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PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

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David Hathcox

APA 2014 ELECTION

Renée Binder, M.D. (right), will become president-elect of APA at the end of APA's annual meeting in May, when Paul Summergrad, M.D., becomes president. See story below and chart on page 24 for all election results.

Binder Voted APA's Next President-Elect

Frank Brown, M.D., wins the race for treasurer, and Anita Everett, M.D., is chosen trustee-at-large.

BY CATHERINE F. BROWN

APA's voting members have selected Renée Binder, M.D., of San Francisco to become APA's next president-elect. She is a professor and director of the Psychiatry and Law Program and associate dean for academic affairs at the University of California, San Francisco, School of Medicine. At APA, she is chair of the APA Committee on Advocacy and Litigation Funding and a former trustee-at-large and Area 6 representative.

Binder outpolled James Nininger, M.D., of New York City and Mark Hyman Rapaport, M.D., of Atlanta.

"I am honored by the opportunity to represent psychiatry on a national level and to advocate for the best possible treatment of our patients," Binder told *Psychiatric News* upon learning of her election. "I look forward to working with an outstanding team of current and past APA leaders, our CEO and medical director, and the APA staff. The field of psychiatry faces many challenges in the coming years."

Commenting on her goals as president, she said, "My plan is to work to combat stigma and discrimination, to ensure reasonable payment for psychiatric services, to maintain federal funding for graduate medical education and research, and to encourage increased APA involvement of our younger members. I also want to increase the friendliness and accessibility of APA to our members. This includes increasing communication with our members and helping our members with the ABPN requirements for Maintenance of Certification/Lifelong Learning and with other aspects of psychiatric practice."

Nininger is a clinical associate professor of psychiatry at Weill/Cornell Medical College and in private practice with a subspecialty in geriatrics. He is APA's outgoing Area 2 Trustee, a director on the American Psychiatric Foundation Board, vice chair of the APA Steering Committee on Practice Guidelines, a past speaker of the Assembly and served on the *DSM-5* Clinical and Public Health Committee. Rapaport is the Reunette W. Harris Chair of Psychiatry and the Behavioral Sciences at Emory University School of Medicine and chief of psychiatric services for Emory Healthcare System. He is the founding co-editor in chief of the APA journal *Focus: The Journal of Lifelong Learning in Psychiatry* and a member of the Council on Medical Education and Lifelong Learning.

see ***Election Results*** *on page 24*

APA Welcomes CMS Acceptance Of Increased Work Values

There is a growing evidence base supporting the value of integrated care that includes clinical oversight that cannot be captured in the current coding structure.

BY MARK MORAN

APA, responding to regulatory issues in the final rule issued by the federal government for the 2014 Medicare fee schedule, is applauding the acceptance of new, increased valuations of psychiatry codes and the creation of a new code category (G codes) to permit physician compensation for the non-face-to-face care-management services they provide to Medicare beneficiaries with complex chronic conditions.

In a January 27 letter to Marilyn Tavenner, administrator of the Centers for Medicare and Medicaid Services (CMS), APA CEO and Medical Director Saul Levin, M.D., M.P.A., also hailed the government's broadening of the definition of "rural areas" to expand the locations qualifying for the delivery of telehealth services to include locations within urban areas.

"The changes that provide for the appropriate valuation of psychiatry services are essential for the realization of many of the objectives of health reform," Levin wrote. "It is well known that a majority of high-cost Medicare patients have primary or secondary mental health and/or substance use disorders. Effective treatment of these

see ***Work Values*** *on page 4*

PERIODICALS: TIME SENSITIVE MATERIALS

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PSYCHIATRIC NEWS

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Register Now!

For APA's 2014 annual meeting, the Association returns to one of its most popular hosting locations, New York City. Register now while advance registration rates are still in effect and reserve a room at the hotel where you'd most like to stay.

Registration information can be accessed at annualmeeting.psychiatry.org.

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

Departments

FROM THE PRESIDENT

Politics of Psychiatry and Mental Health Care

BY PATRICK KENNEDY AND JEFFREY LIEBERMAN, M.D.

Winston Churchill said, "Politics is not a game; it is an earnest business," and finally we are getting serious about the politics of mental health care. After decades if not centuries of neglect, the bona fide health care disparity is receiving an unprecedented amount of attention. In part, this is due to the efforts to reform our nation's health care delivery and financing systems to improve quality and rein in costs. But it represents an attitudinal change in our society toward mental illness prompted by the egregious deficiencies in our mental health care policies, sensationally and shockingly, reflected by the rising number of people with mental illness involved in civilian massacres, imprisoned by the criminal justice system, and homeless on the street. However undesirable the factors that may have occasioned it, the increased public attention to mental health care is welcome.

Most recently, we saw this reflected in the November 2013 release of the final rule for the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), the goal of which is to improve the quality of and access to care for people with mental illness. But this goal can be achieved only if accompanied by adequate oversight and enforcement of the law among insurance companies and providers.

We must be sure health insurance plans are explicitly required to show exactly how their general medical benefits line up with their mental health benefits. Government monitors must be able to determine whether insurance plans are adhering to parity standards in all settings—from primary care offices to specialized mental health and addiction settings.

For consumers to make informed decisions, they need to know what each plan covers. Therefore, we must have clarity on exactly what information insurance plans must disclose to potential customers before they make these decisions. And once they have chosen a plan, medical necessity criteria used for approval or denial of claims must be easily and readily available to subscribers in an understandable and specific manner.

But true parity goes beyond monitoring and enforcement. It extends to the fundamentals of how we practice medicine. Integrated medical and behavioral health models, in which psychiatric physicians and mental health specialists work closely with patients' primary care providers, can expand access, leveraging limited resources for truly comprehensive care that ensures more people are receiving quality health care, including mental health care. Not only do these models help close the gap between physical and mental health, but a growing body of research, including a recent Cochrane review of 79 randomized, controlled trials, demonstrates their potential for lowering health care costs while improving patients' health.

We expect accountable care organizations (ACOs) to incorporate mental health and addiction services into integrated models of care and to make sure these services are paid for—but how it happens and whether it works remains to be seen, as these organizations become more widespread. Our job is to make sure that ACOs meet the mental health needs of the people whose lives are entrusted to them by ensuring that the care they promise is delivered.

Expanded access to health insurance through the Affordable Care Act will increase the population that can avail themselves of quality health care. It is immensely important and gratifying that the ACA incorporates MHPAEA and its final rule.

Perhaps no piece of the puzzle is more complex than payment. Consequently, as this historic new legislation (ACA, MHPAEA) is implemented, we will need to continue to test delivery and payment models designed to improve care, lower costs, and, most of all, better serve individuals in need. We must recognize that all areas of practice have to adapt to a new set of realities if those with mental health and substance use disorders are to be adequately served.

We must continue to be vigilant of our patients' privacy rights. If we are truly embracing the culture of parity, we must find a way to share information with our health care partners with elec-

see ***From the President*** *on page 17*

Patrick Kennedy is a former congressman from Rhode Island and cosponsor of the Mental Health Parity and Addiction Equity Act. Jeffrey Lieberman, M.D., is president of APA and chair of the Department of Psychiatry at Columbia University.

GOVERNMENT NEWS

Work Values

continued from page 1

individuals represents a step forward in both the quality and cost-effectiveness of health care. The appropriate valuation of psychiatry services recognizes the value proposition that psychiatry brings to the total health care system and should help to make psychiatric care more accessible to Medicare patients."

The January comments in response to the government's final rule on the fee schedule focused on regulatory issues and outlined the major points relevant to psychiatry, especially the acceptance of new values for psychiatric codes. Levin's letter also addressed issues related to quality reporting and the "Value-Based Modifier" program. The comments did not address the overall physician fee schedule and the fate of the sustainable growth rate formula, both of which are still a moving target, pending debate on Capitol Hill (see box).

The acceptance of the new work values for psychiatric codes represents a major victory for psychiatry and is the culmination of a multiyear effort by APA and other mental health groups working with the AMA's Relative Value Scale Update Committee (RUC) to create a new framework for psychiatric coding with values that better reflect the complexity of work involved in treating psychiatric patients. For a comprehensive description of the new work values, along with charts showing value increases for specific services, see "Government Accepts Higher Work Values for Psychiatry Codes" in the January 3 *Psychiatric News* (http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=1812232).

Also important is the creation of the new G codes for complex care management that can aid in reimbursement of psychiatrists participating in integrated care team management of chronic conditions. "APA agrees with CMS's efforts to design codes that will allow physicians to be compensated for the non-face-to-face complex chronic care management services they provide Medicare beneficiaries," Levin wrote in the January 27 letter. "Many of our members frequently perform these services for Medicare's most complex, chronically ill patients. . . . We see the establishment of this code [series] as a step toward appropriately reimbursing for care management services. There is a growing evidence base supporting the value of integrated care that also includes non-face-to-face clinical oversight by clinicians, work that cannot be captured in the current coding structure. It is our hope that codes will be developed for these types of services."

Levin also expressed approval of broadening the definition "rural areas" to include certain urban areas—referred to as Metropolitan Statistical Areas (MSAs), where access to care is limited—for telemedicine. "Broadening the definition of 'rural' to include these urban locations will assist a significant underserved population in our cities, within which there is a high incidence of severe and persistent mental illness, in accessing psychiatric care," Levin wrote.

More problematic are a number of issues related to CMS's Physician Quality Reporting System, administrative burdens associated with different quality reporting measures used by multiple programs, the government's Physician Compare website that reports participation in quality programs, and the proposed Value-Based Modifier (VBM).

Levin called for consolidation of quality measures used by different programs, an increase in reimbursement for psychiatric codes (especially for substance abuse), and the inclusion of disclaimers on the Physician Compare website making it explicit that participation—or lack of participation—in quality reporting programs is not indicative of the quality of care provided by a physician.

The VBM is a move by the government toward "pay-for-performance" by providing for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished compared with cost during a performance period.

"We recognize payment systems for medicine are evolving so that 'pay for performance' is becoming the norm," Levin wrote. "In preparation for the beginning of the value-based modifier (VBM), which will affect most of our members seeing Medicare beneficiaries in 2017, we ask CMS to create educational tools that will assist us in better understanding the likely effects of the VBM on the practice of psychiatry." PN

For a summary of APA's response to the final rule on the 2014 Medicare fee schedule, go to http://www.psychiatry.org/advocacy--newsroom/advocacy/advocacy-news and click on the link, "APA Responds to CY 2014 Medicare Physician Fee Schedule."

Congress Yet to Agree on Medicare Fee Reform

The fate of physician Medicare payment and the sustainable growth rate (SGR) formula is still to be resolved pending debate on Capitol Hill.

Days before the end of the 2013 congressional session, the Senate approved a federal budget compromise that included a three-month postponement of the 24.4 percent cut in physician Medicare reimbursement that was scheduled to take effect January 1. The House passed a similar three-month patch as part of its budget bill, and President Obama signed it at the end of the year.

Physicians are currently being paid according to the 2013 fee schedule, but the "patch" passed by Congress expires April 1. The Senate Finance, House Ways and Means, and House Energy and Commerce committees have released bipartisan and bicameral legislation (HR 4015/S 2000) to repeal the SGR and implement physician payment reforms under Medicare.

Highlights of the SGR repeal and Medicare Provider Payment Modernization Act of 2014 (S 2000/HR 4015) are as follows:

- Immediate and permanent repeal of the SGR.
- Positive annual updates—reimbursement increases—of 0.5 percent would be provided from 2014 to 2018, no annual updates would be provided from 2018 to 2022, and positive annual updates of 0.5 percent would be provided from 2023 onward.
- The Merit-Based Incentive Payment System is established that collapses three current incentive payment programs—Physician Quality Reporting System, Value-Based Modifier, and Electronic Health Records Meaningful Use—and incorporates key elements of each into one program for physicians beginning in 2018.

Additional provisions are included regarding chronic care coordination, the targeting of misvalued services, and the sharing/publicizing of physician services.

APA Protests CMS Proposal to Cut Part D Psychotropic Classes

APA argues that CMS misrepresents APA practice guidelines by selectively quoting from them and ignoring factors that must be considered when choosing an antidepressant or antipsychotic.

BY MARK MORAN

APA is working with other medical and mental health organizations to formulate a response strongly protesting a recently proposed rule from the Centers for Medicare and Medicaid Services (CMS) to eliminate antidepressants—and potentially antipsychotics—after 2015 from the Medicare Part D prescription drug program's six protected classes of clinical concern.

Since the inception of the Medicare Part D program, APA has strongly supported its formulary's inclusion of the six protected classes: antiretrovirals, immunosuppressants used for organ rejection, antidepressants, antipsychotics, anticonvulsant agents, and antineoplastics. When a medication is in the protected class, "all or substantially all" of those medications must be offered under Part D.

Removing protected-class status would allow plans to limit the number of covered antidepressants or antipsychotics as determined by CMS formulary review requirements. Part D plans could also impose additional utilization management protocols, such as step therapy on drugs in these classes. Overall, access to medications deemed necessary by the attending physician could be truncated, resulting in new administrative burdens, especially when physicians choose to navigate the coverage appeals process.

But in a proposed rule issued January 6, CMS is seeking to eliminate antidepressants and potentially antipsychotics, stating that the drugs are costly and overutilized. APA is working to develop a broad-based response that includes support from other mental health and medical organizations. Among the key points that will be included in APA's response are the following:

- The removal of antidepressants and antipsychotics can result in unintended consequences, for example, delays in initiation of therapy, hospitalizations, and exacerbation of the mental illness, especially in those with severe and persistent illnesses.

- There is a strong clinical rationale for classifying antidepressants and antipsychotics as protected classes, similar to the rationale for the other protected classes. For example, the drugs in the antidepressant and antipsychotic classes are not interchangeable. Evidence from population-based studies shows that risk

*see **Part D Proposal** on page 8*

Some Need Extraordinary Measures When Extreme Cold Strikes

More effort and resources need to be expended to help homeless people with mental illness find shelter from extreme winter cold.

BY AARON LEVIN

When the polar vortex swept down across the United States in January, small groups of social workers, mental health professionals, police officers, and volunteers scurried down America's frozen streets looking for people who didn't want to come in from the cold.

The cold struck cities north and south. In Lexington, Ky., the daylong search for one homeless woman made headlines but ended happily when she was persuaded to sleep indoors.

Minnesota may have more experience dealing with cold weather, but this year was exceptional.

"It's not unusual to hit 20 below here, but at times temperatures dropped to 35 below zero with wind chills at 70 below," said Mikkel Beckmen, director of the Office of Homelessness in Minneapolis and Hennepin County. However, the combined city-county system is ready regardless of the weather or the time of year.

"We have a right-to-shelter policy," said Beckmen. The system guarantees shelter space to all families in need, currently between 320 and 350 families. It also serves 1,000 single adults and recently opened space for 60 homeless youth.

Homeless people with mental illness fall into one of 16 categories of "disabled" people who can stay in a shelter 24 hours and get three meals a day. They also receive services intended to get them out of shelters and into housing, said Beckmen.

NCH

There is no standard cutoff temperature for extended opening hours for homeless shelters in winter, according to the National Coalition for the Homeless.

In Washington, D.C., workers from the Department of Behavioral Health fanned out to check on the most vulnerable of the city's homeless, including some with mental illnesses.

"We told people they simply had to get off the streets," said Jonathan Ward, M.S.W., director of the mobile crisis and homeless outreach programs.

The city offered alternatives to the usual shelters, which many homeless people avoid, considering them unsafe or too restrictive.

"D.C. did a stellar job using their outreach units and keeping shelters open," said Michael Stoops, director of community organizing for the National Coalition for the Homeless (NCH), in Washington. Stoops has not always seen eye to eye with the District's homeless policies but had only praise for the creative thinking displayed during the extreme cold.

"The innovative use of warming buses, kept running 24 hours a day, saved lives," he said. The District encouraged homeless people to park their shopping carts next to the five buses and even placed portable toilets nearby.

Technical, legal, and ethical questions hover over when and how homeless people with mental illness can be persuaded—or required—to get off the streets.

For one thing, some jurisdictions have no set cutoff temperature for expanding severe weather services. These "Code Blue" temperatures vary. The most common threshold is 32 degrees (F), but it can vary from 40 degrees to -10 degrees. Lower-temperature cutoffs may seem heartless, but they result from insufficient funding or volunteers, which limit shelter hours, except in the most extreme conditions, said Stoops.

These Code Blue temperatures "are not based on any medical or scientific criteria," he said. "If someone is poorly clothed or is in bad health or has been drinking alcohol, temperatures in the 30s and 40s can be harmful."

In fact, the worst conditions may not simply be the coldest, according to a 2010 NCH report on winter homeless services. People may be at serious risk when daytime temperatures are in the 40s or 50s but then drop at night into the 30s.

Those hazy boundaries raise legal and ethical questions, said Elspeth Cameron Ritchie, M.D., M.P.H., chief medical officer of the District of Columbia Department of Behavioral Health.

"When does it become so dangerous that you lower your threshold for an involuntary evaluation in an emergency room for up to 48 hours?" she said. "We decided in January that we faced a life-or-death situation. If in doubt, we want to bring somebody in and do an evaluation."

Civil commitment was not needed to get someone out of the cold. "Anyway, " she said, "we'd rather be sued for putting someone in the ER for 12 hours than for having them die on the streets and not doing anything."

"This was a combined effort with D.C.'s Homeland Security and Emergency Management Agency, the Metropolitan Police, and the Department of Health," said Stephen Baron, M.S.W., acting director of the Department of Behavioral Health and Ritchie's supervisor. "The most important thing is to think and plan in advance, have additional resources, and make sure communications are up and running."

The NCH recommends that expanded winter services include extending shelter hours from the usual dusk-to-dawn operation to a 24-hour-a-day model, opening up additional spaces for shelter use, and adding beds or cots in existing spaces.

"The problem with winter overflow shelters is especially acute for people with mental illnesses because those shelters don't come with services or case managers, so people leave in the same predicament they arrived in," said Stoops. "TTrained mental health professionals should be on outreach teams to decide about placing the person in a psychiatric facility for the night."

Psychiatrists should prepare in advance of cold-weather emergencies, said Ritchie. "You're going to be asked what to do, so look at legal standards for involuntary detention in advance and see what kind of room they give you in extraordinary weather circumstances," she said. "Then work it out with the police to have the same standards." PN

The National Coalition for the Homeless's report on winter homeless services is posted at: http://nationalhomeless.org/publications/winter_weather/index.html

A Psychiatrist on the Cold, Cold Streets

Four years ago, Lloyd Sederer, M.D., now the medical director of the New York State Office of Mental Health, recounted in the *Huffington Post* how, as mental health commissioner of New York City, he had spent several post-midnight hours standing in the cold with four police officers, two emergency medical technicians (EMTs), and three outreach workers trying to persuade one homeless woman to leave the stone steps of a church and spend the night in a shelter.

It was a "Code Blue" night, when city law requires police to offer shelter to people on the streets when the temperature falls below freezing and to bring them to shelter if they refuse, wrote Sederer.

And refuse the woman did, adamantly.

"The irony of the moment did not escape me since we had to remove her to safety precisely because she did not look well, nor competent to make decisions, or likely able to endure the night," recalled Sederer. The police and the EMTs were also hesitant to control or remove the woman, fearing they would be blamed if she were injured or went into cardiac arrest. Eventually, they gathered her possessions and placed them in the waiting ambulance. They kept talking to her, and she did not resist their assistance as they moved her to the emergency vehicle and onto a nearby hospital.

"As I drove home that night, I thought, what does it take to get something done?" wrote Sederer. "Look at the time and resources it took to bring into safety one terribly endangered older woman on a hostile winter night. That experience helped me understand the kinds of judgments that sometimes are made during Code Blue nights (and other potentially deadly days and nights in New York City) that limit the protection from danger our city's most vulnerable residents can receive. The best solution, I think, is not better enforcement of Code Blue (though that would be a good idea). It is doing everything possible to keep moments like these from happening in the first place. We have to get people off the streets before they and the weather reach the gravity of conditions we saw that night."

"What Does It Take to Get Something Done?" by Lloyd Sederer, M.D., is posted at http://www.huffingtonpost.com/lloyd-i-sederer-md/the-homeless----how-to-pr_b_529364.html.

PROFESSIONAL NEWS

Revitalizing Primary Care Said Key To Success of Health Reform

Employers have grown frustrated with buying health care in which no one seems to be accountable for patients' overall health care needs.

INTEGRATED CARE
Putting Together the Puzzle

BY MARK MORAN

For America's employers, whether in the public sector or the private sector, health care is a problem.

And while the movement toward integrated, collaborative care is being driven by many forces, there is no doubt that the nation's employers have been crucial, with a critical interest in the so-called "triple aim" of health care reform: improving quality of and patient satisfaction with care, improving the overall health of populations, and reducing the per capita cost of health care.

"Since the 1980s, health care has become the biggest challenge for employers," psychiatrist David Nace, M.D., vice president for clinical development at the McKesson Corp., a health care services and information technology company, told *Psychiatric News.* "Employees are a company's most valuable asset—if it doesn't have a healthy workforce, it doesn't have a productive company. But for the past 30 years, health care costs have grown at a faster rate than inflation. Very recently the rate of that rise appears to be slowing down—and that's good news—but health care continues to be a huge proportion of employer costs and an enormous concern. And employers have become increasingly frustrated and tired of buying high-cost, frequently low-quality health care that is poorly coordinated."

That problem led some member companies of the ERISA Industry Committee (ERIC, an association representing self-insured companies) to form in 2006 the Patient-Centered Primary Care Collaborative (PCPCC), a broad-based coalition of large and small employers, primary and specialty care medical groups, clinicians, health system administrators, patient and family advocacy groups, and other stakeholders dedicated to advancing an effective and efficient health system built on a strong foundation of primary care.

Nace, who is chair of the PCPCC Board of Directors, said that the collaborative is regarded as the leading advocate of the "patient-centered medical home"—a concept that is central to the Affordable Care Act and to integrated, collaborative care that includes behavioral health. Four primary care specialty groups—the American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, and American College of Physicians—formulated the principles of the patient-centered medical home in 2007 (see box on page 19).

Nace said that the motivating purpose behind the PCPCC is the need for a retooled health care system built around a revitalized model of primary care. "Primary care has been marginalized in this country," Nace said. "If you think about the average family medicine doc—he or she sees patients with diabetes, congestive heart disease, depression, and substance abuse.

"Can you imagine having seven minutes to manage such a patient? But that's what has happened to primary care in a fee-for-service environment—primary care physicians have a short amount of time to do something, but no real time to take care of patients. Certainly, there are pockets of excellence in our health care system, including outstanding psychiatric hospitals, but even in those centers of excellence, the care tends to be uncoordinated outside the hospital, with patients left to fend for themselves to navigate the system.

David Nace, M.D.

Psychiatrist David Nace, M.D., says primary care practices need help with their patients who have comorbid psychiatric or substance abuse problems.

"Meanwhile, employers have gotten tired of buying health care in which no one seems to be accountable for taking care of patients' overall needs," Nace said. "We need a new kind of primary care, built around the patient-centered medical home."

The collaborative achieves its mission through the work of five Stakeholder Centers. The centers are targeted to specific audiences and are dedicated to advancing primary care and the patient-centered medical home among policymakers, health care professionals, employers, researchers, and consumers. Each center is led by a volunteer committee of experts and thought leaders from PCPCC's Executive Committee.

The Stakeholder Centers are Advocacy and Public Policy; Care Delivery and Integration; Employers and Purchasers; Outcomes and Evaluation; and Patients, Families, and Consumers. There are also four task forces formed around special interests: education and training, e-health, medication management, and behavioral health.

The last has been of special interest to Nace during his tenure as board chair. "Very early on in the development of the PCPCC, it became clear that a huge problem and one of the biggest challenges in health care is the comorbidity of mental health and substance abuse problems with general medical conditions," he said.

The Behavioral Health Task Force provides networking and educational opportunities, including expert discussions, around the integration of behav-

see ***Primary Care*** *on page 19*

PSYCHIATRY & INTEGRATED CARE

Learning to Share

BY JÜRGEN UNÜTZER, M.D., M.P.H.

One of the core principles underlying effective integrated behavioral health care programs is a concept called "task shifting" or "task sharing." The World Health Organization (WHO, 2008) has described task shifting as the rational redistribution of tasks among health care teams. When feasible, health care tasks are shifted from higher-trained health care professionals to less highly trained workers to maximize the efficient use of the existing workforce.

At a recent Summit on Innovation in Global Health (http://www.wish-qatar.org/forums/mental-health), I encountered powerful examples (see http://www.wish-qatar.org/app/media/381) of how this approach can be effectively employed in mental health from low- and middle-income countries such as India and Chile. In these settings, task sharing allows psychiatrists to support large populations of patients who would otherwise have little access to specialty mental health care.

The principles of task sharing are relevant not only in low-income countries; they may also be helpful in rural or otherwise underserved settings in the United States, where there may never be enough mental health specialists. In such settings, treatments that might otherwise be provided by a psychiatrist (for example, medication management for depression or anxiety disorders) may instead be provided by a primary care physician or a nurse practitioner who has regular consultation with a designated consulting psychiatrist. Similarly, master's-level counselors and even trained lay individuals such as community health workers can provide education, support, and brief structured psychotherapies with support from a mental health specialist.

Stein and Test demonstrated the value of effective task sharing in the care of patients with severe and persistent mental illnesses in the 1970s when they studied the effectiveness of assertive community treatment (ACT) programs, now the gold standard for good community mental health care. Effective ACT teams have members who respect,

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Jürgen Unützer, M.D., M.P.H., is an internationally recognized psychiatrist and health services researcher. He is a professor of psychiatry and behavioral sciences at the University of Washington School of Medicine, where he directs the Division of Integrated Care and Public Health and the AIMS Center, dedicated to "advancing integrated mental health solutions."

PROFESSIONAL NEWS

Army Learning Complex Factors Associated With Soldier Suicides

A significant percentage of suicide attempts in the Army are found to be linked to pre-deployment factors.

BY AARON LEVIN

Suicide among U.S. troops is often blamed on the stresses of combat, but a group of new studies suggests that factors present before encountering enemy fire may be at least as important.

"It is striking in this regard that the pre-enlistment mental disorders considered here are associated with more than one-third of post-enlistment first-suicide attempts," said Matthew Nock, Ph.D., a professor of psychology at Harvard University, and colleagues in one of the studies.

Their work is part of the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS), which began in 2008. Three early reports, published March 5 in *JAMA Psychiatry,* looked at prevalence of suicidal behavior and mental disorders, as well as predictors for suicide among service members.

"These studies contain important new data to help us try to understand how pre- and post-enlistment factors affect suicidal behavior," said Jitender Sareen, M.D., a professor of psychiatry in the departments of Psychiatry, Psychology, and Community Health Sciences at the University of Manitoba, in an interview. Sareen serves on the scientific advisory board of the Army STARRS project, but is not directly involved in the study.

The suicide rate among U.S. Army regular soldiers rose between 2004 and 2009 regardless of whether they had ever served in an overseas war zone.

Nock's study was based on a representative cross-sectional survey of 5,428 active-duty Army personnel. The researchers found that 13.9 percent of respondents had a history of suicidal ideation, 5.3 percent had made plans for suicide, and 2.4 percent had made attempts, wrote Nock and colleagues.

Surprisingly, about half of those events occurred prior to enlistment, even though pre-enlistment interviews are supposed to screen out anyone with a history of suicide attempts.

Prevalence estimates of post-enlistment nonfatal suicide attempts were no higher among soldiers than civilians, even though the Army suicide rate rose from 2004 through 2009 to exceed the demographically adjusted civilian rate, said Nock.

Lethality of suicide attempts may be higher among soldiers than civilians because service members more frequently use firearms to kill themselves (61 percent) compared with civilians (50.5 percent), he said. "This possibility highlights the importance of means control as a suicide prevention intervention strategy."

Of the *DSM-IV* disorders covered in the study, only major depression and intermittent explosive disorder (IED) were associated (after adjustment) with suicidal behaviors following enlistment.

The association with IED was complex, wrote Nock. Only pre-enlistment IED predicted post-enlistment first suicide attempts, and only post-enlistment IED predicted the transition from ide-

*see **Suicides** on page 24*

PROFESSIONAL NEWS

Athlete Works to Bring Psychiatric Care To Veterans and Their Families

An athlete's experience with mental illness leads him to launch a foundation to help service members and veterans who have PTSD and their families.

BY EVE BENDER

Keith Herrell

Until recently, Cincinnati Reds first basemen Joey Votto (far right) was known for his skills on the baseball field. Now the hope is that his name will be linked to the recovery of service members seeking help for PTSD. University of Cincinnati's Kate Chard, Ph.D. (second from left), joined Votto to announce that the Joey Votto Foundation would be serving veterans seeking help for PTSD and their family members. With them are Michael Newcombe, a Canadian military veteran, and Jill Miller, executive director of the foundation.

Speaking of his experiences with depression and anxiety, Cincinnati Reds first baseman Joey Votto announced last December the creation of the Joey Votto Foundation, a nonprofit 501(c)(3) organization established to provide evidence-based treatment for U.S. service members, veterans, and military families dealing with posttraumatic stress disorder (PTSD).

"Although neither I nor anyone in my family has served [in the military]," he said at a press conference, "I do know what it feels like to suffer from panic attacks, depression, and emotional struggles after a life-changing event."

Votto went on to say that the death of his father in 2008—which happened during Votto's second year in the major leagues—led to overwhelming panic attacks and bouts of depression that landed Votto on his team's disabled list due to stress the following season.

Said Votto, "I've combined my personal perspective on the healing power of clinical professionals with my appreciation for the deserving military heroes who need similar help. As a result, my off-the-field focus these days is on fighting for the cause of veterans and service members who need help healing their nonphysical wounds."

Veterans are receiving treatment through the Joey Votto Military Family Stress Disorders Program at the University of Cincinnati, and the goal is to treat 500 active-duty service members, veterans, or family members on an annual basis, regardless of their ability to pay. The foundation's operating budget for 2014 is approximately $490,000.

Kate Chard, Ph.D., is director of the Joey Votto Military Family Stress Disorders Program and a professor of psychiatry and behavioral neuroscience at the University of Cincinnati. "Evidence-based treatments for PTSD are effective, but making them available to the community at large has been our biggest obstacle," she told *Psychiatric News*.

Chard, who will provide treatment to the veterans as part of the program, also noted that "over 70 percent of patients who receive evidence-based treatment do not have a diagnosis of PTSD within seven to 15 sessions later."

She added that some veterans may be ineligible to receive mental health services through the Veterans Administration (VA) due to a dishonorable discharge status associated with substance use during their time in the military, and she expects that the Joey Votto Foundation will be able to assist these and others who are ineligible for care. "Substance use is often one way to cope with the symptoms of PTSD," she noted. Some individuals may be afraid to seek help through the VA due to stigma as well.

With regard to providing treatment to family members of service members and veterans, Chard said, "PTSD in combat veterans causes very difficult circumstances for the home life. We have seen higher rates of divorce, domestic violence, and truancy and delinquency in children and adolescents." It is often necessary in these cases to bring the entire family in for therapy to begin to address such issues with evidence-based couples therapy and parent training.

While the program is based at the University of Cincinnati, it is expected that veterans and service members in Indiana, Kentucky, and Ohio will make use of the program's benefits. A veteran outreach coordinator will be the first point of contact for veterans and their families who are interested in receiving services through the foundation and will link them to the foundation's clinicians, including psychiatrists, psychologists, and social workers.

The Joey Votto Foundation will also link veterans to the community through volunteer projects, according to the foundation's executive director, Jill Miller. The goal is "to connect them with one another, to something bigger than themselves, and to give them a strong sense of purpose," she told *Psychiatric News*. PN

More information about the Joey Votto Foundation is posted at vottofoundation.org.

Part D Proposal

continued from page 4

of suicide attempts and completed suicide is increased for patients with any psychiatric disorder, and risk is increased multifold for patients with disorders for which antidepressants or antipsychotics are commonly used, including mood disorders, schizophrenia, and anxiety disorders. Patients with mental illness are most vulnerable before an effective medication is provided.

- The potential savings to Part D plans and to patients of removing the protected status of these drug classes would be dwarfed by the clinical harms and social costs of delayed, limited, or denied access to treatment for vulnerable patients. These harms and costs include increased disease disability, increased hospitalization and use of emergency health care services, and death from suicide.

- With respect to patient welfare, CMS cites overutilization as a specific concern for eliminating the protected status of antipsychotics; the high rates of use of antipsychotics, particularly off-label, suggest inappropriate use, such as for treatment of insomnia, and use as a first-line treatment of behavioral symptoms of dementia. However, there are clinical circumstances when off-label use of antipsychotics is appropriate, such as when patients with dementia are at risk of harming themselves or others or when the use of an antipsychotic to manage aggression and agitation can allow patients to receive needed care or avoid transition to a higher level of care, such as from the community to a nursing home or from a nursing home to an inpatient hospital setting.

CMS has cited APA practice guidelines as supporting evidence to eliminate these medications from the protected classes. APA is arguing that CMS is misrepresenting APA practice guidelines by selectively quoting from them and ignoring strong recommendations that evidence for efficacy is only one factor that must be considered when choosing an antidepressant or an antipsychotic.

All APA guidelines that address the use of antidepressants and antipsychotics, including those on major depressive disorder, anxiety disorders, schizophrenia, and obsessive-compulsive disorders, recommend that choice of medication must be made on the basis of how a drug's unique effects may interact with patient factors including age, gender, ethnicity, pregnancy, co-occurring psychiatric conditions, and comorbid medical conditions. These drug effects include different mechanisms of action, pharmacological properties (drug-drug interactions), side effects, and safety concerns. PN

Comments on the proposed rule were due at press time. Information on further developments and comprehensive coverage of APA's response to the rule will appear in a future issue. The CMS proposal is posted at http://www.regulations.gov/#!documentDetail;D=CMS-2014-0007-0002.

Successful 'Mental Health Home' Requires New Way of Thinking

Creating a mental health medical home means rethinking the traditional ways in which the staff interact with patients.

BY AARON LEVIN

Moving to a medical home care model for people with mental illness means aligning the interests of clinicians and patients, not an easy prospect when care is fragmented and patients have complex problems, said Mark Ragins, M.D., medical director at the MHA Village Integrated Service Agency in Long Beach, Calif.

"Our job is not to treat illnesses; it's to help people with illnesses lead better lives," said Ragins in an interview. "The things you have to do to live well with a chronic, serious illness require a comprehensive approach to illness that looks more like a home than a clinic."

The MHA Village has taken some early steps toward becoming a "mental health home." The center's street medicine program sends psychiatric staff out with medical staff from a nearby federally qualified health center to help homeless people and people with mental illness, including substance abuse. More recently, a primary care doctor has begun to serve at the MHA Village one morning a week and works with the Assertive Community Treatment (ACT) team on a second morning.

More broadly, though, a medical home model could learn much from the mental health field, said Ragins.

For instance, the "high utilizers," who often burden therapists and health care systems alike, can benefit from a committed ACT team, one not easily dissuaded by the patient's complex medical issues and difficult behavior.

"ACT must be a no-fail program," he said. "You don't throw [the patients] out, no matter what."

The ACT team's patients often have high levels of suffering and lead chaotic lives, which can burn out staff members unless they unite and rely on each other for support, Ragins said. "Setting up an ACT team forces you to make commitments to individuals you don't really like and get very involved in their lives."

Another group of difficult-to-manage patients are those addicted to drugs.

"We have to confront our own judgment about drug addiction and our lack of acceptance of it," he stressed. "Then we have to realize our own powerlessness and build a culture of acceptance."

Ragins pointed out that familiar social determinants of health—poverty, race, bad neighborhoods, poor social or community support—are additional impediments to treating people with chronic illness.

"We don't treat the sickest of the sick; we treat the poorest of the sick, or vice versa," he said. "Too often they're asking for charity and we give them treatment, so they drop out and don't return."

The solution to helping them means doing whatever it takes to overcome those problems so they don't distract the patient from treatment. Case management is critical to helping them navigate the medical, mental health, and social service systems.

Aaron Levin

Development of a recovery model for the medical home means making an extended commitment to the patient, says Mark Ragins, M.D.

Ultimately, though, the patient—with professional assistance—has to do the hard work to get better, he said.

"My job isn't to protect them; my job is to give them a secure foundation from which they can take risks and grow and learn," he said. "You build trust not on 'I can fix you' but on 'I'll be there to help you learn from your mistakes.' Teaching, guiding, coaching, building skills will get them to take more responsibility for their own lives rather than our taking responsibility for their lives."

Collaboration and shared decision making lead to shared perspectives that can open doors to better compliance with treatment, he said. "You switch from compassion to empathy—feeling, on some level, what the patient is feeling."

Finally, as with any chronic illness, helping patients with mental illness is not always about cure but about living with it as best they can and being resilient enough to manage symptoms at times of relapse. Peers can serve as reminders and examples of that, he said. They are people who are "ill" and "well" at the same time, who accept illness as part of a full life.

"Medical practice will not be influenced by lofty visions of medical homes, but by learning that we have the solutions to their problems," said Ragins. "We can help general medical practitioners answer questions such as noncompliance with treatment, hopelessness, passivity, and the drug abuse that messes up everything. We need to get started with the practical things, then hope they'll buy into the vision."

Making sure a mental health home achieves its goals means analyzing successes, building on strengths, and motivating change—for both clinicians and patients.

Underlying all is not only the substance but the emotional content of a "home," said Ragins: a place where one is welcomed, accepted, respected and—just possibly—healthy and happy. PN

Information about the MHA Village Integrated Service Agency is posted at http://www.mhala.org/index.htm.

Program Prepares Defendants For Return to the Community

The Miami-Dade Forensic Alternative Center restores mentally ill defendants' competency to stand trial—with a twist.

BY AARON LEVIN

Managing people with mental illness in one Florida jail system is now a little less tangled thanks to a pilot program that restores defendants' competency to stand trial and prepares them for return to the community.

Miami-Dade County found itself in crisis in 2006 and 2007. Shrinking public funding, closing of hospital psychiatric units, and reduced access to community treatment pushed more people with mental illness into the criminal justice system, said Miami-Dade County Judge Steven Leifman, J.D. Leifman heads the Judges' Criminal Justice/Mental Health Leadership Initiative and is a member of the American Psychiatric Foundation's Board of Directors.

The usual pattern at that time was to send incompetent defendants to a state hospital for restoration treatment, then return them to jail. Too often, however, those prisoners decompensated while awaiting trial and had to be sent back to the hospital, even though one-third of the county's public mental health dollars was expended in the process. That revolving-door system ultimately ground to a halt.

"The state finally ran out of forensic beds, and the head of the Department of Health and Human Services was held in contempt by the courts," said Leifman in an interview with *Psychiatric News.* "So we needed an alternative system for competency. We persuaded Jackson Memorial Hospital to fund a forensic psychiatry fellowship and the state to fund a competency restoration center."

And so the Miami-Dade Forensic Alternative Center opened as a unit within Jackson in 2009.

"The goal was to provide safe, effective, and cost-efficient alternative placement options for defendants ruled incompetent to stand trial and who faced less-serious offenses, had no histories of violence, and were less likely to face additional prison time if convicted," said Regina Carney, M.D., an assistant professor of psychiatry at the University of Miami Miller School of Medicine. Carney was named chief psychiatrist at the center after she completed the forensic fellowship at Jackson in 2012.

"We are unique in assuring that the patients receive not just medications and competency training here, but also begin the process of recovery," said Carney in an interview.

"Most competency restoration programs have as their goal to get incompetent defendants restored to stand trial so they can go to court," said Peter Ash, M.D., an associate professor of psychiatry and director of the Psychiatry and Law Service at Emory University. "The Florida program also appears to aim to get people released to the community with treatment."

In short, the program serves a diversion function, like mental health courts do, but with a difference, said Ash, who is

see ***Defendants*** *on page 25*

MEMBERS IN THE NEWS

Psychiatrist-Anthropologist Studies Drug Addiction and Recovery

Helena Hansen, M.D., Ph.D., helps patients with addiction further their recovery by making documentaries about their lives, part of an anthropological tradition of visual documentation.

BY JOAN AREHART-TREICHEL

Often you will find psychiatrist Helena Hansen, M.D., Ph.D., in a tiny office located off Washington Square in Manhattan. This is her office as an assistant professor of anthropology at New York University. But she is also an assistant professor of psychiatry, and in that role she has another office 24 blocks north.

Hansen has several passions that bridge both psychiatry and anthropology—social influences on mental health and, more particularly, social influences on drug addiction and recovery.

It all started in 1969 when Hansen was born to two psychology students at the University of California at Berkeley. Her mother was African American, her father Norwegian. "So it is not an accident that I ended up interested in cross-cultural psychiatry and social influences on mental health," she said in a recent interview in her Waverly Place office.

Joan Arehart-Treichel

Helena Hansen, M.D., Ph.D., is co-leader of two group therapy programs at Bellevue Hospital's Chemical Dependency Program—a community performance group and a video self-documentary group.

She did her undergraduate studies at Harvard University, with a major in biology. While there, she found herself moonlighting at the Kennedy School of Government. "I used to sneak over and listen in on their policy debates. I was fascinated by government and how social groups were affected, particularly in terms of the health impact of policymaking."

After graduating from Harvard in 1992, she spent three years working for the National AIDS Fund. "This was an exciting time, when a lot of community organizing around AIDS was taking hold," she recalled. "I had the pleasure of running a mini-grants program for neighborhood leaders who wanted to prevent AIDS. In the process I got a sense of how important social forces are to health outcomes."

At this point, she wanted one foot in clinical medicine, but the other in a domain in which social forces to improve health could be addressed. In 1995 she applied to an M.D.-Ph.D. program at Yale University. "I convinced the M.D.-Ph.D. committee to take me as its first social-science student. They had taken bench scientists up to that point. The reason why they took me, I think, is because I made a strong argument that social determinants have a large impact on health outcomes, and that just as we need basic science to be translated to the bedside, we need social science to be translated to the clinic."

After she was accepted into the program, she decided to pursue a doctorate in anthropology. During her first year, she spent six weeks in Cuba and studied the Cuban response to the AIDS epidemic. She spent time in its AIDS sanatoria. "They are the only country in the world that has established quarantine for HIV-positive people," she noted. Subsequently she studied whether needle-exchange programs helped prevent drug-induced HIV in inner-city Hartford, Conn., followed by a year of field work studying a network of evangelical addiction ministries in Puerto Rico. She found that the ministries were not a panacea, but did help some deal with their lack of employment and struggles with addiction and even gave them "respectable" identities as evangelists.

Meanwhile, Hansen got to know members of the psychiatry faculty at Yale and saw a place for herself in that field. "I think that psychiatry is a field that in the past has taken social influences on health seriously." Thus, after she graduated from the M.D.-Ph.D. program at Yale in 2005, she entered a psychiatry residency program at New York University.

When she entered the program, it didn't have much of a curriculum regarding social and cultural influences on mental health, she noted. In 2008, when she was a third-year resident, the faculty put her in charge of developing one. "I was able to bring experts from New York University's Department of Anthropology and Department of Sociology up to New York University's medical school to teach the psychiatry residents there. Those were exciting moments."

In 2009, she completed her psychiatry residency and then did two fellowships: a clinical fellowship in addiction psychiatry and a population health research fellowship in the Robert Wood Johnson Health and Society Scholars Program. In 2011, she started her positions as assistant professor of both psychiatry and anthropology.

Today she teaches anthropology to graduate and undergraduate students and teaches psychiatry residents as well. She is in charge of the social, cultural, and mental health curriculum in the psychiatry residency program.

Recently, Hansen received a grant from the National Institute on Drug Abuse to look into barriers to buprenorphine treatment for opiate dependence in public clinics. "It draws on my training as an anthropologist. I am spending a lot of time in clinics—listening to what people say on the record and off the record to get a sense of what is happening. This contrasts with traditional psychiatric research, where you survey subjects with closed-ended questions."

This project has made her realize how difficult it is for public addiction treatment clinics to integrate with public primary care clinics, even when staffs in both domains make a concerted effort to do so, because of the financial structures of the clinics. "We are seeing barriers to referring primary care patients for mental health services even within the same hospital," she remarked.

Hansen also leads two group-therapy programs for patients recovering from drug addiction at Bellevue Hospital—therapies that she likes to think of as "socioculturally based psychiatric treatments."

One is the community performance group. "We basically put on events for the hospital—one-act plays, karaoke parties. We are creating a sense of community and social connection among patients in the hospital. When people feel connected to one another and work collaboratively on projects, that is mental health giving."

The other is called the video self-documentary group. With the help of staff and volunteers, addicted patients, many of them homeless and with less than a high school education, get together once a week to make videos about their lives. They are learning camera work, editing, and scripting. "There is therapeutic value in telling one's life story," Hansen observed. "And making the films helps give patients a different sense of identity, of oneself as a filmmaker, as opposed to simply being a patient in addiction recovery."

Where does Hansen want to go from here? "I see myself continuing to build a research base pertaining to the cultural and social aspects of mental health and how we clinicians can intervene at that level. In essence, I hope to be able to stay the course in both psychiatry and anthropology and try to bring the best of both worlds to the other." PN

Helena Hansen, M.D., Ph.D.

Hansen leads a group therapy program called the Community Performance Group for patients recovering from drug addiction at Bellevue Hospital. At the group's Latino Day (above), Bronx high school students demonstrated a Latin dance. Later staff and patients joined in with the dancers.

To watch an interview of Hansen by *Psychiatric News*, go to http://www.youtube.com/watch?v=xydPBSusGX0&feature=c4-overview&list=UUAPLZ4LG-XJgNSB43MbCLRg.

ANNUAL MEETING

Sean Pavone/Shutterstock

The Bethesda Fountain in Central Park is one of the largest fountains in New York.

NYC & Company/Malcolm Brown

The Staten Island Ferry at dawn or dusk is one of New York's greatest free rides.

Breaking News: You Can Have New York for Free!

Parks, museums, walking tours, historic buildings—there's plenty to see and do in New York City without spending a cent.

BY AARON LEVIN

Sure, New York is an expensive city, but you don't have to look far to find plenty of things to do for free.

To start with, there's New York's bucolic crown jewel, Central Park, comprising over 136 acres of woodland, 250 acres of lawns, and 150 acres of lakes and ponds. But there are many other green spaces all over the city, including Brooklyn's Prospect Park and Van Cortlandt Park in the Bronx.

A number of historic sites and museums are always free. To select a few at random:

The **African Burial Ground National Monument** in lower Manhattan is where hundreds of Africans were buried in the 17th and 18th centuries. The 6.6-acre site was revealed during the construction of an office building in the 1990s.

Federal Hall, on Wall Street, served as the first U.S. capitol building, the site of George Washington's first inauguration, and the place where the Bill of Rights was officially passed. The original is gone, and the current structure was built in 1842 as the U.S. Customs House. Free tours are offered.

Another founding father, Alexander Hamilton, built his estate at the other end of Manhattan, in Harlem. The **Hamilton Grange** is now nestled in St. Nicholas Park.

A sobering reminder of the origins of one of the city's best-known immigrant groups is the **Irish Hunger Memorial**, an outdoor commemoration of the Emerald Isle's great famine of 1845-1852, when more than 1.5 million people died. Inside the garden, near Battery Park at Manhattan's southern tip, there are more than 60 types of flora from Ireland and a recreated 19th-century Irish cottage.

Then there are the places that are free on the right day, at the right time. For instance, on Fridays from 4 p.m. to 8 p.m., the world-renowned **Museum of Modern Art** flings open its doors to all who choose to enter.

On Saturday, head for the **Brooklyn Botanic Garden** and the **Jewish Museum**.

Many other museums and cultural sites are open on a "pay-what-you-will" basis, leaving it up to the visitor to decide on the price of admission.

Free Tours by Foot provides walking tours that give an intimate view of lower Manhattan, Greenwich Village, SoHo, Chinatown, Harlem, and many other storied locales. Their tours are officially free, but guests are invited to offer a name-your-own-price donation to the guides, who style themselves as a cross between professors and performers.

Of course, if you've always dreamed of going to New York and **being on television**, here's your chance—if you're lucky. Most shows have online ticket-request systems, but some also may offer walk-up seating. Check show websites well in advance. Shows also may have specific age, dress, or ID requirements. (See box for some choices.)

Perhaps the biggest bang for your non-buck is one you can share with 60,000 people every day: the **Staten Island Ferry**. The five-mile ride across New York Harbor not only takes passengers to and from its namesake borough, but provides unparalleled views of the Lower Manhattan cityscape, Ellis Island, and the Statue of Liberty. One of the fleets' five ferryboats leaves port about every half hour during most of the day, but departure intervals shrink to 15 or 20 minutes during rush hours. Go around sunset for a scene you will remember long after you leave New York.

Incidentally, Staten Island is more than the St. George ferry terminal. Visitors can explore the island by foot, bus, or rail to visit myriad ethnic restaurants and sites like the **Snug Harbor Cultural Center and Botanical Garden**, home to 23 historical buildings, nine botanical gardens, and 10 acres of wetlands. PN

Free Sites to Visit in New York City

Central Park:
http://www.centralparknyc.org/index.html

Prospect Park: http://www.prospectpark.org/

African Burial Ground: www.nps.gov

Federal Hall: www.nps.gov

Brooklyn Botanic Garden: www.bbg.org

The Jewish Museum:
www.thejewishmuseum.org

Free Tours by Foot:
http://www.freetoursbyfoot.com/new-york-tours/

TELEVISION SHOWS

The Colbert Report:
http://www.colbertnation.com/tickets
Tapings: Monday through Thursday

The Daily Show With Jon Stewart:
http://www.thedailyshow.com/tickets
Tapings: Monday through Thursday evening

Good Morning America:
http://abcnews.go.com/GMA/mailform?id=12943471
Live on weekdays at 7 a.m.

Tonight Show Starring Jimmy Fallon:
http://gonyc.about.com/od/tvtapings/fl/How-to-Get-The-Tonight-Show-Starring-Jimmy-Fallon-Tickets.htm

Late Show With David Letterman:
http://www.cbs.com/shows/late_show/tickets/request/
Tapings: Monday to Wednesday at 4:30 p.m.; Thursday at 3:30 p.m. and 6 p.m.

Today Show:
No tickets necessary. Go to 30 Rockefeller Plaza
Tapings: Monday through Friday, 7 a.m. to 11 a.m.
More information: http://www.nycgo.com/tv-show-tapings/

Staten Island Ferry:
http://www.siferry.com/
http://www.nycgo.com/articles/a-day-in-staten-island
http://www.mta.info/nyct/service/pdf/sircur.pdf

MED CHECK

BY VABREN WATTS

CVS Caremark to Rid Shelves Of Tobacco Products

On February 5, CVS Caremark announced that it will stop selling cigarettes and other tobacco products at its more than 7,600 pharmacy locations nationwide by October 1.

"Ending the sale of cigarettes and tobacco products at CVS/pharmacy is the right thing for us to do for our customers and our company to help people on their path to better health," said Larry Merlo, president and CEO of CVS Caremark, in statement. "Put simply, the sale of tobacco products is inconsistent with our purpose."

The company plans to launch a national smoking-cessation program this spring that will include information and treatment options for those who want to free themselves of tobacco addiction. According to CVS Caremark, approximately 70 percent of smokers say they want to quit smoking, and 50 percent attempt to quit each year.

Rob Wilson/Shutterstock

CVS Caremark estimates that it will lose approximately $2 billion in revenues on an annual basis from tobacco shoppers.

Roche Schizophrenia Drug Not Looking Promising

Bitopertin, the first in a new class of medicines known as glycine reuptake inhibitors, is being developed by Roche to remedy negative symptoms of schizophrenia, such as social withdrawal and lack of motivation. However, data from phase 3 clinical trials are showing that the anticipated "blockbuster" therapy keeps missing the mark.

Roche conducted two clinical trials evaluating the effects of bitopertin as an add-on treatment to other antipsychotics to reduce negative symptoms associated with schizophrenia in adults with psychosis. Results showed that bitopertin failed to meet the primary endpoint of a significant improvement on the Positive and Negative Syndrome Scale in both trials.

Current antipsychotics have been successful at remedying positive symptoms of schizophrenia, such as hallucinations and delusions, but no pharmaceutical company has reported success in developing drugs to reduce negative symptoms.

"These results are disappointing for people with negative symptoms because more effective treatments are needed for these debilitating effects of schizophrenia," said Sandra Horning, M.D., chief medical officer and head of Global Product Development at Roche. "We will await data from the remaining bitopertin studies in schizophrenia before deciding on next steps."

A third phase 3 trial investigating patients with persistent negative symptoms is ongoing, with three more trials evaluating the role of drugs in patients who continue to have positive symptoms of schizophrenia despite antipsychotic therapy.

Rivals Join Forces With NIH On Drug Development

On February 4, National Institutes of Health (NIH) Director Francis Collins, M.D., Ph.D., announced that 10 rival pharmaceutical companies have formed a pact to assist government-backed efforts in the accelerated discovery of new drugs indicated for undertreated illnesses such as Alzheimer's disease, lupus, and rheumatoid arthritis.

The collaboration, called the Accelerating Medicines Partnership, will cost approximately $230 million and will consist of the sharing of scientists, tissue and blood samples, and data among NIH and participating drugmakers. The pact prohibits all involved companies from using any discovery for their own drug development until it is agreed by involved parties to make the data on that specific discovery public.

Some big-name companies involved include GlaxoSmithKline, Bristol-MyersSquibb, Sanofi, Takeda, and Johnson & Johnson.

Shire's ADHD Medication Fails Depression Trials

Shire announced in February that it is no longer pursuing its top-selling attention-deficit/hyperactivity disorder medication, ***Vyvanse***, as an adjunctive therapy indicated for adults with major depressive disorder (MDD) after the pharmacotherapy performed poorly against placebo in two phase 3 clinical trials.

Each clinical trial consisted of approximately 400 patients aged 18 to 65 who met *DSM-IV-TR* criteria for a diagnosis of MDD. After eight weeks of treatment, subjects taking Vyvanse averaged a mean reduction of 6.7 points on the Montgomery-Asberg Depression Rating Scale, compared with a 6.6 mean reduction among those taking placebo.

Shire is now exploring new indications for Vyvanse, such as binge-eating disorder.

Schizophrenia Drug Completes Phase 2 Trial

Omeros Corporation announced on January 29 positive results from a phase 2 clinical trial of ***OMS824***—the company's newly developed inhibitor of phosphodiesterase 10, an enzyme expressed in the brain that is suggested to contribute to cognitive impairment in those with schizophrenia and Huntington's disease.

The phase 2 trial included 33 psychiatrically stable patients with schizophrenia who were administered OMS824 or placebo for two weeks. The drug was well tolerated by participants, and pharmacokinetics of OMS824 were not affected by concomitant antipsychotic medications, suggesting that the drug may be developed as both a monotherapy and as an adjunctive therapy to currently approved antipsychotics, according to Omeros. Efficacy conclusions cannot be drawn until sample sizes are increased in future phase 2 and 3 clinical trials

This quarter, Omeros expects to begin enrollment for phase 2 clinical trials evaluating tolerability of OMS824 in patients with Huntington's disease. PN

CLINICAL & RESEARCH NEWS

Animal Study Suggests Potential Role Of Serotonin Receptor Agonist

Pharmacological agents used to treat gastrointestinal disorders are being explored as a therapy for symptoms associated with mental illness.

BY VABREN WATTS

As scientists investigate the fast-acting properties of pharmacological agents that are independent of the serotonergic system, such as ketamine, a study published in the January 22 *Neuropsychopharmacology* shows that such investigation could be on the horizon for the fourth subtype of serotonin receptors, 5-HT4.

In a collaborative effort, researchers from the University of Paris-Sud and Columbia University evaluated the antidepressant and anxiolytic properties of a 5-HT4 receptor agonist, RS67333, in an animal model of anxiety and depression.

"An increase in the density of 5-HT4 receptors has been reported in cortical and striatal tissue of postmortem brain samples from patients diagnosed with major depression," Denis David, Ph.D., coauthor and an assistant professor of psychopharmacology at the University of Paris-Sud, told *Psychiatric News*. "Furthermore, an association has been reported for single nucleotide polymorphisms of the 5-HT4 receptor gene in patients with unipolar depression."

According to David, many of the currently approved serotonergic-associated antidepressants—which focus primarily on the serotonin transporter protein (SERT)—are often limited by a degree of nonresponsiveness among patients and exhibit delayed onset of therapeutic efficacy. Because of these limitations with SSRIs, David said that the development of new antidepressants is of utmost importance and that understanding the mechanisms underlying the delayed onset should offer insights into new approaches.

University of Nebraska Medical Center

Christopher Kratochvil, M.D., says that discovery of the fast-acting anxiolytic and antidepressant effects of 5-HT4 receptors can provide a novel approach for treating mental illness.

To investigate the importance of 5-HT4 in alleviating symptoms of mood disorders, David and colleagues used a mouse model in which the hypothalamic-pituitary-adrenal axis was blunted—resulting in characteristics of depression and anxiety. Comparisons were made between animals that were given a one-month treatment of the RS67333 compound or fluoxetine.

Results showed that chronic treatment with either RS67333 or fluoxetine achieved anxiolytic and antidepressant-like activity in animals. However, these effects were observed after seven days in animals treated with the RS67333 and 14 days in animals treated with fluoxetine. The researchers also found that by making the 5-HT4 receptors nonfunctional, both RS67333 and fluoxetine lost the ability to reduce depression and anxiety—suggesting that 5-HT4 receptors may be essential in fluoxetine's effect on behavior.

"Our results show, for the first time, in a model of anxiety and depression, that a 5-HT4 receptor agonist may be a fast-acting anxiolytic agent and that 5-HT4 stimulation is necessary for the behavioral effects of fluoxetine, a classic SSRI antidepressant," the researchers wrote. They speculated that fluoxetine may act slowly in comparison to relieve depression and anxiety symptoms because it indirectly targets 5-HT4—unlike RS67333.

Currently, 5-HT4 stimulators are approved by the Food and Drug Administration for the treatment of multiple gastrointestinal disorders, such as gastritis and irritable bowel syndrome. According to David, 5-HT4 receptor agonists have never been tested as a treatment option for patients with major depressive disorder. He said that subsequent clinical trials will be needed to confirm the current findings in humans.

Christopher Kratochvil, M.D., associate vice chancellor for clinical research and chief medical officer at the University of Nebraska Medical Center, told *Psychiatric News* that clinician scientists can benefit from the study's discoveries.

"Certainly an animal model like this has limitations on multiple levels in its application to human research, so this study is an early step in better understanding potential approaches to treating anxiety and depression. However, a translational study such as this can help to inform, guide, and motivate additional work in exploring novel mechanisms associated with anxiolytic and antidepressant properties of 5-HT4 receptor agonists," commented Kratochvil.

Agreeing with the authors, Kratochvil concluded that the current findings give hope to clinical researchers and those with mental illness of one day having a faster-acting alternative for the treatment of depression and comorbid anxiety.

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

An abstract of "Rapid Anxiolytic Effects of a 5-HT4 Receptor Agonist Are Mediated by a Neurogenesis-Independent Mechanism" is posted at http://www.nature.com/npp/journal/vaop/ncurrent/full/npp2013332a.html.

Gene Mutation May Be Major Cause Of Dementia Variant

About a third of cases of behavioral-variant frontotemporal dementia appear to be due to a gene mutation on chromosome 9.

BY JOAN AREHART-TREICHEL

In 2011, a gene responsible for some cases of both frontotemporal dementia (FTD) and amyotrophic lateral sclerosis (ALS) was identified. It is an abnormal variant of a gene on chromosome 9 called C90RF72.

"The discovery of the C90RF72 gene mutation as a cause of FTD and ALS represents a clear victory in the war against neurodegenerative disorders," John Hodges, M.D., a professor of cognitive neurology and an FTD expert at the University of New South Wales in Australia, wrote in the March 2012 *Brain*. His hope was that "unraveling the molecular pathology would lead to a cure for these devastating diseases."

Now Hodges and his colleagues have conducted a study that sheds more light on the relationship between FTD and the C90RF72 mutation. Their results were published online January 20 in *JAMA Neurology*.

During a five-year period at an FTD referral center, Hodges and his coworkers evaluated 114 consecutive patients with FTD, FTD-ALS, or corticobasal syndrome. They found that 14 (12 percent) of the patients had the C90RF72 mutation. This is precisely the same rate that Dutch researchers found in an FTD cohort (*Psychiatric News*, May 18, 2012).

The researchers were particularly interested in the relationship between the mutation and behavioral-variant FTD (bvFTD). This is a form of FTD characterized by early and progressive changes in personality, emotional blunting, and/or loss of empathy. They found that out of 29 patients with bvFTD, 10 had the mutation (a frequency rate of 34 percent). Thus the mutation appears to be a common cause of bvFTD.

Moreover, the 10 bvFTD patients harboring the mutation were more likely to have a family member with ALS than were 19 bvFTD patients not carrying the gene mutation. Psychotic symptoms—especially persecutory, negative, and paranoid delusions—were more

see ***Gene Mutation*** *on facing page*

CLINICAL & RESEARCH NEWS

Gene Mutation

continued from facing page

common in patients with the mutation than without. Psychiatric illness in family members was significantly more common in mutation carriers than in those without the mutation.

The findings also have some broader implications, the researchers pointed out. Since most of the bvFTD mutation carriers had a family member with ALS, often in conjunction with psychiatric illness in family members, it's possible that the mutation might contribute to psychiatric disorders as well as to FTD and ALS. Indeed, a recent study conducted by other researchers and published July 9, 2013, in the *Annals of Neurology* found a high prevalence of psychiatric disorders in the first-degree relatives of ALS patients who had the mutation.

"Patients with frontotemporal degenerative changes often develop behavioral symptoms in their 50s and may be referred to psychiatrists for diagnosis and treatment," Robert Roca, M.D., said in an interview. In addition to being vice president and medical director of Sheppard Pratt Health System in Towson, Md., he is chair of the APA Council on Geriatric Psychiatry.

"We need to be aware that the emergence of behavioral disinhibition, loss of empathy, compulsive behaviors, and psychosis in late middle age can be early signs of FTD even in the absence of conspicuous signs of cognitive impairment. This study shows that a specific mutation on chromosome 9 is associated with some of these clinical manifestations, particularly the presence of delusions. This allows us to make a more precise diagnosis and helps us explain to patients and families why these disturbing changes are occurring.

"At this point there are no specific treatment implications, but every step we make toward understanding the causes of disease brings us closer to treatments that may alter the course of disease."

The research was funded by the Motor Neuron Disease Association and the National Health and Medical Research Council of Australia. PN

An abstract of "Frontotemporal Dementia Associated With the C90RF72 Mutation" is posted at http://archneur.jamanetwork.com/article.aspx?articleid=1815003.

From the President

continued from page 3

tronic medical records and in the context of contributing to seamlessly accessible information such as through registries in the broader health care world.

In addition to these overarching issues of access and care delivery, our legislators are now considering mechanisms that would significantly impact the implementation of these policies. Rep. Tim Murphy's Helping Families in Mental Health Crisis Act, introduced partly in response to the Sandy Hook shooting, is aimed at improving interagency coordination, government data collection on treatment outcomes, and creating a centralized effort to implement evidence-based care. We support the bill's intentions, but are also pleased with the opportunity it offers to work with members of Congress to educate them about the changes needed in mental health care. We must stay vigilant to ensure that the rights of people with mental illness are not being jeopardized and the services they need and deserve are secure.

Yet another area requiring attention is the proposal by the Centers for Medicare and Medicaid Services to do away with several of the "protected classes" of prescription drugs under the Medicare Part D program in 2015 and 2016 (see page 4). APA's concern about the effect of this rule is well placed, since it would limit patient choice and provider options for treatment. This is especially important in psychiatry, an area of practice in which we cannot predict which medications a patient will respond to and tolerate best, and in which individuals may uniquely respond to a specific drug.

While the political pendulum has swung in our direction (the result of great effort on the part of APA and many other stakeholder groups, it should be noted) and we have made great legislative strides, we must always bear in mind our end goal. We are working to create a society in which mental disorders and chronic addictions are recognized and understood to be what they are: illnesses that are real and treatable. To truly effect sustainable change, we must view these historic legislative initiatives as more than just laws, but as a means by which to shift the way we collectively think about mental health and integrate it into general health. We are working to ensure that people with mental illness receive the care they need when and where they need it and without bias in a true culture of parity. PN

AACAP Updates Guidelines On Autism Spectrum Disorder

New practice parameter for autism spectrum disorder will help clinicians coordinate treatment.

BY AARON LEVIN

A flood of new research in recent years has prompted the American Academy of Child and Adolescent Psychiatry to revise a key guideline for evaluating and treating autism.

The "Practice Parameter for the Assessment and Treatment of Children and Adolescents With Autism Spectrum Disorder" applies that information to make the case for "multidisciplinary care, coordination of services, and advocacy for individuals and their families."

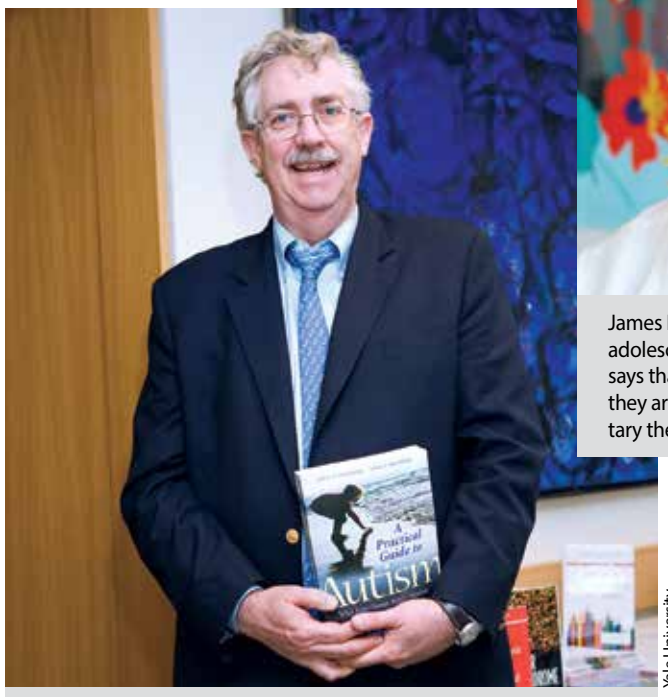
The practice parameter appeared in the February issue of the *Journal of the American Academy of Child and Adolescent Psychiatry.*

"There were about 2,800 papers published last year alone," said lead author Fred Volkmar, M.D., a professor of psychiatry, pediatrics, and psychology at the Yale School of Medicine and director of the Yale Child Study Center. "The field is changing rapidly."

Practice parameters seek to promote effective care and move professional medical methods closer to current best practices.

In all, Volkmar's work group reviewed abstracts of 9,581 articles and selected 186 for full examination based on quality and generalizability.

"This is a very comprehensive effort, based on the current evidence," commented James Harris, M.D., a professor and director of the Developmental Neuropsychiatry Clinic in the Division of Child and Adolescent Psychiatry at Johns Hopkins. Harris was not involved in the preparation of the practice parameter.



Yale University

New research creates a need for revised autism guidelines, said Yale's Fred Volkmar, M.D.

Aaron Levin

James Harris, M.D., a professor of child and adolescent psychiatry at Johns Hopkins, says that psychiatrists need to ask parents if they are using any alternative/complementary therapies with their children.

After summarizing material on the epidemiology, etiology, and clinical course of autism spectrum disorder, the document recommends routine inquiry about symptoms of autism spectrum disorder as part of the developmental assessment of young children and of the psychiatric assessment of all children. If a child has significant symptoms, clinicians should coordinate a full medical, psychological, and communication evaluation. A careful evaluation should differentiate between autism and a variety of developmental and other disorders, as well as intellectual and behavioral disabilities.

"Finding children with autism spectrum disorder early and getting them into treatment helps them do better and develop workaround tools," said Volkmar.

Treatment involves a team approach, he said. Strong evidence now supports structured educational, communication, and behavioral treatments backed by family involvement. There is lesser evidence for the value of pharmacological treatments, but they can help with comorbid conditions like anxiety, depression, aggression, inattention, and other problems.

"The role of psychiatrists is first to closely coordinate diagnosis and treatment with teachers, behavioral psychologists, and speech and language pathologists, as well as looking for co-occurring conditions like anxiety or mood dysregulation," said Harris. "Once a treatment team is in place, the psychiatrist can evaluate whether medications can help the child make productive use of those interventions."

The practice parameter concludes with a strong recommendation that clinicians should "inquire about the use of alternative/complementary treatments and be prepared to discuss their risk, and potential benefits."

"Perhaps 90 percent of parents of children with autism use some kind of alternative or complementary therapies," said Volkmar. "Most of them are harmless, but some, like chelation or secretin, are not, so we have to encourage a discussion with parents about the lack of evidence."

Harris agreed. "The psychiatrist has to ask what the parents are actually doing, then stick with them and educate them." PN

"Practice Parameter for the Assessment and Treatment of Children and Adolescents With Autism Spectrum Disorder" is posted at http://www.jaacap.com/article/S0890-8567(13)00819-8/fulltext.

Got a Question For APA's Leaders?

All APA voting members are invited to attend the Annual Business Meeting and Forum at APA's 2014 annual meeting in New York. It will be held Sunday, May 4, 12:30 p.m.-2 p.m. in the Westside Ballroom 1-4, Fifth Floor, New York Marriott.

The Annual Business Meeting informs members about the state of the Association and its activities and accomplishments over the past year. At the Annual Forum, APA voting members are invited to ask questions of and share comments with APA leaders.

Later Start Times Help Teens Obtain Adequate Sleep

Teenagers in schools that have moved their start times to 8:30 a.m. or later show fewer depressive symptoms and better academic performance than more sleep-deprived peers.

BY LYNNE LAMBERG

Starting high school classes at 8:30 a.m. boosts students' grades, mood, and driving performance, a new multisite study shows.

The three-year study assessed the impact of later high school start times on about 9,000 students in grades 9 to 12, and 500 in grades 6 to 8, in five public school districts in three states. Kyla Wahlstrom, Ph.D., director of the University of Minnesota's Center for Applied Research and Educational Improvement, led the study, which was funded by the Centers for Disease Control and Prevention (CDC).

Decades of research show that teenagers need 9 to 9.25 hours of sleep for optimal alertness. Most teenagers find it hard to fall asleep before 11 p.m., Wahlstrom said, because pubertal changes in the biological clock delay the evening onset of melatonin secretion. The start of sleep occurs about an hour later in adolescents than in prepubertal children.

Starting classes at 8:30 a.m. aligns the school day with the adolescent biological clock, Wahlstrom told *Psychiatric News*. This start time, she said, allows most teenagers to sleep about eight hours and still have time to eat breakfast and get to school.

Eight hours are a practical compromise, she noted, between teenagers' sleep need, parents' work hours, and typical school hours. It also allows students to obtain enough rapid eye movement (REM) sleep to process information from the previous day and consolidate memory.

In Wahlstrom's study, about 60 percent of students in schools that started at 8:35 a.m. slept eight or more hours on school nights. In the latest-starting school, which opened at 8:55 a.m., about 66 percent of students averaged eight or more hours of sleep. In schools starting at 7:30 a.m., only 34 percent of students did so.

Most U.S. public high schools start classes at 8 a.m.; many start before 7:30 a.m. In large metropolitan areas, school bus pickups start before 6 a.m., requiring a wake-up time of 5 a.m. or earlier. Some schools offer extra-credit classes or hold sports practice before the school day starts. Schools and sports organizations, Wahlstrom asserted, need to avoid scheduling early-morning activities that cut into teenagers' sleep.

Eight hours of sleep represents a tipping point that separates greater or lesser amounts of at-risk behaviors, Wahlstrom's group and others have found.

The CDC's most recent Youth Risk Behavior Survey, conducted in 2007, found, for example, that nearly 70 percent of U.S. high school students averaged less than eight hours' sleep on school nights, and 40 percent averaged six hours or less. Sleep-deprived students reported more symptoms of depression, thoughts of suicide, substance use, and other at-risk behaviors than those who slept eight hours or longer.

Wahlstrom's group replicated and extended those findings. When schools in their study started later, academic performance improved. After the Jackson Hole, Wyo., high school delayed its start time from 7:35 a.m. to 8:55 a.m., for example, students earned better grades in their first-period core subjects of English, math, science, and social studies. Attendance rose, and tardiness declined.

Car crashes caused by Jackson Hole drivers aged 16 to 18 also fell, from 23 crashes in the year prior to the change to seven afterward, a 70 percent decline. That's a significant drop, Wahlstrom said, resulting in greater safety of both teens and the general public.

In addition, students who averaged eight hours of sleep or more reported fewer symptoms of depression than those who slept less than eight hours. When asked to describe their mental state in the prior two weeks, she said, the longer the students slept, the less often they reported that they felt sad, unhappy or depressed, hopeless about the future, nervous or tense, or worried.

Teens sleeping eight hours or more also reported lower use of caffeine, alcohol, and illicit substances than their shorter-sleeping peers. A report on the study findings is in preparation. PN

More information about adolescent sleep is posted at http://www.cehd.umn.edu/care. Also posted there are videos from the nation's first conference on this topic.

Primary Care

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ioral health within the medical home. The group has also developed screening tools to help practices identify potential Medicare reimbursements and a list of resources on behavioral health integration including information about reimbursement for depression screening, reimbursement for screening and brief counseling interventions for alcohol misuse, and a comprehensive list of partner resources on behavioral health.

Nace says participation in the collaborative is free for individual clinicians, and he urges APA members to join. The Behavioral Health Task Force has monthly conference calls open to the public at noon EST on the third Wednesday of each month.

When asked how psychiatrists can catch the fast-moving train of integrated care, Nace repeats what other leaders in the field have said: get educated and get engaged. "Clinicians need to learn about collaborative care models and reach out to primary care practices wherever they are," he said. "When I meet with primary care physician practices, I hear time and time again that they are frustrated with patients who present with depression, anxiety, and substance abuse, and they don't know what to do. They frequently can't find someone to refer them to, so they prescribe the meds the drug companies provide, because they only have seven minutes to spend with the patient.

"We are in a remarkable period of transformation in American health care, and there will be winners and losers," Nace said. "The winners will be people who step up and work with others. The transformation will happen locally and will be based on building relationships." PN

The website of the Patient-Centered Primary Care Collaborative is http://www.pcpcc.org/. Clinicians who would like to get involved with the Behavioral Health Group can subscribe to receive agendas, news, and announcements at http://pcpcc.us2.list-manage.com/subscribe/post?u=dcfdd33cdd540f634734cf274&id=56f71f22aa.

Care Is Coordinated in the Medical Home

These are the principles of the patient-centered medical home, adopted by the American Academy of Pediatrics, American Academy of Family Physicians, American Osteopathic Association, and American College of Physicians. The four groups have representatives who are permanent members of the board of directors of the Patient-Centered Primary Care Collaborative; APA is an executive level member.

- Personal physician: Each patient has an ongoing relationship with a personal physician trained to provide first contact and continuous and comprehensive care.
- Physician-directed medical practice: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole-person orientation: The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, as well as acute care, chronic care, and preventive services.
- Coordinated and/or integrated care: Care is coordinated or integrated across all elements of the complex health care system (for example, subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (for example., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- Quality and safety: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care-planning process driven by a compassionate, robust partnership between physicians, patients, and their families. Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision making, and feedback is sought to ensure patients' expectations are being met. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Parental Age Linked to Patterns Of Mental Illness in Offspring

A new study builds on research linking parental age and mental illness in children, revealing a more nuanced pattern of relationships.

BY MARK MORAN

Further evidence has been found linking parental age to risk for various mental disorders among offspring.

In particular, the offspring of younger mothers (those aged 12 to 19) appear to have the highest risk for mental disorders compared with other parental age groups. And fathers' age appears to present a J-shaped risk curve with offspring of teenage fathers and fathers over the age of 45 having increased risk for disorders.

Those were the findings of a large population-based Danish study published online in *JAMA Psychiatry* on January 22. The study adds to growing literature on parental age and mental disorders in offspring; in 2012 a widely publicized study in the journal *Nature* reported that older paternal age was linked with autism among offspring (*Psychiatric News*, October 19, 2012).

The *Nature* study, and much discussion that followed its publication, focused on the role of "de novo mutations" in the DNA of older fathers. But the *JAMA Psychiatry* study, using sophisticated epidemiologic genetics and drawing on a very large birth registry, suggests the role of social, environmental, and epigenetic variables associated with younger or older parents.

"This study really provides more information and greater detail about the genetic mechanisms that are associated with vulnerability to brain disorders affecting behavior and intellectual function," APA President Jeffrey Lieberman, M.D., commented to *Psychiatric News.*

John McGrath, M.D., of the University of Queensland in Australia and colleagues used records from the Danish Psychiatric Central Research Register to follow 2,894,688 individuals born in Denmark from January 1, 1955, through December 31, 2006. Individuals within the study cohort and their parents and siblings were linked via their personal identification number to the Danish Psychiatric Central Research Register to obtain information about mental illness. The register was computerized in 1969 and contains data on all admissions to Danish psychiatric inpatient facilities and, from 1995, information on outpatient visits to psychiatric departments.

Maternal and paternal ages at the time of the child's birth were categorized as 12 to 19, 20 to 24, 25 to 29, 30 to 34, 35 to 39, 40 to 44, and 45 or older. For each psychiatric disorder, individuals were observed from the earliest age at which they may possibly develop the specific disorder or January 1, 1995 (whichever

came last), until onset of the outcome in question, death, emigration from Denmark, or December 31, 2011 (whichever came first).

The cohort was observed for 42.7 million person-years, during which 218,441 members of the cohort had their first psychiatric contact for any psychiatric disorder. Based on the overall risk of psychiatric disorders, the offspring of younger and older parents were at increased risk compared with those of parents aged 25 to 29. Considering the broadest category of "any psychiatric diagnosis" as the outcome of interest, the researchers found that the offspring of the youngest mothers were at the highest risk for any mental disorders: compared with the offspring of mothers aged 25 to 29, the offspring of mothers aged 12 to 19 had a 51 percent increased risk of having a mental disorder. No significantly increased risk for the offspring of older mothers was found.

Paternal age, however, showed a J-shaped relationship, with the offspring of teenaged fathers having a 28 percent increased risk for a psychiatric disorder, while the offspring of the fathers aged 45 or older had a 34 percent increased risk.

When the offspring were examined for particular disorders, the nature of the relationship changed. For example, the offspring of older fathers were at an increased risk of schizophrenia and related disorders, mental retardation, and autism spectrum disorder. In contrast, the offspring of young mothers (and to a lesser extent young fathers) were at an increased risk for substance use disorders, hyperkinetic disorders, and mental retardation.

"For many disorders, the risk for mental disorders in the offspring of young (especially teenaged) mothers is comparable to that seen in the offspring of older fathers," the authors stated. "The offspring of teenaged fathers are also at risk for some disorders. For disorders such as schizophrenia and pervasive developmental disorder, the association between the variables of interest is J-shaped, with a higher risk found in the oldest group of fathers."

McGrath and colleagues also noted that studies have generally suggested that early parenthood may contribute to a cascade of events related to socio-

*see **Parental Age** on page 27*

Key Points

- Compared with the offspring of mothers aged 25 to 29, the offspring of mothers aged 12 to 19 had a 51 percent increased risk of having a mental disorder—the highest of any of the parental age groups.
- Paternal age showed a J-shaped relationship, with the offspring of teenaged fathers having a 28 percent increased risk for a psychiatric disorder, and the offspring of the fathers 45 years or older had a 34 percent increased risk.
- The offspring of older fathers were at an increased risk of schizophrenia and related disorders, mental retardation, and autism spectrum disorder. The offspring of young mothers (and to a lesser extent young fathers) were at an increased risk for substance use disorders, hyperkinetic disorders, and mental retardation.

Bottom Line: The study revealed a more complex and nuanced pattern of association between maternal and paternal ages and the risk for mental illness in the offspring than had been known.

Mental Illness Highly Prevalent Among Incarcerated Women

There is growing research interest in the subject of incarcerated women—especially factors associated with recidivism—and a wider recognition of the prevalence of trauma history.

albund/Shutterstock

BY MARK MORAN

Almost 1 in 3 incarcerated women meets criteria for past-year serious mental illness, and almost half of this group have severe functional impairment, according to a report published February 3 in *Psychiatric Services in Advance.*

Shannon Lynch, Ph.D., of Idaho State University and colleagues at four other institutions interviewed 491 randomly sampled women in jails in Colorado, Idaho, South Carolina, and the metropolitan area of Washington, D.C. Interviews were conducted at nine jails across the four regions between June 2011 and March 2012. The women ranged in age from 17 to 62, with a mean age of 35; 75 percent (n=369) had children under age 18.

One-quarter (n=119) were first-time offenders, and 16 percent (n=79) were charged with or convicted of a violent crime (including assault, battery, non-prostitutional sex offense, manslaughter, or homicide). One in 5 participants was incarcerated for two weeks or less (20 percent, n=98), and 49 percent (n=242) were incarcerated for fewer than five weeks at the time of the interview.

Lynch and colleagues used the Composite International Diagnostic Interview (CIDI), a structured interview that assesses lifetime and 12-month presence of mental illness. The CIDI paper-and-pencil modules for major depressive disorder, bipolar disorder, PTSD, and substance use disorders were used in this study. The CIDI screening items for serious mental illnesses (major depressive disorder, bipolar disorder, and schizophrenia spectrum disorders) and for PTSD and substance use disorders were administered to all participants; those who screened positively on the CIDI psychotic items also were administered an adapted version of the psychotic disorders module of the Structured Clinical Interview for *DSM* Disorders (SCID-I), Research Version, to assess schizophrenia, schizophreniform, or schizoaffective disorder.

Items from the Sheehan Disability Scale are integrated into each CIDI module to assess impairment.

The prevalence of mental disorders in the full sample was high; 91 percent (n=446) met lifetime criteria, and 70 percent (n=343) met 12-month or current criteria for at least one disorder. Notably, 43 percent met lifetime and 32 percent met current criteria for a serious mental illness, including major depressive disorder, bipolar disorder, and schizophrenia spectrum disorders. Substance use disorders were the most commonly occurring lifetime (82 percent) and current disorders (53 percent). Lifetime and current PTSD rates also were high (53 percent and 29 percent, respectively).

Among those meeting criteria for serious mental illness, 45 percent showed signs of severe functional impairment. Almost 1 in 3 met criteria for a serious mental illness and PTSD, 38 percent for a serious mental illness and a co-occurring substance use disorder, and about 1 in 4 for all three in their lifetime.

"The prevalence of serious mental illnesses and their co-occurrence with substance use disorders and PTSD in this large, representative sample of women in jail suggests the critical need for comprehensive assessment of mental health and impairment level at the point of women's entry into the criminal justice system and for increasing alternatives to incarceration, such as mental health and drug courts, and for programs that can address women's treatment needs," the researchers said.

Commenting on the study for *Psychiatric News*, Debra Pinals, M.D., assistant commissioner of forensic services at the Massachusetts Department of Mental Health and an associate professor at the University of Massachusetts Medical School, noted that women and girls are a growing proportion of the incarcerated.

Moreover, women have unique problems and needs that may make alternatives to incarceration especially vital. Chief among these is the fact that, as is true in the cohort in the *Psychiatric Services* study, many of the women are mothers.

The quality of relationships with children—as well as with husbands and boyfriends and family members—is critical in outcomes. "In my experience working with incarcerated women, their relationships with their own mothers, sisters, children, and the men in their lives is a huge factor in long-term outcomes," Pinals said.

She also said that the increasing rate of incarcerated women has stimulated research interest in this population, especially around the subject of recidivism. She also said there is a growing recognition of the prevalence of trauma in the lives of women in the criminal justice system. "Criminal justice settings are not typically trauma informed," she said. "The use of shackles, isolation, the presence of loud noises, and the power dynamics that exist in jails and prisons can exacerbate trauma-related reactivity and can impact symptoms of mental illness in women with a history of trauma.

"Attention to trauma histories, risk levels, and psychosocial variables related to recidivism, along with a focus on barriers to success and the impact of incarceration and offending on families and children warrant specific attention," she said. "Where serious functional impairments are identified, programs that attend to rehabilitation and support can be developed that can help these women achieve additional improvements."

This study was funded by a grant from the Bureau of Justice Assistance, U.S. Department of Justice. PN

"A Multisite Study of the Prevalence of Serious Mental Illness, PTSD, and Substance Use Disorders of Women in Jail" is posted at http://ps.psychiatryonline.org/data/Journals/PSS/0/appi.ps.201300172.pdf.

CLINICAL & RESEARCH NEWS

Neurocognitive Lag Accompanies Early Psychotic Symptoms

Although youth with psychotic symptoms generally lag in complex cognition more than in other neurocognitive domains, the lag pattern may differ from one youngster to another.

BY JOAN AREHART-TREICHEL

In a large population study, researchers found that children experiencing psychotic symptoms lagged behind their typically developing peers of the same age in neurocognition.

Moreover, this lag was found to be present as early as age 8 when children of that age experienced psychotic symptoms.

The senior researcher was Rachel Gur, M.D., Ph.D., a professor of psychiatry at the University of Pennsylvania. The results were reported on February 5 in *JAMA Psychiatry*.

The study included 2,321 youth aged 8 to 21 who reported having psychotic symptoms. They were compared with 1,963 typically developing children with no psychiatric disorders and also with 981 children with psychiatric symptoms other than psychosis.

Each of the subjects was given, for one hour, a battery of neurocognitive tests to evaluate different types of neurocognitive performance—for example, executive function, episodic memory, complex cognition, social cognition, and sensorimotor speed. The results from the psychosis group were compared with those of the typically developing and other psychiatric symptom groups.

The researchers found that subjects with psychotic symptoms lagged behind typically developing subjects of the same age. Furthermore, psychotic-symptom subjects with more severe symptoms showed greater developmental lag than those with milder symptoms. The delay associated with psychotic symptoms occurred across all neurocognitive domains, ranged between six and 18 months, and was present already as early as at age 8 in those children who experienced psychotic symptoms at that age.

As for the subjects with nonpsychotic psychiatric symptoms, they did not show a neurocognitive delay, indicating that the delay was limited to psychosis.

The results have clinical implications, the researchers said. "Combined clinical and neurocognitive assessment can facilitate early detection and targeted intervention to delay or ameliorate disease progression." For instance, "Although as a group psychotic-symptom individuals show greater lag in complex cognition than other domains, including executive function, the lag pattern may differ for individuals and can form the basis for designing tailored intervention approaches."

Gur and her team now plan to follow up to 300 of the psychotic-symptom subjects and 200 of the typically developing subjects. It will thus "become possible to test whether early indicators, such as neurocognitive dysfunction, predict and deteriorate in association with onset of full psychosis among those with subthreshold symptoms at baseline," Tyrone Cannon, Ph.D., of Yale University wrote in an accompanying editorial.

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

An abstract of "Neurocognitive Growth Charting in Psychosis Spectrum Youths" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=1819579.

FROM THE EXPERTS

Krokodil: 'Zombie Drug' Hits U.S.

BY VISHESH AGARWAL, M.D., AND PETROS LEVOUNIS, M.D., M.A.

Krokodil, the so called "flesh-eating zombie drug," is the newest addictive drug to reportedly hit the United States. Scary photographs showing deep wounds on people's extremities abound on the Internet. Television news programs have given us a number of interviews with emergency room physicians who have alerted the public on the dangers of this latest drug menace. How much of this is true, and how much is simply hype?

Krokodil (Russian: крокодил, crocodile) takes its name either from the green scale-like appearance of the skin of its users or from its derivation from alpha-chlorocodide, an intermediate compound during its production from codeine. It was initially reported in Russia in 2003, and its current prevalence is estimated to be around 5 percent to 7 percent among people who inject drugs in Russia and Ukraine. Since Russia banned over-the-counter sale of codeine-containing tablets starting on June 1, 2012, Krokodil use has reportedly been declining.

Krokodil is a mixture of several substances with the primary opioid component being desomorphine and is highly impure due to contamination with multiple toxic ingredients used during its production. Desomorphine (dihydrodesoxymorphine) was first developed in the United States in 1932 and is as much as 10 times more potent than morphine. It was marketed in Switzerland until 1952, under the trade name Permonid, as a postoperative analgesic. Interestingly, its production continued until 1981 for analgesic needs of a single patient with a rare disorder. Desomorphine has a rapid onset of action and shorter elimination half-life, accounting for its increased addictive potential and leading krokodil users to perform more applications as compared with heroin users. krokodil can be conveniently produced from codeine-containing tablets, iodine, and red phosphorous (phosphate source is usually obtained from striking pads of matchboxes), with paint thinner or gasoline (organic solvent) and hydrochloric acid. The inferior chemistry involved in its production results in serious injuries such as thrombophlebitis, skin and soft tissue infections, tissue necrosis, and gangrene. Krokodil-addicted patients die within an estimated two years of addiction.

In September 2013, reports from Phoenix claimed that local hospitals treated two people for "symptoms consistent with Krokodil use," following which *USA Today* reported that "Flesh-rotting 'Krokodil' Drug Emerges in USA" (http://www.usatoday.com/story/news/nation/2013/09/26/heroin-krokodil-flesh-rotting-arrives-us-arizona/2879817/). Since then, *Time* magazine has published more than 10 articles on both suspected and reportedly confirmed reports of Krokodil use in the United States. The most recent one, by Simon Shuster published on December 9, 2013, and titled "Krokodil Tears" (http://content.time.com/time/magazine/article/0,9171,2158683,00.html), discusses its origin in Russia and spread across Europe and the United States. CNN, not far behind, also has published several stories about suspected cases of Krokodil use in Illinois, calling it the "flesh-eating zombie drug" (http://www.cnn.com/2013/10/16/health/krokodil-zombie-drug/).

So, how much of all this is true? In January, Joseph Moses, a spokesperson for the Drug Enforcement Administration, emphatically declared that there has not been a single toxicology report confirming desomorphine in reported cases, and it has not shown up in drug samples reported to be Krokodil. Jacob Sullum, a *Forbes* contributor, added to the discussion in an article published in *Forbes* on January 10 (http://www.forbes.com/sites/jacobsullum/2014/01/10/krokodil-crock-how-rumors-of-a-flesh-eating-zombie-drug-swept-the-nation/) titled "Krokodil Crock: How Rumors of a 'Flesh-Eating Zombie Drug' Swept the Nation." Sullum argued that the reason for the popularity of Krokodil in Russia and Eastern Europe has been the high price of heroin and low price of codeine. On the contrary, in the United States heroin can be much more easily obtained. Also, with much stricter prescription laws in this country, codeine-containing tablets are harder to obtain.

Krokodil use may not have reached our soil (yet), but the Krokodil hype has certainly taken this country by storm. In today's information frenzy, a drug like Krokodil that captures the public's imagination—and fear—can be perceived as far more prevalent than

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Suicides

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ation to attempts.

IED is an impulse-control disorder, which may have some bearing on suicide, since it is an act that often involves impulsivity and aggression, said Sareen.

"Some suicides are based on impulsivity, and IED may be capturing that risk element the most," said Robert Ursano, M.D., co-principal investigator of the ArmySTARRS project and a professor and chair of psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Md., in an interview. "Similar underlying impulsivity risk may also reflect other disorder risks like substance use or anxiety disorders."

Contrary to studies of age-matched civilians, pre-enlistment panic disorder and PTSD did not predict post-enlistment first suicide attempts.

"Pre-enlistment histories of PTSD and panic disorder might be markers of resilience among people who enlist in the Army even though they are markers of vulnerability in the general population," hypothesized Nock.

A second study of seven Department of Defense administrative data systems, focusing on 975,057 Regular Army soldiers, found that being male, less educated, having a lower rank, and being in the service for less than two years elevated risk of suicide death. At the same time, it ruled out one other suspected factor.

During and after the "Surge" in Iraq in 2007-2008, when many more troops were needed, observers suggested that increased suicide rates were due to admitting recruits with waivers for medical, substance abuse, or conduct conditions that would have previously excluded them.

However, the current results "debunk" any such associations, wrote Michael Schoenbaum, Ph.D., a senior advisor for mental health services, epidemiology, and economics in the Office of Science Policy, Planning, and Communications at the National Institute of Mental Health, and colleagues.

That finding reveals significant sociodemographic and Army career correlates of suicide risk, some of which have not been previously documented, said Schoenbaum and colleagues.

A third study, led by Ronald Kessler, Ph.D., a professor of health care policy at Harvard Medical School, examined the 30-day prevalence of *DSM-IV* mental disorders in the same sample of 5,428 soldiers used by Nock.

About 25.1 percent of respondents recorded any disorder in the prior 30 days, 15.0 percent for any internalizing disorder, and 18.4 percent for any externalizing disorder.

While pre-enlistment rates of internalizing disorders (such as major depression or posttraumatic stress disorder) were lower in the Army group compared with civilian population samples, prevalence of panic disorder and PTSD were higher.

Rates of externalizing disorders (such as intermittent explosive disorder or substance use disorder) before enlistment age for both military and civilian cohorts was about equal, although higher rates of those disorders eventually appeared among the soldiers.

Marriage is usually considered a protective factor versus suicidal behavior, but that was not what Kessler and Nock found. Never-married soldiers had a lower prevalence of mental disorders compared with their married counterparts, noted Kessler, who suggested that the strains of military life on marriages might account for the difference. Nock also found lower odds of suicide attempts among unmarried soldiers, a finding "inconsistent with lower rates of suicidal behaviors among married than unmarried civilians."

The Army STARRS study is nearing the finish line, said Ursano.

"We have completed data collection," he said. "New findings and more papers are in the pipeline."

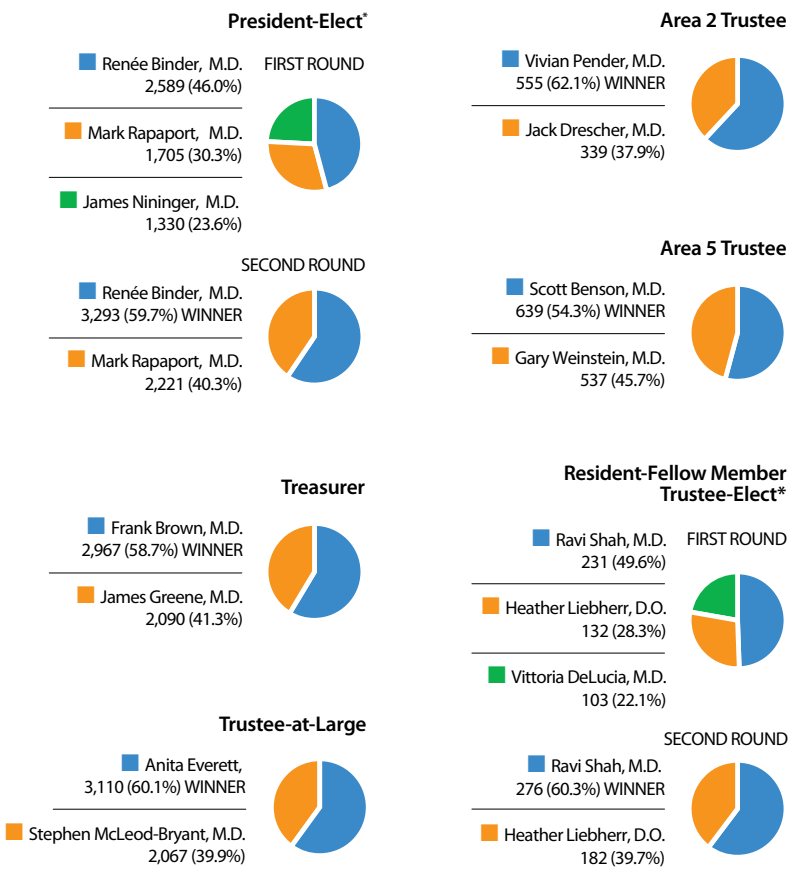
However, some steps might be taken even now to reduce suicidality, based on current research.

"[T]he Army should develop outreach and treatment programs for new soldiers based on the realization that a nontrivial proportion of its new recruits come into the Army with a history of suicidal behavior or mental disorders that are risk factors for suicidal behaviors," said Nock.

Besides revising screening procedures to improve assessment of recruits, the Army might create a risk score like those for heart disease, added Sareen. Then, rather than simply reject recruits at higher risk, the Army might direct them to more appropriate tasks within the service, ones that are less stressful than severe combat or require long deployments. PN

The three studies—"Thirty-day Prevalence of *DSM-IV* Mental Disorders Among Non-Deployed Soldiers in the U.S. Army: Results From the Army Study to Assess Risk and Resilience in Servicemembers," "Prevalence and Correlates of Suicidal Behavior Among Soldiers: Results From the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)," and "Predictors of Suicide and Accident Death in the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)"—can be accessed at *JAMA's* website at http://jama.jamanetwork.com/journal.aspx.

Results of APA's 2014 Election



* A majority vote (>50%) is necessary in a three-way contest. If a majority does not exist after tallying all first-choice votes, voters' second-choice votes for the candidate with the least amount of first-choice votes are tallied and added to the remaining candidates' tallies. This follows the procedure outlined for "Preferential Voting" in Sturgis' *The Standard Code of Parliamentary Procedure.*

Election Results

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In the race for treasurer, Frank Brown, M.D., of Stone Mountain, Ga., emerged the winner over James Greene, M.D., of Memphis.

For trustee-at-large, incumbent Anita Everett, M.D., of Glenwood, Md., outpolled Stephen McLeod-Bryant, M.D., of Old Hickory, Tenn.

This year, two APA Areas elected trustees—Areas 2 and 5. The new Area 2 trustee is Vivian Bender, M.D., of New York City. Her opponent was Jack Drescher, M.D., also of New York City. In Area 5, R. Scott Benson, M.D., of Pensacola, Fla., defeated Gary Weinstein, M.D., of Prospect, Ky.

Each year the Association's resident members elect a resident-fellow member trustee-elect, who the following year rotates into the position of resident-fellow member trustee. Ravi Shah, M.D., a resident at Columbia University–New York State Psychiatric Institute, won this year's race against Vittoria DeLucia, M.D., a resident at the University of Maryland/Sheppard Pratt Program, and Heather Liebherr, D.O., a resident at the University of Pittsburgh Western Psychiatric Institute and Clinic.

Election results were approved by the Tellers Committee in February, and the results became official after the Board of Trustees reviewed them at its meeting early this month. All of the winning candidates will assume their positions on the Board at the close of the annual meeting in May. PN

From the Experts

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it really is. In contrast, drugs of abuse that fail to feed the media's and the Internet's sweet tooth for sensational images, such as prescription pills, continue to go largely unnoticed. In 2014, we are lucky to be able to readily access news from any part of the world within moments of its being reported. At the same time, we are quite vulnerable to the false positives of what has become the social equivalent of a polymerase chain reaction. If our primary source of information comes from Google.com (and we bet you are just about to Google Krokodil, if you haven't already done so), then we shouldn't be all that surprised when the resulting data turn out to be considerably more sensitive than specific. PN

Defendants

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not affiliated with the Miami-Dade center, in an interview. Even a nondangerous defendant who is incompetent to stand trial can't legally reach an agreement in mental health court to accept treatment and other services in exchange for release.

At the Forensic Alternative Center, defendants remain in the criminal court system. Prisoners undergo a psychiatric screening on intake at the county jail and then can be referred for a competency assessment. If a judge then rules them incompetent, they either can be committed to a state mental hospital for treatment and restoration of competency—which was the only option prior to 2009—or, now, to the Forensic Alternative Center.

The unit has 16 beds. The staff includes nurses, a case manager, and competency instructors, as well as the psychiatrist. Patients spend an average of 97 days there in treatment, learning life skills and taking competency classes to improve their understanding of who does what in the courtroom and how to work with their lawyers on their case. Peer counselors offer support on the unit and after release.

"We also help them recognize and react to emotional states without acting instinctively, to improve their functioning in the community," said Carney.

"We needed a hybrid model that fell between community restoration and

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Defendants

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the state forensic system," said Leifman. "The Forensic Alternative Center uses a sophisticated medical model to treat the individual's illness and prepare them to go back to the community."

Following restoration, defendants return to court where they may receive probation, charges may be dropped, or they may choose to have a trial. Recidivism rates so far have been "almost nonexistent," said Leifman.

Other states have competency restoration programs, but the Forensic Alternative Center's approach may herald another approach, one that may someday expand to the rest of the state, he said.

"The Florida program expands the goal of competency restoration from simply a one-size-fits-all model—going to jail and then to court—to a more comprehensive model that considers ultimate disposition," said Ash. PN

Information about the Miami-Dade Forensic Alternative Center is posted at http://www.fccmh.org/resources/docs/forensic_mental_health.pdf.

College MH Caucus to Meet

APA members with a special interest in college mental health issues are invited to participate in a meeting of APA's College Mental Health Caucus at APA's annual meeting in New York on Monday, May 5, from 9 a.m. to 12:30 p.m., in the Riverside Suite on the third floor of the Sheraton New York Times Square Hotel.

Parental Age

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economic exclusion. "Teenaged parenthood has been associated with a broad range of adverse health, educational, social, and crime-related outcomes in the mothers and their offspring," they continued. "However, ascribing these outcomes directly to the ages of the parents versus a wide range of confounding factors is difficult, . . . further highlighting the complex and socially patterned web of causation that may link the variables of interest."

Lieberman said that the wide array of disorders examined in the study and the patterns associated with parental age suggest a much more nuanced picture of risk than a simple linear relationship with de novo mutations. "The story that is emerging about medical genetics when it comes to psychiatric disorders is a far more complicated picture and a more complex set of mechanisms than we have anticipated in the past," Lieberman said. "There are multiple ways in which the genome can express itself and in which the environment and social or cultural factors can influence gene expression leading to risk for mental illness."

This study was supported by the John Cade Fellowship of the Australian National Health and Medical Research Council, the Stanley Medical Research Institute, and the Lundbeck Foundation. PN

"A Comprehensive Assessment of Parental Age and Psychiatric Disorders" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=1814892.

Integrated Care

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trust, and complement each other in their skills and can accomplish things that no one team member could easily accomplish alone. The research evidence for collaborations of psychiatrists and primary care physicians goes back to the early 1990s when Wayne Katon, M.D., and colleagues first studied this approach in a randomized, controlled trial. Since then, more than 70 studies have proven that effective collaborations of psychiatrists with primary care providers and other health care professionals can result in better outcomes for patients with common mental health problems, such as mood or anxiety disorders, who are often seen in primary care and school-based health settings.

Such programs not only help us reach more people in need of mental health care but provide us with an opportunity to provide truly patient-centered care. If we work closely with a patient's primary care provider, we can address both the physical and behavioral health needs of our patients in one place. Mental and physical health are inextricably linked, and it makes sense to have general medical providers and psychiatrists working closely together.

A recent follow-up of participants in the IMPACT study, the largest study of collaborative care to date, reported in the January *Psychosomatic Medicine* that over an eight-year period, patients without preexisting heart disease who received collaborative care were half as likely to have serious cardiovascular events or deaths than those who received care as usual.

We can see examples of effective task sharing in sports, music, and other fields of medicine (for example, surgery, which often requires highly sophisticated collaboration of complementary team members). On a sports team, each member has a clearly defined role and skill, but an effective team is much more than the sum of its parts. In an orchestra, a violinist must master her own instrument, but she also has to learn to play well with others to create truly beautiful music. To be an effective consultant on a collaborative care team, psychiatrists have to be solid and comfortable with their own skill set. They also have to learn to work with and trust other team members who complement their strengths. As the most highly trained mental health professional on a collaborative care team, psychiatrists should also provide leadership to make sure the team is adequately trained, resourced, and supported to be effective.

When we learn to share effectively, we reach more patients than we could on our own and we provide better care. Going back to the music analogy, when we learn to play together, we have an opportunity to produce beautiful music and enjoy the process of making music together.

The concept of task sharing is simple, but in my experience, this kind of sharing or collaboration is not a natural state for most health care providers, psychiatrists included. In other words, we may have to learn to share. For psychiatrists, such learning should start in residency and fellowship training, and recent articles by several early career psychiatrists (see end of column for references) have explored ways to learn such skills early on. Mid-career psychiatrists interested in sharing their knowledge and expertise as part of a collaborative care team are increasingly finding opportunities to learn and share these skills at APA's annual meeting, APA's Institute on Psychiatric Services, and the Academy of Psychosomatic Medicine's annual meeting. PN

"Psychiatric Consultant Helps Shape Care of Wide Range of Patients" is posted at http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1812234; "Preparing Psychiatry Residents as 21st Century Psychiatrists" is posted at http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1827559.