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PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

ISSN 0033-2704

Aaron Levin

First Lady Michelle Obama addresses attendees at the launch of the Change Direction campaign, among whose partners are APA, the American Psychiatric Foundation, and American Psychiatric Publishing. "We have to listen to people with mental health problems, connect with them, and offer them compassion so that our friends and neighbors and veterans can get the help they need," she said.

First Lady Opens Campaign to 'Change Direction' on Mental Health

Among the goals of national campaign are to educate the public about mental health and to destigmatize mental illness.

BY AARON LEVIN

"It is time to tell everyone who is dealing with a mental health issue in this country that they are not alone and that getting support and treatment isn't a sign of weakness—it's a sign of strength," First Lady Michelle Obama told 500 mental health leaders and advocates at the launch in Washington, D.C., of the Change Direction campaign last month.

Change Direction will unite an array of corporations, government entities, and organizations to educate at least 30 million Americans about mental illness over the next five years. APA, the American Psychiatric Foundation, and American Psychiatric Publishing are founding members of the campaign.

The campaign builds on the work of Give an Hour, a nonprofit organization founded in 2005 by psychologist Barbara Van Dahlen, Ph.D., which arranges for mental health clinicians to provide pro bono services for veterans, military service members, and their families.

Speakers at the inaugural event emphasized the necessity of destigmatizing mental illness. People rarely fail to seek treatment for cancer, heart disease, or injuries but routinely do so in the case of mental illness, they noted. Too often they are deterred by feelings of shame, embarrassment, or lack of knowledge about mental illness and its treatments.

see ***Change Direction*** *on page 31*

Volkow to Give Keynote Lecture At Toronto Annual Meeting

Nora Volkow, M.D., whose research has advanced the knowledge of addictions by showing that they are brain disorders, will discuss the neurobiology of substance abuse disorders.

BY VABREN WATTS

Renowned addictions researcher Nora Volkow, M.D., director of the National Institute on Drug Abuse, will present the William C. Menninger Memorial Convocation Lecture at APA's 2015 annual meeting next month in Toronto.

She will present the lecture during the Convocation of Distinguished Fellows, which will be held Monday, May 18, at 5:30 p.m. in Exhibit Hall A, Level 300, in the North Building of the Toronto Convention Centre.

"I was very excited when I got the invitation," Volkow told *Psychiatric News*. "It shows that there is a great sensitivity at APA for recognizing substance use disorders as mental health disorders and that such illnesses must be addressed in those patients who are affected."

She added, "Though substance use disorders are extremely prevalent as a single entity or with other comorbid mental illnesses, substance use disorders have not received the attention that they deserve. I commend APA for bringing this form of mental illness to the fore-

see ***Volkow*** *on page 31*

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Register Now and Save!

PSYCHIATRY: INTEGRATING BODY AND MIND, HEART AND SOUL

Join your colleagues from across the United States and more than 50 countries for the psychiatry event of the year. APA's 2015 annual meeting is being held in Toronto from May 16 to 20 on the theme "Psychiatry: Integrating Body and Mind, Heart and Soul." Take advantage of the low advance-registration rates now in effect by registering now at **annualmeeting.psychiatry.org**. And while you are at it, be sure to reserve your hotel room at APA's preferred convention rates.

For travel information to and from Canada, see the box on page 7.

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FROM THE PRESIDENT

Preparing Tomorrow's Psychiatrists: What We Need to Do

BY PAUL SUMMERGRAD, M.D., AND RICHARD F. SUMMERS, M.D.

The curricula of psychiatric residency and fellowship training literally shape the future of our field—absent our educational enterprise, there are no new psychiatrists. At a time of dramatic change in our science, with nearly daily breakthroughs in genetics and neuroscience; a health care system undergoing transformation; and pressures on graduate medical education, to fail to look broadly at the future of psychiatric training would be shortsighted. In addition, concerns have been raised in the field about the focus of current training and how to incorporate the elements of neuroscience and integrated care in a curriculum that is already complex and under pressure to streamline. While there are many groups charged with the specific oversight of elements of the psychiatric residency experience, we believed that APA, representing the field as a whole, was in the best position to convene the type of high-level review that might

inform future planning and thinking on these important topics.

With this framework in mind, the Board of Trustees voted last summer to create the Ad Hoc Work Group on Education and Training. This group included leaders from many parts of our field who are members of APA, as well as formal representation from the training directors' organization (AADPRT), the chairs' association (AACDP), the American Board of Psychiatry and Neurology (ABPN), and many others. We asked them to take on the tasks of assessing how we are currently training psychiatrists, identifying critical educational goals that will allow us to meet projected future needs, and making recommendations on the best ways forward. The work group, convened in August 2014, was chaired by one of the authors of this column—Richard F. Summers, M.D., co-director of residency training at the Perelman School of Medicine of the University of Pennsylvania. The group's charge was to review current pressures on residency education and training, including the following areas:

- Graduate medical education (GME) funding
- Curriculum changes, especially related to areas such as neuroscience
- Changing models of health care delivery (that is, integrated care and payment models)
- Research training

At our Board meeting last month, Dr. Summers presented the work group's comprehensive report, which included several major overarching recommendations. The report and its recommendations were unanimously approved by the Board.

First, the report recommended that APA must take an ongoing leadership role in advocating for the necessary changes in residency education so that psychiatrists of the future are prepared to meet the public health needs of Americans with psychiatric illness. This will best be accomplished by partnering effectively with the education organizations in the field and with other primary care medical organizations.

Second, APA should vigorously advocate for maintaining and increasing funding for GME, including funding for training in innovative care delivery systems. This also includes advocacy for maintaining psychiatry as a designated primary care specialty in recognition of the unique role that psychiatrists play as the principal physicians for many people with mental illness, especially serious mental illness.

Third, the work group recommended that general psychiatry training programs should remain four years in length because of the knowledge and skill set that will be required in a rapidly changing field. Four years of training is more than warranted due to the need to learn the greater volume of clinical knowledge in our field, including in the areas of neuroscience and integrated health care. Robust exposure to psychosomatic medicine, geriatric medicine, substance abuse/addiction treatment, and integrated care during general residency training will be required to ensure that psychiatrists are well trained to meet the clinical demands of the future. Child and adolescent psychiatry and forensic psychiatry will also continue to be important aspects of training, as will training to ensure that psychiatrists are culturally competent.

Fourth, the work group found that an increase in clinically applicable neuroscience knowledge has created a pressing need for curricular development in this important area, which will undergird so much of our understanding of psychiatric illness going forward.

Two position statements were proposed based upon these third and fourth points:

- General psychiatry residency training should be of four years' duration with an enhanced focus on the curricular elements noted above. The historic exception for child and adolescent psychiatry as a two-year training sequence after the third year of residency should be maintained.
- There is a need for increased focus on neuroscience education.

As position statements of APA require formal review and approval by the APA Assembly, these statements are now being referred to the appropriate APA components for review, after which they will go the Assembly for consideration.

Fifth, the work group made programmatic recommendations to the APA Department of Education and Council on Medical Education and Lifelong Learning to support faculty development, act as a convener of medical education groups in psychiatry, and increase offerings that focus on collaborative care.

Finally, the report calls for increased collaboration between APA's Council on Medical Education and Lifelong Learning and other APA councils to evaluate research training, conduct needs assessments, synthesize recruitment data, and promote training for integrated care.

The work group members reaffirmed the importance of traditional components of residency training, including the physician-patient relationship, professionalism, and psychotherapy, and noted that these important areas have also been strongly supported by the Psychiatry Milestones, the new ACGME framework that shapes residency education.

We owe our thanks to those who served on the work group and volunteered so generously to bring forward this comprehensive report: In addition

*see **From the President** on page 31*

Layperson's Guide to *DSM-5* Describes Sexual Disorders, Gender Dysphoria

Gender dysphoria, which replaces gender identity disorder, gets its own chapter in *DSM-5*, which emphasizes the experience of gender incongruence. This is the fifth in a series of articles.

BY MARK MORAN

"The complete giving of oneself to another person touches the essence of what it means to be human."

So begins a chapter on sexual disorders in the new *Understanding Mental Disorders: Your Guide to DSM-5,* to be published by American Psychiatric Publishing (APP) in May. The new manual is a layperson's guide to the text that was published for clinicians in 2013; the guide covers all of the disorders in the clinician's manual and roughly follows the same developmental scheme in the arrangement of chapters, providing a "lifespan" approach to understanding diagnosis.

The chapter on sexual disorders is followed by a separate chapter on gender dysphoria. (For information about the first 12 chapters in the manual, see preceding issues of *Psychiatric News.*)

The opening lines to the chapter on sexual disorders continue in the same elegant but simple style: "[O]f all our contact with others, sexual intimacy can be the most rewarding," the book states. "Although it can provide intense joy, it also can produce distress."

The new guide explains that because sexual response involves the body, mind, and emotions, often more than one factor is involved—including problems related to one's partner, the relationship in general, individual factors (such as aging, poor body image, low self-esteem), cultural or religious factors, and medical factors.

The disorders covered in the chapter include substance/medication-induced sexual dysfunction, erectile disorder, premature (early) ejaculation, female orgasmic disorder, delayed ejaculation, genito-pelvic pain/penetration disorder, female sexual interest/arousal disorder, and male hypoactive sexual desire disorder.

"Educating people about mental illness is our responsibility as psychiatrists—and one of the crucial missions of APA," says Robert Hales, M.D., editor-in-chief for books at APP and one of a six-member panel of editorial advisers who oversaw the writing and editing of the new consumer guide.

Robert Hales, M.D., editor-in-chief for books at APP and one of a six-member panel of editorial advisers who oversaw the writing and editing of the new guide, said the actual changes to criteria in the chapter on sexual disorders are few—mainly the addition of gender-specific sexual dysfunctions and the combination of female sexual desire and arousal disorders into a new disorder known as "female sexual interest/arousal disorder."

To improve precision regarding duration and severity and reduce the possibility of overdiagnosis, all of the *DSM-5* sexual dysfunctions except substance/medication-induced sexual dysfunction now require a minimum duration of approximately six months.

The chapter is sure to be of interest to the public, and Hales believes psychiatrists will be doing their patients a favor by referring them to the new publication. "Rigorously reviewed by experts with a variety of clinical perspectives, *Understanding Mental Disorders* presents sometimes complex information in readable, user-friendly language," he told *Psychiatric News.* "Mental health professionals can assure their patients that APA's official manual represents the most accurate, up-to-date, evidence-based information available in the field."

A characteristic feature of the new manual is its inclusion of "user-friendly" tools, such as the "Key Points" that accompany each chapter. Here are the key points given for sexual disorders:

- Sexual intimacy involves the whole person and can bring great joy. Sexual dysfunctions disrupt the ability to respond to sexual activity or to enjoy sex.

- These problems occur for many reasons, which can affect how the disorder is diagnosed and treated. Quite often, more than one factor causes a sexual dysfunction. These include health problems, medications, poor body image or low self-esteem, and relationship issues (such as lack of trust or communication).

- Treatment for sexual dysfunctions takes into account all the factors that can cause these problems and that are unique to each person and his or her partner. There may be medications that can be taken or changed, medical conditions to be treated, techniques to learn, and behaviors to help build trust and communication.

- Drugs, alcohol, and tobacco can impair sexual response.

- Other ways to improve sexual health include getting regular exercise (boosts stamina, mood, and self-esteem), coping with stress (so it won't distract from sex), and sharing feelings and preferences (to build closeness and learn what pleases the other).

Gender Dysphoria Replaces GID

Psychiatric understanding of gender has evolved considerably in recent years, and the creation of a chapter on gender dysphoria reflects that evolution. Gender dysphoria is a new diagnosis in *DSM-5*—

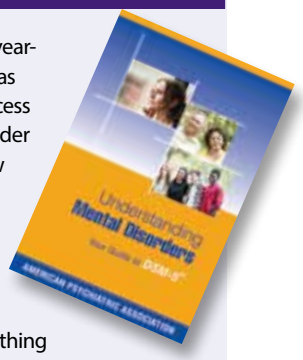
see **DSM-5 *Guide*** *on page 12*

Check Out the New Guide

While you are at APA's 2015 annual meeting in Toronto, be sure to stop by the American Psychiatric Publishing Bookstore and page through *Understanding Mental Disorders: Your Guide to DSM-5*. This is the essential resource on mental illness you've been needing to recommend to patients, families, and community members.

APA members get a 20 percent discount on all APP purchases; resident-fellow members get a 25 percent discount.

Christine's Story



Christopher, a 52-year-old salesperson, has begun a legal process to change her gender to female. Her new name is Christine. Christopher had been born with male genitals and was raised as a boy. Nothing unusual was noted by Christopher's parents until childhood, at which point Christopher was viewed as a "sissy" by other children. Christopher sought out female friends in school and chose activities and clubs that mainly involved girls. … He felt he was "Christine" instead of "Christopher." … Christopher did well in college and became very fond of a longtime girlfriend. Although he did not feel sexually drawn to her, he wanted very much to please his father, so he married her after college. He was fairly content with his married life, but he knew he was living mostly to please his family. … He felt much more at ease when he could think of himself as Christine. When his wife was not at home, he would often wear her clothing.

Over years of marriage, Christopher felt more unhappy and upset with himself that he was not being honest with his own life goals or honest with his wife and family. He sought treatment from a mental health care provider. After he talked about his life at length, he began to talk about his sense that he is "Christine" and his fears of letting down his family. As Christine, he began to share more private feelings in therapy. He became more secure in describing himself as a woman and began to ask some of his closest friends to refer to him as "she." Over time, she (Christine) began to realize that she was not going to have the quality of life that she wanted unless she began to live openly as a woman. Over the next several months, she worked with her mental health care provider to gain courage to tell her wife that she wanted to separate. She also sought a referral with a specialist who could inform her about hormone treatments and surgeries. She might someday explore these options if she wanted to change her physical appearance to a female, but she knew this would be a big decision. The first step would be to learn how to discuss her condition with all of her family and friends and decide how to begin changing her life to match the female role. She sought out a specialist who works with people who have gender dysphoria to help with this process, as she knew that it would be a very hard transition for her wife. Christine's father also would have trouble accepting the diagnosis and why it was crucial to Christine to be able to live her life as a woman.

PROFESSIONAL NEWS

Compliance With ACA's Parity Mandate Falls Short

Strong oversight of health plans is needed to ensure that they comply with federal mental health parity laws and regulations.

BY MARK MORAN

Some health plans offered in health exchanges established by the Affordable Care Act (ACA) appear—on the basis of benefit summary information provided to consumers—to be out of compliance with the law, which requires parity coverage of treatment for mental illness and substance abuse as defined by the federal parity law.

A report in *Psychiatric Services* by Kelsey Berry and Haiden Huskamp, Ph.D., of Harvard, Colleen Barry, Ph.D., of Johns Hopkins, and Howard Goldman, M.D., Ph.D., of the University of Maryland found inconsistencies with the federal parity law in the benefit summaries for mental health and substance abuse services of health plans in two state-run health exchanges. Those inconsistencies—in quantifiable treatment limits (cost-sharing, deductibles, treatment limits) and nonquantifiable treatment limits (prior authorization and other strategies for restricting treatment)—may reflect either actual noncompliance or an effort by plans to dissuade potential consumers who expect to use mental health services from enrolling.

"Consumers select a plan based on their anticipated service needs by using the written coverage information provided through the exchanges," the researchers said. "Benefit design information suggesting unequal requirements and limitations for behavioral health services, relative to other medical services, may affect plan choice decisions among consumers who expect to use behavioral health services."

Moreover, APA General Counsel Colleen Coyle, J.D., and Irvin "Sam" Muszynski, J.D., director of APA's Office of Healthcare Systems and Financing, said the report corroborates their own observations of how health plans are behaving with regard to parity requirements.

Coyle emphasized another area in which health plans may be engaging in practices that are deceptive to purchasers who expect to use mental health services—"network adequacy." Coyle pointed out that plans advertise provider networks that appear to afford options for access to care but in fact frequently include physicians who are no longer accepting patients, have moved from the area, or in some cases are deceased (see article below).

Muszynski, in comments to *Psychiatric News*, expressed frustration with the failure of regulators to force health plans to comply with the law. "Obviously, the ACA and the creation of the plans and extension of parity hold promise for access to mental health and substance abuse services," he said. "But consistency with the law has been flawed and falls short of the promise. The article by Goldman and colleagues mirrors our anecdotal experience, which is considerable and suggests stronger oversight is in order."

Coyle and Muszynski noted that APA has been pursuing a multifaceted strategy with regard to monitoring health plans for compliance with parity (see box at left).

The researchers reporting in *Psychiatric Services* reviewed summaries of benefits documents available to poten-

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APA Pursues Parity Compliance

APA is following a multipronged strategy to ensure that health plans comply with the parity law and with the Affordable Care Act, which require plans to offer mental health benefits at parity with medical-surgical benefits. APA General Counsel Colleen Coyle, J.D., and Irvin "Sam" Muszynski, J.D., director of APA's Office of Healthcare Systems and Financing, said APA is working in several ways to improve enforcement of parity:

- **Advocacy.** APA has resolved hundreds of complaints regarding parity implementation by insurance plans in a manner favorable to patients and members, including removing double copayments and securing refunds for patients and members, eliminating prior authorization when applied inequitably to mental health, and reducing copayments where appropriate under the final rules. Many insurance plans have been responsive to APA's inquiries and have worked to resolve issues, but others have not.

  APA sued two insurers—Anthem and WellPoint—on behalf of its members and their patients in the United States District Court in Connecticut in an effort to improve network adequacy and access for patients. The court found that APA was not an appropriate party to raise that issue, but APA has appealed that decision to the 2nd Circuit Court of Appeals. Also, APA has resolved dozens of potential audit issues favorably to members, resulting in millions of dollars in savings.

  APA is advocating on network adequacy issues on the national and state levels, including providing comments to the National Association of Insurance Commissioners on its model regulations regarding network adequacy and to several state insurance commissions on the same issue.

  At least three federal courts have stated that the Mental Health Parity and Addiction Equity Act is a "civil rights law" designed to end discrimination in mental health/substance use disorder benefits. APA is seeking federal legislation to improve enforcement of parity laws.

- **Education.** APA created the Mental Health Parity Poster and encouraged psychiatrists and other mental health clinicians to post it in waiting rooms to educate patients about their legal right to equal treatment (see box on facing page). More than 100,000 posters have been distributed, with district branches (DBs) and other associations and hospitals cobranding them. A Spanish-language version is being developed.

  Additionally, APA is creating materials for DBs and members to help them understand parity legislation and network adequacy issues and to provide tools needed to join APA's advocacy efforts. These are among other education efforts:

- Fielding press inquiries on mental health parity and lack of mental health parity enforcement to provide background on the law and problems with enforcement.

- Working with DBs to educate state insurance commissioners and state attorneys general regarding the federal law, violations of the law, and enforcement needs.

- Engaging in discussions with employers and human resources personnel to help them understand mental health parity rules and ensure that they do not purchase plans that fail to comply with the law.

Network Adequacy—Not Adequate

Patients who seek mental health care often find that provider networks don't include the psychiatrists they promise.

BY MARK MORAN

"Network adequacy"—the actual access to providers for treatment of mental health and substance abuse disorders experienced by purchasers of health plans—appears to be an area in which many health plans are offering deceptive products.

Colleen Coyle, J.D., APA's general counsel, told *Psychiatric News* that in many instances health plans advertise provider networks that appear to offer users of behavioral health services a wide range of options for access to care. But in reality those networks may be much "thinner" than consumers are led to believe; listed providers may not actually participate in the network or may be unable to take on new patients, while others may have moved out of the area, may no longer be in practice, or may even be deceased.

She noted that the Maryland Mental Health Association released a report in January titled "Access to Psychiatrists in 2014 Qualified Health Plans" assessing the accuracy and adequacy of insurers' psychiatric networks.

The report found that only 43 percent of listed "psychiatrists" were reachable. More than 10 percent of providers who could be reached indicated that they were not even psychiatrists, and many of those who were psychiatrists had extremely long wait times. Only 1 in 7 psychiatrists was accepting new patients and available for an appointment within 45 days.

"In my view that is fraud," Coyle said. "The insurer is promoting a provider list that it knows or should know is not reflective of the access to care that patients who enroll will really have. I don't think it's innocent at all. We know that plans are constantly looking at their providers and analyzing the types and number of claims the provider submits for payment , because that's how they target which providers to audit and whether they are going to challenge the claim. The companies know when a provider on their network list is not submitting claims and therefore not really a 'participating provider.' They could and should remove the providers from the directory who are not participating so the directory accurately reflects the service they are offering. But doing so would demonstrate the inadequacy of their network."

At the 2014 Interim Meeting of the AMA House of Delegates in Dallas last November, delegates approved a report from the AMA's Council on Medical

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tial enrollees for all insurance products offered in two state-run exchanges during the first open enrollment period, from October 2013 through March 2014. The exchanges were selected for variety in health insurance issuers and products and ease of access to summary documents for all insurance products.

For each product, they assessed whether the quantitative treatment limitations described for behavioral health benefits appeared more restrictive than those described for the medical-surgical benefits in each of four classifications of benefits: outpatient in network, outpatient out of network, inpatient in network, and inpatient out of network.

They found that for most products offered on both exchanges, quantitative treatment limitations and prior-authorization requirements described for behavioral health benefits appeared equivalent to or even more generous than those described for medical-surgical benefits.

However, they noted discrepancies with federal parity with some plans in at least three areas: financial requirements (that is, copayment, coinsurance, and deductible) imposed on behavioral health benefits versus medical-surgical benefits; application of financial requirements to mental health versus substance abuse benefits; and financial requirements for outpatient in-network behavioral health visits.

In the last area, they found that 11 percent of products impermissibly matched the financial requirements for outpatient in-network behavioral health visits to financial requirements for outpatient surgical visits rather than to a reference category of general medical office visits.

"Coverage for surgical visits is often more restrictive than for medical visits, so exchange plans that peg their behavioral health benefits to surgical visits may appear less generous to potential enrollees than competitor plans that peg their behavioral health benefits to medical visits. This discrepancy with the parity law may therefore have the effect of encouraging individuals with behavioral health treatment needs to choose a different exchange plan."

With regard to financial requirements for mental health as opposed to substance abuse, they found that in one product, for example, outpatient in-network primary care and mental health visits were combined for the purpose of exempting the first three visits of either kind from the plan deductible. In comparison, outpatient in-network substance abuse treatment remained subject to the plan deductible from the first visit.

And with regard to financial requirements for mental health care as opposed to medical-surgical, they found that in one product, inpatient medical-surgical stays at out-of-network providers require a copayment, whereas inpatient behavioral health stays at out-of-network providers require coinsurance, which typically results in a higher total out-of pocket payment than does a copayment.

Finally, summary documents specified prior authorization as a requirement for all outpatient behavioral health visits. In contrast, for these same products, prior authorization was either not specified at all as a requirement for outpatient medical-surgical benefits or specified as a requirement that would be selectively applied to certain services in the medical-surgical category.

Goldman said that some of the apparent inconsistencies with the parity law are related to the historical practice of separating the behavioral health benefit from the medical-surgical benefit in summaries of benefits available to consumers. This may cause an impression that behavioral health is being treated differently from other service areas.

In comments to *Psychiatric News*, Coyle agreed that the use of mental health carveouts—and the separation of mental health and medical-surgical benefits in the summaries available to potential purchasers—can only create confusion. "Parity is essentially a comparison, and it is confusing for consumers when they look at behavioral health on one side and a different summary for medical-surgical benefits on the other," she said.

Looking beyond the exchanges surveyed in the *Psychiatric Services* report to employer-provided plans, Coyle said states are responsible for ensuring that plans meet parity, but it is the employers that purchase a plan for their employees that are responsible and liable for the inconsistencies with the law.

"There is no doubt that on the face of it, some companies are violating the parity law by requiring prior authorization for all mental health and substance abuse claims," she said. PN

"A Tale of Two States: Do Consumers See Mental Health Insurance Parity When Shopping on State Exchanges?" is posted at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400582.

Empower Your Patients Regarding Parity Law

APA has produced a poster that spells out patients' rights under the Mental Health Parity and Addiction Equity Act and the steps to take when a violation is suspected. Armed with this information, patients are in a stronger position to ensure that they are getting the mental health benefits they are afforded under the law. Psychiatrists are encouraged to download the poster and hang it prominently in their offices or clinics or use it as a handout; also, the link can be forwarded to others in the community, such as employers and members of the clergy. Federal law is clear that insurers can no longer discriminate against patients with mental illness. To download the poster, go to http://www.psychiatry.org/practice/parity. A Spanish-language version of the poster is now being developed.

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Service with recommendations to help ensure that insurance networks provide "meaningful access" to all medically necessary and emergency care at the preferred, in-network benefit level on a timely basis.

"It's a hot topic and an area of major concern to physicians and patients," John McIntyre, M.D., told *Psychiatric News*. McIntyre, a past president of APA, is chair of the Council on Medical Service. "Many insurers, in an attempt to hold down costs, employ very narrow or shallow networks that are inadequate to provide medically necessary care. But patients don't know that when they sign up" (*Psychiatric News,* November 1, 2013).

Coyle said a remedy would be for states to require insurance companies to run claims data on each provider listed in the directory on a quarterly basis and make the information public. "That way it would be possible to see how many claims each provider is filing and who is actually participating in the network and who is not before people buy the product. Another benchmark would be to have the plan compare the number of out-of-network mental health claims paid versus the number of out-of-network medical-surgical claims paid. A significant difference demonstrates that the psychiatric network is not adequate to meet the patient demands and lets patients know in advance the likelihood that their mental health care will be more costly than advertised," she said. PN

Planning to Attend APA's 2015 Annual Meeting? Be Sure You Know Travel Requirements

With the 2015 APA annual meeting being held in Toronto, Canada, there are several travel considerations of which members attending the meeting should be aware.

All travelers to Canada, including those from the United States, must present a valid travel document showing proof of citizenship, such as a passport, birth certificate, or permanent resident card, upon entry to Canada. They must also satisfy an immigration officer that they have "ties, such as a job, home, financial assets, and family, that will take [them] back to [their] country of origin." Permanent residents of the United States who are not citizens should carry their Resident Alien Card. Those traveling with a child under age 18 need the same type of documentation of citizenship status for the child.

Some visitors, depending on country of origin, may also need a medical exam and a letter of invitation from the organizer of the event they are attending in Canada. Visitors from many countries will need a visa to enter Canada. Information about visas, including requirements and locations worldwide for applying for a Canadian visa, is posted at www.cic.gc.ca/english/information/offices/vac.asp. Don't wait until just before the meeting to begin the visa application process! Travelers are also advised that their passport should have six months' validity from the date of entry.

Canada cautions that "if you are a foreign student, temporary worker in the U.S., or visitor in the U.S. who wants to return to the U.S. after visiting Canada, you may encounter difficulties entering Canada without your passport or a Canadian Temporary Resident Visa (TRV). Because your status in the U.S. does not confer any status in Canada, or necessarily give you the right to re-enter the U.S., you should check with an office of the U.S. Immigration and Naturalization Service before leaving the U.S. to make sure you have all the necessary papers to return to the U.S." Information is posted at www.cbp.gov/travel/international-visitors.

Upon returning to the United States, the U.S. government says that all travelers must present a valid passport, though other forms of identification may be acceptable, depending on the traveler's circumstances. Legal residents must present a valid, nonexpired Green Card. Information is posted at www.getyouhome.gov.

PROFESSIONAL NEWS

Medical Homes for SMI Associated With Greater Use of Primary Care

Increases in the use of preventive services were found only in patients with major depression, a finding that may be related to primary care physicians' greater comfort in treating depression as opposed to psychotic illness.

BY MARK MORAN

Enrollment in a primary care–based medical home appears to be associated with increased use of primary and specialty care, better medication adherence, and reduced use of emergency department care by individuals with serious mental illness (SMI).

And among patients with major depression, enrollment in a medical home was associated with increased use of certain preventive services, according to the report "Serving Persons With Severe Mental Illness in Primary Care Medical Homes." The report was published February 17 in *Psychiatric Services in Advance.*

Primary care–based medical homes are a component of system reform envisioned in the Affordable Care Act and are gaining traction as an important means of providing coordinated care. North Carolina's Medicaid program has been a leader nationally in developing medical homes for patients with complex health problems.

Researchers at the Department of Health Policy and Management and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina conducted a retrospective secondary data analysis of medication adherence, outpatient and emergency department visits, and screening services used by adult Medicaid enrollees with diagnoses of schizophrenia (n=7,228), bipolar disorder (n=13,406), or major depression (n=45,000) as recorded in North Carolina Medicaid claims from 2004 to 2007.

A variety of statistical tools was used in the analysis to control for selection and other biases and confounders. Outcomes included an indicator of any visit and the number of visits to primary care providers, any visit and the number of visits to specialty mental health providers, medication adherence for each target medication class, and emergency department visits.

The researchers examined Healthcare Effectiveness Data and Information Set indicators for preventive general medical care using procedure codes in the claims data files, including the receipt of cholesterol screening and cancer screening for age- and gender-appropriate populations according to the American Cancer Association guidelines. These included colorectal cancer screening for enrollees aged 50 and older, breast cancer screening for women aged 40 and older, and cervical cancer screening for women aged 21 to 65.

Results indicated that medical-home enrollees had greater use of both primary and specialty mental health care, better medication adherence, and reduced use of the emergency department. Interestingly, better rates of preventive lipid and cancer screening were found only for persons with major depression.

The association between being enrolled in a medical home and having any primary care visits was similar across diagnostic groups, ranging from an increase of 24 percent to 26 percent in the probability of one or more primary care visits a month, compared with rates for individuals not in medical homes. The effects of being enrolled in a medical home on the number of primary care visits were also similar across groups, amounting to about half a primary care visit a month. Enrollees in medical homes had slightly increased use of specialty mental health care.

"Evidence suggests that such enhanced health care use will decrease symptomatology and the need for emergent care," the researchers wrote. "Of interest, these access gains translated into increased use of preventive services only for persons with a major depressive disorder in medical homes. This difference across groups might reflect the greater integration of depression treatment in primary care and greater physician understanding and comfort in managing depression as opposed to psychotic conditions."

They noted also that the relatively large effects on primary care use were associated with fairly modest incentives provided by the state's Community Care of North Carolina program—amounting to $5 per-member per-month, split equally between practices and networks.

"Enrollment in a medical home was associated with substantial changes in patterns of care among persons with severe mental illness," they wrote. "These changes were associated with only a modest set of incentives, suggesting that medical homes can have large multiplier effects in the primary care of persons with severe mental illness." PN

"Serving Persons With Severe Mental Illness in Primary Care–Based Medical Homes" is posted at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300546.

Key Points

Researchers compared a variety of measures of service use by people with serious mental illness (SMI) enrolled in primary care–based medical homes and those not enrolled.

- Patients with SMI had greater use of primary care services and a modestly increased use of specialty services.
- Patients with major depression enrolled in medical homes were more likely to make use of preventive services—cholesterol and cancer screening.
- The relatively large effects on primary care use were associated with fairly modest incentives provided by the state's Community Care of North Carolina program.

Bottom Line: Enrollment of patients with serious mental illness in primary care–based medical homes appears to be associated with important changes in primary care service use and to be cost-effective.

Treating Patients Enrolled in Medicare Advantage Plans

FROM THE HELP LINE
(800) 343-4671
hsf@psych.org

By Ellen Jaffe

With so many Medicare beneficiaries now enrolled in Medicare Advantage plans, providers who treat these patients need to know the fine print in how they work. There are Medicare Advantage plans that are HMOs and PPOs and even some that are "private fee-for-service plans" (PFFSPs). Since there are only a few PFFSPs, and the rules surrounding them are not as clear as the rules for the HMOs and PPOs, this article will address only HMOs and PPOs.

If You Are an Enrolled Medicare Provider

If you are enrolled as a Medicare provider but are not in a Medicare Advantage plan's network, you have several choices. If the patient has a Medicare Advantage plan that does not allow reimbursement for out-of-network providers, you are not bound by the Medicare fee schedule unless you choose to be.

If the Advantage plan allows its enrollees to go out of network, you can choose to be a "contract provider" and accept the fee the Advantage plan pays, or you can choose to be a "noncontract provider" and be paid what you would have received if the patient was a fee-for-service Medicare patient.

There is, however, a third choice. Even though you are a Medicare provider, you are permitted to see the patient as if he or she did not have Medicare coverage and charge your usual and customary fee (or whatever fee the two of you agree to). If you choose this third option, you are advised to have a contract with the patient to ensure that the patient understands that neither Medicare nor Medicare Advantage fees apply to the care you are providing and that the patient is obligated to pay your fee no matter how he or she is reimbursed by the Advantage plan.

If You Are Not Enrolled as a Medicare Provider

Although you are not permitted to provide care to a fee-for-service Medicare beneficiary unless you are enrolled and can file claims with Medicare as a provider (or have entirely opted out of Medicare), this rule does not apply for beneficiaries who have chosen to receive Medicare services through an Advantage plan. These patients have effectively opted to receive their care outside of Medicare, and since claims are not filed with Medicare, you do not have to be on the Medicare books to see these patients. There is one caveat: If you have been banned from the Medicare program for any reason, you cannot provide care to Medicare beneficiaries even if they are in Medicare Advantage plans.

Since some patients may not understand the terms of their Advantage plans, it is essential that you make it clear how your reimbursement will be determined: whether you will file claims for them with their plan; whether you will accept whatever fee the plan offers with whatever copay is provided; or whether you do not want to have any relationship with their plan and will require them to pay the agreed-upon fee and seek any reimbursement from their Advantage plan on their own. Of course, whatever you choose to do, you must provide patients with the necessary paperwork to file claims on their own.

Have a question or comment on insurance, Medicare, or other practice-related issues? Contact APA's Practice Management HelpLine at (800) 343-4671 or hsf@psych.org.

Ellen Jaffe is a Medicare specialist in the APA Office of Healthcare Systems and Financing.

COMMUNITY NEWS

Steve Heap/Shutterstock

Puerto Rican Residents Return to Island For Mental Health Tour

Psychiatry residents and fellows with roots in Puerto Rico return to the island to raise awareness of mental health issues and the need to increase access to care for the territory's residents.

BY VABREN WATTS

Instead of delivering didactic lessons about the array of challenges associated with mental health care in some Hispanic communities, several APA resident-fellow members (RFMs), with support from APA's Division of Diversity and Health Equity (DDHE) and the Puerto Rico Psychiatric Society, decided to take this information from the lecture halls to the community, in hopes of producing positive change.

In February five RFMs with ties to Puerto Rico traveled to the island to carry out the first "mental health tour" of Puerto Rico. The tour arose from an idea of three residents who just wanted to "give back," according to Auralyd Padilla, M.D., a child and adolescent psychiatry fellow at the University of Massachusetts Memorial Medical Center and a former APA/Substance Abuse and Mental Health Services Administration (SAMHSA) fellow.

"Two of my classmates and I wanted to come back to our medical school in Puerto Rico—Universidad Central del Caribe [UCC] School of Medicine—and encourage students to become interested in psychiatry," Padilla told *Psychiatric News*. "As we were brainstorming, we thought it would be a great idea to contact media outlets on the island so that we could be a part of radio and television broadcasts to spread the message about various aspects of mental health such as recognizing symptoms of mental illness and accessing services to treat mental disorders."

But the idea didn't stop there. The RFMs decided to go to another medical campus in Puerto Rico, middle and high schools, and even offices of legislators, among other places, to talk about psychiatry and issues related to the mental health system in the predominately Spanish-speaking U.S. territory.

Destigmatization and education about mental illness were prominent themes during the three-day tour, which was held throughout the metropolitan area of San Juan, the island's capital.

"Because of stigma surrounding mental illness, many people do not seek mental health services in Puerto Rico," said Vanessa Llenza, M.D., a psychosomatic medicine fellow at George Washington University and a graduate of UCC School of Medicine. During an interview, Llenza, an APA/SAMHSA fellow, explained to *Psychiatric News* that mental health services on the island are more likely to be accessed by people who can afford to go to private providers than those who are more likely to use public-health services, resulting in low access rates for government-funded mental health services. "For this reason, we wanted to speak with legislators to see if there are ways to improve access."

On Day One of the tour, one of the stops included a meeting at the Puerto Rico capitol with Debbie Figueroa, J.D., M.P.H., an epidemiologist with the Senate of Puerto Rico Health and Nutrition Commission. "Right now, the health care system of Puerto Rico offers some of the best health care benefits in the world, but we do not have the best services available," she told the RFMs, especially when it comes to mental health services, since there is just one psychiatrist for approximately every 10,000 people. "We have many people with mental health problems that go unattended."

According to Figueroa, the territory's senate is pushing for health care reform through Bill 15, which would establish an integrated health care system that would include mental health care as a part of general health services. "It's a medical plan that is about more access at lower costs," Figueroa explained.

Training Opportunities Very Limited

The low number of psychiatrists receiving training in Puerto Rico is, however, contributing to the access problem. According to Hector Colon-Rivera, M.D., an RFM at Boston University Medical Center and an APA/SAMHSA fellow, a total of 200 students graduate each year from the four medical schools in Puerto Rico, and about 10 percent to 15 percent say they are interested in a psychiatry residency. Unfortunately, however, there are only 10 residency positions on the island, and open slots are not available each year.

"This forces us to seek training outside of Puerto Rico," said Colon-Rivera, who graduated from the University of Ponce School of Medicine. "It is hard for us to come back because there is not a lot of opportunity for jobs or loan-repayment programs. These are major barriers not only for mental health professionals but other medical professionals as well."

Though Figueroa told the RFMs that there are no plans to create more residency slots in Puerto Rico, she did promise to present the RFMs' concerns to the island's medical board.

Preparing the Next Generation

The tour continued on Day Two with the RFMs being interviewed on local television and radio programs, during which they addressed warning signs of mental illness in children and adolescents and myths and realities about mental disorders. The interviews were followed by a visit to the University of Puerto Rico School of Medicine, where the RFMs had a panel discussion with medical students about potential challenges faced by psychiatry residents from Puerto Rico who are training on the U.S. mainland. Discrimination was the main topic.

"I don't want to talk to you," "Get me another doctor," and "You're not American" were some of the ethnically and racially charged statements that were made to Dimas Tirado-Morales, M.D., a child and adolescent psychiatry fellow

Vabren Watts

Resident-fellow members Hector Colon-Rivera, M.D., and Auralyd Padilla, M.D., speak with former P.R. Sen. Roberto Vigoreaux, P.R. Rep. Lydia Méndez Silva, and her aide about issues concerning the mental health care system in Puerto Rico.

COMMUNITY NEWS

Photos: Vabren Watts

1 Resident-fellow members (RFMs) speak about myths and realities of mental disorders on a morning radio show at WKVM 810 AM in Puerto Rico. **2** Ranna Parekh, M.D., director of APA's Division of Diversity and Health Equity (DDHE), and RFMs sit on panel about the role of psychiatrists at the Colegio San Ignacio de Loyola. **3** Posing for a picture are Hector Colon-Rivera, M.D., Parekh, Elvin Hernandez, M.D, Lisette Rodriguez-Cabezas, M.D., Jose Franceschini, M.D., Vanessa Llenza, M.D., Auralyd Padilla, M.D., Dimas Tirado-Morales, M.D., and Marilyn King. **4** Llenza, Padilla, and Tirado-Morales have a group hug after successfully completing the Mental Health Awareness Tour Puerto Rico.

at Drexel University College of Medicine and a graduate of UCC School of Medicine, when he attempted to treat patients during residency.

"Depending on the situation, I may ask patients to express what it is that is bothering them about me, and maybe we can figure it out," said Tirado-Morales, M.D., who is also an APA/SAMHSA fellow. "Sometimes I try to educate the patient on racism, because some people do not realize that they are making statements that may be offensive to others."

Lissette Rodrigues-Cabezas, M.D., a psychiatry resident at Northwestern University Feinberg School of Medicine, told the audience that culturally insensitive remarks are also made by colleagues when treating patients who are different from them.

Vanessa Llenza, M.D.

As part of the Mental Health Awareness Tour Puerto Rico, members of the organization Puerto Rico Therapy Dogs discuss how they help young boys at the Casa de Niños Manuel Fernández group home manage stress through interaction with animals.

Rodrigues-Cabezas, a native of Chicago of Puerto Rican descent, noted, "When a patient is being treated for symptoms of mental illness in a hospital or outpatient practice, it is often his or her first time coming to a psychiatrist. We need to make sure that patients feel that they are being heard. … We have to help them establish trust with psychiatrists and ensure that we are working collaboratively with them in deciding on a treatment plan, regardless of the patient's ethnic background. If we do not practice cross-cultural psychiatry, it is very likely that person will never feel comfortable seeing a psychiatrist again."

She said these basic tenets of practice are especially important when working with medical students. "We have to be good role models for medical students by being professional and compassionate to patients in order for these students to do the same when they are in our position."

APA Will Continue to Battle Disparities

The final day of the mental health tour included a visit to Casa de Niños Manuel Fernández, a nonprofit group home for boys aged 8 to 18 who are survivors of trauma and have been removed from their homes. The RFMs spoke with the boys about how stress affects the body and behavior and ways to manage stress through friendly interaction with pets, for example, or through engaging in martial-arts activities.

The tour concluded at a shopping mall in Bayamon, where an informational booth about mental illness in Hispanic populations in particular was set up to engage shoppers in conversation.

Ranna Parekh, M.D., who is the director of DDHE and accompanied the residents on the tour, said that the trip was incredible on multiple levels.

"The positive reception that we got from the people at out shopping mall booth, the medical schools, the group home, and the island's legislature was very inspiring," she said. "The people were extremely thankful that APA and the Puerto Rico Psychiatric Society helped fund such an event that recognizes mental health issues and the need to increase mental health services in the Hispanic community. We will make sure that the work that has started in Puerto Rico will continue." PN

EDUCATION & TRAINING

Women Make Progress in Academic Medicine, But Leadership Disparities Linger

Psychiatry ranked sixth among specialties in the number of women residents in 2013-2014 and fifth among the various medical departments in number of women with full-time faculty positions.

BY MARK MORAN

Women continue to make progress in academic medicine but remain underrepresented at key career stages, according to a report from the Association of American Medical Colleges (AAMC).

Despite modest progress in some areas, including an increase in the number of women entering medical school and in the percentage of women in faculty positions, women continue to be underrepresented among senior faculty, department chairs, and medical school deans, according to the report, "The State of Women in Academic Medicine: The Pipeline and Pathways to Leadership." The percentage of women leaving faculty positions also rose, however.

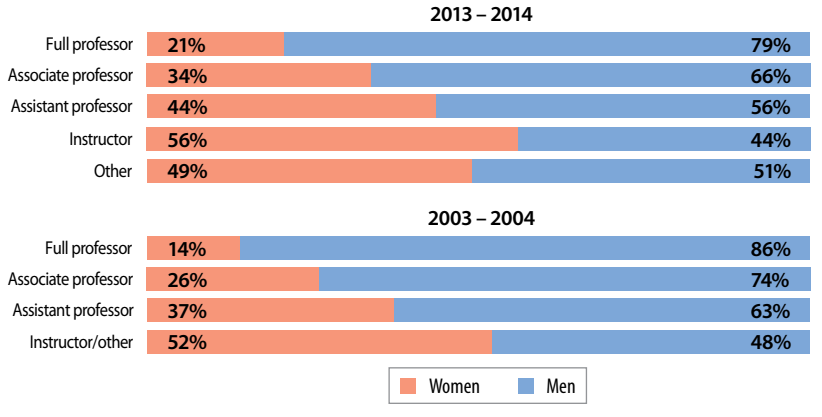
The report draws on data from the AAMC's 2013-2014 survey on Women in Medicine and Science (WIMS) as well as 2014 data from the AAMC Faculty Roster.

"Within academic medicine, medical school deans, department chairs, associate deans, and faculty and staff in a range of leadership positions have opportunities to think innovatively about transforming systems of training, discovery, and health care delivery that keep academic medical centers (AMCs) at the forefront of improving patient care and health in the United States," according to the report. "If women choose to leave the academic medicine workforce, their departures may contribute to a decrease in the diversity and talent of the workforce and may ultimately limit organizational success. Conversely, if AMCs can promote equity through sound institutional practices, they can increasingly retain the talented doctors, scientists, and administrators who are so vital to achieving their missions."

When the WIMS survey was administered in May 2014, 129 medical schools were fully accredited by the Liaison Committee on Medical Education. Of these, 117 responded. Here are some findings from the survey:

Slow Progress in Closing Gender Gap

The percentages of women in all categories of full-time medical faculty positions—professor, assistant professor, associate professor, and instructor—rose since 2003-2004, but with the exception of instructors, the percentages of women remain well below those of men.



Source: *The State of Women in Academic Medicine: The Pipeline and Pathways to Leadership 2013-2014*, AAMC

- **Students and residents:** Although the number of women applying to medical school (48,014) has increased since the last report in 2008-2009, their proportion of the applicant pool, at 46 percent, has decreased.

- **Faculty workforce:** Women make up a little more than a third (38 percent) of the full-time academic medicine faculty (see chart above for a breakdown by position). New hires of women faculty are up 4 percent, but departures are up 5 percent.

- **Leadership positions:** There has been an increase in the number of women who are chairs and deans of medical school departments, but the percentage remains low at 15 percent and 16 percent, respectively. The percentage of women assistant professors has remained stable at 46 percent.

Psychiatry ranked sixth among specialties for the number of women residents in 2013-2014, behind internal medicine, pediatrics, family medicine, internal medicine specialties, and OB-GYN. But psychiatry ranked third among departments with the highest proportion of women in faculty positions, behind internal medicine and pediatrics.

As for the students and residents, the report noted that the percentage of women residents has remained relatively flat since 2008-2009, when women accounted for 45 percent of residents. "Further, while women increasingly are entering specialties where they have been historically underrepresented, such as surgery, large gender disparities still exist," the report stated. "These data point to a need for focused research on individual career decisions of women students after their training."

With regard to faculty workforce, the AAMC noted that the proportion of full-time faculty who are women has risen only 2 percent since its 2009-2010 Women in Medicine and Science Benchmarking Report. "In looking particularly at how women are represented among higher academic ranks, the proportion of women continues to be lower when compared to male counterparts as the prestige of the position increases. … Similar to women entering residency positions, full-time women faculty comprise far less of the proportion of faculty in specific departments such as surgery and radiology. Additionally, since 2008-2009, the percentage of promotions to associate professor or full professor who were women has risen only slightly, and the proportion of new tenures who were women has remained the same (38 percent)."

Finally, the increase in women in leadership positions is encouraging, but the sharp disparities in academic medicine can be seen across all stages of the pipeline from residency application to leadership, according to the report. "As women progress through their careers, they are less represented in positions with decision-making and leadership responsibilities," the report emphasized. "Research is needed to explore how underrepresentation and pace of advancement for women in academic medicine may influence career choice." PN

"The State of Women in Academic Medicine: The Pipeline and Pathways to Leadership, 2013-2014" is posted at https://www.aamc.org/members/gwims/statistics.

DSM-5 Guide

continued from page 5

and a chapter unto itself—replacing the *DSM-IV* diagnosis of gender identity disorder and reflecting a new conceptualization of individuals who seek treatment for problems related to gender.

Criteria for the new category emphasize the phenomenon of "gender incongruence" rather than cross-gender identification. By separating it from sexual dysfunctions and paraphilias (with which it had been included in *DSM-IV* in a chapter titled "Sex and Gender Identity Disorders"), the *DSM-5* Task Force hoped to diminish stigma attached to a unique diagnosis that is used by mental health professionals but whose treatment often involves endocrinologists, surgeons, and other professionals (*Psychiatric News,* April 5, 2013).

"For many people, their gender is never something to question or a source of conflict for their sense of identity," the chapter begins. "Other people strongly identify themselves as a member of the opposite sex. They have great distress that their physical gender does not match the way they think and feel about themselves. This distress and sense of conflict are described as gender dysphoria. The gender that fits with the way they feel is called their experienced/expressed gender, and the gender they were born with is called their assigned/natal gender."

The chapter covers gender dysphoria in adults, teenagers, and children. (For an example of a story of a patient with gender dysphoria, see "Christine's Story" on page 5.)

"The changes to the *DSM* that are reflected in gender dysphoria arose from careful discussion about the importance of the presence of distress as a key factor in the diagnosis," said Susan Schultz, M.D., a member of the six-member panel of editorial advisers who oversaw development of the lay guide. "This is also emphasized through the use of dysphoria in the name of the diagnosis as opposed to calling it a disorder. That is, the language was chosen very carefully, with the hope of keeping pace with new research and a new understanding of these conditions. This is one of the new developments in the *DSM* that is most likely to continue to evolve over time as we grow in our understanding of the gender experience." PN

EDUCATION & TRAINING

Simulation May Improve Trainee Skills With Agitated or Violent Patients

Actors simulating an agitated patient escalating to violence were able to realistically create the kind of adrenaline-producing situation residents may encounter in psychiatric wards, medical-surgical units, and emergency departments.

BY MARK MORAN

Mark Moran

Heather Vestal, M.D., says that simulation of an acute situation in which a patient is escalating to violence can be a crucial complement to lecture-based didactic knowledge.

An agitated, psychotic patient in a medical-surgical ward demands to be released immediately from the hospital against medical advice. The psychiatry resident summoned to assess the patient informs him that he can't be released for 72 hours after signing a discharge form; the patient becomes extremely angry, verbally abuses the resident, and makes threatening gestures signaling a potential assault.

For psychiatry trainees, and for medical-surgical interns as well, the scenario can be the proverbial baptism by fire.

Assaults or threats-to-assault are not uncommon. A report in *Academic Medicine* (January 1, 2012) surveyed 519 psychiatry residents in 13 psychiatry training programs across the United States about residents' experiences of threats and assaults by patients during their training. Of 204 residents who responded, 175 (86 percent) said they had been threatened, 145 reported being physically intimidated, and 51 (25 percent) said they had been physically assaulted. Most of the incidents occurred in inpatient settings.

Two training programs, at Massachusetts General Hospital/McLean Hospital Adult Psychiatry Residency Program and the Hennepin-Regions Hospital Psychiatry Training Program in Minneapolis-St. Paul, Minn., have launched novel simulation programs for their trainees that provide firsthand experience of a threatening situation, equipping residents with skills needed to deescalate a potentially violent encounter and knowledge about the resources available in the hospital to keep the patient, themselves, and staff safe.

The programs were presented in poster sessions at this year's meeting of the American Association of Directors of Psychiatric Residency Training (AADPRT) in Orlando in March.

"This subject is enormously important for resident safety and quality patient care," said Heather Vestal, M.D., an associate director of psychiatry training at Mass General/McLean, in an interview with *Psychiatric News*. "Our motivation for developing the simulation training grew out of the recognition that when our residents begin taking call in their second year, they may not have had experience managing agitated patients. When called to respond to a psychiatric emergency, we want residents to feel well equipped to safely assess, deescalate, and provide appropriate treatment to an agitated patient.

"Our previous method of training was didactic lectures," she said. "There is certainly utility in providing lecture-based knowledge, but when residents are in that high-adrenaline situation for the first time, they may not be able to access that knowledge."

Vestal and colleagues developed a randomized, controlled trial with 22 psychiatry interns to assess the effectiveness of simulation-based training for the management of agitated patients. All interns received a lecture on agitation, after which they completed a self-report form of their knowledge on the subject and a clinical case vignette test.

Then half of the interns received the simulation-based training, during which they were required to assess and manage a patient (as played by an actor) becoming progressively agitated. The other interns, in the control group, received a sham simulation that did not involve agitation or threats (rather, the assessment of a patient with an unwitnessed fall). All interns completed a second self-report form and clinical case vignette as a posttest of their knowledge.

A week later, all 22 interns were given a second assessment simulation experience that involved exposure to an agitated or potentially violent patient. Two blinded raters scored each intern on his or her skill in the following areas: obtaining information from the nurse, maintaining personal safety, assessing the patient, offering medications, when to call security, when to order restraint, response to escalation, and attitude and empathy.

The interns also rated themselves on perceived confidence in dealing with the exposure to agitation on a five-point rating scale from "completely confident" (5) to "not at all confident" (1).

The interns who underwent the simulation-based training reported a subjective increase in their overall ability to manage agitated patients and use verbal deescalation techniques compared with the control group.

"We think this is an improvement over teaching as usual," she said. "In simulation we ask interns to try to get into the moment and suspend disbelief, and a lot

see ***Simulation*** *on page 32*

Showdown Time! MindGames Finalists Announced

Three residency programs—from Creighton University, Cornell-Weill Medical School, and Columbia University/New York State Psychiatric Institute—are the finalists in this year's MindGames competition. They will compete for the top prize at APA's 2015 annual meeting in Toronto on Tuesday, May 19, in the Toronto Convention Centre in Room 106, Level 100, North Building.

The finalists were announced at the meeting of the American Association of Directors of Psychiatric Residency Training in Orlando, Fla., last month. The runners-up in were teams from the University of California, San Diego; University of Texas Health Science Center at San Antonio; University of Texas at Houston; Baylor College of Medicine; State University of New York Health Science Center at Brooklyn; University of Chicago; and New York University School of Medicine.

David Hathcox

The psychiatry residency team from New York-Presbyterian/Weill Cornell Medical Center won last year's MindGames competition. From left are Seth Kleinerman, M.D., Adam Demner, M.D., and Akshay Lohitsa, M.D., with MindGames host Glen Gabbard, M.D.

Now in its ninth year, MindGames tests the teams' knowledge of medicine in general, psychiatry in particular, and patient-care issues. The competition, hosted by Glen Gabbard, M.D., has become a popular attraction at the meeting.

The three trainees who will be playing for Cornell are Akshay Lohitsa, M.D., Andrew Edelstein, M.D., and Seth Kleinerman, M.D.; for Columbia: Elizabeth Koehler, M.D., Ibrahim Abbas, M.D., Ph.D., and William Zoghbi, M.D.; and for Creighton: Venkata Kolli, M.B.B.S., Varun Monga, M.B.B.S., and Rohit Madan, M.B.B.S.

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

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

ANNUAL MEETING

Meet and Learn From American Psychiatric Publishing's Authors at APA's 2015 Annual Meeting

The following is a select list of events at which authors of books published by American Psychiatric Publishing will be participating at APA's 2015 annual meeting in Toronto. Take time to meet some of psychiatry's most esteemed thinkers.

ADVANCES IN SESSIONS

SATURDAY, MAY 16
9 a.m.-Noon
Marc Galanter, M.D.:
Advances in Substance Abuse Treatment
Exhibit Hall G, Level 800, South Building,
Toronto Convention Centre

SUNDAY, MAY 17
8 a.m.-11 a.m.
Roberto Lewis-Fernandez, M.D.:
The *DSM*-5 Cultural Formulation Interview
Room 105, Level 100, North Building,
Toronto Convention Centre

1 p.m.-4 p.m.
Elizabeth Auchincloss, M.D.:
Advances in Psychodynamic Psychiatry
Room 206 A-F, Level 200, North Building,
Toronto Convention Centre

MONDAY, MAY 18
9 a.m.-Noon
Liza Gold, M.D.: Gun Violence and Mental Illness
Room 107, Level 100, North Building,
Toronto Convention Centre

2 p.m.-5 p.m.
Steve Cozza, M.D.: Care of Military Service Members, Veterans, and Their Families
Room 107, Level 100, North Building, Toronto Convention Centre

TUESDAY, MAY 19
9 a.m.-Noon
Lori Raney, M.D.: Advances in Integrated Care: Across the Collaboration Spectrum
Room 107, Level 100, North Building, Toronto Convention Centre

9 a.m.-Noon
Joseph F. Goldberg, M.D.: Managing the Side Effects of Psychotropic Medications: Balancing Risks and Benefits
Room 107, Level 100, North Building, Toronto Convention Centre

2 p.m.-5 p.m.
Phillip Muskin, M.D.: Test Your Knowledge With the Experts: An Interactive Advances In Series on Personality Disorders, Mentalizing, and Network Therapy
Room 105, Level 100, North Building, Toronto Convention Centre

MASTER COURSES

Separate fee required; participants receive a free book. For more information, see http://annualmeeting.psychiatry.org/scientific-program/courses--master-courses.

SUNDAY, MAY 17
9 a.m.-4 p.m.
Frank E. Yeomans, M.D., Ph.D.: Transference-Focused Psychotherapy for Borderline Personality Disorder
Grand Ballroom East, Lower Concourse, Sheraton Centre

MONDAY, MAY 18
9 a.m.-4 p.m.
Robert Boland, M.D.: 2015 Psychiatry Review
Osgood Ballroom, Lower Concourse, Sheraton Centre

9 a.m.-4 p.m.
Darrel Regier, M.D.: *DSM-5:* What You Need to Know
Grand Ballroom East, Lower Concourse, Sheraton Centre

TUESDAY, MAY 19
9 a.m.- 4 p.m.
Alan F. Schatzberg, M.D.: Advances in Psychopharmacology
Osgood Ballroom, Lower Concourse, Sheraton Centre

9 a.m. -4 p.m.
Christopher Kratochvil, M.D.: Update on Pediatric Psychopharmacology
Room 718B, Level 700, South Building,
Toronto Convention Centre

SYMPOSIA

SATURDAY, MAY 16
2 p.m.-5p.m.
Michael Compton, M.D.: Society Unfair, Society Unwell: Addressing the Social Determinants of Mental Health
Room 715 A-B, Level 700, South Building,
Toronto Convention Centre

SUNDAY, MAY 17
8 a.m.-Noon
Mantosh Dewan, M.D.: Brief Therapy: Practical Clinical Pearls
Room 715 A-B, Level 700, South Building,
Toronto Convention Centre

1 p.m.-4 p.m.
Michael First, M.D.: Introducing the Structured Clinical Interview for *DSM-5* Clinician Version (SCID-5-CV)
Room 714 A-B, Level 700, South Building,
Toronto Convention Centre

WEDNESDAY, MAY 20
8 a.m.-Noon
David R. Johnson, M.D.: Trauma-Centered Psychotherapy: Applying Evidence-Based Techniques Within a Psychotherapeutic Frame
Room 714 A-B, Level 700, South Building,
Toronto Convention Centre

MEET THE AUTHORS

SATURDAY, MAY 16
11 a.m.-12:30 p.m.
Otto F. Kernberg, M.D.: Challenges in and Controversies in Personality Disorders and Psychoanalysis
Room 803 A-B, Level 800, South Building,
Toronto Convention Centre

1:30 p.m.-3 p.m.
Jesse H. Wright, M.D.: Challenges in Cognitive-Behavior Therapy: Overcoming Barriers to Effective Treatment
Room 802 A-B, Level 800, South Building,
Toronto Convention Centre

SUNDAY, MAY 17
8 a.m.-9:30 a.m.
Alan F. Schatzberg, M.D.:
An Update on Antidepressant Treatment: Pharmacogenetics, Rapidly Acting Agents, and Brain Stimulation
Room 206 A-F, Level 200, South Building,
Toronto Convention Centre

10 a.m.-11:30 a.m.
Petros Levounis, M.D.: The Behavioral Addictions
Room 803 A-B, Level 800, South Building,
Toronto Convention Centre

12:30 p.m.-2 p.m.
Fadi Haddad, M.D.: Helping Kids in Crisis
Room 803 A-B, Level 800, South Building,
Toronto Convention Centre

David R. McDuff, M.D.: Sports Psychiatry: Overcoming Medical, Social, and Psychological Recovery Barriers From Serious Athletic Injury
Room 801 B, Level 800, South Building,
Toronto Convention Centre

MONDAY, MAY 18
9 a.m.-10:30 a.m.
Stuart C. Yudofsky, M.D.: Fatal Pauses: Stuck in Pleasing Others. An Introduction to Supermentalization
Room 803 A-B, Level 800, South Building,
Toronto Convention Centre

1:30 p.m.-3 p.m.
John M. Oldham, M.D.: A New *DSM-5* Alternative Model for the Personality Disorders
Room 803 A-B, Level 800, South Building,
Toronto Convention Centre

Russell F. Lim, M.D., M.Ed.:
Culturally Appropriate Assessment: Using the Cultural Formulation Interview as an Assessment Tool and Teaching Medical Students and Residents
Room 801 B, Level 800, South Building,
Toronto Convention Centre

TUESDAY, MAY 19
9 a.m.-10:30 a.m.
Glen O. Gabbard, M.D.: A New *DSM-5* Alternative Model for the Personality Disorders
Room 803 A-B, Level 800, South Building,
Toronto Convention Centre

11 a.m.-12:30 p.m.
Charles B. Nemeroff, M.D.: Management of Treatment-Resistant Depression: The Art and the Science
Room 803 A-B, Level 800, South Building,
Toronto Convention Centre

AUTHOR SIGNINGS

Several notable APP authors have been invited to sign copies of their books in the APP Bookstore on Saturday, May 16, and Sunday, May 17, from 11 a.m. to 1 p.m. for customers who purchase books at the meeting. APA members receive a 20 percent discount and resident-fellow members a 25 percent discount on book purchases. Come by and review our books and meet our authors. These are some of the authors who will be signing books and their book titles:

Laura W. Roberts, M.D., M.A., and Alan K. Louie, M.D., *Study Guide to DSM-5*

Lori E. Raney, M.D., *Integrated Care: Working at the Interface of Primary Care and Behavioral Health*

Frank E. Yeomans, M.D., Ph.D., John F. Clarkin, Ph.D., and Otto F. Kernberg, M.D., *Transference-Focused Psychotherapy for Borderline Personality Disorder: A Clinical Guide*

Glen O. Gabbard, M.D., *Psychodynamic Psychiatry in Clinical Practice, 5th Edition*

Stuart C. Yudofsky, M.D., *Fatal Pauses: Getting Unstuck Through the Power of No and the Power of Go*

Dilp V. Jeste, M.D., *Positive Psychiatry: A Clinical Handbook*

ANNUAL MEETING

Richard Kogan, M.D., to Analyze Chopin's Mind and Music

The noted psychiatrist and pianist will discuss how the renowned Polish composer's troubled mental state influenced his compositions.

BY NICK ZAGORSKI

The duality that can manifest in a troubled mind has long fascinated Richard Kogan, M.D.

"Mental illness can lead to great disability, but it also can inspire extraordinary acts of creativity," he said.

For Kogan, an award-winning pianist, this intrapsychic conflict is especially poignant among composers, such as Frederic Chopin (1810-1849).

Kogan is a clinical professor of psychiatry at Weill Cornell Medical College, artistic director of the Weill Cornell Music and Medicine Program, and codirector of the Weill Cornell Human Sexuality Program. He studied piano at the Juilliard School and earned his undergraduate and medical degrees at Harvard.

At age 20, Chopin left Poland to explore the culture and beauty of Western Europe; just one month later, the November 30 Uprising thrust his homeland into a decades-long period of political turmoil and oppression under czarist Russia. Forced to spend his entire adult life in exile, Chopin, already a musical prodigy, poured his hope and suffering into creating some of the most exceptional solo piano pieces ever written, particularly the polonaises and mazurkas that were a tribute to his homeland.

But these masterpieces also coincided with a growing decline of his mental state. Worries about his distant home and family triggered panic attacks, phobias limited his public performances, and a diagnosis of tuberculosis preoccupied his mind with death and melancholy.

Kogan will explore this relationship between Chopin's psyche and his creative output in a special session at APA's 2015 annual meeting titled "The Mind and Music of Chopin." The discussion—which will also examine Chopin's relationship with the brilliant and notorious French novelist George Sand during his later years—will be illuminated by performances of some of the composer's

Richard Kogan, M.D.

Accomplished psychiatrist and pianist Richard Kogan, M.D., observes that mental illness can inspire extraordinary creativity.

ANNUAL MEETING

most celebrated music.

Kogan has been providing such melodious insights into the relationship between the inner turmoil and outer creativity of great composers for many years. He hopes his efforts help destigmatize mental illness by showing it in the positive context of the achievements of a renowned historical figure.

The session will be held on Saturday, May 16, 5:30 p.m. to 7 p.m. in Room 102, Level 100, North Building, Toronto Convention Centre. PN

To watch a video of Kogan's presentation at last year's annual meeting, "Rachmaninoff and His Psychiatrist," go to https://www.youtube.com/watch?v=pM097N2lNEI&list=PLRCvce9oxgsCSPmZ4HUo15Z53kg5hyoY4&index=2.

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MAY 16-20, TORONTO

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

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

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

Low advance registration rates are in effect, so register now!

VIEWPOINTS

There's Good News About Aging

BY MARNIN FISCHBACH, M.D.

Recent research indicates a startling and counterintuitive truth: Older age is one of the happiest periods of life. Happiness has been studied in many countries, and the bottom line is this: Happiness demonstrates a U-shaped curve over the life span. People are happy in their younger years, considerably less so in middle age, and progressively more so as they grow older.

Happiness in the youth and elderly populations is driven by different factors. Younger people seem to thrive on excitement and novelty, which help build a sense of identity. Given their ubiquity, it would stand to reason that these youthful pursuits of the exciting may be biologically and genetically based. Older individuals, in contrast, find happiness not in excitement but in smaller joys nearer to home: family, friends, and hobbies.

Judging from my patients, I would confirm these observations. Allegheny County, Pa., where I practice, has the

Marnin Fischbach, M.D., is in private practice of adult and adolescent psychiatry in Pittsburgh, Pa., and consults to the health care industry.

second largest number of elderly in the country. I treat a number of these people and have been impressed by them. Even as they cope with emotional symptoms, many elderly in Allegheny County are still living in their homes; they are self-sufficient, optimistic in their 70s and 80s, and surprisingly youthful. Many are golfing, vacationing at the shore, visiting friends and family, caring for grandchildren, and pursuing hobbies. Moreover, these elderly are not wealthy—they are very much in the middle class.

Older individuals have generally established their identities, have no more need to prove themselves, and are benefiting from years of accumulated experience and wisdom.

But how can we square these U-shaped data with the many physical ailments that seem to accumulate in older age? Who can be happy in the face of arthritis, diabetes, cardiovascular disease, cancer, or combinations of these? And why is it that many elderly, unlike the younger set of "happy" cohorts, seem not especially afraid of dying, despite being closer to their end?

Every chronic malady produces physical symptoms of one sort or another. Pain, difficulty breathing, unsteady gait, and fatigue are examples. Every chronic symptom results in some loss of prior activities or functionality. Arthritis of the hip or knees makes it difficult to walk, let alone run; of the hands, one is limited in playing piano or knitting. Visual or hearing problems limit the individual's radius of activities. Pulmonary disease leaves one breathless and too fatigued to do much of anything physical. In many cases, independence itself is significantly compromised.

People, elderly included, undergo a natural, subtle grieving process over the loss of function caused by their illnesses. Close attention to conversation among older individuals finds it rapidly turning to their new symptoms and how they cannot do what they could in the past. There is often much laughter in the group, even as they are discussing their maladies, not unlike what one sees routinely, though more intensely, in a Catholic wake or Jewish shiva. These discussions and processes represent mini-bereavements in action.

Grieving may sound negative, but it is a biological, and therefore universal, process whose effects are positive and help resolve the paradox of the U-shaped curve. First and foremost, the older person who has successfully allowed him- or herself to go through the full grieving process comes out more accepting of the loss of functions rather than emotionally paralyzed by it. This is no small gift, as I have interviewed a number of elderly who have gotten stuck in their grief and consequently spent much of their emotional life in deep sadness, regret, and depression.

Another positive outcome is the development of a new sense of self. Having lost some skills that previously defined their "self" (for example, tennis, crocheting, running, piano), older individuals often develop new skills more aligned with their residual abilities. They might attend courses, study a new language, draw closer to children and grandchildren, or take up swimming. Often, older people tend to see life in radically different ways that they had not previously entertained.

Finally, having grieved the loss of multiple parts of their lives, seniors have become more accepting of the end of life. Death is less fraught with the fears that terrified many of us in our youth. It may appear unseemly to derive good news from comfort with death, but good news it is: Would you not rather go calmly, with contentment and acceptance, into that dark night than go there kicking and screaming? Would you not rather feel a sense of completion of your life's tasks and goals than feel your end is premature and you are being cheated out of time rightfully yours?

*see **Viewpoints** on page 33*

CLINICAL & RESEARCH NEWS

ADHD Diagnosis May Increase Risk Of Premature Death, Study Finds

Risk of death by unnatural causes, especially accidents, is found to be increased in people who have been diagnosed with ADHD, but treatment may lower this risk.

BY AARON LEVIN AND VABREN WATTS

A huge study using Denmark's population and health registries found that individuals diagnosed with attention-deficit/hyperactivity disorder (ADHD) have twice the risk of premature death and a lower life expectancy than those without ADHD.

Researchers from Aarhus University looked at health records of 1.92 million people—including 32,061 with ADHD—born in Denmark from 1981 to 2011 to investigate any associations between an ADHD diagnosis and premature mortality.

Previous research has shown that an association between ADHD and other mental illnesses (such as oppositional defiant disorder and substance use disorder) is likely to increase mortality, but it was unknown whether an ADHD diagnosis itself increased risk for premature death.

Overall, 5,580 people in the study population (including 107 with ADHD) died during the study period, which ended in 2013. The fully adjusted mortality rate ratio (MRR) for the general population was 2.21 per 10,000 person-years. But the MRR was 5.85 for decedents with ADHD, wrote Søren Dalsgaard, Ph.D., of the National Centre for Register-Based Research at Aarhus University, and colleagues in *The Lancet* online February 26.

Women had a higher mortality rate (3.01) than men (1.93). Older patients were at greater risk of premature death. The MRR for those first diagnosed between ages 1 and 5 was 1.86 but for those diagnosed at age 17 or later, it was 4.25.

"This finding could be caused by persistent ADHD being a more severe form of the disorder," the researchers suggested.

"[F]ailure to identify and treat ADHD in a timely manner might worsen the course of the disorder and increase the risk to enter one of the pathways to premature death," wrote Stephen Faraone, Ph.D., a professor of psychiatry, neuroscience, and physiology at SUNY Upstate Medical University in Syracuse, N.Y., commenting on the study in *The Lancet.*

Comorbidities played an important role, too. A combination of oppositional defiant disorder, conduct disorder, and substance use disorder increased mortality to an adjusted MRR of 8.29, compared with those without ADHD or those comorbidities.

Cause of death was available for 79 of the 107 people with ADHD who died; 54 died from unnatural causes, including 42 from accidents.

Earlier research pointed to a higher risk of injury among children with ADHD, the researchers noted. "Similarly, other studies have noted that people with ADHD anticipate less severe results of risk-taking behaviour and have poorer skills for prevention of injuries than do peers without ADHD."

The study adds to the medical literature emphasizing the importance of properly diagnosing and treating ADHD, Timothy Wilens, M.D., chief of child and adolescent psychiatry at Massachusetts General Hospital for Children, told *Psychiatric News.*

"While the risk of premature death in this age group remains low, the overall findings are a reminder for individuals with ADHD, their families, and practitioners that early identification and treatment of ADHD may help to improve overall long-term outcome, including issues of safety," said Wilens. "Moreover, individuals with ADHD must continue to be vigilant about the increased risk for addictions as well as mishaps related to driving."

In addition to the value of early identification, the results also suggest a need for more research on how to improve life expectancy in this vulnerable group, said Dalsgaard and colleagues.

"Although talk of premature death will worry parents and patients, they can seek solace in the knowledge that the absolute risk for premature death is low and that this and other risks can be greatly reduced with evidence-based treatments for the disorder," added Faraone. PN

An abstract of "Mortality in Children, Adolescents, and Adults With Attention-Deficit/ Hyperactivity Disorder: A Nationwide Cohor Study" is posted at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61684-6/abstract.

FROM THE EXPERTS

Why Personalized Treatment Decisions Are Important

BY TERENCE KETTER, M.D., SHEFALI SRIVASTAVA-MILLER, M.D., AND PO WANG, M.D.

Optimal management decisions in bipolar depression entail carefully personalized balancing of potential benefits (efficacy) and harms (side effects). With respect to potential benefits, there are only three medications with Food and Drug Administration approval for acute bipolar depression, and these all entail a second-generation antipsychotic (SGA) component (the olanzapine plus fluoxetine combination, quetiapine monotherapy, and lurasidone as monotherapy or added to lithium or valproate).

For many patients, however, the risks of harm with these treatments exceed those seen with other agents commonly administered to patients with bipolar disorder, such as mood stabilizers or antidepressants.

Perhaps due to their efficacy in unipolar major depressive disorder and somatic tolerability that for many patients is superior to that of mood stabilizers or SGAs, antidepressants are commonly administered to patients with bipolar depression, despite having only limited evidence of efficacy in such patients. However, evidence suggests that antidepressants, although somatically fairly well tolerated, may yield psychiatric harms such as exacerbation of depression and emergence of suicidal ideation—particularly in pediatric and young-adult populations—as well as treatment-emergent affective switch (into mood elevation).

Thus, caution is warranted when considering administering antidepressants to bipolar disorder patients with mixed bipolar I (rather than bipolar II) depression with a rapid-cycling course and a history of problems with antidepressant administration. In contrast, certain bipolar disorder patients lacking such clinical characteristics may be reasonable candidates for antidepressant administration. We present a case that demonstrates the former principle.

"Grace" is a 35-year-old, recently separated, Chinese-American bank teller who presented with complaints of irritability, impulsivity, and depression. She noted that in the month since bupropion (current maximum tolerated dose 300 mg/day) was added to her ongoing lithium (current maximum tolerated dose 900 mg/day, level 0.8 mEq/L), she had experienced attenuation of sadness, fatigue, and hypersomnia, but marked increases in irritability and impulsivity; she was requesting medication to address her irritability and anhedonia.

Current depressive symptoms

see ***From the Experts*** *on page 24*

Terence Ketter, M.D., is a professor of psychiatry and behavioral sciences and chief of the Bipolar Disorders Clinic at Stanford University School of Medicine, where Shefali Srivastava-Miller, M.D., is a clinical assistant professor of psychiatry and behavioral sciences and Po Wang, M.D., is a clinical professor of psychiatry and behavioral sciences.

Join With APA to 'Give Back'

In its sixth year, "APA Gives Back" provides an opportunity for APA, its members, and other annual meeting attendees to support a community organization in the host city of the annual meeting. This year's recipient is Covenant House Toronto. Covenant House serves as a crisis-intervention center and provides residential, nonresidential, and community support services, including a pastoral ministry, a runaway prevention program, meals, assessment and referrals, counseling, health care, and housing help. A family practice doctor and psychiatrist are on site. For more information, visit www.covenanthousetoronto.ca.

Contributions may be made when you register for the annual meeting at http://annualmeeting.psychiatry.org/registration. (If you've already registered, you can return to the registration page and donate now.) APA will match the amount contributed. To date, the APA Gives Back program has donated $67,177 to local groups in annual meeting host cities.

Extremely Low Birth Weight May Be Risk Factor for Psychiatric Illness

The subset of extremely low birth weight survivors who were also exposed to antenatal corticosteroids had an even higher risk for some psychiatric disorders.

BY MARK MORAN

Individuals born at extremely low birth weight and exposed to corticosteroids prior to birth may be at increased risk for psychopathology in their 30s, according to a report published online February 9 in *Pediatrics*.

A prospective, longitudinal comparison of extremely low birth weight (ELBW) survivors and normal birth weight (NBW) control participants found that ELBW survivors had a higher likelihood of developing a mental illness not related to substance abuse. More importantly, the subgroup of survivors whose mothers had received antenatal corticosteroids had an even higher risk in their 30s for mental illnesses.

"Preterm babies born before 34 weeks have a number of brain changes that predispose them to psychiatric problems later in life, even without exposure to steroids," said lead author Ryan Van Lieshout, M.D., Ph.D., in an interview with *Psychiatric News*. "But steroids appear to act on the limbic system—especially the hippocampus—and those regions of the brain are involved in emotional regulation and cognition. So it could be that changes in those areas of the brain potentiated by steroid use account for what puts these individuals at higher risk later in life."

But Van Lieshout, who is the Albert Einstein/Irving Zucker chair in neuroscience and an assistant professor in the Department of Psychiatry and Behavioral Neurosciences at Canada's McMaster University, emphasized that the results are preliminary and require replication and that there are a great many areas ripe for research exploration to understand the apparent correlation between extremely low birth weight and/or maternal antenatal steroid use and psychiatric disorders later in life.

Van Lieshout did stress that corticosteroids for very tiny babies are frequently life saving and that the study results should not be construed as advising against their use.

A total of 397 mainly Caucasian infants born at 1,000 g from 1977 to 1982 in Ontario, Canada, were enrolled. Of these, 179 (45 percent) survived to hospital discharge and have been followed longitudinally, with assessments at ages 3, 5, 8, 14, 22 to 26, and 29 to 36.

At ages 29 to 36, 84 participated in a structured psychiatric interview.

Data on maternal antenatal corticosteroid exposure were collected from the medical charts of ELBW survivors at birth. A complete course of steroids was defined as a mother receiving two doses of betamethasone (12 mg) administered intramuscularly within a 24-hour period. The mothers of 24 ELBW participants received a complete course of steroids.

The NBW control group of 145 children born at 2,500 g has been assessed at ages 8, 14, 22 to 26, and 29 to 36. Of these, 90 completed the Mini-International Neuropsychiatric Interview between ages 29 and 36.

Van Lieshout and colleagues found that ELBW survivors had lower odds of an alcohol or substance use disorder but higher odds of current non-substance-related psychiatric problems. And those exposed to antenatal steroids had even higher odds of any current non-substance-related psychiatric disorders—particularly generalized anxiety disorder, the generalized type of social phobia, and the inattentive subtype of attention-deficit/hyperactivity disorder (ADHD).

Moreover, those ELBW individuals exposed to corticosteroids did not manifest the protective effect against substance abuse apparently conferred by small-for-gestational-age status.

(The diminished risk for substance abuse among individuals born at ELBW and small for gestational age has been shown previously and has been hypothesized to be a result of a cautious, risk-averse personality style, lower levels of externalizing behavior, and/or increased paternal oversight earlier in life.)

Van Lieshout and colleagues said the finding that ELBW survivors are more likely as adults to have a psychiatric disorder not related to substance abuse is in keeping with previous studies. "The etiologic factors contributing to this finding are complex and multifactorial, and they probably interact," they suggested. "These factors include prenatal insults

see ***Birth Weight*** *on page 33*

1 in 4 Homeless Children May Need Mental Health Services

Screening of more than 300 sheltered and transitional children helps to clarify the risks of homelessness on cognitive development and social and emotional well-being.

BY NICK ZAGORSKI

The number of homeless children in this country is about 2.5 million, according to the National Center on Family Homelessness. Given the trying circumstances—among them, domestic violence, chronic unemployment, and substance abuse—that typically lead a family into homelessness, coupled with the stress of living in a shelter, these children are at high risk for developing mental health problems. A new study has quantified how serious this risk can be, finding that 25 percent of homeless children in Wake County, N.C., are in need of mental health services.

The findings, which were published in the *Early Childhood Education Journal,* come from a screening of both the developmental and social/emotional status of 328 children, between 2 months and 6 years old, from 11 shelters or transitional housing sites across the county.

As a comparison, other studies have estimated that social and emotional problems impair about 9 percent to 14 percent of all U.S. children in a similar age range.

"While this study was carried out in Wake County, we hope that it can start a national conversation about the scope of problems facing homeless children and their families," said lead author Mary Haskett, Ph.D., a professor of psychology at North Carolina State University.

"The data are especially concerning as many of these children were not in school yet," she continued. "Older children have some protection afforded by the McKinney-Vento Homeless Education Act, but there are no such safety nets for children from birth to preschool."

The McKinney-Vento Act provides federal funding to states to ensure school enrollment and educational stability for homeless youth.

Besides the high prevalence of children with significant mental health concerns, the assessment found that homeless children showed slower development related to language, motor skills, and cognition. While there were almost no differences in functioning between homeless infants and matched controls, homeless toddlers displayed lower communication scores, while homeless elementary-aged children scored lower across all tested skills.

Haskett did stress, however, that there was a good deal of variability among the children, and many did score above expectations.

"Children are vulnerable, but they are also resilient, and future research should look into the factors that enable many homeless children to cope with the tremendous adversity they face," Haskett told *Psychiatric News.* "A better understanding could help shelters make their environment as conducive as possible for children's well-being."

Haskett does believe that shelters should also provide mental health screening services, while acknowledging most are not equipped to do so. "Yet, these settings could be critical portals for developmental and behavioral health care," she said.

This study likely represents the most generalizable assessment of mental health in homeless children to date, given the large population sample and the focused age range (birth to 6 years). It is also one of the first that incorporates data on the heels of the recent recession and the accompanying rises in unemployment, poverty, and homelessness.

The researchers used data made available through the help of Community Action Targeting Children Who Are Homeless (CATCH), a community project designed to assess and assist children who enter shelters across the county. CATCH is funded by the Salvation Army, Wake County Smart Start, and the John Rex Endowment. PN

An abstract of "Developmental Status and Social-Emotional Functioning of Young Children Experiencing Homelessness" is posted at http://link.springer.com/article/10.1007/s10643-015-0691-8.

CLINICAL & RESEARCH NEWS

Amyloid Fragments Found In Young Brains

A study from Northwestern University visualizes this biological hallmark of Alzheimer's disease in people as young as 20 and may provide clues into the earliest development of this disease.

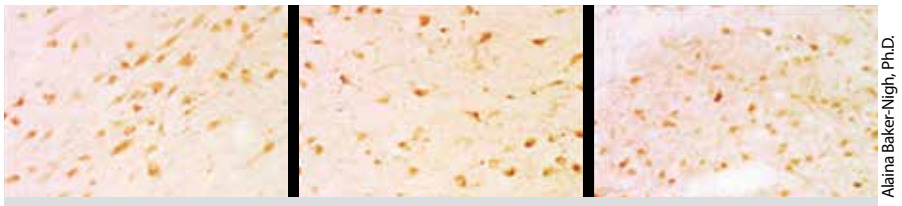
BY NICK ZAGORSKI

Researchers at Northwestern University have uncovered evidence that the development of AD may begin in people as young as age 20.

This new study, published in the journal *Brain*, is significant for visualizing for the first time a hallmark of AD—sticky clumps of beta amyloid—at such an early age. Beta amyloid fragments are produced from the regulated cleavage of a brain protein called APP; over time they converge and grow, becoming more toxic along the way.

"These findings are not a call for alarm, however," said Alaina Baker-Nigh, Ph.D., a postdoctoral fellow at Washington University School of Medicine. "The presence of amyloid is not a marker indicating disease, but it may help us identify the point at which a normal brain flips the switch and becomes pathological."

Baker-Nigh added that the amyloid clumps were contained within one specific type of neuron known as the basal forebrain cholinergic neuron (BFCN). These neurons are involved in memory and attention and are the most vulnerable to damage from AD; by the late stages of AD, almost all BFCNs are typically destroyed.



Alaina Baker-Nigh, Ph.D.

From left: Forebrain neurons from young, old, and Alzheimer's disease brain samples did not differ in total beta amyloid content.

Baker-Nigh and her colleagues examined these neurons from the brains of three groups of deceased individuals: 13 cognitively normal young people (ages 20 to 66); 16 nondemented older people (ages 70 to 99); and 21 people with AD (ages 60 to 95). The 16 older people without dementia included two "super-aged" ones who were 90 and 95 but performed as well as someone decades younger on memory tests.

The researchers identified beta amyloid fragments in every brain sample they looked at, and the total amount was roughly the same regardless of age. However, as people got older, the amyloid was present in larger particles, suggesting these protein fragments exist naturally in the neuron—and possibly serve some purpose—but gradually clump over time.

Interestingly, the largest clumps were found in the oldest healthy adults, as opposed to those with AD. The reason for this phenomenon is not clear, but Baker-Nigh believes it may reflect that the BFCNs in the AD people were already dead, and thus the amyloids stopped growing.

"Therefore, the key factor for determining brain health may not be how big the amyloid clumps get but how well your cells tolerate the clumping," she told *Psychiatric News*.

The next step in research would involve pinpointing exactly how these amyloid clumps kill a BFCN, which might help identify the best way to protect these vulnerable cells, which in turn may help protect the rest of the brain. A clue might be found in "super-aged" seniors, as the two brain samples in this analysis actually displayed some of the lowest levels of amyloid clumping.

Another area to pursue would be how this beta amyloid accumulation connects with a protein called Tau, which is also believed to be a key contributor in the progression of AD.

"Because Alzheimer's usually manifests in later life, we don't necessarily have to prevent these amyloids from forming," Baker-Nigh said. "If we can find a good time for early intervention that could delay the process even for only a few years, it would still reduce the burden of Alzheimer's tremendously."

This work was supported by grants from the National Institute on Aging as well as a Zenith Fellows Award from the Alzheimer's Association. PN

An abstract of "Neuronal Amyloid-β Accumulation Within Cholinergic Basal Forebrain in Aging and Alzheimer's Disease" is posted at http://brain.oxfordjournals.org/content/early/2015/02/26/brain.awv024.long.

Age When Football Hits Began May Determine Future Cognitive Problems

An assessment of 42 former NFL players finds that those who started playing before age 12 perform worse on tests of thinking and memory.

BY NICK ZAGORSKI

A common view among the public is that football players (or other contact athletes) who develop cognitive problems later in life do so because they stayed in the game too long, that they should have retired just a couple of years earlier.

However, new research from Boston University (BU) School of Medicine is suggesting it's not the length of time a football player absorbs physical punishment, but when he first started taking those hits that can prove the most damaging.

melis/Shutterstock

A team led by Robert Stern, Ph.D., a professor of neurology, neurosurgery, and anatomy and neurobiology as well as director of clinical research for BU's Chronic Traumatic Encephalopathy Center, gave 42 former National Football League (NFL) players a battery of psychological tests. The report was published online in the journal *Neurology*.

The NFLers, who were aged 40 to 69 and had all experienced memory and cognition problems, were evenly divided based on one criterion: age of first exposure (AFE) to tackle football.

The players who started to play football before the age of 12 performed about 20 percent worse on these tests than the group that started at or after age 12.

That difference might just be due to a longer overall playing career and greater accumulation of head injuries (most of which would be mild enough to cause no symptoms). On average, the group that started playing football before age 12 played the game for almost 20 years, compared with 17.5 years for the players who started at or after age 12.

However, these same early starters had shorter NFL careers than their counterparts (about one-and-a-half years shorter on average), which may balance out some of that difference in total length.

These findings fall in line with research showing that the ages of 10 to 12 are a critical period of neurodevelopment, as highlighted by increased myelination—the insulating of nerve fibers—and cerebral blood flow.

"Research into the effects of mild, repetitive concussions is an area that is quite new, but we know that this type of injury is a different animal than a major

see ***Football*** *on page 32*

High-Dose Anticholinergic Drugs May Increase Dementia Risk

Because of risk related to cognitive impairment associated with use of anticholinergics, some geriatric psychiatry experts are recommending that other therapeutic options be considered.

BY VABREN WATTS

Previous studies have suggested that medications—both prescription and over the counter—aiming to block the actions of acetylcholine may be associated with increased risk for cognitive impairment, but a recent study published in *JAMA Internal Medicine* shows that use of such medicines in older adults may increase the risk for dementia.

Researchers from the Geriatric Pharmacy Program at the University of Washington led a large-scale study with older adults to examine whether a correlation exists between cumulative anticholinergic drug use and the onset of dementia.

"There are many medications with anticholinergic properties that impair cognitive performance," said Davangere Devanand, M.D., director of the Division of Geriatric Psychiatry at the New York State Psychiatric Institute, who was not involved in the study. "Recognizing the cognitive impact of anticholinergic medications is very important for the well-being of patients," he told *Psychiatric News.*

According to the study, medications with anticholinergic activity are widely used by older adults for an array of conditions, including overactive bladder, seasonal allergies, and depression. Previous studies have shown that the prevalence of anticholinergic use in older adults ranges from 8 percent to 37 percent.

To ascertain patients' cumulative anticholinergic exposure, the researchers analyzed 10 years of pharmacy-dispensing data on 3,400 individuals aged 65 and older who had no history of dementia at the study's initiation.

The results showed that individuals taking daily dosages of at least 10 mgs of tricyclic antidepressants, 4 mgs of first-generation antihistamines, or 5 mgs of antimuscarinics for bladder control for more than three years were at greater risk for developing dementia than their counterparts who did not use such medicines long term.

Dragon Images/Shutterstock

The researchers noted that the study highlights the need to increase awareness among health care professionals and older adults about the potential risk associated with extended use of anticholinergic drugs as well as a need for efforts to minimize such drug use.

"Older adults should be aware that many medications—including some available without a prescription, such as over-the-counter sleep aids—have strong anticholinergic effects," said the study's lead author, Shelly Gray, Pharm.D., M.S., director of the geriatric pharmacy program. "If providers need to prescribe a medication with anticholinergic effects because it is the best therapy for their patient," Gray stated, "they should use the lowest effective dose, monitor the therapy regularly to ensure it's working, and stop the therapy if it's ineffective."

"Physicians prescribing anticholinergics need to monitor the medicines' impact on patients' cognitive abilities and, consequently, functional abilities," said Devanand. Measuring such abilities, he suggested, can be achieved by open-ended questioning of patients and caregivers and by serial administration of brief cognitive assessments such as the Mini-Mental State Examination and the Montreal Cognitive Assessment.

As for Gray and colleagues, she said that future studies with postmortem brain tissue are under way. The researchers plan to investigate differences, if any, of dementia-related pathology between brains that were exposed long term to anticholenergic drugs and those that were not.

The study was funded by the National Institute on Aging. PN

An abstract of "Cumulative Use of Strong Anticholinergics and Incident Dementia" is posted at http://archinte.jamanetwork.com/article.aspx?articleid=2091745.

Neuropsychiatric Symptoms Implicated In Conversion From MCI to Dementia

Neuropsychiatric symptoms may be etiologic for dementia through neuroendocrine axis activation, or they may interact synergistically with a biological factor; either of these suggests that treating neuropsychiatric symptoms might delay dementia onset.

BY MARK MORAN

Neuropsychiatric symptoms in the presence of mild cognitive impairment (MCI), including depression, appear to significantly increase the risk of conversion to dementia—either amnestic or Alzheimer's type dementia—according to a report published February 20 in *AJP in Advance*.

Researchers at Johns Hopkins University School of Medicine and in the United Kingdom searched PubMed (from 1946) and Web of Knowledge (from 1900) through May 22, 2013 (updated June 5, 2014), using a variety of terms such as "mild cognitive," "cognitive impairment," and "age associated cognitive decline" included in longitudinal studies reporting potentially modifiable risk factors for incident dementia in people with MCI.

There were 76 eligible articles reporting epidemiologic and clinical studies.

A principal finding from the study was that diabetes, prediabetes, metabolic syndrome, and low serum folate levels increased risk of conversion from amnestic MCI to Alzheimer's dementia and from any type or nonamnestic MCI to all-cause dementia.

But the researchers also found that the presence of neuropsychiatric symptoms predicted conversion to all-cause dementia. Among the findings are the following:

- There is evidence that more depressive symptoms predict conversion from any-type MCI to all-cause dementia from epidemiologic studies, but the evidence is inconsistent in clinical studies; it is also inconsistent as to whether depressive symptoms predict conversion from amnestic MCI to Alzheimer's dementia or to any-cause dementia.

- There is evidence from clinical studies that the presence of neuropsychiatric symptoms in people with any-type MCI, but not their overall levels of symptoms, predicts conversion to all-cause dementia.

- There is inconsistent evidence about whether anxiety symptoms are associated with conversion from amnestic MCI to Alzheimer's dementia and about whether apathy predicts the risk of conversion from amnestic MCI to Alzheimer's dementia or from any-type MCI to dementia.

"A third to three-quarters of people with MCI have neuropsychiatric symptoms, most commonly depression, anxiety, apathy, and irritability," the researchers stated. "Neuropsychiatric symptoms predicted conversion from any-type MCI to all-cause dementia. Neuropsychiatric symptoms may be etiologic for dementia, for example through neuroendocrine axis activation, or they may interact synergistically with a biological factor, such as genetic predisposition. Either of these putative relationships suggests that treating neuropsychiatric symptoms could theoretically delay dementia."

Dilip Jeste, M.D., a past APA president and a professor of psychiatry and

see ***Dementia*** *on page 30*

High Rates of Fetal Alcohol Disorders Found in Urban Areas

A study of patients in a Chicago clinic finds that nearly 40 percent of psychiatric patients present with a neurodevelopmental disorder due to prenatal alcohol exposure.

BY NICK ZAGORSKI

While the cause of many mental disorders remains mysterious, there are etiologies that can be explained, which makes it even more frustrating when prevention or intervention efforts lag. Such is the case for developmental problems brought on when pregnant women drink alcohol.

Fetal alcohol exposure is one of the leading causes of speech and language disorders, attention-deficit/hyperactivity disorder (ADHD), and learning disorders. Fetal alcohol-related developmental problems are entirely preventable, yet remain fairly common; a recent study of Midwestern first-graders published in *Pediatrics* estimated that between 2.4 percent and 4.8 percent of children have a fetal alcohol spectrum disorder (FASD).

In some communities, such as poor urban areas, however, where liquor stores are a ubiquitous presence, the prevalence might be even higher, though not much research has been done related to populations of these areas. A study published online last month in *Psychiatric Services in Advance* provides some context on how pervasive alcohol-related developmental problems are in one such urban community.

Carl Bell, M.D., a clinical professor of psychiatry and public health at the University of Illinois School of Medicine, and coauthor Radhika Chimata assessed the records of 590 adult and 21 youth psychiatric patients—who were almost all African American—who attended the Family Medicine Clinic at Jackson Park Hospital on Chicago's Southside.

They found that 237 of the 611 patients, or nearly 40 percent, had clinical profiles consistent with a neurodevelopmental disorder associated with prenatal alcohol exposure, while only 53 patients, or 9 percent, presented with a "classical" *DSM-5* neurodevelopmental disorder such as intellectual disability, ADHD, or autism; the authors disagreed on the specific type of neurodevelopmental disorder in seven additional patients.

As anticipated, many of the patients with FASD had been previously misdiagnosed with one of these disorders or with an illness such as bipolar disorder. Even Bell, who is a staff psychiatrist at the Family Medicine Clinic, admits to missing some cases. "I did not have a clue how prevalent this neurodevelopmental problem was, and I was seeing these people clinically."

Roxana Gonzalez/Shutterstock

Regardless of the past, Bell believes this issue is of paramount importance moving forward. "This is the biggest public-health issue since polio," he told *Psychiatric News*.

In addition to causing developmental disabilities—which were for the first time acknowledged in the new *DSM-5* as neurodevelopmental disorder associated with prenatal alcohol exposure (ND-PAE)—alcohol can induce other physical and neurological problems in fetuses, including heart murmurs, facial abnormalities, and reduced size and weight. This combination of disabilities makes children with FASD frequent targets of abuse (physical, verbal, and sexual), which in turn brings on more behavioral problems and an increased risk for substance abuse.

And the problem is not going away. "We identified 237 cases of fetal alcohol disorder during our assessments, but more have come through the clinic doors since then," Bell said. "The clinic now sees more than 400 people with this condition, and like a marching band going down a dead-end street, they just keep filling up the facility."

"This work illuminates the troubles facing an underserved population in Chicago, but it also provides just a snapshot of the 'iceberg' that we find in our society as a whole," said Susan Rich, M.D., M.P.H., a psychiatrist who specializes in fetal alcohol spectrum disorder and raising awareness about it. "Wherever we find social drinkers who on occasion binge alcohol, we will find ND-PAE."

As an example, Rich noted that the Centers for Disease Control and Prevention has cited college-age youth as having the highest risk of ND-PAE because they are frequently sexually active while drinking at binge rates.

To tackle this problem, Rich believes that focused, preconception, prevention strategies are needed to help curb the high unplanned pregnancy rate in the U.S. She pointed out that most of the mothers interviewed in Bell's study stopped drinking once they knew they were pregnant, so even in places with high rates of alcohol use, like disadvantaged urban areas, mothers try to protect their babies' health once they are aware of their pregnancy.

But drinking even during those first few weeks of pregnancy can lead to a lifetime of disability for the unborn child, she noted. PN

An abstract of "Prevalence of Neurodevelopmental Disorders in Low-Income African-Americans at a Family Medicine Clinic on Chicago's Southside" is posted at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400162. An abstract of "Prevalence and Characteristics of Fetal Alcohol Spectrum Disorders" is posted at http://pediatrics.aappublications.org/content/early/2014/10/21/peds.2013-3319.abstract.

From the Experts

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included anhedonia, poor self-esteem and concentration, insomnia, psychomotor agitation, and passive suicidal ideation without intent, preparation, or plans. Current mood-elevation symptoms, which emerged after starting bupropion, included prominent irritability as well as decreased need for sleep (feeling alert and energized despite sleeping only three hours a night), increased goal-directed activity (working 70 hours and socializing 40 hours a week), and impulsivity (starting a romantic affair with a married coworker). The patient denied having substantive anxiety symptoms.

Grace acknowledged having had three depressive and one hypomanic episodes in the prior year, and although she reported being hospitalized for mania at age 18, she denied any lifetime history of anxiety or alcohol/substance use disorder. She admitted to having declined individual and couples' psychotherapy on multiple occasions for a variety of reasons, including "lack of time." She reported having prior pharmacotherapy with mood stabilizers, with lithium having yielded some improvement, but dosage was limited by side effects; lamotrigine having yielded a rash; carbamazepine being refused due to rash risk; and divalproex was refused due to risk of exacerbating her polycystic ovarian syndrome. She also stated that the SGA aripiprazole had been ineffective for depression, and the antidepressant paroxetine had not only been ineffective for depression, but had also yielded insomnia, agitation, irritability, and sexual dysfunction.

Grace's family history was remarkable for having a mother with bipolar I disorder who had experienced psychotic mania, requiring hospitalization on three occasions and not achieving long-term mood stability despite aggressive pharmacotherapy with unspecified mood stabilizers and antidepressants. Grace also reported having a sister with bipolar I disorder who had been hospitalized for psychotic mania on one occasion, but she had eventually achieved adequate control of mood elevation symptoms with lithium 1,200 mg/day and the SGA quetiapine, although its dosage was limited to 75 mg at bedtime due to somnolence.

Thus, Grace had mixed bipolar I depression with rapid cycling, prominent irritability and impulsivity, and a history of problems with antidepressant administration that very recently included "converting" from pure to mixed depression with the antidepressant bupropion. Important alternatives to antidepressants for her did not appear to include mood stabilizers but did appear to include the SGAs lurasidone and olanzapine combined with fluoxetine (although this combination has substantial weight and metabolic tolerability limitations).

Clinicians will commonly encounter cases of patients with bipolar depression, and in these patients, antidepressant treatment needs to be approached with extreme caution. Arriving at the optimal therapeutics entails making carefully personalized treatment decisions. In this case, SGAs rather than mood stabilizers and antidepressants appeared to be priority interventions. PN

MED CHECK

BY VABREN WATTS

EU Approves First Antidepressant With Cognition Claims

Previous studies have shown a range of cognitive symptoms—including difficulties in thinking and remembering new information—to be associated with major depression. In March, ***Brintellix (vortioxetine)*** became the first antidepressant approved in the European Union (EU) to improve cognitive symptoms in patients with depression.

"We are delighted that Brintellix has received this positive opinion from the CHMP [Committee for Medicinal Products for Human Use], particularly given the role cognitive deficits play in impacting treatment outcomes for many patients," said Anders Gersel Pedersen, M.D., Ph.D., executive vice president and head of research and development at Lundbeck, manufacturer of Brintellix.

The antidepressant's claims of improving cognition were approved after the CHMP reviewed comprehensive data from an international clinical program composed of five studies assessing the safety and efficacy of Brintellix as well as the medicine's effects on cognitive function and performance. These were assessed by various neuropsychological tests, such as the Digit Symbol Substitution Test, in patients with major depression.

Brintellix became available in the United States, where it is copromoted by Takeda, more than a year ago and is gradually being introduced across the EU.

FDA Launches Mobile App On Medication Shortages

Information on drug shortages can now lie in the palm of your hand. Last month, the Food and Drug Administration (FDA) launched its first mobile app specifically designed to increase public access to data on current shortages, resolved shortages, and discontinuations of drug products.

"Health care professionals and pharmacists need real-time information about drug shortages to make treatment decisions," said Valerie Jensen, R.Ph., associate director of the Drug Shortage Staff in the FDA's Center for Drug Evaluation and Research. "The new mobile app is an innovative tool that will offer easier and faster access to important drug shortage information."

Users may be able to access information on medications based on therapeutic category, such as "psychiatry." Current psychotropics on the shortage list are attention-deficit/hyperactivity medications ***dexmethylphenidate hydrochloride (Focalin) tablets*** and ***methylphenidate hydrochloride extended release capsules,*** the antipsychotic ***haloperidol lactate injection***, and the antidepressant ***trimipramine maleate (surmontil) capsules.***

The app is available for free download via iTunes (for Apple devices) and the Google Play store (for Android devices) by searching "FDA Drug Shortages."

Company Halts Studies Of Alzheimer's Drug

Development for the Alzheimer's drug category BACE (beta-site amyloid precursor protein cleaving enzyme 1) inhibitors started with a grim first quarter of the fiscal year.

Last month, Vitae Pharmaceuticals and Boehringer Ingelheim announced that they have put a hold on studies concerning their newly codeveloped BACE inhibitor ***BI 1181181*** after observing skin rashes in patients enrolled in a phase 1 dose-ranging study.

"Our partner is working diligently to evaluate and understand this observation," said Vitae Chief Scientific Officer Richard Gregg, M.D. "Depending on the outcome of the evaluation, … we expect that either BI 1181181 or its structurally distinct phase-1-ready backup will be advanced with the goal of delivering a medicine with disease-modifying benefits to patients suffering from Alzheimer's disease."

The setback is the latest in a series of missteps for BACE inhibitors, a highly sought-after therapy in the field of Alzheimer's drug development. Eli Lilly's BACE program was scrapped for off-target toxicity in studied individuals. Roche killed off its BACE program for unexplained reasons, and Astellas, without explanation, backed out of a $760 million deal with CoMentis on another early-stage BACE drug program.

As for Vitea, Gregg stated that the company will remain committed to its partnership with Boehringer and the progression of the joint BACE program. PN

Applications Invited for APA 2015 Achievement Awards

APA's Psychiatric Services Achievement Award Committee is soliciting applications for the 2015 Achievement Awards competition. Innovative programs for people with mental illness or disability that have been in operation for two or more years, have overcome obstacles, and can serve as models for other programs are urged to apply. The deadline is May 12. Information about the awards and an online application can be accessed at http://www.psychiatry.org/achievementawards. Additional information is available from Samantha Hawkins at (703) 907-8612 or shawkins@psych.org.

RESIDENTS' FORUM

The Importance of Hope: How Cultivating Hope Can Enhance Psychiatry

BY MATT GOLDENBERG, D.O.

Mental illness and addiction can be devastating and cause both our patients and their families to lose hope. When this happens, we are often not immune to the negative effects of our patients' suffering. If our patients stumble, lose ground, and lose hope, it can be hard for us not to lose hope as well. This is why learning to maintain and nurture hope is important for our mental health as well as that of our patients.

Our training teaches us the skills needed to be superior diagnosticians. However, Garrett O'Conner, M.D., an associate clinical professor of psychiatry at the University of California, Los Angeles, and former chief psychiatrist at the Betty Ford Center, has presented research that points out that the word choice of Kaplan and Sadock's *Comprehensive Textbook of Psychiatry* is surprisingly negative.

Out of the more than 45,000 lines, he notes that more than 2,000 use negative words such as anxiety, depression, fear, shame, hatred, and guilt. In comparison, hope, joy, compassion, forgiveness, gratitude, love, and faith are given a total of seven lines.

Accordingly, we are trained to look for deficits in mood, problems with sleep, impairments in activities of daily living, and the neurovegetative symptoms of psychiatric illness. Dr. O'Conner points out that our diagnostic criteria—and our training, unfortunately—do not focus enough on the positive aspects of the human condition. If we focus all of our time and efforts on the negative effects of psychiatric illness and addiction, which Dr. O'Conner calls "malignant shame," are we not neglecting to heighten the positive aspects of life with our patients?

Take a moment to reflect on how much time you spend discussing and building your patients' hope.

One of the key tenets of Viktor Frankl, M.D.'s, logotherapy, as described in the bestselling book *Man's Search for Meaning*, is the importance of finding meaning and purpose in even the most dire of situations. A psychiatrist and a survivor of the Holocaust, Dr. Frankl observed that those who maintained their hope were often the ones who survived the prison camp in which he was interned. Dr. Frankl maintained his hope, as did others he observed, by finding purpose and meaning in day-to-day life. He focused on surviving the torturous conditions to publish and share his new theory. Even on his worst days, maintaining his hope helped him to persevere.

Dr. O'Conner noted the overlapping and important role that hope plays in both the rehabilitation of those suffering from addiction and those who have survived trauma like the Holocaust. For example, by using logotherapy, encouraging spirituality, or encouraging the establishment of social/human connections, practitioners can help patients with addiction or victims of trauma find purpose and meaning in their lives. Finding meaning, purpose, and goals redirects the focus to a future orientation and increases resilience and hope. Life's challenges, including relapse of psychiatric illness or addiction, can be trying if we focus only on the past, the present, or both. If we neglect to focus on the future, it is easy to become discouraged. This is true for those suffering from other mental illnesses, such as depression and anxiety.

Dr. O'Conner and Dr. Frankl remind us that hope is a critical part of the human experience and necessary for high quality of life. Working with patients to achieve their goals, in addition to decreasing their symptomatology, can provide motivation and hope for practitioners as well. This is where I encourage you to focus when there are setbacks, because we must always have hope if we expect our patients to have hope as well. PN

Matt Goldenberg, D.O., is a fourth-year resident at Banner Good Samaritan Medical Center in Phoenix.

JOURNAL DIGEST

BY VABREN WATTS

Many Drinkers Use Prescription Drugs That Interact Negatively With Alcohol

The combination of alcohol and certain prescription medications has the potential to lead to adverse health effects, yet little is known about the prevalence of alcohol-interactive (AI) prescription medications among drinkers, according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA). To shed some light on such rates, NIAAA researchers analyzed data on more than 26,000 adults aged 20 and older regarding past-year use of alcohol and past-month use of prescription drugs.

The results showed that 42 percent of current drinkers reported using medications that were classified as AI prescription drugs. Among current drinkers aged 65 and older, the prevalence of AI medication use was nearly 80 percent. Collectively, study participants reported use of almost 600 prescription drugs known to interact negatively with alcohol. Antidepressants, antipsychotics, and antihypertensive medications were among the most commonly reported AI medications.

"Our findings show that a substantial percentage of people who drink regularly, particularly older adults, could be at risk of harmful alcohol and medication interactions," said lead author Rosalind Breslow, Ph.D., M.P.H., an epidemiologist in the NIAAA Division of Epidemiology and Prevention Research. "We suggest that people talk to their doctor or pharmacist about whether they should avoid alcohol while taking their prescribed medications."

Though the study did not confirm whether drinking and medication use overlapped based on the available data, the researchers noted that the study highlights the potential scale of concurrent use of alcohol and AI prescription medicines. "Given the adverse health risks of combining alcohol with AI prescription medications, future efforts are needed to collect data to determine actual simultaneous prevalence," the researchers concluded.

Breslow R, Dong C, White A. Prevalence of alcohol-interactive prescription medication use among current drinkers: United States, 1999 to 2010. *Alcohol Clin Exp Res*. 2015. 39(2):371-9. http://onlinelibrary.wiley.com/doi/10.1111/acer.12633/abstract

Texting May Be Better Than Smartphone Apps as Mental Health Intervention

Instead of suggesting that patients download smartphone apps as an additional therapy for mental illness, try suggesting the use of readily available cellphone technology to achieve the same or better results, said authors of a study in the health-related technology journal *Personal and Ubiquitous Computing*.

After interviewing 325 patients from a mental health outpatient clinic about their cellphone ownership and usage patterns, researchers from Clemson University and Indiana University found that 80 percent of surveyed patients used texting, whereas many did not use mobile applications. Furthermore, participants who used texting also reported that they were more comfortable with texting their mental health care provider, implying that texting may be an appropriate feature for mobile health interventions, said the researchers.

"By utilizing a technology that is readily available and familiar to so many Americans," said lead author Kelly Caine, Ph.D., an assistant professor in human-centered computing at Clemson, "we see a huge potential to improve treatment outcomes" and provide additional treatment options to patients who may have limited access to mental health care. Caine and colleagues plan to undertake research investigating the different types of treatment aids that can be offered via texting as well as mobile security options that will help protect personal medical information.

Campbell B, Caine K, Connelly K, et al. Cellphone ownership and use among mental health outpatients in the USA. *Personal and Ubiquitous Computing*. 2015. 19:2 (367-378). http://link.springer.com/article/10.1007/s00779-014-0822-z

No Increased Risk Found For Behavior Problems In Children of Lesbian Parents

A new study reaffirms earlier findings that adolescents in lesbian-parent households do not display significant behavioral problems when compared with adolescents raised by heterosexual parents.

The study was conducted in 67 youth from lesbian-parent families and 67 youth from heterosexual-parent families in the Netherlands—in 2001 the first country to legalize same-sex marriage.

Results showed that adolescents raised by lesbian parents showed no significant differences in internalizing behaviors, such as being withdrawn, anxious, or depressed, or displaying unfavorable behaviors toward others, such as aggression. When problem behaviors in adolescents of lesbian parents were identified, the researchers found that they were associated with homophobic stigmatization directed as these youth. Youth who reported more homophobic stigmatization demonstrated more behavior problems.

Senior author Nanette Gartrell, M.D., a psychiatrist and visiting distinguished scholar with the Williams Institute of UCLA School of Law, suggested that during routine health assessments of children of same-sex parents, clinicians should ask questions about experiences with stigmatization so that they can identify and recommend support services for such youth, particularly those living in countries that are less accepting of people who are lesbian, gay, bisexual, or transgender. PN

Van Rijn-van Gelderen L, Bos H, Gartrell N. Dutch adolescents from lesbian-parent families: how do they compare to peers with heterosexual parents and what is the impact of homophobic stigmatization? *J Adolesc*. February 3 2015. [Epub ahead of print] http://www.sciencedirect.com/science/article/pii/S0140197115000251

Dementia

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neurosciences and the Estelle and Edgar Levi Chair in Aging at the University of California, San Diego, said that the costs associated with dementia make identification of risk factors a valuable public-health task.

"This is an important paper based on a careful meta-analysis of 76 published articles reporting longitudinal studies on potentially modifiable risk factors for development of dementia in persons with mild cognitive impairment, or MCI," he told *Psychiatric News*. "In *DSM-5*, dementia and MCI are labeled major and minor neurocognitive disorders, respectively. In general, between 35 percent and 45 percent of people with MCI develop dementia within three years. The total financial cost of dementia exceeds that of heart disease and cancer. Therefore, identifying and controlling risk factors for developing dementia among older adults with MCI is of clear public-health significance.

Dilip Jeste, M.D.

Dilip Jeste, M.D., said that between 35 percent and 45 percent of people with mild cognitive impairment develop dementia within three years and that the financial costs of dementia exceed those of heart disease and cancer.

"These authors report that diabetes, pre-diabetes, metabolic syndrome, neuropsychiatric symptoms including depression, and lower serum folate levels were associated with variably increased risk of dementia, whereas the Mediterranean diet seemed to reduce the risk of developing dementia in patients with MCI," Jeste added. "These findings suggest that control and prevention of diabetes, treatment of depressive and other neuropsychiatric symptoms, and use of a Mediterranean diet and of folate supplements may be helpful in lowering the risk of dementia in persons with MCI. A word of caution in interpreting the present results is that they are not based on large, randomized, controlled trials in individuals with MCI. Associations do not necessarily indicate causality or even directionality. Nonetheless, the recommendations should be helpful in at least some people and are consistent with good clinical practice." PN

"Modifiable Predictors of Dementia in Mild Cognitive Impairment: A Systematic Review and Meta-Analysis" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2014.14070878.

Change Direction

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"We need to change the conversation about mental illness and recognize that it is no different from any other illness," said APA CEO and Medical Director Saul Levin, M.D., M.P.A., who also spoke at the event.

To overcome the public's perception of that difference, the campaign seeks to raise awareness and train people to recognize signs of emotional suffering in themselves and the people around them, said Van Dahlen. The five warning signs at the core of the campaign are withdrawal, agitation, hopelessness, decline in personal care, and change in personality. They serve, in a sense, as a simple, layperson's screening tool.

Participating groups pledged to address several primary target audiences: military personnel, veterans, and their family members; corporate and government employees; first responders; students, teachers, school officials, and coaches; religious organizations; and health care professionals.

"There is a lot that ordinary people, those not trained as mental health professionals, can do," said Arthur Evans Jr., Ph.D., director of the Philadelphia Department of Behavioral Health and Intellectual Disability Services. If so, it suggests that the nation could shift its thinking on the subject.

"The next breakthrough in our field will come not in medications or psychotherapy but in how can we change the public's perception of mental health issues," he said. "Learning the five signs demystifies mental health issues and gives people concrete steps they can take to help someone."

Aaron Levin

Mental health organizations need to work together to lessen stigma and bring those who need it into care, said APA CEO and Medical Director Saul Levin, M.D., M.P.A. (center). He is flanked by Norman Anderson, Ph.D. (left), CEO and executive vice president of the American Psychological Association, and Angelo McLain, Ph.D. (right), CEO of the National Association of Social Workers.

Collaboration was a key to bringing the campaign together, said Levin, who appeared on a panel with Norman Anderson, Ph.D., CEO and executive vice president of the American Psychological Association, and Angelo McLain, Ph.D., CEO of the National Association of Social Workers.

"We need to work together to get the word out," he added. "If we don't speak up ourselves, no one else will."

Ultimately, the larger conversation about mental illness and mental health is more than a matter of budgeting and policy, Obama emphasized.

"Our mental health is just as vital as our physical health, and treating it that way will take courage from everybody," she concluded. "If we can summon that strength, then I guarantee that we will save lives, and soon enough, caring for our mental health won't be considered such a courageous act. It will be just another part of our lives." PN

Information about Change Direction is posted at http://www.changedirection.org. Information in *Psychiatric News* about Give an Hour is posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2013.7a11.

From the President

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to Dr. Summers, they are Sheldon Benjamin, M.D., Tami Benton, M.D., Carol Bernstein, M.D., Lara Cox, M.D., M.S., Jed Magen, D.O., M.S., Michele Pato, M.D., Laura Roberts, M.D., John Sargent, M.D., Christopher Thomas, M.D., Glenda Wrenn, M.D., ADMSEP Representative Greg Briscoe, M.D., AAP Representative Carlyle Chan, M.D., ABPN Representative Jeffrey Lyness, M.D., AACDP Representative Mark Rapaport, M.D., and AADPRT Representative Christopher Varley, M.D. Members of the APA staff were also a key part of this work.

Because of the Board's action in response to this forward-looking document, we believe that future psychiatrists will be better positioned to help all individuals who need our care. PN

Mentoring for Residents

These are among the mentoring opportunities available at APA's 2015 annual meeting in Toronto.

MONDAY, MAY 18
7 a.m.-8:30 a.m.
Meet the Experts Sunny Side Up Breakfast
Upper Canada Room, 18th Floor, Fairmont Royal York

TUESDAY, MAY 19
7 a.m.-8:30 a.m.
Early Research Career Breakfast
Salon B, Convention Floor, Fairmont Royal York

Volkow

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front at one of the meeting's most important sessions."

A world-famous research psychiatrist, Volkow has been instrumental in demonstrating that substance use disorder (SUD) and other addictions are diseases of the human brain. Through studies involving brain imaging of people who have a drug addiction, she has helped to identify some of the underlying mechanisms of substance use disorders, such as malfunction of dopamine neurocircuitry.

Volkow's research has also been aimed at changing the public's view of drug addiction from that of a moral or personal failing to one that promotes an understanding that pathophysiological abnormalities in the brain may make some people more prone to addictive behaviors.

Volkow was born and raised in Mexico City, earned her medical degree from the University of Mexico, and did her psychiatry residency at New York University. She said that she chose a career in neurobiology after reading an article on the use of positron emission tomography in studying brain function. She never imagined that one day she would be invited to present the lecture at the convocation.

"I've been going to the annual meeting every year since 1980, when I was a medical student," said Volkow. "It was an important meeting for me as a trainee, for I was able to learn and educate myself on the latest advancements in psychiatry."

Volkow stated that as she advanced in her career, the annual meeting provided her with a platform for sharing her knowledge about the underlying factors of substance use disorders not only with practicing psychiatrists but with residents and fellows—"the future of psychiatry."

NIH

National Institute on Drug Abuse Director Nora Volkow, M.D., says that she is pleased that APA is putting a spotlight on substance use disorders at one of the most visible annual meeting sessions.

Volkow remarked on how far the field of psychiatry has progressed regarding the perception of addiction as a mental illness. "Now the gears are shifting, and APA is putting more focus on getting members to see the importance of understanding every known aspect of addiction and the tools to treat this disorder. This really makes me happy."

At the convocation, Volkow will give a general perspective on the neurobiology of addiction and substance abuse disorders and how neurocircuitries of addiction can overlap those of other psychiatric conditions such as depression. In addition to her convocation address, Volkow will conduct an interactive session titled "Let's Talk About Marijuana," in which the controversial trends in marijuana-related legislation in several states will be discussed, and participate in a media workshop on addiction with National Institute on Alcohol Abuse and Alcoholism Director George Koob, Ph.D. (*Psychiatric News,* February 19). PN

Simulation

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of them indicated they didn't expect the situation to feel so real. But when the actor starts really pacing and yelling and getting in their face, they can't help but respond to that physiologically."

Simulation Evokes Real Responses

Similarly, Valentina Elena Cimolai, M.D., a third-year resident at the Hennepin-Regions Psychiatry Training Program, developed a simulation training with the HealthPartners Clinical Simulation Center at Regions Hospital in St. Paul.

The training involved a one-hour lecture on antecedents of violence, evaluation of violent patients and use of deescalation techniques, and one-hour clinical simulations. Simulated scenarios involved the following: an angry patient with substance abuse disorder and borderline personality disorder seeking early Xanax refills in an outpatient setting; a suicidal woman asking to leave the mental health unit against medical advice and threatening to harm herself with a cut spoon; and an unpredictable, psychotic, and intoxicated patient (using alcohol supplied by a visitor) on the medical-surgical unit.

In the last scenario, the resident is expected to politely attempt to take the alcohol from the patient and ask the visitor to leave. The patient becomes visibly angry and attacks the resident, who is expected to protect himself and activate the PERT (Psychiatric Emergency Response Team) for help. The resident is also expected to work with team members and order appropriate pharmacologic treatment if necessary.

A debriefing session is then held centered around the resident's emotional response to the attack, how to report an assault, and pharmacologic options.

Significant Improvement Seen

Cimolai said pre- and post-course self-rated surveys of residents indicated marked improvement in the comfort level of handling an acute crisis situation, ability to recognize phases of escalation, familiarity with self-defense techniques, and familiarity with verbal deescalation skills.

Scott Oakman, M.D., training director at Hennepin, told *Psychiatric News* there are several discrete skills the training seeks to impart. "We want trainees to identify when a patient is escalating and know what the next steps are when they are exposed to a situation that is getting out of control," he said. "We want them to know about resources in the hospital, who they should call for help, when to call for help—and to call for help earlier rather than later."

Oakman and Cimolai said they expect to expand the training and to incorporate it into resident orientation. "We are lucky to have resources at the Clinical Simulation Center, and a lot of training programs will have to start from scratch," he said. "But this is a subject of interest to all trainees and training program directors. And we want to get this training to medical-surgical residents who often have to confront these situations." PN

"Survey of Threats and Assaults on Psychiatric Residents by Patients" is posted at http://link.springer.com/article/10.1176%2Fappi.ap.10060090.

Football

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blow that would knock you out cold," said David Baron, D.O., vice chair of the Department of Psychiatry at the University of Southern California and director of the USC Center for Exercise, Psychiatry, and Sport.

"And right now, all the data is pointing to the increased susceptibility of a younger brain to these mild concussions," he told *Psychiatric News*.

Stern did point out that "our study does not suggest that incurring a head injury after the age of 12 is safe or free from long-term consequences. Even though the early AFE group performed worse, the over-12 group still scored below average on several measures."

All the players who participated in the study played all or a majority of their football prior to the recent public and league focus on traumatic brain injury (TBI), so children playing in today's youth and school programs may be playing under safer conditions. But given that around 70 percent of all football players in the United States are under age 14, continued research into the short- and long-term effects of TBI in youth is warranted.

The study was supported by grants from the National Institutes of Health, and participant travel expenses were supported by gifts from JetBlue Airways, the NFL, and the NFL Players Association. PN

An abstract of "Age of First Exposure to Football and Later-life Cognitive Impairment in Former NFL Players" is posted at http://www.neurology.org/content/early/2015/01/28/WNL.0000000000001358.abstract. An accompanying editorial, "Children and Football: A Cautionary Tale," is posted at http://www.neurology.org/content/early/2015/01/28/WNL.0000000000001358/suppl/DC1.

Birth Weight

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leading to preterm birth and exposure to stressful neonatal experiences, both of which could lead to brain changes and dysregulation of the hypothalamic-pituitary-adrenal axis.

"We are the first to report that not only are steroid-exposed ELBW survivors not protected against alcohol and substance use disorders, but they may have higher odds of developing generalized anxiety disorder, generalized social phobia, and the inattentive subtype of ADHD. Interestingly, these odds increased with increasing steroid exposure," the researchers said.

Nada Stotland, M.D., a past president of APA and an expert on reproductive health, said the implications of the study are "fascinating" for future research on the relationship between birth weight and later mental illness. "The most promising aspects of this study are about the science," she said. "There isn't much to do with this clinically, except to say that we should be watching these individuals for depression and other mental illnesses."

David Hathcox

Nada Stotland, M.D., says that individuals who were born at low birth weight should be monitored for depression and other mental disorders.

Stotland noted that babies born at extremely low birth weight are at risk for many complications, and clinicians and mothers should not reject steroid treatment because of a possible risk for psychiatric disorders much later in life. "Many of these babies don't live, and they have serious complications of various kinds," she said. "Mothers have no choice but to do what is best for the child who is born so tiny."

Van Lieshout said replication of the findings with a much larger cohort—as might be done in Scandanavian or other countries with national birth registries—could help to better elucidate the correlations among birth weight, steroid use, and mental illness and/or substance abuse. "Additionally, looking at genetic markers and how they interact with birth weight would be illuminating," he said.

"These individuals do have a higher risk in their 30s of having depression, anxiety, and ADHD," he told *Psychiatric News*. "Importantly, though, the majority of ELBW babies don't have any psychiatric problems at all. So it's a risk factor." PN

"Mental Health of Extremely Low Birth Weight Survivors in Their 30s" is posted at http://pediatrics.aappublications.org/content/early/2015/02/04/peds.2014-3143.abstract.

Viewpoints

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I recognize that not everyone benefits from the "silver linings" of older age. Such individuals may have been blocked in their ability to go through the many small grief processes appropriately and might benefit by seeking the aid of a therapist to help them negotiate this process and find peace. But for many older individuals, Mother Nature has provided us a happier older age and a natural mechanism to ease us into a more comfortable parting with our world. PN

Got a Question For APA's Leaders?

All APA voting members are invited to attend APA's Annual Business Meeting and Annual Forum at the 2015 annual meeting. At the Annual Forum, APA voting members are invited to ask questions of and share comments with APA leaders.

SUNDAY, MAY 17
12:30 p.m.-2 p.m.
Annual Business Meeting and Annual Forum
Room 106, Toronto Convention Centre