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PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

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APA is putting the finishing touches on its 2014 annual meeting, which is being held May 3 to 7 in New York City. One of the highlights of this year's meeting is the Integrated Care Track, which will help prepare psychiatrists to collaborate on patient care with other specialists' in new models of care. See page 8. Registration information appears on pages 2 and 7.

Experts Refute Myths Linking Mental Illness, Violence

Despite public perceptions to the contrary, any tie between mental illness and violence is more likely to involve suicide than homicide.

BY AARON LEVIN

"Despite an inclination to seek simplicity, violence is a large, complex problem, and we have to keep its many parts in mind at the same time," Mark Rosenberg, M.D., M.P.P., told an Institute of Medicine (IOM) workshop on mental health and violence in late February in Washington, D.C.

"Mental illness plays only a small role in violence, but that intersection is clouded by misconceptions and disinformation in the public's mind," said Rosenberg, co-chair of the IOM's Forum on Global Violence Prevention and president and CEO of the Task Force for Global Health in Decatur, Ga.

Forum attendees heard presentations by three dozen researchers and advocates seeking points of early intervention to reduce violence against self and others.

The recent wave of mass shootings, often attributed to individuals with mental illness, should be placed in perspective, said Thomas Insel, M.D., director of the National Institute of Mental Health. "Most people with mental illness are not violent, and most acts of violence are not

*see **Violence** on page 23*

CMS Withdraws Proposal Impacting Part D Psychotropic Protection

APA was in the forefront of advocacy groups that fought the CMS proposal that would have severely compromised the care of Medicare patients with mental illness.

BY MARK MORAN

The Centers for Medicare and Medicaid Services (CMS) has dropped plans to eliminate protected status for certain psychiatric drugs following vigorous opposition from APA, patient groups, and other medical and mental health groups.

Medicare's Part D program has six protected drug categories. In a proposed rule issued in January, CMS sought to eliminate two of those categories starting in 2015—antidepressant drugs and those that help suppress the immune system. The agency also said in its draft rule that it was considering dropping protected status for antipsychotic drugs in 2016.

But on March 10, APA learned that its hard work had helped achieve the goal it had sought: CMS Administrator Marilyn Tavenner announced that the proposal was being withdrawn. "We will engage in further stakeholder input before advancing some or all of the changes in these areas in future years," she said in a statement. "We are committed to continuing to work with Congress to continue to ensure that Parts C and D work best for Medicare beneficiaries."

APA hailed the decision. "I am delighted to report that APA has been successful in its efforts to help sustain full access to the psychotropic medications for Medicare patients," said APA President Jeffrey Lieberman, M.D. "[The] decision by CMS corrects what could have been an unwarranted limitation to the quality of mental health care."

Lieberman also expressed gratitude to Rep. Tim Murphy (R-Pa.) for what Lieber-

*see **CMS** on page 24*

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

PSYCHIATRIC NEWS

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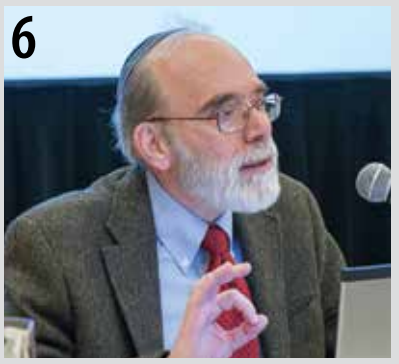
CONTENTS



GOVERNMENT NEWS

MEMBERS IN THE NEWS

ASSOCIATION NEWS

LEGAL NEWS

EDUCATION & TRAINING

CLINICAL & RESEARCH NEWS

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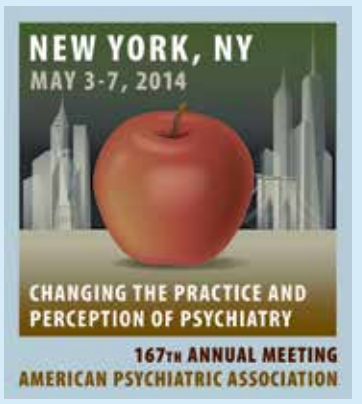
For APA's 2014 annual meeting, the Association returns to one of its most popular hosting locations, New York City. Register now and reserve a room at the hotel where you'd most like to stay. Registration information can be accessed at annualmeeting.psychiatry.org.



A highlight of this year's meeting is a special dialogue among **APA President Jeffrey Lieberman, M.D., Nobel laureate Eric Kandel, M.D.,** and **actor Alan Alda** on the impact of science and the media on psychiatry and how they will influence the future of mental health care.

Departments

FROM THE PRESIDENT

The Role of Psychiatrists in the Brave New World of Health Care

BY GRANT MITCHELL, M.D., AND JEFFREY LIEBERMAN, M.D.

Health care reform has been a long time coming. Although many date the start of the health care reform process by the passage in 2010 of the Affordable Care Act (aka Obamacare), the economic and social forces that are driving it have been building for decades. (Think Medicare, Medicaid, HMOs, managed care, Hillary Clinton, Ira Magaziner, and Harry and Louise [see http://www.youtube.com/watch?v=Dt31nhleeCg]). However, even now, many health care providers, and physicians in particular, would prefer to deny the inevitable: the transformative changes that will occur in the U.S. health care system.

It is true that we don't know whether this change will be a gentle set of waves or a tsunami, and we don't know into what form the health care system and the roles of its providers will ultimately be reconfigured. We just know that a comprehensive transition is looming.

In a previous column ("Change, Challenge, and Opportunity: Psychiatry in the Age of Health Care Reform," *Psychiatric News*, October 4, 2013), Howard Goldman and I discussed the health care reform process from the macro health policy and economic perspectives. In this article, Grant Mitchell and I will discuss how this will impact individual psychiatrists.

The goal of a transformed health care system is to expand care, improve quality, and lower costs. These goals may seem antithetical. Indeed, this is especially concerning to patients with mental illness and limited resources who have historically had limited access to care. Psychiatrists know firsthand this frustration, and that of their patients and their families, with the current models of care and financing: limited payments and visits, with silos between physicians that contribute to fragmented care. And although it's gratifying that timely and ongoing treatment of psychiatric disorders is finally being recognized as critical to controlling health care costs, we are waiting for stronger policies that will remove the barriers to access to care and payment for such care.

These concerns notwithstanding, we must collectively make a leap of faith and be prepared to make changes on the ground in the way that we as psychiatrists practice medicine. Psychiatrists will still continue to provide psychopharmacology and psychotherapeutic services. But this might be focused on specialty mental health care for the most complex patients, while primary care providers increasingly may conduct the first line of mental health screening and provide basic care. It is likely that the relationship between primary care providers and psychiatrists will expand exponentially with brief phone and "curbside" consultations replacing many of the more formal referrals for consultation.

Many psychiatrists will become leaders of multidisciplinary mental health teams providing coordinated services and, in some cases, may be located within large primary care practices. Conversely, we can expect to see primary care providers move into settings such as community mental health clinics to better provide general health care to severe and persistently mentally ill patients (SPMI).

A possible variant of this is that some psychiatrists and allied mental health providers will assume some basic primary health care responsibilities for SPMI patients or may even become their principal caregivers in collaboration with primary care providers. There is an increasing emphasis on addressing health behaviors such as diet, smoking cessation, and exercise as the understanding of the link between mental health and other health behaviors has deepened. Psychiatrists are finding they need to counsel their patients on these issues and even provide more basic medical screening and care to patients or in consultation with primary care providers. Some psychiatrists are even taking refresher courses in primary care to be able to better address this patient need.

To reiterate, multidisciplinary mental health teams will also become more common within hospitals and local health systems. To meet the anticipated demand from more patients while reducing costs, psychiatrists as the team leaders will provide less direct care (again, focusing their direct care efforts on complex, high-risk cases) and more supervision of care, while monitoring and tracking patient progress and increasing their consultative role with other specialists.

In fact, the CMS Center for Medicare and Medicaid Innovation issued its first 10 grants to hospitals to test their models on providing better mental health care. Each has different ideas of execution, but most share the concept of psychiatrists leading a care team and providing more effective coordination of care with other medical disciplines.

CMS isn't the only driver of change. With the enormous pressure to contain costs, health systems and payers are more receptive to trying new models of care, including a new emphasis on early detection and treatment of psychotic disorders. Change is increasingly local and driven by psychiatrists who have a vision and commitment and are willing to examine current practices, determine why care isn't succeeding, and try something new. They realize it isn't always necessary to conduct a formal research or demonstration project to improve care. Trying new ideas may instead require involving staff, patients, and families in the process to garner their insight and a commitment to tracking and collecting data to monitor what is and isn't working to inform ever-evolving care models. Some psychiatrists are becoming entrepreneurs: developing IT solutions or consulting to practices and systems to facilitate these new care models.

The difference between challenge and opportunity is often one of perception. Psychiatrists can view health care reform as leading to an inevitable change from the status quo and worrisome loss of autonomy. Alternatively, they can recognize that psychiatrists are well positioned to participate in and direct new health care initiatives—to become leaders of change, rather than siloed providers outside the mainstream of modern health care. We are the most highly trained, knowledgeable, and best positioned of all health care specialists to determine and provide (or at least oversee) the care of people with mental disorders. We are also mental health advocates who can identify gaps in service, educate others on the role of psychiatry, and offer concrete ways to better serve those within our communities.

There is a historic and exciting opportunity for psychiatrists to influence the future of medical care and occupy our rightful position in the field of medicine. Our nation is still at the beginning of the reform process, and we have the ability to influence its direction, but not if we choose to sit on the sidelines. It is important for psychiatrists to stay involved, not only in practice settings, but as APA members at the local and district branch

see ***From the President*** *on page 23*

Grant Mitchell, M.D., is vice chair for clinical services in the Department of Psychiatry at Columbia University and New York State Psychiatric Institute; and Jeffrey Lieberman, M.D., is president of APA and the Lawrence C. Kolb Professor and Chairman of Psychiatry at Columbia University.

GOVERNMENT NEWS

HHS Rule: Clinicians Do Not Have to Report Patients to Background Check System

The proposed regulations should not inhibit those who need mental health care from seeking it.

BY MARK MORAN

A proposed rule by the Department of Health and Human Services (HHS) addressing barriers to HIPAA-covered entities submitting information on individuals to the federal background check system makes clear that reporting is not mandated by federal law for clinicians treating individuals with mental illness.

On January 3, the Department of Justice (DOJ) proposed a regulation to clarify who is prohibited from purchasing a firearm due to mental illness, and the HHS rule addresses who can report someone to the National Instant Criminal Background Check System (NICS).

Julie Clements, J.D., director of regulatory affairs for APA's Division of Government Relations, said the HHS proposed rule spells out that no one under federal rules is required to report information on anyone, and that the entities that can report information to NICS are limited to those designated as the lawful authorities for performing the adjudications, such as state agencies, commissions or boards, and the institutions serving as repositories for the data arising from them.

Treating clinicians are not required to report patients under federal regulations. Moreover, the HHS and DOJ proposals do not change HIPAA regulations as they pertain to patient-doctor confidentiality; when physicians can disclose a patient's protected health information remains unaltered under the HIPAA privacy rule (*Psychiatric News*, March 21).

The DOJ proposal states that individuals may be reported to NICS if they have been legally "adjudicated" as a "mental defective" because they are unable to manage their own affairs, have been found not guilty of a crime due to mental illness or guilty but mentally ill, are found incompetent to stand trial, or are determined to be a danger to themselves or others.

Also reportable are people who have been subject to "[a] formal commitment . . . to a mental institution by a court, board, commission, or other lawful authority." The latter category, for the first time under the proposal, is clarified to include people subject to involuntary outpatient commitment. During a background check, federally licensed firearms dealers across the country will be alerted if a person who has been reported to NICS under the federal mental health prohibitor attempts to purchase a firearm.

"APA appreciates the balance that HHS strikes to protect the safety of the public by allowing the reporting of appropriate individuals subject to the NICS federal 'mental health prohibitor,' while also preserving the patient-physician relationship and promoting mental health treatment," wrote APA CEO and Medical Director Saul Levin, M.D., M.P.A., in a February 21 letter to the HHS Office of Civil Rights. "We applaud HHS for again recognizing the importance of the patient-physician relationship by limiting express permission for NICS reporting to a circumscribed category of HIPAA-covered entities."

Paul Appelbaum, M.D., chair of APA's Committee on Judicial Action, told *Psychiatric News* that these proposals should not inhibit those who need mental health care from seeking it. Voluntarily seeking either inpatient or outpatient mental health services does not place one within

*see **HHS** on page 23*

Illinois Law Expands Scope of Reporting

Illinois state law dramatically expands the categories of individuals who must be reported to the state's Firearm Owner Identification database and—most egregiously according to APA leaders—requires treating clinicians to report on their patients who meet the state's new expanded standards.

The Firearm Owners Identification Card Act, enacted in July 2013, requires inpatient and outpatient mental health facilities, as well as individual clinicians, to report "any person determined to be developmentally disabled or intellectually disabled." Additionally, unlike the federal National Instant Criminal Background Check System (NICS), which allows reporting of information only for "adjudicated" admissions (that is, those mandated by the judicial system), the Illinois law requires reporting of "nonadjudicated" admissions, including voluntary, informal, detention, and evaluation admissions and emergency admissions that do not have judicial oversight.

Moreover, the definition of "nonadjudicated" admissions includes juvenile admissions.

Steven Hoge, M.D. chair of the APA Council on Psychiatry and Law, called the law "disturbing and remarkable" and said it goes far beyond a requirement to report people deemed to be dangerous to self or others.

"Legislation based solely on diagnosis is discriminatory and is based on unfounded prejudice toward those with mental disabilities," Hoge told *Psychiatric News*. "Such legislation reflects and promotes stigmatization of individuals with psychiatric disorders. Additionally, the extension to nonadjudicated admissions would sweep into the gun registries many voluntary patients and those who may be determined at a legal proceeding not to have been dangerous. Presumably, to the extent that inclusion of those with mental illness has any rational basis, it must be restricted to those who have been adjudicated to be dangerous."

Past APA Trustee and Illinois psychiatrist Sidney Weissman, M.D., said the bill would place diagnosing clinicians in what he called the "absurd" position of having to report 2-year-old children—who can begin to show signs of developmental delay or autism—as being a "clear and present danger." He agreed that the legislation is discriminatory and can increase stigma but said he believes the best opportunity for redress is to remove language in the bill requiring reporting of small children.

Bill Seeks to Boost Number of Psychiatrists in VA

The bill identifies a critical strategy for the VHA to implement to remedy a serious shortage of psychiatrists available to treat veterans.

BY MARK MORAN

Legislation was introduced in Congress last month to address a severe shortage of psychiatrists in the Veterans Administration (VA) to serve members of the military returning from Afghanistan and Iraq.

The Ensuring Veterans Resiliency Act, introduced by Rep. Larry Bucshon (R-Ind.) and Rep. David Scott (D-Ga.), would establish a three-year demonstration program under the VA modeled on the Department of Defense Health Professions Loan Repayment Program, which offers physicians up to $60,000 in medical school loan repayment for each year of service. The bill also authorizes the VA to recruit at least 10 psychiatrists into the loan-repayment program each year; the VA would hire these physicians permanently to fill full-time positions, and participants would be required to demonstrate a long-term commitment to the VA.

Additionally, the legislation requires a report to Congress on the program's impact on psychiatric vacancies and recruitment and authorizes a government study on pay disparities between psychiatric physicians at the VA.

In a letter of support for the bill sent to Bucshon and Scott, APA CEO and Medical Director Saul Levin, M.D., M.P.A., noted that veterans face significant mental health challenges and pointed out that several studies place the rate of posttraumatic stress disorder (PTSD) in veterans of wars in Iraq and Afghanistan at approximately 40 percent. And each year, approximately 6,000 veterans complete suicide.

"Staff vacancies likely contribute to the Veterans Health Administration's (VHA) inability to deliver mental health services in a timely fashion," Levin wrote. "Current policy makes it extremely difficult for the VHA to compete with other public and private entities in offering employment incentives, such as medical school loan repayment. According to USAjobs.gov, on September 17, 2013, there were 142 federal job vacancies for psychiatrists. Of those, 138 were for the VA, and 128 were for permanent hires. Of those permanent positions, only 33 were eligible for medical school loan repayment.

"The demonstrated shortage of psychiatrists is a contributing factor to the inability of the VHA to deliver mental health services in a timely fashion," Levin wrote. "Given that the acute mental health needs of our veterans will persist for years to come, APA strongly supports the demonstration project established by the Ensuring Veterans Resiliency Act. This project . . . promises to identify a critical

*see **VA Psychiatrists** on page 20*

APA Fellow Aiming to Become First Psychiatrist Surgeon General

Inspired by author and poet Maya Angelou, Rhonda Mattox, M.D., first became a physician, then a psychiatrist. Having completed a congressional fellowship, she now has an ambitious new goal.

BY JOAN AREHART-TREICHEL

Joan Arehart-Treichel

Rhonda Mattox, M.D., is photographed with Rep. John Dingell (D-Mich.). "Rhonda has made a very valuable contribution to what we have done here," Dingell said.

Don't let the unpretentious manner of this young, soft-spoken psychiatrist from Stamps, Ark., fool you. Rhonda Mattox, M.D., has big ambitions. "I'm going to be the first psychiatrist surgeon general of the United States," she declared in an interview with *Psychiatric News.*

Former Surgeon General David Satcher M.D., Ph.D., although not a psychiatrist, has long been associated with mental health issues, she noted. "He issued the first surgeon general's report on the topic of mental health and mental illness and underscored that mental health is fundamental to our nation's overall health."

At first glance, Mattox's ambition may seem a bit unrealistic, but when in light of what she has been doing professionally during the last year, the goal doesn't seem out of reach. She has been working as an APA Jeanne Spurlock, M.D., Congressional Fellow in the office of Rep. John Dingell (D-Mich.), dean of the House of Representatives and a key author of the Affordable Care Act.

"Rhonda has made a very valuable contribution to what we have done here," Dingell told *Psychiatric News* on January 17—two days before Mattox completed her fellowship with him. "We are sorry to see her go! She'll be a better-skilled person from what she tells me she has learned here."

During her fellowship, Mattox advised Dingell and his staff on policy issues relating to the Affordable Care Act; worked on repealing the much-derided sustainable growth rate component of the Medicare payment formula; briefed Dingell on health-policy issues prior to hearings of the Energy and Commerce Subcommittee on Health; and compiled "The ABCs of Navigating the Affordable Care Act: A Resource Guide to Understanding Your Rights, Responsibilities, and Choices"—a 60-page document for residents of Dingell's home state.

"I have learned that it takes a village to get things done on Capitol Hill," she observed, "that everyone is valuable, from the interns to the scheduler to the person who picks up the trash. I have learned that you need to be humble and ask for information from the people who have the expertise."

Experiences a Far Cry From Civics Class

There were certainly a number of surprises, she admitted. "What you see on the Hill is not what you read about in civics class. You see the best coming out of people, but also the worst coming out of them, and that can be disappointing. I witnessed how cumbersome it could sometimes be to get something done and how vindictive some people could be in terms of the government shutdown last fall."

Nor is Capitol Hill immune to mental health tragedies, she discovered. During the partial government shutdown, a woman who appeared to be psychotic was shot near the Capitol because "people were on high alert and very protective. She seemed like a threat, so she was killed. That was hard for me," she said.

On a more positive note, Mattox was being courted with job offers even before her fellowship ended in January. "People wanted to fly from Arkansas to Washington, D.C., to meet with me and interview me for job opportunities—for instance, for the Division of Behavioral Health Services for the state of Arkansas. I was also encouraged to become medical director of the Arkansas Minority Health Commission."

She decided that she would continue as medical director of United Family Services in Little Rock—a position she held before her fellowship—but she has also been retained by the Arkansas Minority Health Commission as its medical media consultant. In that capacity, she will host a radio show, "Ask the Doctor," be a television and radio spokesperson on minority health care disparities, and develop a statewide media campaign to reduce mental health stigma.

No Stranger to Media Strategies

She had already had extensive experience in media education efforts, she explained. For example, while a psychiatry resident at the University of Arkansas, she worked on a bilingual statewide educational campaign to reduce stigma associated with depression during and after pregnancy.

She appeared in a television suicide-prevention ad. What she said in the ad was basically this: "My name is Rhonda Mattox. I am not an actor, but a psychiatrist. When my mother was pregnant with me, she had such a severe depression she attempted suicide. I am now devoting my life to helping others prevent the tragedy of suicide." The ad stimulated a statewide dialogue about the effects of depression, she said.

While she was living in Los Angeles a few years ago, she collaborated with Hollywood, Health, and Services, a program at the University of Southern California that provides entertainment industry professionals with accurate and timely health information for story lines. She worked with writers from "ER," "90210," and other popular television shows to help them depict mental illness accurately.

"The work I am most proud of was with the popular teen drama '90210,' " she said. "I worked with the writers and producers to create an educational and entertaining story line that spanned six episodes and that concerned a major character with bipolar disorder. I was thrilled when the writers and producers got a VOICE Award for the episode that aired on April 7, 2009, and was viewed by over 2 million people. The VOICE Awards recognize television and film writers and producers who have given a voice to people with behavioral health problems by incorporating dignified, respectful, and accurate portrayals of these individuals into their scripts, programs, and productions."

When can we look forward to Mattox exerting even more public clout—that

see ***APA Fellow*** *on page 17*

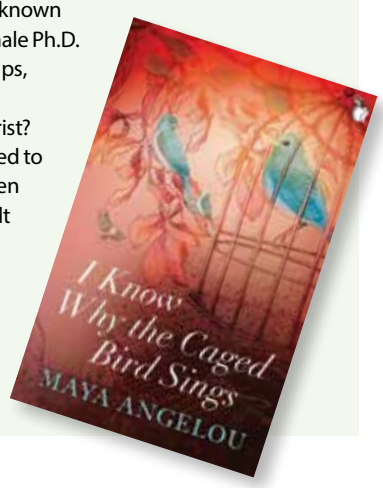
Book Changed Her Life

Rhonda Mattox, M.D., decided to become a physician when she was age 13 or so and read the book *I Know Why the Caged Bird Sings*. It was written by African-American author and poet Maya Angelou, who was identified as "Doctor" on the book jacket. It turned out, however, that Angelou was not a medical doctor, but the impression took hold in Mattox.

"Reading that book changed my career goal," Mattox explained. "Up until that point, I wanted to be a teacher. After reading that book, I wanted to be a doctor. The reason is that all the successful African-American women I had known were teachers. She was the first African-American female Ph.D. I had encountered with ties to my hometown, of Stamps, Arkansas. You can't be what you don't see."

And why did Mattox decide to become a psychiatrist?

"When I was a teenager, I had a mentor who listened to me and validated my thoughts. Most adults didn't listen to kids. I realized how important it was to have an adult listen to you and not criticize. Also, while I was young, friends and acquaintances would tell me intimate details about their lives because I was trustworthy and didn't judge them. They just kept coming, and I realized, 'Hey, I'm doing this for free. You can be paid for that? Well, then, sign me up!' "



ASSOCIATION NEWS

Board of Trustees Prepares For Future of *DSM-5*

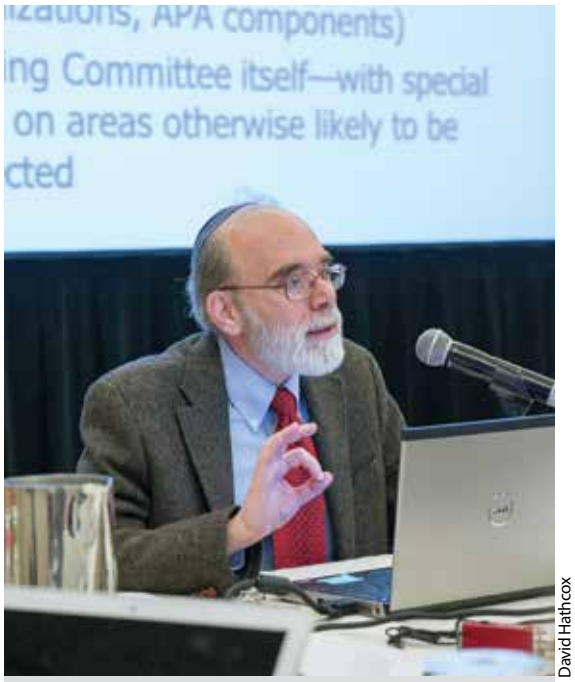
APA Trustees approve a framework for a process to evaluate proposals for making changes to *DSM-5*.

BY KEN HAUSMAN

APA wants to ensure that the new edition of its *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) is a "living document" that can be updated as research developments warrant. Last May, APA President Jeffrey Lieberman, M.D., appointed the Work Group on the Future of *DSM* to craft a system for making incremental changes to the manual.

At last month's meeting of the APA Board of Trustees, the work group's chair, former APA President Paul Appelbaum, M.D., presented a framework for assessing and incorporating deletions, additions, and criteria changes to *DSM*, which the Board accepted.

Among the key principles guiding the process is that "stability of psychiatric diagnosis is a good thing," Appelbaum emphasized. But advances that do alter clinical practice should not have to wait for the next revision of the manual, as has been the case with past *DSM* editions. Now, with the capabilities that come with online publishing, a mechanism for timely revisions exists.



David Hathcox

Paul Appelbaum, M.D., explains a procedure developed by a work group he chairs through which APA can make changes to the *DSM-5* diagnostic criteria as warranted by new clinical and research developments.

The review process for suggested changes, he noted, would be overseen by a steering committee that reports to the Board of Trustees through the Council on Research. Committee members would have "expertise in psychiatric nosology, psychiatric research, clinical psychiatry, and the *DSM*" and would not be limited to APA members. The committee members would also be a source of suggestions for diagnostic categories that might warrant revision, as would psychiatric researchers, clinicians, or specialty or advocacy organizations, Appelbaum said.

The work group also recommended that the *DSM-5* website be expanded to include a section to "allow interested parties to submit concerns about current criteria or proposals for new criteria or disorders. The website could also be a means of promoting the transparency of the revision process by providing the public with a list of proposals that are being developed by appointed working groups."

A small number of review committees would be appointed in major areas of psychopathology to draft proposed revisions once the proposals receive Steering Committee approval. When one of the review committees completes a "close-to-final" draft of criteria changes, the draft would be posted on the website for public comment. And the comments would then go back to a review committee.

"As changes to diagnostic criteria and text are approved by the Board of Trustees, they will be reflected in the online edition of *DSM*, with an electronic mechanism to flag changes for users," the work group suggested. "Periodically, perhaps every five years, the interim changes will be incorporated into a new *DSM* edition (e.g., *DSM-5.1*), which will be published in hard copy."

A work group on another critical issue in psychiatry—health care reform—also reported at the Board meeting. Howard Goldman, M.D., chair of the Health Care Reform Strategic Action Work Group, said the work group is nearing completion of two Medicaid-related toolkits. One describes the opportunities and risks of managed approaches to care in state Medicaid plans, and the other toolkit describes strategies psychiatrists can

see ***Board*** *on page 24*

New Caucus to Promote Value Of Psychotherapy Treatment

Among the possible activities of the caucus is to provide mentoring to young psychiatrists interested in increasing their psychotherapy skills.

BY MARK MORAN

The APA Board of Trustees last December approved establishment of the Psychotherapy Caucus, providing a place within the organizational structure of APA for psychiatrists interested in psychotherapy.

The inaugural meeting of the Psychotherapy Caucus will occur at APA's 2014 annual meeting on Monday, May 5, from 2 p.m. to 4 p.m. in Conference Room E, Lower Lobby, Sheraton New York Times Square Hotel.

APA Assembly member Eric Plakun, M.D., who has taken a lead in gathering support for the caucus, said it is the result of a grassroots movement among members to create a body within the governance structure of the Association where the voice of psychiatrists interested in psychotherapy could be heard. A Committee on Psychotherapy by Psychiatrists was one of many committees that were sunsetted in 2009 in an effort to streamline APA's component structure. In the roughly dozen years of its existence, the committee promulgated evidence about the efficacy of psychotherapy and its association with brain change, organized psychotherapy-related programs for APA's annual meeting and Institute on Psychiatric Services, and developed the "Y-model" for teaching psychotherapy across schools in an integrated, evidence-based way.

In 2012, an Assembly action paper led to the creation of the Task Force on Psychotherapy, which was chaired by Plakun. Last year, task force members gathered letters urging the re-creation of a more formal group to represent psychotherapy and submitted them to APA-President-elect Paul Summergrad, M.D., who took the request to the APA Board of Trustees. The caucus was approved in December 2013.

Plakun said the caucus is a step in the direction of reversing what he believes is the biologically reductionistic stance of the field. "It seems particularly auspicious that a Psychotherapy Caucus exists at this moment in time when, ironically, even as the evidence for the efficacy for psychotherapy grows, there is evidence that the provision of psychotherapy by psychiatrists is declining," he told *Psychiatric News*.

He noted that a 2010 survey by members of the former Committee on Psychotherapy by Psychiatrists and the American Psychiatric Institute for Research and Education found that from 2002 to 2010 there was a 20 percent decline in the provision of psychotherapy to patients by psychiatrists, from 68 percent to 48 percent of office visits reported by 394 psychiatrists. Those providing therapy to their patients tended to be over age 65, white, and U.S. medical school graduates, and half of their patients were self-pay or privately insured. Obstacles to provision of psychotherapy cited by psychiatrists included significant debt burden, lower compensation for psychotherapy compared with other services, and intrusive and time-consuming utilization review burdens.

Plakun said more than 60 APA members have expressed an interest in the caucus, and he said there is a sense of excitement about the inaugural meeting in New York. (He noted that cost of the meeting is being subsidized by the Austen Riggs Center, Sheppard Pratt Hospital and Health System, and the Menninger Clinic; however, he stressed that there will be no marketing.)

He said possible activities of the caucus include networking, sharing new research on psychotherapy, putting together programs for the annual meeting and Institute on Psychiatric Services, developing joint research projects, and providing mentors to young psychiatrists interested in pursuing psychotherapy. Plakun said he also hopes the caucus will be able to review other APA products—such as proposed treatment guidelines—and offer consultation on issues relevant to the practice of psycho-

see ***Caucus*** *on page 23*

ANNUAL MEETING

Central Park Offers Multiple Diversions

Horses and carriages, a vintage carousel, snow-leopard cubs, and an enchanted forest are some of the treasures you can encounter while strolling through Central Park.

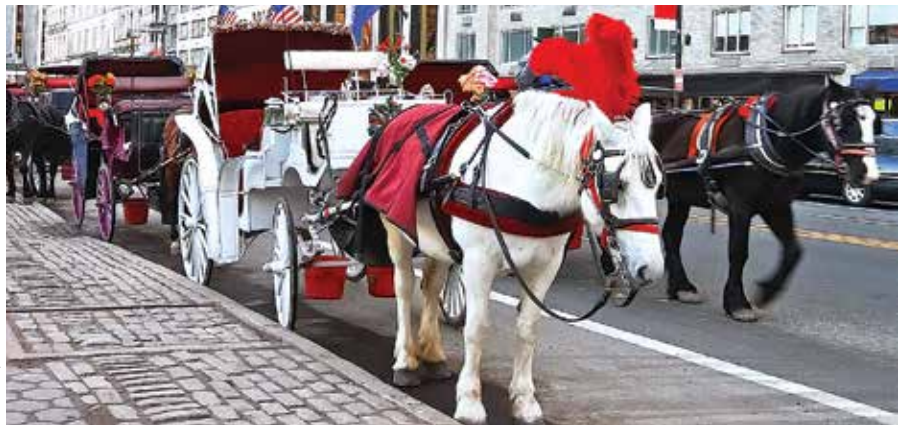
BY JOAN AREHART-TREICHEL

How about taking a walk through New York City's famed Central Park? It could give you a nice break during the APA annual meeting and also a splendid sense of the Manhattan of yesteryear.

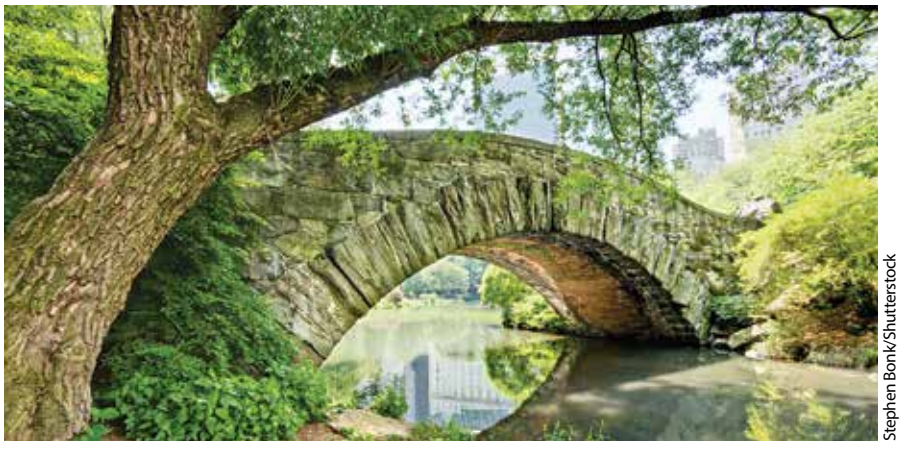
For example, a century or so ago, Central Park was bustling with horses pulling phaetons, runabouts, and tandems. Today you can still hear the clop-clop of hooves as horses pull carriages containing tourists around the park. The horses and carriages can be hired at the southern end of the park—that is, along 59th Street across from the Plaza Hotel.

Walking just a few blocks farther into the park will bring you to a carousel emitting nostalgia-provoking calliope music and making the rounds with 57 magnificent steeds. The carousel has been enchanting children and adults in that location for more than half a century. The carousel was crafted back in 1908, but was later found abandoned in an old trolley terminal on Coney Island before being relocated to Central Park in 1951. It is one of the largest carousels in the United States and an outstanding example of American folk art.

The park offers more recent additions too—such as a garden dedicated to Beatle John Lennon. It is located near 72nd Street and Central Park West—across the street from the Dakota Apartments where Lennon lived until he was murdered in front of the building in 1980. The garden is called Strawberry Fields, after one of the Beatles' songs, and the focus of the garden is an Italian mosaic bearing the title of Lennon's most famous solo song—"Imagine," which evokes a world without strife or war. More than 120 countries have endorsed Strawberry Fields as a Garden of Peace.



Palette 7/Shutterstock



Stephen Bonk/Shutterstock

Cathy Brown

Central Park has something for animal fans as well—the Central Park Zoo. Its five-plus acres will take you through a variety of habitats, all carefully designed to recreate the natural environment of the animals they house. Two of the zoo's most popular residents are snow-leopard cubs that are part of a breeding program designed to enhance the genetic diversity and demographic stability of the animals. Among the world's most endangered big cats, their range is limited to remote mountains in Central Asia and parts of China, Mongolia, Russia, India, and Bhutan.

The newest addition to the Central Park Zoo is the Tisch Children's Zoo. Here, children can get close to goats, sheep, a cow, and a Vietnamese pot-bellied pig. Small bronze sculptures of the animals stand next to their pens. When a child touches a sculpture, it emits an appropriate noise. The Children's Zoo also includes an Enchanted Forest and the Acorn Theatre, where actors perform daily shows.

Finally, you might like to wander over to the Sheep Meadow, located in the southwestern area of the park from 66th to 69th streets. Until 1934, it was just what its name implies—a meadow for a flock of sheep. Today, it is a favorite spot for picnickers, kite flyers, sunbathers, families, and visitors who come to admire the dazzling New York City skyline encircling the park. PN

More information about Central Park is posted at www.centralparknyc.org; information about the Central Park Zoo is posted at www.centralparkzoo.com.

REGISTER NOW!
MAY 3-7, NEW YORK CITY

Information on APA's annual meeting can be accessed at APA's Web site at http://annualmeeting.psychiatry.org/.

Member Registration: Go to http://annualmeeting.psychiatry.org/registration/individual-registration-information and click on "Member Registration."

Nonmember Registration: Go to above URL and click on "Nonmember Registration."

Late advance registration rates are in effect until May 1.

Residents Match Wits During MindGames Competition

The psychiatry residency teams competing next month in the final round of APA's entertaining but challenging MindGames contest were announced last month at the annual meeting of the American Association of Directors of Psychiatric Residency Training. The face-off will occur at APA's 2014 the annual meeting in New York on Tuesday, May 6, at 6 p.m. in Broadway North/South at the New York Marriott Marquis.

David Hathcox

At last year's MindGames, the team from the University of Texas Health Sciences Center at Houston walked away with top honors. They faced teams from New York Presbyterian/Cornell and UCLA Medical Center.

The teams are John Sneed, M.D., Samet Kose, M.D., and Marsal Sanches, M.D., of University of Texas Health Sciences Center at Houston; Seth Kleinerman, M.D., Adam Damner, M.D., and Akshay Lohitsa, M.D., of NewYork-Presbyterian/Weill Cornell Medical Center; and Vladimir Khalafian, M.D., Max Schiff, M.D., and Desiree Shapiro, M.D., of the University of California, San Diego.

MindGames, now in its eighth year, tests the teams' knowledge of medicine in general, psychiatry in particular, and patient-care issues. The "Jeopardy"-style competition will be hosted by renowned psychiatrist and educator Glen Gabbard, M.D.

MindGames is open to all psychiatry residency programs in the United States and Canada. The preliminary online competition for this year's game began in February, when teams of three residents together take a 60-minute online test consisting of 100 multiple-choice questions. The questions follow the ABPN Part I content outline, covering both psychiatry and neurology, with a few difficult history-of-psychiatry questions to make it interesting. The winners were the three top-scoring teams with the fastest posted times.

MindGames is a collaboration between APA and the American College of Psychiatrists.

ANNUAL MEETING

Learn More About Integrated Care Through Special Track

"Integrated health care is the new gold standard for individuals with general medical and mental disorders, whether their 'medical home' is a primary care clinic or a community mental health center," according to a recent article by Thomas Smith, M.D., and colleagues. This year's annual meeting in New York is offering a truly remarkable educational opportunity to get you prepared, with over 20 presentations in an Integrated Care Track that covers the full spectrum of collaboration presented by experts from across the field. In addition, there are several presentations on workforce development, particularly for residency training, occurring on Saturday, Sunday, and Tuesday.

These are just some of the highlights of the Integrated Care Track; it will provide unique skills to meet APA President Jeffrey Lieberman's hope to "change the practice and perception of psychiatry."

Check out the program distributed on site for any additions or changes.

—Lori Raney, M.D., chair of the APA Workgroup on Integrated Care

SATURDAY, MAY 3

9 a.m.-10:30 a.m.
Teaching Residents Collaborative Care in Noncollaborative Settings
Andres Barkil-Oteo, M.D.,M.Sc., Hsiang Huang, M.D., M.P.H., Anna Ratzliff, M.D.,Ph.D.
D05/6, Level 1, Javits Convention Center

Risk Management and Liability Considerations in the Integrated Care Setting
Kristen Lambert, J.D., M.S.W., D. Anton Bland, M.D., Lori Raney, M.D.
Shubert/Uris/Plymouth, Sixth Floor, New York Marriott Marquis

11 a.m.-12:30 p.m.
The Affordable Care Act and the Future of Mental Health in America
Ezekiel Emanual, M.D., Ph.D.
Broadway North Center, Sixth Floor , New York Marriott Marquis

Comorbidity in Schizophrenia: Diagnostic and Clinical Issues
Michael Hwang, M.D., Henry Nasrallah, M.D.
Shubert/Uris/Plymouth, Sixth Floor, New York Marriott Marquis

3:30 p.m.-5 p.m.
Leveraging Psychiatric Expertise: Integrated Care and Health Care Reform
Wayne Katon, M.D., Roger Kathol, M.D., Benjamin Druss, M.D., Jürgen Unützer, M.D., Lori Raney, M.D.
Room 1E08, Level 1, Javits Convention Center

SUNDAY, MAY 4

8 a.m.-9:30 a.m.
Integrated Care Models: The Development of Collaborative Care
Wayne Katon, M.D.
Rooms 3D04/09, Level 3, Javits Convention Center

9 a.m.-4 p.m.
The Integration of Primary Care and Behavioral Health: Practical Skills for the Consulting Psychiatrist (course; extra fee)
Jürgen Unützer, M.D., Lori Raney, M.D., John Kern, M.D., Anna Ratzliff, M.D., Ph.D.
Sutton Center, Second Floor, New York Hilton Midtown

10 a.m.-11:30 a.m.
Integrated Care and the Patient-Centered Medical Home in the Veterans Health Administration and Department of Defense
Paul Sargent, M.D., Andrew Pomerantz, M.D., Patricia Gibson, M.D., Brian McKinney, M.D.
Soho/Herald/Gramercy, Seventh Floor, New York Marriott Marquis

The Integration of Behavioral Health in Accountable Care
Rajesh Tampi, M.D., Deena Williamson, M.S.N., R.N.
Rooms 1D03/04, Level 1, Javits Convention Center

12:30 p.m.-2 p.m.
Comprehensive Care for Patients With Medical and Psychiatric Comorbidity: New Model of Care and Opportunity for Psychiatrists
Steven Frankel, M.D. , James Bourgeois, M.D., O.D. , Roger Kathol, M.D.
Room 1A22, Level 1, Javits Convention Center

1 p.m.-4 p.m.
Epidemiology and Treatment of Patients With Comorbid Psychiatric and Medical Illness
Wayne Katon, M.D., Jeff Huffman, M.D., Ph.D., Lydia Chwastiak, M.D., M.P.H.
Rooms 3D05/06/07/08, Level 3, Javits Convention Center

2:30 p.m.-4 p.m.
Workforce Development in Integrated Care: A Multidisciplinary Approach for Health Care Systems
Robert Joseph, M.D.,M.S., Kimberlyn Leary, M.P.A.,Ph.D., Hsiang Huang, M.D., M.P.H., Jessie Fontanella, Ph.D.
Empire/Hudson/Chelsea, Seventh Floor, New York Marriott Marquis

MONDAY, MAY 5

9 a.m.-4 p.m.
Primary Care Skills for Psychiatrists
Erik Vanderlip, M.D., Lori Raney, M.D., Robert McCarron, D.O., Martha Ward, M.D., Jaesu Han, M.D.
Gramercy, Second Floor, New York Hilton Midtown

9 a.m.-Noon
Developing and Implementing Interventions for Military Patients Targeting PTSD and Related Comorbidities in Real-World Nonspecialty Settings (Collaborative Care Interventions)
Robert Ursano, M.D., Douglas Zatzick, M.D., Stephen Cozza, M.D., Charles Engel, M.D., M.P.H.
Room 1A10, Level 1, Javits Convention Center

Comorbidity of Depression and Diabetes: The Challenge and the Response
Sidney Kennedy, M.D., Norman Sartorius, M.D., M.A., Cathy Lloyd, Ph.D., Roger McIntyre, M.D., Alan Jacobson, M.D.
Room 1E15, Level 1, Javits Convention Center

1:30 p.m.-3 p.m.
Brief Behavioral Interventions for Integrated Care
Anna Ratzliff, M.D., Ph.D., Kari Stephens, Ph.D.
Majestic/Music Box/Winter, Sixth Floor, New York Marriott Marquis

2 p.m.-5 p.m.
The Integration of Primary Care and Behavioral Health: Research Across the Collaboration Spectrum (Advances in Research)
Lori Raney, M.D.
Special Events Hall 1D, Javits Convention Center

TUESDAY, MAY 6

9 a.m.-10:30 a.m.
Providing Medical Care Within Community Mental Health: The Role and Perspective of Assertive Community Treatment Teams
Erik Vanderlip, M.D., Maria Monroe-DeVita, Ph.D.
Empire/Hudson/Chelsea Rooms, Seventh Floor, New York Marriott Marquis

9 a.m.-Noon
Advances in Managing the Side Effects of Psychotropic Medications
Joseph Goldberg, M.D., Carrie Ernst, M.D., Stephen Stahl, M.D., Ph.D., John Newcomer, M.D., Claudia Baldassano, M.D., Anita Clayton, M.D.
Rooms 1A06/1A07, Javits Convention Center

11 a.m.-12:30 p.m.
Primary Care and Pharmacologic Treatment for Chronic Psychiatric Patients
Emily Leckman-Westin, Ph.D. , Maria Chiara Pieri, M.D., Ludmila De Faria, M.D.
Room 1E11, Level 1, Javits Convention Center

1:30 p.m.-3 p.m.
Psychiatric Leadership in the Behavioral Health Home
Lori Raney, M.D., Jaron Asher, M.D., John Kern, M.D. , Joseph Parks, Patrick Runnels, M.D., Michael Silver, M.D.
Rooms 1D03/04, Level 1, Javits Convention Center

2 p.m.-5 p.m.
Collaborative Care: New Opportunities for Psychiatrists
Lydia Chwastiak M.D., M.P.H., Wayne Katon, M.D., M.P.H., Jürgen Unützer, M.D., Anna Ratzliff, M.D., Ph.D.
Rooms 3D05/06/07/08, Javits Convention Center

More information about the track and specific sessions is available from Dr. Raney at lraney@pcbhconsulting.net.

PROFESSIONAL NEWS

California Psychiatrist Helps Develop Integrated Substance Abuse Care

Medication-assisted treatment of substance abuse combines medications with counseling and behavioral therapies to provide a "whole-patient" approach to treating substance use disorders.

BY MARK MORAN

For more than two decades, Robert Cabaj, M.D., has witnessed the enormous toll that substance abuse exacts on overall health among patients in both primary care and public mental health settings.

He has also seen the effect that fragmentation of service delivery has on patient care—and on overall medical costs: primary care physicians in the past have had few medical interventions for substance abuse and little or no training in how to use those that existed, while psychiatrists have tended to refer patients with substance abuse to specialty clinics.

But today there is a wide array of somatic interventions—along with behavioral strategies and 12-step support groups—for treating substance abuse. And in San Mateo County, Calif., where he is medical director of behavioral health and recovery services, Cabaj has helped to operationalize a set of medical interventions to address substance abuse as a standard of care in all settings in the county's public-health system.

The result of this systemwide implementation of medication-assisted treatment (MAT) is that patients with substance abuse disorders can be treated by providers in all settings.

"Traditionally, substance abuse has been in the hands of a psychiatrist who specialized in substance abuse; otherwise, no one else treated it," Cabaj said. "Primary care physicians didn't really feel like they had effective interventions, beyond counseling and recommending 12-step programs. But today treatment is easy to do, medications are benign, so why shouldn't both sides of the house of medicine—behavioral health and primary care—treat everyone, regardless of where they present?"

MAT—defined by the Center for Integrated Health Solutions (CIHS) as "the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a 'whole-patient' approach to the treatment of substance use disorders"—is a form of integrated care that is attracting attention nationwide.

Robert Cabaj, M.D., says medication-assisted treatment of substance abuse allows patients to be treated for substance abuse in whatever setting they present.

Robert Cabaj, M.D.

In an article on the CIHS website, Elinore McCance-Katz, M.D., Ph.D., chief medical officer of SAMHSA, said that as integrated care becomes the norm, all health care providers, whether in primary care, mental health, or substance use treatment, will need to learn how to provide treatment for disorders they may not have historically treated. "Primary care providers especially will need to be ready to assess and provide treatment for clients who present with mental health and substance use concerns," she said. "Individuals with chronic relapsing diseases should have access to MAT. It's just the standard of care."

INTEGRATED CARE
Putting Together the Puzzle

In San Mateo County, the effort has fostered a systemwide dialogue and closer collaboration between mental health and primary care. "As primary care doctors have gotten comfortable with these interventions, it became a two-way dialogue," Cabaj told *Psychiatric News*. "Now our primary care doctors feel like they can finally address the substance abuse problems they see in their patients, and psychiatrists don't feel like they need to refer patients to a specialty clinic."

Cabaj brings to the effort a history of trying to standardize treatment of substance abuse across settings. In 1991 he left Boston and came to San Francisco General Hospital, where he was chief consultant on the hospital's substance abuse consult team.

"It was astonishing—the number of people in the public-health system with substance abuse issues," he told *Psychiatric News*. "The vast majority of them were in primary care, and it was very clear that if physicians had some guidelines, they might better address the problems—but without them, they just stepped back and let someone else deal with it."

So Cabaj created a set of guidelines for treating alcohol and substance abuse disorders and for treating withdrawal. At the same time, one of his staff was doing research on buprenorphine, which was demonstrating superior effectiveness to methadone—an example of a growing number of somatic treatments that would become available.

When he came to San Mateo County three years later, as medical director of behavioral health and recovery services, he witnessed the flip side of fragmented care. "There were all of these people in our behavioral health clinics who had medical care problems," he said. "I hired nurse practitioners to go into our clinics,

see **Integrated Care** on page 21

RESIDENTS' FORUM

Resident's Perspective on a Changing Health Care System

BY ERIK VANDERLIP, M.D.

I think I can speak broadly for most of us traversing the sometimes turbulent waters of medical training when I say that there are intense periods that often radically shape the course of our careers and what we want out of a life in medicine.

I didn't begin medical school with psychiatry on my radar, and it was a confluence of public-health arguments coupled with amazing clerkship experiences that hooked me. At some point near the end of my third year in medical school, it was clear that surgery and probably obstetrics had failed to capture my attention in the same way as behavioral health, and my focus narrowed. Such narrowing isn't unusual in medicine. Gone are the days of the uber-generalist—even primary care has developed niche areas of practice. Increasing interest in sports medicine or hospitalist fellowships arising out of family medicine come to mind. It's inevitable that we all narrow our scope over time and stake our claim within the ever-expanding global map of medical knowledge.

In this vein, I consider the great potential for practice reform within the field of psychiatry currently taking place. Dramatic shifts are occurring in the practice of medicine as health care needs evolve, and our profession must adapt. However, as we prune our medical knowledge, so too do we sometimes focus our notions of psychiatric practice in ways that limit our potential and threaten our profession.

Most young psychiatrists don't begin postgraduate training with a developed sense of how the health system is structured or their place within it. A trainee's role in psychiatric consultation is a blank slate. It's the first three years of residency education that often define our scope and boundaries with seeing patients and our professional relationships with colleagues in mental health care and in the rest of medicine. It's the first three years—our attendings and mentors during that time—that are responsible for dictating our comfort in consultation and breadth of medical management for the rest of our professional lives. Perhaps because

see **Residents Forum** on page 22

Erik Vanderlip, M.D., is a second-year fellow in psychiatry health services research at the University of Washington and the resident-fellow member trustee on the APA Board of Trustees.

LEGAL NEWS

Joe Ravi/Shutterstock

The U.S. Supreme Court hears arguments on the standards states adopt to determine if a murderer is eligible to be executed.

High Court Weighs Standards For Intellectual Disability

The Supreme Court wants to know if a convicted murderer's cognitive abilities can be encapsulated in a single number that makes him eligible for the death penalty.

BY AARON LEVIN

Just how intellectually disabled must a convicted murderer be before the state is barred from executing him?

That might seem like a complex question to a psychiatrist, but Supreme Court justices spent most of their time one cold March morning asking not about the man who spent 35 years on Florida's death row but about statistical aspects of his IQ tests.

Freddie Lee Hall was convicted of the rape and murder of a 21-year-old woman in 1978. In a prior case, *Atkins v. Virginia*, in 2002, the Supreme Court held that executing a mentally retarded (now termed "intellectually disabled") person violated the Eighth Amendment to the Constitution, which prohibits "cruel and unusual punishments."

The Court in *Atkins* left it up to the states to determine standards for intellectual disability. Florida set the bar at an IQ of 70, along with deficits in adaptive behavior and an onset before age 18. Hall had scored 71 or higher on several IQ tests, making him eligible for the death penalty.

Allen Winsor, Florida's solicitor general, argued that once the prisoner scored above 70, the other two criteria became irrelevant. Furthermore, the state couldn't have its laws governed by the subjective—and changeable—views of clinicians.

The statistical argument revolved around whether a score of 70 was a "bright line," a number that must be adhered to inflexibly.

"Because of the standard error of mea-

see ***Court*** *on page 24*

DSM-5 Can Open Educational Dialogue

The international attention focused on the latest edition of *DSM* is an opportunity to educate trainees and patients about the nature of progress in psychiatric knowledge.

BY MARK MORAN

For educators, residents, and medical students, the recently published *DSM-5* may be more than a manual for diagnosis—it can be the touchstone for an educational dialogue about the nature of psychiatry itself.

That's what Richard Summers, M.D., co-director of residency training in psychiatry at the University of Pennsylvania Perelman School of Medicine, said in the article "*DSM-5*: A Teachable Moment," in *Academic Psychiatry* last month. The article is one of six that appeared in the journal based on a symposium on *DSM-5* and education at last year's APA annual meeting.

"The publication of *DSM-5* is a teachable moment for educators and trainees because it opens an opportunity for discussing not just how to do a diagnostic assessment, but also that our knowledge about psychiatric illness moves forward in an iterative way," Summers told *Psychiatric News*. "We keep learning, and as we do, we have to change how we conceptualize diagnostic assessment.

"So *DSM-5* is really an occasion for us to have a discussion about the broader process by which progress takes place in our field," he said. "I think that people who enter psychiatry have a tolerance for—and interest in—a field that is still evolving. We tolerate some ambiguity as we move toward a more complete understanding of mental illness, and the diagnostic manual can be taught as a next step in the progress of our understanding."

Summers believes that the international attention focused on *DSM-5* opens up avenues for dialogue between trainees and the patients they treat.

"Society really cares about what we do," he said. "Open conversation about *DSM-5*, its changes, and what they mean ultimately diminishes stigma. What we are all doing with our patients is helping to educate them and collaborating with them by providing information and having a dialogue."

In his article, Summers outlined recommendations for education around the new manual. They include the following:

- Mobilize and coordinate didactics to teach new criteria and reinforce didactics in bedside teaching, grand rounds, and other clinical teaching settings.
- Model lifelong learning through faculty learning alongside trainees.
- Teach the scientific methods and results that informed the creation of *DSM-5*.
- Tell stories about the context for past and present nosologic systems.
- Incorporate *DSM-5* organization and Section III quantitative measures into clinical practice.
- Emphasize clinical assessment of stressors, resiliency, and level of functioning.
- Clearly delineate for residents when each type of exam will begin testing *DSM-5* criteria.
- Discuss the impact of *DSM-5* on billing, coding, documentation, and patient psychoeducation.
- Promote consideration of the patient as a person along with consideration of diagnosis and formulation.
- Review and assess departmental clinical settings and their role in teaching psychiatric assessment.
- Provide feedback to departmental leadership about the relevance and effectiveness of clinical services.
- Improve "teaching the teachers" training and mentoring for residents as they approach their role as teachers of more junior residents and medical students.

Summers believes that residents today have a positive attitude toward *DSM-5*. Now that the manual is being incorporated into routine practice, the sense of controversy that accompanied the months before publication has died down. "It's less of an 'event' now," he said.

He added that the University of Pennsylvania was one of the field-test sites for *DSM-5*, so faculty and trainees there have experience with the manual. "This has given us a commitment to its success and also gave us a perspective on some of the controversies that arose so that everyone sees it as an incremental advance in the field, not an article of religious faith."

Summers believes that *DSM-5* is an opportunity for the best kind of education. "Great teaching and education happens when there is a sense of salience and immediacy and importance to what is going on, when teachers and learners alike give the subject matter their total attention," he said. "That's why *DSM-5* is important. Residents know that something really important has happened in the intellectual framework of psychiatry, and this lends an immediacy to the education that happens around this important milestone." PN

An abstract of "*DSM-5*: A Teachable Moment" is posted at http://link.springer.com/article/10.1007/s40596-013-0009-3.

FROM THE EXPERTS

Of Supermentalization, Pleasing Others, and Anorexia: The Case of E.L.

BY STUART C. YUDOFSKY, M.D.

At the time of presentation, E.L. was a 20-year-old college sophomore with an 18-month onset of preoccupation with her diet, weight, and the shape of her thighs and hips, which she believed to be "obscenely fat and disgusting to look at." She was 5'10" tall and weighed 97 pounds. Her chief complaint was, "I hate my body, and I hate myself."

Since infancy, E.L. was the focus of her mother's fierce determination for her academic success. The mother's primary goal was that E.L. attend a prestigious Ivy League university, a campaign that she pursued with intensity. E.L.'s assignments were absolute obedience to maternal commands and perfection in their execution. Her reward for success was escape from her mother's persistent physical and psychological brutality for noncompliance. Unlike her peers, E.L. was not permitted to go to parties, have friends over to her house, have a cell phone, or use her laptop computer for any purpose other than schoolwork.

Accepted via "early decision" to the university of her mother's choice, E.L. was unprepared for the social experiences in college. Tall and physically attractive, as well as having tenacious work habits, E.L. aroused the competitive enmity of her female roommates. Perennially monitoring others for their approval, E.L. correctly perceived that her roommates didn't like her, and she tried to do everything possible to please them and to fit in.

E.L.: "Nothing I did could make them like me. All they would comment on was how skinny I looked and how little I was eating. I had no choice but to stuff myself to make them happy. By the end of my three months of college, I had gained over 25 pounds."

When her mother saw her daughter on the Thanksgiving holiday for the first time since E.L. had left for college, she was enraged:

E.L.'s Mother: "What have you done to yourself? You're as fat as a pig. I thought that you went to college to become a doctor, not to waste all your time stuffing your ugly mouth. What will my friends think when they see you?"

Over the ensuing 18 months, E.L. progressively lost 40 pounds. At the time of presentation, she met *DSM* criteria for anorexia nervosa, obsessive-compulsive disorder, and social anxiety disorder. On a medical leave of absence from college, her treatment consisted of twice-a-week psychotherapy and an SSRI antidepressant.

Although numerous issues in E.L.'s case merit emphasis—including the likely personality disorder of her mother (Yudofsky SC, 2005)—the confluence

see ***From the Experts*** *on facing page*

Stuart C. Yudofsky, M.D., is the Distinguished Service Professor and Chair of the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine. He also holds the Drs. Beth K. and Stuart C. Yudofsky Presidential Chair in Neuropsychiatry, is chair of the Department of Psychiatry at Methodist Hospital, and editor of the *Journal of Neuropsychiatry and Clinical Neurosciences*. He is the author of *Fatal Pauses: Getting Unstuck Through the Power of No and the Power of Go*. APA members may preorder the book at discount from American Psychiatric Publishing at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62500.

INTERNATIONAL NEWS

APA Leaders Urge Uganda to Drop Law Criminalizing Homosexuality

Uganda's president ignores warnings that a law mandating prison terms for homosexual activity will lead to discrimination and violence against gay Ugandans.

BY KEN HAUSMAN

The president of Uganda ignored pleas from governments and human-rights and advocacy organizations worldwide that he rethink his announced decision to sign a law imposing severe prison sentences on Ugandans who engage in homosexual behavior. He signed the law on February 24.

APA was one of the organizations that tried to convince Uganda President Yoweri Museveni to reject the law. "APA is deeply disappointed that the president of Uganda signed a law imposing harsh prison terms on people who engage in same-sex activity," CEO and Medical Director Saul Levin, M.D., M.P.A., told *Psychiatric News*.

In a February letter to Museveni, Levin and APA President Jeffrey Lieberman, M.D., emphasized that "criminalizing homosexuality will only lead to public unrest and violence against those who pose no harm to society and cannot change who they are."

Silhouette Lover/Shutterstock

APA provided a detailed summary of scientific research showing that sexuality is the result of a complex interplay of genetics, certain hormones, and environment factors, pointing out that "there is no scientific evidence that either homosexuality or heterosexuality is a free-will choice." The letter states that in light of the scientific evidence on the roots of sexuality, "punishing [homosexuals] with prison terms will not change their orientation or lessen the incidence of homosexuality in Ugandan society."

Despite this information, and protests from a long list of government officials and advocacy groups from multiple countries, Museveni signed the law.

Kenneth Ashley, M.D., president of the Association of Gay and Lesbian Psychiatrists, told *Psychiatric News* that the law "will mean the dismantling of Uganda's LGBT support systems and social networks. The isolation and psychosocial stressors will likely result in increased symptoms of anxiety and depression. It will also be a barrier to health care, as the law has been interpreted by some to mean that even health care providers are included as 'a person who aids, abets, counsels, or procures another to engage in acts of homosexuality, commits an offense, and is liable, on conviction, to imprisonment for seven years.' It also seems likely that there will be a number of LGBT people who will be forced to undergo 'rehabilitation,' while others may seek it out as a way to remain in Uganda."

On March 11, a group of Ugandan human-rights organizations and advocates filed a formal legal challenge to the law, saying that it violates the country's constitutional right to equality and privacy and illegally discriminates against people with HIV disease and disabilities, according to a report in the *Washington Blade*. The coalition's petition to a Ugandan court states that the law "amounts to institutionalized promotion of a culture of hatred and constitutes a contravention of the right to dignity."

Secretary of State John Kerry spoke with Museveni soon after the law was signed, expressing the U.S. government's "deep disappointment" in the decision to enact the law. Kerry noted that the Obama administration is reviewing its relationship with Uganda. The State Department said that Kerry "raised U.S. concerns that this discriminatory law poses a threat to the safety and security of Uganda's LGBT community, and urged President Museveni to ensure the safety and protection of all Ugandan citizens." PN

From the Experts

continued from facing page

of two phenomena has been pivotal in understanding her psychopathology and directing treatment: her superior capacity "to mentalize," a condition that I have termed "supermentalization" (Yudofsky SC, 2015) and her pervasive need to "overplease" others.

"Mentalization" refers to a person's ability to understand the current mental state of oneself and others during interactions and relationships. A simple way of defining the term is "keeping mind in mind (Allen JG, Fonagy P, Bateman, AW, 2008, p.3)." Mentalization enables a person to be aware of the mental state of another person, while simultaneously being conscious of his or her own psychological reactions to that person's state of mind and behaviors. People with certain psychiatric disorders have difficulty mentalizing in ways categorized as follows:

"Hypomentalization" refers to people who attend primarily to what is going on in their own minds, with little or no attention to what is going on in the minds of others with whom they interact (Crespi B, Badcock C, 2008). They tend to think and respond to others in concrete ways and have difficulty seeing things from other people's points of view.

"Hypermentalization" is excessive, inaccurate mentalizing (Sharp C, Pane H, Venta A, et al., 2011) and occurs when a person becomes oversensitive to and overvigilant of what is going on in the minds of others. Hypermentalization involves distortions and misinterpretations of the mental states of others, which leads to feeling insecure or unsafe.

"Supermentalization" is a term that I have coined to describe people, who, at rare and exceptional levels, not only accurately keep the minds of themselves and others in mind but also the feelings of themselves and others in their minds and feelings. They have sharpened perceptions and awareness, are attentive listeners, and are careful, systematic observers. These individuals are highly cognizant of the behavioral and emotional patterns of others and notice when these patterns change. Supermentalizers carefully monitor others' body language, speech patterns, and mental associations. When they detect changes from the normal patterns, they are excellent at figuring out what has brought about these changes. They pick up a great deal from their interactions with others, far more than most people without their special abilities. A lot of what supermentalizers perceive from unsuspecting others leaves them anxious and uncomfortable. Unless they are using their skills constructively as professionals, most supermentalizers tell me that they would be better off not knowing what they pick up from unwitting others.

Supermentalizers do not limit their special perceptive capacities to what others are thinking or feeling about them, but also sense what others are feeling and thinking in general. This applies to human suffering. Supermentalizers, therefore, tend to be empathic and compassionate. As such, they are often at the forefront of recognizing and taking action to help others, even in circumstances that endanger their own safety and well-being. Many also tend to be deeply affected emotionally by what they perceive and thus may require the support and protection of others.

Because supermentalizers are so finely attuned to the wishes and wants of others and have such refined empathic facility, many have problems with "overpleasing" others. However, people arrive at "overpleasing" others by many routes, including those who have low self-esteem and histories of trauma and/or impaired attachments. Because E.L. is a supermentalizer and was abused as a child and adolescent by her mother, she was doubly vulnerable to over-pleasing others.

Currently, E.L.'s parents are divorced, and she chose to reside with her father with limited contact with her mother. After 18 months of excused absence from college and psychodyamically oriented psychotherapy in Houston, E.L. has returned to college. Her weight has been in a safe range and stable for over a year, she is flourishing academically and continues in twice weekly psychotherapy with a local psychiatrist. She also has a boyfriend who is a graduate student at her university. Neither her father nor I have any idea about whether E.L.'s mother would approve of him. E. L. says, "I couldn't care less what my mother thinks." PN

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CLINICAL & RESEARCH NEWS

Depression Should Be Listed As Heart Disease Risk, Says AHA Panel

The American Heart Association's new recommendation illustrates the continuing progress in integrating mental health care with general medical care.

BY VABREN WATTS

Despite publication of numerous studies and meta-analyses showing a link between depression and cardiovascular disease, the American Heart Association (AHA) has yet to formally recognize depression as a risk factor for a poor prognosis in patients with heart disease.

On March 25 in the journal *Circulation*, a statement was issued by the AHA in response to a systemic literature review, which could lead to depression being considered as a major risk factor in heart disease among adults in the United States.

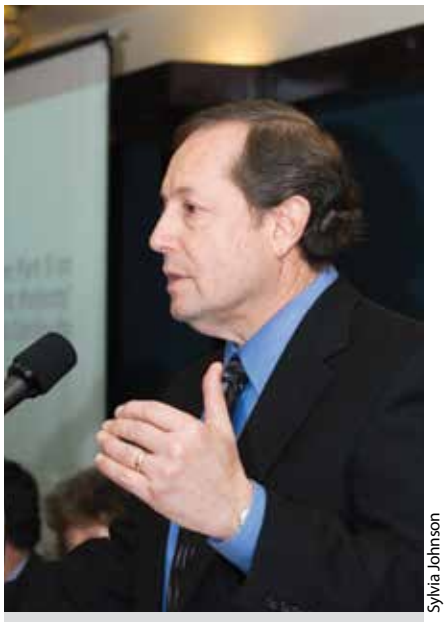
A 12-person panel was organized by the AHA to determine if depression should be elevated to the status of risk factors—along with diabetes, high blood pressure, and smoking—for patients with coronary heart disease (CHD).

"Many studies have found that depression predicts increased mortality [for patients with heart disease]," Robert Carney, Ph.D., a panel member and a professor of psychiatry at Washington University School of Medicine, stated during an interview with Washington University BioMed Radio. "But this was the first time that it was formally done, in this way, by the American Heart Association."

According to the AHA, an estimated 15.4 million U.S. adults have CHD, and approximately 20 percent of patients hospitalized for CHD meet criteria for a *DSM* diagnosis of major depression.

"There is growing recognition among cardiologists that psychosocial factors are associated with [negative cardiac] outcomes," commented Judith Lichtman, Ph.D., M.P.H., lead author and cochair of the National AHA Writing Committee. Lichtman, who is an associate professor at the Yale School of Public Health, said that the goal of the panel was to review studies to evaluate the evidence linking the risk of depression on outcomes for patients with CHD.

The panel was charged with sifting through more than 1,000 studies that indicated an association between depression and CHD. A total of 53 studies were selected for review that met the following inclusion criteria: a prospective design, more than 100 patients were included, established assessment instruments were used to define major depression or depressive symptoms, and nonfatal cardiac events and all-cause mortality, cardiac mortality, or a combination of both were reported. Studies that did not have a nondepressed comparison cohort were excluded.



Sylvia Johnson

Darrel Regier, M.D., former APA director of research, discusses APA's involvement with the AHA's recommendation to consider depression as a major risk factor for heart disease.

After years of evaluating the selected studies, the panel issued the following scientific statement: "Our review identified heterogeneity in the published findings from these studies in terms of the demographic composition of the samples, the definition and measurement of depression, [and] the length of follow-up. . . . Despite this heterogeneity, the preponderance of evidence supports the recommendation that the AHA should elevate depression to the status of a risk factor for adverse medical outcomes in patients with acute coronary syndrome."

The former head of the APA Office of Research, Darrel Regier, M.D., who is now an APA consultant, said he is pleased with the AHA panel's recommendation. "The integration of mental health with the rest of general medicine is illustrated by this linkage between depression and cardiovascular disease," Regier told *Psychiatric News*. "I am glad that the AHA is making another step to elevate depression to a major risk category for cardiovascular disease."

Regier explained that in 2008 APA was asked by the AHA to endorse a scientific manuscript concerning the impact for depression on heart disease, which was intended to initiate the process to highlight depression as a risk factor in cardiovascular disease. After publication of the manuscript and APA's endorsement, the AHA advisory committee decided that there was not enough sound evidence to make such a recommendation.

Shortly after the disappointing news, said Regier, the AHA convened another panel, in which APA was asked to participate. Lawson Wulsin, M.D., a professor of psychiatry and family medicine at the University of Cincinnati, was recommended by APA to sit on the panel.

Regier told *Psychiatric News* that though the extensive literature review conducted by the AHA had many setbacks, the final outcome will definitely payoff for the field of psychiatry.

"The AHA recommendation emphasizes that depression is a whole-body illness. This is very important to consider in terms of future reimbursements for treating depression. It's not just treating a mental health condition; it's also reducing the risk of heart disease." PN

"Depression as a Risk Factor for Poor Prognosis Among Patients With Acute Coronary Syndrome: Systematic Review and Recommendations" is posted at http://circ.ahajournals.org/content/early/2014/02/24/CIR.0000000000000019.full.pdf+html.

Familial Mental Illness Risk Cuts Across Disorders

Based on meta-analysis findings, the familial risk of mental illness appears to be "alarmingly high." Thus, the offspring of parents with mental illness may need help with developing resilience.

BY JOAN AREHART-TREICHEL

A new meta-analysis of familial mental illness risks shows that children in a family where members have a history of serious mental illness appear to be at elevated risk of developing a mental disorder by the time they are adults.

The most important finding from the analysis, said lead researcher Rudolf Uher, M.D., in an interview with *Psychiatric News*, "is that familial risk cuts across disorders. . . . When we look at all types of mental illness, the risk is alarmingly high." Uher is an assistant professor of psychiatry at Dalhousie University in Canada.

A key clinical implication of the findings, he added, is "that family history of mental illness is important. We should urgently look into how we may help the sons and daughters of parents with mental illness develop resilience."

Uher and his colleauges included in their meta-analysis 33 well-conducted studies on the risk of mental illness in the offspring of individuals with a lifetime history of one of three types of mental illness—schizophrenia or nonaffective psychosis, bipolar disorder, or major depressive disorder. The meta-analysis included 7,021 offspring—3,863 offspring of a parent with one of these three disorders and 3,158 offspring of mentally healthy parents matched on demographic characteristics.

The children of parents with a lifetime history of schizophrenia, bipolar disorder, or major depressive disorder had about a 1 in 3 chance of developing one of these illnesses themselves by adulthood, the researchers found. The risk was more than twice that for control offspring.

Furthermore, compared with control offspring, the offspring of parents with one of the three mental disorders were almost four times more likely to have the same disorder as their parent and almost twice as likely to have one of the two other disorders assessed in the study.

The researchers reported their findings in the January *Schizophrenia Bulletin.* The research was funded by the Canadian Institutes of Health Research, the Nova Scotia Health Research Foundation, the European Commission, the Dalhousie Clinical Research Scholar Program, and Genome Quebec. PN

An abstract of "Risk of Mental Illness in Offspring of Parents With Schizophrenia, Bipolar Disorder, and Major Depressive Disorder: A Meta-Analysis of Family High-Risk Studies" is posted at http://schizophreniabulletin.oxfordjournals.org/content/40/1/28.abstract.

CLINICAL & RESEARCH NEWS

APA Fellow

continued from page 5

is, becoming the U.S. surgeon general? "Who knows? During the next five or 10 years," she estimates.

Mattox strongly encourages her colleagues to apply for the fellowship. "It gives you an insider's look at Capitol Hill," she emphasized. "The relationships you make are invaluable for a number of reasons, and not just because of job opportunities. You meet people who are experts in other fields, and they bring a lot of depth and experience. The fellowship also helps you understand how to get things done on a policy level to advance patient health care," she said.

"It's a once-in-a-lifetime opportunity to influence national policy for your patients." PN

In a video interview, Rhonda Mattox, M.D., discusses several of the lessons she has learned from her APA Jeanne Spurlock, M.D., Congressional Fellowship. To view the interview, go to http://www.youtube.com/watch?v=uZlyaGMG5LU&list=UUAPLZ4LG-XJgNSB43MbCLRg or scan the QR code. For information about applying for a Jeanne Spurlock, M.D., Congressional Fellowship, contact Marilyn King in the APA Division of Diversity and Health Equity at (703) 907-8653 or mking@psych.org.

CLINICAL & RESEARCH NEWS

Indoor Tanning Linked With Other Risky Behaviors in Teens

Indoor tanning is common among U.S. high school students and is linked with increased drug use, daily smoking, and suicide risk.

BY JOAN AREHART-TREICHEL

Indoor tanning is common among America's teens and is often accompanied by other risky health behaviors, according to a study published online February 26 in *JAMA Dermatology*.

The study was headed by Gery Guy Jr., Ph.D., a health economist at the Centers for Disease Control and Prevention (CDC).

Indoor tanning is associated with an increased risk of skin cancer, including

CLINICAL & RESEARCH NEWS

melanoma, and the risk increases with the frequency of indoor tanning and is more severe when the tanning begins at younger ages. Thus Guy and his colleagues decided to examine the prevalence of indoor tanning among America's youth and to determine whether it might also be associated with other risky health behaviors.

In 2009, and again in 2011, the CDC conducted a Youth Risk Behavior Survey. Each survey used a nationally representative sample of approximately 15,000 U.S. high school students. Both surveys contained questions about risky health behaviors, including one about indoor tanning. Indoor tanning was defined as having used an indoor tanning device one or more times during the year preceding the survey. Frequent indoor tanning was defined as having used an indoor tanning device 10 or more times during the same period. The researchers used results of the two CDC surveys for their study.

They found that 16 percent of the 2009 survey respondents and 13 percent of the 2011 survey respondents had engaged in indoor tanning, and among the students who engaged in indoor tanning, more than half reported frequent use.

Moreover, the prevalence of indoor tanning by the high school students varied by geographic region, with low-

*see **Tanning** on page 20*

CLINICAL & RESEARCH NEWS

Tanning

continued from page 19

est use in the West and highest use in the Midwest.

When evaluating gender differences, they found that the prevalence of indoor tanning was significantly greater among female students, with the highest prevalence among females aged 17 or older. Yet among both male and female students, indoor tanning was significantly associated with other risky health behaviors, such as binge drinking and unhealthy weight control practices. In addition, indoor tanning among female students was associated with illegal drug use and having had sexual intercourse with four or more partners. Use among male students was associated with daily cigarette smoking and taking steroids without a physician's prescription.

Also of note, attempted suicide was associated with indoor tanning among male students. The reasons why are not clear, although the researchers noted that previous research has "shown a relationship between indoor tanning among males with body dissatisfaction issues, especially those who have been bullied."

"This study highlights that indoor tanning is fairly common in adolescents and can be associated with other high-risk behaviors," Cathryn Galanter, M.D., director of the Child and Adolescent Psychiatry Training Program at SUNY Downstate Medical Center, told *Psychiatric News*. "Child and adolescent psychiatrists and other health care providers should be aware of the high rates of tanning and its association with other high-risk behaviors and should consider inquiring about indoor tanning with their patients."

"This study wisely highlights the likely role that social norms play in shaping risky behaviors, such as indoor and even excessive outdoor tanning, in our culture," said Andrew Gerber, M.D., an assistant professor of psychiatry and a child and adolescent psychiatrist at Columbia University. "More research is urgently needed both to better understand these norms and to develop creative interventions to alter them. The partial, but incomplete, success of interventions on the social norms of cigarette smoking over the past few decades shows how important these can be for public health."

The study was funded by the CDC. PN

An abstract of "Indoor Tanning Among High School Students in the United States, 2009 and 2011" is posted at http://archderm.jamanetwork.com/article.aspx?articleid=1833428.

VA Psychiatrists

continued from page 4

strategy for the VHA to maintain a robust and stable psychiatric workforce." Levin noted as well that APA supports the bill's requirement for a government report to examine pay disparities among psychiatrists at the VHA. "This report is critical for determining how pay disparities negatively affect the stability of VHA's psychiatric workforce," Levin wrote.

In a "Dear Colleague" letter written by Bucshon and Scott to fellow representatives, they urged support for the legislation, saying that a new way of encouraging more psychiatrists to choose a career with the VHA is needed. "We believe this modest legislation promises to identify a critical strategy for the VHA to maintain a robust and stable psychiatric workforce that can serve the acute mental health needs of our nation's veterans," they wrote. PN

HIV in Mental Health Facilities Sometimes Gets too Little Attention

Researchers call for better integration of HIV testing and care in public mental health facilities.

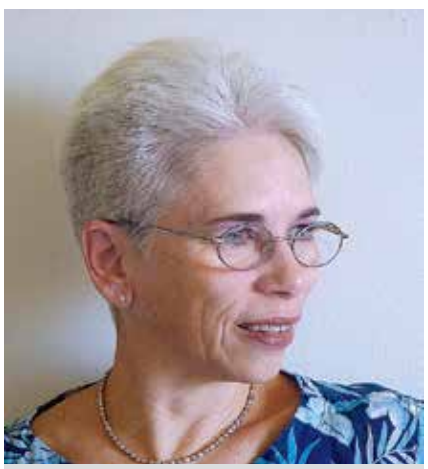
BY VABREN WATTS

Individuals receiving treatment for mental disorders are significantly more likely to be infected with HIV than is the general population.

This is a key finding from to a study published February 13 in the *American Journal of Public Health* led by Michael Blank, Ph.D., an associate professor of psychiatry at the University of Pennsylvania Perelman School of Medicine and a co-director of the Penn Mental Health AIDS Research Center. Blank spearheaded a multisite study with researchers from the University of Maryland and the Centers for Disease Control and Prevention (CDC) to evaluate the prevalence of HIV among patients receiving care at mental health facilities.

In an interview with *Psychiatric News*, Blank stated that it was as a graduate student, more than 20 years ago, when he observed the lack of psychiatric disorders being diagnosed in primary care settings, as well as the dearth of primary health care services available in facilities specializing in mental health care. "Since that time, we haven't made much progress in care for people with complex co-occurring conditions such as HIV and mental illness."

According to Blank, previous studies have evaluated the prevalence of HIV infections among those with mental illness, but they reported wide variations in incidence rates, ranging from 1 percent to 23 percent.



Francine Cournos, M.D., believes that mental health facilities should offer voluntary HIV testing to ensure that patients with mental illness who test positive for HIV are linked to adequate care for their HIV diagnosis.

"Most studies of HIV prevalence among persons with mental illness were limited by the use of a single convenience sample, which caused the prevalence estimates from those studies to vary widely," Blank explained. "While our study also used samples of convenience, we were systematic in including a large number of treatment sites and feel as though we were rigorous in representing a significant amount people receiving mental health care across multiple facilities."

In the current study, Blank and colleagues administered HIV tests to more than 1,000 patients who were being treated for symptoms of depression, psychosis, or substance abuse at 10 inpatient psychiatry units, community mental health centers, and community management programs throughout Baltimore and Philadelphia from January 2009 to August 2011. Psychiatric symptoms were measured by the 24-itiem Behavior and Symptom Identification Scale (BASIS-24). Mental illness diagnoses were based on *DSM-IV* criteria.

Results revealed that 51 of the patients (4.8 percent) receiving treatment for mental illness were infected with HIV, approximately four times the rate for the general public in each city and 16 times the rate for the general U.S. population. In addition, 13 of the 51 individuals reported they were unaware of their HIV status. Rates were higher in those who reported homelessness and in those who reported co-infection with hepatitis C.

"These findings paint a recent picture of HIV infection rates in the community and reinforce how important it is to identify patients. . .in a timely manner while they are being treated for mental illness," commented Blank.

Francine Cournos, M.D., a professor of clinical psychiatry at Columbia University and an expert in HIV disease, agreed. Cournos told *Psychiatric News* that the current findings expose the lack of HIV testing being provided to individuals by mental health professionals, despite recommendations from the CDC to offer voluntary HIV testing in all health care facilities—including those providing mental illness treatment.

"Psychiatrists should ensure that patients who test positive for HIV are linked to adequate HIV care, retained in care, and begin needed treatment," Cournos emphasized.

As for Blank, he told *Psychiatric News* that he and his colleagues have recently developed an intervention program, Preventing AIDS Through Health (PATH), that is individually tailored for people with comorbid HIV infection and mental illness.

"The observation that the current health care system is fragmented, costly, and ineffective has been voiced far too often over many decades. It is time to integrate health care such that health and mental health services are more commonly available to everyone," Blank stated.

The current study was funded by the CDC, National Institute of Mental Health, and National Institute of Allergy and Infectious Diseases. PN

Africa Studio/Shutterstock

An abstract of "A Multisite Study of the Prevalence of HIV With Rapid Testing in Mental Health Settings" is posted at http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301633?journalCode=ajph.

Integrated Care

continued from page 12

and they uncovered loads of untreated medical problems. I started looking into interventions to address those problems, meeting with primary care doctors, and we started to have more joint arrangements across our public health system."

In 2011, Cabaj began to put together a table of interventions for substance abuse with information on side effects and how medications should be used and under what conditions. Additionally, primary care physicians in the San Mateo public-health system received training in the management of behavioral health conditions—for instance, how to treat chronic pain in the context of substance abuse, how to prescribe medications for ADHD in a way that avoids potential for addiction, and how to use benzodiazepines safely and taper medications when needed.

The effort is producing exciting results, he said. A recent follow-up of 10 patients with severe alcoholism and two or more emergency department visits in the prior month found that treatment with once-a-month injectable naltrexone dramatically reduced craving and increased the number of days of abstinence—while also decreasing overall medical utilization.

Cabaj said that in the initial phase of the pilot, emergency room use practically disappeared, from an initial average of 5.8 visits per client in six months, down to 0.2 visits. In an article on the CIHS website, Cabaj noted that this dramatic reduction shows an evident cost benefit.

"The cost of the medication may be high (for Medicaid clients, the medication costs around $750 per month and exceeds $1,000 per month at retail), but if you can eliminate six ER visits in six months, you save more than enough to cover the cost of the medications," Cabaj wrote. "In addition to the reduction in emergency services, we have also seen a decrease in the drinking days of participants, and many participants have been able to switch to less expensive oral medication over time."

Cabaj said that the effort is in keeping with the "triple aim" of accountable care and health care reform—improved outcomes, better patient satisfaction, and lower costs—and he said the successful management of substance abuse allows patients, whether they are seen in primary care clinics or public mental health clinics, to focus on improving overall health

"We started this program as part of our total wellness program, including diet, smoking cessation, and exercise," he said. "Without the burden of substance abuse, our patients can work on their overall health." PN

The MAT guidelines developed by Cabaj for use in San Mateo County are posted at http://www.integration.samhsa.gov/San_Mateo_SUD_Medication_Guidelines_2-13_-1-.pdf. The CIHS articles on MAT are posted at http://www.integration.samhsa.gov/about-us/esolutions-newsletter/e-solutions-february-2014.

MED CHECK

BY VABREN WATTS

Company Moves Forward With Trials for New Antidepressant

Last month, Alkermes announced the initiation of FORWARD (Focused On Results With A Rethinking of Depression), a series of phase 3 clinical trials for ***ALKS 5461***, a once-daily, novel opioid receptor modulator as a potential adjunctive treatment for major depressive disorder (MDD).

The first FORWARD study, evaluating the safety and tolerability of ALKS 5461 in approximately 60 patients with MDD, has already begun, and three core efficacy studies—randomized, controlled trials with approximately 1,500 patients—are expected to begin by this summer. Completion of the FORWARD program will include 12 studies, three efficacy studies, and nine supportive studies, the company noted.

In October 2013, the Food and Drug Administration granted Fast Track status to the development for ALKS 5461 as an additive therapy to standard antidepressants in patients with MDD.

U.S., Japanese Firms Partner On Alzheimer's Treatment

Biogen Idec and Japan-based Eisai have agreed to develop and commercialize potential therapies to reduce accumulation of amyloid-beta plaques in the brains of patients with Alzheimer's disease (AD). The drugmakers will co-develop ***E2609***, a drug that blocks the conversion of amyloid precursor protein to amyloid-beta, and ***BAN2401***, an antibody that uses the body's immune system to suppress the progression of amyloid-beta plaques.

Eisai will serve as the regulatory lead in the codevelopment of both drugs. Eisai and Biogen Idec will also co-promote the products once marketing approval has been granted by U.S. and European regulatory bodies. The two companies will share research and development expenses and future revenue.

Biogen Idec CEO George Scangos, Ph.D., said that the new collaboration is a "natural fit" for Biogen, which has a strong focus on patients with neurodegenerative disease. "Eisai is a pioneer in successfully developing and commercializing AD treatments. This history, combined with their strong scientific heritage, geographical reach, and unwavering commitment to the AD community, makes Eisai an excellent collaboration partner to help drive our mission."

Two Multisite Alzheimer's Clinical Trials Started

The Alzheimer's Disease Cooperative Study announced the spring launch of two new clinical trials to combat AD.

The first project, the Study of Nasal Insulin to Fight Forgetfulness (SNIFF), is a research effort led by Suzanne Craft, Ph.D., research director of the J. Paul Sticht Center on Aging at Wake Forest School of Medicine, to determine if a type of insulin, when administered nasally, improves memory in adults aged 55 to 85 who have mild cognitive impairment or AD. According to Craft, insulin resistance, reduced cerebrospinal fluid insulin levels, and reduced brain insulin signals have been found in AD patients, suggesting that a therapy aimed at correcting these deficiencies may be beneficial.

The Anti-Amyloid in Asymptomatic AD (A4) trial is a prevention study led by the director of the Center for Alzheimer Research and Treatment at Brigham and Women's Hospital, Reisa Sperling, M.D. The study plans to target individuals aged 65 to 85 who have normal cognitive function but may be at risk for developing AD due to the detection of amyloid-beta accumulation by a diagnostic test scan. The participants will be given Eli Lilly's s***olanezumab***, a drug currently being studied to clear amyloid-beta in the brain.

The A4 and SNIFF trials will be conducted at multiple institutions including the University of California, San Diego; University of Alabama, Birmingham; and Johns Hopkins University School of Medicine. Researchers on the two studies plan to recruit more than 10,000 participants. The SNIFF and the A4 trials are funded by the National Institute on Aging.

First Inhaled Antipsychotic Launched in U.S.

In March, Teva Pharmaceutical Industries announced the commercial launch of ***Adasuve*** (***loxapine)***, the only orally inhaled medicine available in the United States for the acute treatment of agitation associated with schizophrenia or bipolar I disorder in adults.

The delivery mechanism for the aerosol version of loxapine—a first-generation antipsychotic—will be through the Alexza Pharmacuetical's ***Staccato*** inhaler, which will allow the maximum concentration of loxapine to saturate the blood in two minutes, the company noted.

Efficacy for Adasuve was demonstrated in two clinical trials with patients with acute agitation associated with schizophrenia or bipolar I disorder. Results showed a 49 percent reduction in agitation symptoms in schizophrenia patients, compared with 33 percent in those administered placebo, and a 53 percent reduction in bipolar I patients, compared with 27 percent with placebo. Improvements in agitation were significantly reduced two hours after exposure, with some improvements witnessed 10 minutes after dosing.

Because of the risk for bronchospasm, Adasuve is contraindicated for individuals with a history of asthma, chronic obstructive pulmonary disease, or other pulmonary disease.

Pfizer Recalls Certain Venlafaxine Lots

On March 6, Pfizer voluntarily recalled one lot of 30-count ***Effexor XR*** (***venlafaxine HCl***) 150mg extended-release capsules, one lot of 90-count Effexor XR (venlafaxine HCl) 150 mg extended-release capsules, and one lot of 90-count Greenstone LLC-branded venlafaxine HC1 150 mg extended-release capsules.

Pfizer chose to recall the lots because a pharmacist reported that one bottle of Effexor XR contained one 0.25 mg capsule of ***Tikosyn*** (***dofetilide***), a drug used to treat irregular heartbeat.

The use of Tikosyn by a current user of Effexor XR/venlafaxine could result in serious adverse health consequences such as abnormal heartbeats and even death, according to Pfizer.

Recalled lot numbers are V130142 and V130140, which both expire in October 2015, and Greenstone lot number V130014, which expires in August 2015. PN

Residents' Forum

continued from page 12

our notions of the practice of psychiatry are more fluid, and linkages with colleagues from medical school more palpable, that less-experienced clinicians are more apt to embrace new models of mental health care delivery, such as the shift to integrated and collaborative care that is now under way.

To be sure, I'm speaking generally—there are significant exceptions everywhere—but if engaged early enough, before traditional notions of psychiatric practice solidify, and with the right incentives and mentorship in place, I've found that practicing in integrated care settings has wide appeal among trainees interested in working within teams and assigning their expertise across populations of patients.

While most residents don't see working in collaborative care—meeting with a care manager and reviewing a caseload of patients to identify those most in need of attention and communicating management recommendations to primary care physicians—a full-time job, some do. Practice systems that have embraced reimbursement for collaborative care consultation and time, such as those in Washington state and Minnesota, and that offer education and mentorship experiences in integrated care, are filling positions and redefining what it means to practice as a psychiatrist.

APA, through the leadership of Lori Raney and others, has developed the capacity to disseminate the necessary skills for practicing in collaborative care settings and is working passionately to provide those opportunities to members, but there's a feeling that the workforce is slow to embrace new models of care.

The challenge to building workforce capacity in integrated care isn't garnering interest or necessarily overcoming payment reform—it's reaching us early enough to alter our career trajectory so that it encompasses a broader vision for psychiatry in the 21st century. It's providing a chance to work in a collaborative care setting early in residency, or even medical school clerkships, and supplying a model of innovative psychiatric practice that is as rewarding as our traditional models before preconceptions about professional identity take root.

It is not to say that the more experienced workforce is incapable of practice evolution, it's just that we should focus more resources on training to the components of the health care system most likely to change and commit to integrating these evidence-based models into every postgraduate training experience. With the right incentives, experiences, and opportunities in place, we can radically reshape the course of our profession within the house of medicine, as well as what we've come to expect from a life of service to others. We can lead the pack among all medical specialists who share similar concerns with chronic disease management and primary care integration. We can navigate the turbulent period of health care reform by trusting in the models we've created to deliver effective care across the entire population and secure our practice and our specialty for future generations. As I embark on a career in mental health care, I couldn't ask for anything more. PN

Violence

continued from page 1

committed by people with mental illness," said Insel in his keynote address. "People with untreated psychotic illness are at increased risk of irrational behavior, including violence, especially directed at family and friends. This usually happens at the onset of illness and before diagnosis or treatment. However, once treatment starts, these people have no higher risk of violence than the general population and are more often victims of crime."

Homicide rates have declined dramatically (from 9.8/100,000 to 4.8/100,000) over the last two decades, Insel noted. Mass shootings are still rare events, however, compared with the ordinary daily toll of violence.

"There were 32 dead at Virginia Tech, but there are also 32 suicides a week today on college campuses," Insel pointed out. "We should be more concerned with suicide. Violence is more often self-directed."

There are 38,000 suicides per year in the United States, compared with 14,000 homicides. Ninety percent of the suicides are committed by people with a mental illness, compared with just 5 percent of the homicides, he said.

Suicide may outweigh homicide as a cause of violent death, but its prevalence is very likely underestimated, said Eric Caine, M.D., a professor and chair of psychiatry at the University of Rochester and co-director of the Center for the Study of Prevention of Suicide at the University of Rochester Medical Center.

"Self-poisoning with opiates or alcohol has skyrocketed," said Caine. "We call them 'unintentional,' but we don't know how to determine intent."

Caine presented county-by-county maps of the United States showing the geographic and cultural patterns of violent death. Homicide is a more urban phenomenon, while suicide has a more rural distribution, overlapping strongly with motor-vehicle injuries and those unintentional poisonings, he noted.

"How you end up dying is less the issue than how you get to dying," he said. "Some people die one way, some people die another way, but they may share many common risks."

Those common risks include early childhood adversity, exposure to trauma, and family and community turmoil, he said. "So we need to start working early with families and children and communities."

How preventable is violence?

"Both homicide and suicide are difficult to predict on the individual level," said Insel. "Means restriction works, and treatment can reduce violence, especially suicide."

The nation also could do a better job of caring for people with untreated psychosis, he said. Now it takes about 110 weeks to get someone into treatment, a figure Insel would like to cut to 12 weeks, in part by detecting prodromes and intervening early.

In addition, better public-health surveillance, better tools for prevention, and better individual predictors of risk and resilience would help reduce suicide, he said.

More research within the field will help, but so will broader educational efforts. "The fear of those with mental illness confounds the assessment of risk, but early detection and early treatment can reduce risk," Insel stated.

"We need to bring this issue to the public with passion, clarity, and data," said Rosenberg. "Keeping science in the forefront will not be easy, but when people understand, they can bring about change." PN

More about the IOM workshop, "Mental Health and Violence: Opportunities for Prevention and Early Intervention," is posted at http://www.iom.edu/Activities/Global/ViolenceForum/2014-FEB-26.aspx.

From the President

continued from page 3

levels. Step up and make your thoughts known to health care and government leaders; most are willing to listen if we offer ideas and solutions.

The health care reform process is under way; the world will be changing around us. If psychiatrists are engaged in influencing that change—if we take a more active role—then we are more likely to be satisfied with the end result. This may be our most important role of all. PN

You can follow Dr. Lieberman on Twitter at @DrJlieberman. To do so, go to https://twitter.com/DrJlieberman, log in or register, and click on "Follow."

HHS

continued from page 4

the federal mental health prohibitor; rather, one must be legally adjudicated by a federal, state, county, or military court or similar body as being in one of the categories above to fall within this NICS prohibitor category, he said.

"The HHS proposal was motivated by concerns in some quarters that reporting persons who met the federal criteria for being barred from gun possession because of a mental health–related adjudication (such as court-ordered involuntary commitment) might conflict with HIPAA's privacy rule," Appelbaum said. "Although it was never clear that this was a real problem, the proposed rule would allow reporting of limited information by entities that conduct the adjudications or are repositories of relevant information. These would include courts and public agencies; psychiatrists and other treaters are not in the position of needing to report under this rule."

Importantly, however, nothing in federal law prohibits individual states from enacting statutes requiring providers to report to NICS the identities of some individuals with mental disorders—as has happened in Illinois (see box on page 4). Moreover, states can additionally create their own mental health prohibitors through the enactment of state statutes that have a lower threshold than the adjudication or involuntary commitment presently required for reporting an individual to NICS under the federal mental health prohibitor.

In the letter to the OCR, Levin emphasized that APA opposes involving physicians or other treating providers in NICS reporting. "NICS reporting is best handled by the judicial system, which performs the adjudications," he said. "Where NICS reporting is performed by a HIPAA-covered entity, we agree reporting should be confined to state health agencies that are the lawful authorities in a given state to perform adjudications or state offices that serve as clearinghouses for information arising from the adjudication.

"We strongly oppose any state law that would require treating providers to report to NICS the identities of persons suffering from mental illness," Levin wrote. "Consequently, we have strong reservations about expanding the newly created express reporting permission to apply to states. It would be much too easy for states to enact a statute expanding the definition of HIPAA-covered entities expected to, or required to, report to NICS so as to include treating providers. Additionally, there is nothing to stop a state from enacting its own mental health prohibitors, which do not meet the heightened threshold of 'committed to a mental institution' or 'adjudicated as a mental defective' as defined in federal statute and federal regulations and which must be met to report individuals under the federal 'mental health prohibitor.' "

Appelbaum said putting psychiatrists in the position of reporting individuals to NICS threatens the psychiatrist-patient relationship by putting them in a law enforcement role. "Clinicians should not be compelled to report directly to the NICS, and HIPAA should not be modified to facilitate changes that will only drive away from treatment the patients who may need it most," Appelbaum told *Psychiatric News*. "There are many more effective ways to protect public safety."

Clements said state laws that would mandate treating providers to report individuals with particular diagnoses to NICS—rather than be able to use their clinical discretion with respect to what personal health information about a patient they disclose—arguably contradict clinicians' rules of ethics and complicate their capacity to adhere to the standard of care legally required of their profession. PN

APA's letter to the Office of Civil Rights is posted on the APA website.

Caucus

continued from page 6

therapy by psychiatrists.

Former APA President John Oldham, M.D., called the caucus a "good idea" and said it can help to keep the Association—and training programs around the country—stay focused on the value of psychotherapy in the skill set of psychiatrists.

Oldham said in the burgeoning movement toward integrated care, psychiatrists who bring together the skills of psychotherapy and knowledge about the effects of medicine and about general medical care can have a powerful role in a reformed health care system.

"Many patients with medical problems—diabetes, heart disease, and other conditions—have significant co-occurring mental disorders," Oldham said. "Psychiatrists who do psychotherapy and can also speak the language of general medical care with primary care colleagues will bring a valuable talent to integrated care networks." PN

Members interested in the Psychotherapy Caucus can contact Plakun at Eric.Plakun@AustenRiggs.Net.

CMS

continued from page 1

man called "his vigorous actions to support psychiatrists and patients with mental illness." In a hearing on the proposal, Murphy had quoted from APA's extensive comments to the administration protesting the proposal and urged the administration to reconsider the proposed rule.

In a March 7 letter to Tavenner, CEO and Medical Director Saul Levin, M.D., M.P.A., outlined a wide range of problems with the administration's reasoning in its proposal with regard to drug selection and interchangeability of drugs, variability of patient response to drugs, problems related to side effects and adherence, and cost concerns, among many others.

The letter especially protested what it called the administration's selective reading and misinterpretation of APA's treatment guidelines on a variety of points, but particularly with regard to what the administration claimed as the "interchangeability" of drugs.

"In the Preamble to the proposed rule, CMS selectively quotes APA's practice guidelines, arguing they support the concept that antidepressants are interchangeable, when, in reality, the practice guidelines state the opposite conclusion," Levin wrote.

CMS had quoted the 2010 Practice Guideline for the Treatment of Patients With Major Depressive Disorder as saying that "the effectiveness of antidepressant medications is generally comparable between classes and within classes of medications."

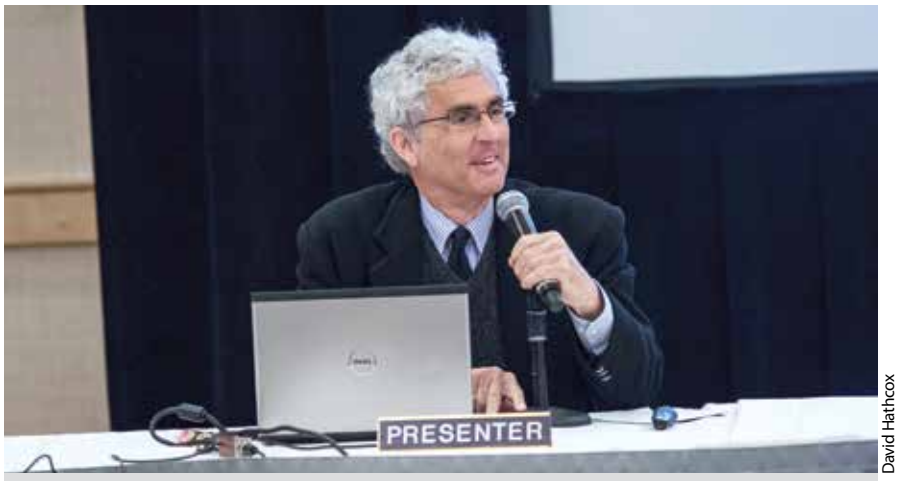
But Levin pointed out that "this sentence fragment is taken out of context and ignores this practice guideline's strong recommendation that the evidence for effectiveness is only one factor that must be considered when choosing an antidepressant for an individual patient. If the sentence is cited completely, it clearly indicates that the choice of antidepressant is a complex decision that must take into consideration multiple other factors besides a drug's effectiveness for symptom control, including its side effects, safety, and tolerability for an individual patient."

Levin wrote, "It is fundamental to the mission of APA to promote scientific inquiry and evidence-based approaches to the treatment of mental illnesses and to ensure that policy is based upon the scientific evidence available. The proposed rule misrepresents the content of the practice guidelines, is not based upon reliable clinical evidence or data, and is a major public-policy change by the Centers for Medicare and Medicaid Services that will impede access to clinically appropriate pharmaceutical treatments for mental illness. As such, this proposed rule cannot stand."

Following the withdrawal of the proposal last month, Levin said the administration had done the right thing.

"We are pleased to see that CMS recognized the potential harm inherent in its proposal to remove the protections currently afforded to antidepressant and antipsychotic medications in Medicare Part D," Levin told *Psychiatric News*. "This is the right decision for Medicare beneficiaries, who will now retain access to these valuable medications." PN

The letters sent by APA in opposition to the proposed rule can be accessed at http://www.psych.org/advocacy--newsroom/advocacy/cms-proposed-rule-to-eliminate-choice-for-individuals-with-mental-illness. Tavenner's letter is posted at http://capsules.kaiserhealthnews.org/wp-content/uploads/2014/03/Tavenner-Part-D.pdf#page=1&zoom=auto,0,800.



David Hathcox

Howard Goldman, M.D., updates the Board of Trustees on the initiatives that the work group he chairs is developing to help psychiatrists respond and adapt to the rapid changes that are occurring in the health care system as a result of the Affordable Care Act.

Board

continued from page 6

use when working with state advocates seeking to amend state Medicaid plans affecting people with mental illness.

Goldman said that the work group is also nearing completion of a white paper that will provide an overview of quality measures and how they will affect psychiatric practice as the health care system evolves.

Other Actions

In other actions it took at its March meeting, the Board of Trustees voted to

- join several other medical societies in endorsing the nomination of Vivek Murthy, M.D., to be the next U.S. surgeon general. Murthy is a hospitalist at Brigham and Women's Hospital in Boston and Harvard Medical School and co-founded Doctors for America, an organization of physicians and medical students that advocates for access to affordable, quality health care. After being nominated by President Obama, he was approved by a key Senate committee, but last month his nomination ran into trouble when Republicans mounted opposition based on Murthy's strong support of the Affordable Care Act, and the powerful National Rifle Association vowed to sink the nomination because of his strong support of gun-control legislation.

- appoint a work group to, with the assistance of APA staff, "evaluate options regarding [APA] endorsement of liability insurance companies."

- change the name of two APA components. The Council on Global Psychiatry will become the Council on International Psychiatry, and the Caucus on Alternative and Complementary Medicine will become the Caucus on Complementary and Alternative Medicine, to mirror the terminology used by the National Institutes of Health, which has a center studying this issue. PN

Court

continued from page 13

surement that is inherent in IQ tests, it is universally accepted that persons with obtained scores of 71 to 75 can, and often do, have mental retardation when those three prongs are met," argued Hall's attorney, Seth Waxman, at the March 10 hearing. "If a state conditions the opportunity to demonstrate mental retardation on obtained IQ test scores, it cannot ignore the measurement error that is inherent in those scores that is a statistical feature of the test instrument itself."

APA joined with other mental health organizations in filing an amicus curiae brief with the Court on Hall's behalf.

"We are saying that if a state relies on some definition of mental illness or intellectual disability, then that definition should reflect current research and current thinking," said Colleen Coyle, J.D, APA's general counsel. That definition requires more than just a pass/fail grade on an IQ test.

APA's position calls for not only recognizing the standard error of measurement but for applying all three criteria—IQ, functionality, and age of onset—in the context of a full evaluation of the person facing execution.

"Using a single IQ score goes against how we think about intellectual disability," said Richard Frierson, M.D., a professor of psychiatry at the University of South Carolina School of Medicine and director of its forensic psychiatry fellowship. Frierson was not involved in the Hall case.

"It is possible to diagnose a person with an IQ score above 70 but who has difficulties with adaptive functioning—their ability to care for themselves or live independently," said Frierson, in an interview with *Psychiatric News*.

"The oral argument underscored the differing perspectives with respect to the death penalty," said APA Treasurer David Fassler, M.D., a clinical professor of psychiatry at the University of Vermont. "A majority of the justices seemed skeptical of the limitations imposed by the current Florida law. The prevailing view was that judges and juries should have access to as much information as possible when considering whether or not a defendant is eligible for the death penalty."

APA and other mental health organizations and advocates may have more work ahead of them, regardless of the Court's decision, which is expected later this spring.

"We must better educate judges and lawyers about the role of adaptive functioning to remind them that this is a gray area, not one that is simply black and white," said Frierson. "There are still so many disparities regarding persons on death row with mental illness and intellectual disability, and it will be interesting to see if the Court takes them up in the future." PN

A transcript of oral arguments to the Supreme Court in *Hall v. Florida* is posted at http://www.supremecourt.gov/oral_arguments/argument_transcripts/12-10882_7758.pdf. The amicus brief filed by APA can be accessed at http://www.psychiatry.org/learn/library--archives/amicus-briefs.