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PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

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AP Photo/Steven Senne

Vice President Joseph Biden (left) smiles as he is introduced by former member of Congress Patrick Kennedy during a forum that Kennedy planned on mental health policies marking the 50th anniversary of President John F. Kennedy's signing of the Community Mental Health Act.

Events Mark 1963 Mental Health Act And Point Way Forward

The Kennedy Forum gala and conference bring mental health leaders and policymakers together to assess the past and suggest the best path for the future of mental health care.

BY AARON LEVIN

Whether by design or chance, the Kennedy Forum gala and conference in Boston last month highlighted a confluence of events of major significance for people with mental illness and those who care for them.

In part, the events commemorated President John F. Kennedy's 1963 Community Mental Health Act. The driving force was former member of Congress Patrick Kennedy, a nephew of the late president. Patrick Kennedy has spent his postcongressional career leading efforts to improve mental health and substance abuse research and services.

The 1963 mental health act marked a major change in how people with mental illness were perceived in the United States, said Herbert Pardes, M.D., a former APA president and former director of the National Institute of Mental Health, who spoke at the conference (see box on page 12).

Historically, people with mental illness were treated with fear, hostility, and isolation, said Pardes. "But the act called for placing mental health centers in communities, not in remote rural areas."

Implementation of the Community Mental Health Act was only partially successful, he pointed out. Just half of the planned 1,500 mental health centers were built, and they were accused of not caring for the most seriously mentally ill patients.

However, aspects of the legislation also presciently resonate with contemporary federal mental health policy, noted Substance Abuse and Mental

*see **Kennedy Forum** on page 12*

Successful Public Mental Health Can't Go It Alone

Recovery from serious mental illness takes more than medical care; it requires social and rehabilitative services as well.

BY MARK MORAN

Successful community mental health requires effective partnerships and an integrated system of care bringing together primary care, mental health, and substance abuse services.

And at the level of the individual living in the community, successful recovery from serious mental illness requires more than just clinical care—it requires a range of human and social-support systems.

That's the message Estelle Richman delivered to psychiatrists in her keynote address that kicked off this year's APA Institute on Psychiatric Services in Phil-

*see **Public Mental Health** on page 30*

Ellen Dallager

APA President Jeffrey Lieberman, M.D., opens the Institute on Psychiatric Services with the traditional bell-ringing ceremony.

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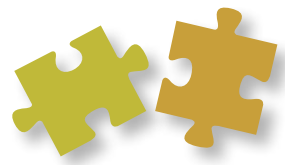

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Back to Big Apple in '14!

For APA's 2014 annual meeting, the Association returns to one of its most popular hosting locations, New York City. Register now while early-bird rates are still in effect, and have first crack at

the hotel where you'd most like to stay. Registration information can be accessed at www.annualmeeting.psychiatry.org. (If you don't have your log-in information, call [703] 907-7300.) To reserve your first-choice hotel, reserve through the annual meeting website (above) or call Travel Planners at (800) 221-3531 or (212) 532-1660. Watch *Psychiatric News* for important meeting announcements.

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FROM THE PRESIDENT

Collaborative Care: An Integral Part of Psychiatry's Future

BY JÜRGEN UNÜTZER, M.D., AND JEFFREY LIEBERMAN, M.D.

In 1974 the music critic Jonathan Landau penned a classic article in which he stated, "I have seen the future of rock and roll and its name is Bruce Springsteen." Landau was commenting on his impression of the debut album of the then-fledgling rock star. If you will permit my imaginative analogy, I believe that the same can be said about the collaborative care model with respect to the future of psychiatry. For this reason I invited Jürgen Unützer to co-author this column for *Psychiatric News*.

With the enactment of the Affordable Care Act, the rise of accountable care organizations and patient-centered medical homes, and the increased national attention on mental health, psychiatrists and primary care providers have an unprecedented opportunity to join together and work collaboratively on increasing the overall health of millions of Americans. APA recognizes this opportunity and has been actively involved in efforts to improve integration and collaboration with our primary care colleagues.

As one of the largest medical specialties, psychiatry is an important component of the physician workforce in the United States, but psychiatrists are distributed unequally around the country. More than half of the counties in the United States don't have a single practicing psychiatrist. Only about 1 in 10 adults with a diagnosable mental disorder

receives care from a psychiatrist in any given year and patients are much more likely to receive mental health treatment from their primary care provider than from a psychiatrist. It is well known and often said that 40 percent of primary care (adult and pediatric) involves dealing with psychiatric problems. Our colleagues in primary care are well aware of the substantial challenges related to treating the millions of patients who present with mental health problems in their offices every year and report serious limitations in the support they receive from psychiatrists and other mental health specialists.

Although we have effective pharmacological and psychosocial treatments for most common mental disorders, they are not widely accessible, and only a minority of patients receive them. Many patients are not on medications at therapeutic doses or for long enough to see positive effects, while others continue to use medications even if they are not effective. As few as 20 percent of patients started on antidepressant medications in primary care show substantial clinical improvements. The situation is not much better for those referred for psychotherapy. Many who are referred don't go. Others may receive an insufficient number of visits or ineffective forms of therapy, leaving big opportunities to close the gaps between what we know and what we do.

One way to help close these gaps is for psychiatrists to work more closely with our colleagues in primary care using a collaborative care approach. Originally developed and tested by Dr. Wayne Katon and colleagues at the University of Washington in the early 1990s, collaborative care has been examined in the treatment of depression and anxiety disorders in more than 80 randomized, controlled trials and has consistently been found to be more effective than care as usual. In such programs, psychiatrists work closely with primary care physicians and mental health care managers (usually a licensed clinical social worker, nurse, psychologist, or therapist). Each team has a designated psychiatric consultant who provides systematic treatment recommendations on patients who are not improving as expected.

Effective collaborative care programs follow the established principles of chronic illness care including measurement-based care, treatment-to-target, and stepped care. Each patient's progress is closely tracked using validated clinical rating scales (for example, PHQ-9 for depression), analogous to how patients with diabetes are monitored via regular HbA1c tests. Treatment is systematically adjusted if patients are not improving as expected. Such adjustments can often be made by the primary care treatment team, with input from the psychiatric consultant. This type of systematic treatment-to-target can overcome the clinical inertia that is often responsible for ineffective treatments of common mental disorders in primary care. The psychiatric consultant typically focuses in-person assessments on patients who present special diagnostic or therapeutic challenges. Patients who continue not to respond to treatment, who have an acute crisis, or who prefer to see a psychiatrist in traditional practice are referred to appropriate specialty mental health care.

In Washington state's Mental Health Integration Program (MHIP), for example, which was designed to help low-income or safety-net populations gain

see **From the President** on page 33

Jürgen Unützer, M.D., is professor and vice chair of psychiatry and behavioral science at the University of Washington. Jeffrey Lieberman, M.D., is professor and chair of psychiatry at Columbia University and president of APA.

Candidates Announced!

The names of the candidates running in APA's 2014 election were announced as this issue of *Psychiatric News* was going to press. The names appear below; more information will be published in the next issue. Please note that the slate is considered public, but not official, until the Board of Trustees approves it at its December meeting. The deadline for petition candidates is November 15. For more election information, go to http://www.psychiatry.org/network/board-of-trustees/apa-national-elections.

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PROFESSIONAL NEWS

Aaron Levin

Kennedy Forum

continued from page 1

Health Services Administration Administrator Pamela Hyde, J.D.

President Kennedy's messages to Congress in conjunction with the Community Mental Health Act legislation included references to financing mental health care in the same way as other medical services, the need to overcome disparities, a nod toward what would be called "recovery" today, and references to social determinants of health, Hyde noted.

In addition, current actions extend the "symbolic inspirational power" of the 1963 legislation, said APA President Jeffrey Lieberman, M.D.

"The 1963 act was the first legislation to truly envision how mental health care could be provided in a much more humane and much more effective way in our society," said Lieberman. "Today, you have the Affordable Care Act being rolled out and the final rule on the mental health parity act being issued soon."

Indeed, the long-term historical trend following the 1963 act highlighted the interplay between the overarching vision of fundamental reform and the need for incremental changes along the way, said Howard Goldman, M.D., Ph.D., a professor of psychiatry at the University of Maryland and editor of *Psychiatric Services*. The evolution of the vision and smaller, pragmatic advances over the years frequently received bipartisan support, he said.

Kennedy may have been the quintessential Democrat, but Republican President George W. Bush's New Freedom Commission called for major changes in mental health services and research, Goldman pointed out. Also, the Mental Health Parity and Addiction Equity Act, passed in 2008 during Bush's administration, helped prepare the way for parity language in the Affordable Care Act.

"We need a strategic vision of where to go, and we need strategic incrementalists to help us get there," said Goldman. "So looking through the historic lens, I think the future looks quite bright."

Pardes cautioned that there were likely to be obstacles along the way to a better mental health care system.

"We've made a lot of progress since 1963, but we still have a long way to go," he said. "Simply passing laws is not enough. We must make sure the laws are observed."

Doing so will take vigilance and oversight of how parity is implemented, emphasized Patrick Kennedy. "We need to hold people accountable for what works."

The conference may have been another restarting point for the field, suggested APA Assembly Speaker Melinda Young, M.D.

"The primary value was bringing together professionals from all fields of mental health and giving us an opportunity to talk about some of the big ideas, like parity and the Affordable Care Act—and how they are going to play out," Young told *Psychiatric News*. "Organizations like APA can educate our members about what lies behind the Affordable Care Act, as well as how we can help implement parity and then begin to collect the information coming back from practitioners."

Kennedy closed the Boston conference by urging attendees to prioritize policies and then concentrate on the factors that have the greatest leverage to improve the whole world of mental health care.

The night before the conference, the Kennedy Forum held a gala fundraiser at the John F. Kennedy Presidential Library at which Vice President Joseph Biden and Secretary of Health and Human Services (HHS) Kathleen Sebelius spoke.

Sebelius announced a long-awaited major step—that HHS will "shortly" publish final rules for the 2008 parity law.

During his remarks, Biden noted that advances in the neurosciences have to be coupled with a major effort to end the stigma that keeps people with mental illness from seeking care.

"In 2013, the brain is the new frontier," he said, using the phrase that characterized President Kennedy's administration. "It's time to approach and explore the brain in ways we haven't done before."

Recent research initiatives from the Obama administration will eventually lead to the expansion of that knowledge, but brain research is only half the battle, he said.

"Too many treatments for mental illness and substance abuse go unused, Biden pointed out. "And too many people are left untreated and still suffer silently. The earlier help is available, the better the chance of recovery will be." PN

Information about the Kennedy Forum is posted at http://thekennedyforum.org.

Vision Revisited: 50 Years of the Community Mental Health Act

Fifty years ago on October 31—and just 23 days before he would be assassinated in Dallas—President John F. Kennedy signed the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963."

The act was designed to usher in a new era of community-based treatment of mentally ill individuals, and around the country advocates celebrated the legacy of a vision that—although very incompletely realized—did manage to help transform the care of those with mental illness. The legislation grew out of a major study of the care of people with mental illness undertaken under President Eisenhower, and resulting in 1961 in the report "Joint Commission on Mental Illness and Health: Action for Mental Health."

In an essay in the October *American Journal of Psychiatry (AJP)*, former Congressman Patrick Kennedy, the president's nephew, remarked upon the legacy of what is often referred to as "the CMH Act."

"The law catalyzed a number of positive changes for millions of Americans: the deinstitutionalization of mental health care and the building of community mental health centers throughout the United States to improve access, improve research funding, increase attention to the needs of those with mental retardation, train physicians and other mental health professionals in community-based care, educate about the importance of working in an interdisciplinary manner to serve patients and families, and integrate medical, social, and environmental factors to enhance recovery," Kennedy wrote.

But almost everyone agrees, in retrospect, that the realization of this vision has been thwarted by a variety of obstacles. In an article in *Psychiatric Services* (May 1, 2000) titled "Whatever Happened to Community Mental Health," past APA President Steven Sharfstein, M.D., outlined a history marked by a national ambivalence about the role of the federal government in caring for mentally ill people.

Commitment to that role waxed and waned over the years, but while state hospitals were largely emptied out, dollars didn't follow the patients into the community. Moreover, Sharfstein noted, citizen governing councils at CMHCs tended to give priority to treatment of less severely ill patients. The vision was revived under President Carter with First Lady Rosalynn Carter's "Presidential Commission on Mental Health" and passage of the Mental Health Systems Act in 1980. But the law was later repealed under President Ronald Reagan, and what had been a federal categorical grant program to local communities became block grants to states.

But Sharfstein, who was director of the Division of Mental Health Service Programs at the National Institute of Mental Health from 1976 to 1981, told *Psychiatric News* that celebrating the vision of the 1963 legislation is entirely appropriate. "This was landmark legislation and a bold new approach that initiated for the first time federal leadership and a role in the public mental health care," he said. "The core idea is that to the extent possible people should be taken care of close to where they live and work. I credit the visionaries of that era for thinking about how we might move to a different mode of care."

Kennedy, in his *AJP* essay, suggested that now may be a time to revisit the vision behind the 1963 legisaltion. "An updated vision is required," he concluded. "[T]he time has come for America to boldly explore the `inner space' of our brains with the same verve and collective energy we used to explore outer space under President Kennedy's goal to land a man on the moon by the end of the 1960s.... Indeed, while it may be a half-century late, such an initiative could finally achieve another of his dreams, stated as he signed the CMH bill: '[T]oday, under present conditions of scientific achievement, it will be possible for a nation as rich in human and material resources as ours to make the remote reaches of the mind accessible. The mentally ill and the mentally retarded need no longer be alien to our affections or beyond the help of our communities.' "

"Whatever Happened to Community Mental Health" is posted at http://ps.psychiatryonline.org/article.aspx?articleID=84430#R5151097.

Kennedy Calls Parity More Than an Insurance Issue

The former member of Congress says regulatory guidance from the federal government ensuring transparency with regard to how insurance companies make medical necessity decisions is crucial.

BY MARK MORAN

Parity for treatment of mental illness and substance abuse is a human- and civil-rights issue, said former member of Congress Patrick Kennedy during the "Conversations" event with APA President Jeffrey Lieberman, M.D., last month at APA's Institute on Psychiatric Services in Philadelphia. "Conversations" is an annual event at APA meetings sponsored by the American Psychiatric Foundation in which a well-known person discusses his or her experience with mental illness.

"There is something deeper here that this issue is speaking to," Kennedy said of the campaign for parity. "That's why I think there is an opportunity today to carry this cause forward, not simply as a health care issue or an insurance-discrimination issue, but as a human- and civil-rights issue."

Kennedy and Lieberman spoke for over an hour before a packed hall, and Kennedy, who was instrumental in helping to pass the landmark 2008 parity bill, discussed his journey toward understanding the importance of equal coverage for mental illness and substance abuse. He recounted his mother's struggle with alcoholism and his own problems with addiction, as well as his Aunt Rosemary's intellectual disability.

Lieberman opened the discussion by asking Kennedy why—when he might have used his postcongressional career to go into any field or champion any cause—he chose to be an advocate for mental health.

"Mental health chose me," Kennedy replied. "It was the subject we never talked about in our family, and yet it was ever present in my life growing up. Most people know about my mother's struggles with alcoholism; she was very public with her struggles in the 70s. . . . But we never talked about it in our family. It was the elephant in the room. I was aware of stigma, and internalized it growing up."

He also spoke about the fear and guardedness that pervaded the atmosphere of a family with a famous politician father whose two older brothers had been assassinated. "I remember people carrying firearms all over our house, and people armed with machine guns outside," Kennedy said. "I remember [my father] putting on bulletproof vests before going out. But we didn't talk about it. It was something I lived with . . . but I didn't know I lived with it."

So it was with a bemused irony that Kennedy recounted how he championed the landmark parity bill on Capitol Hill. "I could never have foreseen that I would be going through my own travails, suffering from the same illness my mother suffered from, and being a champion on a policy level for equal treatment of that illness. And insofar as I was the champion of parity, [I could never have foreseen] that I would also be a champion against stigma while I myself was parking my car three blocks away from my psychiatrist's office in Rhode Island."

see **Kennedy** on page 14

Ellen Dallager

Patrick Kennedy talks with APA President Jeffrey Lieberman, M.D., about his personal journey that led him to become a champion of mental health parity.

VIEWPOINTS

A Day to Remember

BY JOSEPH T. ENGLISH, M.D.

Few people fail to remember where they were on November 22, 1963. I will never forget.

For me, the day began with a 10 a.m. appointment at the White House with Stafford Warren, M.D., special assistant to President Kennedy. Dr. Warren was returning to the University of Southern California School of Medicine and had been asked to speak to me about being his successor in this position that involved assisting the community mental health and mental retardation centers program being developed by the Kennedy administration. I was then serving as the first chief psychiatrist of the Peace Corps on loan from the National Institute of Mental Health.

I returned to my Peace Corps office at about 1:15 p.m. and shortly afterward received a call from Mary Ann Orlando, personal assistant to Sargent Shriver. Word had been received of an attack on the president in Dallas, and Mary Ann was being asked to find Mr. and Mrs. Shriver, who were having lunch nearby. Mr. Shriver and his wife, Eunice, sister of the president, returned as the corridors of the Peace Corps headquarters were filled by anxious and devastated staff members. The three of us gathered in Mr. Shriver's office, where wire service reports were given to us by Sam Yette, public relations officer of the Peace Corps. The first one reported a head wound, and a few minutes later he gave me the one that said the president had expired at Parkland Hospital. Nothing in my training or life experience prepared me adequately for such a moment—having to give the sister of the president such a report. Sarge looked at us with tears streaming down his cheeks and said "Let's kneel down and say the rosary for Jack."

A car was sent to bring us to the White House; Sarge asked me to come along to help out. Once there, he received a call from the president's brother, Robert Kennedy, who asked him to take charge of the arrangements for the funeral. I lived in the White House for the next four days.

Sarge worked from a large West Wing office filled with mourning staff who were beginning to realize that their beloved president would return to this house in a way they could never have imagined. Soon, members of the cabinet, high officials of the government, and personal friends of President Kennedy began to arrive, all asking how they could help. How Sarge was able to put aside his personal grief to organize all these grieving men and women into giving advice and consoling each other was remarkable to observe.

In helping Mr. Shriver, there were experiences I will never forget. To mention a few:

I was asked to prepare a traditional Mass card to be distributed at the funeral. When I showed it to Mrs. Kennedy, she asked that "some words the president had said in his first inaugural address were themselves a prayer and that they should replace the traditional prayers" usually found on Catholic Mass cards. "Let us go forth to lead the land we love, asking his blessings and his help, but knowing that here on earth God's work must truly be our own."

She asked Defense Secretary Robert McNamara and me to view the president's remains, which were in a closed casket in the East Room where soon people would be able to come to bid farewell. Some felt that the casket should be open; others felt as strongly that it should not. After Mr. McNamara and I viewed the remains in the casket, which had been opened for us, we both agreed that it would be better for people to remember the president as they had known him rather than as a victim of an assassin's bullet.

President Johnson felt that the funeral would be the way the country and the world would grieve and feel about the tragedy. He made clear that great sensitivity to the wishes of the Kennedy family were paramount. Bill Moyers, then a fellow worker and friend at the Peace

see **Viewpoints** on page 30

Joseph T. English, M.D., a former president of APA, was the first chief psychiatrist of the Peace Corps. Currently he is the Sidney E. Frank Professor and Chair of the Department of Psychiatry and Behavioral Sciences at New York Medical College.

Some Gaps in ACA Coverage Seen For Patients With Mental Illness

Health plan exchanges may not offer a full array of supportive services beyond inpatient and outpatient coverage, but a provision in the ACA allows states to amend their Medicaid plans to include them.

BY MARK MORAN

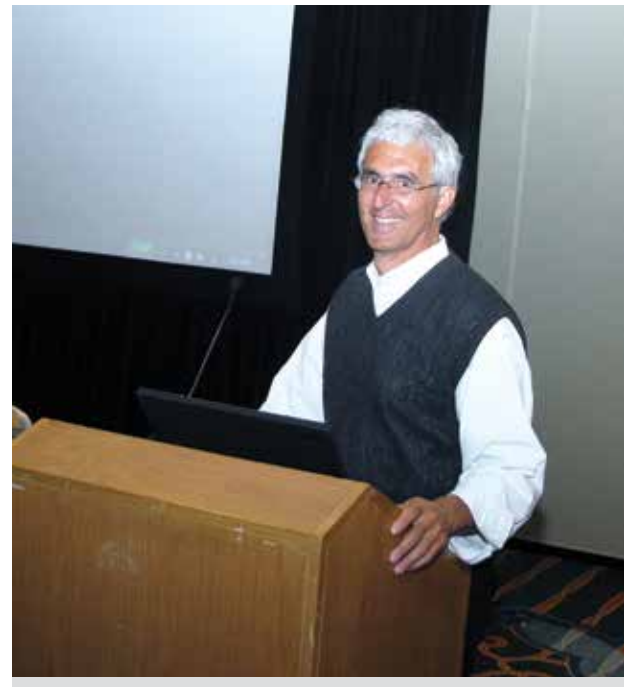
There are some holes in the Affordable Care Act (ACA) when it comes to coverage of mental illness—as well as a few opportunities for improvement that will require attention and advocacy.

That was the message psychiatrist Howard H. Goldman, M.D., Ph.D., delivered to psychiatrists at APA's 2013 Institute on Psychiatric Services last month in Philadelphia. Goldman, who is editor of the APA journal *Psychiatric Services* and chair of the Board of Trustees Health Care Reform Strategic Action Work Group, lectured on the topic "Health Care, Health Insurance, and Psychiatric Services."

Goldman reviewed aspects of the ACA that are bound to benefit patients with psychiatric illness: the removal of exclusions for preexisting conditions and annual and lifetime limits on benefits, the expansion of Medicaid (in states that choose to do so) to include millions more individuals; the opening of health insurance exchanges with plans that may offer subsidies to qualifying individuals; and provisions allowing young people to remain on their parents' insurance until age 26. This last provision, especially, may be vital for individuals being identified and treated in early psychosis intervention programs, he said.

But Goldman also drew attention to areas in which psychiatrists, and APA as an organization, must be vigilant. Among these is the possibility that health plans in the new exchanges could practice subtle forms of selection bias to discourage patients with psychiatric illness.

"There are some problems with the exchanges we need to be concerned about," he said. "There remain incentives for plans on the exchange to stint with respect to mental health coverage and to try to not attract as beneficiaries people with mental health conditions."



Mark Moran

Howard Goldman, M.D., chair of the Board of Trustees Health Care Reform Strategic Action Work Group, says APA must be vigilant to ensure that people with mental illness do not experience discrimination as they seek coverage under the ACA.

Goldman's APA work group is charged with monitoring the rollout of health reform and its implications for clinicians and patients. He said the question of selection bias would be on the work group's agenda. "There are activities under way to better understand this," he said. "It's an area of concern where more information is needed. But I think if plans know that people are looking at this question, they might be less likely to engage in selection practices."

Possibly of more immediate concern to clinicians is that exchange health plans are mandated to provide mental health coverage at parity with general medical coverage—but are not required to provide the variety of ancillary services that some patients with severe mental illness may need. These include rehabilitative and supported housing or employment services.

"The other problem with the behavioral health mandate is that it's a traditional insurance design," Goldman said. "While there is parity, it doesn't mean an insurance company will recognize all the array of services we offer patients. It could be a much more traditional benefit of inpatient, outpatient, and maybe partial hospitalization. We may have to advocate with states to provide these kinds of services that are not covered by the exchanges."

Goldman also drew attention to a little-known provision in the ACA known as 1915i. "That's a provision that says a state may amend its Medicaid plan to include a wide array of home- and community-based health services," he said. "That will require advocacy at the state level, and the Board work group is developing advocacy toolkits to help states and district branches know more about 1915i and to help them work with other stakeholders to get their state Medicaid plans to cover these services."

Goldman concluded: "From my perspective, the ACA is a grab bag of much-needed and much-appreciated elements. But it doesn't do everything for everyone, and there are things we as a professional association can do to monitor [rollout of health reform] and to advocate for additional changes." PN

To listen to an interview with Goldman, go to http://www.psychnews.org/update/audio/HOWARD_GOLDMAN.mp3 or scan the QR code with your smartphone.

Kennedy

continued from page 13

Kennedy emphasized that a final rule from the government providing a regulatory framework for implementing the 2008 law—which at press time was expected imminently—will be crucial. He said transparency in the way insurance companies make medical-necessity decisions will be vital to ensuring the full implementation of parity.

"The exciting thing for all of you is that with health care reform, we are rewriting the rules," Kennedy emphasized. "Organizations like APA need to be even more aggressive than ever before, because we are at a formative point. . . . This is the moment in history when we really have the opportunity to change the landscape."

In comments to *Psychiatric News* commemorating the five-year anniversary of the parity bill, Lieberman had echoed Kennedy's remarks about the importance of the final rule. "Five years after the passage of the Mental Health Parity and Addiction Equity Act, we have yet to realize the goal of this legislation," Lieberman said. "While its passage was a historic milestone—much like the Community Mental Health Act legislation in 1963—the promise of the MHPAEA remains unfulfilled and will until the final rule for its implementation is issued and we are assured of its enforcement. We are grateful for these seminal legislative efforts, which like the civil-rights and voting-rights acts have the potential for transformative change in our society, but will not be satisfied until this law becomes our reality."

After the Conversations event, Lieberman said it had been "a privilege and a pleasure" to discuss mental illness and mental health care with Kennedy. "His comments about his views and personal experience with mental illness, and how it has affected his family, were insightful, inspiring, and refreshing in their candor and sincerity." PN

EXCLUSIVE ONLINE CONTENT

Organizations Protest Suicide Theme of Popular Comic

APA President Jeffrey Lieberman, M.D., was among the leaders of three major mental health organizations that protested a supposedly "humorous" depiction of a suicidal cartoon character. Go to http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1762717.

Prenatal Stress, Gene Variant Interact to Raise Conduct Disorder Risk

Prenatal stress can contribute to development of conduct disorder in children if they possess a particular variant of the dopamine receptor gene. Stress-management training or treatment during pregnancy may help prevent conduct disorder in offspring. Go to http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1765297.

Problem Behaviors in Children Linked to Later Depression

Youngsters who show signs of oppositional defiant disorder at age 13 may have an elevated risk of both depression and delinquency. Go to http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1765298.

Advertisement

CMHC Medical Director Becomes Integrated Care Champion

The effort to integrate primary and mental health care for people with serious mental illness in the community has been an experience of "building the plane while flying it."

BY MARK MORAN

Like many psychiatrists in community mental health, John Kern, M.D., heard an alarm bell in the night when Joseph Parks, M.D., chief clinical director in the Missouri Department of Mental Health, published his data in 2006 demonstrating the high rate of premature death among people with serious mental illness.

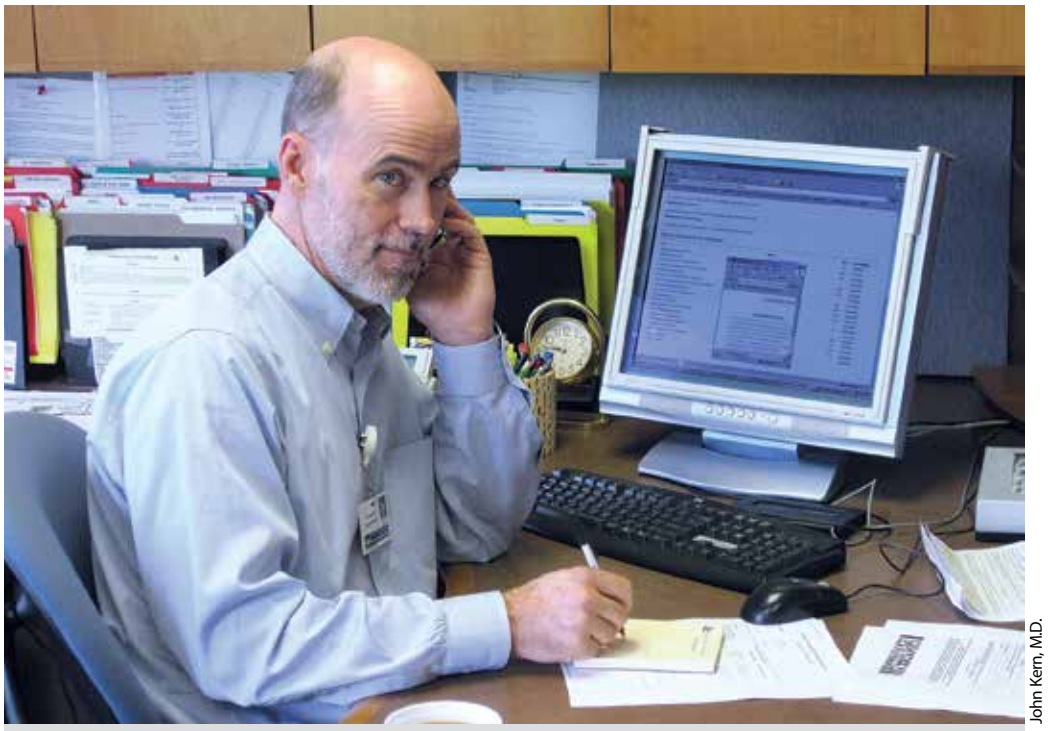
Those data showed that people with serious mental illness were dying on average 25 years earlier than the general population—largely because of complications related to general medical conditions, especially metabolic syndrome. "Those were our patients he was talking about," Kern said.

As the director of Regional Community Mental Health Center in Merrillville, Ind., Kern had spent the previous 20 years doing the familiar tasks of a community mental health center (CMHC) medical director—supervising psychiatrists, providing direct care, and overseeing an inpatient unit—and he was unacquainted (at that point) with the work of Jürgen Unützer, M.D., and the growing movement toward collaborative care.

But in the past seven years, Kern has become a true believer and one of a growing cadre of psychiatrists dedicated to the integration of primary care and psychiatric services for people with serious mental illness in the community. Today, he is working with his staff toward establishing the CMHC as an "FQHC-look-alike" (a special designation of federally qualified health center) with on-site primary care and a range of ancillary services—smoking-cessation classes and diet, nutrition and exercise counseling.

He is project director for a primary and behavioral health care initiative (PBHCI) at the CMHC, funded with a grant from the Substance Abuse and Mental Health Services Administration that provides support to communities to coordinate and integrate primary care services in publicly funded, community-based behavioral health settings. And he acts as the "face" of integrated care—to the CMHC board, fellow physicians in the community, and patients and the public.

Kern told *Psychiatric News* he believes other psychiatrists need to seize this moment of health care reform. "I think psychiatrists need to lead the way," he said. "When you are director of a CMHC, there is always plenty to do, always lots of things to fill up your day. And you can do that and keep doing things the way we've been doing them for a long time, and the moment will pass us by."



John Kern, M.D.

CMHC Medical Director John Kern, M.D., says psychiatrists need to take a leadership role in integrated care.

Building the Plane While Flying It

The path Kern has followed in the last six years is a case example of how psychiatrists can seize the moment: learn the models of integrated care, network with other physicians in the community, make yourself available to primary care physicians, build relationships, and become a leader.

"I started calling around to the local primary care doctors in the community," he recalled. "There was a nearby FQHC [federally qualified health center], and I picked up the phone and called the CEO and said, "Would you be willing to see our CMHC patients?' She said, 'Sure, the more the merrier.'

"Then she said, 'By the way, are you a psychiatrist?' I said yes, and she said, 'Would you come over—*like right now*?' "

'I Became a Part of This Community...'

So began, in 2007, a partnership with the local FQHC providing behavioral health services at two primary care sites. Later, Kern applied for and was accepted into a "learning collaborative" sponsored by the National Council for Community Behavioral Health where he met Unützer and other leaders. "I became a part of this community of psychiatrists interested in expanding integrated care."

Out of that experience, Kern adopted the collaborative care model developed by Unützer and others at the University of Washington, with an "embedded" mental health consultant at the two FQHC sites.

So what does this mean for Kern's day-to-day practice? "I take phone calls through the workday from the behavioral health consultant and occasionally from PCPs about clinical issues as they arise," Kern explained. "I visit the FQHC sites, talk to the PCPs, and supervise the behavioral health consultants, including talking about difficult cases, reviewing registry of ongoing cases, talking about systems issues and refining our model of care. I provide clinical training to the PCP provider staff on behavioral health issues, such as appropriate prescribing practices for controlled substances, the care of bipolar disorder, ADHD, use of meds in pregnancy and the perinatal period, and management of patients with traumatic brain injury. I also work with the FQHC administration on matters related to billing and improving clinical procedures connected to the behavioral health services.

"I'm still a CMHC director with all of those duties," he said. "All of my work with the FQHC is done in about 10 percent of my time."

Kern said it has been an experience of "trying to build the plane while flying it" with some lessons learned along the way. And all of this is happening in the context of a larger payment system that is still in flux. "One of the challenges is that the system is still fluid," he said. "Many of the things we are excited about doing in integrated care depend on a global payment system. Right now if a patient comes to us and gets integrated primary care instead of going to the emergency department all the time, that's saving someone money—but it's not us, and we don't get any credit for it. In a global payment system like the VA or an accountable care organization, you can see the cost savings, and we believe it has real potential to bend the cost curve."

Kern has advice for other psychiatrists he's learned while traveling his long, slightly winding road. "You need to lead the way," he said. Recalling, for instance, when he learned of the opportunity to apply for the PBHCI grant, he realized he would have to write the thing—or no one would. "We didn't have anybody to write grants. I was a CMHC medical director; I didn't write grants. But I realized this was crucial, and if the medical director doesn't step up and write the grant, this program would never happen.

"As psychiatrists, we need to get on board, because this integrated care movement is our best opportunity in decades to make our work more interesting and effective and to help our patients more than we have been able to do." PN

A primer on integrated care through a series of FAQs is posted at http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1742623. Send your questions to cbrown@psych.org. To listen to an interview with Kern, go to http://www.psychnews.org/update/audio/JOHN_KERN.mp3 or scan the QR code at left.

Judges, Psychiatrists Confer on Handling Mental Illness in Justice System

Judges and psychiatrists are putting their heads together to devise ways to temper justice with mental health care for defendants and prisoners.

BY AARON LEVIN

Ellen Dallager

Fred Osher, M.D. (left), and Judge Steven Leifman, co-convened the Judicial-Psychiatric Leadership Forum to address issues of mental illness among people in the criminal justice system.

Psychiatrists and judges must learn more from each other to make headway together in dealing with the thousands of people with mental illness confined in U.S. jails and prisons, said speakers at the Judicial-Psychiatric Leadership Forum in Philadelphia last month.

"Having doctors at the table is important," said Judge Ernie Glenn of San Antonio, Texas. "They understand far less about what we do than they should, and we understand far less than we should about what they do."

Jail should be the last place for people with serious mental illness, rather than the first, emphasized Miami-Dade County Judge Steven Leifman head of the Judges' Criminal Justice/Mental Health Leadership Initiative (JLI) and a long-time champion of reform, addressing the 60 psychiatrists, judges, and court administrators at the forum. "We have the leaders in this room to make a difference and change a horrific policy that has been an absolute, intolerable, unacceptable failure."

There needs to be a mutual recognition by judges and psychiatrists of the need to rehabilitate the prisoner and protect public safety, said Fred Osher, M.D., director of health systems and services policy at the Council of State Governments Justice Center in New York. "I have optimism about the ways we can move forward."

The Judicial-Psychiatric Leadership Forum was cosponsored by the Justice Center, the JLI, and the American Psychiatric Foundation. Leifman is a member of the foundation's board.

Judges have a great advantage when they want to get something done, said former Ohio Supreme Court Justice Evelyn Stratton. "People listen to judges, and judges are used to being obeyed," Stratton noted.

Most of the judges in attendance were already part of the solution, working in mental health, drug, or veterans courts or other specialized dockets.

However, mental health training, perhaps in the form of continuing legal education, should also be expanded to reach judges in the system who do not have experience in specialty mental health courts, said Glenn. Better yet, crossover education should start early in professional training, in law school and medical school.

The two professions could do more at both the beginning and end of a prisoner's sojourn in the criminal justice system, since special mental health courts get only a small number of those with mentall illness. For example, judges could encourage police training to divert people with mental illness to hospitals for evaluation before they are arrested, because it's much harder to get them out of the system once they're inside.

More than 4,000 police officers in the Miami area have been trained to do just that, reducing arrests of people with mental health problems sufficiently to permit. Miami-Dade County to close one of its jails, its Women's Annex, earlier this year. The average number of inmates fell from around 7,400 a year to just 4,800 at latest count, saving about $12 million a year. There was also a 73% reduction in jail bed days.

"Judges and psychiatrists are both interested in gathering information," noted Michael Champion, M.D., director of Champion Forensic Services in Santa Fe, N.M. "Judges can do a good social history but don't know how to turn that into a defined intervention strategy, and information is sometimes blocked on the psychiatrists' side as well, because clinicians are not clear about what the information will be used for. Will it help or hurt the patient?"

Both groups struggled with the problem of transitioning people out of the criminal justice system. Clear release policies and procedures are needed for people with mental illness who are being treated in jail or prison, and then connections must be made with outside mental health providers.

One county found a simple solution: faxing or e-mailing a list of prisoners about to be released to local mental health agencies, said Judge Chad Schmucker, state court administrator for the Michigan Supreme Court. The agencies frequently find the names of released inmates who were already on their client list and reconnect with them after release.

"We need to bring the criminal justice system into the continuity of care," agreed Debra Pinals. M.D., an associate professor of psychiatry and director of forensic education at the University of Massachusetts Medical School.

The dialogue between the two professions has to continue, Leifman and Osher maintained. They want to see more, and larger, meetings like this one, to expand the interactions.

"We need an army of *you*," Osher told attendees. "Let's go back to our communities and work together on this issue." PN

More information on the Psychiatric Leadership Group for Criminal Justice is posted at www.americanpsychiatricfoundation.org/criminaljustice. To listen to an interview with Leifman, go to http://www.psychnews.org/update/audio/JudgesPhila.mp3 or scan the QR code at left with your smartphone.

Psychiatrist Norquist Chairs Outcomes-Research Project

Grayson Norquist, M.D., brings a history of involvement in important research on clinical treatment outcomes, including the CATIE and STAR*D studies.

BY MARK MORAN

Grayson Norquist, M.D.

At the center of any health care encounter is a patient who confronts the clinician with a question: what is the best treatment for this particular individual, with this particular set of symptoms?

Answering that question is the goal of the Patient Centered Outcomes Research Institute (PCORI), created as part of the Affordable Care Act. In the words of the institute's mission statement, it aims to "help people make informed health care decisions and improve health care delivery and outcomes by producing and promoting high integrity, evidence-based information that comes from research guided by patients, caregivers, and the broader health care community."

In September, psychiatrist Grayson Norquist, M.D., became chair of the Board of Governors of PCORI. He was appointed to the board three years ago by the Government Accountability Office (GAO), which oversees the institute, and was nominated for the position by APA. He was chosen by the GAO to be chair when Eugene Washington, M.D., M.Sc., vice chancellor for UCLA Health Sciences and dean of the David Geffen School of Medicine at UCLA, stepped down.

"The reason PCORI was created is to develop information that would inform everyday health care decisions, so that if you are the patient or the caregiver, you have the information you need to make a decision about your health care," Norquist told *Psychiatric News*. "As clinicians, we struggle with this every day—what is the best medication to use for this patient with schizophrenia, or what is the best form of psychotherapy for the patient sitting in front of me right now?

"The whole idea of PCORI is to

*see **Norquist** on page 28*

ASSOCIATION NEWS

APA Gives More Prominence To International Psychiatry

A council devoted to international issues in psychiatry will address research and education beyond the borders of the U.S. and Canada and encourage psychiatrists from around the world to join APA.

BY KEN HAUSMAN

In keeping with its commitment to have APA become more involved in international issues and to encourage international psychiatrists to see the benefits of membership, the APA Board of Trustees voted at its October meeting in Philadelphia to establish a Global Psychiatry Council.

The Board's International Psychiatry Work Group recommended the formation of the council following the May 2012 passage by the APA Assembly of an action paper stressing the need for such a component as issues of international membership, research, advocacy, and education arise. APA previously had a similar council—the Council on Global Psychiatry—that was sunsetted in 2009.

The work group's chair, former APA President Michelle Riba, M.D., told *Psychiatric News* that the Board's vote "reflects APA's strong interest and goals to develop programs and align with colleagues throughout the world on mental health issues. Past President Dilip Jeste set up the work group so that we could review what would be needed in APA's structure to help move the important agenda about global health in the area of education, public policy, improving research, and public mental health. We also appreciate the support of current President Jeffrey Lieberman to extend the work group so that we were able to help bring the action of setting up the council to the Board." Riba is secretary for scientific publications of the World Psychiatric Association (WPA) and a former zonal representative from APA to the WPA.

RHImage/Shutterstock

While the specific charge of the new council has not yet been finalized, it will likely deal with a broad range of international and cross-cultural issues related to global mental health, clinical care, psychiatric training, scientific research, and public education about mental illness and its treatment. The new council is expected to begin its work next May.

At the end of October, 93 countries were represented among APA's nearly 1,500 international members and 63 international distinguished fellows. The largest contingent—189 psychiatrists—is from the Netherlands, followed by Brazil, Australia, India, and the United Kingdom. About 150 psychiatrists have applied for the newly established category of international fellow, and their names will come to the Board of Trustees for approval in December.

While international members cannot vote in APA elections, they have online access to APA journals and receive the same discounts on American Psychiatric Publishing products, annual meeting registration, and online courses as do members in the United States and Canada. PN

Information about international membership and activities of APA's Office of International Affairs is posted at http://www.psychiatry.org/join-participate/international-psychiatrists/office-of-international-activities.

RESIDENTS' FORUM

Lessons We Can Learn From the March on Washington

BY STEVEN STARKS, M.D.

On August 28, our nation commemorated the 50th anniversary of the March on Washington for Jobs and Freedom. The civil-rights organizations leading this demonstration viewed it as an "outpouring of the deep feeling of millions of white and colored American citizens that the time has come for the government of the United States . . . to grant and guarantee complete equality in citizenship of the Negro minority of our population."

In the preceding decades, African Americans faced formidable obstacles to living the promises made in the Emancipation Proclamation. Nowhere was this challenge greater than in the Jim Crow South. There, African Americans were cast in a second-class social order governed by diabolical laws. Despite local governments' efforts to stymie justice with intimidation, imprisonment, and brutality, members of the civil-rights movement chose nonviolent resistance—a mindset of peace with the hope that it would lead to freedom.

Conceptualized by A. Phillip Randolph, a civil-rights pioneer who held many administrations (from Franklin Roosevelt through Lyndon Johnson) to the task of equality, the march tested our collective conscience. Leading up to it, mounting fear and uncertainty about the threat of violence loomed, even among White House officials.

Now, we fondly look back on the day's unity and harmony, highlighted by the more than 200,000 white and black faces present and enhanced by Rev. Dr. Martin Luther King Jr., who presented America with a moral question—Would our country guarantee civil-rights protection to all Americans regardless of race or religion, culture or creed, and gender or socioeconomic status? King noted in his speech that 1963 was "not an end but a beginning." As resilient as civil-rights groups had been prior to the march, afterward they remained firm despite a repeat wave of local governments' retaliation. Through much tribulation, the following years would see passage of the Civil Rights Act and the Voting Rights Act.

As we remember the March on Washington for Jobs and Freedom, 2013 marks another anniversary—the 40th year of the Minority Fellowship Program.

Much of the fellowship program evolved from the context of the civil-rights movement. (Two books, *Black Psychiatrists and American Psychiatry* edited by Jeanne Spurlock, M.D., and *Mental Health, Racism, and Sexism* edited by Charles Willie, Patricia Rieker, Bernard Kramer, and Bertram Brown, provide important historical background regarding this era and challenges to diversity in psychiatry.) African-American psychiatrists, sociologists, psychologists, social workers, nurses, and other leaders in the health field recognized that racism permeated American culture. Many were a part of the movement and noticed a traumatized nation, particularly its traumatized minority populations. African-American psychiatrists led this charge and prompted the National Institute of Mental Health (NIMH) to review its policies and systemic prejudices. Nationally, racism began to be recognized as a major public-health problem with extreme psychosocial ramifications.

Under government pressure, NIMH evaluated its decisions and hiring practices and developed the Center for Minority Group Mental Health Programs. Dr. James Ralph oversaw this center, which evaluated the impact of racial inequity and advocated for minority and disenfranchised groups to assist communities in developing adequate mental health services. Rising to the challenge and acknowledging the importance of both research and clinical training,

see **Residents' Forum** on facing page

Steven Starks, M.D., is a clinical fellow in geriatric psychiatry at Yale University School of Medicine.

Ellen Dallager

William Lawson, M.D., Ph.D. (second from left), points out that African Americans are perceived to be more violent, so a lethal response is considered more acceptable. Others pictured are (from left) Karriem Salaam, M.D., Kenneth Braswell, and Janet Taylor, M.D.

Racism Lingers in Mental Health System

Continued racial discrimination against African Americans worsens disparities in diagnosis and treatment of psychiatric disorders, said speakers at the Institute on Psychiatric Services.

BY AARON LEVIN

The relationship between African Americans and the general and mental health care systems has a rocky history, the effects of which remain today, said several psychiatrists at a session at APA's 2013 Institute on Psychiatric Services in Philadelphia in October.

Physicians in the 19th century used "scientific" arguments to justify black inferiority and the practice of slavery, said Janet Taylor, M.D., M.P.H., a community psychiatrist in New York. In the 20th century, the notorious Tuskegee study from 1932 to 1972 left hundreds of impoverished black men without treatment for syphilis for decades after the discovery of antibiotics that could have treated the disease.

Centuries of discrimination, unequal access to education and employment, and institutionalized racism continue to infuse every aspect of physical and mental health. "Racism has shaped our understanding of status, power, and social stratification," she said. "It has left African Americans with a sense of inferiority and self-hatred, and those negative feelings get internalized."

The problem is especially acute for black men, she said. They frequently have poor general health outcomes, partly because of long delays in seeing a doctor because they don't wish to be seen as "weak."

"Black men have fewer preventive care visits, lower life expectancy, and increased morbidity and mortality from preventable conditions, compared with other demographic groups," she noted.

"There is then a delay in recognizing mental health symptoms because so many physical symptoms must be dealt with first," said Taylor. This "crowd-out effect" only furthers disparities in who gets access to mental health care.

"In addition, African Americans are perceived to be more violent, so a lethal response is considered more acceptable, even if the target individual is mentally ill or just in the wrong place at the wrong time, as in the case of Trayvon Martin," said William Lawson, M.D., Ph.D., chair of psychiatry at Howard University.

Lawson recalled the 2001 U.S. surgeon general's report on mental health, which concluded that blacks were less likely to get mental health services and more likely to get poorer-quality care than whites.

"Blacks are more likely to receive no diagnosis or less-optimistic diagnoses, too." said Lawson. "They are diagnosed with schizophrenia at a much higher rate than whites, despite research showing no actual differences in rates of occurrence, but they receive mood disorder diagnoses less often."

When it comes to treatment, even though pharmacokinetics research has shown that people of African ancestry metabolize many psychotropic drugs more slowly, blacks continue to be prescribed higher doses of medication and are more likely to be exposed to polypharmacy, leading to greater toxicity, he said.

African Americans also have to navigate along a poorly defined line between "mad" and "bad," in Lawson's words. "Aberrant behavior is more likely to send them into the criminal justice system, a punitive approach to mental illness," he said. Once there, they are vulnerable to diseases such as hepatitis, tuberculosis, or HIV that permeate back into the community after release. Mental health treatment begun in prison may be discontinued or delayed on release as well, he emphasized.

While legalized racism has been formally abolished in the United States, more insidious forms, such as racial profiling, still exist, said Karriem Salaam, M.D., a clinical assistant professor of psychiatry at Drexel University College of Medicine.

Less obvious are "microaggressions," a term coined in 1977 by psychiatrist Chester Pierce, M.D., that denotes "subtle, stunning, often automatic, and nonverbal exchanges" with negative overtones, he said. The effects of this on children are especially noteworthy, said Salaam, a child and adolescent psychiatrist: "Increased risk taking, externalizing, and physical aggression" are often the results.

A range of solutions must be used to overcome this combination of history and disparity, Taylor suggested. Early intervention with children is one key, as is teaching black men that taking control of their health is an act of power, not weakness.

Psychiatrists and other physicians might adopt a strength-based approach that focuses on developing self-reliance and resiliency, said Salaam. "But we must also focus on what can be controlled—one's own actions—rather than what cannot be controlled, like the beliefs of others, and develop community-based resources to encourage mental health treatment."

"Ultimately, we must also acknowledge racism and bias in medicine and then eliminate it by developing cultural sensitivity across the health system," said Taylor.

"Whenever psychiatrists meet, conversations like this are important in order to highlight the social injustices that still exist in the U.S. and their profound impact on mental health," noted Annelle Primm, M.D., M.P.H., APA deputy medical director and director of the Office of Minority and National Affairs, who introduced the session. "Having an opportunity to dialogue on this subject can be a catalyst for psychiatrists to become a part of the solution in clinical settings as well as in their communities," she said. PN

Information from APA on African Americans and mental health is posted at http://www.psychiatry.org/mental-health/people/african-americans.

Residents' Forum

continued from facing page

NIMH created the Minority Fellowship Program (MFP) in 1973. This program was to be aligned with professional organizations in the fields of psychiatry, psychology, nursing, and social work. Two decades later, oversight and implementation of the MFP was transferred to the Substance Abuse and Mental Health Services Administration. More recently, MFP training expanded to include marriage and family therapists and professional counselors.

The APA Office of Minority and National Affairs coordinates the APA MFP. To date, more than 600 fellowships offering specialized training in cultural competence, mental health advocacy, and leadership have been awarded. The continued success of APA's MFP spans multiple levels. It offers a direct benefit at the most critical point in a psychiatrist's professional life—during training. Decisions early in one's professional development enrich later career choices. Additionally, the MFP is extra-organizational; it extends from the purview of organized psychiatry within APA to directly influence the local community while emphasizing leadership skills.

As was the case with psychiatrists who confronted NIMH and the civil-rights leaders who challenged Congress, meaningful and long-lasting change occurs when institutional policies are addressed. The APA MFP views its commitment to minorities and underserved groups as the professional responsibility of all members, regardless of whether they are a member-in-training or a distinguished life fellow.

The country's increasingly diverse population and the stubborn persistence of racial disparities highlight the importance of examining our past to shed light on the present. Mental health in America has come a long way, yet the means to effectively coordinate and improve outcomes for all of our patients continues to feel like a ceaseless beginning. PN

Photos: Aaron Levin

Philadelphia's Mural Arts Program builds immigrant communities and connects them with general and mental health care, said Ellen Plumb, M.D. (middle). Artist Shira Walinsky designed two murals, one of mountainous Bhutan (left) and one of an archetypal Asian tiger with patterns derived from Bhutanese, Karen, and Chin Burmese textiles.

Philadelphia Artists, Doctors Ease Immigrants' Access to Care

A special cooperative venture among artists, physicians, and communities of new Americans breaks down barriers to care and creates art in the process.

BY AARON LEVIN

Mental health is up against the wall in Philadelphia.

The city's Porch Light Program uses mural painting as one tool to strengthen community bonds and improve the life of Philadelphia's immigrants. Support for the collaborative initiative comes from both the city's mural-arts program and its Department of Behavioral Health and Intellectual disAbility Services (DBHIDS).

Porch Light (it "symbolizes warmth and security") is not a clinical program, although its role in developing community cohesion and resilience may indeed be therapeutic. Its primary goal is to draw individual immigrants together, often in places like the storefront that houses Southeast by Southeast in South Philadelphia. Artists employed by the city work with them to design and paint walls in the neighborhood.

A presentation about Porch Light and a tour of area murals were cosponsored by APA's OMNA on Tour project the day before the Institute on Psychiatric Services began in Philadelphia in October. OMNA on Tour is a program of the APA Office of Minority and National Affairs.

The murals and other activities in the city's community centers benefit refugees from Iraq, the Democratic Republic of the Congo, Nepal, Burma, and Bhutan who may have been on the run or living in camps for years, said Melissa Fogg, M.S.W., a DBHIDS immigrant mental health specialist. "Talking about their trauma is hard for them."

Artist Shira Walinsky (left) and her assistant, Tasha Billington, prepare buckets of paint for mural makers in South Philadelphia's Mural Arts Program.

Fogg and Ellen Plumb, M.D., have also used a program called PhotoVoice to take pictures and then discuss their observations.

"The participants become visual anthropologists in their own communities," said Plumb, a faculty development and primary care research fellow in the Department of Family and Community Medicine at Thomas Jefferson University. "But it also links needs assessment with community participation."

Discussing their photos reveals differences among the immigrant groups in their responses to migration and resettlement. For instance, the Burmese appreciate the educational opportunities and the greater cultural freedom available for individuals in the United States, while the Iraqis tend to focus on their sense of loss caused by their displacement.

The photographs also reveal disappointments, such as the lack of snow-capped mountains in Philadelphia or the presence of too much trash on the city's streets.

"Trash is a strong mental health stressor," said Plumb, who runs a refugee clinic staffed by medical residents. More than 800 refugees have received physical exams and psychological evaluations there since 2007.

"We changed the way we approach mental health in primary care, and so we talk to these patients differently from the way we would to American-born patients," said Plumb.

Of course, clinic physicians inquire about infectious diseases and other general medical problems, but they also ask why patient became refugees. Who was left behind? Who or what do they miss about their home country or village? The answers may provide insight into possible trauma or extended deprivation that the refugees experienced.

"This tells us much more than 'How are you sleeping?' and starts a more productive conversation," Plumb noted. "Family and community are very important to them."

Drop-in storefronts such as Southeast by Southeast reduce isolation, provide a community connection in a safe space, and let the immigrants embrace their cultural heritage, she explained. "It's an empowering place because it's their space. They have a voice."

That growing sense of community and safety also helps break down cultural stigma that may surround mental health issues and eases the connection to treatment for those who need it, said Fogg. The approach seems to be working.

"This is a special place for our community," said Naw Doh, a neighborhood Burmese leader. "It gives us an opportunity to dream something new." PN

Information about the Porch Light Program is posted at http://muralarts.org/programs/porch-light.

Teens, Adults With Autism Need More Support

More must be learned about the effects and care of the transition from adolescence to adulthood among people with autism, says psychiatrist Fred Volkmar, M.D.

BY AARON LEVIN

In the past, autism was seen as a disorder of very young children. But children grow up, and far too little is known about autism in adults, said Fred Volkmar, M.D., at APA's 2013 Institute on Psychiatric Services in Philadelphia in October.

"Autism is a disorder of variability, and it has a tremendous range within the person, across populations, and across time," said Volkmar, a professor of psychiatry, pediatrics, and psychology at the Yale School of Medicine and director of the Yale Child Study Center.

The social difficulties experienced by people with autism affect how they learn, he pointed out. "A typically developing child takes cues from other people—what they're looking at, how they respond, how they are feeling as shown by the expression on their faces—and integrates those observations with the context," he said. "However, children with autism are more interested in things and prefer consistency and stability and have a gestalt learning style and difficulties in multitasking."

Transitions at each stage of life present challenges for everyone, but adolescents with autism need additional support to cope with new social demands and an awareness of sexuality in themselves and others.

"Outcome studies suggest that some individuals make gains, while others exhibit a decline in function" at this stage, he said.

Preparing adolescents for transition to an adult world requires more than using interventions originally tailored for children, Volkmar maintained. "Adaptive skills must be taught explicitly," he said, recounting the case of one patient who could do complex mathematics in his head but could not order a hamburger and count the change.

Educational transitions take additional effort. College students are not covered by the same laws as elementary and high school students. If college students self-identify as autistic under the Americans With Disabilities Act, they can receive services and accommodations. But many don't do that and may behave in socially transgressive ways that get them expelled from school.

However, colleges also can be havens for people with autism. They offer a structured, predictable environment in which a student can control his or her level of social isolation or interaction. Several universities now have supportive programs for students with autism, and others refer students to supports in surrounding towns.

Once youth with autism reach adulthood, additional issues come into play. Adults with autism have an increased risk of being perpetrators or victims of crime or accidents because of their poor judgment, social isolation, literality, and narrowly focused interests, Volkmar noted, like a man in New York who liked to steal buses and subway trains.

Adults with autism may also develop both physical and psychiatric problems as they age, said Volkmar. A sedentary lifestyle (and some medications) may increase risk of obesity. Anxiety and depression are increasingly prevalent as well.

Ellen Dallager

Fred Volkmar, M.D., says that adolescents being prepared for the transition to adulthold must be explicity taught adaptive skills.

Life after school or college also calls for careful preparation. Ask adults with autism what they want and they will say they'd like safe, secure, quiet places to live and work. However, for more impaired individuals, living and working independently may increase stress and worsen outcomes, he pointed out.

"There are various paths to adult independence and support," he said. "You need a realistic assessment of the individual, covering more than academic factors and extending to functional, social, and vocational matters."

Much more research focused specifically on this cohort is needed to provide the evidence base for their lifelong care, Volkmar stated.

Of the approximately 14,000 papers published on autism, only 23 cover interventions for adults. "We need more and better research on the aging process among people with autism, on services, and on outcome measures," said Volkmar. "Then we need to translate research results into practical applications and disseminate high-quality and understandable information to parents, schools, students, and the public." PN

Information about the Yale Child Study Center is posted at http://www.childstudycenter.yale.edu/index.aspx. To watch an interview of Volkmar, go to http://www.youtube.comwatch?v=vjJVumJSlKE&feature=c4-overview&list=UUAPLZ4LG-XJgNSB43MbCLRg or scan the QR code with your smartphone.

Gene Variants May Contribute to Bipolar Illness by Changing Brain

Although variants of the CACNA1C gene and the ANK3 gene may contribute to bipolar disorder by acting on an area of the brain involved in processing facial emotions, how they might do so is a mystery.

BY JOAN AREHART-TREICHEL

Two genes are known to influence neuronal firing by modulating calcium and sodium channel functions, respectively. Both affect nerve activation and nerve connectivity in the brain. One gene, called CACNA1C, is located on chromosome 12. The other gene, ANK3, is located on chromosome 10.

One variant in the CACNA1C gene and one variant in the ANK3 gene have been linked with bipolar disorder. A brain area involved in the processing of facial emotions has also shown an association with bipolar disorder. Facial affect is processed mainly in a right-sided network that involves occipital and temporal regions of the ventral visual pathway within the inferior occipital gyrus, fusiform gyrus, amygdala, and ventral prefrontal cortex.

Therefore, Sophia Frangou, M.D., Ph.D., of the Icahn School of Medicine at Mount Sinai in New York City, and colleagues decided to evaluate whether having the CACNA1C gene variant linked with bipolar disorder as well as the ANK3 gene variant also linked with the illness showed a relationship with the brain area involved in processing facial emotions.

Their study included 87 subjects—41 with bipolar disorder and 46 healthy controls. Some of the bipolar subjects had the CACNA1C gene variant of interest and some did not. Some of the healthy controls had the ANK3 gene variant of interest and some did not.

The researchers used functional MRI to analyze the activity of the facial-affect-processing area of the subjects' brains while they were viewing emotionally provocative faces. The researchers then assessed whether they could find an association between the two gene variants of interest and facial-affect-processing brain activity.

They did find such a link in both controls and bipolar subjects. However, the associations were somewhat different between the two groups.

In control subjects, looking at emotionally arousing faces increased activity in the entire facial-affect-processing region of the brain. And those controls who had either of the gene variants of interest showed even more activity in the facial-affect-processing region than did controls without the gene variants.

*see **Gene Variants** on page 31*

Cognitive Decline in HIV/AIDS Linked to Lipid Disorder

Risk factors found in cerebrospinal fluid increase the likelihood that individuals with HIV disease will develop dementia or other neurocognitive disorders.

BY VABREN WATTS

In September the World Health Organization reported a 21 percent drop in HIV-related deaths since 2008. Though advancements in antiretroviral (ARV) therapies have contributed significantly to this decrease, ARV therapies have not reduced the rates of HIV-associated neurocognitive disorders (HAND), which can put infected individuals at a higher risk for mortality.

Norman Haughey, Ph.D., an associate professor in the Department of Neurobiology and Psychiatry at Johns Hopkins University School of Medicine, led an investigation to identify metabolic factors that may contribute to HAND.

"Approximately 50 percent of HIV-infected subjects will develop some form of mild cognitive impairment—ranging from difficulties in counting money to frank dementia," Haughey told *Psychiatric News*. "We don't understand why—despite adequate viral suppression by antiretroviral therapies—some subjects still develop cognitive impairment. Our [recent] work has begun to unravel the molecular aspect of neurocognitive decline, which pointed us toward lysosomes."

Lysosomes are responsible for breakdown of waste and metabolites, such as lipids, in cells. When lysosomes are dysfunctional, it can be damaging for neurons and other cells, leading to profiles similar to that of lysosomal storage disorder—which is defined by lipid accumulation.

"Dyslipidemia is common in HIV-infected individuals, and in some cases this condition is increased by ARV medications," said Haughey. He explained that HIV-associated dyslipidemia is most often noted in the blood and is characterized by elevated levels of cholesterol and other fat derivatives, such as sphingomyelin, that affect the cardiovascular, renovascular, and neurovascular systems.

"What has not been reported," he added, "is that these [fat derivatives] are also elevated in the cerebrospinal fluid [CSF]."

Diverse Population Studied

In the current study, published September 11 in *Neurology*, Haughey and colleagues enrolled 291 HIV-positive and 30 HIV-negative individuals to assess the correlation between CSF lipid content and ARV therapies with HAND progression. The longitudinal study was performed at seven U.S. sites, including ones in Hawaii and Puerto Rico, to ensure that the study population was diverse.

CSF was collected from each participant and evaluated for cholesterol and sphingomyelin concentrations. Cognitive impairment was measured by the Memorial Sloan-Kettering (MSK) Dementia Severity Scale. Participants were measured on all parameters at baseline and during a one-year follow-up.

ARV drug classes prescribed to treat HIV infection included protease inhibitors, nucleoside reverse transcriptase inhibitors (NRTIs), nonnucleoside reverse transcriptase inhibitors (NNRTIs), and integrase inhibitors.

HIV Infection Alters Lipid Profiles in CSF

At baseline, HIV-positive individuals could be distinguished from controls by elevated levels of CSF cholesterol, which was further increased by an average of 50 percent by ARV therapy—in particular, NRTIs and NNRTIs. There was no difference in overall MSK scale scores among subjects from baseline to follow-up.

At follow-up, elevation of a single sphingomyelin and reduction of cholesterol esters, a less water-soluble form of cholesterol, were predictive indicators for the onset of HAND in the HIV-infected cohort.

"This suggests that this dyslipidemia that occurs in the periphery may also occur in the central nervous system and seems to be related to a particular class of drugs," said Haughey. He noted that NRTIs and NNRTIs are generally the first line of therapy for HIV viral suppression.

"Prior to ARV therapy, neurocognitive impairment occurred at a quicker rate and was very progressive. After ARV [therapies], there was still a forward progression, but it was milder," he explained. "People are living longer, and impairment onset is variable."

When asked about the clinical implications of his research, Haughey said, "It's good to remember that rates of cognitive impairment [in HIV-infected individuals] are quite high. The rates of comorbid depression and other psychiatric disorders are also quite high, and sometimes it's difficult to tease these conditions out. From our studies we hope to have a biomarker that can be identified very early in HIV [positive] subjects who seem perfectly normal by any cognitive test but whose lipid profiles indicate that they are at risk for cognitive impairment."

"Neuroprotective therapy works best prior to neurocognitive damage. . . . Several trials have failed trying to reverse it," he concluded.

The study was funded by the National Institutes of Health. PN

"A Lipid Storage-like Disorder Contributes to Cognitive Decline in HIV-Infected Subjects" is posted at http://www.neurology.org/cgi/pmidlookup?view=long&pmid=24027056.

Key Points

Approximately 50 percent of HIV-infected individuals experience neurocognitive decline, along with dyslipidemia in peripheral tissues. Researchers studied the relationship to cognitive decline of HIV infection, antiretroviral therapies, and fat content in the central nervous system. They found that

- HIV infection increases cholesterol in cerebral spinal fluid (CSF).
- Antiretroviral drugs—in particular nucleoside reverse transcriptase inhibitors (NRTIs) and nonnucleoside reverse transcriptase inhibitors (NNRTIs)—further increase CSF cholesterol content.
- Alterations in the fat derivatives sphingomyelin and cholesterol esters were predictive of the onset of HIV-associated neurocognitive disorder.
- Researchers hope that early detection of CSF lipid profiles for neurocognitive disorders in people with HIV will prompt a regimen of neuroprotective therapies before cognition declines.

FROM THE EXPERTS

Living in the Eternal Present: A Case of Failed Memory

BY TREVOR HURWITZ, M.B., CH.B., AND WILLIAM PANENKA, M.D., M.SC.

In 1982 a 23-year-old Caucasian male developed a flu-like illness, accompanied by vomiting, headache, disorientation, and insomnia. He was diagnosed with herpes simplex virus (HSV) encephalitis and treated with antiviral medication.

Profound memory problems were immediately apparent. His short-term memory was most affected. Long-term memory was less affected. He confabulated extensively. Attention and working memory were relatively unaffected. Procedural memory, as judged by his ability

to perform daily grooming tasks, was unaffected.

MRI of his brain showed dramatic cystic encephalomalacia involving the anterior two-thirds of the right temporal lobe and approximately one-half of the anterior left temporal lobe. The tissue destruction also extended into the cingulate gyri and orbitofrontal cortices bilaterally.

There has been little improvement in his memory. His attention remains mostly intact. Recent verbal and nonverbal memory remains impaired. He can name common objects, but cannot name or describe the function of modern objects such as computers, compact disks, or pagers. He cannot, when asked, place himself into yesterday by providing details of what he did or the circumstances in which he found himself. Similarly, he cannot, when asked, imagine a tomorrow by providing any immediate or long-term plans or desires. He has neither recent memories nor any future hopes and exists entirely in the present. Not

see **From the Experts** on page 31

Trevor Hurwitz, M.B., Ch.B., is a clinical professor of psychiatry at the University of British Columbia and medical director of the British Columbia Neuropsychiatry Program. William Panenka, M.D., M.Sc., is an assistant professor of psychiatry and a researcher in the British Columbia Neuropsychiatry Program. Hurwitz is a coeditor and Panenka is a contributor to the *Casebook of Neuropsychiatry*, published by American Psychiatric Publishing. The book, which APA members may purchase at discount, may be ordered at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62431.

Expert Says Early Identification Of Psychosis Should Be Priority

A leading researcher discusses a unique endeavor in Philadelphia looking at genetic, neurodevelopmental, and behavioral observations to track thousands of individuals over time.

BY MARK MORAN

Early identification of psychosis should be a priority, made possible by a growing research base that is bringing together genetic, neurodevelopmental, and behavioral observations to provide a picture of the unfolding psychotic process over time.

That's what Raquel Gur, M.D., told psychiatrists at APA's 2013 Institute on Psychiatric Services in Philadelphia. She is a professor of psychiatry and vice chair of research development in psychiatry at the University of Pennsylvania.

She noted that early identification has become a leading priority at the National Institute of Mental Health and said it should be a "national priority," spurred in part by publicity surrounding recent incidents of gun violence that have involved mental illness. Gur outlined the challenges confronting this effort—especially the unique complexity of psychosis, its multidimensional nature, and heterogenous presentation—as well as the tools that are becoming available to meet these challenges.

The latter include the use of large "informative samples"—cohorts of individuals with at least two first-degree relatives with schizophrenia—genetic risk studies that follow individuals with a known genetic vulnerability over time, the development of structured interview tools for assessing risk, and a large and growing number of intervention programs in the United States, Europe, and Australia. Finally, she described a unique longitudinal research project in Philadelphia that is combining genetic, neurodevelopmental, neuroimaging, and behavioral data to follow a large cohort of young people.

"It is time we do it," she said. "We need to investigate the precursors that will allow us with increased confidence to detect early [those at risk for psychosis]."

'We Aren't Done When We Are Born'

Gur said the effort to identify psychosis in its early developmental stages is not different from prevention strategies in other areas of medicine, noting that much clinical cardiology now involves strategies aimed at reducing stress, increasing exercise, and promoting better diet and other behavioral changes designed to reduce the risk for cardiovascular disease in individuals at risk.

"It's no different for psychosis," she said. "When someone presents with a risk, we cannot send them away until they meet *DSM* criteria for schizophrenia. So we share a common goal with medicine regarding any other disorder—namely, that we would like to prevent the consequences of a serious and complex disorder through early identification and intervention."

Mark Moran

Raquel Gur, M.D., notes that people who later develop acute psychosis begin to deviate from developmental norms as early as age 10. "So the train toward psychosis leaves the station early, and we are trying to capture it before it derails."

But she acknowledged obstacles and challenges that are unique to psychosis. Principal among these is the stigma associated with psychiatric illness. Also, the complexity of the brain and of psychosis is uniquely daunting. She said early notions that schizophrenia may be related to a "lesion" in the brain have been discarded with the emergence of genetic and neurodevelopmental data showing instead that psychosis is a disorder of neurocircuitry.

Additionally, there are multiple risk genes and epigenetic factors—such as in-utero events—that may influence the development of psychosis. These are all influenced developmentally over time by an individual's environmental experience. "Experience matters," Gur said. "The brain continues to develop and change throughout life. We are not done when we are born."

It is this etiological complexity and neurodevelopmental evolution that accounts for the "rich phenotypic expression" of schizophrenia, she said. "It's fascinating; every patient is an individual. . . . When we write in a clinical note that the patient has 'delusions,' it's a code for communicating with other clinicians. But it doesn't capture the richness and complexity that differentiate one individual from another."

She noted that evidence has accumulated showing that people who later develop acute psychosis began to deviate from developmental norms as early as age 10. "So the train toward psychosis leaves the station early, and we are trying to capture it before it derails," Gur said. "When it derails, it's too late. So what we are looking for are signs to help us identify people at risk and get them as close to the developmental curve as possible."

To meet these challenges, instruments and research methods have been developed at academic medical centers to help "dissect" psychosis. These include a number of population-based studies using very large cohorts of patients, typically in European countries with relatively stable, homogenous populations and large databanks.

First-Degree Relatives Studied

There are also smaller studies looking at "informative samples"—cohorts with two or more individuals having first-degree relatives with schizophrenia; she said some 50 families in Pennsylvania meeting this criterion are being followed.

Additionally, there are individuals with a known specific genetic risk factor that can be similarly followed. Gur noted that the "22Q11.2 deletion syndrome" is known to account for multiple medical problems, including schizophrenia. "In terms of presentation and response to treatment, they are no different from other people with schizophrenia, but because we know the risk, we can follow them from an early age, and we can see the psychotic process unfold."

Moreover, many prevention programs have grown up in North America, Europe, and Australia using behavioral interventions for youth deemed to be at ultra-high risk for psychosis. A Structured Interview for Prodromal Symptoms (SIPS) has been developed by Thomas McGlashan, M.D., and colleagues at Yale that has proven effective in identifying ultra-high-risk individuals.

Ultimately, Gur said, research efforts at academic medical centers need to be translated into community settings. She described an extraordinary initiative—the Philadelphia Neurodevelopmental Cohort—that seeks to describe how genetics impact trajectories of brain development and cognitive functioning in adolescence and understand how abnormal trajectories of development are associated with psychiatric symptomatology.

Nearly 10,000 youth aged 8 to 21 presenting at Children's Hospital of Philadelphia for nonpsychiatric reasons have received a comprehensive genetic, psychiatric, and cognitive assessment, with a subsample of these participants receiving multimodal neuroimaging.

Participants received a one-hour computerized neurocognitive battery to evaluate a broad range of cognitive domains: executive control and mental flexibility, attention, working memory, episodic memory, verbal reasoning, nonverbal reasoning, spatial processing, social cognition, and sensorimotor and motor speed. Psychopathology was assessed using a computerized structured screener known as GOASSESS that was developed from a modified version of the Kiddie-Schedule for Affective Disorders and Schizophrenia.

Gur said such research will in time yield more positive predictive information about psychosis risk. "If we can understand behavior and how it is linked to the brain and to the processes of genetic vulnerability, we can put it all together and come up with treatments," she said.

Gur concluded by saying that families and young people at risk often endorse symptoms of subthreshold psychosis and express a desire to participate in research and treatment. "They know that something is going on, and their ability to talk about it with someone is a relief, when we can say as clinicians, 'We understand what you are going through.'

"We have the tools [for early identification and intervention]," she said. "They are not perfect, but the effort is important and doable." PN

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Global Genome Initiative Finding Roots of Mental Illness

By sharing data, technology, expertise, and new discoveries, researchers are quietly but rapidly pushing forward to reveal the genetic and biochemical causes of psychiatric disorders.

BY JUN YAN

This is the first of a two-part series on the state of the art in studying the genetics of mental illness. Part 2 will look at advances in research on the genetics of schizophrenia.

Story Driven Multimedia

Patrick Sullivan, M.D., is one of the founders of the PGC, a coalition including "nearly all researchers in the field of psychiatric genetics."

The past few years have seen a flurry of genomewide association studies (GWAS) reporting newly discovered, statistically robust genetic variants linked to schizophrenia, bipolar disorder, and attention-deficit/hyperactivity disorder (ADHD). The field of psychiatric genetics seems energized once again.

For example, a recent study uncovered 22 locations on chromosomes (loci) associated with increased risk of schizophrenia (*Psychiatric News*, October 18), and cross-disorder analyses pointed to overlaps of risk loci among five psychiatric disorders (*Psychiatric News*, April 5, September 17). Several genes have emerged as potential links in the chain of biological dysfunction. These discoveries are robust and replicable, with convincing statistical power.

Behind the progress is a worldwide collaboration called the Psychiatric Genomics Consortium (PGC), which has united most researchers in the field and created a synergy that is rapidly advancing the biochemistry of mental illness. The consortium has already produced tantalizing clues about the nature of these disorders, with the promise of a lot more to come.

Previously, twin and family studies estimated that psychiatric disorders are partially heritable and that some, such as schizophrenia, bipolar disorder, ADHD, and autism, are highly (70 percent to 80 percent) heritable. However, early searches for disease-causing genes have not turned up major contributors that follow the Mendelian inheritance pattern. Scientists have been hunting for the culprit genes for over a decade in common variants, rare variants, and copy number variants (CNV).

Early genetic studies found a handful of candidate genes in schizophrenia and bipolar disorder that each contribute to only a very small percentage of illness in all patients, which led scientists to believe that psychiatric disorders each involve a large number of disease-related genetic defects. GWAS in other multifactorial diseases, such as diabetes, cardiovascular diseases, and autoimmune diseases, demonstrated that the smaller a gene's contribution to disease risk, the larger the study sample has to be in order to detect it while weeding out false "hits."

It became apparent that psychiatric genetic research needs big datasets, big tools, and "big science."

Thus, consortia in the United States, United Kingdom, and Europe were formed to pool separate genomic datasets to achieve large sample sizes. In 2007, the PGC emerged to "conduct meta-analyses of genomewide genetic data" collected from patients with various psychiatric disorders, according to the consortium's Web site (http://pgc.unc.edu).

The PGC is a coalition of, to date, approximately 400 scientists from 25 countries, encompassing "nearly all researchers in the field of psychiatric genetics," Patrick Sullivan, M.D., a professor of genetics and psychiatry and director of the Psychiatric Genomics Department at the University of North Carolina School of Medicine, told *Psychiatric News*. Sullivan is a founding member of the PGC and coordinates the major depressive disorder (M.D.D) analysis group.

As researchers around the world independently conduct their studies, the genotyping data of patients, families, and controls they have collected are forwarded to one of several repositories, including the National Institute of Mental Health Genomics Resource and Repository (https://www.nimhgenetics.org), the database of Genotypes and Phenotypes (dbGaP, http://www.ncbi.nlm.nih.gov/gap), and the Wellcome Trust Case-Control Consortium (http://www.wtccc.org.uk).

Initially, the datasets included schizophrenia, bipolar disorder, M.D.D, autism, and ADHD. Recently, genotyp-

see **Genome Initiative** on page 32

Antisocial Behavior Raises Violence Risk In Some Psychosis Patients

Since individuals with a history of antisocial behavior before a first-episode psychosis are at higher risk for violent behavior than individuals without such a history, treatment targeted only at psychotic symptoms may not be enough to prevent violence.

BY JOAN AREHART-TREICHEL

The first episode of psychosis may represent a period of heightened risk for violence, recent studies have suggested. Yet determining which individuals are at risk for such violence is difficult.

Now some guidance has emerged from a prospective study published online October 2 in *JAMA Psychiatry*. Patients who have been engaging in antisocial behavior for some time before experiencing a first episode of psychosis may be especially in jeopardy of engaging in violence after the episode.

Heading the study was Swaran Singh, M.D., a psychiatrist and head of the Division of Mental Health and Wellbeing at the University of Warwick Medical School in England.

The study included 670 young adults being treated at five treatment locations in England for a first episode of psychosis. They were evaluated at baseline with a self-report instrument called the PAS School Adaptation Scale to assess whether they had engaged in antisocial behavior during childhood, early adolescence, or late adolescence.

Examples of antisocial behavior were truancy, vandalism, or disciplinary problems. Forty-nine percent of the subjects were found to have engaged in stable low levels of antisocial behavior, 29 percent in stable moderate levels of antisocial behavior, 13 percent in stable high levels of antisocial behavior, and 10 percent in early-adolescent-onset high-to-moderate levels of antisocial behavior.

At six months and 12 months after the study began, the subjects were evaluated with the Adverse Outcomes Screening Questionnaire to determine whether they had engaged in any violent behavior during the previous six months. Physically harming another person was considered violent behavior; 14 percent of the cohort were violent at the six- or 12- month follow-up.

Finally, the researchers assessed whether the subjects' antisocial behavior histories had a bearing on whether they engaged in violence during the six months or one year following their psychotic episode.

Nine percent of the group with stable low levels of antisocial behavior, as well as 9 percent of the early-adolescent-onset high-to-moderate levels of antisocial behavior group, engaged in

see **Antisocial Behavior** on page 32

Two Factors May Impact Prognosis for Depression

When major depression is accompanied by anger or irritability, patients' treatment prognosis is less optimistic than when the disorder appears without these two traits.

BY JOAN AREHART-TREICHEL

People with major depression are often irritable and angry as well, and such individuals tend to experience a more severe depression and to have a less favorable long-term outcome than those who are depressed without these accompanying characteristics.

These findings emerged from a 31-year prospective study headed by Lewis Judd, M.D., chair of psychiatry at the University of California, San Diego, and a former APA president, and published online September 11 in *JAMA Psychiatry.*

Darin Dougherty, M.D., an associate professor of psychiatry at Harvard Medical School who has researched the biological underpinnings of anger plus depression, told *Psychiatric News* that the new study "supports previous smaller studies reporting a high incidence of anger and irritability during major depressive episodes. Most important, in addition to the additional burden these symptoms place on the patient and those around them during the depressive episode, this study demonstrates that the presence of anger and irritability during major depressive episodes is associated with greater severity and worse long-term outcomes."

The study included 536 individuals who had been diagnosed with unipolar major depression from 1978 to 1981 at academic medical centers in Boston, Chicago, Iowa City, New York City, and St. Louis. The Schedule for Affective Disorders and Schizophrenia was used to diagnose the subjects for unipolar major depression and to evaluate them for symptoms of irritability and anger independent of manic or hypomanic symptoms.

More than half the subjects had clinically significant irritability or anger at study intake, the researchers found. They were more likely to be younger, male, less well educated, to have more severe depressive symptoms, and to engage in irresponsible, reckless, or antisocial behavior, compared with subjects in the group without irritation and anger.

> "[T]he presence of anger and irritability during major depressive episodes is associated with greater severity and worse long-term outcomes."

The researchers then followed the subjects for 16 years on average and compared the outcomes for the two groups.

Compared with the nonirritable group, subjects who had anger and/or irritability in addition to depression took considerably longer to recover from the major depression they had at the start of the study—on average 91 weeks versus 49 weeks.

In addition, during the years of follow-up, the irritable group was significantly more likely to experience affective symptoms, an affective episode, or a major affective episode; to have substance use disorders or anxiety disorders; to have difficulties with their partners or trouble performing at work or school; and to experience a lower quality of life.

Thus it looks as if major depression accompanied by irritability and anger represents a more severe, complex, and chronic illness than major depression without these factors, Judd told *Psychiatric News.* "And, as such, it deserves careful [clinical] attention," he stressed.

"The results of our study [also] support the possibility that unipolar depression with overt irritability/anger may be a marker for a distinct subtype of unipolar major depressive disorder," Judd and his group suggested in their report.

Maurizio Fava, M.D., a professor of psychiatry at Harvard Medical School, is convinced that there is such a subtype, based not just on this study, but on his extensive research during the past several decades, he said in an interview. Several of the findings in this new study also confirm several of his earlier findings, he noted—for example, that anger and irritability are common in depressed patients and that patients who are irritable and angry as well as depressed have a form of unipolar depression, not bipolar disorder.

However, Jan Fawcett, M.D., a professor of psychiatry at the University of New Mexico who headed the *DSM-5* Work Group on Mood Disorders, is more skeptical about the combination of anger, irritability, and depression constituting a subtype of major depression, he told *Psychiatric News.* "To alter major depression criteria as much as major depression has been studied, you need a lot of data to add a subtype," he explained. "[For example,] we had enough data on the effect anxiety has on outcome to add an anxiety specifier across all mood disorders, but not enough to create a new subtype." In contrast, he said, a "major depressive episode may represent over 20 subtypes that have not yet been defined."

The study was funded by the National Institute of Mental Health. PN

An abstract of "Overt Irritability/Anger in Unipolar Major Depressive Episodes" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=11737169.

Norquist

continued from page 17

develop this kind of information but make it patient-centered, so that at front and center of everything we do are the needs of patients," Norquist said. "We want to promote through our funding and infrastructure development high-integrity, evidence-based information that can be used to guide patients and caregivers and the broader health care community in improving health care."

Norquist brings to the task a long history of experience with patient-centered outcomes research. For 15 years he worked at the National Institute of Mental Health (NIMH). There, Norquist was director of the Division of Services and Intervention Research, which was responsible for clinical, prevention, and services research. In that role, Norquist was instrumental in helping to instigate two of the most fruitful—and highly publicized—treatment outcomes trials: the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) and the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE).

After leaving NIMH, Norquist returned to his native Mississippi because he had a passion for disseminating best practices to underserved populations. Currently he is professor and chair of the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center in Jackson. His research focuses on the use of telemedicine to reduce disparities in mental health treatment for those living in the Delta region in Mississippi and to improve the quality of care they receive at local community health centers.

The 21-member board of governors of PCORI includes two fixed positions for the director of the National Institutes of Health (Francis Collins, M.D.) and the director of the Agency for Health Research and Quality (Richard Kronick, Ph.D.). The rest of the board includes representatives of patients and caregivers; health care providers from academia and private practice; health researchers; developers of pharmaceuticals, devices, and diagnostics; the health insurance industry; and the business and employer community.

As chair, Norquist is responsible for leading this diverse group in developing an agenda to meet the priorities of the institute. In 2012, the PCORI board adopted the report "National Priorities for Research Agenda," which identified 10 priority areas of interest: prevention, acute care, care coordination, chronic disease, palliative care, patient safety, engagement, overuse, information technology, and the impact of new technology.

Since its inception, PCORI has approved 147 awards, totaling more than $243 million over three years, to fund patient-centered, comparative clinical-effectiveness research projects under the five priorities.

Norquist is dedicated to improving patient-centered outcomes research in all areas of medicine, but he noted that mental health-related research is among the leading award winners at the institute. Currently the institute is funding, among other mental health-related projects, research comparing the effectiveness of treating maternal depression to improve fetal health, improving psychological distress among critical illness survivors and their informal caregivers, and developing "decision algorithms" to help people make decisions about their own mental health care.

Norquist said he hopes psychiatrists with take an interest in PCORI. Even those not actively involved in research are invited to participate in review groups, reviewing the Institute's grants. And clinicians can partner with a PCORI researcher to help ensure, as Norquist says, that research is grounded in the real-world of clinical care. Finally, he said PCORI would be looking to APA for help in determining what kinds of research would be most useful to psychiatrists and patients.

"Having a psychiatrist as chair of the board of governors of PCORI is a sign, I believe, of how far we have come as a field, and how important we are to the rest of medicine," he said. "I also think it signals recognition that what PCORI is doing is something we have been trying to do in mental health for a long time, which is really trying to engage with our patients. We in mental health have been a leader in this area and I think we have an opportunity to get more engaged on this topic with the rest of our colleagues in health care." PN

JOURNAL DIGEST

BY VABREN WATTS

Children With ASD Have Poor Sleep Quality

A study published in the *Archives of Disease and Childhood* followed 8,000 children from birth until age 12 to evaluate sleeping patterns associated with autism spectrum disorder (ASD).

The results showed that around age 3, children with ASD were more prone to sleep an average of 30 minutes less than their peers without ASD. Sleeping time lost by children with ASD was attributed to their likelihood to awaken three or more times during the night. This observation remained consistent after adjusting for factors such as birth prematurity and social class.

The authors acknowledged that the long-term impact of shortened sleep patterns in children with ASD is unknown. They pointed out that other researchers have suggested that sleep loss may have an impact on neuronal development; however, this must be confirmed through additional studies.

Humphreys J, Gringras P, Blair P. "Sleep Patterns in Children With Autistic Spectrum Disorders: A Prospective Cohort Study." 2013. Arch Dis Child. Sep 23. [Epub ahead of Print] http://adc.bmj.com/content/early/2013/08/22/archdischild-2013-304083

Protein May Be Able to Relieve AD-Associated Toxicity

Scientists at the University of Western Ontario in Canada discovered that adjusting the levels of a protein called stress-inducible phosphoprotein 1 (STI1) can prevent neuronal toxicity through inhibiting specific protein interactions with amyloid-beta—a factor that appears to be key in the progression of Alzheimer's disease (AD).

"When we studied the brains of people with AD, we saw that STI1 levels were increased. We think of this increase as a compensatory response that could protect against insults from amyloid-beta [interactions]," said Marco Prado, Ph.D., a study author and professor in the Department of Pharmacology.

To test their hypothesis, Prado and colleagues manipulated STI1 concentrations in mouse neurons. They observed that when STI1 levels were decreased, the neurons were more sensitive to amyloid-beta attack, whereas increased STI1 levels resulted in less sensitivity to amyloid-beta.

The researchers concluded that although AD is a very complex disorder, their findings provide additional clues about which proteins can help the brain achieve toxicity resistance during the progression of AD.

Ostapchenko, V, Beraldo, F, Mohammad, A. "The Prion Protein Ligand, Stress-Inducible Phosphoprotein 1, Regulates Amyloid-β Oligomer Toxicity." 2013. J Neuro Sci. October 16, 33(42):i. http://www.jneurosci.org/content/33/42/16552.abstract

Cocaine Makes Immune Cells More Vulnerable to HIV Entry

Researchers at the University of California at Los Angeles AIDS Institute collected CD4 T cells—immune cells that are highly susceptible to damage during viral infections—from healthy human donors to assess the rate of HIV infection in the presence of cocaine.

After exposing immune cells to cocaine and subsequently infecting them with HIV, the researchers found that the presence of cocaine made cells more vulnerable to viral entry and new virus production than HIV-infected cells in the absence of cocaine.

"The co-epidemics of illicit drug use and infectious disease are well documented," stated John Wherry, Ph.D., deputy editor of the *Journal of Leukocyte Biology*—where the study was published. Wherry said the study adds to the literature by suggesting that drugs such as cocaine "may directly help to fuel infections by altering the immune system." He said that the study highlights the need for improved education for both HIV prevention and drug abstinence.

Kim S, Jung J, and Dixit D. "Cocaine Exposure Enhances Permissiveness of Quiescent T Cells to HIV Infection" 2013 J Leukoc Biol. Oct;94(4):835-843. http://www.jleukbio.org/content/94/4/835.abstract

Gene Deletions May Be Linked to Autism

Researchers reported that individuals with autism spectrum disorder (ASD) are more likely to have gene deletions than those without the disorder.

Published in the *American Journal of Human Genetics,* the comparison study included genetic analyses of 431 participants with ASD and 379 people without the condition.

Results showed the ASD cohort had 803 gene deletions, compared with 583 deletions in the control group. In addition, participants with ASD were more likely to have multiple gene deletions related to autophagy—a protective process that involves degradation of excessive or dysfunctional cellular components.

Joseph Buxbaum, Ph.D., lead author and a professor of psychiatry at Mount Sinai School of Medicine, told *Psychiatric News* that "this is the first time that the [autophagic] pathway has been implicated in autism. Since we know that there is excess brain size early in life in individuals with autism, it may be a result of the pathway's failure to properly prune brain connections." Buxbaum and colleagues plan to further investigate the link between autophagy and ASD through additional research.

Poultney C, Goldberg A, Drapeau E. "Identification of Small Exonic CNV from Whole-Exome Sequence Data and Application to Autism Spectrum Disorder." 2013 Am J Hum Genet. Oct 3;93(4):607-619. http://www.ncbi.nlm.nih.gov/pubmed/24094742 PN

DSM-5 SELF-EXAM

Paraphilic Disorders

An overarching change from *DSM-IV-TR* is the addition of the course specifiers "in a controlled environment" and "in remission" to the diagnostic criteria sets for all the paraphilic disorders. These specifiers are added to indicate important changes in an individual's status. There is no expert consensus about whether a longstanding paraphilia can entirely remit. In *DSM-5,* paraphilias are not *ipso facto* mental disorders. There is a distinction between paraphilias and paraphilic disorders. A paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm or risk of harm to others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not automatically justify or require clinical intervention. The distinction between paraphilias and paraphilic disorders was implemented without making any changes to the basic structure of the diagnostic criteria as they had existed since *DSM-III-R*.

The questions below are from *DSM-5 Self-Exam Questions: Test Questions for the Diagnostic Criteria,* which may be preordered from American Psychiatric Publishing at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62467. The answers and rationales are posted at http://www.psychnews.org/pdfs/DSM-5_Self_Examination_QandA_16.pdf. The book, available in February 2014, contains 500 questions for all the categories of psychiatric disorders and includes Section III. The questions were developed under the leadership of Philip Muskin, M.D., a professor of clinical psychiatry at Columbia University College of Physicians and Surgeons. APA members may purchase the book at a discount.

1. What change had been made in *DSM-5* to the diagnosis of paraphilia/paraphilic disorder?

a) Paraphilia has been distinguished from paraphilic disorder so as to distinguish between those who have benign interests/behavior and those whose interest/behavior is associated with distress or impairment
b) The "benign" specifier has been added to paraphilic disorder
c) Transvestic disorder has been eliminated from *DSM-5*
d) To be diagnosed as a paraphilic disorder, a paraphilia must go beyond fantasy or urge to include behavior
e) Paraphilic disorders are grouped in a chapter with sexual disorders

2. In *DSM-5,* which of the following is not included among the paraphilic disorders?

a) sexual masochism disorder
b) transvestic disorder
c) transsexual disorder
d) voyeuristic disorder
e) fetishistic disorder

3. Which of the following is true about pedophilic disorder?

a) The extensive use of pornography depicting prepubescent or early pubescent children is not a useful diagnostic indicator of pedophilic disorder
b) Pedophilic disorder is stable over the course of a lifetime
c) There is an association between pedophilic disorder and antisocial personality disorder
d) While normophilic sexual interest declines with age, pedophilic sexual interest remains constant
e) Vaginal plethysmography is a less reliable diagnostic instrument for pedophilia in women than is penile plethysmography for pedophilia in men PN

Public Mental Health

continued from page 1

adelphia last month. During her address, she drew on her extensive background in public service and especially in closing the old Philadelphia State Hospital at Byberry (it was officially closed in 1990) and helping to build a successful community-based mental health system in the city to replace it.

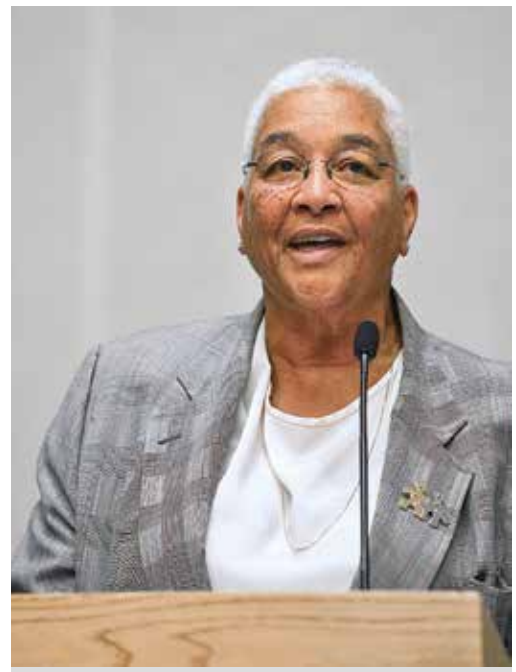
"It was clear to all of us making public policy that for people with mental illness to be successful in the community, community resources needed to be expanded," Richman said. "Some of these resources that we began to work so hard for and that we maintained a budget for were in some very concrete areas. First, housing—moving [people] from institutions to group homes to independent living with supports was the most expensive but most critical thing we could do. Housing remains a challenge for most systems.

"Work and employment are central to the growth of the individual," she continued. "People want meaningful activities of their choice. We were quick to spot the development of day-treatment programs that offered opportunities for education and work. We worked hard to resolve homelessness, and there was a point in the 1990s when we had our homeless population [in Philadelphia] down to fewer than 200.

"We invested in teams and case management with caseloads low enough that there was time to work with clients with serious mental illness," Richman said. "The recognition of the role of families and consumers was there in everything we did. We believed in peer support, and we believed in consumer-run services. We put our money where our mouth was, and we invested heavily."

Richman has a long history of public service, working most recently as senior advisor to the secretary of Housing and Urban Development for health and human service issues. From 2003 to 2009, she was secretary of the Pennsylvania Department of Public Welfare. Prior to that, she was director of social services, commissioner of public health, and deputy commissioner for mental health, mental retardation, and substance abuse services for Philadelphia.

Looking back over a challenging career that has seen, as she said, "the best of times and the worst of times," she posed the question: What does successful community mental health look like, and how will we know when we have achieved it?



Ellen Dallager

Estelle Richman says that successful community mental health services call for partnerships of key agencies, family involvement when possible, and an integrated system of care.

She expressed optimism about the movement toward integrated care and the expansion of care, including parity coverage of mental illness/substance abuse treatment under the Affordable Care Act, but she said the vision of a truly successful mental health system has not yet been achieved.

She said, "My theme today is, 'You've come a long way baby . . . but are we there yet?"

So, what does success look like? "Success has the following characteristics," she said. "Teams and partnerships exist at every level. State and local governments must encourage innovation and risk-taking, stress performance-outcome measures, develop a unified-system strategy, let research drive policy and practice, and not let the perfect get in the way of the good. The federal government must be a model of collaboration for the states and must insist on partnerships between housing and health care, child welfare and health care, education, and health care. And we must find ways to integrate mental health and addiction policy." PN

Viewpoints

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Corps who became the most important assistant to President Johnson, asked me to alert him if there was any resistance to the plans Sarge was getting under way for what would be the most televised event in history up to that time.

Because of President Kennedy's military service, Mr. Shriver felt that it would be important to involve soldiers and sailors to provide an honor guard from St. Matthew's Cathedral to the burial site in Arlington. The military aide responded that to do so would involve more troops than were available. When he asked the Air Force aide if a flyover could be arranged as the motorcade proceeded to the burial site, the aide replied that this would not be advisable since the airplanes would panic the horses in the procession. That was my cue.

The new president was holding his first cabinet meeting, and Bill Moyers came out for a few moments to hear my account of what was going on. At Bill's request, Mr. McNamara left the meeting, put his arm around my shoulder and said, "Let's go visit Sarge."

Needless to say, the ceremonial military officers had never seen the secretary of defense before. To the military aide he said, "Sir, if it takes 500 soldiers, you will have them available; if it takes 50,000 you will have them available even if we have to mobilize the reserves." He then turned to the Air Force aide and said, "Sir. I want on my desk by 6 p.m. this evening the exact altitude at which an overflight can be held without panicking horses." Needless to say, the guard of honor representing all the military services lined the road from St. Matthews to Arlington Cemetery without having to mobilize reserves, and the airplanes that flew above the cortège never panicked a single horse.

When Mrs. Kennedy decided to walk with her children behind the casket to St. Matthew's Cathedral from the White House, President Johnson decided he would do so as well (despite the security concerns of the Secret Service), and then the greatest gathering of heads of state the world had ever seen decided to march behind the family and the new president.

Because of the age and poor health of Emperor Haile Selassie of Ethiopia, Mr. Shriver asked if I would get into a morning coat and march behind him in case he needed assistance. And so a member of our profession was able to participate in this moving tribute to President Kennedy.

Even after 50 years, I have never had a prouder moment in my life.

Here's the prayer that appeared on the Mass card for President Kennedy.

Now the trumpet summons us again—not as a call to bear arms, though arms we need—not as a call to battle, though embattled we are—but a call to hear the burden of a long twilight struggle, year in and year out. "Rejoicing in hope, patient in tribulation"—a struggle against the common enemies of man: tyranny, poverty, disease, and war itself. . . .

In the long history of the world, only a few generations have been granted the role of defending freedom in its hour of maximum danger. I do not shrink from this responsibility—I welcome it. I do not believe that any of us would exchange places with any other people or any other generation. The energy, the faith, the devotion which we bring to this endeavor will light our country and all who serve it—and the glow from that fire can truly light the world. . . .

With a good conscience our only sure reward, with history the final judge of our deeds, let us go forth to lead the land we love, asking His blessing and His help, but knowing that here on earth God's work must truly be our own. PN

A full account of the funeral can be found in the book *The Death of the President: November 20-November 25, 1963,* by William Manchester.

From the Experts

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angry, anxious, or sad, he is perpetually content in the now.

A comprehensive neuropsychological testing battery demonstrated severe impairment in verbal and nonverbal memory, significant executive function difficulty, with relative preservation of other cognitive intellectual capacities.

Discussion

HSV is the most frequent causative agent among infectious encephalitidies, with an incident rate of 1 million to 3 million cases a year. When HSV encephalitis is suspected, antiviral treatment with 10mg/kg IV acyclovir TID should be instituted immediately. Although the early use of acyclovir has reduced the mortality to approximately 10 percent, over 50 percent still suffer severe neurological impairment including profound memory disturbances attributable to HSV's proclivity for localizing in the medial temporal and frontal areas, neuroanatomical structures critical in the neurophysiology of memory

Memory is now understood to be a nonunitary complex process that is subdivided into different capacities that utilize different neural circuitries. The classification of these systems has become increasingly complex (Budson and Price, 2007). A major distinction is made between explicit memory-acquired information/experience that can be verbally reported and implicit memory-acquired information/experience that is unconscious and not readily verbalized or declared and mostly expressed as recallable motor skills.

Explicit (declarative) memory is divided into episodic memory (similar but not identical to the old term "recent memory"), semantic memory (similar but not identical to the old term "remote memory"), and working memory (similar but not identical to the old term "immediate memory"). *Implicit (non-declarative) memory's* main taxonomical subdivision is procedural memory. Procedural memory is skill memory. It can be conceptualized as the mind's ability to learn a sequence or task, usually motoric in nature. The anatomical structures that subserve this memory system are also integral to modifying motor activity—namely the cerebellum, basal ganglia, and supplementary motor cortex (Budson and Price, 2005).

Working memory is the most transient of the memory systems and likely the most neuroanatomically widespread. Working memory has evolved to mean a composite of both the attentional matrix (consciously holding the information in mind) and memory manipulation—the "working" part. Working memory has a widespread cortical and subcortical localization. One neuroanatomical commonality, however, is the dorsolateral prefrontal cortex.

Episodic memories are recallable experiences that are fixed to a specific time and place. Episodic memory is centered in the hippocampus, with significant contributions from other medial temporal lobe structures, the Papez circuit, the prefrontal area, and the parietal lobes.

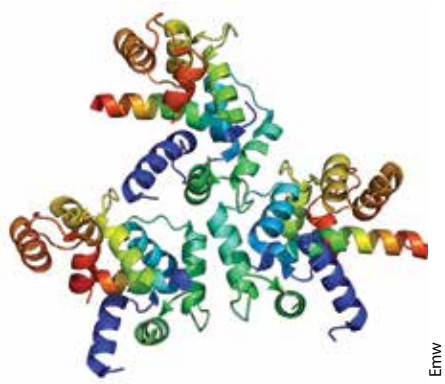
Autobiographical memory and *autonoetic consciousness* are intimately tied to episodic memory. Autonoetic consciousness is a concept originally advanced by Endel Tulving that denotes the uniquely human capacity to place ourselves in time, self-reflect using past memories, imagine ourselves in the future, and thus influence our behavior (Tulving, 1985). Failure of autonoetic consciousness not only erases past recollections, but also the ability to put oneself in the future. Neuroanatomically the hippocampus and the parietal lobes are critical for autonoetic consciousness.

Source memory is the recollection of the context around a specific memory and is unique to the episodic memory system. The frontal lobes are integral to source memory (Budson, 2009). Frontal lesions result in memories that lack context; the memories become difficult to link with other memories or to an internal time sequence. Failure of source memory may underpin the phenomenon of confabulation, which is a prominent feature of frontal lobe damage, and may represent an unconscious compensatory attempt to create context around these decontextualized memories.

Semantic memory is the term applied to memories that can no longer be clearly recollected but still maintain an element of familiarity and broadly describes the process of remembering and using decontextualized facts (Saumier and Chertkow, 2002). The inferior-lateral temporal lobes are the main storage site for the semantic memory system (Budson and Price, 2005). Unlike episodic memory, semantic memory has no associated self or source, meaning that we remember the fact or figure, but we do not associate it with any specific time period or episode in our life.

Understanding these various memory capacities and their neuroanatomical substrates is helpful in understanding this patient's clinical presentation. His encephalitis spared his cerebellum, basal ganglia, and supplementary motor cortex. Thus, his procedural memory was seemingly unaffected within the context of his highly custodial environment. He had severe, bilateral involvement of his medial temporal lobes, which resulted in maximal impact on his episodic memory system. He also had a superimposed semantic memory deficit, either attributable to the damage of his inferior-lateral temporal lobes or to the long-term effect of persistent profound episodic memory failure preventing the transfer into and hence the formation of updated semantic memory. His tendency to confabulate was likely a problem with source memory stemming also from his frontal injury. Lastly, his injuries have profoundly altered his autobiographical memory and his autonoetic consciousness: in his world, there is no past and no future. PN

References are posted at http://psychnews.psychiatryonline.org/newsArticle.aspx?doi=10.1176/appi.pn.2013.11b26.



Emw

Gene Variants

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In bipolar disorder subjects, in contrast, looking at emotionally arousing faces led to hypo-activation in the ventral prefrontal cortex part of the facial-affect-processing region. And this abnormality was exacerbated in bipolar disorder subjects who had either of the gene variants of interest.

The findings thus suggest two things—first, that these gene variants act on the facial-affect-processing region of the brain in both healthy individuals and those with bipolar disorder, and second, that the variants might contribute to the bipolar disease process by acting on this brain region. How the variants might actually do so, though, remains to be determined.

The findings were published online October 9 in *JAMA Psychiatry.*

The research was funded by the Brain and Behavior Research Foundation. PN

An abstract of "Independent Modulation of Engagement and Connectivity of the Facial Network During Affect Processing by CACNA1C and ANK3 Risk Genes for Bipolar Disorder" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=1748837.

Advertisement

Antisocial Behavior

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violence. In contrast, 16 percent of the group with stable moderate levels of antisocial behavior and 25 percent of the group with stable high levels of antisocial behavior engaged in violence. Compared with the stable low-level group, the stable moderate group was twice as likely to commit violence, and the stable high group was four times as likely to commit violence.

There are two key implications of these findings, Singh told *Psychiatric News.* "First, management of psychosis in some individuals must also target the risk of aggression. Secondly, if the risk of aggression in this subgroup is driven by underlying personality traits rather than the overlying psychotic illness, legal issues such as 'diminished responsibility' should be carefully considered rather than simply assumed."

"The findings from this study of first-episode schizophrenia patients in England indicate continuity of antisocial behavior pre- and post-onset of illness," forensic psychiatrist Paul Appelbaum, M.D., said in an interview. "People who were more likely to offend before they manifested symptoms of schizophrenia were also more likely to be violent afterward." A former APA president, Appelbaum is the Dollard Professor of Psychiatry, Medicine, and Law at Columbia University and chair of the APA Committee on Judicial Action.

"These data have implications for violence prediction and treatment in patients with schizophrenia," Appelbaum continued. "From a prediction perspective, first-episode patients with a long history of juvenile offenses constitute a higher-risk group for violence after illness onset. A quarter of this group reported committing violence, even though they were in ongoing contact with treatment services. In addition, from a treatment perspective, these data suggest that treatment targeting psychotic symptoms in higher-risk patients may not be enough to prevent violent behavior—interventions aimed specifically at propensities for violence may be needed as well."

Also commenting on the study for *Psychiatric News* was Thomas McGlashan, M.D., a professor of psychiatry at Yale University and an expert on the prodromal phase of schizophrenia.

"Simply put," he said, "these data point out that youth with a history of delinquent behaviors and a vulnerability for psychosis are clearly at risk for behaving violently once that vulnerability becomes expressed as a first episode of schizophrenia. For this subsample of young people," he said, "early detection and intervention at the pre-onset or prodromal phase of the disorder may be doubly protective by preventing not only the onset of psychosis, but also the perpetration of any associated expression/magnification of antisocial behaviors. It is hard enough for a young person to deal with either problem. Dealing with both is much more likely to be overwhelming and to result in a poor long-term outcome."

The research was funded by the United Kingdom Department of Health. PN

An abstract of "Pathways to Violent Behavior During First-Episode Psychosis" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=1748056.

Genome Initiative

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ing data from patients with anorexia, posttraumatic stress disorder, substance use disorders, as well as obsessive-compulsive disorders and Tourette syndrome have been added.

Each group conducts meta-analyses of pooled data on the disorder, and members agree to share their results as quickly as possible. They also share the credit, as each PGC publication lists all investigators who have contributed data to the analyses.

Currently, 170,000 individuals' genotyping data, including patients, families, and controls, are being analyzed by PGC. The number will increase by another 100,000 within the next year. The consortium is "by far the largest biological experiment in the history of psychiatry," said Sullivan.

"Scientists in the field have come together in an altruistic manner," he noted. "We just had two groups who contributed their data even before their own studies are published. It shows a profound sign of commitment to collaboration." PN

Advertisement

From the President

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access to quality mental health care, psychiatric consultants typically support primary care–based care managers with active caseloads of about 50 to 100 patients. For patients who suffer from anxiety, depression, or bipolar disorder, most of the consultation is done directly with the care manager who then passes on psychotherapy and/or psychotropic recommendations to the primary care physician. Patients who are not improving or those with more serious forms of mental illness can be prioritized for a face-to-face or televideo consultation with the psychiatric consultant who then provides advice on an appropriate treatment plan. Using this collaborative care approach, MHIP has served over 35,000 patients in more than 148 primary care clinics statewide with the support of five FTE psychiatric consultants, a reach that would be impossible in a more traditional practice model, especially in rural areas.

Collaborating with our colleagues in primary care can substantially improve access to mental health care and create a more patient-centered care experience for patients who often have both mental health and acute or chronic medical problems. Closer collaboration may also help our patients with more severe mental illnesses such as bipolar disorder or schizophrenia. These patients often receive most of their care in community mental health centers and other specialty mental health programs where a psychiatrist is often the only physician they will see. Research from the United States and several European countries has demonstrated that patients with such chronic and persistent mental disorders die 10 to 25 years earlier than those without mental disorders, most often not from their mental illness but from health risk factors such as smoking and obesity and from inadequately treated hypertension and diabetes, sometimes worsened by the antipsychotic medications we prescribe. This is a situation where we need help from our primary care colleagues.

When behavioral health problems are effectively treated with collaborative care, patients experience improved quality of life, better self-care, better adherence to medical and mental health treatments, and better overall health outcomes. Evidence on collaborative care also suggests that these programs not only improve care at the individual and population-based levels, but also they can lower total health care costs. In the language of health care reform, this is called achieving the "Triple Aim." For psychiatrists who enjoy working in teams and working closely with their nonpsychiatric physician colleagues, collaborative care presents a wonderful opportunity to bring their expertise to help a larger population of patients. PN

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