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SEE STORY ON PAGE 14

Yadira Sortre and William Fontan Quintero sit with what is left of their belongings as their children build a room for protection against the elements after Hurricane Maria devastated Puerto Rico last month. "We lost everything," Fontan Quintero said. Addressing the mental health needs of the island's residents will require an ongoing effort.

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UCSF program teaches medical students the value of self-care.

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Can supplements help pregnant women with depression?

Planning and Preparation Help Floridians Weather Hurricane Irma

Representatives from APA's Florida district branch credit rigorous disaster planning for the state's effective response to Hurricane Irma. ***BY MARK MORAN***

For the four days before Hurricane Irma made landfall on mainland Florida on September 10, it was all hands on deck for physicians and staff at BayCare Health System and BayCare Behavioral Health.

As Irma approached the coastal tip of the state, contingency plans had to be made for all Baycare facilities, taking into account the possible paths of the storm. (BayCare's headquarters are in Clearwater, but it has facilities throughout Tampa Bay and Central Florida.) Supplies of water, medications, and fuel had to be secured.

Eventually, four behavioral health facilities within the BayCare Health System were evacuated, including a residential facility for traumatized children and adolescents and a residential facility for patients with substance use disorders. In hospitals that remained open, physicians and nursing staff brought sleeping bags and "camped out" for the duration.

Psychiatrist Nick Dewan, M.D., chief medical officer at BayCare Behavioral Health, recalled the period of planning and preparation as tense, anxious, and uncertain, but also steady and focused.

"As an organization, we had to plan for and adjust to any number of possible scenarios," he told *Psychiatric News*. "We didn't know if the storm would travel up the eastern coast or ride up the Gulf coast on the west and hit Tampa directly. We had to determine which of our facilities would be in flood zones and which would not. We had regular conference calls with senior management, as well as meetings within our own division with physicians and staff."

see **Irma** *on page 15*

PERIODICALS: TIME SENSITIVE MATERIALS

One Month After Harvey, We Remain #HoustonStrong

BY DAKOTA CARTER, M.D.

As I sit at my dining room table and survey the ongoing "remodel" of my home, it has been exactly one month since Hurricane Harvey pummeled Houston. During the disaster, it was easy to feel helpless and lost, especially while worrying about friends and family and witnessing floodwaters that would not stop rising.

see **Harvey** *on page 14*

Dakota Carter, M.D., is a PGY-4 psychiatry resident at the University of Texas McGovern Medical School at Houston and an APA/APAF/SAMHSA/Diversity Leadership Fellow.

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Innovation Linked to Physician Well-Being

BY ANITA EVERETT, M.D.

Innovation and professional well-being are two of the central priorities of my year as your president. As I see it, part of my responsibility is to use the experience, perspective, and opportunity afforded by being APA's president to think about the health and future opportunities of psychiatrists as well as the profession of psychiatry as practiced in this country. Key components of our capacity to thrive in the future are professional well-being and innovation. Why do I say this?

Practice what you practice. This is a phrase developed by Dr. Terrance McGill, who worked with me and APA's Work Group on Psychiatrist Well-Being and Burnout chaired by Dr. Rick Summers early in its development. Developing the foundation for several of my presidential projects was an elective experience in the final year of Terrance's preventive medicine residency training at Johns Hopkins. One of the great advantages in working at a place like Hopkins is the opportunity to work on projects with creative and intelligent people. Terrance is a nontraditional resident with experience in telecommunications. The notion of bringing something that is used or developed in one setting into an alternative setting can be called analogous learning. Analogous learning is one technique in the tool box of innovation teams.

Regarding well-being, the notion of "practice what you practice" is not new to us; many of us have told our patients, "You can't be there for others (family members, children, unwell parents, friends, bosses, co-workers, to name just a few of the people in your life) if you are not well yourself." We often tell patients, "You can't be there for others if you are not well yourself." We support patients with the notion that treating the depression, psychosis, anxiety—whatever the disorder may be—so that they can resume family and other life roles. Many times, a caring professional helps by giving permission to patients to prioritize self-care as a precondition to functioning and recovery. All of us in clinical practice are likely to have experience with this fundamental principle, no matter what patient population we serve.

The notion of practice what you practice has to do with encouraging us as practicing psychiatrists to look at our own lives, our own vulnerabilities, and our own behaviors—to give ourselves permission to be vulnerable beings who need to take care of ourselves so that we can function well for ourselves and for others. Many of us need to consciously move from the contemplation or even precontemplation phase of change into the action phase.

A first action we can take is to collect more information about our circumstances. We know that common causes

see **From the President** *on page 5*

APA Petition Candidates: Please Note

The deadline to submit a petition to run for APA office in the 2018 election is November 15. More information is available by sending an e-mail to election@psych.org.

IN THIS ISSUE

DEPARTMENTS

Reserve Your Hotel Room For 2018 Annual Meeting In New York City

APA returns to the Big Apple and all the excitement that New York City has to offer for its 2018 Annual Meeting, which is being held May 5 to 9. APA members will have an exclusive two-week opportunity to be at the head of line to reserve a room at the hotel of their choice beginning on Tuesday, **October 24**, at www.psychiatry.org/annualmeeting. Nonmembers must wait until Tuesday, November 7, to make their reservations. Also, be ready to take advantage of the meeting's lowest registration rates when registration opens for members on Tuesday, **December 5.**

APA Promotes Telemedicine At Capitol Hill Briefing

Experts from APA, the AMA, and the Health Resources and Services Administration discussed the importance of telemedicine in improving access to care and the need for passage of the CONNECT for Health Act. **BY NICK ZAGORSKI**

David Hathcox

APA CEO and Medical Director Saul Levin, M.D., M.P.A., discusses APA's support of telepsychiatry as a reliable and cost-effective tool for increasing access to mental health care.

At a briefing on Capitol Hill last month sponsored by APA, speakers urged members of Congress to expand the opportunities for health care professionals to engage in telemedicine, including telepsychiatry. In particular, they voiced their support for CONNECT for Health Act (S 1016, Creating Opportunities Now for Necessary and Effective Care Technologies), a bipartisan bill first introduced in the Senate in 2016 and reintroduced this past spring. It has been referred to the Senate Finance Committee.

The CONNECT for Health Act seeks to remove several Medicare restrictions on telehealth and remote patient-monitoring services. This includes allowing the types of clinical sites eligible for reimbursement to be expanded and enabling telehealth services to be reimbursed in a bundled payment with other services. The 2017 version of CONNECT tweaks some of the provisions for reimbursement while also adding a major change—it allows the secretary of Health and Human Services to remove additional restrictions on reimbursement in the future without requiring legislation when certain quality and cost-effectiveness criteria are met.

These changes will improve access to care across medicine, but will be especially valuable in mental health care, where cliniciains are in limited supply and demand is high.

Sylvia Trujillo, J.D., a senior counsel for the AMA, said that quick action on this bill is essential. "We have little time to prepare for a seismic change in health care." Trujillo pointed out that according to the U.S. Census Bureau, by 2030 (just 13 years away) more than 1 in 5 U.S. residents will be age 65 or over, and this population will have access to a diminished number of younger caregivers.

"While we advocate for CONNECT, we also ask CMS [Centers for Medicare and Medicaid Services] to use all existing flexibilities to use these proven technologies," she continued.

Trujillo also noted that CONNECT—sponsored by Sen. Brian Schatz (D-Hawaii) and co-sponsored by Sens. Ben Cardin (D-Md.), Thad Cochran (R-Miss.), John Thune (R-S.D.), Mark Warner (D-Va.), and Roger Wicker (R-Miss.)—is just one of several telehealth-related bills under consideration in Congress. Their failure to become law is due in part to bureaucratic delays, but also to some concerns by the Congressional Budget Office (CBO) that expanded telehealth services may not be cost neutral for Medicare.

On that subject, Peter Yellowlees, M.D., a professor of clinical psychiatry in the UC Davis Health System, believes that the CBO is mistaken, especially with regard to mental health costs.

"Emergency department visits and hospitalizations are the biggest drivers of costs, and these outcomes go down with telehealth," he said. Yellowlees added that the Veterans Administration—which oversees a large, Medicare-like population—has strong national data that back this claim.

Yellowlees highlighted two other policy measures that should be short-term priorities for the federal government. One of these is to change the CMS rule that allows reimbursement for telehealth services provided only in rural areas. Many urban patients, such as elderly individuals in nursing homes, are just as limited in accessing care as people in rural communities.

The second is to modify language in the Ryan-Haight Act that prohibits the dispensing of controlled substances over the Internet without a "valid prescription." A valid prescription is one that is issued for a legitimate medical purpose by a practitioner who has conducted at least one in-person medical evaluation of the patient or a covering practitioner. Because of the nature of telemedicine, meeting that requirement can oftentimes be difficult, said Yellowlees. **PN**

Information on telepsychiatry, including explanatory videos, is posted on APA's website at https://www.psychiatry.org/telepsychiatry. The text of the CONNECT for Health Act of 2017 is posted at https://www.congress.gov/bill/115th-congress/senate-bill/1016/text.

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Share Your Accomplishments With Us!

Psychiatric News has launched a new online feature that reports on APA members' promotions, honors, and other achievements at http://www.psychnews.org/update/members.html. A link to the new feature is included in the weekly *Psychiatric News Update* and in each print issue of *Psychiatric News*. Members are invited to send brief announcements to Executive Editor Cathy Brown at cbrown@psych.org. If you do not receive the *Update*, subscribe at https://paracom.paramountcommunication.com/form/65107/1202.

OVERCOMING BURNOUT

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Program for Medical Students Emphasizes Need for Self-Care

BY HOWARD RUBIN, M.D.

A program at UCSF supports the notion that trainees don't need to undergo trial by fire to learn how to be effective healers. The article is part of series spearheaded by APA President Anita Everett, M.D.

Howard Rubin, M.D., is chair of the University of California, San Francisco, Medical Student Well-Being Program.

When I entered medical school in the late 1980s, I felt initiated into a mysterious sect that would train me to become a physician. Despite the emotional support of some teachers, school often seemed an entrenched culture that valorized personal sacrifice for undefined long-term gain.

Interns and residents worked 36 hours straight and 110 hours weekly with the promise of becoming healers upon whom society bestowed prestige and monetary rewards. The culture on the wards could be crass and brutalizing. Education and learning came at a high cost.

Through the years, our field has started to learn, often the hard way, that the cost of this kind of training is too high. The rate of depression and suicide among physicians, especially psychiatrists, is higher than those of many professionals, and the rates of burnout are significant.

Fortunately, medical education is changing. As a profession, we have come to recognize that wellness and well-being are more than the absence of disease and that we need to heal ourselves so that we can take care of our patients more effectively and compassionately.

At the University of California, San Francisco (UCSF), we have developed the Medical Student Well-Being Program, which advances a different way of thinking about our own health and well-being. We support and disseminate the idea that physicians needn't be wounded healers to learn and to treat their patients. Nationwide, wellness programs for medical students are becoming more common, as educators grapple with how to change the culture of sacrifice and pain that medicine has embraced.

Our program partners with physicians-in-training to develop their "basic self-maintenance plan" for taking care of themselves and learning to modify the plan when extremely busy.

As a psychiatrist who directs the program, I ask students about various aspects of their lives outside of medicine in our first clinical interview. How much sleep do they need? What does a healthy diet look like? What kind of exercise do they enjoy? What activities give them pleasure and meaning? How do they remain in contact with family and friends? Have they been able to make new connections with classmates? Are they in intimate relationships? How have their studies impacted those relationships?

I inquire whether students have an interest in aspects of medicine outside of academics, like medical policy and social justice. I urge them to get involved with organized medicine.

I never used to ask students whether they have any spiritual practice, but now I do. The goal is not to push a particular form of organized religion or faith or foist a meditation practice upon them, but to encourage them to engage or reengage with a spiritual practice that may lend new meaning. I sometimes hear, "I used to go to church on Sundays, and I loved it" or "I used to meditate a few minutes daily, but I stopped my practice." For one student, her connection with the sublime was getting out of the school environment to hike, but she didn't have a car anymore.

I ask students to consider how much caffeine and alcohol (or other substances) they regularly consume and to consider how those substances affect performance. Do their consumption patterns need to be changed?

The students and I then craft a personalized treatment plan that incorporates their interests and preferences, given the time constraints they face. Short-term psychotherapy and psychopharmacology may also comprise part of treatment.

When students enter clinical clerkships, the medical student well-being

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From the President

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of unwellness or burnout are often associated with two groups of factors: personal and work-environment factors. In this context, personal factors include individual perspectives, experiences, and risk factors. These may or may not be obvious, and probably more often for psychiatrists than for other physicians, we are taught through attention to countertransference to identify and manage some of these risk factors. Our attention in training to formal and informal countertransference issues may be part of the reason that psychiatrists report lower overall rates of burnout than many other types of physicians. We are taught that what is happening in our treatment settings has an impact on our personal selves and that awareness and active management of it is an important basic psychotherapy skill.

In thinking about work-environment factors that could contribute to burnout, we receive little or no training about the management of workflow optimization, electronic medical record (EMR) screens and workflows, staffing and HR issues, caseload management, productivity expectations, and other practice-related issues. In fact, we may be disadvantaged compared with our peers in faster-paced and higher-volume settings like primary care, emergency medicine, and surgical specialty care. For many of us, the initial attraction to psychiatry might have included self-awareness that chaotic busy practice environments would not match well with our personal strengths.

Several major hospital systems have begun initiatives to look at work environments and what can be done to restore the "joy in practicing medicine." It turns out that a major work-environment contributor to stress that was not present even as much as 10 years ago is, in fact, EMRs. A survey of 1,016 physicians in Wisconsin revealed that while many thought that electronic access to and exchange of medical information could lead to improvements in patient care, the burden of data entry was a major contributor to practice burnout, extended work at home, and increased professional dissatisfaction. "Electronic health records serve as both a satisfier and dissatisfier and as a potential driver for future physician satisfaction interventions," the authors reported in the August 2015 Wisconsin Medical Journal. Many other studies have demonstrated that EMRs alone are a major contributor to the current causes of physician burnout in this country.

The discipline of innovation about which I wrote in an earlier column (*Psychiatric News,* September 1) offers some genuine possibilities. Many aspects of the discipline of innovation about which I wrote can be applied to improving our well-being. I think of innovation as a pathway forward for psychiatry in America. Specifically, to use EMRs as an example, innovation techniques can help us move from the role of data entry clerk into power user. Let's use some analogous thinking (as I also pointed out in my earlier column, analogous thinking is an innovation tool) to analyze the problem further. What other example can we think of where data entry was a problem, and what solution was used? By identifying the specific problem as a data entry problem, we have used another facet of innovation, which is clarity in defining the "problem to be solved." The data entry problem can be addressed in various ways. According to Dr. Luming Li, who is an APA/APAF Public Psychiatry Fellow and president of the Executive Board of the Yale New Haven Hospital Resident/Fellow Senate, her institution has started a medical transcription service to help mitigate the data entry problem.

Innovation is an important element in the path forward for psychiatry. Thinking about, reading about, digesting, and becoming familiar with some of the foundations and practices of innovation can be useful for solving problems like professional burnout. Unless we as a profession align ourselves with innovation as an important part of our future, we risk becoming less relevant and at increased risk for helplessness in the management of burnout and the future of our profession. We need to practice what we practice, look at ourselves as essential healers, and harness the promises of innovation so that we advance as valuable providers of accessible, safe, and effective medicine for the patients we serve. **PN**

Wichita Psychiatrist Assaulted, Murdered by Patient, Police Say

While people with mental illness are more apt to be victims of violence than perpetrators, psychiatrists need to be vigilant about taking precautions to ensure their safety. **BY MARK MORAN**

Achutha Reddy, M.D., a Wichita, Kan., psychiatrist died last month after allegedly being assaulted and stabbed multiple times with a knife by an individual later identified by police as one of his patients.

Reddy was the founder of Holistic Psychiatric Services (HPS) in Wichita. He was 57 years old and is survived by his wife and three children.

During a press briefing on September 14, Wichita Police Lt. Todd Ojile said Reddy was found the night before in an alley behind the HPS clinic with "multiple stab wounds." He was pronounced dead at the scene by EMS, Ojile said during the press briefing that is posted on YouTube.

Later that evening police were called to the Wichita Country Club, where a man with blood on him had been spotted by a security guard sitting in a car. "During an investigation, we learned the 21-year-old suspect was a client of Dr. Reddy and had been at the office," Ojile said. "He was in the [clinic] for a short time; he left and later came back…. After going into the office, a disturbance was heard. An office manager entered the office and observed the suspect assaulting Dr. Reddy. She attempted to stop the assault, which allowed Dr. Reddy to flee the office. The suspect then chased Dr. Reddy out of the [clinic] and caught up with him in the alley behind the [clinic], where we believe a second assault occurred."

In 2006, psychiatrist Wayne Fenton, M.D., an associate director of the National Institute of Mental Health and an internationally known expert on schizophrenia, was murdered by a patient in Fenton's private office. Studies of violence by patients on hospital inpatient wards indicate a significantly higher risk for psychiatrists and other mental health staff of being the victim of violence than for other occupations (*Psychiatric News*, December 30, 2016).

Psychiatrist Achutha Reddy, M.D., brought to his practice an interest in holistic health, combining yoga, exercise, meditation, and spirituality with the traditional practice of psychiatry.

Violent assaults by outpatients would seem to be much rarer, but psychiatrists are nevertheless advised to take precautions when meeting with patients who may be at risk for being violent (see box).

Kansas Psychiatric Society (KPS) President Matthew Macaluso, D.O., in a statement released by KPS, expressed condolences to Reddy's family and urged the public and media to keep the event in perspective.

"We are saddened and distressed by the untimely passing of our colleague, Wichita psychiatrist Dr. Achutha Reddy," Macaluso said. "His passing is made more tragic since it reportedly occurred at the hands of a patient.

"KPS condemns all acts of violence and supports our local law enforcement, who are gathering information related to this devastating event. It is also important that the community not generalize this act to all persons with mental illness, because most individuals with mental illness are of no greater risk of violent crime than the general population."

In comments to *Psychiatric News*, Macaluso said Reddy was held in high regard by his fellow psychiatrists and admired and loved in the wider community in Wichita.

"He had an interest in holistic health care that certainly included the traditional practice of psychiatry but also focused on spiritual issues in patients' lives," Macaluso said. "He was well known and respected in the community. I attended his memorial service and was touched by the hundreds of people who were there. People who spoke at the service agreed this was a kind and gentle individual who went out of his way to help patients and often treated very difficult patients, encouraging a healthy lifestyle that incorporated spirituality."

According to a flyer prepared by the family for the memorial service, Reddy was born in Suryapet, India, and attended medical school at Osmania Medical College in India. He immigrated to the United States shortly after marrying in 1991.

Reddy lived in St. Louis and later moved to Wichita, where he completed his residency in psychiatry at the University of Kansas. In 2002, he founded HPS. Its website says that services include "psychiatric medication evaluation and treatment that may include yoga and meditation; office-based opioid use disorder treatment including suboxone; individual therapy sessions; and crisis and emergency appointments."

The flyer at Reddy's memorial service stated, "Achutha has helped countless people in his community through a combination of his psychiatric and physical exercise therapies. His goal was always to make people happy and to convince everyone of the health benefits of running." **PN**

APA's "Resource Document on Psychiatric Violence Risk Assessment" is posted at http://apapsy.ch/Risk_of_Violence. The police briefing by Wichita police is posted at https://www.youtube.com/watch?v=M8EB6ALd7Rg.

History of Violence Is Best Predictor

Statistics on workplace violence against psychiatrists and mental health professionals largely involve violence committed on hospital inpatient wards. Assaults against psychiatrists by patients in an outpatient setting are much rarer. But the phenomenon is not unheard of, as demonstrated by the murder last month of Wichita, Kan., psychiatrist Achutha Reddy, M.D.

The APA "Resource Document on Psychiatric Violence Risk Assessment" includes the following risk factors for violence in general psychiatric settings:

- History of violence
- Child abuse
- Prior arrest
- Young age at time of first arrest
- Cruelty to animals and/or people
- Fire-setting
- Behavior suggesting loss of control or impulsivity
- Seeing oneself as a victim
- Access to weapons
- Lack of compassion/empathy
- Lack of concern over consequences of violent acts

Past APA President Renée Binder, M.D., a co-author of the APA resource document (along with Alec Buchanan, M.D., Ph.D., Michael Norko, M.D., and Marvin Swartz, M.D.), emphasized that most patients with psychiatric illness are not violent. "But violence risk increases in individuals who are in an acute stage of psychosis, who are noncompliant with medications (or have not yet been treated), who have a history of violence, and who are intoxicated with drugs or alcohol," she told *Psychiatric News*. "Sometimes patients may even have guns or knives. When concerned about patients who might be violent, clinicians should consider seeing them in a secure environment with the availability of security staff and weapons screening."

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PSYCHIATRY & INTEGRATED CARE

Maternal Mental Health: Moving Mental Health Care Upstream

BY AMRITHA BHAT, M.D., M.P.H., AND JÜRGEN UNÜTZER, M.D., M.P.H.

Nearly three decades ago, a senior official of the World Health Organization asked me what I would do if I had only $1 to spend on mental health care. I replied that I would use the dollar to provide mental health care for a pregnant woman with depression and/or an addiction problem. I would give that same answer today. In this column, I have partnered with Dr. Amritha Bhat, an expert in perinatal mental health care, to review the potential benefits of providing effective collaborative care to mothers at high risk for mental health and substance use problems.

—Jürgen Unützer, M.D., M.P.H.

Most people with a mental health or substance use problem experience the first symptoms of illness during childhood, adolescence, or early adulthood, but it often takes more than a decade to get effective mental health care. This is a critical period in life, and we need to think about what we can do to intervene earlier on, perhaps even to prevent mental illness altogether. In other words, we need to look for opportunities to "move care upstream."

Let's take the case of Ms. C., who is pregnant with her second child and anticipates a difficult postpartum period. She epitomizes high risk for postpartum depression—two episodes of major depression (one of which was in her first postpartum period), recent separation from her abusive husband, low social support, and a strong family history of mood disorders. She's receiving weekly psychotherapy, is building her resilience, and will receive services from a home visiting nurse in the postpartum period, reducing her risk of postpartum depression by up to 44 percent.

What if Ms. C.'s mother had received similar services? Would Ms. C.'s trajectory have been different? Her mother had a tumultuous history of multiple depressive episodes, suicide attempts, and hospitalizations. Even when not in a depressive episode, she alternated between being distant and overly intrusive. Ms. C. inherited some risk for developing depression. Ms. C.'s child will inherit that same risk, but she or he will have a mother whose depression is adequately treated. Because of this, Ms. C.'s baby may not have the 39 percent to 49 percent higher risk of preterm birth or low birth weight, the 1.34 times higher odds of developmental delay, or the three times higher odds of externalizing disorders and adolescent depression. Addressing prenatal risk factors, including maternal mental health, brings us as close to primary prevention as we can get in the field of mental health care. Ms. C.'s treatment plan is mental health immunization for her baby.

Home-visiting programs and school-based mental health care are good examples of moving health care out of hospitals and into communities. What if we moved care further upstream? In the context of perinatal mental health, moving care upstream might imply comprehensive identification and adequate treatment of perinatal mental health disorders and parenting support for caregivers suffering from mental health problems. We need to deliver effective mental health care to pregnant and postpartum women—women are more likely to contact health service systems than men and are more motivated to receive treatment in the perinatal period. It is crucial that these services are easily accessible to women at highest risk—in primary care or obstetric settings and in patients' homes, rather than in specialty mental health settings.

Over the past decade, studies have demonstrated it is both effective and cost-effective to integrate perinatal mental health care into obstetric and primary care settings. Real-world practice experience from a county-funded collaborative care program for high-risk mothers in 13 community health clinics demonstrated that collaborative care leads to substantially improved depression outcomes. A case management program targeting high-risk moms with addiction problems also showed

see **Integrated Care** *on page 13*

Amritha Bhat, M.D., M.P.H., is an acting assistant professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington. She provides mental health care to pregnant and postpartum women in the University of Washington Perinatal Psychiatry Clinic. Jürgen Unützer, M.D., M.P.H., is a professor and chair of psychiatry and behavioral sciences at the University of Washington, where he also directs the AIMS Center, dedicated to "advancing integrated mental health solutions."

Government, Private Sector Leaders Develop Cultural Competency Tools at APA Event

Summit participants worked together to derive best practices, training modules, and metrics for measuring improvement in cultural competency and inclusiveness at their agencies and institutions. **BY JOANN BLAKE AND MARK MORAN**

Fear of people who are different in some way from the majority population—because of physical characteristics, dress, or language—is a learned response rooted in a neurobiological mechanism. And it can be changed.

So said Mohammed Milad, Ph.D., in an address last month at APA headquarters to more than 50 leaders in industry, government, and the nonprofit sector attending the Cultural Competence and Inclusive Excellence Summit. He is an associate professor of psychiatry at Harvard Medical School and the director of the animal models and behavioral neuroscience lab at Massachusetts General Hospital.

Milad described the network of brain structures that generate day-to-day reactions to perceived differences: the amygdala, where negative, defensive, and protective associations are stored that trigger the feeling of fear; the frontal cortex, which can provide a cognitive regulation of fear; and the hippocampus, which communicates between the amygdala and prefrontal cortex depending on the context of any given scenario or situation.

"We are the product of neuroactivity," Milad said. "Everything we think and feel is mediated by brain structures, so if you want to understand bias and how to change it, we need to understand where it comes from. A broad understanding of the biology of fear-based bias can be useful in educating people about their emotions and understanding where our biases come from."

He emphasized that biases can be challenged and changed. "Fear can be inhibited or extinguished," Milad said. "The brain is the most plastic structure in our anatomy and is amenable to change. We can change the connections that underlie fear and bias and rewire those connections."

David Hathcox

Psychiatrist Ramaswamy Viswanathan, M.D., D.M.Sc., the 2016 APA George Tarjan Award winner, said physicians need to be able to reach across cultural boundaries to connect with their patients.

His remarks began a day of small-group discussions aimed at identifying and implementing best practices to develop cultural competence and drive inclusion in organizations of all types, as well as metrics for assessing change.

The all-day event, sponsored by APA, General Motors, and the Ohio State University Wexner Medical Center, followed up on a similar event in 2016, which in turn was catalyzed by the 2015 STEM Diversity Forum convened by the White House Office of Science and Technology Policy. ("STEM" stands for science, technology, engineering, and math.)

"The summit last month at APA, following on the very successful summit two years ago at the White House, addressed how to chart a strategy toward organizational excellence," said Ranna Parekh, M.D., M.P.H., director of APA's Division of Diversity and Health Equity. "The most visionary leaders in health care, government, and private industry agree that cultural competency and inclusiveness are critical elements of organizational excellence. We want to thank our partners for making the summit an enormous success."

Speakers at the summit included, in addition to Milad, Jayne B. Morrow, Ph.D., senior science policy advisor at the National Institute of Standards and Technology at the Department of Commerce; Ted Childs, principal of Ted

see **Summit** *on page 21*

INSIDE PSYCHIATRY

Back to the Future: Psychiatry's Re-Commitment to Public Mental Health

BY JEFFREY LIEBERMAN, M.D.

On September 11, Elinore McCance-Katz, M.D., Ph.D., a psychiatrist specializing in addiction psychiatry with a background in academic medicine and public mental health, was sworn in by then Health and Human Services Secretary Tom Price as the first Assistant Secretary of Mental Health and Substance Use in the history of our country. Ellie brought her own copy of an antique Torah to the ceremony, which was witnessed by her friends and colleagues, including principals of APA. This occasion was important for many reasons, but none more so than it symbolized the return of psychiatry to its core mission of public mental health.

American psychiatry had strayed from this mission in the years after World War II into the 21st century. Most psychiatrists may not be aware of how this came about and why, but the origins of this story began with the creation of APA itself.

APA is actually the oldest medical specialty association in the United States. Of course, when it was created in 1844, it wasn't called the American Psychiatric Association; rather it had the somewhat unflattering title of the Association of Medical Superintendents of American Institutions for the Insane. The name conferred the fact that psychiatrists managed institutions that warehoused "in however a humanely way" people with mental illness who could not reside in the community or function in society and for whom there was no treatment. While this reflected, at the time, a progressive movement in the evolution of mental health care, as mental illnesses became recognized as medical conditions rather than some type of moral, social, or legal deprivation, it moved psychiatrists away from the mainstream of medicine to the backwaters of scientific progress that advanced medicine over the 19th and early 20th centuries and the hinterlands of society.

In 1892 the name was changed to the American Medico-Psychological Association and then again in 1921 to its current name. Over this same period, Freud's psychanalytic theory, and the talking cure that derived from it, had begun to transform the field of psychiatric medicine and mental health care. In addition to revolutionizing our understanding of the mind and human behavior, psychoanalytic theory and practice offered an alternative career path for psychiatrists that redirected their clinical efforts from people with severe mental illness to those with milder forms (extending to the "worried well") and shifted their location from the asylum to the practitioner's office. In general, psychiatrists found this to be a more intellectually appealing, therapeutically gratifying, and lucrative form of clinical endeavor.

However, as this became the dominant mode of practice, many psychiatrists withdrew from the public sector and abandoned its primary mission to care for people with schizophrenia, manic-depressive illness, and melancholic and psychotic depression. The contingent that remained engaged in "public mental health care" became known as "community psychiatrists." By the 1970s, leadership of state mental health systems, hospitals, and community mental health centers were being transferred to nonphysician health care professionals. The schism that this produced was reflected in the uneasy alliance and ambivalent relationship between the principal agencies of the federal government responsible for mental illness and addiction research and services.

Jeffrey Lieberman, M.D., is chair of psychiatry at Columbia University Medical Center and psychiatrist in chief of the New York Presbyterian Hospital as well as past president of the APA. He is the author of *Shrinks: The Untold Story of Psychiatry* (Little Brown, 2015).

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Smartphone Apps May Help Reduce Depressive Symptoms

Data on smartphone apps for patients with depressive symptoms suggest they may offer some usefulness, but the effects in patients with major depressive disorder are not known.

BY JOHN TOROUS, M.D., AND JOSEPH FIRTH, PH.D.

TECH TIME

While there are more than 10,000 mental health–related smartphone apps available for immediate download, little is known about their effectiveness. What would you tell a patient who wanted to know if an app may be effective for his mood-related symptoms? A new meta-analysis of randomized, controlled trials of app interventions for depressive symptoms, published October 1 in the journal *World Psychiatry,* offers some guidance for psychiatrists. We were co-authors of that meta-analysis.

After conducting an exhaustive search, our team identified 18 randomized, controlled trials with outcomes data from 3,414 participants. The average effect size for reduction in depressive symptoms was 0.38, although in studies that featured an active control group, the effect size was reduced to 0.22. While this is a small effect size, it is statistically and clinically significant—it suggests that smartphone apps may offer tangible benefits to individuals with depression. However, with regard to major depressive disorder, there were only two randomized, controlled studies of app interventions, and the pooled effect size was lower, 0.09.

John Torous, M.D., is co-director of the Digital Psychiatry Program at Harvard-affiliated Beth Israel Deaconess Medical Center in Boston and a member of APA's Committee on Mental Health Information Technology. Joseph Firth, Ph.D., is a research fellow at the National Institute of Complimentary Medicine at the University of Western Sydney, Australia. His research focuses on novel, nonpharmacological interventions for improving outcomes of psychiatric disorders, particularly those applicable to young adults.

Apps that included in-app feedback (that is, provided feedback to users), cognitive-behavioral therapy (CBT) focus, and /or mindfulness focus were found to have significant effects on depression. Additionally, digital treatment programs delivered solely through smartphone apps were more effective than those that also relied upon external elements, such as computer programs and support.

The literature on smartphone apps for depression is expanding rapidly, and 14 of the 18 studies included in this meta-analysis were conducted in the last two years. As research on smartphones continues to grow, it will be increasingly important that psychiatrists stay up to date with the latest evidence about them.

In terms of advising patients about apps, there is no simple "one size fits all" answer—just as there is no one answer for all patients regarding exercise or medication. But having information about the effectiveness of specific apps can help with informed and shared decision making with patients. **PN**

"The Efficacy of Smartphone-Based Mental Health Interventions for Depressive Symptoms: A Meta-Analysis of Randomized Controlled Trials" is posted at http://onlinelibrary.wiley.com/doi/10.1002/wps.20472/full. Information about discussing smartphone apps with patients and an app evaluation model are posted at https://www.psychiatry.org/psychiatrists/practice/mental-health-apps/app-evaluation-model.

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In 1973, the National Institute of Mental Health (NIMH), which had been created in 1946, was joined with the Health Services and Mental Health Administration to form the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). However, like immiscible solutions, the medically minded researchers and socially oriented service administrators never really united and became factionalized and in some instances adversarial. As a result, in 1992, they were separated by Congress into three research institutes (NIMH, National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism), which rejoined the National Institutes of Health, and a standalone agency, the Substance Abuse and Mental Health Services Administration (SAMHSA). This, in effect, ceded the services (as opposed to the research) component of mental health to non-medical health care disciplines. The last physician to hold a position of authority for mental health services in the federal government was Frederick Goodwin, M.D., who was a psychiatrist noted for his research in bipolar disorder; he headed ADAMHA just prior to its dissolution.

As a result, for over a quarter century, SAMHSA pursued an agenda that diverged from scientifically guided, evidence-based care and predominantly emphasized services and programs addressing social pathologies and promoting wellness. Over this period, the dissatisfactions of stakeholders and Congress grew, and they criticized SAMHSA for wasting money on services based on unproven theories and feel-good fads; alternatives to proven treatments that encourage patients to go off medications; wellness initiatives, including children's books like *A Day in the Park*; brochures on "Making and Keeping Friends" and "Building Self-Esteem"; and workshops such as "Unleash the Beast" that promised to help attendees learn about mental illness by studying animal movements, instead of focusing efforts on programs proven to help people with severe mental illnesses.

This renegade policy, which marginalized scientific influence, was exemplified by the fact that SAMHSA had only one psychiatrist on its staff, in a subordinate position. In a 2014 congressional hearing, Congressman Tim Murphy questioned "how can the government's number one mental health agency have only one psychiatrist on its staff of 574 employees?"

Several auspicious developments have recently occurred that could be game changing and signal psychiatry's reengagement in public mental health. To mention just a few: Ann Sullivan, M.D., former APA Assembly speaker and director of psychiatry at Elmhurst Hospital in Queens, N.Y., is now the first psychiatrist to become commissioner of the New York State Office of Mental Health in 34 years. Working with her are Lloyd Sederer, M.D., Tom Smith, M.D., and Michael Compton, M.D., all accomplished community psychiatrists, as medical and associate medical directors, respectively. In addition, the last three people elected to serve as APA president have been public mental health–oriented psychiatrists (Maria Oquendo, M.D., Ph.D., Anita Everett, M.D., and Altha Stewart, M.D.). Joe Parks, M.D., the former commissioner of mental health for Missouri, was appointed medical director of the National Council for Behavioral Health, the largest organization of mental health providers in the United States. In anticipation of the mental health components of the 21st Century Cures Act being enacted, Anita Everett, M.D. and Steve Daviss, M.D., joined SAMHSA as medical director and senior medical advisor, respectively. All these and other such developments culminating in Ellie's appointment, which entails operational authority over all federal government agencies supporting mental health care, first and foremost SAMHSA and its $3.5 billion budget. Her appointment also calls for a close working relationship with the NIH institutes and NIMH in particular, currently led by Josh Gordon, M.D., a psychiatric neuroscientist and graduate of Columbia University's training program.

In a way, we have come full circle to rediscover our roots in mental health care. While it is gratifying and exciting to see this happening, the real challenge is to use our recommitment and assumption of leadership roles to fix the mental health care system and improve the quality and availability of care. This will not be easy, but we are better prepared and positioned to do so than ever before. **PN**

Advertisement

RHD

A Delaware ACT team conducts a weekly briefing with its telepsychiatrist.

Delaware Takes Its ACT To the Next Level

Delaware's assertive community treatment (ACT) teams have addressed the shortage of available psychiatrists by using telepsychiatry. **BY NICK ZAGORSKI**

Delaware is known as the "First State" since it was the first colony to ratify the United States Constitution, but that motto can also apply to another bold step undertaken in the state more recently. A few years back, Delaware became the first state to merge telepsychiatry with assertive community treatment (ACT).

Two teams managed by the nonprofit Resources for Human Development (RHD) have been using telepsychiatry since 2014. The teams are known as RHD Kent ACT2 and RHD New Castle ACT2 and are based in Dover and Wilmington, respectively.

For some, it may seem an odd pairing. A core aspect of ACT—a proven therapy for severe mental illness such as schizophrenia—is the idea of face-to-face contact. Multidisciplinary ACT teams meet with patients both in clinics and in their communities (at home, at work while on lunch break, or at another similar location in the community) to help patients recover and reintegrate into society.

Could this model still work if the ACT psychiatrist was present via an iPad or similar device?

"I had some concerns about telepsychiatry coming in, since I thought many clients wouldn't want to talk to a television, but it has not been a problem at all," said Shelley Sellinger, M.D., a New York–based psychiatrist and mental health consultant for the Kent ACT team. "A couple of patients had some wariness initially, but they warmed quickly. I even had one patient with television-related paranoia, but he was totally fine with the arrangement."

Laura Marvel, director of RHD Kent ACT2, agreed. "It doesn't matter if the psychiatrist is in person or on a screen," she told *Psychiatric News*. "If we have access to a good doctor, it doesn't matter where the doctor is."

The incorporation of telepsychiatry was born out of necessity. In 2012, Delaware awarded ACT contracts to RHD to help provide better outpatient care to people with severe mental illness such as schizophrenia. RHD found out quickly that getting psychiatrists involved was difficult given the time commitments; in addition to traveling across the state to make scheduled or emergency house visits, ACT team members meet weekly to discuss patient progress.

Around that time, Dan Khebzou, an account executive with the telepsychiatry firm InSight, was meeting with RHD administrators in Philadelphia to discuss service options. He heard about the difficulties RHD was having in hiring psychiatrists for the newly formed ACT teams and suggested the telepsychiatry option.

"I've encountered resistance in using telepsychiatry for vulnerable populations from regulators; they cite issues such as licensing, technical problems, or handling civil commitments through video," said Khebzou. "But Delaware was willing to embrace telepsychiatry, so it presented an opportunity to prove this model."

After a successful pilot program, RHD moved full steam ahead with telepsychiatry in 2014, and the program is still going strong today, Marvel said. Besides patient acceptance, she said that other ACT team members—which include case coordinators, nurses, and social workers—are on board with the technology. They have not seen Sellinger's participation via video during their weekly team meetings as hindering the team dynamic.

If anything, Sellinger said, the remote aspect can help build some relationships with the team. "I can conduct most assessments remotely as well as in person, but there are elements that are difficult, such as testing AIMS (Abnormal Involuntary Movement Scale) or rigidity," she said. "In these cases, the on-site nurses are my eyes and ears, and we communicate about what's going on. In addition, they will let me know about hygiene if it's pertinent, so they also are my nose."

There are occasional technical glitches as well, but Marvel said the teams have established back-up plans to reach Sellinger in case of some malfunction with the video monitor used in the clinic or the iPad used on the road. "I've found Dr. Sellinger is as accessible to me or the team as an on-site person would be," she said. "Sometimes even more so; maybe there is a sense of overcompensating since she can't be physically present."

"ACT is a wonderful way to provide care to persistently ill folks who might not be able to get care otherwise," Sellinger said. "However, it is a demanding job to go into communities every day and work with these individuals, and it can lead to psychiatrist burnout. This telepsychiatry model has allowed me to continue to practice and give care longer than I might have otherwise." **PN**

More information about Resources for Human Development is posted at www.rhd.org.

RESIDENTS' FORUM

APA's Component Meetings: One Resident's Experience

BY LUMING LI, M.D.

Leadership is a skill. Although some would argue that leadership is innate, I disagree. I think that leadership takes training, and I've found the fellowship program of APA and the APA Foundation (APAF) to be a terrific opportunity to learn about leadership and networking opportunities within the APA community.

Leadership is cultivated through a combination of resilience, determination, friendship, and self-care. I want to share more about how I've taken advantage of the September Components Meeting, which was held September 13 to 16 in Arlington, Va. During the meeting—which is actually made up of many meetings—the members of APA's components and leadership convene to work on issues of importance to psychiatry and our patients and forward APA's mission.

This year is the first year I attended the meeting, and it was a blast! I participated in a one-day resident/fellow orientation and engaged in numerous stimulating conversations. Not only did I see familiar faces from Yale, but I also met with old friends from the residency interview trail. Also, I exchanged ideas with new friends who are doing groundbreaking work in advancing psychiatry. In addition to being inspiring, the colleagues with whom I engaged were thoughtful, caring, and passionate. The conversations and sessions in which I participated spanned numerous relevant topics. These included social determinants of health and personal experiences in health equity and diversity, just to name a few. I was particularly impressed with the information on resilience leadership, mentorship, and governance.

At the beginning of the meeting, I met with a group of bright-eyed folks who were Public Psychiatry Fellows and had come from as far away as Canada and Hawaii. We heard from Ranna Parekh, M.D., M.P.H., who heads APA's Division of Diversity and Health Equity. One of the poignant thoughts she conveyed is the idea of "sponsorship" within mentorship—it refers to a mentor's going above and beyond to do back-end work that will help a trainee become visible when that trainee might have otherwise gone unnoticed. Examples of "sponsorship" are sharing the trainee's CV with the right person at the right time or talking about a trainee's qualifications when being considered for a job. Dr. Parekh graciously encouraged us all to take advantage of the opportunity to network with each other and with APA leaders so we can form alliances, friendships, and mentoring relationships.

I also attended a keynote lecture by Beth Payne, J.D., of the U.S. Department of State's Center of Excellence in Foreign Affairs Resilience. At first, I was

see **Residents' Forum** *on page 30*

Luming Li, M.D., is the chief resident in quality improvement and administration at the Yale Psychiatric Hospital and president of the Resident/Fellow Senate at Yale New Haven Hospital. She is also an APA/APAF Public Psychiatry Fellow.

Psychiatric Pioneer and Historian Lucy Ozarin, M.D., M.P.H., Dies

Ozarin was a trailblazer as a psychiatrist in the military as well as a leader in community psychiatry at the National Institute of Mental Health. **BY MARK MORAN**

Psychiatrist Lucy Ozarin, M.D., M.P.H., who was among the first women psychiatrists in the U.S. Navy and a psychiatric historian, died September 17. She was 103 years old.

Ozarin spent the last decade and a half of her life as a volunteer at the National Library of Medicine (NLM). A 2012 feature profile of Ozarin ("NLM Volunteer Extraordinaire!"), published on the library's website, stated that Ozarin was born in New York in 1914 and graduated from New York University. She earned her medical degree from New York Medical College in 1937.

"She began a lifetime interest in psychiatry and neurology during her residency at Grasslands Hospital in Valhalla, New York (1939-1940), and at Gowanda State Hospital in Helmuth, New York (1940-1943)," according to the article. "Certified by the American Board of Psychiatry and Neurology in Psychiatry (1945), Ozarin later earned an M.P.H. from Harvard University School of Public Health (1961)."

Ozarin served as a Navy psychiatrist from 1943 to 1946. From 1946 to 1956, she was assistant chief and chief of the Division of Psychiatry and Neurology at the Veterans Administration. In 1957, she joined the National Institute of Mental Health (NIMH) and some of her service was spent as a consultant and advisor to the World Health Organization regional office in Copenhagen until retiring in 1981.

Ozarin was a volunteer at the APA's Library and Archives for over 30 years and made a significant contribution to the preservation of APA's historical heritage. She began this work as a member of the search committee to hire the third APA librarian (Zing Jung) in 1979 and took on any project that needed attention—from filing or typing to shelving books.

Later, Ozarin joined APA's Committee on History and Library, including serving as chair. In this capacity, she worked with the fourth librarian (William E. Baxter) on a revival of APA's oral history program, contributed articles to the "History Notes" column in *Psychiatric News*, and helped with sorting papers in the Archives.

David Hathcox

At APA's 2003 September Components Meeting, Lucy Ozarin, M.D., M.P.H., poses with Lifers President Raphael S. Good, M.D. (left), and former Lifers presidents Captane Thomson, M.D., and Philip Margolis, M.D., after being presented the Lifers' Harold Berson, M.D., Award. She was honored for her many years of service to APA's Library and Archives and her stewardship of psychiatric history, which resulted in her writing a popular column for many years for *Psychiatric News* called "History Notes."

Past APA President Steven Sharfstein, M.D., a lifelong friend and colleague of Ozarin from their days together at NIMH (where Sharfstein was director of mental health services programs), recalled Ozarin fondly.

"I visited with Lucy two weeks before she died on the occasion of her 103rd birthday," he told *Psychiatric News*. "She

see **Lucy Ozarin** *on page 21*

FRESH TALK

Returning From Off the Grid to Back Online

BY RAISSA TANQUECO, M.D.

I'm a millennial, part of a generation for whom using social media is supposedly second nature. However, I doubt that any of you "follow" me on social media, given my abandonment of these means of communication. Deciding how I should engage in digital communications as a psychiatrist has been something with which I've been wrestling for a while.

I recall a time when a patient wanted to stay in touch with me by email. I was flustered, unsure whether that was a best practice or a boundary violation. In med school, we learned so much about pathophysiology, brain circuits, and drug mechanisms of action that it is easy to become insulated from Real Life 101. My senior colleagues are facing the same questions: Where do we begin? What are the potential pitfalls? What is proper social media etiquette? How should I set boundaries? Is it as difficult as it seems? I thought so, and that's what led me to quit.

Yes, I gave up on social media a few years ago. Quit. Cold turkey. At the time, I felt liberated—like a digital hermit, freed from the pressures of online life. I left because part of me worried I would write something inappropriate that would later be deemed offensive and disastrous for a medical career; another part of me was consumed by the demands of residency training, with no time available to stay up to date on rapidly changing social media platforms.

But I've decided to give it another try and deal with some of the questions that gave me so much anxiety in the past. I have discovered some useful resources. For starters, there is the AMA Code of Medical Ethics. Chapter 2 has specific information on electronic communication with patients and maintaining professionalism. Among the pointers: it should not be used to establish a patient-physician relationship, patients must be made aware of the risk of a breach in confidentiality or loss of privacy, consent to communicate must be obtained, and professional standards must be upheld.

Precautions we should all take include separating personal and public content, maintaining appropriate boundaries in accordance with ethical guidelines, and remaining steadfast in our duty to protect patients and their information.

Other guidelines that we should adopt are common sense. Among them: we should not tolerate offensive, discriminatory, or harassing content; personal attacks and other messages that can be perceived as violent; and illegal activities. Also, we should not engage in commercial activities or use copyrighted material.

Raissa Tanqueco, M.D., is a PGY-4 psychiatry resident in the Department of Psychiatry at the University of Hawaii. She is also an APA/APAF SAMHSA minority fellow and the APA/APAF Minority Fellowship Program representative to the Assembly. This column is sponsored by APA's Council on Communicatons.

With guidelines like these, it's not quite the ethical conundrum I imagined it to be. So, I am back in. Our thoughts, opinions, and values matter! Social media can serve as an instrument—a voice—for issues that are important to us. I joined LinkedIn several months ago, and I am enjoying the connections to friends and colleagues and sharing professional information. I am also considering becoming more active on Twitter, which is a good vehicle for such advocacy work as spreading messages about the effectiveness of psychiatric treatment, correcting misinformation that feeds stigma, speaking out against legislation that could harm our patients, and sharing links to relevant articles and videos in the lay media.

I highly encourage you to view a short video on social media on APA's website at https://www.psychiatry.org/psychiatrists/practice/social-media. Also, the APA website is extremely user friendly. We are fortunate to have APA staff members who are very tech-savvy, accessible, and happy to give feedback. APA's Council on Communications launched a campaign at the 2017 Annual Meeting in which council members wore a button with the message "Ask me about social media." The invitation still stands; the names of council members are posted at https://www.psychiatry.org/about-apa/meet-our-organization/councils/communications, and we can be contacted through the membership directory.

My venture back into social media may seem like an Odysseus-style homecoming at first, but oh! What stories we have to share! I am braver and taking bigger strides in the digital world. So what do you say? Are you ready to give social media a try? **PN**

The AMA Code of Medical Ethics is posted at https://www.ama-assn.org/delivering-care/ama-code-medical-ethics.

Advertisement

WHY I ASPIRED TO BE A PSYCHIATRIST

My Path to Psychiatry

BY JOHN KRYSTAL, M.D.

I feel lucky to be a psychiatrist. I came to this choice through a path in which I benefitted from incredible role models, mentors, colleagues, trainees, and patients who helped me grow as a person, doctor, and scientist.

My first role model, and that of my brother Andrew (also a psychiatrist), was my father, Dr. Henry Krystal. He was a Holocaust survivor who turned experiences in the Nazi death camps into a psychiatric career focused on the problem of psychological trauma. Not only was his career inspiring, but he embodied traits and values—such as integrity, skepticism, curiosity, and humanism—that we aspired to emulate.

In 1976, I entered the University of Chicago with only rough ideas about a career in medicine. There, Dr. Daniel X. Freedman was a charismatic psychiatric leader. I was interested in learning about addiction. Drs. Ed Senay, at Chicago, and Ed Khantzian, at Harvard, included me in activities at their methadone programs. I also interned with Dr. Martin Mitcheson at University College London, where I observed methadone, heroin, and even cocaine maintenance treatment.

Seminal moments that shaped my career happened by accident. One epiphany came during a college biochemistry course with Dr. Earl Evans in which he discussed the discovery of endogenous opiates and opiate receptors, highlighting the work of Dr. Solomon Snyder and his colleagues. I realized that specific molecular mechanisms could be identified for addiction, and perhaps other psychiatric illnesses, and that there might be opportunities for transformative scientific discoveries. After that class, on the advice of Dr. Freedman, I contacted Dr. Richard Miller. I studied opiates and endorphins in his laboratory in my free time for the remainder of my college career.

Another epiphany came in 1979, when Dr. Senay graciously brought me to the College on Problems of Drug Dependence meeting. There, I heard Dr. Mark Gold describe one of the first successes of translational neuroscience: the discovery of clonidine as a nonopiate treatment for opiate dependence. This work was a team effort at Yale University involving basic scientists, such as Drs. George Aghajanian and Eugene Redmond, and clinical investigators, such as Drs. Gold and Herbert Kleber. At that point, I wanted to go to Yale to join the hunt for molecular mechanisms of illness and novel treatments.

I arrived at Yale for medical school in 1980 and I never left. Along the way, I had numerous influential mentors, particularly Drs. Dennis Charney, George Heninger, and Patricia Goldman-Rakic. Also, I have had wonderful colleagues and collaborators, whom I count among my most important influences and closest friends. I also have worked with enormously talented mentees, who forged successful independent careers. So far, my career has been more stimulating than I could have imagined. I focused my work on translational neuroscience and, with my colleagues, identified a promising new treatment, that is, the rapid antidepressant effects of ketamine. The opportunities to have an impact on mental illness through science are greater than ever. We are fortunate that despite some obvious challenges, this is the best time in the history of the field to pursue a career in academic psychiatry. **PN**

John Krystal, M.D., is the Robert L. McNeil Jr. Professor of Translational Research and chair of the Department of Psychiatry at Yale University School of Medicine. He is also director of the NIAAA Center for the Translational Neuroscience of Alcoholism and director of the Clinical Neuroscience Division at the VA National Center for PTSD and serves on APA's Council on Research.

Integrated Care

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encouraging results. Several initiatives are working to improve detection of perinatal mental health problems, such as recommendations for perinatal depression screening, and an Early and Periodic Screening, Diagnostic, and Treatment Medicaid provision to screen for maternal depression as a pediatric risk factor. Other programs are supporting prenatal providers in the delivery of evidence-based mental health treatments. Ensuring maternal mental health gives children a head start on optimal physical, emotional, and cognitive development. By delivering perinatal mental health treatments in primary care and prenatal settings, we are integrating care not only across health care settings, but across generations.

Perinatal collaborative care for moms and babies presents an enormous opportunity for psychiatrists and other behavioral health care professionals to improve mental health at a population level and, perhaps, even to prevent mental illness altogether. **PN**

AP Photo/Carlos Giusti

People impacted by Hurricane Maria last month wait in line at Barrio Obrero in San Juan to receive supplies from the National Guard.

Puerto Rico Reeling After Maria; U.S. Psychiatrists Plan Visit to Island

The speaker of APA's Assembly told Congressional representatives that flooding has been associated with elevated levels of anxiety, depression, and posttraumatic stress disorders. **BY MARK MORAN**

As *Psychiatric News* went to press, the U.S. territory of Puerto Rico was reeling from the devastation of Hurricane Maria, and conditions there were dire.

Much of the island was without power after Maria swept across the territory on September 20, making communication difficult or impossible. Puerto Rico was already recovering from Hurricane Irma, which hit the island just two weeks prior to Maria.

Hector Colon-Rivera, M.D., past chair of the APA/APAF Minority Fellowship Program and a graduate of Ponce School of Medicine and Health Science in Puerto Rico, told *Psychiatric News* that he was preparing a team of psychiatrists to go to the island to provide direct services. As of the last week of September, the airport in San Juan was only just opening, and Colon-Rivera said it would be two weeks or more before the team would be prepared to depart.

Colon-Rivera is the coordinator of "Salud A Flote," an educational radio segment transmitted every other Thursday by Radio Vieques (http://radiovieques.net/), a nonprofit radio station serving Puerto Rico.

Meanwhile, APA leaders were making efforts to reach out to the district branch in Puerto Rico and urged members to help however possible.

"Hurricane Maria was the second major hurricane to hit Puerto Rico this month and the strongest storm to hit the U.S. territory in nearly 90 years, leaving much of the island destroyed with no electricity, food, or clean water," wrote APA President Anita Everett, M.D., and APA CEO and Medical Director Saul Levin, M.D., M.P.A., in a September 26 email to the APA leadership.

They said assistance is available to the Puerto Rico Psychiatric Society through APA's Erich Lindemann Disaster Support Grant and the APA Foundation's Disaster Relief Fund. APA also sent letters to the Trump administration and Congressional leaders in support of federal aid to the U.S. territory.

The APA Foundation's fund was set up to provide services to those impacted by major disasters. Members are urged to visit the Foundation's Disaster Relief page at http://apapsy.ch/ReliefFund. Additionally, Everett and Levin recommend the following organizations and resources for members who want to help:

- **United for Puerto Rico:** http://unidosporpuertorico.com/en/. This organization, spearheaded by the Puerto Rican First Lady Beatriz Areizaga, details how individuals or companies can donate emergency and construction supplies, including bottled water, hand sanitizer, formula, extension cords, tarp, and safety glasses.
- **Hispanic Federation's "Unidos":** https://hispanicfederation.org/media/press_releases/a_hurricane_relief_fund_for_hurricane_maria_victims_in_puerto_rico.
- **The One American Appeal:** https://www.oneamericaappeal.org/. This organization, spearheaded by the five living former U.S. presidents (Jimmy Carter, George H.W. Bush, Bill Clinton, George W. Bush, and Barack Obama), has been expanded to include recovery efforts in Puerto Rico and the U.S. Virgin Islands.
- **Catholic Relief Services:** https://support.crs.org/donate/hurricane-irma-relief.
- **Save the Children Hurricane Maria Relief Fund:** https://secure.savethechildren.org/site/c.8rKLIXMGIpI4E/b.9535647/k.A2B9/Hurricane_Maria_Childrens_Relief_Fund/apps/ka/sd/donor.asp.
- **National Voluntary Organizations Active in Disaster:** https://www.nvoad.org/howtohelp/donate.
- **Red Cross:** https://www.redcross.org/donate/donation.

Everett and Levin said that most organizations are asking for cash rather than supplies, so they can quickly route money exactly where it's needed. The National Voluntary Organizations Active in Disasters (https://

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Harvey

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In the days immediately following Harvey, it was challenging to balance various roles—from first responder at the shelters, to checking on friends and family in the area, to being a survivor myself. A month later, many of us continue to rebuild our lives and strive to return to some level of normalcy. We are not alone in this, however; we have the overwhelming support of our local community and caring individuals from across the state and country.

Having never experienced a natural disaster of this magnitude, I have found this tragedy to be a huge learning experience as a survivor and a psychiatric trainee. I was impressed by the city's ability to care for survivors, mostly through dedicated medical personnel and extensive planning, and to turn chaos into organization. Shelters were a "go" immediately, with the full-scale needs of survivors met early on. A medical model that included triage, physical health care, mental health care, and a pharmacy were up and working within hours with effective coordination and collaboration between the teams. An overwhelming number of volunteers arrived at the shelters including psychiatrists and trainees, even as many of them were grappling with their own problems involving their homes and businesses. The number of shelters continued to grow as more and more survivors needed help, as did the volunteer base.

The selflessness I witnessed cannot be adequately described; some individuals were able to get to the shelters to volunteer their services, while others rescued individuals from their homes in canoes, kayaks, and boats. As the floodwaters started to recede, we saw the true extent of the devastation. Entire homes and businesses were simply unsalvageable. In fact, as I sit here today, debris from thousands of homes and offices that sustained damage continues to litter the streets.

As a first responder, I would be remiss if I failed to mention feeling overwhelmed. I had both humbling and humorous experiences like having to explain that psychiatrists are medical doctors capable of providing all types of medical care. Many of us in training, and even practicing physicians, had to have a crash course in disaster medicine to help survivors dealing with grief, trauma, and loss. Seeing cot after cot lined up, many of which were holding an individual's entire belongings, can put responders' day-to-day stress in perspective. We witnessed the full range of human emotions—anger, sadness, fear, humility, and gratitude. Just being there to listen, offer support, and organize resources was often enough and was typically received as an act of grace and kindness.

Partisan and other kinds of division have become our daily national fare. But as has been demonstrated time and again when disaster strikes and the chips are down, Harvey showed us the spirit of human compassion and working together. Our first responders, shelter volunteers, and even survivors helping other survivors showed our immense commitment to help one another and our Texas toughness and resiliency. The flooding, devastation, and rebuilding after Hurricane Harvey will likely have repercussions for some time, but through it all, we will band together and remain #HoustonStrong. **PN**

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www.nvoad.org/) is coordinating individual and corporate donations.

Everett and Levin said that once infrastructure is stable, the island will also need volunteers.

"The Red Cross has deployed funds and volunteers to Houston, the Florida Keys, and Puerto Rico," Everett and Levin wrote. "APA and the APA Foundation have assisted with these efforts. APA also has educational resources on its "Disaster and Trauma" webpage [https://www.psychiatry.org/psychiatrists/practice/professional-interests/disaster-and-trauma], which includes a link to disaster mental health training from the American Red Cross. This information was provided to the Puerto Rico Psychiatric Society before hurricane Maria hit the island."

APA Assembly Speaker Theresa Miskimen, M.D., who has family in Puerto Rico, told *Psychiatric News* that the outpouring of support has been swift, "but there is so much more to be done."

Miskimen, communicating with *Psychiatric News* on September 30, said, "Over the past week, I have been in sporadic contact with Michel Woodbury-Farina, M.D., a member of the Puerto Rico Psychiatric Society, and indeed the situation is dire. The Assembly and the APA Disaster Committee have been working on various fronts on how to best offer relief."

Miskimen participated in a Capitol Hill visit on September 27 with other APA leaders and representatives from six other medical organizations—the American Academy of Family Physicians, the American Academy of Pediatrics, the American Congress of Obstetricians and Gynecologists, the American College of Physicians, and the American Osteopathic Association. In addition to health care reform, they talked about relief efforts for Puerto Rico.

"We highlighted the humanitarian crisis confronting Puerto Rico in the aftermath of Hurricane Maria, including health-related repercussions," Miskimen told *Psychiatric News*. "Experiencing disasters related to climate and weather can cause significant distress and contribute to more serious mental health issues. We also know that flooding has been associated with elevated levels of anxiety, depression, and posttraumatic stress disorders, thus increasing the need for mental health services in the aftermath of climate-related disaster. Another such health repercussion is the potential threat for a reemergence of the Zika virus as a consequence of the extensive flooding, which provides the perfect breeding ground for mosquitoes. All six medical groups stand ready to work with members of both parties to come up with health care solutions in all these various fronts that put patients first." **PN**

Irma

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The preparations at BayCare mirrored those by psychiatrists and other physicians at hospitals and health care facilities throughout Florida, as the Category 5 storm churned across the Caribbean and headed for the Florida Keys.

BayCare's medical facility—Morton Plant North Bay Hospital, in New Port Richey, Fla.—was evacuated, along with four BayCare behavioral health facilities: Morton Plant North Bay Hospital Recovery Center (a 72-bed facility in Lutz), the BayCare Behavioral Health–Statewide Inpatient Psychiatric Program (SIPP) for Children, in New Port Richey, and the Community Recovery Center and Integrated Stabilization Unit, both of which are also in New Port Richey.

Patients at all facilities either returned home to their families or were transferred to other BayCare facilities in various parts of the state. Children at the SIPP facility who could not go home were transferred to St. Joseph's in Tampa. The entire behavioral health staff accompanied the children to St. Joseph's—where there were also 75 family members "camping out" with their loved ones, as well as some 37 pets in crates (sheltered in sealed sections of the hospital).

"All of this transportation was done in hospital vans the day before the Hurricane made landfall since we knew we couldn't be driving around in hurricane-force winds," Dewan said.

By Friday, September 8, hundreds of thousands of Floridians had evacuated for points north in what was described as the largest mass evacuation in U.S. history. When Irma's eye passed over Naples, Fort Myers, and Tampa on September 10 and 11, it had lost some strength but remained a fierce and potentially deadly storm.

BayCare physicians and staff were battened down. "For three and a half days you are hypervigilant, and then the thing is on you," Dewan said. "I remember looking out at the pelting rain and seeing a light pole in the parking lot shaking violently in 80-mile-per-hour winds."

When it was over, power outages were nearly universal across the state, and it was days before the extent of storm damage could be determined. Some 70 deaths were attributed to the storm, and there was substantial destruction of homes and other property in the hardest hit areas, especially in the Florida Keys.

But given the magnitude of Irma, it became clear as thousands of Floridians returned to their homes that the state had emerged battered but not devastated. This is Florida, after all, no stranger to hurricanes, and Dewan and others with the Florida Psychiatric Society (FPS) credit three things: planning, planning, and planning.

FPS President Rajiv Tandon, M.D., said the district branch, headquartered in Tallahassee, offered help to the governor's office, which has been coordinating all hurricane-related operations, and to physicians around the state. "The good news is that our services have not been called upon," he told *Psychiatric News*. "We think this is because the evacuation was massive, early, and relatively orderly, or at least not chaotic."

Margo Adams, executive director of the FPS, agreed. "We plan continually and implemented well," she told *Psychiatric News*. "It wasn't comfortable or convenient or flawless, but no state handles water storms better than Florida.

"There was pretty widespread flooding in South Florida, and some in Northeast Florida, but it was more tidal than Houston's rain and rivers, so the waters receded in days rather than weeks," Adams said.

Communicating with *Psychiatric News* in the last days of September, Adams said, "We won't hear for a while about the inland agricultural counties where food and supplies were being flown in from here. There are still housing issues in the Keys, but FEMA is working on them.

"We were hit pretty thoroughly, but looking now at Puerto Rico in the aftermath of Maria, and looking at the damage Irma did in the islands and Harvey [in Texas], I feel fortunate as a Floridian for our planning and our resourceful and caring citizens," Adams said. "We have had members contribute to recovery efforts in Texas and Louisiana, and now our folks are looking at what we can do for our neighbors in the islands. And not all of our members have completely finished with their own recovery efforts.

"Psychiatrists are good people," Adams said. **PN**

BayCare Behavioral Health

All essential personnel were on hand at BayCare's St. Joseph's Behavioral Health Center in Tampa, Fla., which served as a shelter during Hurricane Irma for individuals evacuated from other BayCare facilities. From left: David Kidd, security officer; Laura Frigo, mental health technician; Brendan Ferguson, security officer; and Robert Glass, manager of acute services.

BayCare Behavioral Health

Workers at St. Joseph's Behavioral Health Center kept people safe and ensured they had access to health and mental health care. From left: Valdinio Cambry, R.N.; Fontana Byssainthe, R.N.; Vera Startin, manager of the behavioral health center; Maggie Viskniskki, nurse manager; Jack Joseph, mental health technician; Jay Lewil, R.N.; and Chris Ervin, security officer.

The website of the FPS is http://www.floridapsych.org/.

Percentage of Americans Taking Antidepressants Climbs

One contributing factor to the increase may be that they are being prescribed the medications for non-depression diagnoses, such as anxiety, sleep, and neuropathic pain.

BY JUN YAN, PHARM.D.

Between 2011 and 2014, approximately 1 in 9 Americans of all ages reported taking at least one antidepressant medication in the past month, according to national survey data released by the Centers for Disease Control and Prevention (CDC). Three decades ago, fewer than 1 in 50 people did.

The use of antidepressants increased with age and reached nearly 19 percent in adults 65 years and older (see chart). From 1988 to 1994, only 3 percent of older adults were taking antidepressants.

The data were collected in the National Health and Nutrition Examination Survey (NHANES) by the CDC.

The sharp rise of antidepressant use in all adult age groups studied followed the introduction of the first selective serotonin reuptake inhibitor (SSRI), fluoxetine (Prozac). Prozac was first approved in the United States in 1987 and entered the market in 1988. Since then, many more SSRIs and other types of antidepressants have become available. The rise of direct-to-consumer marketing since the 1990s further pushed antidepressants into the public consciousness.

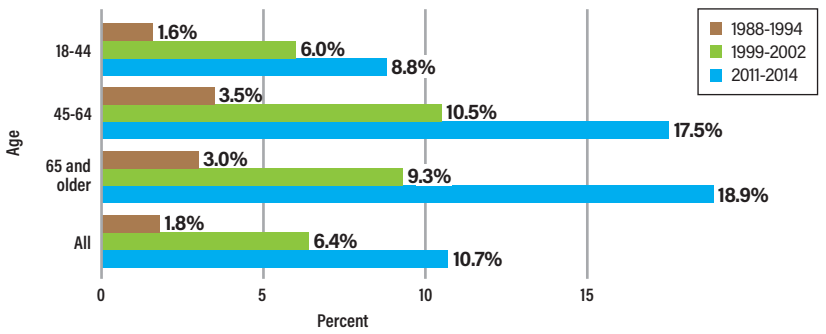
Because SSRIs do not carry the potentially life-threatening cardiac risks associated with tricyclic antidepressants, they are considered safer and easy to manage, particularly for elderly patients who often have coexisting cardiovascular diseases.

While the current prevalence of antidepressant use among older people is more than twice that among adults under 45, this does not mean older people are more likely to have depressive disorders. Epidemiological research has shown that depression is not more common in older adults than in younger adults and antidepressants tend to be less efficacious for older patients.

One reason contributing to the popularity of antidepressants is the expansion of their indications. "Many patients are given antidepressants for non-depression diagnoses, such as anxiety, sleep, and neuropathic pain," Donovan Maust, M.D., M.S., a geriatric psychiatrist and assistant professor of psychiatry at the University of Michigan, told *Psychiatric News*.

Antidepressant Use Rises Among Adults

This chart shows the change in the percentage of the U.S. population who took at least one antidepressant in the past 30 days in 1988-1994, 1999-2002, and 2011-2014.



Source: National Health and Nutrition Examination Survey, National Center for Health Statistics

Since older adults tend to have more contact with the health care system than younger adults, they may be more likely to be given an antidepressant prescription by their family physician, internist, or other specialist.

"There has been more recognition and awareness of major depression, along with more willingness to prescribe drug therapy," Maust added. The increase in antidepressant use is, therefore, partially justified, he stated.

Overtreatment with antidepressants remains a concern, as geriatric patients are far more likely to suffer side effects and drug interactions from the many more medications they take than younger adults.

"[SSRIs] may be safer than tricyclics, but they still have side effects, particularly in older patients, such as hyponatremia and risk of falling. Meanwhile, there is limited evidence to support their effectiveness for [treating] subsyndromal depression," said Maust.

For example, antidepressants are frequently prescribed to older patients with dementia to treat mood symptoms, but there is no solid evidence that they are effective for this purpose.

Rather than immediately reaching for the prescription pad, physicians should first clearly establish the diagnosis that may require an antidepressant and plan to measure and monitor the effectiveness, Maust recommended. "Such prescriptions are often motivated by the [physician's] desire to help patients, especially when resources for psychosocial intervention are not available."

Even without psychosocial resources, however, watchful waiting by scheduling an early return visit may be enough for some patients and help reduce unnecessary prescribing, he suggested. **PN**

"Depression Among Older Adults: A 20-Year Update on Five Common Myths and Misconceptions "is posted at http://www.ajgponline.org/article/S1064-7481(17)30357-3/fulltext.

When Should SAMe Be Considered For Major Depression?

ANUP SHARMA, M.D., PH.D., AND DAVID MISCHOULON M.D., PH.D.

S-adenosyl-L-methionine (SAMe) was discovered by Giulio Cantoni, the late Italian scientist and biochemistry director of the National Institutes of Health. It is an intracellular amino acid metabolite and enzyme co-substrate involved in multiple crucial biochemical pathways, including the biosynthesis of hormones and neurotransmitters.

SAMe serves as the universal methyl donor in more than 100 methyltransferase reactions, which regulate essential metabolic pathways. Methylation involves the transfer of a methyl group to an acceptor molecule, including DNA bases, proteins, phospholipids, amino acids, and neurotransmitters. Aberrant methylation has been implicated as a pathogenic mechanism in central nervous system disorders, including depression and dementia. Methyl group donation is a target mechanism to prevent disease, delay disease progression, and enhance therapeutic outcomes.

SAMe deficiency in cerebrospinal fluid (CSF) has been reported in major depression as well as other neuropsychiatric conditions. As a dietary supplement, SAMe crosses the blood-brain barrier and increases CSF levels, hence its potential benefit to patients with depression. More than 50 clinical trials in the United States and Europe have evaluated SAMe in the treatment of depressive disorders, including 19 double-blind, randomized, placebo-controlled trials with more than 850 patients, and 21 controlled trials with more than 1,500 patients comparing SAMe with other antidepressants.

A seminal meta-analysis commissioned by the Agency for Healthcare Research and Quality found that SAMe monotherapy was more effective than placebo and comparable to tricyclic antidepressants in treating depressive symptoms. A recent meta-analysis examining adjunctive nutraceuticals for depression demonstrated positive results for SAMe. While additional studies are needed, SAMe appears to be safe and efficacious both as a primary and add-on treatment for major depressive disorder (MDD).

Depressed patients often present with a broad array of comorbid conditions, may take concurrent medications, and may report medication-related side effects. Evidence suggests that SAMe can ameliorate symptoms associated with medical conditions such as hepatic disease (for example, alcoholic cirrhosis), osteoarthritis, fibromyalgia, and cognitive and memory decline. Compared with prescription medications, SAMe may cause fewer and less severe side effects and result in considerably fewer drug interactions. The evidence generally supporting the safety and efficacy of SAMe in psychiatric and comorbid illnesses offers opportunities for the use of SAMe in diverse clinical contexts. For example, patients with MDD and comorbid rheumatologic illnesses may find SAMe to be particularly beneficial.

Careful consideration of pursuing treatment with SAMe as opposed to a

see **SAMe** *on page 21*

Anup Sharma, M.D., Ph.D., is a research fellow in neuropsychiatry at the University of Pennsylvania Perelman School of Medicine. David Mischoulon, M.D., Ph.D., is director of the Depression Clinical and Research Program at Massachusetts General Hospital and an associate professor of psychiatry at Harvard Medical School.

Researchers Examine Link Between Mood, Food, and Obesity

A greater understanding of the biological pathways that mediate the association between diet and mental health could result in improving people's overall health. **BY RITA RUBIN**

Individuals who overindulged in food when sad and/or stressed and then questioned why they did so when they didn't feel any better may wonder if mood and food are connected.

"There have been many suggestions that dietary patterns are related to depressive symptoms," but the evidence so far has been mixed, said Marjolein Visser, Ph.D., a professor of health aging in the Health Sciences Department at Vrije Universiteit (VU) in Amsterdam. Visser spoke at a meeting of the International Society for Nutritional Psychiatry Research (ISNPR) in Bethesda, Md.

The studies have probably been too small, which explains their inconsistent results, Felice Jacka, Ph.D., director of the Food and Mood Center at Deakin University in Australia and founder and president of ISNPR, said at the meeting.

In January in *BMC Medicine*, Jacka published the results of SMILES, a randomized, controlled trial of dietary improvement in 67 adults with major depression. Of these, 55 were being treated with psychotherapy and/or medication therapy. The intervention consisted of seven individual consulting sessions with a clinical dietitian. At the end of the 12-week study, the dietary intervention group demonstrated significantly greater mood improvement compared with baseline, leading the authors to conclude that a healthier diet might represent an efficacious and accessible treatment for managing depression.

Jacka, who has focused on the role of inflammation and oxidative stress, called for more research to identify biological pathways and targets that mediate the association between diet and mental health, although she acknowledged, "getting funding is really hard."

Could it be that certain dietary patterns are associated with depression because they lead to obesity, which itself is linked to depression? Could changing food-related behaviors and the nutritional status in people with a tendency to be overweight or obese prevent depression?

> "There have been many suggestions that dietary patterns are related to depressive symptoms."
>
> —Marjolein Visser, Ph.D.

It makes sense that a cardio-protective diet, such as the Mediterranean diet, could also protect against depression, Almudena Sánchez-Villegas, Ph.D., an associate professor at the University of Las Palmas de Gran Canaria, Spain, said at the meeting. Sánchez-Villegas noted several mechanisms by which such a diet could protect against both heart disease and depression, including an anti-inflammatory effect, a high antioxidant content, improved insulin sensitivity, and reduced risk of metabolic syndrome.

Sánchez-Villegas is an investigator with the SUN study, an ongoing prospective cohort study of Spanish university graduates. In 2015, she and her collaborators reported findings in *BMC Medicine* about diet and depression in a cohort of 15,000 people.

The researchers had assessed their subjects' dietary intake at baseline and after 10 years of follow-up. They also looked to see whether the study participants, who were not depressed at baseline, were diagnosed with depression during the follow-up. They observed 1,051 incident cases of depression among the 15,000 participants after a median follow-up of 8.5 years. Cohort members whose eating patterns were rich in fruits and vegetables and whole grains and

see **Food and Mood** *on page 21*

Advertisement

The Valbenazine Story: Small Company Makes Big Breakthrough

By incorporating an innovative video review system, the KINECT-3 study overcame a major obstacle in conducting multisite clinical trials—variability. **BY NICK ZAGORSKI**

This past April, the U.S. Food and Drug Administration (FDA) approved the first pharmacotherapy for tardive dyskinesia—valbenazine (Ingrezza).

The approval was based largely on the 234-person KINECT-3 study, published in the May issue of *American Journal of Psychiatry (AJP).* The study subsequently received praise in a June 29 perspective article published in the *New England Journal of Medicine (NEJM).*

The commentary highlighted how a small biotech company with no previous FDA approvals brought an important medication to market quickly through efficient trial design. It also reflects how *AJP* is committed to publishing groundbreaking research.

The key element of KINECT-3 that was noted was the use of independent video raters to diagnose the severity of movement problems. It was an innovative approach, the seeds of which Christopher O'Brien, M.D., chief medical officer at Neurocrine Biosciences—the company behind valbenazine—remembers vividly. It occurred after completion of the drug's first phase 2 clinical study. "It was a period of heartbreak and epiphany," O'Brien said.

Prior to that, the drug discovery process at Neurocrine was a typical affair. The drug discovery team started by testing hundreds of potential molecules that would specifically inhibit the VMAT2 receptor, which is known to be relevant in movement disorders. Researchers eventually developed a derivative of a drug used to treat chorea in Huntington's known as tetrabenazine; Neurocrine's improved version, valbenazine, easily cleared preclinical safety studies and a phase 1 human safety study, so the stage was set to see how well this compound worked. The assessment tool used was the Abnormal Involuntary Movement Scale (AIMS).

The study failed.

As O'Brien described to *Psychiatric News,* the period after the failure was dark; the company's stock, as well as morale, plummeted. This was the type of setback that could spell the end of a small startup.

Following that failure, Neurocrine invited Robert Hauser, M.D., a professor of neurology at the University of South Florida and head of the University's Movement Disorders Center, to help determine why the study had failed and design a rigorous trial.

"It seemed apparent that the key weakness of the study was that all the evaluations were being done by the site investigators, each one with a different level of familiarity with tardive dyskinesia," Hauser said. "We developed the notion that a small group of dedicated raters would solve that issue."

Getting a small team of experts to travel across the country would be costly and time consuming, however. Then the epiphany struck. As part of the phase 2 study, the investigators had videotaped every participant at the beginning and end of the trial. Hauser and a colleague, Stewart Factor, D.O., a neurologist at Emory University, agreed to review the videos in a blinded manner and score the patients.

The result: there was a clear, statistically significant signal of improvement in the valbenazine group.

With these new data, the company proceeded with a new phase 2 study (known as KINECT-2) followed by KINECT-3, both of which incorporated blinded video reviews. All AIMS evaluations were done by one pair of experts who reviewed every video and had to reach a consensus score before moving on to the next video.

As noted in the *NEJM* perspective, KINECT-3 judiciously incorporated other elements—such as using multiple active doses, adding an extension phase, and evaluating participants who dropped out of the study—to show that valbenazine provided a sustained clinical improvement; the results were good enough to give valbenazine a breakthrough designation by the FDA.

"I was most proud of what we accomplished in creating the video rating system, but the drug also did its part," said Hauser, who was one of the lead authors on the KINECT-3 study. "Valbenazine had solid efficacy and high tolerability, and most of our patients stayed in the trial."

Hauser added that while the medication directly benefits patients, it has had another positive impact. The arrival of the first-ever tardive dyskinesia drug helped spur broader physician interest in this condition, which benefits patients indirectly as more doctors can identify this problem and refer patients to specialists.

O'Brien and other researchers at Neurocrine, meanwhile, are already moving valbenazine down a second pipeline for the treatment of tics in children with Tourette's syndrome. While the experience of the initial approval process is valuable, each new approval has its own challenges.

In the case of Tourette's, one hurdle is that the video rating system cannot be employed. The Yale-Brown Obsessive-Compulsive Scale is used to measure symptoms of Tourette's. "That involves not only observing a patient but also asking about tic behaviors in the past week," O'Brien said.

The drug did not perform well in a recent phase 2a study, but O'Brien believes that was linked to using doses that were too low due to concerns about safety. A phase 2b is starting later this fall, and the team is confident that the results will be positive. O'Brien is maintaining a measure of caution, however: while Neurocrine may be one-for-one right now, he knows that drug development is difficult and time consuming, especially in psychiatry.

"KINECT 3: A Phase 3 Randomized, Double-Blind, Placebo-Controlled Trial of Valbenazine for Tardive Dyskinesia" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2017.16091037.

FROM THE EXPERTS

When and How to Care for Adults as Elders

BY SOPHIA WANG, M.D., AND ABRAHAM NUSSBAUM, M.D.

Pediatricians like to say that ill children are not just miniature adults, but members of a special population. So pediatricians typically tailor their treatments for the developmental, physiological, and social experience of each child they examine.

Geriatricians and geropsychiatrists have similarly adapted medical and psychiatric treatments for older adults. As each of us ages, we enter new developmental stages and experience physiological changes and altered social patterns. These changes affect our functional ability. Whatever their age, when patients' functional status becomes geriatric and they become more dependent upon others, we favor treating an adult as an elder. You can see the difference a geriatric approach makes from our experience with a recent patient.

Florence was admitted with a straightforward story: suicidal in the setting of a recurrent depressive episode. A 55-year-old, thrice-divorced, retired seamstress, Florence was first diagnosed with bipolar disorder three decades ago and had experienced suicidality several times. So the suicide note she had placed next to a supply of emptied medication bottles seemed like a clear indication for a crisis hospitalization.

During an admission interview, the story grew complicated. Florence appeared older than her stated age, needed assistance to ambulate, and exhibited deficits in long-term memory and executive functioning. While she denied symptoms of mania and depression, she admitted her intentional ingestion, saying, "I did not take enough pills to die; I took enough of my pills to get out of her house." Florence's act of self-harm was a way out of her living situation.

Even though she was younger than the age typically regarded as geriatric,

Sophia Wang, M.D., is an assistant clinical professor of psychiatry at Indiana University School of Medicine. Abraham Nussbaum, M.D., is an associate professor of psychiatry at the University of Colorado School of Medicine. They are the co-authors of the *DSM-5 Pocket Guide for Elder Mental Health,* which APA members can purchase at a discount at https://www.appi.org/DSM-5_Pocket_Guide_for_Elder_Mental_Health.

Florence was disabled by arthritis, bipolar disorder, and congestive heart failure. She had lived in an assisted living facility several states away for the past few years. Six months before hospitalization, she could no longer

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Researchers Consider Value of Supplements For Pregnant Women With Depression

Pregnant women with depression and their physicians have concerns about the effects of antidepressants on their offspring. Are there safer alternatives? **BY RITA RUBIN**

iStock/KatarzynaBialasiewicz

Concern about the safety of taking antidepressants during pregnancy has spurred women to turn to nonpharmacological alternatives such as dietary supplements. But while there have been intriguing hints of small benefits, researchers say, more studies are needed.

The use of supplements to treat depression during pregnancy was the focus of a session at the first major conference of the International Society for Nutritional Psychiatry Research (ISNPR), held in Bethesda, Md. ISNPR, based in Adelaide, Australia, was founded in 2013 "to support scientifically rigorous research into nutritional approaches to the prevention and treatment of mental disorders and their comorbidities," according to the organization mission statement. It now counts more than 200 member scientists at academic centers around the world.

Depression in pregnancy is a worldwide health problem. According to the World Health Organization (WHO), an estimated 10 percent to 20 percent of pregnant women in high-income countries such as the United States will experience depressive symptoms. The WHO's estimate is even higher for pregnant women in low- and lower-middle-income countries—13 percent to 33 percent.

Considering that half of all U.S. pregnancies—and 40 percent globally—are unplanned, "there's a good chance women are going to become pregnant on what you're prescribing," Marlene Freeman, M.D., said at the conference, referring to women psychiatry patients of reproductive age. Freeman, an associate professor of psychiatry at Harvard Medical School, is associate director of the Perinatal and Reproductive Psychiatry Program at Massachusetts General Hospital.

Sometimes women aren't diagnosed with a psychiatric disorder such as depression until after they become pregnant, Freeman said. "It's clear that women don't get a break from psychiatric disorders during pregnancy. The risk of occurrence is about the same in pregnancy as not in pregnancy."

Obesity, the most common high-risk condition in pregnancy, has a bi-directional relationship with psychiatric disorders, she noted. Obesity is associated with a higher risk of psychiatric disorders, while psychiatric disorders are associated with a higher risk of obesity, Freeman said.

"Many women will need psychotropic medications during pregnancy," she continued, but "there may be some patients who can switch to nonmedication treatments."

Fish oil, which is rich in omega-3 fatty acids, lacks side effects and potentially could benefit the developing fetal brain. Those characteristics make it an attractive alternative to medication in treating depression during pregnancy, but so far studies have been inconclusive. Pooling fish-oil study results in a meta-analysis is difficult, because the studies have used different doses and treatment duration and different scales to measure depression, Freeman said. In addition, such studies also focused on different populations, with some enrolling pregnant women and others enrolling postpartum women.

In 2008, Kuan-Pin Su, M.D., Ph.D., a psychiatrist at China Medical University in Taichung, Taiwan, published the first clinical trial to show that omega-3 fatty acid supplements had an antidepressive effect in women with depression.

So far, the effect sizes of omega-3 fatty acids on depression in pregnancy have been modest, Su pointed out at the ISNPR conference. "Maybe we need a huge clinical trial," he said, although he noted that the effect sizes of antidepressants are similarly modest.

More than a decade ago, APA's Omega-3 Fatty Acids Subcommittee published a review that concluded that a daily omega-3 supplement might complement the standard treatment for mood disorders. "There's no reason something like that couldn't be tailored for pregnancy," she said.

Freeman discussed other possible nonmedication options for treating depression in pregnancy but emphasized that data are lacking about their effectiveness:

- **Folic acid:** While its effectiveness in protecting against neural tube defects in the fetus is well established, no specific evidence supports it as an adjunctive treatment for major depressive disorder in the mother.

- **L-methylfolate:** One double-blind, placebo-controlled, randomized trial found 15 mg/day supplements of this form of folic acid was more effective in treating SSRI-resistant depression. However, study participants were not pregnant.

- **SAM-e:** The human body makes s-adenosyl-l-methionine (SAM-e) from methionine, an amino acid in foods. It is also sold as a dietary supplement. Abnormally low levels of SAM-e have been reported in depressed individuals, and research

see **Supplements** *on page 31*

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afford the facility, so she moved across the country and into her adult daughter's home. Suddenly living together after years of estrangement, the two fought daily, the daughter externalizing her anger and Florence internalizing her shame.

When evaluating adults who have, or may have, a mental illness, we have come to expect complicated stories. Patients like Florence present with a combination of mental illness, cognitive ability concerns, character structure issues, substance and medication use, medical illness, family dynamics, and socioeconomic factors. Florence needed an acute hospitalization, but also changes in her medication regimen, individual therapy, a cognitive evaluation, family counseling, and increased social services.

The geriatric approach took a little longer, but it was necessary to understand Florence's story.

First, we had to educate Florence and her daughter about what to expect as Florence aged. In family meetings, Florence's daughter admitted that she did not understand her mother's mental illness, but resented the ways it had taken Florence out of her life when her mother was young, but forced her back into her life as her mother aged. The daughter ultimately benefitted from attending a support group for family members, while Florence met with the staff psychologist to discuss the aging process.

Second, we made several psychosocial interventions for Florence. After assessing her gait and functional ability, we assessed her cognition and behavior and eventually recommended a nursing home placement. Florence and her daughter elected to go home together, with home health services, while awaiting a bed in an area nursing home.

Third, in an acute hospitalization, we selected a depression-focused psychotherapeutic approach called problem-solving therapy (PST). PST is an evidence-based psychotherapy that teaches suffering people how to solve their daily problems, decrease stress, and utilize these skills when problems arise.

Fourth, as people age, pharmacokinetic and pharmacodynamics changes occur. As muscle mass decreases and peripheral fat stores increase, lipophilic drugs remain in the body longer. Decreased renal clearance and hepatic blood flow combine to slow the clearance of medications. For older adults, the result is that in many older patients, drugs exert greater therapeutic and adverse effects at lower doses than expected. With Florence, we reviewed every medication prescribed to her, eliminated several, and optimized dosing and time of administration while educating Florence and her daughter about the safe administration and storage of prescription medications.

Coordinating or providing all these services can overwhelm even an experienced geropsychiatrist. To untangle a story like Florence's, it helps to begin with a shift in thinking. Florence is not just another adult with bipolar disorder; she is an elder adult. When treating an elder like Florence, we try to engage the life story of a patient, consider how each treatment affects functional status, care for the patient and her caregivers, and recommend simple, pragmatic treatments. We learned the process of caring for our elders from people like Florence. **PN**

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Wellness Programs

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program reaches hospital sites to conduct wellness rounds. This group intervention allows students to discuss their experiences in a nonjudgmental setting where they are not evaluated.

I stress the importance of choice and of students' making healthy decisions. I want students to thrive in the extremely demanding and rewarding field of medicine, avoid burnout, and take care of their basic needs.

I often tell students that going to medical school is like running four consecutive marathons or biking 500 miles weekly. Students must learn to implement healthy practices to finish these endurance tests and to allow their best selves to emerge.

I also tell them that the field of medicine is like a giant tent and that finding a place under that tent that feels right for them is a crucial task. Maintaining their integrity and wholeness is an essential skill to learn. It is as important as learning to take a clinical history and do a physical exam. Our lives and the lives of our patients depend on it. **PN**

Information about the Physician Well-Being Program at UCSF is posted at http://meded.ucsf.edu/wellbeing.

Lucy Ozarin

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was wonderful, reminiscing with me about when we worked together 40 years ago at NIMH. I was her 'boss,' but she was 30 years my senior and was already a legend in community psychiatry and as a pioneer for women in psychiatry. She made site visits, conducted evaluations of community mental health centers, and set policy. She was a joy to work with. I am so lucky to have known her and to have occasion to celebrate her remarkable life."

Psychiatrist Leah Dickstein, M.D., wrote an oral history based on discussions with Ozarin, titled, "Lucy D. Ozarin, M.D., M.P.H.: A Life of Service to Psychiatry and the Nation."

"Lucy was a role model and a pioneer in so many ways across her lifetime," Dickstein said. "I would always talk to her on her birthday. She was just an inspiration—a humble but remarkably brilliant and creative physician, who was a role model not just for women but for the entire profession." **PN**

The NLM profile is posted at https://infocus.nlm.nih.gov/2012/08/24/dr_lucy_ozarin_nlm_volunteer_e/. "Diseases of the Mind: Highlights of American Psychiatry Through 1900" is posted at https://www.nlm.nih.gov/hmd/diseases.

SAMe

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registered antidepressant is required on the part of the clinician and the patient. Clinicians who recommend SAMe should inform patients that it has not been tested as rigorously as its FDA-approved counterparts. However, the risks of SAMe compare quite favorably with prescription antidepressants, particularly in that it does not cause sexual dysfunction or weight gain (two of the most common causes of antidepressant discontinuation), and it is less likely to be life-threatening in patients who are at risk for overdosing during suicide attempts. As with other antidepressants, SAMe can trigger hypomanic or manic symptoms in patients with bipolar disorder and cause gastrointestinal upset.

SAMe is sensitive to moisture. Thus, clinicians are advised to instruct patients to purchase SAMe that is contained in foil blister packaging.

Although the cost of SAMe is not covered by insurance companies and is among the more expensive natural antidepressants, when compared with the high copayments for many prescription medications, the cost is reasonable, and patients should weigh the costs against potential benefits. **PN**

Food and Mood

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low in added sugars were less likely to have been diagnosed with depression.

Researchers in a multi-country European project called MooDFOOD—Multi-country cOllaborative project on the rOle of Diet, FOod-related behaviour, and Obesity in the prevention of Depression—hope to determine whether it is feasible and effective to change food and nutrient intake and/or food-related behaviors to protect against depression.

MooDFOOD is analyzing six prospective cohort studies from across Europe to examine the link between food intake, nutrient status, and obesity.

In addition, MooDFOOD is conducting a prevention trial involving 1,000 overweight and obese individuals (those with a body mass index of 25 to 40) who are at risk for depression but not depressed currently or in the year prior to enrollment. People with eating disorders were excluded.

By country, they were randomly divided into four groups: multi-nutrient supplement with food behavioral change (FBC) intervention, supplement with no FBC, placebo pills with FBC, and placebos and no FBC.

They have been taking two supplements or two placebo pills daily. One supplement is a pill containing the omega-2 fatty acids DHA and EPA (the placebo contains sunflower oil), while the other supplement contains minerals and vitamins.

"We took the hardest evidence that there was, and we selected the nutrients based on that," said Visser, who leads MooDFOOD with VU colleague Ingeborg Brouwer, Ph.D.

As for the FBC intervention, "we're not telling people 'You should eat this or that,'" Visser said. It will consist of up to 15 individual sessions and up to six group sessions. The intervention includes analyzing each participant's behavior to determine triggers and unhelpful and helpful food-related behavior.

"The actual food that you eat might be of importance, but I think that other food-related behaviors might be related to depression," such as not eating mindfully, Visser said. **PN**

"A Randomised Controlled Trial of Dietary Improvement for Adults With Major Depression (the 'SMILES' Trial)" is posted at https://bmcmedicine.biomedcentral.com/track/pdf/10.1186/s12916-017-0791-y?site=bmcmedicine.biomedcentral.com. "A Longitudinal Analysis of Diet Quality Scores and the Risk of Incident Depression in the SUN Project" is posted at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4573281/pdf/12916_2015_Article_428.pdf. "The MooDFOOD Project: Prevention of Depression Through Nutritional Strategies" is posted at http://onlinelibrary.wiley.com/doi/10.1111/nbu.12254/full.

Summit

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Childs, LLC, a global strategic diversity consulting firm; and Subha Barry, senior vice president and managing director at Working Mother Media.

After each presentation, participants broke into small groups for workshops in which they were tasked with developing tools and products. Among them:

- Assessment tools that can be used across public and private sectors to measure cultural competency at an agency or institution.

- Resources for training administrators and employees in cultural competency, along with cost estimates for implementing such training.

- An adaptable cross-sector "inclusion scorecard" to track cultural competence and inclusive excellence over time.

Among those attending the summit was psychiatrist Ramaswamy Viswanathan, M.D., the recipient of the 2016 APA George Tarjan Award, which honors a psychiatrist who has advanced the cause of international medical graduates. Viswanathan described a "best practice" from his own practice of consultation/liaison psychiatry (see box).

The summit was preceded the night before by a "networking" event in which Childs delivered a keynote address, followed by remarks by Joan Y. Rede, M.D., dean for diversity and community partnership at Harvard Medical School, and APA President Anita Everett, M.D. In opening remarks, APA CEO and Medical Director Saul Levin, M.D., M.P.H., said that cultural competence has become critical in health care and to the profession of psychiatry and to APA.

In comments to *Psychiatric News*, Levin said, "We wanted to host the summit here at APA headquarters as a sign to our partners in government and the private sector as well as to our own members that APA strives to be ahead of the curve in this area. I believe psychiatrists in particular need to understand the nature and importance of unconscious bias and its effect on the quality of care for our patients." **PN**

Resources related to cultural competency can be found on the APA website at https://www.psychiatry.org/psychiatrists/cultural-competency.

'Establishing the Human Connection'

At last month's Cultural Competency and Inclusive Excellence Summit at APA headquarters in Arlington, Va., psychiatrist Ramaswamy Viswanathan, M.D., of SUNY Downstate Medical Center and the APA Trustee for Minority and Underrepresented Groups, shared a narrative describing a "best practice" in cultural competency drawn from his practice of consultation/liaison psychiatry.

"Often I encounter patients who are angry or anxious and are refusing help or even life-saving treatment. One factor that reinforces the patient's resistance is his or her feeling [of being] alienated. It is important to establish a human connection to gain the patient's confidence before one engages in a dialogue to understand and solve the patient's resistance."

Viswanathan described vignettes in which he was able to make a cultural connection with patients that produced clinically meaningful results. For instance, a non-English-speaking Chinese patient who had initially agreed to mitral valve replacement surgery suddenly refused it on the eve of the surgery. By approaching the patient with some rudimentary Chinese language greetings, Viswanathan was able to open a conversation that ultimately led her to reconsider the surgery.

"In another situation, elderly Caribbean-American patients with cognitive impairment who were initially untrusting became trusting after I engaged in a little conversation about cricket, a favorite sport in Caribbean countries," he said.

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Resident's Forum

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skeptical at the relevance of the content; however, after hearing her lecture, I was sold. The work she presented centered on making use of existing research literature on resilience and applying resilience concepts to overcoming challenges, including those presented by natural disasters. Among the points she made were that leaders need to promote self-care; individual resilience does not equate to team resilience; and people can have a dramatic impact on the environment by modeling resilient behaviors such as applying a positive outlook. She also noted that all individuals can reframe situations for their own well-being and that of others. She further discussed the fundamental principles of developing social support, finding meaning and purpose, and using active problem solving. During a roundtable discussion, we focused on challenges that occur when discussing wellness/well-being with the people around us. In particular, we talked about the fear and stigma of telling a colleague that we are experiencing a problem or feel that something is wrong with us. However, we learned that the cost of not doing so includes jeopardizing patient safety and our residency as well as the health care system in which we work.

Beyond lectures and workshops, what I particularly enjoyed at this meeting was the opportunity to meet with other residents and potential mentors. For example, I had dinner with three fellows from three APA fellowship programs and had a long conversation about health equity and inclusion. I participated in a very insightful discussion on the importance of mentorship to be successful in medicine, particularly for minority trainees. We talked about the all-too-common micro-aggressions aimed at African Americans in the clinical setting and the need for professional dress codes that take into account cultural differences with the goal of overcoming racial and gender-based stereotypes and stigma among hospital staff. We also shared experiences that stemmed from our different cultural characteristics and upbringing—I shared what it was like to be a short, Asian psychiatry resident while my new friends recounted their growing-up experiences as Southerners. The discussion confirmed my commitment to promoting health equity and inclusion.

Beyond making new friends, I met some terrific mentors. I had numerous conversations with psychiatrists who support young physicians in their professional and personal journeys in psychiatry and were glad to share their knowledge. Francis Lu, M.D., of the UC Davis Health System discussed the use of films as a way to think about wellness/well-being in mental health. Geetha Jayaram, M.D., M.B.A., a former chair of APA's Scientific Program Committee, gave me feedback about how to put together a strong workshop proposal for the Annual Meeting. I learned that she and I share similar interests in quality improvement and mental health systems administration. One day between sessions, I chatted with APA President Anita Everett, M.D., who encouraged my idea about developing a seminar for young psychiatry leaders through SAMHSA, the organization where she is the chief medical officer.

As the meeting came to a close, I was able to sit in on the Health Systems and Financing Committee and listened to an exciting discussion on collaborative care. Through friends, I was able to get together for happy hour with Altha Stewart, M.D., who is APA's president-elect. She shared insights she had learned as a strong advocate for public sector mental health systems and discussed her initiative to engage residents/fellows during her presidential year. It was truly inspiring to hear her share her thoughts.

Although the story of my attendance at APA's September Components Meeting is just one of many, I encourage all residents to consider applying for one of the APA/APAF fellowships. APA and the APAF have made a strong investment in these

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fellowships as well as in mentorship and leadership training. I am truly grateful for the relationships I've built through APA and plan to continue my involvement in the Association. **PN**

More information about the APA/APAF fellowships is posted at https://www.psychiatry.org/residents-medical-students/residents/fellowships. Applications may be submitted from November 1 through January 31, 2018.

Supplements

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has hinted that supplements might be an effective treatment, but it has not been studied in pregnancy.

- **Vitamin D:** Low levels of vitamin D might be associated with a higher risk of depression in both pregnant and nonpregnant individuals. So far, however, there is little evidence that vitamin D is an effective treatment for depression during pregnancy, and prenatal vitamins generally contain little of it.

Despite the lack of data supporting the use of supplements to treat depression, many pregnant women turn to them because they consider them to be natural and, therefore, safer than medication.

"They're torturing themselves about whether they should take this really small dose of an antidepressant that's been well studied in pregnancy," Freeman said. And yet, she said, they give little thought to taking multiple supplements. **PN**

"Omega-3 Fatty Acids: Evidence Basis for Treatment and Future Research in Psychiatry" is posted at https://www.ncbi.nlm.nih.gov/pubmed/17194275.

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