RIVERSIDE TOWNSHIP
Mental Health Board
Consultant's Report
(March 18, 2026)

1. Dr. Troiani attended the American Psychological Association (APA) - Military Psychology Summit from March 2nd, 3rd, & 4th.

2. The following email was received from Lorenzo Cordova, Technical Director, Riverside TV, Village of Riverside, which is a following up on the Riverside Mental Health Board's Community Presentation held on Saturday - February 21st held from 1 P.M. to 2:30 P.M. titled, "The Kids ARE NOT All Right".

Lorenzo Cordova" <lcordova@riverside.il.us>
Sent: Sun, Feb 22, 2026 at 11:12 PM
Subject: VIDEO LINK(S): Riverside Township Mental Health Board Presents: The Kids Are NOT All Right

Hi everyone,

Below are the links to the videos produced on Saturday afternoon. Riverside TV directly uploads videos to YouTube and Facebook. The videos are also now available on Xfinity channel 6, exclusively in Riverside, and on AT&T U-Verse channel 99, throughout the State of Illinois.

Riverside Township Mental Health Board Presents: The Kids Are NOT All Right

Facebook Link: https://www.facebook.com/reel/1473994394285586

YouTube Link: https://youtu.be/PLQwPrw_FyA

Thank You and Acknowledgements

Thank you to Riverside Township Mental Health Board Vice-President and Riverside Township Trustee **Timothy W. Heilenbach** for working with Riverside TV to coordinate video coverage of this timely and relevant presentation.

Alongside him, I also thank Riverside Township Supervisor **Vera A. Wilt** and Riverside Township Deputy Clerk **Andrew Lutha** for making Riverside Township Hall and its auditorium accessible to Riverside TV for the setup of the equipment needed to record this presentation.

Thank you to **Dr. Joseph E. Troiani** for leading the presentation and facilitating the delivery of information from his fellow presenters. Having worked with **Dr. Troiani** for a total of five presentations up to this point, I must state that he always arranges programs in a way that makes them engaging and accessible for all audiences. I can see why he is highly regarded as an educator, and I wish I could be in his classes.

In addition, thank you to the program's featured presenters, Village of Riverside Director of Public Safety **Matthew Buckley** and military clinical psychologist **Dr. Denise Dailey**. As we continue to live in the age of anxiety in the years following the COVID-19 pandemic, **Director Buckley** and **Dr. Dailey** delivered information that every parent or guardian should hear.

I must also thank the other individuals who spoke and shared key information throughout the presentation. Thank you to Riverside Township Mental Health Board President **Adam Wilt** as well as **Daisy Gomez** from Pillars Community Health, **Yaritsa Carrasco** from Pillars Community Health and The Loft at Eight Corners, **Yvette Williams** from Community Support Services, and **Shawn Lewis** from Aging Care Connections.

Finally, thank you to Riverside TV veteran crew member **Sara Vacek** for working as camera operator and floor director during the presentation. We would not have had a smooth presentation without her.

3. Attachment "A", Is the article titled Township Partnerships Drive Impact was written by Desiree M. Scully, M.A., the Executive Director of Aging Care Connection. She also serves as the Secretary for the Illinois Township Association Senior Services (ITSSA). It highlights the Community Resource Center (CRC), and the collaboration between the township government and the community-based organizations.

4. Attachment "B", Is a February 4, 2026, article titled A New Era of Mental Health: Increasing Youth Access to the 988 Lifeline and Campus Suicide Prevention, by Leah Kuntz, a writer for the online newsletter, Mental Health Journal.

5. Attachment "C", From the Wall Street Journal (March 14-15, 2026) is the REVIEW section article, Where Have All the Male Therapist Gone? Psychology is increasingly a female dominated Profession. This may have implications for boys and men, by Pamela Paul.

6. Attachment "D" Also from the Wall Street Journal (March 3, 2026) is the article by Allessendra DiCorato titled, Alcohol can make you feel anxious or irritable the next day. We ask experts what causes this – and how to manage it b

7. Attachment "E" The third Wall Street Journal (December 23, 2025) is an articled, America's Seniors are Overmedicated: One in six seniors enrolled in Medicare's drug benefit were prescribed eight or more medications at the same time, Wall Street Journal analysis of Medicare data finds. The investigative report was conducted by Anna Wilde Mathews, Christopher Weaver, Tom McGinty and Josh Ulick.

8. After the successful program this month we are now planning for the second 2026 RTMHB community program in the Fall that would focus on the behavioral health crisis response programs serving the township. We plan on inviting the three police departments (Police Chiefs/Public Safety Directors) to discuss the Crisis Intervention Team (CIT) training (funded by the RTMHC) and the township's 988 agencies' Mobile Crisis Responders (MCR), and the Dial 988 Crisis Response system along with the CIT Coordinator for Northern Illinois John F.S. Williams, LCPC, M.Ed. Also considering having a CIT trained Officer(s) discuss the impact the training has had on their engagement with individuals experiencing a behavioral health crisis.

9. We have identified that the certified CIT police officers in the township are needing to complete the one-day CIT refresher course. It has been requested by the Riverside Director of Public Safety that the training be completed this year. To cover all the current CIT Officers there will need to be two separate days paced apart for the one-day refresher course. The CIT Coordinator for Northern Illinois, John F.S. Williams, is waiting for us to provide proposed dates for the offering of the one-day CIT Refresher course for those currently CIT trained police officers. We will be getting the provide cost estimates.

Respectfully Submitted,

Joseph E. Troiani

Joseph E. Troiani, Ph.D., CADC
RTMHBIL@gmail.com.

Attachment: "A"

ITSSA submission February 2026

Desiree M. Scully, M.A.
Executive Director, Aging Care Connections
ITSSA Secretary

Township Partnerships Drive Impact

When township government collaborates with community-based organizations, remarkable things happen. Now in its sixth year, the Riverside Township Community Resource Center (CRC) demonstrates how a strategic partnership between local government and three nonprofit organizations can deliver comprehensive, accessible services to residents in need—and offers a replicable model for other Illinois townships.

Riverside Township Mental Health Board

"The Riverside Township Community Resource Center is a grass-roots effort to see and meet people that need assistance in a caring and compassionate, non-threatening way," says Desiree M. Scully, MA, Executive Director of Aging Care Connections. "Township Government is the closest level of government working for the people that they serve. This collaborative effort with the **Riverside Township Mental Health Board** and three community-based non-profit organizations is innovative, creative and truly a huge resource to serve people in the community."

The Operational Model: What Makes It Work

The CRC brings together three partner organizations under one roof at the Riverside Town Hall: **Aging Care Connections**, which provides guidance and support for older adults; **United Cerebral Palsy Seguin of Greater Chicago**, which serves adults and children with intellectual and developmental disabilities; and **Way Back Inn**, which offers addiction recovery services. Each organization contributes skilled staff who work collaboratively while focusing on their area of expertise, creating a single point of access for Township residents seeking help.

The staffing model is both efficient and strategic. Community Resource Specialists from the three organizations maintain 22 hours weekly of on-site coverage: Aging Care Connections staffs Monday, Wednesday, and Thursday mornings (12 hours weekly); UCP Seguin covers Monday and Thursday afternoons (6 hours weekly); and Way Back Inn is available Tuesday mornings (4 hours weekly). Staff remain accessible via phone and email outside office hours for

urgent situations. This schedule ensures consistent availability while maximizing the expertise available to residents without requiring full-time positions from each partner.

Real Impact: Beyond the Numbers

During the most recent grant year (April through December 2024), the **CRC served 212 clients with a variety of services.** But the numbers only tell part of the story. Consider the 67-year-old Riverside Township resident who needed SSA and Medicaid assistance. The Community Resource Specialist spent 67 minutes on hold with the Department of Human Services to clarify required documents, then helped the resident create an SSA account, reviewed benefit options, and coordinated a benefits comparison. In another case, staff assisted a 65-year-old resident with creating multiple accounts, requesting a replacement SSA card, applying for Medicare, and navigating various discount programs, all comprehensive support that might otherwise require multiple trips to different agencies.

"In our small township, I manage all the assistance myself, so having the CRC there to guide applicants to other benefits and support services they may not even know exist is a huge help," explains Vera Wilt, Riverside Township Supervisor. "Seniors are especially overlooked as the world moves toward accessing everything online, and the staff of the CRC often steps in to help our residents find help, and apply for benefits they otherwise could not access. Both qualified applicants and those I cannot help through township programs often have other issues that impact their wellbeing. The interview process often reveals anxiety, disorientation, and other emotional and mental health issues, and having the staff of the CRC in the next room is a tremendous help in my work."

Community Engagement as a Core Strategy

The CRC actively works to reduce stigma and increase awareness through strategic outreach. Staff maintained a presence at the Riverside and Brookfield Farmers Markets throughout the 2024 season and attended 12 additional community events. In June, they hosted their third annual Health & Wellness Fair at the North Riverside Village Commons, drawing thirty vendors. These outreach efforts collectively reached approximately 1,600 individuals in 2024. The CRC also maintains an annually updated Community Resource Guide distributed to local police, fire departments, libraries, churches, and the park district, and works with the village to include information in water bills.

Lessons Learned

For Illinois townships considering similar collaborative models, Riverside's experience offers several actionable insights. *First, strategic partnerships between township government and specialized nonprofits can enhance service delivery beyond what any single entity could provide.* The multi-organization model creates natural cross-referrals and catches issues early; when a resident comes in for one type of assistance, staff can identify and address other needs that might otherwise go unmet.

Second, centralized access points with extended hours significantly reduce barriers for residents. Locating services at the Town Hall, where residents already come for other township business, eliminates the intimidation factor of visiting specialized agencies. *Third, the staffing model demonstrates that meaningful coverage doesn't require massive budgets*; 22 hours weekly of combined expert staffing creates comprehensive support. *Finally, the bimonthly meetings among specialists and quarterly partner organization meetings ensure coordination, continuous improvement, and shared learning across the collaborative.*

As townships across Illinois face increasing pressure to serve residents with complex needs despite limited resources, collaborative models like Riverside's CRC offer a practical path forward. The six-year track record proves that when township government, mental health boards, and community nonprofits pool their expertise and resources, the result is greater than the sum of its parts—and residents receive the comprehensive, dignified support they deserve.

Aging Care Connections has been a leader in providing a full spectrum of client-centered programs that enhance the quality of life of older adults for over 50 years. Located in La Grange, Aging Care Connections serves over 13,000 older adults, and their caregivers and family members each year, from 38 communities in **Lyons, Proviso, Norwood Park, Riverside, and Leyden townships**. To learn more about Aging Care Connections, visit www.agingcareconnections.org.

professionals serving older adults. Please reach out to ITSSA President Becky Cordes at Schaumburg Township (847-285-4542) or bcordes@schaumburgtownship.org. Join us, and make a difference to the older adults in YOUR Township!

Attachment: "B"

News | Articles | February 4, 2026

A New Era of Mental Health: Increasing Youth Access to the 988 Lifeline and Campus Suicide Prevention

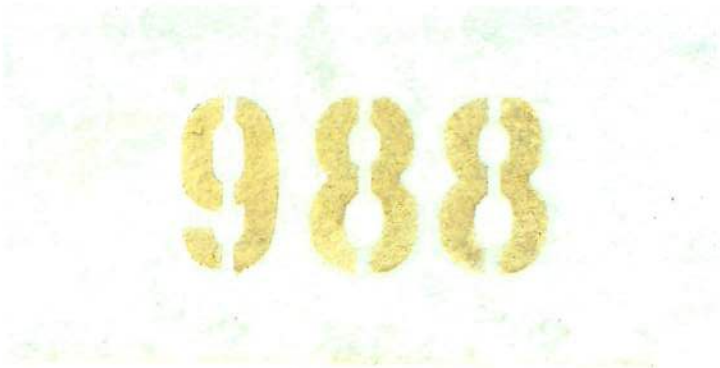
Author(s) *Leah Kuntz*

Key Takeaways

- Congressional directives encourage SAMHSA to operationalize printing 988 Lifeline information on student ID cards, aiming to reduce friction in crisis access across secondary and postsecondary settings.
- FY2026 appropriations increases allocate $15 million to 988 and $4 million to Garrett Lee Smith programs, signaling prioritization of upstream youth suicide prevention infrastructure.
- Active Minds is scaling youth policy engagement via an Advocacy Policy Champions program, collecting participants' topical interests and optional LGBTQ+ identification to inform advocacy priorities.
- Termination of 988 LGBTQ+-specific "Press 3"/"PRIDE" pathways heightens equity concerns and reinforces clinician-facing calls to lobby for restored, tailored crisis services.

SHOW LESS

Congress backs printing 988 on student ID cards, boosting youth crisis access and funding.



Pisan/AdobeStock

Thanks to advocacy by Active Minds, a leading nonprofit organization dedicated to mobilizing youth and young adults to redefine ideas about mental health, new report language will be used to advance youth access to crisis support, specifically the 988 Suicide & Crisis Lifeline. For the very first time, there is now a push to place information about 988 on student ID cards.[1]

Congress is now explicitly encouraging the Substance Abuse and Mental Health Services Administration to coordinate the publication of the 988 Lifeline on student ID cards for both high school and college students. This has been a long-standing priority of Active Minds, according to their recent statement.

"This agreement affirms Congress's commitment to suicide prevention and youth mental health," said Anika Rahman, the director of policy at Active Minds. "The idea to publish the 988 Suicide & Crisis Lifeline on student ID cards originated with the Active Minds chapter at the University of Dayton, and this moment represents the full cycle of student advocacy—from ideation on campus to passage into federal law. These investments will help ensure that more young people are aware of and can access lifesaving support when they need it, reflecting our mission of championing a new era of mental health."[1]

The nonprofit also shared news of fiscal victories for youth mental health: In 2026, there will be a $15 million increase for the 988 Lifeline and a $4 million increase for the Garrett Lee Smith Youth Suicide Prevention programs.

Active Minds is also actively recruiting youth aged 15 to 24 who are interested in shaping federal mental health policy and/or participating in an upcoming Hill/Advocacy Day to join the Active Minds Advocacy Policy Champions group, a program that enables youth to engage directly in federal advocacy efforts that advance mental health causes. As part of their signup, they ask youth to share what topics related to mental health they are interested exploring, what grade they are in, and (optionally) if they identify as a member of the

"Like all marginalized populations that have experienced historical and present-day discrimination, LGBTQ+ individuals can experience mistrust or harm when interacting with general mental health systems—related to any number of actions like misgendering, making assumptions, or overt discrimination," Christine Yu Moutier, MD, the chief medical officer of the American Foundation for Suicide Prevention shared with *Psychiatric Times*.[3] "We encourage mental health professionals to lobby for dedicated LGBTQ+ mental health funding and tailored services, and join AFSP in pushing policy makers to restore the 988 LGBTQ+ specific crisis service,"

Youth interested in participating in the Active Minds Advocacy Policy Champions group can be directed to sign up here.

References

1. Active Minds secures first-time youth mental health provisions alongside federal funding increases for 988 Lifeline and campus suicide prevention. News release. February 4, 2026. Accessed February 4, 2026. https://www.prnewswire.com/news-releases/active-minds-secures-first-time-youth-mental-health-provisions-alongside-federal-funding-increases-for-988-lifeline-and-campus-suicide-prevention-302679300.html

2. Kuntz L. Loss of 988 hotline services tailored to LGBTQ+ youth. *Psychiatric Times*. June 19, 2025. https://www.psychiatrictimes.com/view/loss-of-988-hotline-services-tailored-to-lgbtq-youth

3. Kuntz L, Moutier CY. The loss of a vital LGBTQ+ suicide prevention resource: in conversation with AFSP's Christine Yu Moutier, MD. *Psychiatric Times*. June 23, 2025. https://www.psychiatrictimes.com/view/the-loss-of-a-vital-lgbtq-suicide-prevention-resource-in-conversation-with-afsps-christine-yu-moutier-md

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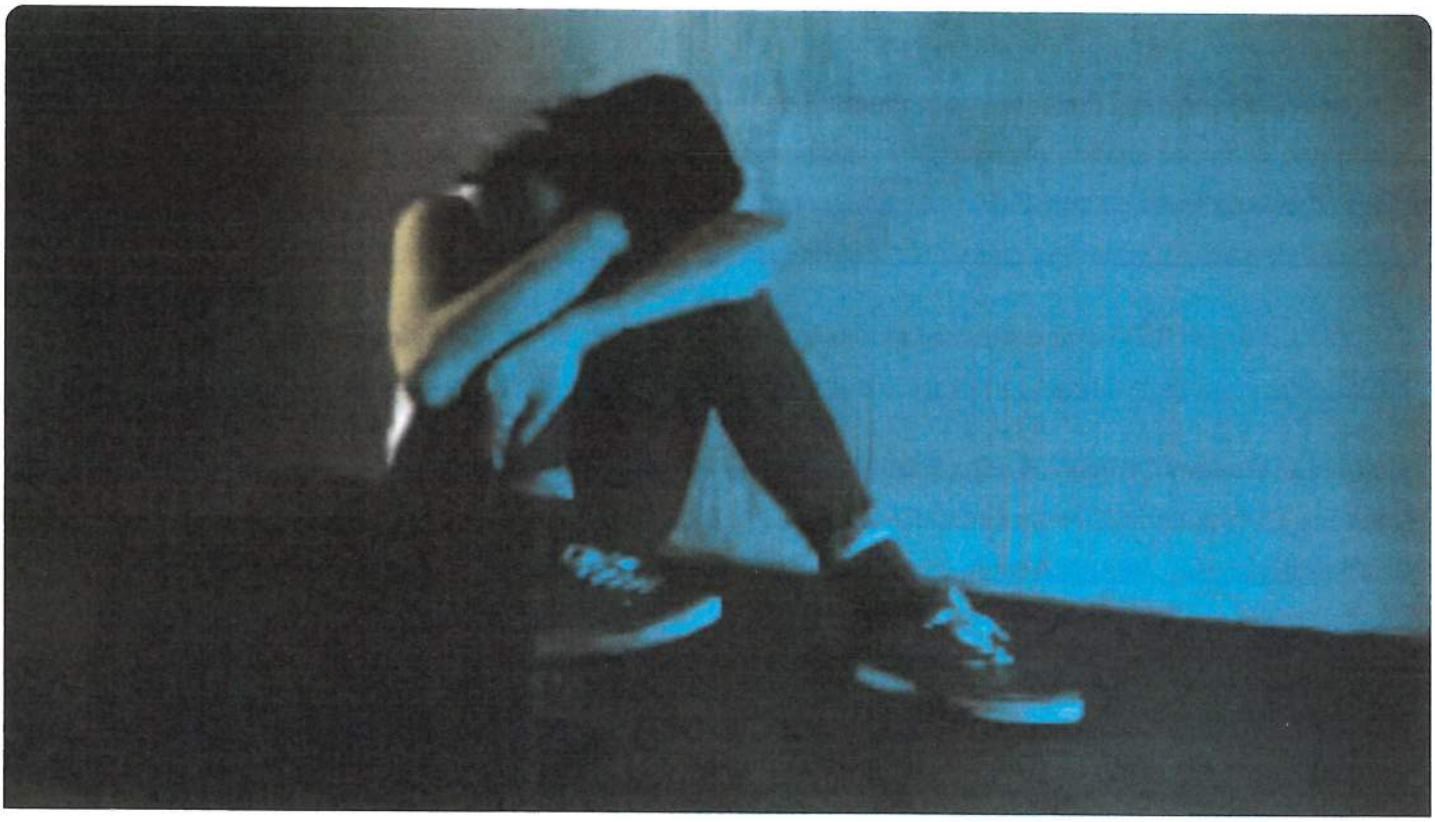


Psychiatric Euthanasia in the Netherlands: Young People, Procedural Medicine, and the Limits of Psychiatry

By Jim van Os, MD, PhD, Wilbert van Rooij, MD, Mark S. Komrad, MD, DFAPA

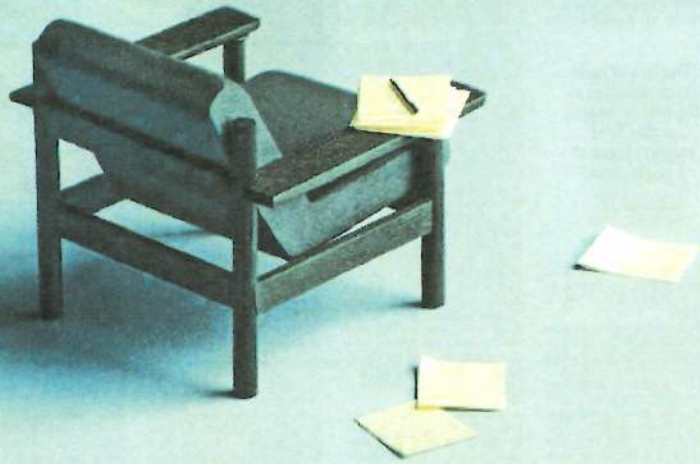
March 5th 2026

Attachment: "C"

Where Have All the Male Therapists Gone?

Psychology is increasingly a female-dominated profession. That may have implications for boys and men.

By Pamela Paul



When Martin Seligman, bestselling author, professor of psychology at the University of Pennsylvania and one of the most influential figures in the field, became a psychologist in the mid-1960s, the ratio of men to women in the field was 80 to 20. Today, that ratio has flipped.

"The main consequence of the feminization of psychology is the topics that are worked on," says Seligman. "From the 1960s through the 1980s, it was aggression, conflict and trauma, but not love, meaning, friendship or cooperation." Then, in the '90s, the prevailing areas of research flipped, becoming less violent and more humane.

Fittingly for the founder of the field of positive psychology, Seligman sees this as a good thing. "But one downside," he says, "is there's not as much research now on therapy and issues for boys and men." *Please turn to the next page* ▸

Inside

What Fewer Male Therapists Means

Continued from the prior page

For decades, the field of Freud and Jung tended to prioritize males and pathologize females. (Think hysterical women and refrigerator mothers). But the landscape of mental health, from research psychology to psychiatry, has since skewed, in some cases overwhelmingly, female. In the U.S., men now account for only 18% of social workers and 20% of psychologists, down from 38% and 68% in 1968 respectively, according to the American Institute of Boys and Men (AIBM), a research and advocacy organization founded in 2023.

"The lack of male representation in the mental health professions couldn't come at a worse time," says Richard Reeves, founder of AIBM and author of "Of Boys and Men: Why the Modern Male is Struggling, Why it Matters, and What to Do About It." American boys are falling behind in school and tumbling into perilous internet rabbit holes. Suicide rates among men ages 25 to 34 are on the rise. Men are trailing women in the workplace. Popular discourse is dominated by phrases like "toxic masculinity," "the male loneliness epidemic" and "male malaise."

Both male and female therapists stress the importance of providing positive, pro-social and professional alternatives to the often noxious influence of the manosphere. But

> **'The lack of male representation in the mental health professions couldn't come at a worse time.'**
>
> RICHARD REEVES
> Founder of the American Institute of Boys and Me

while there's plenty of talk about the problem with men, there is far less conversation around how to help them.

That second problem is poised to get even worse. While a field increasingly dominated by women has become more open to studying issues like pregnancy, motherhood and female sexuality, it may also exert its own biases. Nonetheless, when it comes to a deliberate exploration of men's inner lives—how they think, feel and express themselves—the male psyche is becoming less the norm than an aberration.

"One of the big problems with the helping professions now is that they approach men and boys with a deficit perspective," says Mark Kiselica, a former president of the Society for the Psychological Study of Men and Masculinities at the American Psychological Association. "They are greatly influenced by models that look at how boys and men are flawed rather than about how boys and men are different."

Guy Talk

Though men have historically been therapy-avoidant, in recent years, more are interested in getting professional help. In 2024, 17.3% of men sought some form of counseling up from 8.7% in 2002.

Mental health professionals are adamant that a skilled clinician can work with both sexes and that a therapist's gender rarely determines outcome. A large body of research shows that "therapeutic alliance"—a combination of shared method, communication preferences and approach—is the strongest indicator for success.

That said, some men prefer to open up to other men. According to one of the few studies on the subject, 40% of men have a gender preference in therapists, evenly divided between men and women. The most common reasons they gave for preferring men were feeling more comfortable (46%) and feeling better understood (26%). They also felt more empathy from and less judged by male therapists.

In interviews, clinicians noted that men who work in male-dominated fields—combat veterans, police officers, firefighters and other emergency workers—are especially likely to want a therapist either with similar experiences or who "speaks the same language." Some men prefer to talk to someone they think will viscerally understand what they're grappling with, whether it's bullying, sexual issues, intrusive thoughts, masculinity, fatherhood, divorce or job loss.

"The stuff that's embarrassing, the pornography they're looking at, whether it's heterosexual or homosexual, they don't want to tell a female therapist," says Adam Schachar, a social worker in private practice. "They don't want to tell a male therapist either, but they're more willing to share."

This may be especially true for young people. "There's a commonsensical understanding that it may be easier for teenage boys to talk to male clinicians and girls with female clinicians," says Lisa Damour, a clinical psychologist and author of "The Emotional Lives of Teenagers."

Yet starting in school, most kids' first encounter with the helping professions, the face of mental health is increasingly female; in 2025, only 10% of school counselors were men. As of 2021, only 10% of master's degree recipients who specialized in developmental and child psychology were male.

Above: The psychologist Orna Guralnik on the show 'Couples Therapy.' Left: For decades, Sigmund Freud's field tended to prioritize men.

An influx of women into mental health has had the unintended consequence of declining pay and prestige, which only compounds men's tendency to steer clear of the field. But longtime practitioners point to other factors behind the trend. "A lot of guys aren't drawn to grad school in psychology because they sense they're not wanted there," says psychologist Daniel Ellenberg, a past president of the Society for the Psychology of Men and Masculinities at the American Psychological Association. "If you have women grad students who tell guys to 'just shut up, you've talked long enough,' a 24-year-old guy will be like, "What? I'm responsible for that?"

Ellenberg, who has run men's therapy groups in the Bay Area for decades, blames binary thinking in our culture, which tends to see certain roles as strongly gender coded. Men who want to work with kids, for example, are looked on with suspicion, he says. "Guys still learn that being in the healing arts is somehow very feminine. As much as I would love to see this craziness die of what's considered masculine and what's considered feminine, it just doesn't go away."

Benji Hadar, who recently got his masters in social work and works as a psychotherapist at a community behavioral health clinic in New York, was surprised not only by the paucity of fellow male students but also by the extent to which men were overlooked in his coursework.

"I was very unimpressed with how unseriously men's mental health was taken in classes," Hadar says. "Men's concerns and needs were generally ignored relative to those of other demographic groups. We are just making it harder for anyone to approach men's mental health in a serious way."

What's Men's Problem?

Men's and boys' mental health needs often differ from those of females in key ways. According to both researchers and clinicians, broadly speaking, women tend more toward internalizing behaviors like anxiety and depression while men tend to externalize their problems into addiction, aggression, risk-taking and anger. They often avoid emotional disclosure and regard vulnerability as a sign of weakness, which can make them challenging as patients.

"A male clinician can reduce the fear of being judged or exposed or misunderstood and lower the threshold for exposure," says Michael Zakalik, a clinical psychologist based in Seattle. "It normalizes the experience without necessarily feminizing it." Simply seeing an emotionally fluent adult man can, he says, can itself be a therapeutic intervention.

In his own practice, Zakalik tries to reframe therapy in ways that men can more easily relate to. "A patient might describe a difficult experience and then say, 'But I was tough.' And I say, 'What do you mean by tough? I think it's pretty tough coming in here and crying in front of me. *That's* tough."

Offering group therapy—which builds on men's tendency to communicate "shoulder to shoulder" rather than face to face—is another effective way to get men to open up. Ronald Levant, author of "The Problem with Men: Insights on Overcoming a Traumatic Childhood from a World-Renowned Psychologist," has found men's groups especially useful in engaging men who foot-drag their way to therapy.

"The men come in and are surprised to see so many other men because they have long believed that they're the only ones with this problem and that other guys are fine," he says. "They think, 'I'm the only schmuck that feels this bad,' and never get the corrective feedback that depression is like the common cold of mental illness."

> **Clinicians note that men who work in male-dominated fields are likely to want a therapist who 'speaks the same language.'**

Roughly 15 percent of U.S. men aged 21 to 25 years reported experiencing a major depressive episode in 2024. It's estimated that roughly 1 in 5 men suffer from some form of mental illness—a share that has increased from 13.6% in 2008.

More research into these trends could help clinicians better understand how to address them, says Zac Seidler, global director of Men's Health Research at Movember in Sydney. But rather than devote resources to researching the underlying issues, "we continue to try to diagnose a problem without actually speaking to the men."

"People in the field often refer to me as a 'specialist' because I focus on men and I'm like, 'No this is 50% of the population,'" says Seidler. "That says everything about where we're at." Seidler, who conducted the study on men's gender preferences in therapists, is often viewed with suspicion—by the left as a Trojan horse for the men's rights movement and by the right as a radical feminist who is somehow emasculating men by wanting to explore their emotional lives.

"I'm only 10 years out of my Ph.D. and it only took me a few years to become one of the top 10 experts in the world on the subject," Seidler says. "I walked into a very wide-open space."

Richard Reeves, left, and Zac Seidler would like more research to be directed toward men and their issues.

Attachment: "D"

The New York Times https://www.nytimes.com/2026/03/03/well/mind/alcohol-emotions-hangovers.html

Alcohol can make you feel anxious or irritable the next day. We asked experts what causes this — and how to manage it.

By Allessandra DiCorato

March 3, 2026

Q: I've noticed I feel emotional and anxious the morning after drinking. Why is that, and is there anything I can do to prevent it?

In the moment, having a drink can seem like a good idea. Alcohol can make you feel relaxed, less inhibited and even euphoric. The next morning, though, you might find yourself regretting that extra glass of wine.

Beyond the unpleasant physical signs of a hangover — headache, nausea, thirst and sensitivity to light and sound — alcohol can also cause lingering emotional symptoms. Sometimes called "hang-xiety," this can show up as brain fog, anxiety, irritability and feelings of regret or shame.

Sally Adams, an associate professor of psychology at the University of Birmingham who studies the cognitive and behavioral effects of alcohol, said that she used to have a few drinks after a stressful week to relax and quell her anxiety, but that "it always came back tenfold the next morning."

These day-after feelings are just one of the mental health effects of alcohol. Long-term excessive use has also been linked to depression and anxiety.

"We know that people are starting to make this link between mental health and alcohol, and it's a reason that they are giving for cutting down or not drinking at all," Dr. Adams said. (In her case, Dr. Adams quit drinking because her next-day anxiety wasn't worth the short-lived enjoyment, she said.)

Here's a look at what experts believe might cause post-drinking emotions, and how you can deal with them.

What happens in your brain when you drink

Drinking has wide-ranging effects on the body. In the brain, it disrupts a delicate balance of signaling molecules called neurotransmitters that help your cells communicate. When you start to drink, alcohol triggers a release of dopamine in the pleasure center of your brain, making you feel buzzed and happy. It also enhances the effects of a neurotransmitter called GABA, which can make you feel relaxed and sleepy, and it dampens the effects of the neurotransmitter glutamate, which can impair your memory and movement.

"Alcohol is a pretty complex drug," said Dr. Stephen Holt, a primary care physician and director of the Addiction Recovery Clinic at the Yale School of Medicine. "It's doing all those things simultaneously, and that's why it has so many different effects."

As your body metabolizes the alcohol, your brain works to return to base line. That can make you feel "pretty rubbish the next day," Dr. Adams said. Some studies have found that people report feeling less "tranquil" and more fatigued the day after drinking. And in 2021, Dr. Adams and other researchers found that hungover volunteers were less able to regulate their emotions than their peers. "Everything seemed a bit more negative when they were hungover," Dr. Adams said.

Alcohol has complex effects on mood

Dr. Hugh Cahill, a neurologist at NewYork-Presbyterian The One, said it can be difficult to pin post-drinking emotions on a single cause, given the array of factors at play when you drink.

Take sleep: While alcohol can make you fall asleep faster, it also reduces the amount of REM sleep you get, which can make you feel anxious. Drinking also makes you dehydrated, which can affect your mood, according to some studies. And because alcohol lowers your social inhibitions and impairs your memory, it can lead you to make decisions you regret or can't remember.

The severity of a hangover can vary based on factors like genetics, body weight and body fat, as well as what you've eaten and how hydrated you are, Dr. Adams said. Emotional responses can be individualized, too. One 2019 study found that highly shy people were more likely to report anxiety the morning after drinking than people who were less shy, for example.

Research suggests that chronic alcohol use can also change the brain's base-line neurotransmitter levels and make you more likely to become hyper-excited — or to have a panic attack — if you stop drinking abruptly. Though experts say it's not clear what amount of alcohol causes those effects.

How to cope

To avoid a night that might leave you with an emotional hangover, try to "play the tape through" and envision not only the benefits you'll get from drinking that night but also how you'll feel the next morning, said Hayley Treloar Padovano, a psychologist and associate professor of psychiatry and human behavior at the Center for Alcohol and Addiction Studies at Brown University.

Researchers don't yet have strategies for decoupling the physical and emotional effects of alcohol, but approaches like spacing out drinks and adding ice to dilute them can help you consume less alcohol and prevent hangovers in general.

Because alcohol and hangovers are complex, there's unlikely to be a single cure for hang-xiety, Dr. Adams said. If you're experiencing a low mood related to drinking, she said, remember that those emotions are part of the hangover and will pass eventually.

Unfortunately, Dr. Cahill said, the reality is that your body just needs time to break down alcohol. An afternoon nap, he said, probably "provides the biggest bang for the buck."

A version of this article appears in print on , Section D, Page 6 of the New York edition

Attachment: "E"

PERSONAL JOURNAL.

A10 | Tuesday, December 23, 2025 THE WALL STREET JOURNAL.

America's Seniors Are Overmedicated

One in six seniors enrolled in Medicare's drug benefit were prescribed eight or more medications at the same time, Wall Street Journal analysis of Medicare data finds

For years, Barbara Schmidt's family feared an illness was behind a pattern of terrifying falls that repeatedly landed the 83-year-old great-grandmother in surgery with broken bones. Instead, Schmidt's frequent tumbles might have been tied to something else: medications intended to make her better.

Schmidt, who lives with her husband of 65 years in Lewes, Del., filled prescriptions for more than a dozen different drugs in the past year, according to pharmacy and medical records.

By Anna Wilde Mathews, Christopher Weaver, Tom McGinty and Josh Ulick

That isn't unusual for America's seniors, according to a Wall Street Journal analysis of Medicare data. One in six of the 46 million seniors enrolled in Medicare's drug benefit, which pays for most drugs taken by older Americans, were prescribed eight or more medications.

In 2022, 7.6 million seniors were simultaneously prescribed eight or more medications for at least 90 days.

Of those seniors, 3.9 million took 10 or more drugs at once.

And more than 419,000 of them were prescribed 15 or more drugs at the same time.

Schmidt considers herself healthy—she still works a few days a week at a Marshalls store, and she is a dedicated crafter who creates intricate birthday cards for her four children, 14 grandchildren and eight great-grandchildren. But osteoporosis has made her bones brittle, while arthritis and back problems sometimes cause agony. Schmidt counts nine different operations over the years, including replacements for both hips and knees. She has also suffered from anxiety and sleep issues, largely related to the pain.

Doctors layered on medications to help.

Among the earliest was gabapentin, which she says started about a decade ago for lingering back problems. The drug seemed to help with her pain, and she wanted to continue her active life, so she kept taking it, getting up to three 300-milligram doses a day.

For years, records show, Schmidt also took diazepam for anxiety. The drug is better known as Valium, from the class of medications called benzodiazepines.

More recently, she has had prescriptions for hydroxyzine, an antihistamine sometimes used as an anxiety treatment, and methocarbamol, a muscle relaxant that she typically took daily with the gabapentin. For sleep, she got trazodone, an antidepressant, though she had no depression diagnosis.

Some of the drugs Schmidt took are on a widely used list of medications that might be dangerous for seniors. The guidelines, maintained by the American Geriatrics Society and named the "Beers Criteria" after the doctor who first led their development, suggest some drugs should almost never be taken by older patients. That includes Schmidt's benzodiazepine diazepam, antihistamine hydroxyzine and muscle relaxant methocarbamol.

Barbara Schmidt, 83, filled prescriptions for more than a dozen different drugs in the past year. Above, the Schmidts put up Christmas decorations.

Other drugs, the guidelines say, still pose risks for patients with certain medical conditions or when combined with other medicines. They warn, for instance, that seniors should minimize the number of drugs they take simultaneously that affect the central nervous system, including gabapentin.

Among the seniors in the Journal analysis who were taking eight or more drugs, 3.6 million had prescriptions for at least one medication that geriatricians say elderly patients should generally avoid.

Many patients, like Schmidt, were on multiple types of these drugs.

Among seniors prescribed eight or more drugs, 1.6 million got benzodiazepines, sedatives that appear on the Beers list.

In addition, 568,000 of those seniors were prescribed gabapentin or a similar drug. Gabapentin can have sedating effects.

More than 310,000 of the benzodiazepine patients also received muscle relaxants, another type of drug the Beers guidelines say seniors should avoid.

The Journal found 147,000 seniors took all three categories of drugs at once.

Mixing multiple medications that affect the central nervous system can magnify their side effects, leading to falls, say the Beers guidelines.

As Schmidt added more drugs with sedative effects, she began having regular falls.

She shattered her hip after tripping on the edge of a driveway. During a family vacation in Germany, she ended up at a hospital after toppling down an escalator. Another time, she fell off a ladder while working on Christmas decorations, knocking herself out and severely bruising her face. Her family grew increasingly alarmed, but Schmidt refused to use a walker or a cane, blaming the falls on outside causes like uneven ground.

Schmidt's recent prescriptions came from at least five different healthcare providers. Most were affiliated with the nearby hospital system Beebe Healthcare, including a nurse practitioner whom she sees for primary care and a gastroenterology office. An orthopedic surgeon who has treated her back problems and prescribed medications to help with her pain works for an independent practice, First State Orthopaedics.

A Beebe spokesman said it has reviewed its prescribing patterns and, this November, added a new electronic medical record that will allow doctors to "view consolidated medical and medication histories" for patients and deliver "safer, more informed care." First State Orthopaedics said it doesn't comment on matters of patient care unless it is legally required to do so.

Pharmacists who work with seniors say doctors might not be aware of their patients' full medication list. Patients don't always mention what their other doctors have prescribed when a history is taken, and specialists might not have access to a shared medical record.

7.6M

Number of seniors simultaneously prescribed 8 or more medications.

The Journal analysis found that, among seniors taking eight or more drugs, it was common for the prescriptions to come from a large number of doctors.

Some doctors prescribe medications to their patients at alarming rates, at times single-handedly ordering eight or more drugs for a single patient. The Journal found doctors who prescribed the most drugs were concentrated in rural areas across the South, where chronic disease is prevalent.

Schmidt's daughter Debra Schindler, who works in Maryland for the hospital system MedStar Health, thought her mom needed to go to a specialized clinic that focuses on seniors. "I just knew it wasn't normal for her to be falling all the time," Schindler says.

In March 2023, Schmidt met with George Hennawi, the MedStar system's physician executive director of geriatrics and senior services, as well as others, including a pharmacist who went through her medications.

Hennawi zeroed in on three of her prescriptions: hydroxyzine, methocarbamol and gabapentin. The drugs were likely a cause of her confusion and falls, he told her. "They all work somewhat the same way," Hennawi says. "Combining all of them is a higher risk for complications."

Schmidt was shocked. No one had previously raised the danger of her multiple prescriptions.

A drug rundown such as the one received by Schmidt, part of a process known as medication therapy management, is supposed to be a requirement under Medicare. The insurers that sell drug coverage must provide the service.

The federal mandate applies to only a limited subset of enrollees, and Schmidt didn't qualify, likely because she didn't have enough chronic health conditions.

The Journal's analysis found that what are known as the comprehensive medication reviews mandated by Medicare didn't affect the average number of drugs prescribed to patients.

A spokesman for the Centers for Medicare and Medicaid Services said the comprehensive reviews can identify many different potential problems and their impact "may not be reflected in a simple count of prescriptions over time."

Schmidt says that after her 2023 appointment, she largely stopped taking gabapentin and methocarbamol. She takes the hydroxyzine only when she feels stressed. She says she hasn't had a fall since, and feels more clear-headed.

Schmidt had earlier quit the benzodiazepine, after experiencing withdrawal symptoms during a hospital stay and learning it was a controlled substance.

"I'm better than what I was," she says.

Schmidt says she is still stockpiling medicines she doesn't take regularly, including the gabapentin. "I hang on to it in case a time comes when I might need it," she says. "You get old and you don't throw drugs away."

See the Data

Scan this code for graphic analysis of the data and the methodology used by the WSJ.

If Your Doctor Uses A Bot, Ask Questions

By Saeed Akhlaghpour

A mother recently wrote to me with concerns about her 14-month-old daughter. The child's hospital had begun using AI to record visits—and her husband had unknowingly consented. The woman feared that her child's sensitive information might live online forever or leak.

That fear captures what many families feel as artificial intelligence moves quietly into exam rooms, in the form of AI scribes. These digital tools transcribe and summarize your doctor visit into notes—sometimes recording and storing the audio in the process. After the doctor reviews the notes, they go into your medical record so you and the doctor can refer to them in the future.

Some doctors recorded patient visits and used computer dictation and transcription before AI, but adding the new technology to the mix has made the practice much more popular. Around 30% of U.S. physician practices have adopted AI scribes, and doctors praise them for reducing after-hours paperwork (often referred to as "pajama time") and allowing more attention for patients.

Yet these systems also raise hard questions about privacy, accuracy and consent. Perhaps the biggest issue: With AI scribes, your words are usually sent to a third party, often cloud-based, that converts audio to text. It is often not clear where the recordings are stored, for how long and who has access to them.

Here are questions every patient or parent should ask their providers before agreeing to let an AI scribe into the consultation room.

1. Can the doctor record without my consent?

It varies. States have different rules about getting patient consent before recording a doctor visit. In some cases, the providers must ask you first; in others, they don't. That said, most health systems still obtain explicit patient consent as a matter of policy—but once again, policies vary, and some practices may not let you opt out of an AI scribe for a nonurgent visit.

So, be sure to check your state's rules and ask about the provider's policy right off the bat. Let them know your preference explicitly. You can also ask providers to have a human handle the transcription, not an AI, but in most cases they have no legal obligation to comply.

2. What is being recorded?

Assume everything is. And that means anything you say while the recorder is on may be reflected in your medical record, where your insurer may be able to see it. So you should have the doctor pause the recording during any discussion of sensitive topics such as sexual or mental health, or substance use. As always, your rights vary from state to state and clinic to clinic—but, generally, if doctors are required to get your consent to record in the first place, they must also pause a recording when you ask them to.

3. Who is processing my data, and where is it stored?

The visit recordings usually end up in the hands of third-party vendors—ranging from big names like Microsoft to medical-technology startups—usually in the cloud. As you would expect, their privacy practices differ.

Ask the doctor's office which vendor processes your visit and ask for specifics. Some critical points to check on: Who can access the data? How long it is kept, what security controls apply and who contacts you if there is a breach? Also be sure to find out if your healthcare provider has a HIPAA Business Associate Agreement with the vendor. This imposes requirements for things like permitted uses and safeguards of your data, and makes vendors directly liable for security under HIPAA.

4. Who checks the notes for accuracy?

The transcription process, meanwhile, poses risks of its own. Modern AI tools often deliver lower overall error rates (around 1% to 3%) than older speech-recognition systems (7% to 11%). Even so, small percentages matter in medicine, and AI can introduce new kinds of errors, like invented details known as hallucinations. It may omit relevant information while summarizing, mix up who is speaking and misinterpret context—such as missing nonverbal cues.

Bias is a risk, too. Recent studies found that AI scribes showed substantially poorer accuracy in transcribing strong regional accents, as well as Black patients' speech. Problems also arise when patients have limited English proficiency.

5. Will my information be shared, or used to train AI?

Reputable clinics should be able to say no—both about their own policies and their vendor's. Under HIPAA, a healthcare provider may use a patient's information for treatment, payment and routine operations. But if the data is used by the clinic or third-party vendor to develop a product, service or other commercial application, separate patient consent is generally required.

The bottom line: If you don't want your information used for these purposes, tell your provider to record the preference in your chart. That way, any other provider in the network will know what you want.

6. Can I say no to a scribe and get the same care?

Once again, it varies. Even in states that require your consent to record, providers may *technically* refuse to see you if you say no, provided the visit isn't an emergency. Most clinics, though, will respect your wishes.