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PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

ISSN 0033-2704

Glenn O'Neal

Last month APA President Renée Binder, M.D. (second from left), led a congressional briefing on the criminalization of mentally ill people in the United States. Also speaking at the briefing were (from left) Rich Stanek, sheriff of Hennepin County, Minn.; Robert Trestman, M.D., Ph.D., executive director of correctional managed health care at UConn Health; APA CEO and Medical Director Saul Levin, M.D., M.P.A.; Mary Ann Borgeson, chair of the Douglas County Board of Commissioners, Nebraska; and Ron Honberg, national director for policy and legal affairs at the National Alliance on Mental Illness. See page 19. Related articles are on pages 8 and 14.

Psychosocial Treatments Found Effective for Early Psychosis

Patients who received comprehensive specialty care remained in treatment longer, experienced greater improvement in quality of life and psychopathology, and more.

BY MARK MORAN

First-episode psychosis patients who participated in a comprehensive, team-based treatment program at community clinics that included a combination of medication and psychosocial support experienced significant improvements in symptoms and quality of life compared with those receiving usual care.

That's the finding from a landmark study—the NIMH-funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative—that was published on October 18 in *AJP in Advance*. Importantly, the study also found that the best results were for patients who had shorter durations of psychosis, underscoring the importance of early intervention.

"The most important implications are that patients with early-stage psychotic illness will benefit most from a comprehensive specialty care model," said lead study author John Kane, M.D., chair of the psychiatry department at Hofstra North Shore-LIJ School of Medicine, in an interview with *Psychiatric News*. "That implies that the presence of a multidisciplinary team can help patients achieve their goals by providing a consistent array of treatments, including pharmacotherapy, individual psychotherapy,

see **RAISE** on page 26

APA Election Season Begins With Announcement of Candidates

APA 2016 ELECTION

APA members can begin considering whom they want to represent them on the Board of Trustees beginning next May now that the roster of candidates running in the 2016 election is set.

BY KEN HAUSMAN

The slate of psychiatrists chosen to compete for APA Board of Trustees positions provides members with the opportunity to choose among experienced psychiatrists from a broad range of specialties, practice settings, and geographic areas who have made their mark in the field.

Heading the list are Frank Brown, M.D., of Stone Mountain, Ga., and Anita Everett, M.D., of Glenwood, Md., who are seeking to become the next president-elect of APA.

Frank Brown, M.D.

Anita Everett, M.D.

Brown noted that he has been involved with APA since 1989, serving on 21 committees, councils, and the Board of Trustees, including being APA treasurer, chair of the Finance and Budget Committee for four years, and chair of the Board Work Group on Real Estate. His involvement has been primarily in the areas of finance, aging, minority affairs, and telepsychiatry.

Everett indicated that she is division director of community psychiatry and faculty at the Johns Hopkins School of

see **Candidates** on page 28

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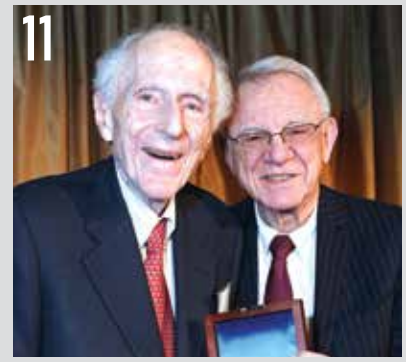

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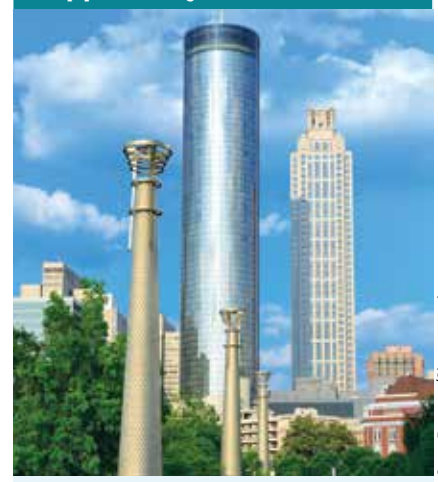
Don't Miss This Exclusive Opportunity!



Sean Pavone/Shutterstock

APA members will have an exclusive opportunity to register, enroll in courses, and make hotel reservations for APA's 2016 annual meeting in Atlanta from **Tuesday, December 1, through Monday, December 14.** Nonmembers will have access beginning Tuesday, December 15. The meeting runs from May 14 to 18. To access the annual meeting website, go to www.psychiatry.org/annualmeeting. More information is available by calling the APA Meetings and Conventions Department at (703) 907-7822 or by emailing registration@psych.org.

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FROM THE PRESIDENT

Mental Health Courts: An Effective Alternative to Incarceration

BY RENÉE BINDER, M.D.

One way to decrease the number of mentally ill people who are incarcerated is through diversion programs such as collaborative courts where defendants are offered treatment as an alternative to incarceration.

In October, while attending the annual meeting of the American Academy of Psychiatry and the Law, other forensic psychiatrists and I visited the mental health court in Broward County, Fla. Established in 1997, it was one of the first mental health courts in the United States. Judge Ginger Lerner-Wren is a dynamic, energetic judge who has presided over the court since its inception. In the court session I attended, she heard from seven clients who had been arrested for crimes such as disturbing the peace, trespassing, assault on police officers, solicitation for prostitution, and petty theft. All of the clients had a mental disorder diagnosis, and most had a co-occurring substance use disorder.

Although Judge Lerner-Wren wore her black robe, she interacted with her clients in a supportive rather than judgmental manner. She made comments about one client's new attractive hair color and about the stylish jeans of another. She said she aims to "build trust," "build self-esteem," and "restore their personhood." One of the clients was struggling with maintaining sobriety and had stopped attending her dual-diagnosis program. "I know this whole process is not easy," Judge Lerner-Wren told her. "I want to appeal to you. Hang in there." When a client was doing well, everyone in the courtroom applauded.

Mental health courts are an example of a postbooking diversion program that diverts a person with mental illness who has been arrested from jail to treatment programs. Participation is voluntary, in the sense that the individual can decline to participate and choose to remain in the traditional court system. If individuals agree to participate, they are linked to services such as case management, therapy, psychotropic medications, substance abuse treatment, and housing.

Mental health courts take a therapeutically oriented approach. They intervene when mentally ill patients have failed community institutions and services. They use a harm-reduction model and try to facilitate treatment adherence. There are now over 300 mental health courts in the United States and the number continues to grow.

An example of another mental health court is the San Francisco Behavioral Health Court (BHC), established in 2002. In the SF BHC, there is a morning conference with the judge; the district attorney; representatives from the public defender's office, jail psychiatric services, probation services; case-management services; and community treatment providers. As in Broward County, the courtroom is open, and the judge speaks directly to clients. Eligibility is based on having a mental illness that is connected to the offense. BHC participants follow a judicially supervised treatment plan that is individualized for each client. Participants attend status hearings, in which the judge may apply various incentives and/or sanctions to encourage adherence to the treatment plan. Incentives may include encouragement and praise from the judge, less restrictive treatment, and eventual reduction or dismissal of the original charges upon graduation from BHC. The SF BHC also uses sanctions. These include admonishment or reprimands from the judge, community service work, increased frequency of court appearances or intensity of treatment, and, most significantly, termination of BHC and return to regular criminal court for adjudication.

Does the mental health court model work? My coauthors and I have done several studies evaluating the BHC in San Francisco (see resources listed at the end of this article). In one retrospective study, we found that when compared with other mentally ill inmates, participants in the mental health court reduced their probability of a new criminal charge by 26 percent and reduced the probability of a new violent criminal charge by 55 percent. In a more recent prospective study, we found that during follow-up, 25 percent of the mental health court group perpetrated violence compared with 42 percent of the control group.

Mr. A (a composite case) is an example of a successful outcome. When he entered mental health court, he was a 45-year-old man who had a diagnosis of schizophrenia and crack cocaine dependence. He had been homeless for years and rarely took his psychotropic medications. He had a long history of

see **From the President** on page 20

Wherever General Medicine Went, Psychiatry Was There First

Experts say that many of the innovations trumpeted as part of the health care reform movement actually arose from psychiatric practice.

BY AARON LEVIN

New models of medical care may owe more to psychiatry than either general medicine or psychiatry may realize, said speakers at IPS: The Mental Health Services Conference in New York in October.

Those big state mental hospitals, now so discredited, may have been the first regional, population-based accountable care organizations, given that they covered all the general medical, dental, and mental health needs of the patients in their catchment areas. However, that broad-based view of psychiatric care declined as biological psychiatry rose, said Vivek Datta, M.D., M.P.H., a PGY-4 at the University of Washington in Seattle.

"The focus on cells and molecules and genes deflected attention from social risk factors or explanations," said Datta. "Outside political pressures transformed 'patients' into 'consumers.' Mental illness was uncoupled from the social environment and moved to the marketplace."

Now, in the Affordable Care Act (ACA) era, there is a return to population health in which Medicaid expansion, parity rules, the elimination of preexisting conditions as a barrier to care, and new models of service delivery are bringing general medical and mental health services to a wider population.

Such changes have also brought greater attention to issues surrounding the health care of people who make exceptionally high use of the medical system ("high utilizers"), many of whom have high rates of mental health problems.

As the ACA leads to more integrated general medical and mental health care, experts hope that this combination will bring improvements in patient adherence and reductions in frequent and costly returns by patients to the clinic or emergency room. By driving down service use, both accountable care organizations and the Medicaid system can benefit from the savings.

In fact, this special attention to high utilizers serves as a reminder that many of the innovations trumpeted as part of the health care reform movement actually arose from psychiatric practice, said Kenneth Thompson, M.D., a clinical assistant professor of psychiatry at the University of Pittsburgh.

Assertive community treatment (ACT) programs were developed decades before the idea was adapted for general medical care, said Thompson. This intervention is a team-oriented model that involves providing services to individuals in the communities in which they live. The ACT model provides services for general medical, mental health, and substance abuse in a coordinated and targeted fashion.

"We gave it to them, but we forgot to tell them," he said. The list of similar uncredited borrowings goes on.

The underfunded community mental health centers antedated Federally Qualified Health Centers, which are well supported on both sides of the Congressional aisle. Also, the case-management approach to treating psychiatric patients recognized early on what are now called the social determinants of health—poverty, housing, and employment, said Thompson. The doctor-patient relationship at the core of primary care today is merely another version of psychiatry's therapeutic alliance.

Aaron Levin

Kenneth Thompson, M.D., says that many of the innovations of the health care reform movement actually arose from psychiatric practice. At left is Vivek Datta, M.D., M.P.H.

In addition, the emphasis on involving patients in their own care reflects psychiatry's recovery model.

"We know that patients have capabilities, not just disorders," he said. "The physician can't help the patient alone. It takes a patient actively involved in self-care to manage long-term, persistent problems."

Finally, the new emphasis on population health and the expansion of public resources is a reminder that psychiatry is the field of medicine whose patients are most dependent on public funding and services because they are often too impaired to participate in the traditional working world, said Thompson.

"Psychiatry itself has not been paying attention to what it is we've been doing relative to what its meaning might be for the rest of medicine," he said. "And there is a legacy we've been leaving behind that is unrecognized." PN

Fellowship Connects Psychiatrists With Patients In Underserved Regions

The University of Pittsburgh responds to unmet psychiatric needs in rural Pennsylvania with outreach and a successful fellowship program.

BY AARON LEVIN

Bringing psychiatry to rural areas has never been easy or simple, but one team has created a way to link its academic medical center in Pittsburgh with patients living in more rural regions of the state.

"We cover a wide area but we all belong to the same practice," Kenneth Nash, M.D., M.M.M., chief of clinical affairs for Community Care Behavioral Health Organization, based at the Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh Medical Center, told an audience at last month at IPS: The Mental Health Services Conference.

In addition to 310 beds at WPIC, the network includes six inpatient sites with a total of 500 beds across western Pennsylvania. Through the use of telepsychiatry, the group connects to eight additional clinics located 70 to 250 miles from Pittsburgh, said Nash. A rotating group of 10 psychiatrists also spend about 62 hours weekly connecting with about 80 patients via the telehealth system. This includes some combination of 60- to 90-minute evaluations and 15- to 30-minute follow-up sessions.

Aaron Levin

Working with patients in rural areas can create new opportunities for personal growth and systems innovation, says Manish Sapra, M.D., M.M.M., an assistant professor of psychiatry at the University of Pittsburgh School of Medicine.

There are plenty of challenges for both patients and clinicians in rural areas, said Manish Sapra, M.D., M.M.M., an assistant professor of psychiatry and senior director of community and public service psychiatry at the University of Pittsburgh School of Medicine.

Rural areas are often poor and face shortages of all kinds of health resources, including options for mental health care. The distance between patients and the closest clinics or hospitals can be great. Additionally, the stigma associated with mental illness combined with concerns about seeking care in a place where people all seem to know each other can keep those in need from seeking treatment.

According to Sapra, psychiatrists in rural areas may

see **Fellowship** on page 12

Mental Health Research Symposium Highlights Cutting-Edge Science

The symposium highlighted research on the early, prodromal stages of disease and even fetal determinants of mental health, in hopes of being able to diagnose and treat mental illness before it fully manifests.

BY NICK ZAGORSKI

At the 27th Annual New York Mental Health Research Symposium, held October 23 in Manhattan's Kaufmann Music Center and sponsored by the Brain and Behavior Research Foundation (formerly NARSAD), keynote speaker Keith O'Neil—a former NFL player who founded the 4th and Forever Foundation to help raise awareness of mental illness—spoke movingly about his difficulties growing up.

While on the outside he seemed a typical student who was well liked and driven both in the classroom and football field, he battled continual mood swings, insomnia, and even suicidal thoughts, he explained to the audience. This internal struggle continued for years, and it wasn't until after he retired that O'Neil was diagnosed with bipolar disorder.

As encapsulated by O'Neil's story, a recurring theme of this year's symposium was the need to appreciate that mental illness develops and changes across a person's entire life course.

"Mental disorders like schizophrenia are not silent in the early years," said Robert Freedman, M.D., chair of the psychiatry department at the University of Colorado School of Medicine in Denver and editor in chief of the *American Journal of Psychiatry*. "And psychiatrists need to rethink their approaches to diagnosis and treatment."

Freedman, one of the recipients of this year's Lieber Prize for Outstanding Achievement in Schizophrenia Research, discussed this shift in views during a lecture about rethinking schizophrenia's origins. He described the association between a gene called CHRNA7, which makes a receptor targeted by acetylcholine, and psychiatric disorders including schizophrenia and autism. This discovery has led to some clinical studies showing that supplementing pregnant women with the nutrient choline can lead to improved attention and social skills in their infants.

If additional studies bear this out, choline might join folate as a preventative supplement to reduce the risk of neurodevelopmental problems during pregnancy. Yet there are other areas of mental illness—such as psychosis risk—where prevention or early intervention of mental illness is not given a high priority, Patrick McGorry, M.D., Ph.D., explained during a lecture.

McGorry, a professor of youth mental health at the University of Melbourne, was also awarded the Lieber Prize for Outstanding Achievement in Schizophrenia Research. McGorry is credited with shifting the therapeutic paradigm for schizophrenia to early detection and intervention in young people. His research has also helped to identify ways to help reduce the likelihood that those at high risk for psychosis develop the disorder.

"Bob Freedman and Patrick McGorry are exemplary researchers and terrific people who truly embody the caliber of scientist that the Liebers wanted to recognize and reward," said former APA President Herb Pardes, who is the president of the BBRF's Scientific Council and executive vice chair of New York-Presbyterian Hospital's Board of Trustees.

"All of the award winners are outstanding," he continued (see box on facing page). "And they show the international scope of high-quality mental health research."

During the symposium, Barnaby Nelson, Ph.D., an associate professor and director of the Ultra High Risk for Psychosis research program at Orygen in Melbourne, Australia, and a recipient of the Sidney R. Baer Jr. Prize for Outstanding Achievement in Innovative and Promising Schizophrenia Research, expressed optimism that research into prodromal disease, especially psychosis, has increased significantly in the past few years. However, being able to predict which at-risk individuals will eventually develop psychosis remains challenging.

Nelson went on to discuss his own research at employing "self-disturbance" as a marker for psychosis. Basic self-disturbance involves a sensed loss of ownership over one's body or experiences, and Nelson has found this to be a significant predictor of a psychotic transition; he is currently exploring the neurological mechanisms behind this.

Fellow Sidney R. Baer Jr. Prize recipient Camille Hoffman, M.D., an assistant professor of maternal-fetal medicine at the University of Colorado School of Medicine in Denver, has gone back even earlier in the development process to explore the fetal origins of psychosis. The prenatal period is the most active time in the development of the human brain, but studying the brain of a developing fetus can be challenging.

Hoffman has overcome some of these issues by making use of more available resources; as part of a team effort between Colorado's psychiatry and obstetrics departments, she is taking hair and fingernail samples from pregnant women and later their infants to assess the role of stress on the developing brain. These regions house reservoirs of cortisol and other agents that could be used to measure hormone levels at specific times.

Such collaboration represents what the Brain and Behavior Research Foundation strives for in the many research grants it supports, especially the Young Investigator Awards handed out every year.

Robert Hirschfeld, M.D., a professor of psychiatry at Weill Cornell Medical Center and moderator of the symposium, explained, "We want to find young, exceptional researchers who could choose to work in any medical area, and we want to get them working in mental health."

The two recent Young Investigator Award recipients chosen to speak at this year's event—pharmacogenomics researcher Jianping Zhang, M.D., Ph.D., of the Feinstein Institute for Medical Research and engineer Markita Landry, Ph.D., of the University of California, Berkeley—are prime examples of this goal.

Landry in particular highlights the foundation's mission to connect the brain and observed behaviors. Her work involves developing optical sensors using nanotechnology to visualize how brain cells

continued on next page

Robert Freedman, M.D., co-recipient of the Lieber Prize, discusses his pioneering research on the convergence between physiology and genetics in schizophrenia that has increased the understanding of the early origins of this disorder.

Lieber Prize co-recipient Patrick McGorry, M.D., Ph.D., emphasizes the importance of appreciating the early and pre-disease stages of psychosis and developing better interventions for youth with emerging mental illness.

Jianping Zhang, M.D., Ph.D., and Markita Landry, Ph.D., are two of this year's recipients of Young Investigator awards and presented their projects at the symposium.

Photos: Charles Manley

Hamburgs Honored for Lifelong Dedication To Conquering Mental Illness

Betty Hamburg, M.D., and David Hamburg, M.D., receive the 2015 Herbert Pardes Humanitarian Award for their unstinting efforts to reduce the stigma of mental illness, advance adolescent psychiatry, and speak out against genocide.

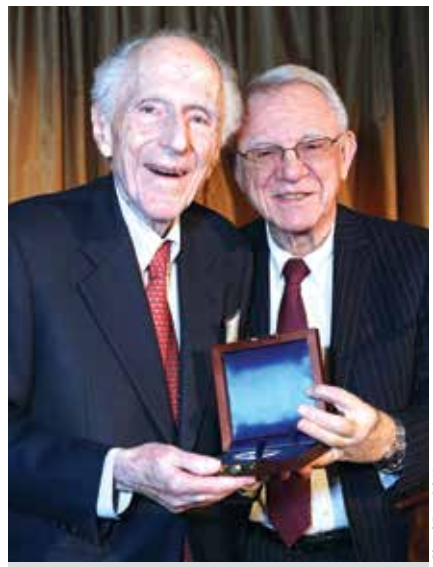
BY NICK ZAGORSKI

At the Brain and Behavior Research Foundation's (BBRF) symposium last month in New York City, achievements in research were front and center; but later that day, the focus shifted to the people who helped make new breakthroughs in mental health possible.

For while private groups like the BBRF—which invests 100 percent of donor contributions into its NARSAD Grants—play pivotal roles in supporting research that might not be funded by traditional, federal grants, they require philanthropy to meet their goals, and that requires the efforts of people who are willing to tirelessly educate and advocate for the cause of mental health.

To honor people whose extraordinary contributions have greatly helped to advance the understanding of mental illness, the burden it places on individuals and society, and the need to expand mental health services around the world, BBRF inaugurated the Pardes Humanitarian Prize in Mental Health in 2014.

The award is named in honor of Herbert Pardes, M.D., a past president of APA and long-time advocate for people with mental illness. Pardes, president of the BBRF's Scientific Council and executive vice chair of the Board of Trustees at New York-Presbyterian Hospital, was the award's first recipient.



Chad David Kraus

Former APA President Herbert Pardes, M.D., presents the Pardes Humanitarian Award to David Hamburg, M.D. He and his wife, Betty, received the prize for their 60 years of advocacy in mental health and violence prevention.

This year, during BBRF's 28th Annual National Awards Dinner that followed the research symposium (see story on facing page), Pardes had the honor of presenting his namesake award to Beatrix (Betty) Hamburg, M.D., and David Hamburg, M.D.

"David and Betty Hamburg are extraordinary individuals who have blended their scientific knowledge and profound compassion to raise our understanding of the behavioral aspects of medicine," Pardes told *Psychiatric News*. "They have taught us about the importance of hope and respect, and using our knowledge toward the greater good for all humanity."

"Through their work, Drs. David and Betty Hamburg have transformed our view of mental illness and their work has gone far to minimize its stigma," said Jeffrey Borenstein, M.D., president and CEO of BBRF and editor in chief of *Psychiatric News*. "They represent the epitome of psychiatry not only for the mental health field, but for the world—they are true humanitarians."

The Hamburgs started their intertwined careers shortly after meeting at Yale School of Medicine in 1948 (where Betty would become the school's first African-American female graduate). After graduating, they went to the National Institute of Mental Health (NIMH), where they established the institute's first clinical research center and began studying the role of stress in severe mood disorders.

Afterward, David Hamburg became chair of the psychiatry department at Stanford University, then director of health policy research and education at Harvard University, and then president of the Carnegie Corporation. (Along the way, he also served as president of the Institute of Medicine, National Academy of Sciences, and American Association for the Advancement of Science). He is currently the DeWitt Wallace Distinguished Scholar at Weill Cornell Medical College.

At the same time, Betty Hamburg was advancing the field of adolescent psychiatry when children's mental health was profoundly neglected, first at Stanford and then at Mount Sinai and Cornell universities. Her groundbreaking work included the illumination of the critical role of early development in physical and mental health and the recognition of early adolescence as a distinctive developmental period.

In later years, ending violence has become a major cause for the Hamburgs. Betty has conducted research on the use of school-based programs as venues for conflict resolution and violence prevention and together with David published a book about violence and hate titled *Learning to Live Together*. David also wrote *Preventing Genocide: Practical Steps Toward Early Detection and Effective Action* and has chaired commissions for both the United Nations and the European Union to help deal with this pressing issue.

"We are deeply honored to receive the Humanitarian Prize from our dear friend and colleague, Herb Pardes," David said as he reflected on the couple's six decades of work (Betty was unable to attend due to illness). "It is especially meaningful for Betty and me to share this award for our work together, a lifelong effort to understand how human beings cope during the most difficult circumstances. This work has ever greater urgency in today's world of strife and conflict."

The foundation also recognized former first lady Rosalynn Carter with an "honorary tribute" for her tireless work in mental health advocacy, which has helped shape both positive public perception and public policy. Though she was also unable to attend, the former first lady thanked the BBRF in a videotaped interview. PN

More information on the Pardes Humanitarian Prize is posted at https://bbrfoundation.org/the-pardes-humanitarian-prize-in-mental-health.

continued from previous page

interact with each other. With her Young Investigator grant, she aims to use these nanosensors in animal models to study the uptake and release of neurotransmitters.

This work could one day lead to diagnostic tools that could identify minute changes in brain cells, thus identifying psychiatric and neurological problems at their earliest stages. PN

More information about the nine recipients of the Brain and Behavior Research Foundation's Outstanding Achievement Prizes is posted at https://bbrfoundation.org/news-releases/brain-behavior-research-foundation-honors-nine-scientists-for-outstanding-achievements. More information about the Brain and Behavior Research Foundation is posted at https://bbrfoundation.org/.

2015 BBRF Outstanding Achievement Prizewinners

The Lieber Prize for Outstanding Achievement in Schizophrenia Research

Robert Freedman, M.D.
Chair, Department of Psychiatry, University of Colorado Health Sciences Center, and Editor in Chief of the *American Journal of Psychiatry*
Patrick McGorry, M.D., Ph.D.
Professor of Youth Mental Health, University of Melbourne, and Executive Director, Orygen, National Centre of Excellence in Youth Mental Health

The Colvin Prize for Outstanding Achievement in Mood Disorders Research

Michael Berk, M.B.B.Ch., M.Med., Ph.D.
Alfred Deakin Professor of Psychiatry, Deakin University
L. Trevor Young, M.D., Ph.D.
Dean of the University of Toronto's Faculty of Medicine and Vice Provost, Relations With Health Care Institutions

The Ruane Prize for Outstanding Achievement in Child and Adolescent Psychiatric Research

B.J. Casey, Ph.D.
Sackler Professor of Developmental Psychobiology and Director of the Sackler Institute, Weill Cornell Medical College
Francisco Xavier Castellanos, M.D.
Brooke and Daniel Neidich Professor of Child and Adolescent Psychiatry and Professor of Radiology and Neuroscience, New York University Langone Medical Center

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Amy F. T. Arnsten, Ph.D.
Professor of Neurobiology, Yale University School of Medicine and a member of the Kavli Institute of Neuroscience

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M. Camille Hoffman, M.D.
Assistant Professor in the Departments of Obstetrics and Gynecology and Psychiatry and Women's Reproductive Health Research Scholar, University of Colorado School of Medicine
Barnaby Nelson, Ph.D.
Associate Professor and Director of the Ultra High Risk for Psychosis Research Program at Orygen, National Centre of Excellence in Youth Mental Health

Resource Document May Provide Guide To Ethical Issues in Everyday Practice

The resource document can never tell a psychiatrist exactly what to do in any given situation, but it can help psychiatrists to think systematically and in a theoretically vigorous way about what values are at stake and why the particular situation poses a dilemma.

BY MARK MORAN

An educational resource on psychiatric ethics is being developed to provide APA members with practical guidance about how to approach ethical dilemmas that arise in everyday practice.

At a symposium at IPS: The Mental Health Services Conference in New York last month, Rebecca Brendel, M.D., J.D., described the work that an APA Board-appointed ad hoc work group is doing to develop the document, which may be presented to the Board at its meeting next month in Washington, D.C.

She emphasized that the educational document will be based on the existing *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry,* last revised and approved by the Board of Trustees in 2013.

"We want to produce a comprehensive document that will provide practical guidance on major topics including tools to manage ethical dilemmas that come up in day-to-day practice," Brendel said at the meeting. "The document will not be freestanding but will be cross-referenced to the existing APA principles so we can be clear about where the ethical tenets we are applying to any situation are coming from."

Ellen Dallagher

Rebecca Brendel, M.D., J.D., chair of an APA ad hoc work group developing an educational document about psychiatric ethics, says ethical dilemmas arise in day-to-day practice when two or more ethical principles come into conflict.

She added, "This document could never tell a psychiatrist exactly what to do in any given situation, but it could help the psychiatrist to think systematically and in a theoretically vigorous way about what values are at stake and why the particular situation poses a dilemma. If we can help our colleagues have the tools, the rationale, and the resources to engage ethical challenges, it could really be a critical resource for the profession."

Brendel explained that the idea for the resource document was first conceived under past APA President Paul Appelbaum, M.D. An early draft of an ethics resource document was developed by a work group chaired by Laura Roberts, M.D., and Edward Hundert, M.D.; however, that document was never acted on and and hadn't been updated since 2008.

APA President Renée Binder, M.D., and immediate past President Paul Summergrad, M.D., both wanted to revive the document and update it. Binder made it a priority and appointed the ad hoc work group with Brendel as chair. The other members of the work group are Wade Myers, M.D., of the APA Ethics Committee; Charles Dike, M.D., chair of the Connecticut District Branch Ethics Committee and and consultant to the APA Ethics Committee; Harold Ginzburg, M.D., J.D., of the APA Assembly; and Robert Weinstock, M.D., of the Council on Psychiatry and Law. Phil Candilis, M.D., serves as a corresponding member, while Appelbaum, Roberts, and Ezra Griffith, M.D., who is chair of the Ethics Committee, serve as consultants.

"Our professional ethics are the backbone of psychiatric practice," Binder told *Psychiatric News* after the IPS. "This new resource document, developed by a distinguished group of psychiatrists with expertise in ethics, will help our members understand how our *Annotations* are relevant to the challenges and dilemmas we face in our day-to-day practice."

At the IPS, Brendel told psychiatrists that the composition of the work group is intended to facilitate input from relevant components of APA and continuity with the earlier draft of the resource document. She noted that while many portions of that 2008 document need to be updated, some portions are still relevant.

She led psychiatrists at the symposium in a conversation about the key concepts underlying the document and some of the specific topics the resource may cover. Core concepts of ethics include "deontology" (or duty to the patient), consequentialism (for instance, the question of whether an ethical professional should work toward the greatest good for the greatest number of people); virtue ethics and professional ethics; and principlism, which is a system

see **Resource Document** on page 23

Fellowship

continued from page 9

face lower salaries, isolation from their peers, and faster burnout.

Despite these challenges, Sapra said that working in rural areas can create new opportunities for personal growth and systems innovation. He noted that many of the changes now being encouraged in psychiatric care are already present to some degree in rural psychiatry: services integrated with primary care, telehealth, and school- or home-based interventions.

To encourage psychiatry residents to consider a career in rural psychiatry, WPIC created the Rural Public Psychiatry Fellowship, based at the Lake Erie College of Osteopathic Medicine in Erie, Pa. (WPIC also offers a second fellowship in public service psychiatry, which also provides some experience in rural clinical settings.)

"Psychiatry residents are well trained in inpatient care and medication management but less so in community psychiatry," said Penny Chapman, M.D., a clinical assistant professor of psychiatry at WPIC and medical director of Stairways Behavioral Health.

The rural fellowship, co-directed by Chapman and Sapra, gives new psychiatrists the opportunity to gain subspecialty training with senior psychiatrists in fields such as geriatrics and substance abuse. Fellows receive a full attending's salary as well as one day off per week to complete their fellowship requirements. Academic opportunities include biweekly webinars and the opportunity to present research at WPIC's annual conference on rural psychiatry.

Aaron Levin

Penny Chapman, M.D., a clinical assistant professor of psychiatry at Western Psychiatric Institute and Clinic, says the school's Rural Public Psychiatry Fellowship is helping to bridge the gap in psychiatric care in western Pennsylvania.

Over the eight years since the fellowship was established, fellows have worked with patients at a federally qualified health center as well as a clinic for women just released from a local jail. The fellows have also trained rural primary care physicians and developed a program to educate families of people with mental illness about how best to manage the care of those with a mental disorder.

"We have trained six fellows so far, and they have all stayed in Pennsylvania and are doing community psychiatry," said Chapman.

The current fellow, Joseph Holmes, D.O., who grew up in rural West Virginia, appreciates the clinically focused fellowship.

"I'm getting the opportunity to develop a system to provide care for people who have no care," he said. PN

More about the Rural Public Psychiatry Fellowship of the Western Psychiatric Institute and Clinic is posted at http://www.pprp.pitt.edu/index.html.

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Domestic Violence More Burdensome On Underserved Diverse Populations

A diverse panel addresses the issue of the many manifestations of domestic violence in underserved populations.

BY AARON LEVIN

Domestic violence knows no ethnic, geographic, or chronological boundaries, said speakers at a special program presented by APA's Division of Diversity and Health Equity (DDHE) at Bellevue Hospital during IPS: The Mental Health Services Conference in New York on October 9.

Existing health disparities caused by race, ethnicity, religion, cognitive status, or gender have an increased burden on minorities and are only worsened by the presence of intimate partner violence (IPV), said Mayumi Okuda Benavides, M.D., an attending physician at New York Presbyterian Hospital-Columbia University Medical Center.

Aaron Levin

From left are panelists Obianuju Berry, M.D., M.P.H., Mark Nathanson, M.D., and Mayumi Okuda Benavides, M.D., and moderator Margarita Guzman, J.D.

Often, such violence goes unreported by immigrants because of language difficulties, lack of knowledge of legal rights, and/or the absence of economic alternatives to remaining in an abusive relationship, said Benavides. Physical violence can induce depression, anxiety, and substance abuse and increase rates of suicidality.

Worse yet, she said, is the presence of syndemic illnesses—two or more interacting, synergistic epidemics, such as substance abuse, IPV, and AIDS.

"About 55 percent of women who are HIV positive have also experienced IPV," she said. The combination can result in low birth weight for children of these women, increasing developmental and behavior problems, and creating a transgenerational perpetuation of health disparities."

"In the United States, rates of IPV vary by ethnicity," said Obianuju Berry, M.D., a child and adolescent psychiatry fellow at New York Presbyterian Hospital, who spoke about IPV in African immigrant populations. "There has been little formal study of that group, and many epidemiological surveys conflate black African and Caribbean immigrants with African Americans."

More than 1.5 million immigrants from Africa's 47 countries have come to the United States in the last 20 years,

see **Domestic Violence** on page 28

Electronic System Links Police Queries To Mental Health System

Police officers in Georgia are testing a new system to help them better manage confrontations with people with mental illness.

BY AARON LEVIN

One way of reducing the number of persons with mental illness in U.S. jails and prisons is to avoid locking them up in the first place, noted Beth Broussard, M.P.H., of the Department of Psychiatry at Lenox Hill Hospital in New York.

"The best place to intervene to reduce unnecessary incarceration and criminalization is at the beginning," said Broussard at IPS: The Mental Health Services Conference, held last month in New York.

One well-tried intervention is Crisis Intervention Training (CIT), in which police officers learn to recognize the signs of mental illness and then direct individuals to appropriate settings for evaluation or care.

CIT is widely recommended but is far from universally taught to officers, many of whom are skeptical of its value, said Broussard. "CIT requires a lot of resources, time, training, and changes to department policies."

So Broussard and colleagues are testing another model of intervention in Georgia, one that can be used by officers without CIT training but can offer another path to early diversion. Their work is one segment of the Opening Doors to Recovery (ODR), a multicomponent case-management service model developed in conjunction with the Georgia chapter of the National Alliance on Mental Illness that seeks to reduce inpatient psychiatric rehospitalization, arrests, and incarcerations.

The research was supported by the Bristol-Myers Squibb Foundation.

When patients enroll in ODR, they are offered participation (with additional informed consent) in a plan under which they disclose that connection to the state's criminal justice information system. In general, when officers respond to a call, they conduct a routine background check by computer. If the individual is registered in the ODR program, the officers get a message to call a toll-free number linking them to the local mental health system. The community navigation specialist on call then works with the officer, either on the phone or in person, to help resolve the situation.

Early results from the ongoing trial indicate good acceptance by police officers, especially those who have not taken CIT training.

Aaron Levin

An intensive, team-based community support program for persons with mental illness and a history of inpatient psychiatric recidivism is supported by electronic connections to local police, reported Beth Broussard, M.P.H.

"The non-CIT-trained officers liked it because they did not have to struggle over whether mental illness was present," said Broussard. "They don't have to step outside their usual role, and just running their usual routine check can give them useful information."

The system offers the police another tool in their tool box, said Broussard. They prefer receiving advice from mental health professionals rather than being on their own. Not all arrests were averted, but getting people to a follow-up appointment was better than simply letting them go or arresting them, they felt. In addition, the intervention of the community navigation specialist sometimes resulted in the officer placing lesser charges against the subject, she said. Patients liked the system as well, she said.

Curiously, many of the hits to the system have been coming from sources other than the police, she said. Some have come from jail personnel doing discharge planning prior to release or from parole officers, suggesting other potential future uses. PN

An earlier report on "Opening Doors to Recovery: Recidivism and Recovery Among Persons With Serious Mental Illnesses and Repeated Hospitalizations" is posted at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300482.

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Ellen Dallagher

Board Approves Response to ABPN On General, Subspecialty MOC Process

Trustees also approved criteria by which to determine whether and when APA should formulate policy or position statements on social issues.

BY MARK MORAN

At its October meeting, held in conjunction with IPS: The Mental Health Services Conference in New York, APA's Board of Trustees dealt with an action-oriented agenda. Perhaps the issue with the most immediate impact on members was the discussion on maintenance of certification (MOC).

Prior to the meeting, the Board had been asked by the American Board of Psychiatry and Neurology (ABPN) for input on the question of whether maintenance of general psychiatry certification be a prerequisite for maintaining certification in a psychiatric subspecialty. The Board unanimously decided that there should not be more than one MOC process.

Current ABPN policy is that psychiatrists (with the exception of child psychiatrists) must maintain certification in general psychiatry and in their subspecialty. In response to the query, Trustees voted to convey the following five points in a letter to ABPN President Larry Faulkner, M.D.:

- APA does not agree that there should be an exam every 10 years for MOC.

- Certification of lifelong learning should be an integrated, ongoing process relevant to actual practice.

- APA is willing to work with the ABPN to improve the MOC process.

- For subspecialists taking a recertification exam, the ABPN should ensure that the exam primarily consists of questions related to the diplomates' subspecialty. Any general psychiatry questions that are included should be relevant to the diplomates' practice.

- No psychiatrist should be forced to maintain her/his underlying general and subspecialty certification through more than one certification process.

Ellen Dallagher

APA President Renée Binder, M.D., leads a discussion on the criteria APA should follow when determining whether a position on a social issue is warranted.

APA President Renée Binder, M.D., said at the meeting that feedback on the question of separate MOC subspecialty requirements was garnered from the councils on Medical Education and Lifelong Learning, Geriatrics, Psychosomatic Medicine, Children and Adolescents, Psychiatry and Law, Addictions, and the Assembly Work Group on MOC. While there was some disagreement on the question of separate certification processes, there was general agreement that the ABPN should simplify requirements and continue to offer combined exams and that the examinations should reflect the knowledge set required for actual practice.

The Assembly MOC work group provided the following statement: "The strongest reason to [oppose the current ABPN policy of requiring separate MOC processes for generalist and subspecialty practice] is that like child psychiatrists, some other specialists do not practice much if any general psychiatry, and it would be irrelevant to their practice to have to study for the general exam. There was further consensus that the requirement to do both will be a barrier to recertification as it is onerous, time consuming, and of no value to have to do both. We believe that, above all, recertification should cover relevant topics to the clinical practice of the individual, and therefore the individual should be able to decide in what areas to recertify."

Binder noted that the American Board of Internal Medicine had previously voted that internists who subspecialize (such as cardiologists) do not have to maintain certification in general internal medicine.

"We believe in the principle of lifelong learning, but it should be relevant to practice," Binder said. "If there is an exam, it should include questions about what the physician is actually doing in practice. We are volunteering to work with the ABPN and other representatives to develop reasonable standards for MOC."

Criteria for Responding to Social Issues

In other business, the Board approved four criteria by which APA could be guided when challenged to respond to social issues that may or may not have immediate bearing on psychiatric practice or psychiatric patients. The criteria, recommended by the Ad Hoc Work Group on Social Issues, chaired by Assembly Speaker Glenn Martin, M.D., are as follows:

- APA should have substantial expertise or perspective to offer.

- Positions should be relevant to access to care or the prevention, diagnosis, or treatment of psychiatric disorders.

- The issue being considered should be significant for psychiatrists and their patients.

- APA should develop positions on issues on which APA may have a meaningful impact and positively shape public opinion.

"Our charge was to come up with some criteria for if and when APA should take a stand on what some people might call social issues," Martin said at the meeting. "There are a lot of different perspectives among our members, and many say we should just focus on issues directly relevant to psychiatry. There are others who say we should take a more activist stand on social issues."

Martin cited gun control, abortion, and the death penalty as the kind of issues on which there are differing opinions. He said the ad hoc work group was composed of members on both sides—those who favored a more activist stance on social issues and those who favor a more conservative approach focusing on issues directly relevant to psychiatry.

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Congressional Briefing Highlights Mental Health Crisis in Jails, Prisons

APA holds an event on Capitol Hill to raise awareness of the many challenges that inmates with mental illness face and highlight possible policy solutions to help meet their needs.

BY AARON LEVIN

"The criminalization of mental illness is a national tragedy," APA President Renée Binder, M.D., told an audience gathered October 29 for a congressional briefing on Capitol Hill.

During the event, which was sponsored by APA, Binder, a forensic psychiatrist and a professor of psychiatry at the University of California, San Francisco, School of Medicine, spoke of the numerous challenges people who are living with mental illness in U.S. jails and prisons face.

According to Binder, an estimated two million people with serious mental illness are admitted to U.S. correctional facilities each year. Once incarcerated, these inmates often spend more time behind bars than other members of the prison population, in part because they incur more infractions there and are more vulnerable to victimization. They are also more likely to return to the criminal justice system after release.

U.S. correctional facilities are often ill-equipped to offer appropriate mental health treatment options for inmates, meaning that those with mental illness often face numerous hurdles to receiving adequate care.

The strain of coping with the mental health needs of prisoners falls heavily on the 3,069 U.S. counties that have to maintain and staff their jail systems. This must change, said Binder and other speakers at the briefing.

"We are spending way too much on incarceration," said Ron Honberg, J.D., the national director for policy and legal affairs at the National Alliance on Mental Illness, during the briefing. "It is more effective to spend money on treatment to keep people out of jail."

albund/Shutterstock

Rich Stanek, the sheriff of Hennepin County, Minn., who also spoke at the briefing, agreed: "I understand how we got here, but I don't understand why we stay here." Stanek said he would like to see more inpatient psychiatric beds available so that inmates could receive psychiatric evaluations sooner and not languish in jail—often for longer periods of time than most who are sentenced for low-level misdemeanors.

Improvements to the information-sharing system that allows legally appropriate communication between providers, agencies, and the criminal justice officials could better direct police or sheriff's deputies when they encounter someone with a mental illness, Stanek said.

"The correctional environment is not the place to treat people with mental illness," said Robert Trestman, M.D., Ph.D., a professor of psychiatry and medicine at the University of Connecticut. To reduce recidivism in this population, Trestman said strong discharge planning and transition resources are essential. "We must not do harm by getting people out of jail without getting them into care," he said.

"Local and state leaders must join with criminal justice, mental health, and substance use professionals to steer and support long-term efforts to move men-

see **Briefing** on page 28

Advertisement

Analysts to Host 'Virtual Rounds' on Psychodynamic Psychotherapy

The virtual rounds hope to engage early career psychiatrists who may have received some training in psychodynamic psychotherapy, but would like to deepen their understanding and improve their skills through an interactive discussion led by seasoned psychotherapists.

BY MARK MORAN

Jessica Brown, M.D.

Jessica Brown, M.D., says she hopes participants in the virtual rounds will come prepared to share case material in a safe and collegial environment.

Beginning early next year, two seasoned psychoanalysts will offer early career psychiatrists a unique "virtual rounds" in psychodynamic psychotherapy.

Jessica Brown, M.D., of Washington, D.C., and Estelle Bender, M.D., of New York will be leading "Clinical Enhancement of Psychodynamic Skills: Virtual Rounds," a series of online interactive discussions about using psychodynamic skills in patient care. The rounds are especially intended for early career psychiatrists (ECPs)—defined by APA as those in the first seven years of practice since graduating from residency.

Brown and Bender will lead two separate groups that will meet for a total of eight sessions beginning in January 2016. Brown's group will begin Wednesday, January 28, at 8 p.m. EST, and will meet every second and fourth Wednesday after that from 8 p.m. to 9:30 p.m. Bender's group will begin Monday, January 12, at 8 p.m. EST and will meet every second and fourth Monday from 8 p.m. to 9:30 p.m. EST.

There is no charge for the virtual rounds (they are being supported by a grant from the Laughlin Fund). Participants will need a computer with microphone and camera; Brown and Bender will be using Adobe Connect, a web-conferencing software, to host the virtual rounds.

"The sessions will be very interactive, and their success will come from the participants' willingness to share their experiences with talking with their patients, with due regard for confidentiality," Norman Clemens, M.D., president of the American College of Psychoanalysts, which is sponsoring the virtual rounds, told *Psychiatric News*. "Both teachers expect to bring their own experiences to the table, as well as psychoanalytic thought, theory, and practical knowledge about how to work with patients with a variety of problems. This is not about how to do psychoanalysis, but rather about the many ways in which psychodynamic skills in a good working alliance can be invaluable in understanding and helping people."

Estelle Bender, M.D.

Estelle Bender, M.D., says the goal of the virtual rounds is to help early career psychiatrists feel more competent and secure in their use of psychodynamic skills in whatever kind of psychiatry they practice.

Brown and Bender both have a profound understanding of psychodynamic psychotherapy, Clemens said. "Jessica Brown is a well-trained psychoanalyst in Washington, D.C., who spends part of her time working in a community mental health clinic practicing general psychiatry and part of her time seeing patients in psychoanalytic therapy and psychoanalysis in her private practice. She is in mid-career but has vivid memories of the early career years juggling psychoanalytic training and practice development along with the needs of a young family, so she is very much in touch with the practice environment that ECPs have to deal with.

"Estelle Bender is a psychoanalyst who has had a long career as a teacher of medical students at Columbia and medical students and residents at Cornell, where she is a clinical associate professor of psychiatry and has won three awards for teaching medical students and residents psychodynamic psychotherapy. She is on the faculty of the Columbia Psychoanalytic Center."

Brown said that the rounds will include "a little bit of didactics—not a lot" and that participants should come prepared for an interactive discussion. "We would like each person to present clinical vignettes or case material that they might be struggling with so we can discuss how to use psychodynamic skills in their approach," she said. "I expect an enriching experience with like-minded people who have chosen psychiatry and value and appreciate how psychodynamics can enrich any psychiatric practice."

Bender concurred. "I have supervised residents in psychodynamic psychotherapy for 37 years at Cornell and feel it has been a very enriching experience," she said. "I want to offer that same experience to early career psychiatrists who may not have had that training in their residency. We are excited about using new computer technology to reach ECPs all around the country.

"Our plan is to discuss basic psychodynamic concepts such as empathy, transference and countertransference, object relations, and resistance and then allow participants to share case material in a safe, collegial environment that illustrates the basic concepts and highlights common problems in doing psychodynamic psychotherapy. The goal is to encourage more ECPs to feel more competent and secure in their knowledge base about psychotherapy." PN

Psychiatrists interested in participating in the virtual rounds should contact Patricia Troy at (410) 647-5002 or ptroy@nextwavegroup.net.

From the President

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arrest going back to his teenage years and had been sentenced to three state prison terms and had three extended stays at state hospitals. Mr. A was on probation for a felony and had four open felony drug cases. His treatment plan included participation in mental health and substance abuse treatment, working with a case manager, staying away from substance-abusing peers, and being regularly monitored by the court.

After he became clean and sober and more stable with his antipsychotic medications, he was linked to supportive housing and a supported-employment program. As Mr. A achieved stabilization, he was able to graduate from mental health court. Over time, his charges were dismissed, one by one. Mr. A has not been arrested since entering mental health court three years ago, which is the longest time he has gone without being arrested in decades. In addition, Mr. A has obtained work as a custodian.

There are other specialty courts, including drug courts and veterans courts. The latter link veterans to services within the VA system. These types of courts represent one way of sending people who live with mental illness for treatment instead of to jails and prisons. As Judge Lerner-Wren said, "I want to give a message of hope and support." PN

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Opioid Use Found to Be Decreasing, While Opioid-Related Deaths Increase

To reverse adverse outcomes associated with the illicit use of prescription opiates, guidelines are needed to address prescription practices for such drugs, experts say.

BY VABREN WATTS

In a study published October 13 in *JAMA*, researchers at the Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute on Drug Abuse (NIDA) reported both good and bad news regarding prescription opioid use in the United States.

"Opioid use in this country has reached a level of public health significance," Wilson Compton, M.D., M.P.E., deputy director of NIDA and a study coauthor, told *Psychiatric News*. "We have seen a marked increase in deaths related to prescription opioids over the past decade, and we've also seen a marked increase in heroin use, which we believe may be related to the prescription opioid problem."

Heroin has been speculated by some addiction psychiatrists to be an alternative drug of choice for people who are addicted to prescription opioid-derived medications.

A previous report from SAMHSA estimated that rates of emergency department (ED) visits involving prescription opioids more than doubled from 2004 to 2011, from 82.5 per 100,000 ED visits to 184.1 per 100,000 ED visits. The Centers for Disease Control and Prevention reported that the

see **Opioid Use** on page 25

NIDA

Wilson Compton, M.D., M.P.E., is confident that more focus on evidence-based treatment and stricter clinical guidelines for prescribing opioid painkillers may serve as a significant starting point for reducing usage rates and deaths associated with prescription opioid drugs.

FROM THE EXPERTS

Psychotherapy: How to Steer a Course for Success

BY RICHARD MAKOVER, M.D.

Psychotherapy can be frustrating. It may begin with a motivated patient and an eager therapist, only to unexpectedly lose momentum. The patient's enthusiasm wanes, and the therapist feels increasingly ineffective. Unproductive sessions are followed by canceled or missed appointments. Lack of forward progress leads to a stubborn treatment impasse. The patient may drop out or remain in an interminable, static dependency. These failed cases almost always reflect inadequate or absent treatment planning.

Contrast these adverse outcomes with the observation that, early on, some patients, perhaps half, improve without any apparent contribution from the therapist. (Some patients even report these "remissions" while on a waiting list!) The placebo effect and nonspecific factors—a supportive relationship, mobilized affect, cognitive structure—account for most of this progress. The timely easing of environmental stress and the natural history of the disorder may also contribute to these "spontaneous" recoveries. If the effectiveness of psychotherapy is to be measured by outcomes, these improvements, which are independent of the therapist's interventions, obscure the data and question the value of psychotherapy. Worse, they suggest that even an inept therapist can achieve a 50 percent success rate. The challenge to a skilled therapist is to help every willing patient: 100 percent or as close to it as possible.

In today's mental health care landscape, with its emphasis on cost containment and the intrusion of third parties into the clinical setting, psychotherapists are under increasing pressure to deliver efficient and time-limited results. Early termination and spontaneous remission may gladden the hearts (if, indeed, they have hearts) and help fill the pockets of third parties, but these unplanned, short-lived encounters leave the psychotherapist dissatisfied, self-doubting, and vulnerable to burnout.

An outcome that benefits the patient and satisfies the therapist requires an effective, "top-down" treatment plan. It will first designate the optimal result; second, delineate the objectives needed to achieve it; then select the best psychotherapeutic modality; and last, anticipate the necessary techniques. Elsewhere, I have labeled this hierarchy as the AIM (the desired outcome), the GOALS (the enabling steps), the STRATEGIES (the selected therapies), and the TACTICS (the tools each modality provides) that comprise a completed treatment plan. If the top-down approach was a car trip, it would first determine its final destination; then identify the intermediate waypoints; next, select the best routes; and, once under way, use tools like traction control and GPS navigation.

By contrast, unplanned or poorly planned treatment exemplifies a "bottom-up" approach. Bottom-up therapy begins without a determined outcome. It lacks clear treatment objectives and relies on the "usual and customary" therapy. It focuses technique only on immediate concerns.

Bottom-up therapists take an opportunistic approach and focus on day-to-day problems. Any squeaky symptom gets the therapeutic grease. They choose an intervention—medication, interpretation, support, advice, instruction—in response to the latest complaint. The bottom-up car trip would begin by tapping the fuel gauge and kicking the tires. It would head off in whatever direction seemed promising. It might stop halfway to change the oil or adjust the brakes. It would alter course each time a new landmark appeared. Whether this haphazard excursion reached its destination, or any destination, would be a matter of chance.

An effective treatment plan emerges from a thorough assessment of the patient's needs and wants. Next, a formulation with cause-and-effect statements generates an initial hypothesis for the question: why does this patient have these problems at this time? The answer determines the best therapy outcome and the goals, strategies, and tactics needed. Patient and therapist must then reach agreement and forge a therapeutic contract. Instead of a hopeful reliance on spontaneous recovery, planned treatment seeks targeted improvement through active collaboration.

Treatment planning is a high-yield investment. A good plan supports the working alliance between patient and therapist. It promotes efficiency and effectiveness. It avoids therapeutic impasses and patient dropouts. It facilitates a successful outcome. It helps satisfy third-party demands. Patients benefit from better results, and therapists experience greater satisfaction with their work. PN

Richard Makover, M.D., is a lecturer in psychiatry at Yale School of Medicine. He is the author of *Treatment Planning for Psychotherapists, Third Edition,* from American Psychiatric Association Publishing. APA members may purchase the book at a discount at https://www.appi.org/Course/Book/Subscription/JournalSubscription/id-3446/Treatment_Planning_for_Psychotherapists.

APA Task Force to Address 'What's Next?' for Ketamine

One expert recommends that patients be referred for ketamine treatment only after they have failed all approved appropriate treatments, including ECT.

BY JENNIFER CARR

It has been more than 15 years since researchers first discovered that a single infusion of the anesthetic ketamine could reduce symptoms of depression in a fraction of the time it typically takes a standard antidepressant to take effect. As more evidence has pointed to ketamine's efficacy in patients who have failed to respond to other depression treatments, the number of those seeking the medication have grown.

Despite all of the excitement over ketamine's antidepressant properties, however, experts warn that serious questions about the medication remain.

"We are in the unusual situation where ketamine is readily available, but there is little clinical-trial data to drive practice," said Charles Nemeroff, M.D., Ph.D., the Leonard M. Miller Professor and chair of the Department of Psychiatry and Behavioral Sciences at the University of Miami Miller School of Medicine. "There are a number of questions: What kind of psychiatric screening should be done in potential patients? How should a patient be monitored? What kind of follow-up should take place after treatment?"

> "We are in the unusual situation where ketamine is readily available, but there is little clinical-trial data to drive practice."
>
> —Charles Nemeroff, M.D., Ph.D.

University of Miami

To begin to answer these questions, the APA Task Force on Novel Biomarkers and Treatments scrutinized the literature for placebo-controlled, double-blind, randomized clinical trials that examined ketamine and other N-methyl-d-aspartate (NMDA) antagonists in the treatment of depression.

The results of the group's meta-analysis, which appeared October 1 in the *American Journal of Psychiatry*, focused on 12 clinical trials; seven (including 147 ketamine-treated participants) evaluated ketamine's effectiveness as a monotherapy or in combination with other psychotropic medications, and five (including 89 ketamine-treated patients) evaluated whether the medication might augment electroconvulsive therapy (ECT).

The analysis confirmed that a single intravenous infusion of ketamine consistently produced a rapid and robust antidepressant effect that peaked within 24 hours of administration, accompanied by brief psychotomimetic and dissociative effects. However, within one week, these antidepressant effects were largely diminished. Additionally, while ketamine accentuated the antidepressant effects of ECT following an initial treatment, it did not have any significant effect at the conclusion of the ECT treatment regimen.

"[The] current data provide compelling evidence that the antidepressant effects of ketamine infusion are both rapid and robust, albeit transient," Nemeroff, chair of the task force, and colleagues wrote.

While the meta-analysis adds further evidence confirming ketamine's rapid antidepressant effect, Carlos Zarate Jr., M.D., chief of the Experimental Therapeutics and Pathophysiology Branch of the Division of the Intramural Research Program at the National Institute of Mental Health, told *Psychiatric News* that more research is needed to establish how long or short term these effects might be.

"It is important to remember that we are talking about very sick patients

Study Identifies Factors Predictive Of Response to Risperidone

The genotype associated with a better response to risperidone encodes for a specific potassium channel that has been shown to be linked to schizophrenia by contributing to disorganized neuronal firing.

BY MARK MORAN

The presence of a genetic polymorphism and the speed with which a patient metabolizes risperidone may help to predict those with schizophrenia who are the most likely to respond to the medication, according to a report in *AJP in Advance*.

Moreover, the report indicates a possible mechanism for this association involving the binding of risperidone to a specific potassium channel that has been associated with schizophrenia.

"One of the major challenges in psychiatric therapeutics, indeed in medical therapeutics in general, is to individualize medicine to optimize response," wrote senior author Daniel Weinberger, M.D., of the Lieber Institute for Brain Development in Baltimore and colleagues.

Previous studies show that patients with slow metabolizer status and variants in the potassium channel gene KCNH2 associated with increased expression of Kv11.1-3.1 tend to have better responses to antipsychotic medications. (The expression of Kv11.1-3.1 has been shown to be increased in the brains of people with schizophrenia and is believed to be associated with disorganized neuronal firing.)

In the study, the authors analyzed drug clearance data in patients receiving risperidone in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study in order to test the hypothesis that a better response to the medication is associated with binding to the Kv11.1-3.1 potassium channel.

They found that 52 patients with genotypes associated with increased Kv11.1-3.1 expression showed a better treatment response to risperidone compared with other drugs. But they also found that this association was dependent on metabolism status; that is, patients with KCNH2 risk genotypes and slow metabolizer status showed marked improvement in symptoms when treated with risperidone compared with patients with fast metabolizer status or without the KCNH2 risk genotypes.

Moreover, risperidone caused greater in vitro block of the Kv11.1-3.1 potassium channel than other atypical antipsychotics.

While more research is needed to inform clinical decision making, "The data in this study strongly suggest that schizophrenia patients who are slow metabolizers and have KCNH2 risk-associated genotypes do better when treated with risperidone than with other antipsychotics, and they have by far the best response of anyone in the CATIE trial," the authors wrote.

"Based on the numbers in this study, we estimate that approximately 7 percent of schizophrenia patients would have the risk genotypes and slow risperidone metabolism and so would obtain the selective enhanced benefit from risperidone treatment. Conversely, the data suggest that individuals who are not slow metabolizers and do not have KCNH2 genotypes associated with Kv11.1-3.1 expression do not have a beneficial response to risperidone."

The results of the in vitro analysis of ris-

Key Points

The authors tested the hypothesis that better response to risperidone among patients with schizophrenia was associated with drug binding to a potassium channel linked with schizophrenia.

- Fifty-two patients enrolled in the CATIE trial with the KCNH2 genotype associated with increased expression of the potassium channel Kv11.1-3.1 showed a better treatment response to risperidone compared with other drugs. However, the association was also dependent on drug metabolism speed.
- Specifically, patients with KCNH2 risk genotypes and slow metabolizer status (approximately 7 percent of patients) showed marked improvement in symptoms when treated with risperidone compared with patients with fast metabolizer status or without the KCNH2 risk genotypes.

Bottom Line: The results, if replicated, point the way toward tailoring the choice of antipsychotic treatment according to genotype and drug metabolizing status.

CLINICAL & RESEARCH NEWS

who responded to a single infusion of ketamine for up to a week," said Zarate, who led several of the ketamine trials included in the task force meta-analysis but was not involved with the current study. "In the studies performed by our group, the majority of patients had failed six or more antidepressant trials. … No chronic condition gets better with one dose [of treatment]."

Recent preliminary data suggest that multiple doses of ketamine are associated with rapid and sustained improvements in mood, Zarate said.

NIH

Carlos Zarate Jr., M.D., points out that the patients who responded to a single infusion of ketamine for up to a week were very sick.

Still, there are concerns over the abuse liability of ketamine—the drug is sought after for recreational use for its ability to produce "out-of-body" experiences and hallucinations. Preclinical trials suggest that the drug may also be neurotoxic if administered at high doses or over extended periods. Additionally, Nemeroff noted, much is unknown about the precise mechanism of ketamine's antidepressant effects.

The task force also analyzed the findings of several randomized, controlled trials of other NMDA antagonists, including lanicemine, memantine, and nitrous oxide, and two partial agonists at the NMDA coagonist site, d-cycloserine and rapastinel. They found that while lanicemine, memantine, and nitrous oxide—which bind to the receptor at the same site as ketamine—failed to demonstrate efficacy consistently, d-cycloserine and rapastinel significantly reduced depressive symptoms without psychotomimetic and dissociative effects.

"It is important to hone in on mechanism of action, what's responsible for ketamine's side effects and what's responsible for its antidepressant effects," Zarate said. He and his colleagues are searching for biomarkers that identify individuals most likely to respond to ketamine; they are also studying other medications that modulate NMDA receptors. Such information could one day guide the development of "safer, ketamine-like drugs," he added.

Veronica Szarejko

James Murrough, M.D., asks that for those patients who respond quickly to ketamine, what should the next step be in their treatment?

"The evidence is now pretty clear that low-dose ketamine can have a meaningful antidepressant effect with a rapid onset of action," James Murrough, M.D., an assistant professor of psychiatry and neuroscience at Mount Sinai School of Medicine, told *Psychiatric News*. "If patients do respond, then the question becomes, again, 'What's next?' "

This is one of the questions that Nemeroff hopes the task force may be able to answer as they begin to work on developing a set of treatment recommendations for ketamine based on the information that is now available. "There is a pressing need to provide treatment recommendations for use of ketamine right now," he said.

Nemeroff noted that when faced with a patient with treatment-resistant depression, it is first important to verify the patient has tried and failed to respond to FDA-approved antidepressant treatments and other evidence-based "tried and true" treatment strategies before considering ketamine.

"If someone has received all treatments possible without success, including ECT," Nemeroff said, "only then would I refer the patient to one of the academic centers with specialized treatment-resistant depression clinics that are currently conducting ketamine trials." PN

"Ketamine and Other NMDA Antagonists: Early Clinical Trials and Possible Mechanisms in Depression" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.15040465.

peridone binding to the Kv11.1-3.1 channel also provides a "plausible mechanistic explanation for the clinical observations that response to risperidone treatment is influenced both by KCNH2 genotype and metabolizer status," the group noted. "Not only do these data have implications for pharmacogenomics and individualized therapy in schizophrenia, they also suggest that development of drugs with an even greater selectivity for inhibition of Kv11.1-3.1 channels relative to Kv11.1-1A channels could be of significant clinical benefit. …"

Paul Shepard, Ph.D., of the Maryland Psychiatric Research Center and an associate professor of psychiatry and pharmacology at the University of Maryland School of Medicine, told *Psychiatric News* that several potassium channels have been known to exist in the heart, effecting electrical activity, and only more recently were discovered to reside in the brain, including in dopamine neurons. In a paper in *Schizophrenia Bulletin* (September 28, 2007), he wrote "the discovery of [a particular type of potassium] channel in the brain suggests that central actions of antipsychotic drugs could include alterations in the intrinsic electrical properties of neurons. … Indeed, it seems quite possible that partial block of [potassium] channels in dopamine neurons by antipsychotic drugs could increase neuronal excitability, … a phenomenon that has been implicated in the therapeutic effects of these agents."

He explained that what the study by Weinberger and colleagues suggests is that there is a synergy between the action of risperidone and slow metabolism of the drug: the slower the breakdown of the drug, the higher the levels circulating in the bloodstream, and the more effectively the drug blocks the specific potassium channel presumed to be disrupting norm al neuronal activity.

As the cost associated with genotyping continues to decrease and the technique becomes easier to perform, Shepard predicts it likely won't be long until it becomes "a normal part of clinical practice."

"It's pretty clear that tailoring the therapeutic approach based on genetic predisposition is the way forward. Weinberger and colleagues have given us two variables that appear to synergize in a way that may provide for a small group of patients to have a better therapeutic option," he said. PN

"Differential Response to Risperidone in Schizophrenia Patients by KCNH2 Genotype and Drug Metabolizer Status" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.14050653#.

Resource Document

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of ethics based on the four principles of autonomy, beneficence, nonmaleficence ("do no harm"), and justice.

Each of these core concepts engages specific issues in contemporary psychiatric practice when what constitutes ethical practice may or may not be clear. "For some situations, there is a bright line and clear guidance," Brendel said. "These tend to be situations in which only one ethical tenet is called into question. They implicate so intrinsically one major principle of psychiatric ethics that there really is never a conflict about what constitutes ethical practice. More nuanced problems and ethical conflicts arise when two or more competing values that we hold to be important come into conflict with one another."

Some of the specific topics the resource document will cover include confidentiality, informed consent, boundaries, philanthropy (institutional versus patient perspectives), relationships with colleagues, working in organized systems of care, clinical innovation, end-of-life issues, relationships with industry, use of technology in practice, and physician participation in executions or interrogations.

In comments to *Psychiatric News*, Appelbaum said the resource document is intended to fill a gap that exists with regard to educational materials in psychiatric ethics.

"APA's *Annotations*, which are the basis on which the ethics committees of APA and its DBs adjudicate ethics complaints, were never intended to provide a comprehensive overview of ethics in psychiatry, and hence they are of limited value as an instructional tool," he said. "Until now APA has lacked a document that offers a clear overview of the area. This new resource, which reflects the thinking of an experienced group of psychiatrists and experts in ethics about the state of art of psychiatric ethics, should be an excellent resource in residency training and for continuing education of practicing psychiatrists." PN

Orientation Program Shows Value Of Recovery-Oriented Care

Staff of the Connecticut Mental Health Center discuss a model to teach the value and potential of recovery-oriented care to new medical personnel through the insights of current and former patients.

BY NICK ZAGORSKI

Recovery-oriented care models have been gaining traction in many mental health and substance abuse settings, but it's been a slow process due to the many demands on an underfunded, overworked mental health system.

"Of course all clinicians want and hope for their patients to recover," said Rebecca Miller, Ph.D., at IPS: The Mental Health Services Conference, held last month in New York. She is an assistant professor of psychiatry at the Connecticut Mental Health Center (CMHC), one of the oldest community mental health centers in the country and a place that has embraced a recovery-oriented care model. "If physicians are able to bring out in the workplace the principles they all think about, it can bring dramatic results. Even something small like a cup of coffee or a smile helps."

It's a practice that the CMHC has been employing for years, though their most recent initiative—which was highlighted in the IPS session—has been getting everyone involved.

The effort itself is relatively simple and involves panels of about five to seven people involved in the recovery process—both people receiving services as well as peer-support staff (people who have lived with mental illness and work at the center to help current patients). They meet with new medical personnel as part of the CMHC's orientation program for new staff. The panelists then discuss what they liked the most and least about their current or previous time in therapy, as well as what they thought worked best for their recovery goals.

"These panels rely on the power of stories and the contact hypothesis to bridge the gap between the provider and patient," said David Howe, L.C.S.W., who brought this idea to the CMHC after serving for many years as the director of programs and services at Connecticut Valley Hospital.

"What makes these panels effective is that it's a low-cost method to teach recovery care that can work in a variety of settings," he said during the lecture. "And, importantly, it empowers the patients to have them involved."

Miller noted that this orientation program—which started in 2014—seems to have the desired effect on physicians and other staff as well; among the feedback she's received are comments on how powerful it was to hear directly from people in recovery and how these sessions helped define recovery-oriented care.

"It even got some staff to open up themselves and discuss their own personal experiences with mental illness or addiction," Miller said.

Miller, Howe, and other staff at the CMHC are exploring how to incorporate these recovery panels throughout the year to broaden their reach. One of the attractive elements of the CMHC is its association with Yale Medical School, which provides a fertile ground of residents, fellows, students, and visiting scientists who have an opportunity to learn about recovery-oriented care and spread this knowledge at their next destinations. PN

FDA to Review NDA for Abilify Pill With Ingestible Tracking Device

Although digital medicines have the potential to improve health outcomes, it remains to be seen how eager patients and psychiatrists will be to embrace the technology.

BY VABREN WATTS

Otsuka Pharmaceutical and Proteus Digital Health recently announced that the Food and Drug Administration has agreed to review the New Drug Application for the combination product of Abilify (aripiprazole) embedded with the Proteus ingestible sensor for the treatment of schizophrenia, acute treatment of manic and mixed episodes associated with bipolar I disorder, and an adjunctive therapy for the treatment of major depressive disorder.

The modified Abilify tablet contains an ingestible sensor that communicates with a sensor patch worn by the patient and medical software application. The patch records and time stamps information from the ingestible sensor in addition to collecting other patient metrics, including rest and activity patterns. Such information can then be transmitted to a patient's mobile phone or Bluetooth device. Patients as well as physicians and caregivers—with the patient's consent—can view the information using a secure web portal.

"The ingestible sensor measures medication-taking patterns and physiological response of the patient," said Timothy Peters Strickland, M.D., a psychiatrist and senior director of Global Clinical Development at Otuska. With the ingestible sensor, "we can actually tell that the patient ingested the pill and not just punched it out of a card or removed the cap of the pill bottle."

John Kane, M.D., a professor of psychiatry at the Zucker Hillside Hospital and the Hofstra North Shore-LIJ School of Medicine, conducted a pilot study with the antipsychotic/medical device. The pilot study consisted of 28 patients with bipolar disorder or schizophrenia.

The results, published in the *Journal of Clinical Psychiatry* in 2013, showed that 27 out of 28 people completed the study. Of those who completed the study, 70 percent reported the software for the medical device to be easy to understand; 89 percent considered the device to be useful to them in terms of adherence. The most common adverse event was minor skin irritation that occurred at the site of the wearable sensor.

Proteus Digital Health

Otsuka Pharmaceutical and Proteus Digital Health's monitoring system for Abilify includes a mobile app, pills with an embedded sensor, and a stick-on patch that tracks the patient's body data and adherence to the medication.

"The technology can provide important advances in addressing highly prevalent problems in patients adhering to medications," Kane told *Psychiatric News*. However, Kane mentioned, major concerns regarding the use of this technology are likely to arise, such as how the information obtained by the device will be protected.

William Carpenter, M.D., a professor of psychiatry and pharmacology at the University of Maryland School of Medicine, agreed.

In addition to issues of privacy, Carpenter told *Psychiatric News* that convincing people who are already vulnerable to paranoia to take a medication that may be viewed as highly intrusive as well as the potential high cost of the medicine could present additional challenges.

Carpenter described several other looming questions about the therapy, including how best to determine candidates for the ingestible-sensor medications. Additionally, he said psychiatrists may need to consider questions such as, "Is this an acceptable privacy compromise in an involuntary commitment?" or "Will the device lead to fewer in-person visits with clinicians and reduce the chances for integrative treatment and early detection of relapse?"

Carpenter concluded, "Some [psychiatrists] will be ready for this innovative approach of treating mental illness; and if this device is successful—with little compromise to the patient—the field will embrace it." PN

MED CHECK

BY VABREN WATTS

FDA Approves Aristada for Treatment of Schizophrenia

Last month, the Food and Drug Administration approved Aristada (aripiprazole lauroxil), a long-acting injectable antipsychotic, for the treatment of schizophrenia. The medication requires administration by a health care professional every four to six weeks.

The approval of Aristada was based, in part, on the results of a 12-week clinical trial of 623 participants with schizophrenia who were experiencing an acute exacerbation. Participants were randomly assigned to receive a gluteal intramuscular injection of aripiprazole lauroxil (441 mg or 882 mg) or matching placebo once monthly for 12 weeks.

Patients in the 441 mg and 882 mg aripiprazole lauroxil groups demonstrated greater improvements in total scores on the Positive and Negative Syndrome Scale and the Clinical Global Impressions-Improvement scale than those treated with placebo. The most common side effects reported by participants receiving the medication were insomnia, headaches, and akathisia.

Similar to other atypical antipsychotics used to treat schizophrenia, Aristada comes with a boxed warning alerting health care professionals about an increased risk of death associated with off-label use of the medication to treat behavioral problems in older adults with dementia-related psychosis. To date, no atypical antipsychotic has been approved to treat dementia-related psychosis.

According to a press release by Alkermes Plc, the manufacturers of Aristada, the newly approved antipsychotic is being prepared to be launched "immediately."

Chantix Not Associated With Increased Risk of Cardiovascular, Psychiatric Events, Study Finds

The smoking cessation drug varenicline (marketed as Chantix by Pfizer) does not appear to be associated with an increased risk of cardiovascular or psychiatric events when compared with other nicotine replacement treatments, according to a study published in the October issue of the *Lancet Respiratory Medicine.*

The study tracked over 160,000 patients who received a prescription for a nicotine replacement treatment (NRT), the anti-smoking drug bupropion, or varenicline for up to six months to compare incidence of depression, self-harm, and cardiovascular events.

At study completion, the results showed that people taking varenicline were no more likely to suffer a heart attack or develop depressive symptoms than those on an NRT or bupropion. In fact, the researchers found that varenicline was associated with a significantly reduced risk of ischemic heart disease, cerebral infarction, heart failure, arrhythmia, depression, and self-harm.

Since the initial marketing of varenicline in 2006, it has been at the center of nearly 3,000 lawsuits allegedly claiming that use of the drug causes serious adverse events. All lawsuits were settled by the company in 2013.

Kotz D, Viechtbauer W, Simpson C, et al. Cardiovascular and Neuropsychiatric Risks of Varenicline: A Retrospective Cohort Study. *Lancet Respir Med.* 2015 Oct;3(10):761-8. http://www.thelancet.com/journals/lanres/article/PIIS2213-2600(15)00320-3/abstract

Oral Cannabidiol Boosts Response To Antipsychotic Treatment

G.W. Pharmaceuticals recently announced positive results from its phase 2a trial of oral cannabidiol (CBD) intended as an adjunctive therapy to antipsychotics for the treatment of schizophrenia.

The six-week, double-blind, placebo-controlled trial included 88 patients with schizophrenia who had previously failed to adequately respond to first-line antipsychotic medications. Patients remained on their antipsychotic medication during the trial while being randomized to receive 500 mg of CBD or placebo twice a day.

Results showed that as an adjunctive therapy to antipsychotics, CBD was consistently superior to placebo, with the most notable differences in the positive subscale of the Positive and Negative Symptom Scale, Clinical Global Impression of Severity, and Clinical Impression of Improvement. The most common adverse events reported by patients included diarrhea, nausea, headache, and somnolence.

The company announced that it will conduct further studies based on the current findings and future studies exploring the effectiveness of CBD in rare neuropsychiatric conditions that affect children.

FDA Requests Change to Zoloft's Warnings

The FDA has asked Pfizer to modify its labeling for the antidepressant Zoloft (sertraline) to acknowledge data that suggests infants whose mothers took the medication may be at an increased risk of heart defects. The agency is specifically asking for the label of the antidepressant to include warnings from researchers who found prenatal use of Zoloft to be associated with "increased risk of congenital cardiac defects" in infants, according to company court papers obtained by Bloomberg.

Although the majority of studies investigating the safety of Zoloft found that it did not increase risk for major birth defects in the offspring of women taking the drug, the medication's current label reads that there are "no adequate and well-controlled studies of pregnant women," according to *Bloomberg.*

Pfizer has maintained that Zoloft does not cause congenital heart defects in infants and that its label warns women and their doctors about the medication's risk.

The company is facing hundreds of lawsuits by women who say they were not adequately warned the drug would cause defects in their newborns. The company was exculpated of these claims in two court cases in St. Louis and Philadelphia earlier this year. PN

Opioid Use

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prevalence of drug-poisoning deaths involving prescription opioids has more than tripled from 1998 to 2013, from 1.4 per 100,000 population to 5.1 per 100,000 population.

"Since illicit use of prescription opioid drugs has become an epidemic, we conducted the current study to have an updated summary of the prescription drug situation over the last 10 years, which is extraordinarily important for clinicians as well as policymakers," said Compton.

For the study, whose first author was Beth Han, M.D., Ph.D., M.P.H., a statistician at the Center for Behavioral Health Statistics and Quality at SAMHSA, the prevalence of the nonmedical use of prescription opioids and prescription opioid use disorder (OUD) as well as mortality related to prescription opioid use were examined in U.S. adults aged 18 through 64. Datasets were generated from the 2003 to 2013 studies of the National Survey on Drug Use and Health (totaling 472,200 people) and the 2003 to 2013 reports of the Multiple Cause of Death Files from the National Vital Statistics System.

The analysis showed that the rate of nonmedical use of prescription opioids decreased from 5.4 percent in 2003 to 4.9 percent in 2013, but the prevalence of prescription OUD—in accordance with *DSM-IV* criteria—increased from 0.6 percent to 0.9 percent within that same period. The 12-month prevalence of high-frequency use (200 days or more) also increased from 2003 to 2013, from 0.3 percent to 0.4 percent.

Mortality assessed by drug overdose death rates involving prescription opioids increased from 4.5 per 100,000 in 2003 to 7.8 per 100,000 in 2013.

"The study's findings are complex," said Compton. "If we were just to look at the overall rates for opioid use, the findings would be considered great news; however, we see an increase in the intensity at which nonmedical users of prescription opioids use the drugs and the ramifications associated with illicit [prescription] opioid use, such as rates for opioid use disorder and mortality."

Although Compton said that the reasons for the current rates associated with illicit opioid use are multifactorial, one area that must be addressed is prescription guidelines for chronic pain.

"These rates are highly related to access of prescription opioids and diversion of prescription opioids—with physicians being one of the primary sources of these pills," Compton told *Psychiatric News*. "It's important for us as physicians to ensure that these lifesaving medications are available to those who need the medicines, while ensuring that these drugs are not prescribed in excess amounts."

In an accompanying editorial, Lewis Nelson, M.D., director of the fellowship in medical toxicology at New York University School of Medicine, and colleagues wrote that although much work is needed to decrease the prescription opioid use epidemic in this country, it is encouraging that the recent study shows a downward trend in the illicit use of prescription opioids. This is especially important "when considering the marketing of a plethora of new opioids for the treatment of chronic pain, none of which has been shown to be safe and effective over the long term. … Although multifaceted approaches are needed to successfully address the opioid epidemic, an important step is to start at the beginning and keep opioid-naive patients opioid naive." PN

An abstract of "Nonmedical Prescription Opioid Use and Use Disorders Among Adults Aged 18 Through 64 Years in the United States, 2003-2013" is posted at http://jama.jamanetwork.com/article.aspx?articleid=2456166.

JOURNAL DIGEST

BY VABREN WATTS

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Patients With Severe Depression May Benefit Equally From CBT, Antidepressants

Previous studies have shown psychotherapies, in particular cognitive-behavioral therapy (CBT), to be just as effective as pharmacotherapies in treating mild to moderate symptoms of depression. But less is known about the relative effectiveness of psychotherapy compared with pharmacotherapy in populations with severe depression. Current guidelines recommend the use of antidepressant medications for the treatment of severe depression in the context of major depressive disorder. Now, a recent meta-analysis published in *JAMA Psychiatry* suggests that only a modest difference is seen in the effectiveness between the two therapies among patients who are severely depressed.

Researchers from the VU University Amsterdam analyzed primary data submitted by the authors of 16 randomized, controlled trials in which CBT was compared with pharmacotherapy among outpatients with a primary diagnosis of a depressive disorder (major depressive disorder or dysthymia). Main outcome measures included improvements in scores on the 17-item Hamilton Rating Scale for Depression (HAM-D) and Beck Depression Inventory (BDI), as well as the rates of response and remission.

Based on their analysis, the researchers identified a modest (less than 1 point) main effect of antidepressant pharmacotherapy over CBT on the HAM-D and a nonsignificant trend on the BDI, but no significant differences in rates of response (defined as 50 percent reduction in scores on post-test HAM-D) or remission. Additional analysis indicated that baseline depression severity does not moderate reductions in depressive symptoms between CBT and antidepressant medications.

The authors wrote that while their analysis "shows that pharmacotherapy provides minor improvement in the treatment of depression relative to CBT in terms of the continuous measures, there is no indication that differences between the modalities were moderated by the degree of baseline depression severity. Therefore, the data are insufficient to recommend [antidepressant medications] over CBT in outpatients based on baseline severity alone." They added, "More research is needed to examine whether other demographic and clinical characteristics moderate the differential response between CBT and [antidepressant medications]."

Weitz E, Hollon S, Twisk J, et al. Baseline Depression Severity as Moderator of Depression Outcomes Between Cognitive Behavioral Therapy vs Pharmacotherapy: An Individual Patient Data Meta-analysis. *JAMA Psychiatry.* September 23, 2015. [Epub ahead of print] http://archpsyc.jamanetwork.com/article.aspx?articleid=2436905

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Choice of Youth Alcohol Brands Linked to Alcohol Ads

Exposure to specific alcohol advertising plays a major role in what brand youth use to engage in illegal use of alcohol, according to a recent study published in the *American Journal of Drug and Alcohol Abuse.*

Researchers from the Johns Hopkins School of Public Health and Boston University School of Public Health evaluated the impact of brand-specific alcohol advertising in national magazines and television programs on 30-day consumption prevalence of that brand in approximately 1,000 youth aged 13 to 20 between December 2011 and May 2012.

Youth were 36 percent more likely to consume brands of alcohol that were advertised in national magazines and five times more likely to consume brands of alcohol advertised on television.

The study authors hope that the findings will eventually lead to policies similar to those that limited alcohol advertising four decades ago.

"It was [once] controversial to say that a relationship between cigarette marketing and youth cigarette consumption existed," said lead study author Michael Siegel, M.D., M.P.H., a professor of community health sciences at the Boston University School of Public Health. "Once the relationship between cigarette ads and the brands that youth were smoking was established, significant policy shifts occurred as state and federal policymakers took the issue of advertising exposure to youth much more seriously."

Siegel M, Ross C, Albers A, et al. The Relationship Between Exposure to Brand-Specific Alcohol Advertising and Brand-Specific Consumption Among Underage Drinkers - United States, 2011-2012. *Am J Drug Alcohol Abuse.* October 19, 2015. [Epub ahead of print] http://www.tandfonline.com/doi/full/10.3109/00952990.2015.1085542

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Cardiovascular Disease, Cancer Top Causes of Death In Schizophrenia Patients

A study published last month in *JAMA Psychiatry* reported that adults with schizophrenia die at 3.5 times the rate of that of the general U.S. population. While this increased risk of mortality was distributed across multiple diseases, it was particularly elevated for cardiovascular disease, diabetes mellitus, and suicide.

The purpose of the study was to examine the specific causes of deaths among Medicaid patients—aged 20 to 64—who died between January 1, 2001, and December 31, 2007. Mortality data were extracted by the U.S. Compressed Mortality File.

The results showed that natural causes accounted for 55,741 of deaths in schizophrenia patients, with cardiovascular

RAISE

continued from page 1

family psychoeducation, and supported education and employment."

Kane and colleagues at multiple institutions used a model called NAVIGATE that includes four core interventions: personalized medication management, family psychoeducation, resilience-focused individual therapy, and supported employment and education. Thirty-four community mental health treatment centers in 21 states were randomly assigned to the experimental intervention (n=17) or to standard care (n=17). A total of 223 patients received the experimental NAVIGATE intervention, and 181 participants received usual care.

The study found that NAVIGATE patients remained in treatment longer, experienced greater improvement in quality of life and psychopathology, and experienced greater involvement in work and school compared with patients in community care. When the researchers compared NAVIGATE participants with duration of untreated psychosis of less than 74 weeks with those with more, they found that those with less had greater improvement in quality of life and psychopathology.

"These results demonstrate the importance of early detection, early engagement, and integrated care following the onset of psychosis," then-NIMH Director Thomas Insel, M.D., wrote in an accompanying editorial.

Lead author John Kane, M.D., believes the comprehensive model of specialty care for first-episode psychosis will prove cost-effective in the long run.

The findings also suggest the implementation of such a model is feasible, Kane said. "We were able to implement this model in a series of community clinics across the country—these were not teaching hospitals or research facilities, but real-world clinics. … it shows we can work with clinicians in a diverse range of settings to help them develop the skills necessary to deliver this kind of specialty care."

Will insurance pay for this kind of comprehensive specialty care? Last month, the Centers for Medicare and Medicaid Services released an informational bulletin that described ways that states can use the federal Medicaid program to pay for evidence-based, first-episode psychosis services, such as those tested in RAISE.

"Initially this kind of model may be associated with some increase in cost, but we believe over time the improvements in functional recovery and quality

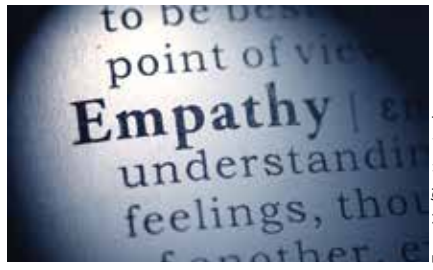
continued on next page

disease having the highest mortality rate at 403.2 per 100,000 person-years, accounting for almost one-third of all natural deaths. Cancer had the second highest mortality rate (200.5 per 100,000 person-years), with lung cancer being the most prevalent cause of death by cancer at 74.8 per 100,000 person-years. Chronic obstructive pulmonary disease (89.5 per 100,000 person-years) and diabetes (61.8 per 100,000 person-years) were other leading causes of natural deaths among study participants with schizophrenia.

Unnatural causes of death accounted for 9,812 deaths, with accidents and suicide being the leading causes, with mortality rates of 199.7 per 100,000 persons-years and 52 per 100,000 persons-years, respectively.

"The excess of cardiovascular deaths further supports initiatives aimed at improving … medical and behavioral interventions, including more consistent management of diabetes mellitus, hypertension, dyslipidemia, and other cardiovascular risk factors," noted the researchers. They concluded that based on the study's findings, aggressive identification and management of cardiovascular and cancer risk factors, including tobacco smoking, should be leading priorities in the medical care of adults with schizophrenia.

Olfson M, Gerhard T, Huang C, et al. "Premature Mortality Among Adults With Schizophrenia in the United States." *JAMA Psychiatry.* October 28, 2015. [Epub ahead of print] http://www.ncbi.nlm.nih.gov/pubmed/26509694



Feng Yu/Shutterstock

Youth Perceive Empathy and Competence of Psychiatrists Based on Clinician's Name

Although Dr. Doe, Dr. John, and John are the same person, the title that psychiatrists choose to use when introducing themselves to young patients could influence how their levels of competence and empathy are perceived by patients, according to a study presented at the 2015 Annual Meeting of the American Academy of Child and Adolescent Psychiatry.

Researchers from the Children's Hospital of University of Buffalo Psychiatric Clinic randomly assigned 54 young patients one of three vignettes in which psychiatrists introduced themselves with the title of "doctor" with their last name or first name, or without the title of "doctor" using their first name only ("Dr. Jones," "Dr. Bob," or "Bob"). Patients were asked to rate the psychiatrists' ability to be empathetic (based on the Jefferson Scale of Patient Perception of Physician Empathy) as well as the psychiatrists' competence (based on the Medical Interview Satisfaction Survey).

Results showed that "Dr. Bob" was significantly perceived to be more empathetic than "Dr. Jones" and "Bob." "Dr. Jones" was significantly perceived to be more empathetic than "Bob." "Dr. Bob" was also significantly perceived by patients to be more competent than "Bob." No significant difference was observed in patient-perceived competence between "Dr. Bob" and "Dr. Jones."

The researchers mentioned that child and adolescent psychiatrists, especially those in training, may consider using the title "Doctor" followed by their first name in addressing a child and their parent since this particular title had a higher association with perceived empathy and competence by patients.

On the basis of their findings, the researchers recommencded that child psychiatrists should also consider asking the child and their parents on their comfort levels of addressing psychiatrists in a particular manner, which could improve the therapeutic alliance. PN

DiGiacomo M, Cogswell A, and Pierre-Louis, M. What's in a Name? 2015 AACAP Annual Meeting. https://aacap.confex.com/aacap/2015/webprogram/Session13169.html.

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The other six members of the work group are Lama Bazzi, M.D., Scott Benson, M.D., Brian Crowley, M.D., Elizabeth Henderson, M.D., Gail Robinson, M.D., and Altha Stewart, M.D.

Assisted Outpatient Treatment Discussed

The Board also heard a report from Steven Hoge, M.D., chair of the Council on Psychiatry and the Law, and Marvin Swartz, M.D., corresponding member of the council, on a proposed position statement on assisted outpatient treatment (AOT). The proposed position statement, which includes 15 recommendations, will be voted on by the Board in December.

In an interview with *Psychiatric News* after the meeting, Swartz said pending mental health reform legislation in Congress includes provisions regarding AOT so the council believes it is important for APA to formulate policy on the issue.

"Basically, the position we take is that outpatient commitment can be effective if it is systematically implemented, if it includes the intensive services necessary to meet the needs of the patient, and if it is sustained for a reasonable period of time," Swartz said. "If a state is going to implement AOT, it has to be purposeful, and it has to include the combination of services necessary to make it meaningful. And it takes time."

Swartz added, "It is a controversial procedure because there are people who think that the court has no business ordering people into treatment if they haven't broken the law," Swartz said. "And often it is the mental health system that has failed a person.

"That's a strong point, but we believe that AOT can also provide guidance to the system," he said. "AOT is also a court order for the mental health system to prioritize care. When someone is under a court order, they get priority—they get attention and services."

Swartz added that the council evaluated the AOT program in New York state and found that it did reduce hospitalization and arrests and saved the state approximately 50 percent in the first two years (*Psychiatric News,* November 6). "When we asked patients about their experience with the program, generally those with serious mental illness responded that if they really get the benefits of AOT—a place to live and consistent treatment—then they are willing to trade off their freedom to get those benefits." PN

APA members can access summaries of actions taken at Board of Trustees meetings at http://psychiatry.org/about-apa/meet-our-organization/governance-meetings/governance-meeting-archive.

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of life will lead to further cost offsets and in the long run will be cost-effective," Kane said.

The National Alliance on Mental Illness (NAMI) plans to use this program and study findings in support of a major campaign to promote broader adoption of coordinated specialty care services throughout the United States for people experiencing first-episode psychosis. As part of this effort, NAMI arranged a Congressional briefing that took place on the day the study was released in which Kane and Lisa Dixon, M.D., presented the RAISE comparative effectiveness and implementation results.

Kenneth Duckworth, M.D., medical director of NAMI, told *Psychiatric News* in an interview that the findings could be "a game changer for the field."

"This is one of the biggest and most important studies coming out of NIMH," he said. "This is a study of approaching psychosis with a public health intervention—that's a strategy we have not traditionally done well in this country.

Key Points

The study by Kane and colleagues tested a comprehensive specialty care model for treating first-episode psychosis in community clinics versus usual care.

- The experimental intervention was a model called NAVIGATE that includes four core interventions: personalized medication management, family psychoeducation, resilience-focused individual therapy, and supported employment and education.
- NAVIGATE patients remained in treatment longer, experienced greater improvement in quality of life and psychopathology, and experienced greater involvement in work and school compared with patients in community care.
- Patients with a duration of psychosis of 74 weeks or less benefitted from the intervention more than those with a longer duration.

Bottom Line: Early intervention in first-episode psychosis employing a comprehensive model that includes psychosocial treatments as well as psychopharmacology can significantly alter the trajectory of illness.

"So this is a profound finding—that if you get people early in their illness and give them services we know work, they get better," Duckworth said. PN

"Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.15050632. An accompanying editorial, "RAISE-ing Our Expectations for First-Episode Psychosis," is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.15091204.

Candidates

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Medicine and School of Public Health. She leads health care transformation and clinical program development. She is active in APA leadership on the Board of Trustees, councils, and Assembly. She is a Maryland Psychiatric Society past president and member of the Maryland Psychiatric Foundation.

The treasurer's position, which is for a three-year term, is also up for election this cycle. Vying for that post are Bruce Schwartz, M.D., of the Bronx, N.Y., and Linda Worley, M.D., of Fayetteville, Ark.

The Board's trustee-at-large election is a three-way race for 2016, with Rebecca Brendel, M.D., J.D., of Boston, Geetha Jayaram, M.D., of Baltimore, and Richard Summers, M.D., of Philadelphia facing off. This position is also for a three-year term.

Two of APA's seven geographic Areas will vote for a trustee in this cycle. In elections for Area trustee, the Area Council rather than the APA Nominating Committee chooses the candidates.

Competing in Area 3 are Steven Daviss, M.D., of Baltimore and Roger Peele, M.D., of Rockville, Md. Area 3 encompasses the district branches of New Jersey, Pennsylvania, Delaware, Maryland, and the District of Columbia.

In Area 6, which includes the five district branches in California, the candidates are Robert Cabaj, M.D., of San Francisco and Melinda Young, M.D., of Lafayette, Calif.

Resident-fellow members (RFMs) will also have three of their colleagues from whom to choose as they vote for the Board position of resident-fellow member trustee-elect. The candidates are Adrian Jacques Ambrose, M.D., a resident at Dartmouth-Hitchcock in Lebanon, N.H., Uchenna Okoye, M.D., M.P.H., a resident at the UCLA Semel Institute in Los Angeles, and Matt Salmon, D.O., a resident at Maricopa Integrated Health System in Phoenix.

APA announced the slate of candidates for the 2016 election in late October, and while it is considered public, it is not official until the Board of Trustees approves it at its meeting next month. All of the winning candidates will take office at the close of the 2016 APA annual meeting in May in Atlanta.

All members for whom APA has a valid email address on file will receive an electronic ballot. Other members will receive a paper ballot along with instructions on how to vote online if they choose to do so. All candidates as well as their supporters are strongly urged to review APA's recently updated Election Guidelines.

Voting will begin on January 4, 2016, at 5 a.m. (EST) and end on February 1, 2016, at 11:59 p.m. PN

Additional election information and a link to the Election Guidelines are posted on the APA website at http://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/leadership-opportunities/election-information.

Briefing

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tal health care from our jails to the community," said Mary Ann Borgeson, who has served as the county commissioner in Douglas County, Neb., for 21 years. "But, we can't do it alone. We need federal leadership, and we ask Congress to make the efforts needed to reduce the criminalization of people with mental illness."

The American Psychiatric Association Foundation, the National Association of Counties, and the Justice Center of the Council of State Governments have joined together to create the Stepping Up Initiative, intended to reduce the number of persons with mental illness in the nation's jails (*Psychiatric News*, June 5). The initiative will convene a national summit conference in April 2016 to develop strategies to help counties move toward that goal.

Some counties have already begun to make changes by modifying arrest policies and law enforcement training, establishing mental health courts, and developing re-entry supported housing programs.

"We need to give local jurisdictions help to decrease the number of people with mental illness behind bars," Binder urged the audience, noting the array of bipartisan mental health reform bills already proposed in both the House and Senate. These include the Comprehensive Justice and Mental Health Act, the Comprehensive Addiction and Recovery Act of 2015, the Helping Families in Mental Health Crisis Act of 2015, and the Mental Health Reform Act of 2015.

"APA has taken the lead in collaborating with leaders in Congress toward the furtherance of these goals, but we can't do it alone," Binder wrote in a related blog post. "I urge you to get involved with your state and local legislature and communicate to them the unique issues that your community faces in regards to the criminalization of people with mental illness." PN

Binder's blog post "Working to Decriminalize Mental Illness" is posted at http://psychiatry.org/news-room/apa-blogs/apa-blog/2015/10/working-to-decriminalize-mental-illness.

Domestic Violence

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she said. "They are educated but in poverty, with 90 percent having at least a high school education, but that does not translate to job opportunities in the United States."

Cultural issues increase the acceptability of violence in this population, said Berry. Males are valued more highly than females, for example. Men are in charge of the family's financial security, while women run the household, but a woman may be beaten if she fails at that task.

"In addition, women immigrants may find social isolation, prejudice, and language barriers upon moving to the United States," she said. Leaving an abusive partner is difficult because it also means leaving one's own community and identity.

Any interventions must be done in a culturally sensitive manner, said Berry. "Asking if a woman is 'victim' doesn't work, but inquiring about specific symptoms, like 'sadness' or 'crying' are more likely to elicit useful information."

Aaron Levin

Victims of domestic violence may present with many somatic symptoms, especially among minority groups, says Obianuju Berry, M.D., M.P.H.

Finally Mark Nathanson, M.D., addressed abuse among another marginalized, underserved population—the elderly.

The typical elderly victim of abuse is a woman living in social isolation and in physical and mental decline, said Nathanson, an attending physician at New York Presbyterian Hospital and director of the geriatric fellowship program at Columbia University and the New York State Office of Mental Health.

Aaron Levin

Physical, emotional, and financial abuse of older people may not be immediately visible, and competent individuals have the right to make bad decisions, says Mark Nathanson, M.D.

"The typical abuser is a family member who has substance abuse or mental health problems, a controlling personality, and is under some financial, emotional, or marital stress," he said.

One complicating problem regarding the elderly is that if they retain decisional capacity, they have the right to make bad decisions and to refuse help from adult protective services, he said.

When such cases come to the attention of clinicians, they can begin by developing good written documentation, encouraging individual and group counseling of victims and abusers, and linking patients to community resources like adult day care programs or support groups. Recourse to the legal system may be a final step, if necessary.

Over the longer term, educational programs for caregivers, health care providers, and the public as well as changes in government policies may reduce abuse of the elderly, said Nathanson. "A multidisciplinary team approach can improve life for this group."

In the second half of the program, representatives from a range of community support organizations in the New York area discussed the services they provide to domestic violence victims. The speakers included Margarita Guzman, J.D., executive director of the Bronx Family Justice Center; Vilma Torres, L.C.S.W., director of Safe Horizon at the Bronx Family Justice Center; Deirdre Lok, J.D., assistant director and general counsel at the Harry and Jeanette Weinberg Center for Elder Abuse Prevention at the Hebrew Home at Riverdale; and Hayley Carrington-Walton, Ph.D., program director of HELP-ROADS, a nonresidential family safety program. PN

Information about APA's Division of Diversity and Health Equity is posted at http://www.psych.org/psychiatrists/cultural-competency.