expenditures increased from \$17.7 billion to \$29.9 billion, and direct-to-consumer advertising for prescription drugs and health services accounted for the most rapid growth during this period (Meller & Ahmed, 2019). When Dr. Thomas Insel, Director of the National Institutes of Mental Health (NIMH), publicly acknowledged the DSM's limita-

tions upon the release of its fifth edition in 2013, his writings were carried by major media establishments and signaled rising skepticism of the manual's validity and the industries that informed its development (Pickersgill, 2014).

Dr. Insel's critiques have been broadly embraced and amplified throughout the past decade. Psychiatry's propensity to pathologize human experiences that do not conform to established norms or that represent adaptive responses to abnormal circumstances is ceding ground to more nuanced, holistic, and progressive approaches rooted in recovery-oriented models. For instance, etiological studies have affirmed a relationship between traumatic life events and physical or psychological distress that manifest as diagnosable health conditions. The pioneering Adverse Childhood Experiences (ACEs) investigation revealed a robust correlation between ACEs (i.e., traumatic events experienced during childhood) and the subsequent development of various physical, emotional, psychological, and behavioral difficulties (Felitti et al., 1998). An ensuing expansion of trauma-informed interventions has enabled practitioners to recognize the universality of human experience and to engage recipients on these terms. Practitioners for whom the question "What's wrong with you?" was once a hallmark of clinical practice (figuratively, if not literally) now recognize this question betrays a deeply entrenched belief that recipients of mental healthcare are fundamentally broken and in need of repair. In many corners, this question has been replaced by a trauma-informed alternative ("What happened to you?") that recognizes and embraces the primacy of life experience in the therapeutic process.

Other auspicious developments promise to transform our approach to the most vulnerable among us. Practitioners, payers, regulators, and other stakeholders now recognize Social Determinants of Health (SDoH), the circumstances in which people live, learn, work, and socialize, are not ancillary considerations but central to health and wellness and must be treated accordingly. Investments in goods and services that address SDoH are now commonplace, and few practitioners would consider service interventions complete if they failed to acknowledge or to address the significant events, stressors, or circumstances that have defined the lives of those entrusted to their care. In these respects, our current trajectory is more aligned with those of other industrialized societies that commit greater shares of public resources to social welfare services (and lesser shares to conventional healthcare). To the extent this trajectory is successful in delivering more holistic and preventive care to exceptionally vulnerable individuals, it will reduce healthcare expenditures and improve our population's overall health and wellbeing.

The author may be reached at [abrody@searchforchange.org](mailto:abrody@searchforchange.org) or by calling (914) 428-5600 (x9228).

References

see *Industry* on page 42



Search for Change, Inc. has been rebuilding lives for over 40 years. It continues to be a leader in the field of recovery, enabling the most vulnerable among us to establish valued roles within the community. Services provided are integrated, person-centered, and fully aligned with leading principles of healthcare reform that aim to improve quality, reduce cost, and enhance recipients' overall experience.



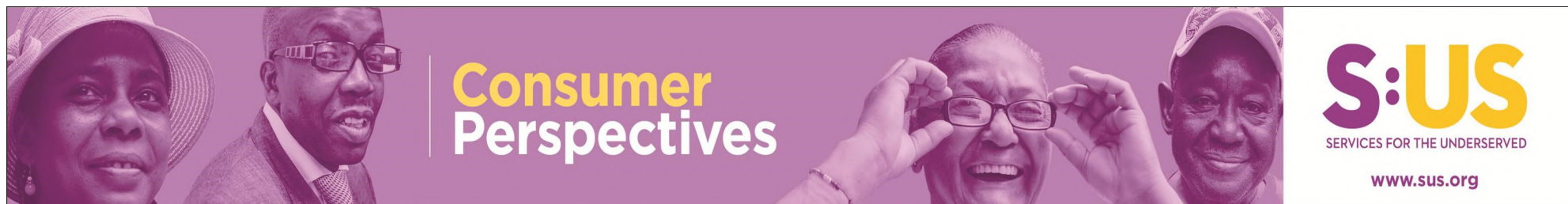
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## Consumer Perspectives: Overcoming Mental Health Challenges

By Herman, Raymond, and Regina  
Services for the UnderServed (S:US)

This article is part of a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The authors 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 that they can use to lead a life of purpose.

We're New Yorkers in our 50s and 70s, who have been receiving services from S:US over the last nine to 22 years, such as housing, help with Section 8 housing vouchers, counseling, therapy, medicine, and weekly wellness checks. We're all living with serious mental illness.

No family is unaffected by mental illness and substance use. Mental illness is the leading cause of disability worldwide and only 9% of the 21 million Americans with drug or alcohol addiction challenges

are receiving treatment. With the right set of supports and by working together, people like us can recover, lead productive lives, and move past our challenges.

### Mental Health and Other Challenges

We've overcome domestic violence, homelessness, depression and other mental illness, and substance use disorder. We're all grateful for where we are now and the help we've received to get here.

"I'm a living miracle because not only did I have to go through domestic violence and hope and pray that I come out on the other side of that, but I could have been blind. I am blind in my right eye because of domestic violence, but I'm still alive, and I still have the use of one eye," said Regina. "And if it wasn't for S:US giving me that love, that support, that encouragement to keep on going, I have no clue where I would be right now... My healing really came from being supported by S:US and supporting other people in S:US while I was a resident. That to me

was the groundwork of my healing."

"I went through the shelter system. I was homeless for three or four years, and I had to go to a shelter in Brooklyn, in East New York. From there, I ended up going into one of S:US' houses, and then I moved here to another S:US house. I've been here for about 22 years, in a one-bedroom apartment, just by myself. I'm one of the oldest residents here," said Raymond. "My healing journey has been up and down because I've been really depressed at a certain time of my life due to the passing of a lot of my peers and family members."

Herman said, "There's no recovery from [a] mental disorder. Depression is a constant battle that never ends. It has no beginning, and it has no end. You can only feel good sometimes, but most of the time, 80% of the time, you have depression inside of you that you try to stay stable as much as you can. That's the only way out: try to stay stable and try talking to people, try to speak to family members, and stay around people all the time."

"I get in the way—that's the only thing that gets in the way of my recovery. If I allow certain things to affect me, if I don't talk about them, they fester in me. There are certain things I know I can't do. And if I choose to do them, then here we go," said Raymond. "One time I was in a really bad situation with my rent, and the reason I was in a bad situation was because I was using. I would quit, but I wouldn't stop."

### Encouragement Helps Us Overcome Adversity

One thing that has really helped all of us is encouragement from our family, friends, S:US, and therapists.

"My story, even though it's unique, is one that I share with a million people: Adversity. When you are faced with adversity, what do you do? You have your pity party, then you pick yourself up by your bootstraps and you keep pushing, you keep on fighting for the person that

*see Consumer on page 32*

## Do you have a passion for helping others?

S:US provides recovery and treatment services to thousands of New Yorkers facing behavioral health challenges. We are hiring for the following positions to support the health and wellbeing of the people who seek our services.

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# Safe Options Support: Charting a Path to Stability for Homeless Individuals Through Coordinated Care

By Pamela Mattel, LCSW,  
Gerardo Ramos, MPA, MSW,  
and Barry Granek, LMHC  
Coordinate Behavioral Care (CBC)

A transformative shift is underway for New York City programs focused on helping homeless individuals. Instead of relying on a singular approach to homeless outreach, new initiatives and adaptations are reshaping and diversifying the community-based services available. This remodeled, multidimensional approach is harnessing the power of a centralized and streamlined access to care hub, a cross-system collaboration, a learning community framework, and enhanced resource accessibility to address the unique needs and challenges of those experiencing homelessness, particularly those with serious mental illness.

In April 2022, Coordinated Behavioral Care (CBC) and the New York State Office of Mental Health (OMH) launched Safe Options Support (SOS). This new initiative aims to help individuals living on the streets by transitioning them into stable housing. Over the course of 12 months, SOS employs focused engagement, identification and provision of immediate needs, and service linkages. SOS teams consisting of licensed mental health practitioners, nurses, peer specialists, and



care managers work together to rapidly connect individuals with housing and establish strong connections to social, medical, mental health, and substance use care. In collaboration with emergency shelters, outreach providers, and permanent and supportive housing agencies, SOS flexibly provides the person-centered care needed during this crucial transition period with the goal of sustained housing placement. Individuals experiencing street home-

lessness cite several barriers to housing, including services that feel unreliable, unsafe shelter options due to fear of theft, violence, and unsanitary conditions, and the general public's resistance to helping with even basic needs like food and public transportation. For service providers working tirelessly to support the homeless, their experiences include systemic barriers like well-intended policies with counterintuitive effects, complex systems

failing to work together and communicate efficiently, ongoing discriminatory practices, and the absence of key stakeholders at the decision-making table, such as managed care organizations.

CBC has adopted a comprehensive model designed to tackle each aspect of the challenge directly.

CBC Hub: Centralized and Streamlined Access to Care

CBC plays a crucial role in the SOS program by serving as a centralized administrative Hub. This Hub manages contracting, maintains a single point of access for referrals, enhances coordination among behavioral health agencies, facilitates collaboration across different sectors, handles logistics, maintains a centralized care management electronic record, conducts data analysis and reporting, and oversees quality improvement through program evaluation and an active learning community. Moreover, CBC offers 24/7 on-call access to address urgent needs for individuals and their support network.

Within CBC, a dedicated housing specialist possesses extensive knowledge and experience in navigating the complex landscape of housing resources. They provide invaluable support to the SOS

see Care on page 43

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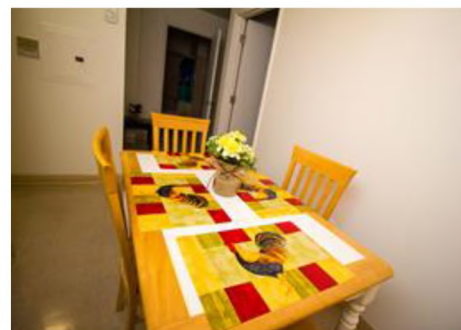
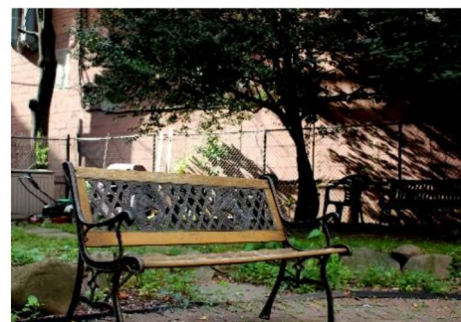
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# The Mental Health Association of Westchester's Intensive and Sustained Engagement Team (INSET)

By Ruthanne Becker, MA and Raquelle Bender, LMHC, The Mental Health Association of Westchester

Anyone involved in the mental health system, whether an individual diagnosed with a behavioral health condition, family member, or practitioner of services, knows that there is pervasive stigma in our country concerning mental health. Although the COVID pandemic has brought increased attention to the benefit of talking openly and honestly about mental health, the media often continues to portray people with a diagnosis as those of which to be wary or feared.

The research does not support a relationship between violence and a mental health diagnosis; however, movies, television shows, and news reports frequently depict otherwise. Without the necessary balance of describing individuals as “normal” citizens of our communities who work, go to school, love, and play just like others without a diagnosis, we run the risk of promoting and continuing public, self, and structural stigma. Unfortunately, stories of individuals who are living their lives and are working on their mental health and wellness do not have the sensationalizing impact that bring



Raquelle and Ruthanne at the 2023 Mental Health America Affiliate Conference

viewers to movie theaters, television, or newsstands.

What the research does show is that “about two thirds (67%) of people with any mental illness in their lifetime met symptomatic recovery, meaning they no longer met the diagnostic criteria for a particular illness. The rate at which people recover from mental illness and attain moderate to good, rather than optimal,

levels of well-being is likely much higher, the researchers speculate.” (1)

However, those in the mental health field also know that there are certain individuals who have a behavioral health diagnosis who are struggling and not getting the type of services that support their vision of their own recovery. Instead, they are vulnerable to being coerced into support services and treatment that are not

wanted, effective, or necessary. These experiences can often lead individuals to be distrustful of the mental health system and those who are employed by “the system.” This mistrust of “the system” makes it more difficult to introduce support services that do invite collaboration and dialogue. These types of supports help to destigmatize mental health issues for individuals who traditionally shy away from support or have been traumatized by the mental health system because they have received inadequate, coercive, and/or ineffective services.

In 1999, New York State Enacted Legislation that “provides for Assisted Outpatient Treatment for certain people with mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision. This law is commonly referred to as “Kendra’s Law” (2). Supporters of Kendra’s law and AOT “point to statistics showing reduced rates of hospitalization, arrests, and homelessness among people who receive AOT orders, but research also suggests that compulsory treatment is no more effective than voluntary treatment—and, in some cases, may even cause harm.” (3)

In 2017, The Mental Health Association of Westchester, in collaboration with the

see INSET on page 40



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# Helping Families Cope with SMI: Maternal vs Social Work Instincts

By Ruth Colón-Wagner, LMSW  
CEO and Executive Director  
VCS Inc.

I am a Social Worker. I am also a mom of an adult child with SMI, specifically bi-polar disorder. My child is 23 and I pray that she welcomes God into her life. That's the mom in me talking. As a social worker, I want her to get a job, find a great partner who will love her, and become as independent as she possibly can. I am one person with 2 perspectives that can easily send me into a tailspin. My two perspectives are not objectively insulated from each other and so they both tire me out equally, regularly leaving me doubly burned out.

My daughter started to experience an escalation in behaviors at around 8 years old. Since that time, I've been in hyper-acceleration mode to get her all the interventions at my disposal. I contacted people I knew professionally, from psychiatrists, peers, social workers, nurses, etc. to find that magical combination of resources that would, I'd hoped, set her on a recovery path. I know that I was trying to save her from a future that I saw every day in so many. I obtained for her psychiatrists, social workers, Waiver services, PINS, School Resource Officer home visits, therapeutic school placements, peer services, tutors, employment support, drivers' education twice and in the end



Ruth Colón-Wagner, LMSW

when academic success was faltering, finally, trade school. Almost none of these were successful.

My daughter participated in each intervention only because she had no choice. As she got older, my influence and authority over her waned until it eventually stopped like a deer in headlights. She said "no" and meant it. Now, self-direction is what we as professionals strive for with the people with whom we work. However, as a mom, I knew she was lost. And I believed she needed me despite not wanting me.

During those tumultuous years, I received a lot of support from my coworkers, all professional in one discipline or another. I sought out therapy for myself once I realized the immense stress I had been experiencing. Despite this, no one truly understood. They responded as I had... "Get her services." When I explained what I was going through or specific events that transpired, people were dumbfounded. Over time, I came to understand that I needed more than their ear or their recommendations. I had done all of the tasks in the list. I'd tried what I thought would work and then tried things I was skeptical about just in case. In the quieter moments I'd talk and talk with her and tried to reason with her to help her look at her decisions and her situation. Reasoning remained elusive and decisions so often came out of crises.

So, how does one know better to do better and help families with these similar experiences? To help families, yes, it's important to listen. I wasn't lacking listeners at all and most of all I had people telling me what to do from a professional perspective. What I think I've learned in retrospect is that what I truly needed was another mom to connect with: specifically, a mother with similar challenges. Does this need to be a formal support group, or would a peer relationship be enough? Not having had it myself, I wouldn't be able to prescribe the "service" behind what I needed but I knew in my bones was that something was terribly wrong in my daughter and my relationship. I felt that I needed to put "me" first, but everyone knows that "A mother does not do that!" Judgement abounded in my head and my heart ached with this internal battle. One day I made a terrible decision; I threw her out of the house. I told myself that I was holding firm to the rules of our house and when it became possible, I helped to be sure she had again the supports and resources she needed. But I would be lying if I didn't tell you that it was terrible for both of us. But over time, freed from the day-to-day struggle for safety and control, I began to heal. I felt that we both did.

We began to patch up our relationship and I felt growing hope. But, again, this didn't last very long.

As a professional, I can look to her diagnosis as the main culprit here causing the ebb and flow of our interactions

against the ebb and flow of her perceptions of the world, but over time, I know that she and I have a very fractured relationship that isn't just because of her SMI. And even though I was there, I will never get a chance to redo her childhood; to wish her mental illness away; to find her that magical intervention... even though I still do have that wish.

I am left asking "Is she too fractured, or am I?" When I think about it, she and I shared some of the same traumas but each of us from very different perspectives: one person living with mental illness and its unbalancing influences and the other forcing treatment on her to try and construct the mental and social structures she lacked.

Is it my decision to find a path to heal or is it hers? If she says "no", can I still have my "yes?"

My trauma becomes drama to the many who do not understand because they do not share the pain. To this day, I find myself connecting with moms with the same challenges. There is something magical when two moms who share similar experiences get together! When you find yourself saying, "Yeah" and "Oh, I had that too!" Of the moms I've connected with, some still have their children at home and others do not. Some have also seen the back end of the trauma and are recovering themselves. This gives me hope. I also believe that others have found hope in what I've shared. I've come to believe that it is this mutual sharing that is most important for my ongoing healing and possibly the source for some new idea that would light a new path to my family's future that I'd never have found on my own.

The social worker in me has hope for my daughter's recovery because every person has the potential and resilience to find a recovery path, and, on a good day, the mom in me feels the bright rays of hope fill my heart as I detect the little signs that progress is being made and her decisions are leading to new possibilities. It is there that my two perspectives can finally converge. I can walk into this day with the belief that my daughter will heal and that she will find her path to recovery.

Ruth Colón-Wagner, LMSW, is CEO and Executive Director of VCS Inc. For more information, email [rcwagner@vcs-inc.org](mailto:rcwagner@vcs-inc.org).



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# Suicide Risk and Safety Planning

By Rachel F. Held, PhD  
Supervising Psychologist, Psychology  
Externship Coordinator, and Intensive  
Outpatient Program Coordinator at  
Westchester Jewish Community  
Services (WJCS)

Behavioral health workers are understandably distressed by the recent rise in the rates of suicide, suicide attempts, and reported suicidal ideation, including increases among teens and young adults, minorities, and those affected by the Covid-19 pandemic (Molock et al, 2023; Pathirathna et al, 2022; Akkas, 2023). While these statistics are alarming, a lot can be done to help individuals who are experiencing suicidal thoughts. Steps include recognizing who is at greater risk for suicide, assessing suicidal thoughts in a nonjudgmental, compassionate way, and safety planning to help provide people with alternative behaviors when they have suicidal impulses.

Suicidal thoughts and behaviors can affect anyone, regardless of age, race, or gender and must always be taken seriously. There are certain factors, though, which have been identified as putting individuals at a higher risk and to which we, as behavioral health workers, must give special attention and further assessment. The Centers for Disease Control and Prevention groups risk factors into four categories (CDC). There are risk factors:

- 1) On the individual level, particularly if someone has a previous history of suicide attempts, chronic pain, mental illness, job loss or financial problems, substance use, or childhood trauma;
- 2) Pertaining to one's relationships with other people, including loss of a relationship, social isolation, and family history of suicide;
- 3) On a community level, including living in a community with a cluster of suicides, being exposed to community violence, and experiencing discrimination or racism; and
- 4) On a societal level, risk factors that predict higher suicide rates include people at risk having easy access to guns and living in a community where there is greater stigma associated with seeking help for mental illness.

Unfortunately, we cannot always prevent people from experiencing these risk factors. Therefore, we must be mindful of an individual's community and familial situation as well as their personal experiences and history when thinking about who might be at greatest risk of suicide.

The most effective way to know whether someone is at current risk for suicide may be to ask them. Questions about suicidal thoughts can be valuable coming not just from clinical providers, but also, at times, from an individual's friends, family, caregivers, care managers and more. Some people are afraid that asking about suicide can put the idea into someone's mind. However, research has shown that this fear



is unfounded and, in fact, that asking about suicide can in itself reduce suicidal ideation (Dazzi et al, 2014) and increase hopefulness that they may be able to get help. Being asked may also help the person who is feeling hopeless feel connected, which combats feelings of isolation.

How people ask about suicidal thoughts can be important. In a lot of contexts, providers are required to ask questions about suicide using a checklist, such as the Columbia Suicide Severity Rating Scale. Scales can be extremely valuable to make sure we gather needed information, but *reading the questions off a form without connecting to the patient is more likely to lead to false negative responses, in which people deny suicidality even though they are experiencing it. The more questions can be asked in an empathic way, connecting with the person, acknowledging their struggles, and validating their feelings, the more helpful the questions will be.* For people who work in the field, it can take practice asking these questions in order to increase comfort level.

When people seek mental health treatment, they are acknowledging that at least a part of them doesn't want to be feeling the way they do. To people struggling with suicidal ideation, those thoughts can sometimes feel like a potential way out, if they feel they don't have other ways to cope with their situation. Feeling validated and heard can be an important start to their gaining hope that there are better solutions to their problems than suicide.


Once someone has acknowledged suicidal thoughts or been deemed at risk of suicide, an important step towards helping them stay safe is safety planning. The most commonly used safety plan was developed by Stanley and Brown (2012). It aims to help people find substitutes for suicidal behavior. It starts with having a person recognize the triggers to when the safety plan would need to be implemented, and then moves on to help the person identify alternatives, whether on their own (e.g. engaging in a specific distracting or enjoyable activity), or by contacting other supports or professionals. When a person has planned out other options beforehand, they are less likely to choose suicide as their go-to option to relieve suffering during heightened moments of distress.

sible to the individual, and when possible, *to others involved in their care as well.*

Since mental illness is a risk factor for suicide, it could be argued that anyone who is in treatment for serious mental illness should create a safety plan. Even if someone is not reporting current suicidal thoughts, having a safety plan can help them know where to turn if those thoughts ever arise. Sometimes such a plan can be referred to as a crisis plan, helping them recognize tools they can use to cope with any dangerous or unhelpful urges, including not only suicide but also the urge to harm others or to use substances.

Just as it is important how we ask questions about suicide, how we create a safety plan is also crucial. Safety planning needs to be done collaboratively with the provider and individual. If someone is just told, "here are the things you should do to keep yourself safe," they will feel much less buy-in and agency and be less likely to follow those recommendations. Instead, the person needs to feel like they are taking a much more active role in their care by collaboratively developing the plan. Stanley and Brown (2012) suggest asking individuals to identify the most helpful aspects of the plan in order to increase their motivation to use it. They also stress the need to identify any potential obstacles to using the plan, and to help the individual problem solve.

*see Safety on page 40*



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# Access for All: Achieving Behavioral Health Equity in Healthcare

By Jorge R. Petit, MD  
Healthcare Executive Leader  
[www.drjpetit.org](http://www.drjpetit.org)

**H**ealth equity is a fundamental principle that aims to ensure that all individuals have an equal opportunity to achieve optimal health, regardless of their social or economic circumstances. Behavioral health equity refers to the fair and just distribution of behavioral health resources, supports, services, and opportunities to achieve optimal well-being for all individuals, regardless of their socioeconomic status, race, ethnicity, gender, sexual orientation, or other social determinants of health.

When it comes to serious mental illness (SMI), behavioral health equity is particularly crucial. All too often individuals with SMI face numerous and at times insurmountable barriers to accessing timely, affordable and quality behavioral health care, exacerbating health disparities and perpetuating inequities. Behavioral health equity encompasses equal access to prevention, early intervention, diagnosis, treatment, psychosocial rehabilitation and ongoing support services, ensuring that everyone has an equal opportunity to attain and maintain good mental health. Achieving behavioral health equity involves addressing systemic inequities, promoting inclusivity, and creating a supportive environment that values and respects the diverse health needs and experiences of all individuals.



In my last BHN article, entitled: [Creating a Social Justice Action Framework for a NYC Social Service Provider](#), I laid out the critical importance of the non-profit, community-based health and human services sector to embrace social justice intentionally and make concerted efforts at ensuring equitable behavioral health care to those most in need. In my experience as a public sector behavioral healthcare leader, I am certain that the foundational underpinnings of behavioral health equity are all readily available and in front of us. It is my estimation that we can achieve equity if we coordinate efforts and planning across our systems of care: government (local, state and federal levels), private

sector, hospital based, non-profit sector, community/grass-roots organizations and most importantly, the people served.

The needed components are knowable and within our reach, but we must—whether through system-wide payment reform (for example the NYS Health Equity Reform (NYHER) 1115 Waiver Amendment), or regulatory reform and more targeted oversight of evidence-based interventions, or the collective adherence to true data collection and analytics with meaningful quality measure and outcomes that are transparent and readily available to all—collectively act in concert if we are to truly achieve behavioral health equity.

In my 30+ years of public sector

healthcare leadership, I can attest to many of the approaches that are necessary for achieving equity. The latest evidence on the integration of mental health and substance use disorder services highlights the importance and effectiveness of a comprehensive, integrated approach to addressing these interrelated issues. Research consistently shows that integrating mental health and substance use disorder services leads to improved outcomes for individuals with co-occurring conditions with higher rates of engagement and retention in treatment.

Studies have demonstrated that integrated care models, such as co-location of services or integrated treatment teams, result in higher rates of engagement and retention in treatment. By providing coordinated and simultaneous care for mental health and substance use disorders, individuals experience better continuity of care, reduced fragmentation, and improved treatment adherence.

The current federal and state investment in Certified Community Behavioral Health Clinics (CCBHCs) is another critical piece in achieving equity. CCBHCs are a specialized model of care designed to provide comprehensive and integrated mental health and substance use disorder services to individuals in the community. CCBHCs offer a wide range of services, including outpatient treatment, crisis intervention, case management, peer

*see Equity on page 37*

## Substance Use Disorders: Frequency and Treatment for People with SMI

Jeridith Lord, LCPC, BCBA  
Clinical Counselor; Adjunct Professor  
of ABA and Mental Health  
Endicott College

**T**hroughout its history, America has attempted to punish substance users as a means to encourage their abstinence. These attempts have included imprisonment, fines, and forced rehabilitation programs, often sentenced at a higher rate to people of color (Volkow, 2023). Punishments like these often fail to address the underlying issues that initiated or perpetuated substance use: severe mental illness (SMI).

It is important to note that while substance use does not always lead to mental health disorders, nor do mental health disorders always lead to substance use disorders, the two are highly correlated and may develop in response to the other. This could look like an individual who is struggling with their mental health turning to substances as a coping mechanism or an individual who has been using substances struggling with their mental health as a byproduct of their substance use. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 25% of individuals diagnosed with a SMI also meet the criteria for a substance use disorder (2021).

**Prevalence:** The prevalence of substance use disorders as they relate to SMI



seems to be increasing, with over 20 million people in the United States having been diagnosed with a substance use disorder in the past year (HHS, 2021). Data collected during the COVID-19 pandemic indicated that the primary catalyst for many young people's mental health and substance use struggles was loneliness and lack of connection. In a survey of over 1,000 participants, "49% reported a great degree of loneliness, 80% reported significant depressive symptoms, and 61% reported moderate (45%) to severe

(17%) anxiety. Participants disclosed harmful or dependent levels of drinking (30%), with 44% reporting binge drinking at least monthly. And while only 22% of the sample reported using drugs, 38% of users reported severe drug use" (Horigan et al., 2021, p.6). While neither COVID-19 nor loneliness can be identified as the sole factor for SMI or substance use disorders, it begs a strong enough correlation to be considered when devising a treatment intervention.

*Common Comorbidities and Risk Fac-*

*tors:* The most common comorbid diagnoses for individuals with a substance use disorder include generalized anxiety disorder, panic disorder, post-traumatic stress disorder, depression, bipolar disorder, attention-deficit hyperactivity disorder, borderline personality disorder, antisocial personality disorder, and schizophrenia (SAMHSA, 2021). The development of these disorders in duality with substance use can be compounded by the individual's age. If a young person in their adolescent years begins experimenting with substances before their brain is fully developed, they are at higher risk for substance use and severe mental illness (Kelly & Daley, 2013).

A significant risk factor for the development of dual diagnoses is early traumatic experiences. Early exposure to trauma may result in an increased production of norepinephrine and cortisol, i.e., Stress responses (Bremner, 2022). With an increased state of stress, the individual may develop chronic anxiety, depression, and mood disorders (Bremner, 2022). In addition, the individual may turn to substances as a coping mechanism; using substances as a coping mechanism while the brain is still developing increases the risk of substance use disorders later in life (Kelly & Daley, 2013).

**Treatment:** Despite the growing number of individuals diagnosed with a

*See SUD on page 38*



# St. Francis Friends of the Poor's SMI Programs in the Community

By Linda Flores, MSW, MPP  
Development and Communications  
St. Francis Friends of the Poor, Inc.

Picture this; you wake up on a therapeutic mattress and push aside your shades to catch a glimpse of the city's hustle and bustle. Next, you reach into your mini fridge for a bottle of water and begin your day thereafter. You walk downstairs, locking your private room behind you, and check out today's lunch menu. Barbeque chicken, you rejoice knowing there is a warm meal, but then remember that this is your new normal. For breakfast you are joined by friends you've made in the weeks since you moved in. On your way to check-in with Nurse Peggy, you remember that time she came to check on you when you didn't come downstairs one morning. You feel at home knowing there is someone looking out for you. Later that day, after your walk to the farmer's market, you stop-by the art room to look over the daily newspaper, where you read an article titled, "Deaths among NYC's homeless population reach record high in 2022." And you cannot help feeling a sense of survivor's guilt.

There is a residence on West 22nd Street where this is the reality for about 100 men and women. On East 24th Street there is room for 90 and on Eighth Avenue, 80 more. Nearly 300 formerly home-



Art Room in St. Francis Residence II

less men and women experiencing serious mental illness call the St. Francis Residences their home - not a temporary shelter, not a mental institution, not a concrete sidewalk - a true home.

St. Francis Friends of the Poor (SFFP) was established in 1980, although the work to do something more for the homeless, mentally ill 'living' on the streets began 10 years earlier for three Franciscan friars. At the time, services from local hospitals, psychiatric centers, and social

workers were provided to homeless folks residing in abandoned hotel buildings across the city. Three Franciscan friars who knew the necessity of these services also understood that more needed to be done. Upon the sale of the abandoned west Manhattan hotel the friars had been working out of, they knew the fate of those men and women residing in the space. "We saw that people were in danger of being in the street, literally, so we started looking for our own hotel," said

Father McVean. In 1980, the friars purchased their first building on East 24th Street but did not stop there. "Our purpose in buying the property was to move the program and the people," Father McVean explained. A purpose which has transformed into a model of care we are all familiar with today, permanent supportive housing.

The program which began all those years ago evolved, from social workers and nurses visiting individuals experiencing homelessness, into a full range of home-based and community services. Today, arts, wellness, meals, medical and benefits management programs are available to each tenant. Services such as medical and benefits management allow tenants to lead a sustainable healthy lifestyle, backed by the full support of caring staff. At the core of these programs lies the resolute team of case managers, nurses, psychiatrists and more who meet weekly to discuss the progress of each tenant. Using a holistic approach, their serious mental illness always stands at the center of any programming. For example, in addition to serving healthy meals, tenants are encouraged to participate in nutrition groups, exercise classes and recreational activities and so much more. The opportunity to participate in these activities means that tenants whose medications often include side effects such as weight

see Programs on page 42

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# Improving Medication Adherence in People with Serious Mental Illness

By Jonathan Keigher, PhD  
Vice President, Chief Clinical  
and Compliance Officer, New York  
Psychotherapy and Counseling Center

Psychotropic medication non-adherence in populations with Serious Mental Illness (SMI) can lead to inadequate symptom control, reduced treatment effectiveness, significant relapse risk, and increased risk of death (Semahegn, 2020). Nonadherence to medication also results in increased healthcare utilization. Individuals who do not adhere to their prescribed medication regimen require more frequent visits to healthcare providers, emergency department visits, and hospitalizations (Ascher-Svanum et al., 2006). This places an increased burden on the individual, their families, and healthcare systems. Studies (Walsh et al., 2019; Phan, 2016) have found that individuals who are non-adherent to medication are more likely to require hospitalization due to worsening symptoms, increased functional impairment, or the inability to manage their condition in the community.

As one of the largest providers of outpatient mental health services in New York State, New York Psychotherapy and Counseling (NYPCC) collaborates with thousands of New Yorkers experiencing serious mental illnesses such as schizophrenia, schizoaffective disorder, and bipolar disorder. As a part of our commitment to improving the quality of care for NYC's underserved populations, NYPCC has an intrinsic interest in reducing instances of non-adherence. Our therapists, psychiatrists, and nurse practitioners continuously monitor medication adherence among all our patients and intervene to increase adherence.

Improving medication compliance in people with serious mental illness can be challenging, as individuals may experience side effects, forget to take their medication, or resist treatment due to personal beliefs



or concerns. However, there are several strategies that strengthen medication adherence and are essential for assisting patients to achieve their treatment goals.

## The Therapeutic Alliance

At NYPCC, we emphasize the importance of a good therapeutic alliance in addressing potential adherence issues. A good therapeutic alliance fosters trust and promotes open communication between the patient and the clinician. Patients are more likely to share their concerns, doubts, and challenges related to medication adherence when they feel comfortable and trust their provider. This open dialogue allows the provider to gain insights into the patient's adherence behaviors and potential barriers.

Patients may not always be forthcoming about their struggles with medication adherence due to fear of judgment or other reasons. A strong therapeutic alliance helps providers assess adherence more accurately by creating a safe and non-judgmental environment. Patients are

more likely to disclose any non-adherence or difficulties they face, enabling providers to gather comprehensive information about their medication-taking behaviors. A good therapeutic alliance also allows clinicians to understand the patient's motivations, beliefs, and attitudes toward medication. By exploring the patient's perspectives, providers can identify potential factors that may influence medication adherence, such as concerns about side effects, doubts about the medication's effectiveness, or conflicting beliefs about healthcare. Understanding these factors helps tailor interventions to address the specific needs and concerns of the patient. Finally, a strong therapeutic alliance promotes collaborative decision-making, where providers and patients work together to develop strategies that fit the patient's lifestyle, preferences, and capabilities.

## Tailoring Treatment Plans

NYPCC clinicians also tailor treatment plans to meet an individual's needs

through collaboration and shared decision-making. When patients actively participate in the treatment planning process and feel that their opinions and preferences are valued, they are more likely to adhere to the prescribed medication regimen. By shaping the treatment plan to the individual's needs, clinicians can choose a route of medication delivery that minimizes side effects and enhances tolerability. This personalized approach improves the individual's overall treatment experience and reduces the likelihood of discontinuation or non-adherence due to intolerable side effects. When treatment plans are based on an individual's needs, it increases their satisfaction with the treatment and fosters a sense of engagement in their own care. By involving patients in the decision-making process and considering their preferences, clinicians empower individuals to take an active role in managing their condition. This increased engagement can lead to better treatment adherence, improved trust in the provider, and a higher overall satisfaction with the treatment experience.

## Family Involvement

Involving family members or key persons in the care of a patient and providing them with psychoeducation can have several medication adherence benefits. Family members and key persons play a vital role in providing emotional and practical support to patients. By involving them in the care and treatment process, patients have access to a strong support system that can positively impact medication adherence. Family members can offer reminders, assistance with medication administration, and help create a structured routine around medication-taking, thereby increasing adherence. In certain cases, patients may have difficulty managing their medication independently due to cognitive impairments, physical

*see Medication on page 41*



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# Supporting Veterans and Families in Conquering PTSD

By Claire Szewczyk, BS  
Digital Content Coordinator  
Hill & Ponton

As the echoes of war fade, a different kind of battle wages on for many courageous veterans who return home. An estimated 6% of US adults, or 6 out every 100 people, will be diagnosed with post-traumatic stress disorder (PTSD), at some point in their lifetime. In veterans, it increases to 7 out of 100 (or 7%). While PTSD can be a debilitating disorder, with the right support and resources, veterans and their families can successfully learn to cope and thrive.

*What is PTSD and why is it more prominent in the veteran population?:* Post-traumatic stress disorder is a mental health diagnosis that is often triggered by a terrifying event—either by experiencing it firsthand or witnessing it. While most people who go through traumatic events usually recover with good self-care and coping skills, if symptoms get worse, last for extended periods of time, and interfere with day-to-day functioning, it may be PTSD related.

When you serve in the military, you may be exposed to more traumatic events and at a higher frequency than civilians are. Since the disorder is triggered by trauma, the frequency and the severity of events servicemembers experience often-



times is the major reason why it is more prevalent in this population than the general public.

PTSD is recognized as one of the most common disabilities in veterans. Because of this, it's important to understand how it impacts them as a whole, the steps they can take to help their symptoms and what family members and friends can do to support them.

*Understanding PTSD in Veterans:* While there has been a substantial amount of research done over the last decade or

two regarding the prevalence of PTSD in military veterans, the results of these studies have varied quite a lot. PTSD was only made a mental health diagnosis in 1980, it's still relatively new and needs to be understood.

In a recent meta-analysis of thirty-two scientific articles, researchers found the estimated incidence of PTSD among veterans ranged from 1% to nearly 35%, showing that understanding the true impacts of this disorder within this community will require a lot more research.

The incidence of PTSD also varies greatly depending on which conflict a service member happened to be involved with.

*Recognizing the Signs, Symptoms and Challenges of PTSD:* Individuals diagnosed with post-traumatic stress disorder may experience a wide variety of symptoms, and veterans are no exception to this rule. However, the disorder is generally characterized by a few specific categories of symptoms, which mental health professionals often use to assess and treat the disorder.

These symptom categories, as described in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* explain the different kinds of mental health concerns veterans have, at varying degrees. The diagnostic criteria is widely accepted in psychiatry and related mental health fields. To understand the daily struggles that PTSD can entail for veterans, or to assess whether or not you may be experiencing the condition yourself, consider the following symptoms:

*Intrusion of Thoughts, Memories, Flashbacks and Dreams:* This category is sometimes referred to as "re-experiencing symptoms," and describes repeated, unwanted recollections of the traumatic event(s) in question. These "intrusive" forms of thinking include memories and dreams, which are oftentimes quite vivid

see PTSD on page 32

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## Addressing the Intersection Between Severe Mental Illness and Homelessness

By **Nadjete Natchaba, EdD, LCSW, MPA**  
and **Lisa Snider, BA**  
Services for the UnderServed (S:US)

**S**ervices for the UnderServed (S:US) is one of the largest community-based health and human services organizations in New York State that works intentionally daily to right societal imbalances by providing comprehensive and culturally responsive services. We provide services to people living with severe mental illness, substance use disorder, homelessness, and poverty. We are cognizant of the intersectionality of severe mental illness, poverty, homelessness, and the history of the United States as it relates to caring for people who are marginalized due to disability and/or socio-economic status. We cannot begin to talk about people living with severe mental illness without looking into how mental healthcare started and progressed in America.

Before the 16th century, care for people with mental illness was the responsibility of the family.<sup>i</sup> Once mental illness was classified in the same category as physical illness and treatment methods were developed, asylums were created.<sup>i</sup> In the United States, three asylums established between 1756 and 1773 treated people using methods of bloodlettings and tranquilizer chairs, as promoted by Benja-



min Rush, the pioneer of American psychiatry.<sup>iii</sup> Asylums kept people with mental illness isolated while providing treatment that did not prove to improve the conditions.<sup>iv</sup> New asylums utilizing the psychogenic frame (compassionate care and sheltered workshops) were established in New York City and Pennsylvania between 1817 and 1821 to provide care that could rehabilitate people.<sup>v</sup> By the 1850s, while the population in the asylums grew, the institutions were un-

able to appropriately care for all their patients due to the stagnation of their resources.<sup>vi</sup> Advocacy led by Dorothea Dix helped establish state hospitals to provide better care to people with mental illness.<sup>vii</sup> The institutional inpatient care model was deemed the most effective model of treatment until data from the National Institute of Mental Health (NIMH) and other experts demonstrated that community-oriented care combined with the use of psychotropic medications would improve

the quality of care and life of people with mental illness.<sup>viii,ix</sup> However, in the mid-1950s ongoing studies conducted by the NIMH recommended deinstitutionalization and community-based care as the best approach to improve the quality of life of people with mental illness.<sup>x,xi</sup> Subsequently, partial hospitalization, emergency services, outpatient psychiatric treatment, and short-term inpatient care and smaller supervised residential homes became a substitute to institutionalizing people who required mental health treatment.<sup>xii,xiii,xiv</sup>

Regrettably, these alternatives were not comprehensive and intensive enough to effectively address the needs of people who were previously in institutions or needed a higher level of care in the community.<sup>xv</sup> Even though community-based treatment programs enhance the quality of life of people with mental illness, they are falling short in helping people with mental illness address their physical health, poverty, inadequate living conditions, and social connectedness issues in the community.<sup>xvi</sup> The population previously kept in hospitalization was now in the community at risk of homelessness, substance use disorder, suicide, and incarceration.<sup>xvii</sup> With limited availability of hospital beds compounded with inadequate community treatment options, people with severe mental illness returned to the street due

*see Homeless on page 35*

## What Do We Know About the Relationship Between Cannabis and Psychosis?

By **Grace Hennessy, MD**  
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Grossman School of Medicine

**F**rom 2002 to 2021, the number of individuals aged 12 or older reporting last year cannabis use increased steadily from 26 million to 53 million (SAMHSA, 2022). Accompanying this increase in the number of individuals using cannabis is a decline in the percentage of individuals who believe that cannabis use is associated with a risk of harm, with the greatest percentage decline seen among high school aged adolescents (Johnson, et al., 2022). Despite this perception, the harms associated with cannabis use have been researched and well-documented, including those that occur during intoxication such as impairments in cognitive and motor functioning to those that occur with heavy and regular cannabis use such as lower educational attainment and lower life satisfaction (Volkow, et al., 2014; Thompson, et al., 2019). Another area of research about the harmful effects of cannabis has focused on the development of psychosis.

Individuals who use cannabis have a



significantly increased risk of developing psychosis compared to those who do not use cannabis (Sideli, et al., 2020). While any use may be associated with an increased risk of developing psychosis, the frequency of cannabis use, as well as cannabis potency may be more relevant factors. For example, daily cannabis use has been associated with a three-fold increase in the odds of developing psychosis among individuals with first episode psychosis (FEP) (Marconi et al., 2016). Daily use of high-potency cannabis, defined as having a concentration of  $\Delta$ -9 tetrahydrocannabinol or THC greater

than 10%, conferred a five-time greater risk of developing psychosis among individuals with FEP (Di Fiorti, et al., 2015). The finding that regular use of high potency cannabis may be associated with developing psychosis is of particular concern because the THC concentration in cannabis has been rising over time. Indeed, the average THC concentration of illegally grown cannabis seized by the United States Drug Enforcement Agency (DEA) nearly doubled from approximately 9% in 2008 to 17% in 2017 (Chandra, et al., 2019). Lastly, initiation of cannabis use at an early age, frequently defined

as age 15 or younger, is related to an increased risk of developing psychosis but confounding factors such as the use of other substances has not allowed for a clear association to be made (van der Steur, et al., 2020).

Other biological and environmental factors among those who use cannabis also may influence psychosis risk. Some studies have shown that genetic variations affecting dopamine metabolism increased the risk of developing psychosis during adolescence among those who smoked cannabis, but other studies have not found such an association (Wahbeh, et al., 2021). The combination of childhood trauma such as physical and emotional abuse combined with cannabis use increased the risk of developing psychosis in adolescents (Harley, et al., 2010) and exposure to high levels of childhood trauma and severe cannabis use (defined as more than once per week to daily use) was significantly associated with an increase in psychosis risk (Arranz, et al., 2018).

In addition to the influence cannabis can have on the development of psychosis, cannabis use negatively affects the course of individuals who have experienced a first psychotic episode. Poor adherence to psychosocial and pharmacological treatments (Schoeler, et al., 2017),

*see Cannabis on page 37*



# Suicide in Adolescents: Warning Signs, Risk Factors, and What Parents Can Do to Support Their Teens

**Hongmarie Martinez, PsyD**  
**Psychologist**  
**Behavior Therapy Associates**

**S**uicidality can affect all age groups, including during the adolescent years (Centers for Disease Control and Prevention [CDC], National Center for Injury Prevention and Control, 2023). The CDC's Division of Adolescent and School Health (2023) reported data concerning U.S. high school students' mental health and experience with suicidal thoughts and behaviors from 2011 to 2021 in their Youth Risk Behavior Survey (YRBS). The findings from the survey revealed that the percentage of U.S. high school students who felt "persistent feelings of sadness or hopelessness" increased from 28% in 2011 to 42% in 2021. Since 2011, those who seriously contemplated attempting suicide rose to 22%, individuals who made a suicide plan increased to 18%, while those who made a suicide attempt rose to 10% in 2021. The



data from the CDC's YRBS survey further indicated that U.S. high school students across genders and racial/ethnic groups were affected in all domains. Moreover, currently suicide has also been found to be the third leading cause of death for adoles-

cents aged 15-19 years-old (CDC, National Center for Health Statistics, n.d.). It can certainly be disconcerting for parents to think about your teens struggling with their mental health and feeling suicidal. Fortunately, there are indicators that par-

ents can look for to better understand suicidality in adolescents.

The warning signs or "red flags" of suicidality that parents should attend to can manifest as changes in your teen's thoughts, feelings, and behaviors, such as (Alvord, Kaslow, Owens, & Gurwitch, 2018; American Psychological Association, 2019):

- Making statements (verbally or in writing) related to death or suicide threats, such as "I wish I were dead", "Everybody would be better off without me", "I can't go on", "I want to die/kill myself", "I thought about how I would end my life", and "I tried to end my life";
- Preoccupation with death and dying, which may show up via teen's social media, artwork, or writings;
- Exhibiting symptoms of depression

*see Teens on page 36*

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## Preventing Suicide: Addressing Trauma-Related Symptoms in Individuals with Serious Mental Illness

**By Ann Marie Kavanagh, PhD,**  
**Richard LaMonica, PhD,**  
**and G. Mitchell Mazzone, MA**  
**Pilgrim Psychiatric Center**

**T**he incidence of mental illness is pervasive in the United States, a recent estimate suggesting it impacts more than one in five adults (NIMH, 2023). While "mental illness" is a category that embodies all diagnoses, a subset of this category, serious mental illness (i.e., schizophrenia spectrum and other psychotic disorders, major depressive disorder, bipolar disorder) receives considerable empirical attention due to significant associations of persistent psychosocial and functional impairment (Martínez-Martínez *et al.*, 2020). According to recent data, approximately 5.5% of all adults ( $\geq 18$  years old) in the United States reported SMI. Moreover, the prevalence of SMI varies across age and self-identified gender; SMI was reported to be higher among females (7.0%) compared to males (4.0%) and elevated among young adults (age 18-25; 11.4%) compared to older age groups (NIMH, 2023).



**Suicide and SMI:**  
**The Impact of Experiencing Trauma**

Suicidality (i.e., suicidal thoughts and behaviors) is considered a serious public health issue; prior to the COVID-19 pandemic, suicide was indicated among the top ten leading causes of death among adults (Xu *et al.*, 2021). While suicidality is prevalent in the general population, extensive literature suggests suicidality (in particular, death by suicide) to be disproportionately

common among individuals with SMI (Yates *et al.*, 2019). Given this significant discrepancy, it is vital to explore mechanisms which may posit risk of suicidality among individuals with SMI to adequately inform prevention efforts (Edgcomb *et al.*, 2021). One of the mechanisms that has been suggested to influence suicidality in various populations (including individuals with SMI) is trauma exposure and subsequent posttraumatic stress symptoms (PTSS; Tarrier & Picken, 2011).

Individuals who die by or attempt suicide reported elevated rates of exposure to traumatic events (e.g., physical and sexual violence, accidents, natural disasters, serious injury and harm, etc.) and PTSS, underscoring the importance of a trauma-informed approach to suicide prevention (Harford, Yi, & Grant, 2014; Krysinska & Lester, 2010). Although exposure to traumatic experiences is relatively prevalent in the general population (Knipsheer *et al.*, 2020) individuals with SMI disproportionately report more traumatic experiences and subsequent PTSS (Grubaugh *et al.*, 2011). Along these lines, research suggests the experience of psychosis is in itself traumatic as it often involves significant distress due to symptoms of (often personalized) hallucinations and paranoid delusions in addition to external stressors of hospitalization (Bendall *et al.*, 2008; Berry *et al.*, 2013). Given the increased risk of trauma exposure and subsequent PTSS in addition to suicidality, (trauma-informed) interventions to target symptoms of PTSS may be especially beneficial to those with SMI. Despite, research

*see Trauma on page 33*



**PTSD from page 29**

and realistic. Sometimes they also can assume the form of “flashbacks,” in which a veteran may feel they are reliving the traumatic event over again.

**Avoidance of Reminders of the Traumatic Event(s):** When we recall traumatic events, it can often be very emotionally distressing. This is much the same for veterans, who, when diagnosed with PTSD, may intentionally or unconsciously steer clear of stressors that might “trigger” the painful thoughts and feelings associated with their trauma.

**Alterations in Cognition and Mood:** Veterans who have undergone trauma and are experiencing PTSD symptoms often have complex cognitive and emotional consequences as a result. They may have difficulty remembering details of events, have negative beliefs about oneself and others, feelings of guilt and/or shame, feelings of detachment and other emotional responses as a result.

**Alterations in Arousal and Reactivity:** Those who experience PTSD symptoms often feel a continued sense of danger even after the actual threatening event has passed. This is because the amygdala, the region of the brain that processes fear and emotion, remains overactive, much like if real life-threatening danger was present. Veterans often report symptoms of feeling “on guard” or what mental health experts call “hypervigilance.” This can lead to being easily startled, excessive wariness, problems with focus, difficulty sleeping and other issues.



**Claire Szewczyk, BS**

**PTSD Risk Factors for Veterans:** In a comprehensive meta-analysis published back in 2015, it was suggested that there may be certain variables that influence the [likelihood of a veteran developing PTSD](#). These include the following:

- Degree to which they were exposed to combat situations
- If they discharged a weapon during combat (and if that weapon caused lethal damage)
- Witnessing life-threatening injuries or death while deployed
- The levels of social support after the traumatic exposure (such as having family and friends to rely on outside of service).

**Providing Support for Veterans and Their Families**

1. **Creating a Safe and Supportive Environment:** Being able to be empathetic, understanding, and non-judgmental are the cornerstones to a safe and supportive environment for veterans suffering from PTSD. Fostering open communication and active listening can help facilitate the healing process, while creating a community can reduce the feeling of isolation. Remember—it’s essential to respect a veteran’s boundaries and readiness when trying to discuss their traumatic experiences.

2. **Accessing Professional Help:** Access to professional medical help is key to managing PTSD. Mental health providers can offer different types of therapy, like cognitive behavioral therapy (CBT), eye movement desensitization and reprocessing (EMDR), or exposure therapy. The VA website or the National Center for PTSD can be used to help find qualified therapists and psychiatrists to help.

3. **Educating about PTSD and its Management:** Among the powerful tools useful in addressing PTSD, perhaps one of the most important is education. Learning about the disorder, understanding how it impacts veterans (and those around them as a result), and how to help them cope and manage it, can help dispel myths and reduce stigma. This knowledge is also often very empowering to help implement coping strategies and stress management techniques.

4. **Building a Supportive Network:** As mentioned above, another very important part of PTSD management is the establishment of a solid support network. This network might include friends, family and mental health professionals, but also could include peer support groups and other organizations that work with those struggling with PTSD, and their families. Examples of these organizations that help vets include the American Legion or the Wounded Warrior Project.

**Promoting Self-Care for Veterans and their Families:** Much like any health concern, proper lifestyle choices are also a huge part in managing the symptoms. Regular exercise, a balanced diet and quality sleep, all have been scientifically shown to help reduce symptoms and severity of PTSD. Stress reduction techniques, like meditation and mindfulness, are also extremely beneficial. Having hobbies and creative outlets can be a way for veterans to feel a sense of achievement and enjoyment and take some of the intensity out of their mental health battles.

Supporting veterans and their families affected by PTSD is an issue of great importance. With the right understanding, a good dose of empathy and the availability of resources, a positive impact can be made. Learn about PTSD, become an advocate for veterans’ mental health and promote organizations that support it. After all, our veterans have made the ultimate sacrifice fighting for us—it’s about time we fight for them, too.

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**Consumer from page 21**

you know that you can be. And S:US will not only care for you while you’re fighting for your existence, but they’ll also fight for your existence right along with you,” said Regina. “They made me feel like I was worth the help. They made me see that just because I went through so many difficulties, that does not compare to finding my strength again, finding who I am again. They were very instrumental, in the encouragement aspect. They encouraged me to go forth with my dreams of becoming an actress. If I hadn’t received that encouragement from S:US, friends and family, I would not be in the position that I’m in now.”

“S:US has given me a lot of backup with [the] therapy they give me once or twice a month and [by] calling me once a week. I’m very grateful for all the members of the staff of S:US because they show compassionate care for human beings that’s struggling with mental disorder/s, and I’m one of them that has the ailment. I appreciate all that I can get from S:US,” said Herman.

Raymond said, “I have a therapist,

Emma. The reason I searched her out is because one of my daughter’s mothers passed away, and I was going through a whole lot. I went to find a therapist, and I’ve been seeing her for seven years. And that helps me a lot.”

**Giving Back**

One of us, Regina, loves helping other S:US residents and even eventually became a Peer Specialist with S:US! People with lived experience of mental health challenges, like us, can help others in a unique way. We serve as role models, lending our peers the benefit of our own learned lessons and experiences in recovery. Peer to peer support helps individuals explore and realize opportunities for community participation, including employment, and pursue social and recreational opportunities. Peers also help each other maintain a physically healthy lifestyle and actively take charge of their own life.

“Before I became a Peer Specialist, I would advocate for people who were in S:US as a resident. I would teach them the ropes; this is what you do, this is what you’re not to do. This is how you secure

your premises so that no one gains entrance in it. Keep your nose clean. Always meet with your counselor. Pay your rent so that you have a better standing when you move on. You can always say, ‘Hey, look, S:US was my landlord for X years and they can always give you a very good report.’” said Regina. “I jumped at the opportunity to give back to S:US because they’ve given me so much. I became a Peer Specialist, and everything has been so beautiful. My clients, my residents are beautiful. I literally work right across the street from where I grew up. It’s like life coming full circle for me. So, this is absolutely incredible, even with the challenges, too.”

**Messages for Others Experiencing Similar Challenges**

We have encouragement to share with people who may be having a hard time and experiencing some of the challenges that we’ve been through.

“Talk to someone, don’t hold it all inside,” said Regina. “Don’t give up. Do whatever you have to, but do not give up. Don’t quit. It’s going to get ugly, it’s gonna get beautiful. You’re gonna be up,

you’re gonna be down, you’re gonna be left, you’re gonna be right. Just don’t quit. Just trust the S:US process, because the process works. And be honest.”

Herman said, “Don’t give up the ship. Try to accept the depression. Not to conquer it, but to somehow find a way to alleviate it, because it’ll never go away. Try to stay [as] stable as you can and try to find a way to alleviate it. If I’m alone, when I’m around nobody, depression attacks, and attacks strongly. Being around friends and family helps.”

“I want other people to know that whatever situation they’re in right now, good or bad, it can change. But it’s up to them,” said Raymond. “There’s help that’s available. You gotta go out and seek it. It ain’t gonna come to you. You gotta let other people know what’s going on in your life. And prayer helps, sit still and pray, ask for help. The situation will get better, for real. Just look at me, if you’d seen me years ago, boy, I was a mess, mentally and physically. But now I’m much better. I don’t run from situations now. So, sit down and talk about it. There’s light at the end of the tunnel. Just don’t give up.”



**Trauma on page 31**

in this area is nascent (as treatment studies have typically excluded individuals with SMI), studies of those with SMI have found that evidence-based treatments (i.e., Cognitive Restructuring, Prolonged Exposure and Eye Movement Desensitization and Reprocessing; van den Berg et al., 2015) targeting PTSS to be efficacious in reducing symptomatology. However, there are often barriers (e.g., cost, time, etc.) to training and implementation of these treatments.

**Can Implementing Mindfulness Alleviate PTSS and Suicidality Among Individuals with SMI?**

Literature has implicated mindfulness, a therapeutic practice promoting present-moment awareness, self-compassion and nonjudgment of inner experiences (i.e., emotions, cognitions, physiological sensations, etc.) to be especially suitable in acute inpatient settings due to its short-term adaptability, feasibility and effectiveness of targeting cognitions and behaviors associated with psychiatric crisis (Jacobson et al., 2011). Moreover, mindfulness-based interventions have been utilized as an adjunct to traditional PTSS-treatment in effort to mitigate PTSS and suicide risk (Cheng et al., 2018). Along these lines, facets of mindfulness (specifically, *acting with awareness* and *nonjudgment of inner experiences*) have been shown to be negatively associated with PTSD-related mechanisms specifically implicated in increasing suicide risk, such as avoidance and hyperarousal (Stanley et al., 2019). Given these interventions are suggested to be effective in reducing PTSS and suicidality, could these findings be applied to individuals with SMI?

Indeed, mindfulness-based interventions has its advantages (e.g., feasible, short-term and acceptable) in treating trauma-related symptoms and suicidality in various clinical populations, including inpatient (a treatment setting in which individuals with SMI are overrepresented). Acceptance and Commitment Therapy (ACT), a third-wave evidence-based treatment that uses mindfulness as a core

tenet has been found to decrease trauma-related symptoms among those with SMI (Spidel, et al, 2018). One may then assume that a treatment that decreases symptoms related to suicidality (i.e., avoidance and hyperarousal) among individuals with SMI endorsing a history of trauma will exhibit a reduction in these symptoms leading to less suicidality. Along these lines, the first step of evidence-based treatments is indeed the 'evidenced-based' portion, thus more empirical research is needed to explore how to effectively reduce PTSS and suicidality by utilizing mindfulness-based intervention, given its advantages. Once efficacy is established, accelerating training and implementation of these interventions may promote healing from previous trauma and increase global functioning in a population deemed high-risk for suicide.

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**Research from page 1**

following childbirth. Its beneficial effects are usually felt within about 2 days of administration.

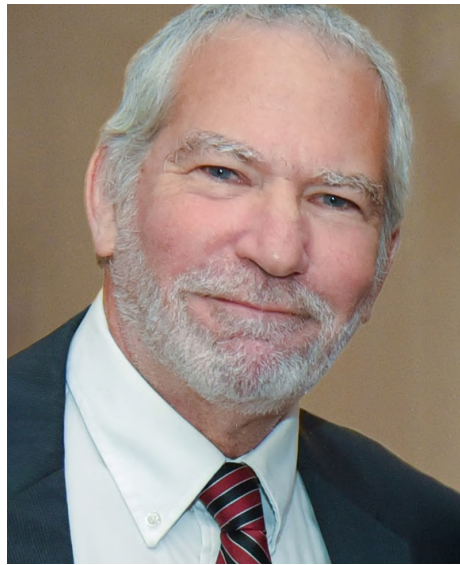
The development of both medicines exemplifies the power of investing in basic research. Both medicines emerged after years of careful clinical testing. But the research that led to their testing was driven by prior inquiries over many years in dozens of labs into the fundamental biology of the brain. In basic investigations of this kind, direct links between research and goal are not known, *or even knowable*, when grants are awarded that make the work possible.

The Brain & Behavior Research Foundation (BBRF, formerly “NARSAD”) has since its inception 36 years ago stressed grant-making of this kind. In fact, 90 grants awarded by BBRF over more than two decades and totaling over \$6.5 million substantially contributed to the development of the first two rapid-acting antidepressants.

**Transcranial Magnetic Stimulation (TMS) to Treat Depression**

The modern application of electroconvulsive therapy (ECT) has enabled people with severe, treatment-resistant depression to carry on with their lives. But it involves a medical procedure that must be performed under general anesthesia, usually in a clinic or hospital, and is usually considered a treatment of last resort due to side effects, which can include short-term memory loss.

In the 1990s, a researcher used BBRF grants to study and develop a very different way of using “neuromodulation” to alter connectivity in brain circuits implicated in depression. Called rTMS (repetitive transcranial magnetic stimulation), this technology is non-invasive and is delivered on an outpatient basis. Patients experience only minor side effects such as headaches, which typically pass in minutes, and have no loss of memory. BBRF grantees demonstrated that rTMS was effective in a substantial percentage (one-third or more) of treatment-resistant depression patients. This led to FDA approval in 2009. The treatment is used around the country and across the globe today, including as a first-line treatment in some depressed patients. More powerful and equally safe rapid-acting versions of TMS are being tested in clinical trials and show promise not only in TRD but as treatments for hospitalized patients experiencing a suicidal crisis. A protocol named SAINT developed by a BBRF grantee was given the go-ahead for commercialization by the FDA last September. In three clinical trials, it has enabled nearly 80% of refractory major-

**Peter Tarr, PhD**

depression patients to achieve remission after only 5 days of accelerated, individually targeted non-invasive stimulation. Other advanced neuromodulation therapies are being tested in PTSD, OCD, and other psychiatric disorders.

**Clozapine in the Treatment of Schizophrenia**

Schizophrenia is a chronic and often disabling brain disorder that affects 1 in 100 (about 2.5 million) American adults. Symptoms include delusions, hallucinations, disorganized speech, trouble with thinking, and lack of motivation. With treatment, some symptoms of schizophrenia can greatly improve. Yet roughly 750,000 Americans have “treatment-resistant schizophrenia” (TRS).

*Clozapine* was the first antipsychotic drug proven to be effective in treating TRS and remains the “gold-standard” treatment. It has also been found to significantly lower the risk of suicidal behavior in schizophrenia patients. Clozapine’s effectiveness in treating schizophrenia was demonstrated in a clinical trial in the 1980s co-led by a scientist who was working on a BBRF research grant. His work provided a scientific underpinning for the FDA’s approval of clozapine in 1989. This, in turn, led to the development of a whole new “second generation” of antipsychotics such as Abilify, Risperdal, and Seroquel—medicines that are now treating millions of patients globally.

**Decreasing Schizophrenia Risk Via Maternal Choline Supplements**

Prevention might be considered the ultimate goal of neuropsychiatric research. It is intriguing to consider, for instance: what if something could be done to reduce the risk of schizophrenia developing?

BBRF grantees and others have

**Jeffrey Borenstein, MD**

shown that the illness is highly complex. Factors thought to contribute to its causation are remarkably diverse. Chief among these are genetics: variations in one’s DNA that one carries from the beginning of life, along with environmental factors in the months and years following birth. BBRF-funded research has shown that complications during pregnancy can increase the chance that genetic risk factors in the fetus actually trigger changes in the brain’s development. These can affect the formation of neural cells and circuits in the fetal brain and the crucial thinning of synaptic connections early in life.

What if something as simple as taking a nutritional supplement by the mother during pregnancy could be shown to reduce risk or even prevent the future onset of schizophrenia? Researchers with BBRF funding have performed pioneering clinical studies that supplemented the diet of pregnant women with the essential nutrient choline. This research has shown that choline supplements during pregnancy do indeed appear to reduce the risk that a child will go on to develop psychotic disorders including schizophrenia. While the research is ongoing, the American Medical Association now recommends including choline in prenatal vitamin supplements.

**Optogenetics Launches a Revolution in Brain Research**

The 6200+ grants awarded over 36 years by BBRF have helped enable a rising generation of neuroscientists to shape a revolution in brain science. In addition to their contributions to the development of new treatments, grantees also have developed new technologies that help identify mechanisms in the brain that give rise to depression, anxiety, schizophrenia, autism, and other brain and behavior disorders.

These new technologies help them establish direct linkages between the devastating symptoms of mental illnesses and biological processes that alter the structure and function of the brain’s genes, cells, and circuitry. It’s very hard to examine or perform experiments in the living brain. But grantees have devised remarkable methods and new technologies that have catapulted research forward.

BBRF support for basic research was instrumental, for instance, in the development of optogenetics, a game-changing technology that gives researchers precise control over brain circuitry in animals. In 2021 a BBRF-funded scientist won the prestigious Albert Lasker Basic Medical Research Award for his role in developing the technology. Optogenetics involves the use of colored beams of laser light to rapidly open and close the membrane channels that make neurons fire and cease firing. This allows observation of the effects on behavior. This technology is now in use at thousands of labs all over the world and promises breakthroughs in the identification of mechanisms that give rise to depression, anxiety, schizophrenia, autism, and other brain and behavior disorders.

**Stem-Cell Technology Provides a Window on Developing Brain Cells and Circuits**

One of the challenges in studying the brain is not being able to sample living brain cells in patients with psychiatric disorders. To figure out how pathology related to mental illness arises, BBRF grantees have harnessed stem-cell technology to obtain views of the brain in its earliest stages of development, a time when pathologies associated with autism, schizophrenia, and other disorders are thought to begin.

Taking advantage of the unique properties of stem cells, BBRF-funded scientists have harmlessly sampled skin cells from people diagnosed with illnesses such as autism and schizophrenia, both of which are thought to have a strong genetic component, and “reprogrammed” these cells to return to the stem-cell state that marks the beginning of every cell’s life. These cells can then be induced to redevelop as mature brain cells.

Using this method, scientists can study such “reborn” brain cells with the hope of seeing when and how abnormalities develop. This remarkable technology has already yielded insights into abnormalities in autism and schizophrenia that can be traced to the earliest stages of life.

*Peter Tarr, PhD, is Chief Science Writer and Jeffrey Borenstein, MD, is President & CEO at the [Brain & Behavior Research Foundation](#).*

***Read the Inspiring Story of Ira H. Minot, LMSW  
Founder and Publisher of Behavioral Health News  
“A Personal Journey From a Survivor of Suicide:  
From the Depths of Despair to A Mission of Advocacy”***



**Homeless from page 30**

to a lack of stable housing.<sup>xviii</sup>

People living with SMI experiencing homelessness continue to be a public health concern demanding attention from people who care for them, the community at large, and legislators. Many new program initiatives (Safe Options Support Teams, Welcome Centers, Intensive Mobile Treatment Teams, Safe Havens, etc.) have been implemented in New York City to address the issue of chronic homelessness. Services for the UnderServed (S:US) engages with people living with SMI in our various homeless and domestic violence shelters; people living on the streets and subways as well as those receiving services at our Certified Community Behavioral Health Clinics (CCBHC).

Our staff approach persons served with the understanding that SMI is a complex illness that must be addressed with creativity, compassion, and patience. We are deliberate in hiring persons with "lived experience" as we aim to foster an environment where those served feel understood, empowered, and encouraged. Utilizing staff who appropriately share their past experiences related to homelessness, poverty, mental illness, racism, and other forms of oppression, normalizes and externalizes some of the battle persons served are struggling with. All of our staff are provided with a series of trainings that help them to explore their own biases around people who are homeless and those with severe mental health disorders. They learn how to promote engagement through the concept of accompaniment and that persons served are the subjects in their recovery journey, and, we serve as a supportive partner. Staff are expected to approach persons served using the harm reduction lens which for people living with SMI means celebrating small successes (i.e., be ok with person served only communicating in five-minute increments; facilitating shorter groups for 20 minutes rather than 45-minute groups, etc.).

Establishing the rapport and professional relationship that will help persons served adjust to their temporary living arrangement is a principle responsibility of staff. Once there is rapport and a professional relationship, staff can begin to guide and assist persons served with achieving their chosen goals; staff with lived experience are such an intricate part of this recovery process. Some examples of being supportive is evidenced by staff creating the space for persons served to be themselves, be accepting of persons served exhibiting symptoms that are non-life threatening, and promoting connection



**Nadjete Natchaba, EdD, LCSW, MPA**

to mental health providers at our CCHBC clinics who understand the intersection between homelessness, racism, and poverty. While working on helping persons served honor their own agency, staff's focus does not lose sight of the ultimate goal of moving them out of the shelter to their home. With our single point of access, our teams do their best to find the most appropriate level of housing that will allow for persons served to remain housed and improve their quality of life.

Whether informal or formal, our staff provides the necessary support and assistance needed for persons served living with SMI to achieve their chosen goals outlined in their independent living and treatment plans. Our core values reflect a system where we maximize individual potential. Therefore, living with SMI and being homeless should not limit the interventions to the traditional goals of avoiding hospitalization and obtaining housing. S:US' commitment of taking care of people with SMI who are homeless is affirmed daily through our actions, programming, and celebration of all successes small or big.

*Nadjete Natchaba, EdD, LCSW, MPA, is Chief Program Officer, and Lisa Snider, BA, is Associate Vice President, Homeless Services, at Services for the UnderServed.*

#### Footnotes

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**Lisa Snider, BA**

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amount of time and interfere with daily life.

6. Post-traumatic stress disorder (PTSD): A disorder triggered by experiencing or witnessing a traumatic event. Symptoms may include intrusive memories, nightmares, flashbacks, avoidance of reminders, hypervigilance, and emotional numbness.

It's important to note that the term "serious mental illness" may vary in usage, and specific definitions can differ across healthcare systems and regions. Professional evaluation and diagnosis by qualified mental health professionals are essential for accurately identifying and treating these conditions.

## Fact Sheet: Serious Mental Illness

**S**erious mental illness (SMI) refers to a category of mental health disorders that significantly impact a person's thoughts, emotions, behavior, and daily functioning. These conditions are typically chronic, persistent, and often require long-term treatment and management. While there is no universally agreed-upon list of disorders classified as serious mental illnesses, some common examples include:

1. Schizophrenia: A severe mental disorder characterized by disturbances in thinking, perception, emotions, and behavior. People with schizophrenia may experience hallucinations, delusions, disorganized speech, and impaired social functioning.

2. Bipolar disorder: A condition marked by extreme mood swings, ranging from manic episodes (elevated mood, high energy levels) to depressive episodes (low mood, loss of interest). These mood shifts can significantly disrupt daily life and functioning.

3. Major depressive disorder: Also known as clinical depression, it involves persistent feelings of sadness, hopelessness, and

a loss of interest or pleasure in activities. Symptoms may include changes in appetite, sleep disturbances, fatigue, difficulty concentrating, and thoughts of self-harm.

4. Borderline personality disorder: A disorder characterized by unstable moods, relationships, and self-image. People with this condition may experience intense fear of abandonment, engage in impulsive and risky behaviors, and struggle with emotional regulation.

5. Obsessive-compulsive disorder (OCD): An anxiety disorder marked by recurring, intrusive thoughts (obsessions) and repetitive behaviors (compulsions) aimed at reducing distress. These compulsions can consume a significant



*Teens from page 31*

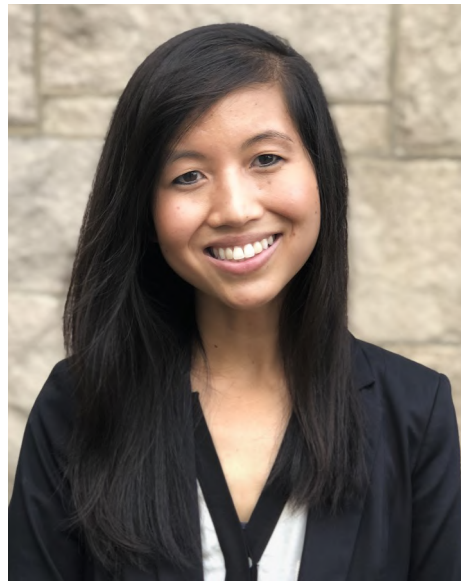
such as persistent low/depressed mood, feelings/expressions of hopelessness (i.e., doesn't indicate hope for the future) and worthlessness (i.e., negative thoughts about self, perception that one is a burden to others), self-harm behavior (i.e., cutting), loss of interest in activities and maintaining appearance/hygiene, withdrawal/spending less time with friends/family, difficulties with appetite, sleep, and focusing;

- Increase in risk-taking behaviors (i.e., reckless driving)
- Demonstrates extreme changes in behavior;
- Increase in substance use;
- Dramatic decline in academic performance;
- Giving away one's possessions;
- Looking into methods for suicide and accessing the means (i.e., collecting pills, obtaining a weapon)

In addition to being familiar with the warning signs, it can also be valuable for parents to have knowledge about the risk factors for suicidality or various biological, psychological, and interpersonal factors that may increase the likelihood of suicidal thinking and behavior, such as (Bilsen, 2018; Alvord et al., 2018):

- Presence of mental illness (i.e., mood disorders such as depression are often commonly associated with suicide, bipolar, anxiety disorders, substance abuse, PTSD);
- Feelings of hopelessness and worthlessness;
- Family history of mental illness and suicide attempts;
- Challenges with substance use;
- Difficulties with impulsive behavior;
- Relationship challenges/loss (i.e., romantic breakup, friendship ending, death of a loved one, parental or peer conflict, lack of social support);
- Bullying (being either a victim or a perpetrator);
- Poor problem-solving skills and ways of coping with emotions;
- Access to means (i.e., firearm in the home);
- Exposure to a peer completing suicide;
- Past suicide behavior/attempts

As one's mental health can be impacted by a complex set of genetic and environmental factors, teens may exhibit any combination of warning signs and risk



**Hongmarie Martinez, PsyD**

factors. When parents have this knowledge along with an understanding of supportive practices to engage in with teens about addressing suicidality, both teens and parents alike may be better equipped to navigate this serious mental health challenge. So what steps can you take as a parent if you suspect or have knowledge that your teen is struggling with suicidality?

1. Approach discussing the topic of suicide rather than avoiding it. Undoubtedly, it can be worrisome to associate suicidality with your teen. Parents may therefore be inclined to not talk about the topic out of fear that it will increase suicidality in their teen. However, talking about suicide may provide your teen with a sense of relief and comfort knowing that you care to ask and are willing to talk about their struggles. This can open the door for ongoing communication with your teen going forward.

2. Communicate with your teen in a calm, empathic, and non-judgmental manner. Once you decide to approach talking about suicide with your teen, you may be wondering, "What do I say? How exactly do I start talking about it with them?" It may be helpful to start with a general check-in about their mental health overall before asking about more specifics, such as "I wanted to check-in and see how you've been feeling lately" which can be coupled with "I'm here to support you with whatever you may be feeling or going through." And then really listen to what they have to say. If your teen chooses to divulge anything, including anything related to suicide, it can be beneficial to follow up with validating statements that can help them to feel heard and understood, such as "That sounds really difficult what you've been experiencing" with the addition of "I'm really glad you're sharing this with me, I know this may not be easy to talk about." Due to natural feelings of concern, parents may feel inclined to ask questions, such as "Why didn't you tell me sooner you were feeling suicidal? Why would you be thinking that?" Questions like these may result in your teen feeling judged, invalidated,

and want to retreat; as difficult as it may be for parents to address the topic, it may also be stressful for teens to discuss their mental health or suicide with parents. If your teen doesn't appear to be ready to talk, emphasizing an open-door policy that you are always available to them when they are ready can also increase open communication.

3. Be intentional about when and where you have check-ins with your teen. When and where you have conversations with your teen about their mental health may impact the outcome of your check-in. Identify with your teen a specific time of day and place that will be workable for you both. Having a conversation where you and your teen have privacy, have sufficient time to connect, and when both of you can be fully present and not distracted or interrupted are factors for consideration to help with appropriate timing of important conversations. For example, checking in before bedtime may be more ideal than during a ten-minute car ride to soccer practice.

4. Ask direct questions to assess your teen's safety. When asking questions to assess your teen's safety, it's important to ask direct questions about suicidality that allow your teen to freely respond; try to avoid inserting your own answer into the response. For example, you can ask, "Have you had any thoughts of ending your life?" versus "I just want to make sure...you're not suicidal, right?" The latter may send the message that it's not okay for them to be feeling suicidal. Additionally, if your teen responds 'yes', it's critical to also ask if they have thought about any specific methods/plan, intend to follow through, or have engaged in any preparatory behaviors to end their life. Continue with empathy, non-judgment, and follow-up questions that may lend themselves to your teen elaborating further, such as "Can you tell me more so I can better understand?"

5. Keep your teen safe; remove access to means and supervise your teen. If your teen expresses specific methods of how they plan to hurt themselves or has already taken steps to do so, it is important to maintain a safe environment for them by removing any access to means that they may describe (i.e., knives, firearms, medicine such as Tylenol). In any of these cases, you should assume that they are in imminent danger, and it is imperative to supervise them until they are connected with emergency care.

6. Take your teen's warning signs seriously and seek professional help/emergency care. Avoid assuming that your teen will "get over it" or assuming that they would never do anything to hurt themselves. Seek out mental health treatment for further evaluation/9-1-1/immediate emergency care at your nearest hospital if you suspect your teen is at imminent risk of harming or killing themselves.

7. Consider pursuing psychotherapy for your teen. Therapy may provide your

teen with some hope knowing there is professional support available to them. In pursuing a mental health therapist, you and your teen may better understand the nature of their suicidality, any possible underlying mental health diagnoses, and learn additional ways that you can support them. Also, it is important for your teen to have a professional who can help them navigate their difficult thoughts and feelings and gain the tools to address their mental health challenges/suicidality.

8. Identify supports in all settings. Work with your teen to identify all of the trusted adults that they can connect with at home and school (i.e., school counselor, school psychologist), so your teen has the necessary supports in place when they need it. This may involve reaching out directly to your teen's school-based mental health providers and/or working with a private therapist to ensure there is an ongoing support team in all environments.

Thus, it is critical for parents to familiarize themselves with the warning signs and risk factors for suicide and to approach the topic with your teen in a diligent, compassionate manner. It is also important to understand that additional supports and care may be needed. These steps may contribute to your teen feeling supported with their mental health and help to mitigate their experiences with suicidality.

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*If You are Feeling Helpless and in Despair, Dial 988 to Speak to Someone Who Can Help*



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support, and 24/7 access to care. These clinics adhere to rigorous certification requirements and quality standards set by the Substance Abuse and Mental Health Services Administration (SAMHSA).

CCBHCs focus on delivering person-centered, recovery-oriented care that is coordinated and evidence-based. They strive to address the unique needs of individuals through a holistic approach that incorporates physical health, behavioral health, and social determinants of health. This model emphasizes collaboration with community partners, such as primary care providers and social service agencies, to ensure continuity of care and support for individuals.

Studies and evaluations of CCBHCs have demonstrated positive outcomes. These include improved access to care, reduced hospitalization rates, decreased emergency department visits, increased engagement in treatment, and enhanced overall well-being for individuals receiving services. CCBHCs have shown effectiveness in reaching underserved populations, reducing health disparities, and promoting recovery and resilience. We can (and must) further the impact of CCBHCs in addressing health equity by enhancing the delivery of basic primary care services, such as health promotion, preventive services, health maintenance and education, and basic diagnosis and treatment of certain co-morbid medical conditions.

It is also very apparent that we need the current system of care to be more person-centered and culturally responsive by tailoring services to the individual's unique needs, preferences, and cultural background. Additionally, involving individuals with lived experience in the design and delivery of behavioral health services is paramount and can further enhance engagement and outcomes. Behavioral



**Jorge R. Petit, MD**

health consumers, peers, individuals with lived experience, play a crucial role in the workforce with their unique perspectives and insights contributing to the development of more effective health services, policies, and programs.

By actively involving behavioral health consumers/peers in the planning, decision-making, evaluation, and monitoring, as well as being key members of our workforce, organizations can create a more inclusive and empathetic environment that better meets the needs of individuals facing behavioral health difficulties.

The inclusion of consumers/peers in the workforce promotes destigmatization and can help reduce discrimination surrounding behavioral health. When consumers/peers openly disclose their experiences, it challenges stereotypes and misconceptions, leading to a more accepting and supportive workplace culture. By recognizing the value and contributions of be-

havioral health consumers/peers, we can foster a more inclusive, supportive, and effective approach to mental health and well-being.

There are many more well validated approaches that we can and must deploy across our current fragmented system if we can all agree on coordinating efforts and building a more encompassing and holistic, person-centered system of care. Everyone is entitled to timely, quality and affordable proven behavioral health interventions (by eliminating all external barriers, such as cost, transportation, language, etc.), everyone should have a roof over their heads, everyone should be able to access the needed educational and vocational supports in order to achieve meaningful activities and/or gainful employment, everyone should have access to sufficient, nutritious, and culturally appropriate food. These are but a few of the many ways that we can achieve behavioral health equity in our system of care... the pieces of this complex puzzle are all there, we just need to work collaboratively to put them all in their right places.

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*Dr. Petit is extensively published as an expert in health and behavioral health. Prior to S:US, Dr. Petit was the President and CEO for Coordinated Behavioral Care (CBC), a not-for-profit organization dedicated to improving the quality of care for individuals with serious mental illness, chronic health conditions and/or substance use disorders, through a Health*

*Home, an Independent Practice Association (IPA) and an Innovations Hub.*

*Dr. Petit was the Regional Senior Vice President for New York State for Beacon Health Options and before that was the Founder and President of Quality Healthcare Solutions, a consulting firm that provided training and consulting services for healthcare systems including community-based behavioral health agencies, hospital systems, and local and state regulatory entities. He was the former Associate Commissioner for the Division of Mental Hygiene in the New York City Department of Health and Mental Hygiene.*

*Dr. Petit sits on the board of Primary Care Development Corporation (PCDC) and Mental Health News Education (MHNE); is a Distinguished Fellow in the American Psychiatric Association (APA) and a member of the Committee on Psychiatric Administration & Leadership in the Group for the Advancement of Psychiatry (GAP), United Hospital Fund (UHF) Health Policy Forum, as well as a member of the National Council for Mental Well-being's Medical Director Institute (MDI).*

*Dr. Petit is the author of [Handbook of Emergency Psychiatry](#) and [The Seven Beliefs: A Step-by-Step Guide to Help Latinas Recognize and Overcome Depression](#) and the recipient of the Schiff Community Impact Award from The Jewish Board, the 2017 Greater Good Honoree, Corporate Social Responsibility Award, 2018 Heritage Healthcare Organizational Leadership Award and the Community Partnerships Award, Virtual Community Partners Award from Federation of Organizations (FOO), Crain's New York Business 2022 Notable LGBTQ Leader, City & State New York 2022 Nonprofit Power 100, and City & State New York 2022 Responsible 100.*

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**Cannabis from page 30**

significantly higher levels of psychotic symptoms (Clausen, et al., 2014), and an increased frequency of hospitalizations, an increased likelihood of involuntary hospitalization, as well as a greater number of days hospitalized (Patel, et al., 2014) have been associated with ongoing cannabis use by individuals with FEP. Conversely, cessation of cannabis use after a first psychotic episode was found to diminish negative symptoms significantly and improve overall functioning (Gonzalez-Pinto, et al., 2011). These findings highlight the importance of treatment interventions targeting reductions in cannabis use to improve clinical and functional outcomes among individuals with FEP.

Unfortunately, effective, evidence-based treatments for individuals with psychosis who use cannabis are lacking. Although there is good evidence that cognitive behavioral therapy (CBT), motivational enhancement therapy (MET), and contingency management (CM), alone or in combination, can be effective treatments for cannabis use disorder (CUD), their effectiveness in reducing cannabis use in individuals with psychosis has not been demonstrated (Lees, et al., 2021). However, integrated treatments\* that simultaneously address psychosis and cannabis use may be more effective for this population than therapies that only target



**Grace Hennessy, MD**

cannabis use. For example, a combination of Motivational Interviewing (MI) and interaction skills training that teaches problem solving skills for managing conflicts related to symptoms of psychosis to the parents of young adults with the recent onset of a psychotic disorder was found to be superior to routine family support in reducing cannabis use, suggesting that family involvement may be an important component of treatment for this population (Smeerdijk, et al., 2012). Additional-

ly, cannabis users with FEP who received a specific CBT for cannabis cessation combined with treatment as usual (TAU) for FEP not only had reductions in cannabis use severity but also had reductions in psychotic symptoms and improvement in overall functioning (Gonzalez-Ortega, et al., 2022).

In terms of pharmacological treatments, a systematic review examining the effectiveness of antipsychotic medications among individuals with psychosis who use cannabis found no significant differences among clozapine, haloperidol, olanzapine, quetiapine, risperidone, and ziprasidone in reducing psychotic symptoms or cannabis use (Wilson, et al., 2016). One 12-month, randomized, controlled trial did find that both clozapine and ziprasidone were associated with significant reductions in cannabis use and psychotic symptoms, but the sample consisted of only 30 subjects, limiting the generalizability of the findings (Schnell, et al., 2014).

In summary, the frequent use of high potency cannabis by genetically and environmentally vulnerable populations is associated with the development of psychosis. While there is some promising preliminary evidence for integrated treatment and certain pharmacological interventions for psychosis and problematic cannabis use, more research is needed to determine what are the most effective

treatments for individuals with psychosis who also use cannabis. Finally, part of the public health approach to psychosis must be preventing and limiting the harm that individuals who are vulnerable to developing psychosis and those living with psychosis may experience if they use cannabis. Prevention strategies such as delaying the initial use of cannabis until after adolescence and harm reduction strategies such as using low THC content cannabis may help decrease the co-occurrence of cannabis and psychosis in the future.

\*A SAMHSA publication about creating programs that integrate treatment for mental health conditions and substance use can be found here: [Integrated Treatment for Co-Occurring Disorders: Building Your Program](#).

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*see Cannabis on page 41*



### Outcome from page 16

variance (overlap) among the variables ranged from 0% to 19%.<sup>2</sup> Thus, targeting one category is not likely to have an appreciable impact on other outcome categories. Consequently, each outcome category may require a distinct treatment strategy.

*Point 4. “Outcome” is not “quiescent” or “stable” in later life but continues to evolve.*

Because of a paucity of longitudinal data in OAS, the literature has often depicted the course in later adulthood as a flat line. Our longitudinal data showed that significant changes (improvement or worsening) in 5 outcome categories (remission, depression, cognition, community integration, and physical health) ranged from 26% to 40% over a 52-month follow-up period.<sup>2</sup> Fewer than one-fifth experienced no changes in any outcome category and over three-quarters experienced changes in 2, 3, or 4 categories. The good news is that patients show considerable movement in later life; the bad news is that patients can get worse as well as better. Because of earlier erroneous models of “end-stage” schizophrenia, policy makers have failed to provide sufficient treatment resources to address the fluctuations in symptoms that may occur in later life.

*Point 5. “Outcome” is heterogeneous with a variety of combinations that necessitate*



**Carl I. Cohen, MD**

*a personalized approach to care and a more nuanced approach to research.*

When the 5 outcome categories described above were dichotomized into “persistently unfavorable or worse over time” versus “persistently favorable or better over time”, we found considerable variation in the clinical profiles of our patients, with fewer than 10% having no fa-

vorable outcomes, about 5% having all favorable outcomes, and the rest, having between one and four favorable outcomes.<sup>1,2</sup> Thus, even in later life, each person’s outcome is a dynamic multidimensional process with various combinations of features. This finding is consistent with adopting a personalized approach to care.

*Point 6. “Recovering” (aka “clinical recovery”) can be assessed empirically and yields a 5-tier taxonomy with varying degrees of recovery that can guide treatment and research.*

Clinical recovery, commonly viewed as the ultimate outcome goal, is based on meeting empirical criteria for clinical remission and community integration. It should be distinguished from the consumer model in which recovery is seen as a process of striving to reach one’s full potential. Adhering to the consumer model alone can blur the boundaries between persons who remain disabled and those who have achieved relatively normal mental and social functioning. Our work identified a 5-tier model of clinical recovery: 12% who remained persistently in clinical recovery at both baseline and follow-up (Tier 1); 18% who never attained any components of clinical recovery (Tier 5); and 35% who attained clinical recovery at either baseline, follow-up, or both (Tiers 1 and 2). Overall, 70% of the subjects exhibited a variety of components of

clinical recovery at baseline and follow-up (Tiers 2, 3, and 4). Here again, a more nuanced and targeted treatment approach is required to meet the clinical and/or social needs based on a patient’s tier level.<sup>2</sup>

*Point 7. Quality of life (self-perceived well-being) is a pivotal variable and an Important point for Intervention.*

Although the focus of this article is on clinical outcomes, among persons with schizophrenia, quality of life (QOL) is considered one of the most crucial indicators of well-being along with symptomatic remission and functional recovery. Our findings in OAS indicate that QOL is not only critical in its own right but that it has significant salubrious effects on positive symptoms, depression, anxiety, and insight.<sup>1,2</sup> Notably, QOL seems to improve in later life. OAS had QOL scores that were only 6% lower than their healthy age peers, whereas they were 28% higher than people with chronic pain, and nearly double those with chronic fatigue syndrome.

In summary, despite the dramatic increase in persons with schizophrenia reaching old age, they have been largely invisible to researchers and policymakers. Historically, the illness course was thought to be static in later life. Recent studies have shown that outcome in later life is dynamic and multidimensional,

*see Outcome on page 42*

### SUD from page 26

substance use disorder, only about 10 percent receive substance use treatment (HHS, 2021). There are several reasons for this low participation, including a lack of social support/stigma, fear of treatment, concerns regarding privacy, inability to meet the time demands, limited treatment availability, barriers to admission, and belief in the absence of a problem (Rapp et al., 2006). With the disparity of treatment for people of color, there is also concern that self-reporting substance use will result in criminal prosecution (Valkow, 2023). When an individual has an SMI in addition to their substance use, it is even less likely that they will seek and/or complete treatment.

Fortunately, for those who are ready to accept treatment, there are multiple options available for both substance use and SMI. Supportive treatment options include individually tailored therapy (cognitive behavioral therapy, contingency management, motivational interviewing, trauma informed therapy, etc.) with a combination of prescription medications to reduce the effects of withdrawal, along with peer support programs such as group therapy. There are different levels of care depending on the severity of symptoms, ranging from in-patient detox programs, intensive outpatient programs, sober living facilities, community-based meetings, and individual therapeutic support. Preferences for each of these options will depend on the person and their circumstances; for instance, while someone may benefit from an in-patient detox program that collaborates with mental health professionals, their personal life may only allow them the flexibility to attend an intensive outpatient program. Regardless of the program chosen, it is important to note that shame and blame are never, ever con-



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ducive to recovery or to positive mental health. Individuals making the decision to seek treatment should be given support and resources to empower them throughout this daunting process. Compassion and empathy are critical.

*Outcomes:* There are significant risks associated with substance use, including lung and heart disease, stroke, and cancer (NIDA, 2022). There is also an increased risk of infections such as HIV, hepatitis C, endocarditis, and cellulitis (NIDA, 2022). As mentioned before, substance use can precede a SMI or exacerbate the severity of an otherwise manageable disorder; when substance use is compounded with SMI, the outcome can be deadly. In 2019, over 70,000 people succumbed to fatal overdoses and 47,500 lives were lost to suicide (HHS, 2022; Stone et al., 2021). The non-fatal effects are also deleterious and may include physical long-term conditions with poorer outcomes, lower quality of life, and overall shorter life span

(Carswell et al., 2022). In its very name, mental illness is considered severe when the symptoms are an impediment to the individual’s abilities to function; however, even less severe mental illness can cause impairment, especially when amplified with substance use disorders.

*Conclusion:* Given the history of America’s approach towards individuals with substance use disorders, SMI, or both, there is understandable hesitance to seek treatment. With this in mind, the impact of substance use disorders and SMI on an individual’s quality of life cannot go untreated. With a uniquely tailored approach based on the distinctive needs of the patient, interventions can seek to address the impact of substance use on a mental illness, the impact of mental illness as a catalyst for substance use, or the correlated development of both diagnoses. It is critical to note that approaching this topic with disdain towards the patient will *not* result in recovery. Compassion and empathy are critical attributes when working with this population and great care should be taken to treat the whole person rather than just their diagnosis.

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**Live from page 18**

significant growth of mental health services for people with severe, long-term mental illness. Nearly 2/3 of them now get treatment and other services that go beyond the provision of medication and verbal therapy and also include supportive housing, day programs, psychiatric rehabilitation, and case/care management, all mostly outside of state hospitals.

Nevertheless, about 35% of people with serious mental illness do not get any treatment, more among people of color. And there are significant problems with the quality of treatment they do get. It frequently is not even “minimally adequate”, and it is often fragmented and chaotic.

So, there need to be vast improvements, including:

- more effective psychiatric treatment,
- more widespread psychiatric rehabilitation,
- more personalized care management,
- more humane crisis intervention,
- outreach to find people who do not come to designated places for care and to connect with them before they are in crisis,
- a more just criminal justice system, and
- greater respect for their rights as human beings.

There is widespread agreement about all this, but there are significant details that are incredibly complicated and controversial. For example, and most prominently, there is disagreement about whether more people with serious, long-term mental illnesses need inpatient hospital care and about whether coercive interventions should be used more extensively for people reluctant or unable to use organized mental health services. Some argue



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in favor of increased coercion so as to reduce homelessness and incarceration. Some maintain that increased outreach and engagement and expansion of community support services, especially housing, would be far more effective.

Unfortunately, the dispute between those who favor more hospitalization and coercion and those who oppose it dominates the headlines about mental health policy. As I've said, there is considerable agreement about the need for more and better treatment, rehabilitation, and community support services, and I have argued for many years that the mental health community should unify around these areas of agreement so as to become a more effective advocacy force.

But unity is difficult to achieve in large part because of differences in fundamental perspectives about serious mental illness. Many advocates and providers have a “treatment-oriented” perspective. Others have what has come to be called a “recovery-oriented” perspective. The difference is that from one perspective the primary question is what services (especially treatment services) people with serious mental illness need. From the recovery perspective, the key

question is what people with SPMI need to lead satisfying lives in the community. The answers to the two questions overlap, but the services-oriented perspective emphasizes the need for treatment, rehabilitation, supportive housing, care management, and the like while the recovery-oriented perspective emphasizes, to say it again, the need for a decent place to live, income for necessities, good physical health, satisfying family and social relationships, meaningful activity, and spiritual life in addition to mental health services.

One way to think about this difference in perspectives is that typically mental health policy focuses, quite understandably, on needs due to abnormality. The alternative is to focus as well on the fundamental humanity of people with serious mental illness, on the needs and desires they share with others, on their—this may seem strange—normality.

People with serious, long-term mental illness can have lives that they find satisfying and meaningful. Helping them have such lives should be the first goal of mental health policy.

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**Safety from page 25**

Unfortunately, safety plans are not a guarantee of protecting people against suicide. Studies have shown that they are effective in decreasing suicidal behaviors (Stanley et al, 2018), and in some settings, such as Emergency Departments, safety plans can increase people's treatment engagement for follow up appointments and act as a stand-alone intervention. However, safety plans do not completely eliminate suicidal behaviors, and they do not decrease reported frequency of suicidal thoughts (Nuij et al, 2021), only behaviors. This could be because safety plans focus on providing people with alternative behaviors to suicide, but do not focus on providing alternative thoughts to suicidal or hopeless thoughts. Safety planning is a concrete, brief intervention and an important first step in keeping people safe. Other ongoing forms of mental health treatment must then follow. For example, at WJCS, we offer a comprehensive Dialectical Behavior Therapy (DBT) program. DBT focuses on helping people learn alternative ways of thinking and build meaningful skills in order to create what they feel is a life worth living, there-



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by decreasing suicidal thoughts.

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**INSET from page 23**

New York Association of Psychiatric Rehabilitation Services (NYAPRS) and a legislative grant from New York State Assemblywoman Aileen Gunther, created an Intensive and Sustained Engagement Team (INSET) to utilize a persistent, yet non-coercive, approach to seek out individuals who were at risk of being court-ordered for Assisted Outpatient Treatment (AOT) or had an AOT order in place.

Offering a voluntary set of supports and peer services, INSET is available to individuals who meet AOT criteria or for those who have been court ordered to have AOT and are interested in the service. These individuals are often characterized as being difficult to engage or “non-compliant,” which further stigmatizes them and often leads to short-term treatment where individuals only attend treatment until they are no longer mandated to receive services. “Poor engagement may lead to exacerbation of symptoms, re-hospitalization, and not fully realizing the potential benefits of treatment.” (4)

INSET's philosophy empowers individuals and encourages recovery by increasing personal agency, self-determination, and shared decision-making. Unfortunately, the population of individuals served by INSET have not usually had the opportunity to participate in services that are respectful of their choices and desires. In fact, in most cases, there is a prolonged amount of time to engage individuals into INSET, as trust is regained. However, participants who have been categorized as difficult to engage and therefore in need of mandated services voluntarily engage in INSET supports and services at a rate of 83%.

It is our contention that these individuals are not difficult to engage and when and if they are able to get the support they want and need, they will no longer be

viewed as a “risk to the community.” We believe that they have not been involved in services that examine the reasons behind their inability to connect and the associated traumas they have experienced. Additionally, since most traditional services require quick engagement so that they are able to be enrolled, the lengthy engagement phase that INSET provides allows for the development and building of rapport, trust, and mutuality.

Mutuality in peer services is defined as “a non-hierarchical relationship that is of equal value to both parties and is based on a shared experience of service use and recovery. An ability to draw on the knowledge that peer support is: non-directive – helping the person find solutions that work for them, rather than suggesting solutions,” (5) INSET participants have been able to find true partnership with the INSET team, which has resulted in decreased hospitalizations (length of stay and frequency), involvement in the criminal justice system, and increases in employment, training, and stable housing opportunities.

Gigi, a participant of INSET, had two hospitalizations in another state, and after a particularly bad breakup, she ended up returning to New York to live with her parents. When she came home, she did not have a therapist or connection to any mental health supports. She started to experience symptoms related to bipolar disorder, which led her parents to call 911. During this hospitalization, Gigi was placed on AOT. Although a very bright woman with a college education, Gigi admits that she struggled to understand the court process that she was participating in and did not fully appreciate how “limiting” the AOT would be. For example, she had no choice in what medications she would be prescribed and although she attempted to advocate for herself when a medication was causing side

effects, she was told that she would be out of compliance if she did not take the medication. After successfully completing her AOT, she was working and living her life when her medications became ineffective. Gigi decided to seek a hospitalization to help her with a medication change and to ensure that she had coping mechanisms to deal with the stressors in her life. She was unaware that this choice would lead to her being referred for AOT again without any other options.

Gigi stated that “having an AOT made me feel worse about myself and my diagnosis. It was very stigmatizing.” She further added that she “toughed it out” but the experience made her distrustful of her mental health providers, psychiatrists, and family members. Fortunately, she was able to forge a trusting relationship with a care manager, who referred her to a therapist at MHA, who then referred her to MHA's INSET program. Gigi states that she knew from her first meeting with an INSET peer that things were going to be different. “It was very casual. It was not a meeting where you had to do a bunch of things or fill out a bunch of paperwork. She [my peer] went at my own pace. The first meeting, we went to Dunkin, and it was nice because she got me a treat and we just sat there and chatted. It felt different from other mental health services.” She further added that the voluntary aspect of peer services helped her to combat the feeling of not having many choices.

Through her team at MHA, Gigi was connected to MHA's Peer Specialist Training program, which she successfully completed. She is now awaiting her New York Certified Peer Specialist-Provisional (NYCPS-P) certification, and her goal is to find employment as a Peer Specialist, so she can provide supports to others who need to be engaged persistently, without coercive methods, treated with dignity

and respect, and given a variety of choices to pursue their own dreams and desires.

As we continue to witness the success of INSET's model for Gigi and many others who are able to avoid unnecessary hospitalizations or incarcerations while building fulfilling lives in the community, we are pleased to see the commitment of New York in the recent Executive Budget. With the proposed inclusion of \$2.8 million to expand INSET through the creation of three new teams in NYS, more adults with a serious mental illness diagnosis will have access to peer-based outreach and engagement.

“I think INSET's peer support is the way of the future,” shares Gigi. “It's the way of moving forward - out of the things that don't work in mental health - into a new place where they do.”

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## Footnotes

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**Medication from page 28**

limitations, or other factors. Involving family members or key persons can ensure proper medication supervision and reduce the risk of missed or incorrect doses. This involvement enhances medication adherence, particularly for patients who require assistance with complex medication regimens. Involving family members in psychoeducation provides them with a better understanding of the patient's condition, treatment plan, and the role of medications. This shared knowledge promotes effective communication between the patient, family members, and clinicians. It allows for informed discussions, shared decision-making, and the development of strategies to overcome potential barriers to medication adherence. Family members or key persons who are actively involved in the patient's care can provide valuable insights into adherence challenges that the patient may be facing. They may notice patterns of non-adherence, identify barriers, or observe changes in the patient's behavior that could impact medication adherence. This information can help clinicians develop targeted interventions and support strategies to address those challenges. It's important to note that involving family members or key persons should be done with the patient's consent and in line with their preferences and privacy considerations.

**Additional Adherence Strategies**

Providing comprehensive education about the benefits of medication, the specific condition being treated, and the importance of adherence are valuable

**Jonathan Keigher, PhD**

strategies to improve compliance. Helping individuals understand how their medication works, what to expect, and how it can improve their quality of life helps address concerns or misconceptions patients may have. Clear communication is key to adherence. Fostering open and honest communication by encouraging individuals to ask questions, express their concerns, and discuss any challenges they may face in adhering to their medication regimen is crucial to support adherence. Providers actively listen, provide clear instructions, offer support, and address key information about medications (what, why, when, how, and how long). Some individuals are hesitant to take medication due to concerns about side effects or perceived

lack of efficacy. To address these concerns, prescribers must take time to discuss potential side effects, their likelihood, and ways to manage them. If side effects are interfering with adherence, prescribers work with the individual to explore alternative medications or adjunctive treatments.

NYPCC prescribers foster adherence by simplifying medication regimens as much as possible by minimizing the number of medications and reducing dosing frequency whenever appropriate. A simpler regimen is easier to remember and follow, reducing the chances of missed doses. Switching to a Long-Acting Injectable (LAI) medication is also a useful strategy to improve medication compliance in individuals who have difficulty adhering to oral medications or experience frequent relapses despite treatment. Therapists complement medication treatment with psychosocial interventions, such as therapy, counseling, or support groups. These interventions help individuals develop coping strategies, enhance motivation, and provide a holistic approach to managing their condition. NYPCC therapists also help individuals implement reminder systems to help remember to take medications as prescribed. These aids include alarms, pill organizers, smartphone apps, or setting medication-taking routines. Additionally, therapists encourage individuals to consider involving family members or trusted individuals who can provide support and reminders.

Medication compliance is a shared responsibility between individuals, the treatment team, and support networks. By implementing these strategies and fostering a collaborative approach, it is possible

to improve medication adherence and enhance the treatment outcomes of people with serious mental illness.

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**Another Day from page 18**

well. This shortcoming appears to most people as being cold hearted and callous, which makes making new friendships and maintaining them as well next to impossible for me. This lack of emotions paired with an extreme fear of abandonment and rejection, constant feelings of embarrassment, self-loathing and fear, a crippling fear of public spaces and social interactions, paranoia, self-doubt, fatigue, volatile and unstable mood swings, racing thoughts, and melancholy are all commonplace for me on a day-to-day basis.

So, what does mental illness feel like? It feels like you're drowning, alone and helpless. I however finally found a healthy coping mechanism to help me ease the many burdens I struggle with day in and day out, and that is Family. As tired and cliché as that might seem, I never truly understood the vital role family plays in my life. But the moment I chose to surround myself with people I care about the most instead of pushing them away, the weight I had carried with me for so many years suddenly lessened. Mental illness may seem impossible most days but if you allow it, family can give



**Alissa Langevin**

you the strength you otherwise never knew you had. Even on my worst days, I know I can count on my family to help keep me going.

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**Programs from page 27**

gain and lethargy, have the support to get and stay healthy.

Fast forward more than four decades since its inception; not much has changed in the landscape of homeless services across the city. In 1981, Father McVean noted, "We all have a common goal: to keep people out of the hospitals, and to keep them in a safe and healthy environment." A goal for which SFFP has kept their end of the bargain. For more than forty-years (and counting!), SFFP has helped hundreds of formerly homeless adults living with serious mental illness get healthy and stay housed with an 18-year average length of tenancy. "Our tenants, with an average life span of 68 years, are living longer and healthier lives than many individuals with chronic mental illness 'living' on the streets or in shelters, jails, or hospitals, whose average life expectancy is between 42 and 52 years" said SFFP Executive Director, Christina Byrne. As the COVID-19 Pandemic ravaged New York and escalated critical care disparities city-wide, SFFP was steadfast in their commitment to provide essential services to this most vulnerable population. "The staff worked tirelessly through the pandemic to keep everyone healthy and safe, and it worked! Over 95% of our tenants received the recommended

COVID vaccines and we did not have any fatal COVID-19 outbreaks across the three residences." said Christina Byrne.

Tenant, Monica, puts it best when she recalls her multi-year experience with homelessness, "I have nowhere to sleep, where do you expect me to go? I do not care about the food, I have nowhere to sleep tonight." The shelters she encountered over the three-year period of homelessness often offered her food and a chair to sleep in, but never a permanent solution to her chronic homelessness, let alone her serious mental illness. But in June 2020, Monica's journey led her to the St. Francis Residences, where she is living her best life with the support from staff and her peers. She enthusiastically participates in wellness activities such as "salad group," enjoys exploring the city's offerings and going on 'road trips' to the country, and takes joy in helping her peers where she can. Monica is only one beam of light out of nearly 300 others who call the St. Francis Residences, home. Should you like to learn more of our tenants' life stories and see what they are up to today, please visit [www.stfrancisfriends.org](http://www.stfrancisfriends.org) to learn more.

Linda Flores, MSW, MPP, is Development and Communications Manager at St. Francis Friends of the Poor, Inc. She can be reached at [lflores@stfrancisfriends.org](mailto:lflores@stfrancisfriends.org).

**Industry from page 20**

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**Rola Aamar, PhD**

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**988 from page 19**

deaf or hard of hearing and experiencing distress or other mental health concerns can use their videophone-enabled device to call the 988 Lifeline.

As leaders, advocates, educators, and innovators in mental health, Vibrant and the 988 Lifeline have been raising awareness and offering support to everyone struggling. We work daily to help save lives and assist people to get care anytime, anywhere and in any way that works for them. We are unwavering in believing everyone can achieve emotional wellness with the right care and support. If you or someone you know is struggling or in crisis, help is available. Call or text 988 or chat at [988lifeline.org](http://988lifeline.org).

Tia Dole, PhD, is the Chief 988 Suicide & Crisis Lifeline Officer at Vibrant Emotional Health. Dr. Dole is a licensed clinical psychologist and a long-time advocate for the rights of those with intersectional identity. Prior to stepping into the role of Chief 988 Officer, Dr. Dole was the Executive Director of The Steve Fund, the nation's only organization focused on the mental health and emotional well-being for young people of color. Additionally, Dr. Dole was the Chief Clinical Operations Officer at The Trevor Project, the world's largest suicide prevention and crisis intervention organiza-

tion for LGBTQ youth. Dr. Dole oversaw all of The Trevor Project's crisis services programs as well as their volunteer community and increased their impact by a factor of four.

After completing her bachelor's degree at Carleton College, Dr. Dole received her Master's degree in Developmental Psychopathology from Columbia University (Teacher's College), and she received a Fulbright Fellowship to study Forensic Psychology in Switzerland. She then completed her doctorate in clinical psychology at Fordham University. Dr. Dole is a published author and sits on several committees. One of her passions is normalizing mental health conditions within communities of color, LGBTQ communities, and helping people get access to services. She is based in New York/New Jersey.

Vibrant Emotional Health's groundbreaking solutions have delivered high-quality services and support when, where and how people need it for over 50 years. Through our state-of-the-art technology-enabled services, community wellness programs, and advocacy and education work, we are building a society in which emotional wellness can be a reality for everyone. Learn more about Vibrant Emotional Health and the 988 Suicide & Crisis Lifeline at [www.vibrant.org](http://www.vibrant.org) and follow us on social media @vibrantforall.

**Outcome from page 38**

with components that are largely independent of each other, and individuals have varying combinations of favorable and unfavorable outcome dimensions. More resources must be enlisted to provide the multi-prong, personalized care that is required.

Carl I. Cohen, MD, is SUNY Distinguished Service Professor and Co-Director, Division of Geriatric Psychiatry and Center of Excellence for Alzheimer's Disease at SUNY Downstate Health Sci-

ences University. You may contact him at [carl.cohen@downstate.edu](mailto:carl.cohen@downstate.edu).

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*Care from page 22*

team and its members, facilitating connections to a variety of housing opportunities.

By serving as a centralized hub, CBC streamlines the process, making it easier for individuals experiencing homelessness to access the care and services they need. Through close collaboration with SOS teams and other stakeholders, CBC ensures seamless coordination and communication. The Hub's comprehensive resources, including clinical expertise, integrated technology, data analysis, and evidence-based practices, further enhance the effectiveness and efficiency of the SOS program, ultimately maximizing its positive impact on the lives of those it serves.

**CBC's Model Development  
Across Systems and Agencies**

SOS operates as a collaborative effort, involving a network of providers including ACMH, BronxWorks, Federation of Organizations, Services for the Underserved (S:US), and The Bridge. These agencies have extensive expertise in working successfully with people experiencing homelessness and operate temporary and supportive housing to provide expedited access in addition to behavioral health care. CBC assumes a critical role in the operation of SOS, overseeing program implementation, coordinating services, and ensuring that providers adhere to best practices and evidence-based treatment approaches. At CBC, concerted efforts are underway to integrate diverse perspectives and develop a unified theory of change and care delivery, encompassing immediate needs, workforce development, and systemic transformation across multiple levels.

The community of homeless service providers has been seeking an approach that accommodates the nuances of individual needs while allowing for flexibility, scalability, and program fidelity. In line with CBC's "we are one network" approach, a team of thought leaders in the field meets weekly to continuously improve on the model focused on lasting change and adaptability for diverse populations while never losing focus on meeting the homeless community's needs. It is recognized that there are multiple paths to achieving the same goal, and each agency and its staff utilize their unique strengths to achieve the desired outcome.

**Cross System Collaboration**

The SOS Program stands as an exceptional example of how a large city's traditionally fragmented service system can come together to provide a powerful intervention for a stigmatized, marginalized, and discriminated-against population. CBC has established an inclusive ecosystem that involves coordination between



**Pamela Mattel, LCSW**

behavioral health community-based organizations, multiple government agencies at the state and city levels, public and voluntary hospitals, the public transit system, emergency medical services, law enforcement agencies, food pantries, supportive and private housing providers, harm reduction providers, social care providers, and others.

CBC's active formation and participation in cross-system collaboration meetings present a valuable opportunity for SOS staff to engage with a diverse range of stakeholders and foster cooperation. These meetings serve as a platform for sharing ideas, receiving feedback, and forming partnerships with like-minded professionals who share common goals. By actively engaging in these collaborative efforts, CBC remains informed and shares knowledge about emerging projects, new initiatives, and innovative approaches in the field of homeless services. Additionally, these meetings provide a forum for discussing challenges, sharing successes, and exchanging best practices. This exchange of information informs decision-making processes and contributes to improved outcomes for members served.

Cross System Collaboration approach has had a positive impact on administrative, supervisory, and frontline SOS staff by cultivating a sense of community, promoting motivation, fostering connections, facilitating shared learning, nurturing productive working relationships, and enhancing overall engagement in the mission of homeless outreach initiatives.

**Learning Community and Collaborative**

Collaborative work and learning present an invaluable opportunity to leverage collective expertise, share innovative approaches, and foster collaboration, thereby resulting in enhanced services and outcomes.

In partnership with OMH and SOS Agencies, CBC developed a comprehensive



**Gerardo Ramos, MPA, MSW**

training curriculum for SOS staff to enhance their clinical skills and knowledge. Moreover, the implementation of a Learning Management System through the Center for Practice Innovations at New York State Psychiatric Institute ensures convenient tracking of staff progress toward meeting training requirements. The CBC Hub offers interactive trainings, encompassing informative sessions, webinars, and opportunities for learners to engage through live presentations and experiential exercises. The learning curriculum encompasses a range of training sessions and workshops designed to deepen staff understanding of the unique challenges involved in serving individuals experiencing homelessness. Topics covered include effective outreach strategies, engagement techniques, safety and de-escalation and the latest evidence-based practices in the treatment of serious mental illness.

A Learning Collaborative was initiated to create a dynamic platform for providers in the homeless outreach sector to exchange knowledge and enhance their practices. The role of CBC is to gather a network from various parts of the city healthcare ecosystem and meet and dialog with the aim to improve and evaluate the system of care efficacy of current and new models. With a focus on improving the quality of services for homeless individuals, fostering collaboration and communication, and sharing best practices, the collaboration is poised to drive significant positive change in NYC's homeless outreach efforts.

The collaboration consists of regular meetings involving representatives from SOS, homeless outreach providers, and other local health and human services. Through these meetings, participants engage in discussions, brainstorming sessions, and review real-life care narratives to learn from each other's experiences. Anticipated outcomes include increased collaboration, improved service quality, and shared best practices. The SOS Learn-



**Barry Granek, LMHC**

ing Collaborative holds great promise in enhancing homeless outreach efforts and fostering a more effective and impactful approach to serving individuals experiencing homelessness.

Initial data from the first year showcases the positive impact made already. With 7,690 canvassing encounters conducted, SOS has demonstrated a proactive approach in reaching out to those in need. As a result, over 140 members have been successfully placed in permanent housing, providing them with stability and a place to call home, and over 600 members placed into emergency/temporary housing from the street. The program's commitment to comprehensive care is evident in the 1,253 referrals received, with an impressive enrollment rate of 903 members (72%). The demographics of those served reflect the diversity of the community, with 78% of the members being male, 73% identifying as black, 27% falling between the ages of 51 and 60, and 23% between the ages of 31 and 40.

CBC's centralized Hub and streamlined access to care, engagement in cross-system collaboration, and commitment to continuous learning position the SOS program at the forefront of innovative homeless outreach and care. By actively facilitating a learning collaborative and leveraging the valuable insights gained from stakeholders, CBC remains adaptable and open to refining its model to enhance access and improve care. The collaborative spirit fostered through these initiatives ensures that CBC can respond effectively to emerging challenges and incorporate new approaches into the SOS care model.

*Pamela Mattel, LCSW, is President and CEO, Gerardo Ramos, MPA, MSW, is Senior Vice President, and Barry Granek, LMHC, is Vice President, at Coordinate Behavioral Care, Inc.*

*For more information about Safe Options Support, visit <https://cbc.org/innovative-programs/nyssos/> or call the 24-hour toll-free information line 1-866-SOS-4NYC.*



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Behavioral Health News (BHN) (formerly Mental Health News), published by the 501(c)(3) nonprofit organization Mental Health News Education, began as a quarterly print publication in 1999. In response to readership feedback, BHN became an online-only publication in 2021. BHN is committed to improving the lives of individuals living with mental illness and substance use disorder as well as their families and the professional communities that serve them by providing a trusted source of science-based, education, information, advocacy, and quality resources in the community.

BHN provides hope through education by collaborating with leading provider agencies and educational institutions across the US that are improving lives every day. The publication serves to unite and improve our evolving systems of care, build bridges, and increase visibility to connect consumers to quality community programs and evidence-based services, bring awareness to important policy issues, and advocate to address the harmful effects of the stigma which surrounds mental illness and substance use disorders in the community.

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A smiling woman with short dark hair, wearing a grey turtleneck sweater and a ring, stands with her arms crossed in a modern office setting. The background shows office desks and windows. The text is overlaid on the image.

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