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PSYCHIATRIC NEWS

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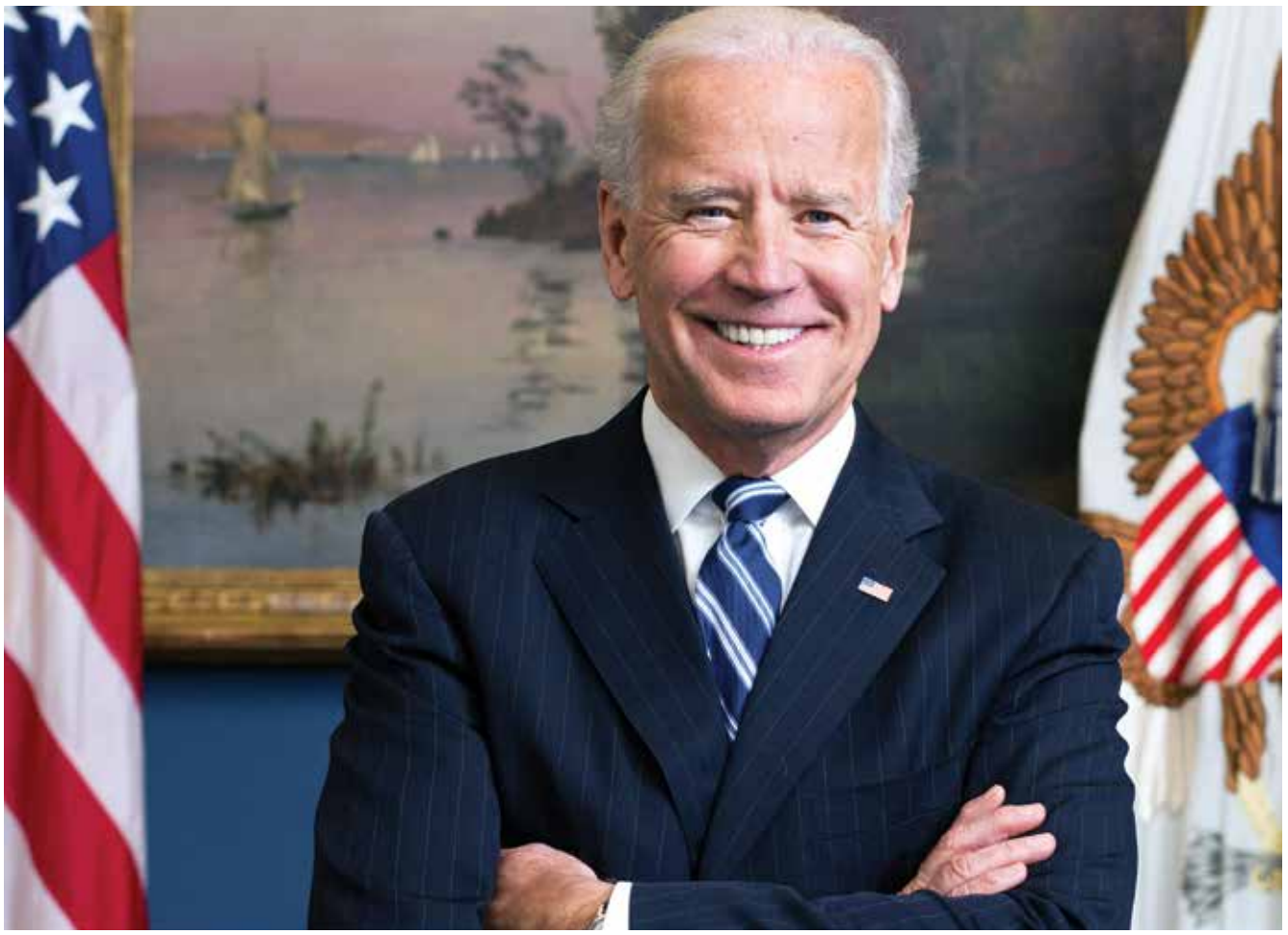

White House

Vice President Joe Biden to Speak At APA Annual Meeting

BY CATHERINE F. BROWN

Vice President Joe Biden will address APA's 167th Annual Meeting in New York City on Monday, May 5. He will deliver the William C. Menninger Memorial Convocation Lecture at 2 p.m. at the Javits Convention Center in Hall 3E, Level 3.

"We are delighted that Vice President Biden will join us at the APA annual meeting to address the psychiatric community on the important issues of how our country can best care for persons with mental illness and addictions," said APA President Jeffrey Lieberman, M.D.

APA's annual meeting runs from Saturday, May 3, to Wednesday, May 7.

"Vice President Joe Biden has been a long-time supporter of the importance of psychiatric research and access to care, and has been a leading voice on reducing the stigma of mental illness and bringing an end to the suffering it has caused," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "We are honored that the Vice President has agreed to present the keynote lecture at this year's annual meeting."

Biden graduated from the University of Delaware and Syracuse Law School and served on the New Castle County Council. Then, at age 29, he became one of the youngest people ever elected to the United States Senate. As a Senator from Delaware for 36 years, Senator Biden established himself as a leader

*see **Biden** on page 18*

Miami Schools Expand 'Typical Or Troubled?' Program

The head of one of the nation's largest school systems lauds the value of a program focusing on early recognition and intervention for students' mental health problems.

BY AARON LEVIN

The American Psychiatric Foundation's "Typical or Troubled?" school mental health education program now being implemented in the Miami-Dade County School system is training key staff members in the nations' fourth-largest school district on how to educate their coworkers about signs of mental illness in students.

"Typical or Troubled?" trains teachers, other school personnel, and students to differentiate ordinary teenage behavior from possible mental health warning signs.

"We are doing a deep dive into intervention and prevention, empowering our people to engage in the early identification of behavior that is troubling to a student but can be mitigated if addressed early on," said Miami-Dade County Public Schools Superintendent Alberto Carvalho, in an interview with *Psychiatric News*.

The program works on a premise analogous to education, he said: "It is best to invest aggressively early on in the social and academic facets of raising a child than to deal with the remediation costs for a 10th grader."

Carvalho has headed the Miami-Dade schools since 2008 and was named

*see **Miami** on page 29*

PERIODICALS: TIME SENSITIVE MATERIALS

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MEMBERS IN THE NEWS

EDUCATION & TRAINING

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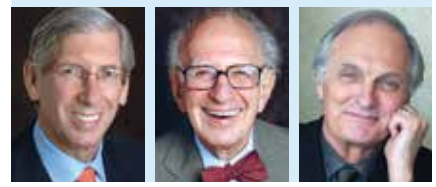
COMMUNITY NEWS

Register Now!

For APA's 2014 annual meeting, the Association returns to one of its most popular hosting locations, New York City. Online registration ends May 1; beginning Friday, May 2, at noon, you can register on site at the Javits Convention Center.

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

Marijuana Legalization and Young Brains: Time for Serious Study

BY ROBERT DUPONT, M.D., AND JEFFREY LIEBERMAN, M.D.

While we debate and differ on the risks and benefits of legalization, decriminalization, and medical uses of marijuana, all will agree (or say they do) that marijuana should remain illegal for young people. However, we should not deceive ourselves; just like with alcohol and tobacco, young people will almost certainly have ready access to pot with the liberalization of our laws and the commercialization of marijuana. What we are missing in fully understanding the ramifications of this new legislation, which can have broad effects on our country and culture, is firsthand knowledge of how marijuana affects the brain, particularly the young brain. Without more scientific evidence, we are gambling with the health and safety of our young people based on speculation and wishful thinking. Moreover, our national wager will increase as more states move to legalize marijuana.

The irony is that we currently have the capacity to determine whether there are harmful effects of marijuana on the developing brain. The rapid growth of brain science in the last two decades has provided the capacity to measure the effects of drugs on behavior and mental functions and to identify brain changes in structure and function—something not previously possible. Substantial evidence from animal models and several human studies has shown that drug use produces a sensitization of brain circuits that leads to sustained drug use and to progression to additional damaging drug use and to perpetuation and relapse during abstinence. The tragic death of Philip Seymour Hoffman is a prime example of these enduring effects. After a period of extensive drug use in his youth, he was drug-free for 20 years, only to fall victim to a common prescription for a pain medicine that triggered a fatal relapse into addiction at age 46.

The National Institute on Drug Abuse (NIDA) has funded groundbreaking research to understand specifically how drugs change the brain in a way that impairs mental functions and leads to addiction. This research has revealed how otherwise dissimilar drugs act through common neural pathways of reward to cause addiction. These fundamental pathways are hijacked by drugs that stimulate them far more intensely than do natural rewards like food and sex, which affect the same brain-reward system. That is why food and sex pathologies have so much in common with addiction to tobacco, alcohol, and other drugs, including marijuana.

This capacity for drug-induced alterations in the brain is greatly enhanced during childhood and adolescence, when the brain is developing. In recent years, the National Survey on Drug Use and Health has annually reported that children who initiated alcohol or marijuana use at age 14 or younger report a fivefold increased prevalence of a substance use disorder later in life. These results suggest that drugs affect the trajectory of the developing adolescent brain. What we don't know is how this differs from what would have been the drug-unexposed trajectory and what is the end result.

Missing is the scientific evidence to enable us to appreciate the specific impact of marijuana on the developing brain. Proponents of legalization argue that pot is "no worse" than alcohol and tobacco in terms of their potential for medically harmful effects. While this may be true (to some extent), many of the potential deleterious effects and long-term brain pathologies from adolescent drug use are seen in mental health where marijuana use can trigger serious and persisting anxiety and psychotic disorders. And no one is talking about the possible effects of adolescent marijuana use on more subtle brain effects, including information processing, academic achievement, and motivation.

Research has already shown that early marijuana use is linked to these problems. We need data to show whether those changes have enduring biological underpinnings. Answers to this and other questions are essential to guide future drug policy and legislation.

There are many things that can and should be done to address the problem of substance abuse in our population. The major barrier has been the limited resources available to fund this research. However, given this new wave of legislation and its potential impact on the youth of our nation, it should be an urgent priority to determine the effects of marijuana use on the developing brain. Now is the time to launch a long-term study of a large, carefully selected, national cohort of 10-year-olds to be followed continuously for at least 15 years. It should begin before adolescence when the brain is rapidly developing, reorganizing, and undergoing final formation of major connections, the time when enduring brain biology can be established or changed. Uniquely among signaling systems, adolescence is the period when the wiring of the brain dopamine system is completed, the same dopamine involved with brain reward, learning and memory, psychosis, and sexual response. It is also the time before and during youthful initiation and novelty seeking.

Only with such a study, a veritable Framingham Study, of the effects of drug use on youth, with the support of the National Institutes of Health (NIH), will it be possible to advance our understanding of the brain impact of marijuana and other drug use on youth. However, support for this study must come from new funds and cannot cannibalize the meager existing budgets of the NIH institutes, which are already stretched by the lingering effects of the Great Recession and sequestration.

With the recent state laws making marijuana more acceptable and more widely available, we are already behind schedule. A national investment in science must be made now to answer the essential questions about the impact of drug use, especially marijuana use, on the adolescent brain. Imagine if our country a century ago had the knowledge we have today about the negative health effects of tobacco. We cannot afford to wait any longer to learn the truth about the possible adverse brain effects of marijuana use. PN

You can follow Dr. Lieberman on Twitter at @DrJlieberman. To do so, go to https://twitter.com/DrJlieberman, log in or register, and click on "Follow."

Robert DuPont, M.D., was the first director of the National Institute on Drug Abuse (1973-1978) and is president of the Institute for Behavior and Health Inc. Jeffrey Lieberman, M.D., is president of APA and chair of the Department of Psychiatry at Columbia University.

MEMBERS IN THE NEWS

Psychiatrist Remedies Lack of MH Care For Women in Rural India

Until recently, limited mental health care was available to women in several rural villages of southern India. Thanks to a U.S. psychiatrist, these women's lives have improved considerably.

BY EVE BENDER

The women walk for hours over dusty roads and under the hot sun to a clinic in the village of Mugalur, some 30 miles outside of Bangalore, India. One of them has been beaten severely and abandoned by her husband and has been identified as having dysthymia. She struggles with thoughts of suicide. Another acted out violently against several members of her family and wandered the fields aimlessly with little concept of herself or others, showing evidence of psychosis. Yet another spent six hours a day washing herself and her clothes compulsively by hand and so would miss her school bus. Her washing rituals routinely disrupted her studies.

Geetha Jayaram, M.D.

These women and hundreds more like them benefit from mental health services offered at no cost through the Maanasi Project.

Psychiatrist Geetha Jayaram, M.D., established the project in 2002 ("maanasi" means "of sound mind" in Kannada, the local language) with funds raised through the Rotary Club of Howard West, Md., and the personal contributions of family, friends, and others. The funds are administrated by and supplemented through the Rotary Club of Midtown, Bangalore. Jayaram, a longtime Rotarian, is a faculty member in the Johns Hopkins University departments of Psychiatry and of Health Policy and Management and the Armstrong Institute of Patient Safety. Through a partnership with the departments of Psychiatry and Community Health at St. John's Medical College in Bangalore, Jayaram launched the project, beginning with an assessment of the extent of the need for mental health services among the area's women.

"India has a mere 4,500 psychiatrists," Jayaram told *Psychiatric News*. "Yet it has a population of more than 1.2 billion people, so there is a huge shortage of psychiatric care. What we are doing is really just a drop in the bucket."

Geetha Jayaram, M.D.

Maanasi Project caseworkers (from left) Shantha, Usha, Anjum, and Gowramma traverse hundreds of miles on motorbikes to provide mental health services and medications to women in villages in southern India. Over the years, they have also helped educate many of the villagers about mental illness and treatment.

The project began with a survey of 12,000 households in 25 villages regarding the prevalence of common mental disorders to determine the need for psychiatric care, said Jayaram, who supervises the project from abroad and during annual visits. To conduct the surveys, her team obtained permission of the "panchayat," a local council with authority over villagers. The team consisted of four trained women caseworkers with a high school education who were fluent in the local languages and had good standing in the community.

Jayaram and her team established a psychiatric clinic that dovetailed with the primary care health clinic in Mugalur, which was already familiar to villagers. Women who screened positive for symptoms of mental illness with various standardized instruments translated into the local languages, including the Structured Clinical Interview for *DSM-IV-TR,* were encouraged to come to the clinic on Friday afternoons, when the psychiatrist sees patients.

The psychiatrist works with an internal medicine or family medicine clinician who assesses patients for symptoms of mental illness and refers them to the psychiatrist when necessary. "In this culture, many symptoms of mental illness are expressed somatically anyway, so it makes sense that they are examined by the internist first," Jayaram said. The psychiatrist and primary care physicians are affiliated with St. John's Medical College, and Jayaram supervises the care provided at the clinic.

Since many of the women are agricultural workers and cannot afford to take a day off from working in the fields to make the trip to and from the clinic, caseworkers travel to the villages, Jayaram said. Each caseworker received a moped to traverse miles of unpaved roads between 187 villages where the women most at risk for relapse live. During home visits, caseworkers evaluate the women for symptoms; track patients' behaviors, thoughts, and feelings; dispense medications with the commu-

see ***India*** *on page 17*

Former APA President Dies at 89

Robert Gibson, M.D., APA's 105th president, died March 8 in his Parkton, Md., home.

Gibson was president of APA for the 1976-1977 term and had been secretary of the Association from 1972 to 1975. He received his medical degree from the University of Pennsylvania School of Medicine and served his psychiatric residencies at the Veterans Administration Hospital in Coatesville, Pa., the U.S. Naval Hospital in Bethesda, Md., and Chestnut Lodge, a private psychiatric hospital in Rockville, Md. He also received psychoanalytic training at the Washington Psychoanalytic Institute. He remained at Chestnut Lodge as clinical administrator until 1960.

In 1960, Gibson moved to the Sheppard and Enoch Pratt Hospital in Baltimore as director of clinical services. He became medical director and CEO in 1963 and served in that position until 1982, when he was named president and CEO of the hospital. While at Sheppard Pratt, Gibson oversaw the end of its segregationist policies and a return to fiscal health after the hospital emerged from bankruptcy. He also established a school for adolescents who were hospitalized at the facility and moved Sheppard Pratt from being a closed community to one involved in its surrounding community.

APA leaders hailed Gibson as a leader who emphasized integrity, accountability, and public service. "Dr. Gibson was an example to us all—a man ahead of his time," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "Not only was he an exceptionally gifted psychiatrist, teacher, and administrator, he was key in earning the public's trust in the profession, initiating a team approach to psychiatry, and ensuring that individuals from all backgrounds had access to psychiatric care. Let us honor Dr. Gibson for his vision and tireless leadership for patients."

Past APA President Steven Sharfstein, M.D., who succeeded Gibson as president of Sheppard Pratt in 1992, described him as a visionary who helped to introduce the idea of providing a continuum of services in a hospital setting. Sharfstein told *Psychiatric News*, "At Sheppard Pratt, . . .a long-stay hospital within the psychoanalytic tradition, he brought, during his 30-year tenure as president from 1962 to 1992, day programs, a community mental health center—the only one in the country at the time sponsored by a private psychiatric hospital—an education center, and an employee assistance program. He wrote and spoke widely on the economics of psychiatric care. He was a wonderful mentor to me when I joined Sheppard Pratt in 1986. As APA president in 1976, he fought for third-party coverage of psychiatric treatments, both inpatient and outpatient. He loved APA, our professional standards and ethics. Psychiatry has lost one of its best leaders." PN

EDUCATION & TRAINING

Summergrad Addresses Training Directors On Development of Physician Identity

BY MARK MORAN

"Not everything that counts can be counted, and not everything that can be counted counts."

In a lecture at last month's meeting of the American Association of Directors of Psychiatric Residency Training (AADPRT) in Tucson, Ariz., APA President-elect Paul Summergrad, M.D., alluded to the above statement—often attributed erroneously to Albert Einstein—to highlight the tension experienced throughout medicine today between the emphasis on accountability and measurement and the harder-to-quantify developmental challenge of being and becoming a physician.

Referring to the remark attributed to Einstein, Summergrad said, "Something in that non-quote speaks to a sense that we may have overemphasized accuracy, proof, and measurement." He added that that "there are also other ways of knowing and judging the completion of key tasks in the development of young physicians."

These tasks include professional values, the ability to form a trusting relationship with patients, and—most relevant for educators—the formation of a professional identity as a physician that has traditionally been forged in what Summergrad called the "crucible" of medical school and residency training. He delivered the annual Harvey Shein Memorial Lecture, which he titled "Going to Sea: Psychiatric Education in an Era of Accountability."

As important as measurement, reliability, and evidence of effective training are to the field and the general public, they need to be balanced with other important considerations in the training of young physicians, Summergrad said.

"The title of my talk is really about a far broader trend than the Accountable Care Act," he told educators at the meeting. "It's about the balance and tension between measurement—what we measure, how we measure—and what we don't or can't do because of where our limited attention is focused."

It was a timely message for educators who are wrestling with the demands of the so-called "next accreditation system"—one that aims to move the training of physicians toward an outcome-based measurement system, as exemplified by the Milestone Project, for assessing the progress of trainees from the beginning of residency through entry into professional practice (*Psychiatric News*, August 28, 2013).

They are also wrestling with resident duty-hour restrictions that can, in some cases, cause disruptions in continuity of patient care.

Summergrad assured educators that the movement toward measurement and outcome-based performance is a generally healthy one—and one that was not likely to recede in any case. "Measurement and evidence are very important in making sure we graduate psychiatry residents and fellows who are as capable as they can be," he said. "It is more a question of really thinking together about the tasks of training and how we not only assess their presence or absence in our trainees, but also what methodologies and approaches will achieve which of those ends."

Rick Brandt/AADPRT

APA President-elect Paul Summergrad, M.D., tells educators at AADPRT's annual meeting that the professional values that compel physicians to be present for their patients are forged in residency.

He reviewed the broad historical trends that have led to the era of accountability, including a dramatic expansion of knowledge about the genetic and neurobiological bases of psychiatric disorders that have helped to make psychiatry increasingly a part of the house of medicine—bringing with it the demand for outcome-based measurement of all medical care, including psychiatric practice.

"We are in an extraordinary period in the history of neuroscience, genetics, cognitive neuroscience, and therapeutics, with a flood of findings," he said. "While we have not yet clearly elucidated the fundamental causes of psychiatric illness, we someday will. Our immersion in the world of medicine has revealed other links. . . . Our disorders are highly comorbid with many other common medical illnesses, and the costs of these illnesses together are potentially staggering. . . . While it is unclear whether our interventions can reduce costs in all settings, there is no question that psychiatric illness is rife in the health care system, and ignoring these conditions will not reduce suffering and will certainly not reduce costs."

Meanwhile, he said, health care reform has focused on population health, which demands measurement and evidence-based care. "The movement from fee-for-service to global or so-called value-based reimbursement depends in large degree on outcome and quality measures," he said. "The expectation of accurate measurement is unlikely to diminish."

But with specific reference to the challenge of duty-hour restrictions, Summergrad pointed out that some aspects of medical professionalism—such as the willingness to be present for patients in an hour of need—may not be measurable.

"That you can't improve what you don't measure has become axiomatic in our culture," he said. "However, when issues of patient safety . . . become a *summum bonum* ['the highest good'] regardless of other considerations, such as the importance of continuity of patient care, we have shifted the ground of our expectations and values. It may be important at least at some point in life to stretch yourself beyond what you may think you can do, if for no other reason but to reshape one's character or identity. If we don't, then we risk developing other longer-term problems, including physicians who may not feel it is their responsibility to answer a call at 3 a.m. when someone is standing at the precipice of life and death."

Similarly, he said that psychiatrists in particular must learn through encounters with difficult and extremely ill patients to tolerate and manage painful or frightening feelings. "Our capacity as physicians to manage very difficult experiences both in and with our patients requires a capacity to absorb fearful emotions and mental states," he said. "While our observational capacities and measurement activities may be able to assess this in part, our trainees—and we as their mentors—are also embarking on a journey. If our time and attention are diverted to only filling out rating sheets, it will work as well for residency training as filling out an electronic medical record during a patient visit works for patient care."

Summergrad said that the professional values that compel physicians to be at the bedside for their patients, including the most difficult and severely ill, are forged in residency. He gave a passionate defense of what he called the "crucible" of medical training; it is in that crucible of long hours, rigorous training, and encounters with difficult patients that a new identity—as a physician—is formed.

That crucible is not different from the rites of initiation that young people undergo in the pursuit of professional identity in other fields—the military, priesthood, law, and architecture; as in those professions, aspiring physicians in training are separated from their customary surroundings and expected to venture into unknown territory so that a new identity can be forged.

"Uncertain, sleep deprived, facing internal and external risk . . . we expect [our trainees] to change, . . . to place the needs of their patients ahead of their own, even at 2 a.m., and to otherwise achieve not only competence and expertise but a new identity," Summergrad said. "Not all succeed in this process, and at the moment, with our overweighted valuation of measurements rather than relationships, of duty-hour limitations rather than the crucible, of education rather than service or intense clinical experience, we risk overcorrecting for the sins of prior training regimes."

He concluded, "I hope we don't forget what Osler called the higher walks of medicine, nor forget under the weight of current fashion Charcot's wise guidance about ideological fashions—theory is good, but it doesn't prevent the existence of reality. If we are to change and grow during residency training, we must learn to let go and leave our comforting shores; if we don't, how will we ever get to the other side?" PN

A *Psychiatric News* article about the Milestone Project is posted at http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=1733838.

Passing ABPN Exam To Be Based on Total Test Score

Terminology from *DSM-5* will begin to be phased into the exam in 2015, but candidates taking the exam this year will still be tested using *DSM-IV* criteria.

BY MARK MORAN

Beginning this year, the standard for receiving a passing score on the American Board of Psychiatry and Neurology (ABPN) psychiatry certification examination will be based on the total score on the entire examination—not on separate scores on the three sections of the exam.

The change is a significant one that marks a departure from past years when candidates had to pass each of the three sections—basic concepts in psychiatry, neurology and neurosciences, and clinical psychiatry.

At the annual meeting of the American Association of Directors of Psychiatric Residency Training (AADPRT) last month in Tucson, Ariz., Larry Faulkner, M.D., president and CEO of the ABPN, announced the change, saying it continues a trend in which the psychiatry and neurology examinations have focused increasingly on their respective candidates and not on the candidates of the other council. (ABPN is composed of two councils—the Psychiatry Council, made up of eight psychiatry directors, and the Neurology Council, made up of eight neurology directors.)

At the meeting, Faulkner also described how new criteria in *DSM-5* will be phased into the ABPN certification exam beginning in 2015, with conversion to *DSM-5* terminology complete by the 2017 exam.

The change in pass/fail scoring on the psychiatry exam will be of immediate importance to candidates preparing to take the exam this year.

"Historically, psychiatry candidates had oral examinations—which were called Part 2—with neurology patients, and neurology candidates had oral examinations with psychiatry patients," Faulkner explained. "In addition, written examination (Part 1) psychiatry candidates had to pass sections focused on neurology as well as psychiatry. The same was true for neurology candidates."

But oral exams were phased out starting in 2008. When the board decided to phase out the oral exams, it added a third section ("clinical psychiatry") to the written psychiatry exam and made the new three-section written exam the only certification examination.

ABPN President Larry Faulkner, M.D., tells residency directors that the psychiatry certification exam will now be based on one total score rather than on separate scores for the exam's three sections.

Pass/Fail Score Introduced

"When the oral examinations were eliminated for neurology candidates and the new three-part neurology certification examination was developed, the Neurology Council decided to go to a single pass/fail score," Faulkner said. "The Psychiatry Council decided not to do so immediately and wanted to see a few years of examination results first. Based upon the results of recent new certification examinations, it has become apparent that few candidates fail only one of the three examination sections."

Faulkner added that combining the three sections of the new certification examination into a single-section examination with many more questions will make it much easier to achieve higher examination reliability.

Linjun Shen, Ph.D., M.P.H., vice president for test development and core competencies at ABPN, said the change in the passing standard can be beneficial to candidates in the sense that, theoretically, good performance in one area can compensate for poorer performance in other areas. "However, our data repeatedly demonstrate that performance in one area typically is highly correlated with that in other areas," Shen said. "In other words, if a candidate is good in one area, it is likely he or she is also good in other areas. Similarly, if a candidate is weak in one area, it is not likely he or she can get too much help from performance on other areas. Therefore, regardless of how the standard changes, the best strategy of test preparation still is to be ready for all the content areas specified in the test content outlines. Betting on stronger areas to rescue the overall test outcomes can be risky."

Shen said the "cut score" for passing the exam will be established by a Standard Setting Committee that is to meet in October and will use established psychometric methods to establish the new passing standard.

DSM-5 to Be Phased In

Also of critical importance to candidates taking the exam is the plan for conversion to *DSM-5* criteria and terminology. Importantly, written examinations administered this year will continue to use only *DSM-IV* classifications and diagnostic criteria.

However, for years 2015 and 2016, the board will be phasing in the use of *DSM-5*. In those years, diagnoses and diagnostic subtypes from *DSM-IV* that are obsolete with the publication of *DSM-5* will not be tested. As an example, substance-induced mood disorder is a subtype from *DSM-IV* that is obsolete.

At the same time, diagnoses and diagnostic subtypes that are new to *DSM-5* will not be tested in 2015 and 2016. As an example, cannabis withdrawal is new to *DSM-5* and so will not be tested.

Finally, diagnoses that are "exactly or substantially the same" in both *DSM* editions will be tested in 2015 and 2016 using terminology from both editions. According to ABPN, "substantially the same" includes diagnoses that have had a name change only, those that have been expanded into more than one new diagnosis, and those that have been subsumed or combined into a new diagnosis.

Examples of diagnoses that have changed in name only are phonological disorder (*DSM-IV*), which in *DSM-5* is called speech sound disorder, and factitious disorder (*DSM-IV*), which in *DSM-5* is called factitious disorder imposed on self.

An example of a diagnosis that has been expanded into more than one new diagnosis is hypochondriasis *(DSM-IV)*, which in *DSM-5* has been expanded into two diagnoses: somatic symptom disorder and illness anxiety disorder.

Examples of *DSM-IV* diagnoses that have been subsumed or combined into a new diagnosis are alcohol abuse and alcohol dependence, which in *DSM-5* have been combined into alcohol use disorder. (For an example of an exam question using the dual listing of *DSM-IV* and *DSM-5* terminology, see box, below left.)

By 2017, the ABPN exams will exclusively use *DSM-5* diagnostic criteria and terminology.

At the AADPRT meeting, Faulkner and Shen said steps are being taken to make the conversion process during 2015 and 2016 as clear and seamless as possible for candidates, and they emphasized that questions will be designed to test knowledge of the concepts behind the diagnoses, not the correctness of their knowledge about the converted terminology.

"There will be instructions at the beginning of every 2015 and 2016 computer-delivered examination to explain the format of the dual listing of *DSM-IV* and *DSM-5* terminology in the examinations," Shen said. "Instructions will also state that it is not the intention of the examinations to test the correctness of the conversion." PN

Information about the ABPN exam is posted at www.abpn.com.

Dual-Terminology Questions

Below is an example of a question with multiple-choice answers demonstrating the use of dual terminology from *DSM-IV* and *DSM-5* for those categories that are "exactly or substantially the same." For candidates taking the ABPN exam in 2015 and 2016, terminology from both editions of *DSM* will appear in the manner shown below. A and D are examples of disorders that are exactly the same in both editions. B and C are examples of disorders that have had a change in name only (B) or that have been expanded into more than one diagnosis (C), and so will appear with terminology from both editions. E is an example of a category that is obsolete in *DSM-5* and so will not appear on the exam.

A xx-year-old man reports that he has been experiencing ____. The most likely diagnosis is

(A) Delusional disorder, somatic type
(B) Factitious disorder (*DSM-IV*)/factitious disorder imposed on self (*DSM-5*)
(C) Hypochondriasis (*DSM-IV*)/somatic symptom disorder (*DSM-5*) or illness anxiety disorder (*DSM-5*)
(D) Schizophrenia
(E) Somatization disorder [obsolete and will not appear].

DSM-5 Coding Update

Be sure you have the latest *DSM-5* coding updates by going to http://dsm.psychiatryonline.org/DSM5CodingSupplement. To stay current with any future *DSM-5* coding updates, sign up at this same site to receive them automatically. The online version of *DSM-5* will be updated in the coming weeks; the app will be updated this summer. "This important update for our *DSM-5* print and online/electronic edition users will ensure that all who have this vital psychiatric resource will have access to the most current information—which is the heart of our mission," said Patrick Hansard, director of sales and marketing for American Psychiatric Publishing.

EDUCATION & TRAINING

Psychiatry Match Numbers Increase Slightly

Educational leaders worry that the increasing number of medical students needed to meet the expected physician shortage will not be coupled with a commensurate increase in residency slots.

BY MARK MORAN

A total of 685 U.S. medical student seniors matched into psychiatry residencies in this year's National Resident Matching Program (NRMP).

This is a small increase from 681 in 2013. The percentage of U.S. seniors selecting psychiatry (4.2 percent) is unchanged from the previous year.

This is good news for psychiatry in that it continues the reversal of a trend of several years in which the numbers were dropping; in 2012, for instance, the 616 graduates entering psychiatry represents a decrease from 640 in 2011 and 670 in 2010.

The annual match, in which the choices of graduating medical students are paired with those of residency programs, is typically watched as an indicator of workforce size and makeup of the various medical specialties for the coming years.

But a new wrinkle in the match program, introduced last year, makes the numbers slightly harder to interpret. In 2013, an "all in" policy was instituted whereby programs were required to enter all of their residency slots in the match. In past years, programs could participate in the NRMP by registering and filling some available residency positions, while also reserving some to be filled outside the match.

With the "all in" policy, there were more slots offered in the match: in 2014 the number of psychiatry slots increased to 1,322. Of those, 1,297 positions were filled in the match, with 685, or 51.8 percent, filled by U.S. seniors. As in past years, positions not filled by U.S. seniors were filled by international medical graduates (including U.S. and non-U.S. citizens), Canadian students, students of osteopathic schools, and individuals who graduated from medical school in previous years.

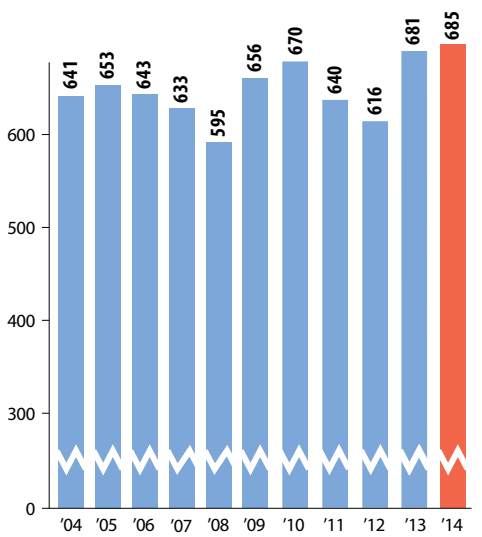
Psychiatric educators' concern for the future is based not only on the match results but also on the expected increase in the number of medical school graduates coupled with the absence of a commensurate increase in residency positions and the ongoing cap on funding of residencies by the Medicare program. The number of medical students is on the rise to meet the forecast physician shortage.

Former APA Trustee Sidney Weissman, M.D., explained that the number of U.S. seniors obtaining positions in the match rose from 14,992 in 2010 to 16,399 in 2014, paralleling the increase in U.S. medical graduates. "It is anticipated that in 2018 we will have 20,055 allopathic seniors and 2,600 osteopathic seniors in the match," he said. "These combined

see ***Match*** *on page 30*

More U.S. Grads Matching Into Psychiatry

The number of medical students entering psychiatry residencies this year increased slightly over last year. Increasing numbers of graduates and a new "all in" policy have increased competition for highly sought specialties—which may have benefitted psychiatry.



Source: National Resident Matching Program, 2014

PSYCHIATRY & INTEGRATED CARE

Get Started in Integrated Care by Picking Up the Phone

BY JOHN KERN, M.D.

This month, John Kern, M.D., an experienced medical director of a community mental health center, shares his experiences with collaborative care programs that have brought new joy to his work and improved the lives of his patients. Enjoy!

—Jürgen Unützer, M.D., M.P.H.

One day in 2007, while minding my own business as a community mental health center medical director, I was first exposed to troubling data on the health outcomes of the patients with severe mental illness published by the National Association of State Mental Health Program Directors.

That was never my problem before, I thought, but now I need to do something about it.

Right there at my desk, I picked up the phone and started to call primary care providers in my community, something that had never occurred to me to do before, though I had been a community mental health doc for 18 years. Integration efforts followed, including a system of collaborative mental health provided in a partner Federally Qualified Health Center (FQHC) organization, then a Primary Behavioral Health Care Initiative grant to improve the health outcomes of our seriously mentally ill adults, and most recently the establishment of Regional Mental Health Center as a completely integrated organization with the creation of our own FQHC.

Blessed by the generous support of the board and leadership of my organization, I have also been fortunate to discover a marvelous, challenging, supportive community of U.S. psychiatrists interested in improving the delivery of care using collaborative models. Many of us work in relatively obscure settings, where scarcity has driven a willingness to risk the implementation of new models of care. Connection to such a community is a tremendous gift, because rolling out novel programs can be challenging.

For example, when I was first invited to set up a collaborative mental health program in a primary care organization, I needed to explain to the primary care staff some peculiar facts: Using our collaborative model, I wasn't going to be seeing their patients, or writing prescriptions, or whisking the troublesome "frequent flyers" away. They were somewhat mollified to hear that they could get people seen right away by the behavioral health consultant assigned to the clinic and have direct phone access to a psychiatrist through the day. "I can't remember the last time I saw a psychiatrist up close," one said. I kept showing up, and fairly soon they decided that I was "almost like a normal person," which I was assured was high praise when applied to a psychiatrist and good enough reason to give my program a try.

Accepting the collaborative program required some faith on the part of my primary care colleagues. For my part, I was guessing that the collaborative care literature would actually translate to the real world and that I wasn't jeopardizing my professional reputation by recommending a slapdash model of care.

I was especially worried about a project to manage primary care patients with bipolar disorder. At a Learning Collaborative on Primary Care Behavioral Health, run by the National Council for Behavioral Healthcare, I met some smart people who seemed to think this was a good idea. This didn't keep me from sitting bolt upright in the middle of the night a few times, and at one point I made a list of the most serious-minded senior psychiatrists I could think of and called them all. I told them what we had

*see **Integrated Care** on page 16*

John Kern, M.D., is chief medical officer at Regional Mental Health Center in Merrillville, Ind., and at Regional Health Center in Hammond, Ind. Jürgen Unützer, M.D., M.P.H., is an internationally recognized psychiatrist and health services researcher. He is a professor and chair 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

Advocates Urge More Cooperation Among MH Organizations

Multiple benefits accrue to patients with psychiatric disorders when the many organizations in the mental health field pool their advocacy efforts to improve care and insurance coverage.

BY VABREN WATTS

The African proverb "it takes a village to raise a child" may apply in the context of treating people with mental illness.

On February 28, Debbie Plotnick, M.S.S, M.L.S.P., senior director of state policy at the advocacy organization Mental Health America, spoke at the 2014 Intensive Winter Institute sponsored by the American Nurses Association (ANA) and the APA Minority Fellowship Program to discuss the importance of caring for those with mental illness in the community and collaboration among mental health care organizations.

Mental health professionals are often located in the facilities in which people are being treated for their mental illness, Plotnick said, but "we should often go into the community to ensure that there are resources available concerning mental illness, so that people will know how to obtain help if they or a loved one is struggling with mental illness."

Plotnick emphasized that the community-based outreach concept can also be applied to help individuals recover from mental illness. "As we explore what we need [to improve] quality, we should consider more than clinical quality," Plotnick said, explaining that mental health facilities often see patients when they are seriously ill and do not see those patients when they are well. "We need to know how they are doing . . . whether they're back to a fulfilling life with a safe place to live and with meaningful work."

In an interview with *Psychiatric News,* Plotnick said that she has had personal experiences with the integration of mental health treatment and community outreach practices. "My daughter struggled with serious mental illness as an adolescent, and she was able to find community resources to keep her in school and help her take control of her illness. She is now a successful young woman who is a nurse."

Debbie Plotnick, M.S.S., M.L.S.P., discussed the importance of caring for those with mental illness outside of mental health care facilities.

In light of the multiple recent changes reshaping the health care system, Plotnick emphasized that it is especially important to advocate for both public and private insurance plans that will guarantee coverage of prevention efforts, peer-counseling services, and wellness programs, in addition to community inclusion services—that is, intervention services that guide those with psychiatric disabilities back into society to live a functional life. Plotnick said that this goal will be achieved only through a col-

see ***Cooperation*** *on page 30*

Annelle Primm, M.D., said that, "When mental health care organizations work collaboratively, it can only mean great things for the field of mental health."

Integrated Care

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in mind—an IMPACT-style consulting psychiatrist program—and waited for them to tell me that this was malpractice, or at least watering down the soup beyond recognition. They said, "Can you come teach my residents about this?" and "I don't see why you're fretting about this. This sounds like a really good idea."

After a few months, the primary care docs picked up that I was eager to please and liked a challenge. "So, smart guy," said one, "what about all of these patients who say they have ADHD?" Back when I was in training, adult ADHD wasn't even on the radar, so it was clear that I had a lot to learn if I was going to live up to my promise to be of use to the primary care physicians. I read up and asked the CMHC child psychiatrists (that I was supposedly supervising) to teach me, and after seeing some cases of my own, I was able to write a usable protocol. This is now a routine part of the care provided at the clinic. Who knew such an old person could learn something new?

Psychiatrists providing collaborative care in primary care know that it is usually tons of fun, but I still hadn't done anything to make an impact on the health outcomes of my patients with serious mental illness, which was supposed to be the point.

Despite some delays, we decided to start working toward providing on-site primary care, by ourselves if necessary. In 2009 came the Primary Care Behavioral Health Initiative from the Substance Abuse and Mental Health Services Administration (SAMHSA). Well, this was right up our alley, all the cool kids were doing it, of course we should apply—only it involved writing a grant. Things have changed a lot since then, but at that time, there was no one at my agency to write this grant, the notion of primary health being our business was still foreign, and of course I had my medical director job.

On the other hand, my kids were pretty much grown, I wasn't coaching soccer any more, and I had just shelled out for a shiny new MacBook. So I went looking for "Grant Writing for Dummies," which is the approximate title of the website that SAMHSA maintains for the uninitiated. In the end, this was much like being pushed to manage ADHD—an unexpected opportunity to learn. Near the end, my wife, who had watched me perch at the end of the kitchen table for months, said, "I sure hope you get this grant, or I expect you'll be in extreme distress." She also said, "Don't you ever bring that laptop down here again!" Healthier than she thought, I remained intact after not being awarded the grant, and we continued with unfunded efforts. What did I expect as a rookie?

We were thrilled to be awarded the grant in the second cohort, and then I had another kind of learning opportunity: what do you do when you actually have the resources whose lack you had used as an excuse for not making enough progress on your problem? The first thing you have to learn is your own story. After three months of confusing my staff with talk about metabolic syndrome and clinical decision support and theories of behavior change, one of my staff pointed out that we could explain the objective of the program in nine words: "Improving health outcomes of people with serious mental illness."

In the tradition of "see one, do one, teach one," once you have worked in an integrated system for a little while, you are suddenly an expert. People call you to get advice and consultation, and to cry on your shoulder. Recently I got a call from an old friend asking me to chair an initiative for the Illinois Psychiatric Society. "But I don't even practice in Illinois," I said. "Doesn't matter," he said. "We need your help. No one does this here." So I squeezed it in—it was too interesting to pass up.

So, here's what I want my colleagues to know about integrated care:

- This is really fun work, by far the highlight of my career.
- The demand for psychiatrists to be involved is tremendous already and will grow in the years ahead.
- It makes a huge difference to people without access to psychiatric care.
- It is an opportunity to make an impact in the most interesting part of health care reform.
- It will transform the work of psychiatrists into something much more interesting and central to medicine.
- And to get started, all you have to do is pick up the phone and call someone with whom you want to work or one of us who is already doing this. PN

India

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nity medicine physicians; and provide supportive therapy. Doctors and social workers may provide behavioral therapy onsite when indicated.

They also educate women and families at monthly women's cooperatives about symptoms of mental illness and treatments that will help them. The clinic doctors, including Jayaram, also conduct home visits for patients who need specialized attention. The Maanasi clinic now serves approximately 1,600 patients. "Many have been successfully treated and are well," said Jayaram, and the success of the venture has resulted in services being provided to women from 187 villages.

She recalled being asked to speak on an Indian TV program about the topic of depression. "As a result of that segment, the community medicine program at St. John's Medical College was besieged with calls, emphasizing the great unmet need for depression treatment," she noted.

The clinic continues to be a site for research and teaching, in addition to patient care.

Obstacles Threatened Treatment

The project was not always greeted enthusiastically at the start. Jayaram initially encountered resistance from villagers. For instance, a myth spread among villagers that antidepressant medications would lead to blindness, causing some of the women to resist the treatment. Members of the village mafia threatened some patients who had been encouraged to stop drinking as part of their treatment because they could no longer sell liquor at inflated prices, Jayaram said.

In addition, some women skipped clinic visits, telling caseworkers that they felt shame in accepting free medications.

In one unexpected obstacle, the caseworkers had to be convinced to wear protective helmets when riding their motorized bikes, "because they didn't think the helmets went with Indian apparel," Jayaram explained. "But I told them I didn't want to lose them in an accident, and they complied."

To educate women in the villages about mental health concerns, the caseworkers attend street festivals in the different villages and act in plays that portray the manifestation of different mental illnesses and how they may affect the villagers in everyday life. Over the years, the villagers have come to "embrace the caseworkers with love and respect," Jayaram noted.

Bringing Maanasi Project to the World

Jayaram and her husband, Jayaram Kumar, a fellow Rotarian, received an invitation to attend the 2013 forum of mhGAP (Mental Health Gap Action Program), a project of the World Health Organization (WHO) from Shekhar Saxena, M.D., director of the WHO Department of Mental Health and Substance Abuse. The goal of the forum was to discuss how to improve the delivery of mental health services in low-income countries around the world. Jayaram presented information about the Maanasi Project. "Dr. Saxena felt strongly that this was a project that could be replicated in other parts of the world," Jayaram said.

Even certain areas in the United States, she remarked, could benefit from a model of integrated care like the one used by the clinic in Mugalur. "For so many of our low-income patients, care is fragmented. Someone with acute schizophrenia cannot negotiate the burden that we place on them and be expected to show up at five different appointments in five different places" for varying health care needs.

The Maanasi Project not only embodies the model of integrated care and collaboration between providers, Jayaram pointed out, it "applies transatlantic innovation to community psychiatry," she said. PN

A short film about the Maanasi Project is posted at http://www.youtube.com/watch?v=s5NNjAazd6M.

ANNUAL MEETING

Here's a Tasting Menu of Easy-on-the-Wallet Dining Options

New York may have a well-deserved reputation for high-end dining palaces that garner acclaim worldwide, but eating on a budget is easy, with some guidance from a local psychiatrist.

BY DAVID MCDOWELL, M.D.

So, you are all set for the APA annual meeting in New York next month. But with the cost of getting there, staying, and just being in New York City, you don't expect to have much cash left over. This article is for you.

New York has amazing food and some of the best restaurants in the world. Sure, a meal at one of the most famous of these will cost you about the same as an average mortgage payment in much of the country. But don't fret. You do not have to be rich to eat richly here.

Below is a quirky and personal list of my favorite bargain dining spots. Remember, when you are in New York, there is no shame in being poor—only eating poorly.

My advice for the diner on a budget? Look to the streets! It's the best place to people watch, of course, but don't miss the vast array of food trucks that now dot the city—and appear to be multiplying rapidly. You will find some of the best authentic and delicious food anywhere on the planet at these colorful vehicles. The trucks can be found throughout the city, but are concentrated in midtown, where discerning office workers take their lunch breaks.

- **Calexico** is one of New York's many food trucks and serves up the best Mexican fare around (and often much better than the fare at Mexican restaurants), but this is the best one. There are two locations: Prince and Wooster streets in SoHo and 1030 Broadway in General Worth Square near the famous Flatiron Building.

- At **Daisy Mae's BBQ,** be sure to order the chunky Texas chili at any of these three chili carts, with locations at East 50th Street near Sixth Avenue, Broadway and West 39th Street, and 40 Wall Street.

- **Luke's Lobster** is pure seafood perfection. You can find the truck near Times Square, and the owners also operate a hole-in-the-wall restaurant on the Upper West Side. The seafood is fresh, and it is the best lobster roll you will find south of Bangor, Maine.

- **Moshe's Falafel** stand sits at West 54th Street and Sixth Avenue. I assure you that this is the best falafel you will ever eat. And the long lines, even when it is not prime time, attest to New Yorkers' devotion to Moshe's.

- **Waffle and Dinges** truck can be identified by its mustard yellow hue. The waffles qualify as incredible. Think sundae and make sure to get yours with ice cream, fresh fruit, and hot fudge.

And for some tasty treats not prepared on wheels, where you can go in and sit down to eat for very reasonable sums of money, here are a few of my favorites.

- **The Burger Joint** is tucked inside the first floor of the elegant Parker Meridien Hotel at 119 West 56th Street and is just what the name implies—a burger joint designed to resemble a roadside hamburger place. The food is as delicious and affordable as it is incongruous.

- **Mamoun't Falafel Restaurant,** located at 119 MacDougal Street, offers up Middle-Eastern treats that are simple, cheap, and utterly delicious.

- **Rice and Beans** is a no-frills Brazilian restaurant serving dishes native to that South American land at unbeatable prices. The fish is fresh, the beef tender, and the atmosphere cramped but very warm and inviting.

- **Massawa** is a fabulous place to try excellent and authentic Ethiopian cuisine. Utensils are not to be seen, since you eat these amazing dishes with your hands, by tearing off pieces of Ethiopian bread and dipping in to scoop up the food. It's great for sharing. Find it at 1239 Amsterdam Avenue at 121st Street.

- **Xi'an** has several locations throughout the city and is a great place for authentic Chinese noodles dishes, soups, and dumplings. It's always fresh and delicious.

And for something in between food trucks and sit-down dining, stop by Mario Batali's **Eatily** at Fifth Avenue and 23rd Street where the selection of Italian foods will have your jaw dropping. You can get many of the delights to carry out or enjoy outside, and some purveyors that have small seating areas in the complex.

Enjoy! PN

David McDowell, M.D., is an assistant professor of psychiatry at Mt. Sinai Medical Center and is in private practice in New York.

REGISTER NOW!
MAY 3-7, NEW YORK CITY

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

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

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

Online registration ends May 1; beginning Friday, May 2, at noon, you can register on site at the Javits Convention Center.

Daily Bulletin Gives Annual Meeting Preview

The preview issue of the *Daily Bulletin* is now available at http://www.nxtbook.com/tristar/apa/preview2014/index.php. As you plan for APA's 167th annual meeting in New York, the *Daily Bulletin* will help jump-start your meeting experience by highlighting just a few of the exciting activities and local attractions waiting for you. Find articles featuring the special dialogue event, "Science, Psychiatry, and the Media" with APA President Jeffrey Lieberman, M.D., Nobel Prize–winning psychiatrist Eric Kandel, M.D., and actor/science communicator Alan Alda; the American Psychiatric Foundation's annual benefit on the USS Intrepid; the Resident Resource Center; the Women's Center; and information on exclusive discounts in New York.

Biden

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on some of our nation's most important domestic and international challenges. As Chairman or Ranking Member of the Senate Judiciary Committee for 17 years, then-Senator Biden was widely recognized for his work on criminal justice issues including the landmark 1994 Crime Bill and the Violence Against Women Act. He has been at the forefront of issues and legislation related to terrorism, weapons of mass destruction, post-Cold War Europe, the Middle East, and Southwest Asia.

Now, as the 47th Vice President of the United States, Joe Biden has continued his leadership on important issues facing the nation. The Vice President was tasked with implementing the American Recovery and Reinvestment Act, helping to rebuild our economy and lay the foundation for a sustainable economic future. As part of his continued efforts to raise the living standards of middle-class Americans across the country, Vice President Biden has also focused on the issues of college affordability and American manufacturing growth, key priorities of the Administration.

While the convocation lecture will be presented on Monday afternoon, the Convocation of Distinguished Fellows will still be held that day at its regular time: 5:30 p.m. to 6:30 p.m. APA members and award recipients who are being honored this year will receive further instructions about the evening ceremonies. The convocation will be held in Hall 3E, Level 3, of the Javits Convention Center.

To accommodate the afternoon change in schedule and allow the largest number of attendees to hear Vice President Biden's address, the scientific sessions and other meetings and events that were scheduled to occur at 2 p.m. will be moved to a later time that day. More information on the adjusted schedule will be emailed to meeting registrants, and information will be available on site at the Javits Convention Center and other locations where sessions will be held.

Those who plan to attend the Vice President's address should arrive early so they have ample time to pass through security and obtain a seat, as seating will be limited. Live video feeds will also be available where scientific sessions and other events are being held at the New York Hilton, the Sheraton New York and Towers, the Marriott Marquis, as well as in several locations in the Javits Convention Center. This will allow those attending events in those facilities to watch the live feed without having to travel to the Javits Convention Center. The additional locations in the Javits Center will allow attendees to avoid the long lines and security checks to get into the room or if there are not enough seats in the room to accommodate all who want to hear the Vice President. Signs listing the exact locations for the live video feeds will be placed throughout the meeting venues. PN

For the latest news about APA's annual meeting, follow @APAPsychiatric and #APAAM14. Registration information is posted at http://annualmeeting.psychiatry.org/registration/registration. Online registration closes on May 1; on-site registration begins Friday, May 2, at noon.

ANNUAL MEETING

Museums, Zoos, and Much More Await Families in New York City

APA members bringing children and other family members to New York will have plenty of attractions from which to choose.

BY MARK MORAN

New York City is a playground for families and children, and APA members arriving in the city for the annual meeting with kids in tow will have no problem finding interesting diversions.

Here's a handful, including some of the perennial favorites plus a few you may not have heard of.

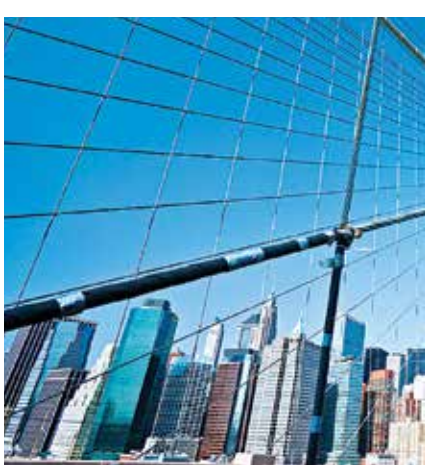
- **Central Park Zoo:** More than a million visitors a year flock here to enjoy some 130 species that inhabit this 6.5-acre corner of Central Park. Kids will want to visit the penguin house and try to spot four new king penguins. Visitors are also advised to look for a California sea lion pup named Bruiser, a new addition to the sea lion exhibit. The outdoor Tisch Children's Zoo houses more than 30 species, including goats and cows that enjoy being petted. The Central Park Zoo is open daily 10 a.m. to 4:30 p.m. It is located near the southeast corner of Central Park and can be entered off of Fifth Avenue at 64th Street.

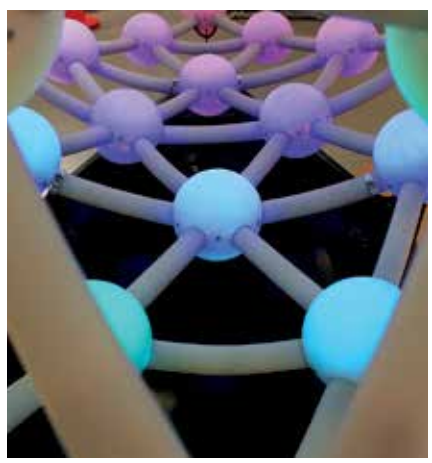
Julie Larsen Maher/Wildlife Conservation Society

Julie Larsen Maher/Wildlife Conservation Society

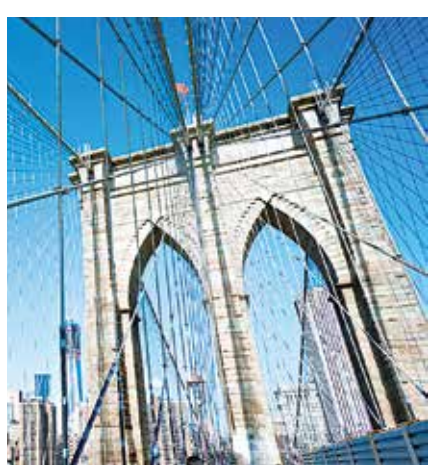
- **Bronx Zoo:** The famed institution is home to more than 5,000 creatures in a great variety of habitats, including an outdoor baboon reserve, a sea lion pool, and an exhibit dedicated entirely to Madagascar. Visitors can ride the Wild Asia Monorail, which tours 38 acres of exhibits that house elephants, Indo-Chinese tigers, deer, antelope, and Mongolian wild horses. The zoo's indoor attractions—the World of Birds, Mouse House, World of Reptiles, and Congo Gorilla Forest—can be a blast on a rainy day. In April through October, the Bronx Zoo is open Monday to Friday from 10 a.m. to 5 p.m. and on Saturday and Sunday from 10 a.m. to 5:30 p.m. Note that on Wednesdays admission is free. The zoo is located at 2300 Southern Boulevard (at Fordham Road) in the Bronx.

- **Walk the Brooklyn Bridge:** This elegant and stirring achievement of architecture and engineering is one of the iconic symbols of New York City, offering a pedestrian walkway with spectacular views of lower Manhattan and other city landmarks, such as the Statue of Liberty and Governors Island. Historian David McCullough, in his book *The Great Bridge: The Epic Story of the Building of the Brooklyn Bridge*, writes that for nearly 50 years after its opening in 1883, the bridge "reigned supreme as the most magnificent, if not technically the largest, suspension bridge on earth." Visitors can enter the bridge walkway at Cadman Plaza East near Prospect Street on the Brooklyn side of the East River. While there, be sure to visit **Brooklyn Bridge Park**, a nearly 85-acre expanse on the Brooklyn waterfront with landscaped play spaces, including the Water Lab, a stone-strewn area with water to splash in, and Sand Village, a huge sandbox flanked by two long metal slides. Also located in Brooklyn Bridge Park is **Jane's Carousel**, which opened in 2011 after undergoing almost 30 years of renovations. The original 1922 structure has been repainted and embellished with 1,200 lights in a pavilion designed by Pritzker Prize–winning architect Jean Nouvel.





Museum of Math



Luciano Mortula/Shutterstock

Children's Museum of Manhattan

- **Children's Museum of Manhattan:** For families with toddlers and young children, this choice may be an especially good one. It houses five floors of exhibits, many of them geared to tots aged 6 and under, including a "Dora the Explorer" play area. The museum also hosts traveling exhibits. The entrance fee is $11, with children under 1 admitted free. It's located at 212 West 83rd Street between Amsterdam Avenue and Broadway.

- **Museum of Math:** This new museum has 30-plus interactive exhibits, including Math Square; a Jumbotron on the floor that connects each person standing on it by the shortest path possible, changing the moment anyone moves; a design studio where participants create a 3-D design on a screen and can have it "printed" into a sculpture via a 3-D printer; and Enigma Café, a place where families can sit at tables to work on digital puzzles. The museum is open daily 10 a.m. to 5 p.m. and is located at 11 East 26th Street, between Fifth and Madison avenues. PN

More Information

Central Park Zoo
(212) 439-6500
www.centralparkzoo.com

Brooklyn Bridge and Park
(718) 222-9939
www.brooklynbridgepark.org

Jane's Carousel
www.janescarousel.com

Children's Museum of Manhattan
(212) 721-1223
http://www.cmom.org/

Museum of Math
(212) 542-0566
www.momath.org

For a comprehensive listing of family-friendly activities, see New York's top 50 attractions for families and children listed at http://www.timeout.com/new-york-kids.

Take a Chance and Win a Night on Broadway!

Sylvain Gaboury/PatrickMcmullan.com/AP Images

The American Psychiatric Foundation is raffling four tickets and a private backstage tour to one lucky winner for the Tony Award–winning musical "Kinky Boots." Tickets are for the 7 p.m. performance on Tuesday, May 6, and the winner will be announced Saturday evening, May 3, at the annual benefit of the American Psychiatric Foundation. More information is posted at http://americanpsychiatricfoundation.org/get-involved/events/kinky-boots-raffle.

JOURNAL DIGEST

BY VABREN WATTS

Smailhodzic/Shutterstock

Mental Illness Risk Increases in Children Of Older Fathers

Researchers from Indiana University and Karolinska Institute in Stockholm analyzed medical records from everyone born in Sweden from 1973 to 2001 and found a significant association between advancing paternal age and increased risk for psychiatric disorders in offspring.

The findings showed that a child born to a 45-year-old father, when compared with one born to a 24-year-old father, is 3.5 times more likely to have autism spectrum disorder, 13 times more likely to have attention-deficit/hyperactivity disorder, 25 times more likely to have bipolar disorder, and two times more likely to have a psychotic disorder. The outcomes were consistent after adjusting for parental education level and income.

The researchers hypothesized that unlike women, who are born with all their eggs, men continue to produce sperm throughout life. However, each time sperm replicates, as molecular studies have shown, there is an increased risk for genetic mutations to occur, which may be the reason for the increased incidence of psychiatric disorders in those born to older fathers.

D'Onofrio B, Rickert M, Frans E, et al. "Paternal Age at Childbearing and Offspring Psychiatric and Academic Morbidity." 2014. JAMA Psychiatry. Feb 26. [Epub ahead of print] http://archpsyc.jamanetwork.com/article.aspx?articleid=1833092&resultClick=3

Association Found Between Hearing Loss and Depression

Previous studies have found a link between hearing impairment and depression in children, but data are lacking on whether this holds true for adults as well, according to a study published in *JAMA Otolaryngology-Head and Neck Surgery*.

Chuan-Ming Li, M.D., Ph.D., a health and medical researcher at the National Institute on Deafness and Other Communication Disorders, and colleagues conducted a study in more than 18,000 individuals aged 18 and older to assess the impact of hearing loss on depression rates in adult populations. The study found that the rate of moderate to severe depression was 11.4 percent in adults who self-reported hearing impairment, compared with 7.1 percent in those with "good" hearing and 4.9 percent for individuals with "excellent" hearing. Women were more likely than men to have an association between moderate hearing impairment and depression. There was no association found between self-reported hearing impairment and depression among people aged 70 and older.

After adjusting for health conditions and others factors associated with depression, the data showed that self-reported hearing impairment was in fact independently associated with depression, particularly in women. The authors urged health care professionals to be alert to an increased risk for depression in adult patients who have hearing loss.

Li C, Zhang X, Hoffman H, et al. "Hearing Impairment Associated With Depression in U.S. Adults, National Health and Nutrition Examination Survey 2005-2010." 2014. JAMA Otolaryngol Head Neck Surg. Mar 6. [Epub ahead of print] http://archotol.jamanetwork.com/article.aspx?articleid=1835392

Moving From Impoverished Areas Affects Girls and Boys Differently

Ronald Kessler, Ph.D., a professor of health care policy at Harvard Medical School, and colleagues evaluated 3,689 children from families receiving public-housing assistance to determine if housing mobility intervention programs might serve as a mechanism for reducing mental health risk in youth living in areas of high poverty. The youth were divided into three groups: a low-poverty voucher group (those given vouchers to move to an area with a low poverty rate), a traditional voucher group (those given geographically unrestricted vouchers), and a control group (no intervention).

After assessing the rate of mental disorders 10 to 15 years later, the researchers found that compared with the control group, boys in the low-poverty voucher cohort were twice as likely to be diagnosed with major depression and three times as likely to have post-traumatic stress disorder (PTSD) or conduct disorder. Boys in the traditional voucher cohort were also three times as likely to suffer from PTSD, while girls in the same group had a reduced risk for major depression and conduct disorder. Girls who moved from high to low areas of poverty had no increased risk for psychiatric disorders.

The authors noted that "it is. . .difficult to draw policy implications from these results, because the findings suggest that the interventions might have had harmful effects on boys but protective effects on girls." Though the findings demonstrate that the effects of housing mobility interventions are more complicated than expected, the researchers concluded that a better understanding of mental health risks concerning neighborhood characteristics is needed before future changes in public-housing policy are made.

Kessler R, Duncan G, Gennetian L, et al. "Associations of Housing Mobility Interventions for Children in High-Poverty Neighborhoods With Subsequent Mental Disorders During Adolescence." 2014. JAMA. 311(9):937-947. https://jama.jamanetwork.com/article.aspx?articleid=1835504

'Mismatch Negativity' A Potential Biomarker For Psychosis

A new biomarker may be on the horizon to more accurately identify psychiatric patients who may later develop acute psychosis, according to a study published in *Biological Psychiatry*.

Daniel Mathalon, M.D., Ph.D., a professor of psychiatry at the University of California, San Francisco, led a study evaluating the amount of mismatch negativity (MMN)—an auditory signaling process that travels to the frontal lobe regions in response to sound—in 101 individuals with schizophrenia, at high clinical risk for psychosis, or with no history of mental illness.

The results showed that MMN was significantly reduced in subjects with schizophrenia and in those who were at high clinical risk for psychosis, compared with controls. There was no difference in MMN between schizophrenia patients and those with elevated risk for psychotic disorder. In addition, MMN was significantly reduced in high-risk patients who later developed acute psychosis, compared with those who remained in the high-risk category.

"Our study results show that mismatch negativity deficits precede the onset of psychosis in clinical high-risk individuals and further show that the larger the deficit, the more imminent the risk for conversion to a psychotic disorder," commented Mathalon. "This remarkable convergence of findings points to the mismatch negativity as a promising electroencephalography-based biomarker of psychosis risk that, with further development, could enhance our ability to identify which individuals are at greatest risk for psychosis and in greatest need of early treatment, particularly if the treatment is associated with potential adverse effects (such as antipsychotic medication)."

Perez V, Woods S, Roach B, et al. "Automatic Auditory Processing Deficits in Schizophrenia and Clinical High-Risk Patients: Forecasting Psychosis Risk With Mismatch Negativity." 2014. Biol Psychiatry. Mar 15;75(6):459-69. http://www.biologicalpsychiatryjournal.com/article/S0006-3223(13)00730-0/abstract

Psychiatric Diagnoses More Prevalent In Some ICU Patients

Though more people are surviving critical illness due to advances in medicine, severely ill patients are often exposed to respiratory distress and delirium, which may negatively impact mental health.

Researchers from Columbia University assessed the prevalence of psychiatric diagnoses and medication prescriptions given—before and after critical illness—to patients who were connected to a mechanical ventilation device while in the intensive care unit (ICU).

The analysis showed that among the 24,179 critically ill patients, 6.2 percent had one or more psychiatric diagnosis within the five years prior to the severe illness, compared with 2.4 percent of people in the general population. Critically ill patients were also more likely to have prescriptions for a psychoactive medication than were the general population (48.7 percent versus 33.2 percent). Previous ICU patients with no history of psychiatric disorders were 25 times more likely to receive a psychiatric diagnosis after hospitalization than the general population and 18 times more likely to be given a prescription for psychoactive drugs three months after ICU release. The differences in psychoactive prescriptions between former ICU admittees and the general population decreased after one year.

"Our data suggest both a possible role of psychiatric disease in predisposing patients to critical illness and an increased but transient risk of new psychiatric diagnoses and treatment after critical illness," said the authors. They concluded that prompt evaluation of patients' psychiatric history and management of psychiatric symptoms post-ICU may be an important focus for interventions concerning mental health among critically ill patients.

Wunsch H, Christiansen C, Johansen M, et al. "Psychiatric Diagnoses and Psychoactive Medication Use Among Nonsurgical Critically Ill Patients Receiving Mechanical Ventilation." 2014. JAMA. 311(11):1133-1142. http://jama.jamanetwork.com/article.aspx?articleid=1841968

CLINICAL & RESEARCH NEWS

Marc Bruxelle/Shutterstock

Electronic Cigarettes May Be Gateway To Tobacco Smoking

The popularity of electronic cigarettes may threaten the success of the decades-long battle against tobacco use in the United States.

BY VABREN WATTS

Electronic cigarettes (e-cigarettes) are marketed to help people quit smoking regular cigarettes and reduce addiction to nicotine, but a new study published March 14 in *JAMA Pediatrics* demonstrates that it may be doing the opposite in some adolescents.

Researchers from the Center for Tobacco Control Research and Education at the University of California, San Francisco (UCSF), conducted the first published analysis of the relationship between e-cigarette use and conventional smoking among adolescents in the United States.

"Despite claims that e-cigarettes are helping people quit smoking, we found that e-cigarettes were associated with more, not less, cigarette smoking among adolescents," said Lauren Dutra, Sc.D., lead author and a postdoctoral fellow at UCSF.

E-cigarettes are cigarette-like mechanical devices that vaporize a liquid form of nicotine without the smoky smell and high levels of toxins associated with conventional cigarette smoking, the authors noted. The devices are being aggressively promoted by tobacco manufacturers as a smoking-cessation aid and safer alternative to cigarettes. The advertisements can be seen on the Internet and even traditional media channels, which banned cigarette advertisements more than 40 years ago.

"This is an exploding product on the market—being marketed to both adults and youth," said Douglas Ziedonis, M.D., M.P.H., a substance abuse expert and chair of the Department of Psychiatry at the University of Massachusetts Medical School. "Flavors, such as cinnamon apple and strawberry, and the vibrant colors in which e-cigarettes are sold, make them appealing to children and teens."

Ziedonis told *Psychiatric News* that until recently, e-cigarettes—which are unregulated by the Food and Drug Administration—have received very minimal academic press. "The scientific community is beginning to become aware of e-cigarettes and ask a lot more questions about the harms or benefits of these products. Research is telling us that we need to treat e-cigarettes and other nicotine vapor products as we do cigarettes."

In the UCSF study, data were gathered from the nearly 40,000 middle-school and high-school youth who completed the National Tobacco Youth Survey in 2011 and 2012. Adolescents were surveyed on their tobacco use—including cigarettes, smokeless tobacco products,

*see **Cigarettes** on page 31*

Smoking Cessation Bestows Multiple Mental Health Benefits

A large meta-analysis suggests that smokers who quit gain improved mental health when compared with peers who continue the habit.

BY JOAN AREHART-TREICHEL

Many people believe that smoking gives them a mental lift. After all, they experience irritability, anxiety, and depression when they have not smoked for a while, and these feelings are relieved by smoking.

But actually it is giving up smoking—not engaging in it—that confers mental benefits, a meta-analysis published February 13 in the *British Medical Journal* suggests.

The senior investigator was Paul Aveyard, a professor of behavioral medicine at the University of Oxford in England.

The meta-analysis included 26 studies that measured subjects' mental health before and after quitting. The included studies examined six measures of mental health: anxiety, depression, mixed anxiety and depression, positive affect, psychological quality of life, and stress. Eleven of the studies were cohort studies, 14 were secondary analyses of cessation interventions, and one was a randomized trial.

Fourteen studies enrolled smokers from the general population, four enrolled patients with psychiatric disorders, three enrolled patients with chronic physical conditions, two enrolled patients with either psychiatric or physical conditions, two enrolled pregnant women, and one enrolled patients after surgery. Subjects smoked on average 20 cigarettes a day and scored 5.4 on the Fagerstrom test measuring nicotine dependence, indicating moderate dependence.

Finally, mental health outcomes were evaluated from seven weeks to nine years after baseline, but on average six months later.

Four studies reported a change in anxiety from baseline to follow-up, with follow-ups ranging from seven weeks to 12 months. Compared with continuing to smoke, quitting smoking was associated with a significant decrease in anxiety from baseline to follow-up.

Five studies reported a change in mixed anxiety and depression from baseline to follow-up. Compared with continuing to smoke, quitting smoking was associated with a significant decrease in mixed anxiety and depression from baseline to follow-up, which ranged from six months to three years.

Ten studies reported a change in depression from baseline to follow-up, with follow-up ranging from 11 weeks to five years. Compared with continuing to smoke, quitting smoking was associated with a significant decrease in depression from baseline to follow-up.

Three studies reported a change in stress from baseline to follow-up, with follow-up from six months to six years. Compared with continuing to smoke, quitting smoking was associated with a significant decrease in stress.

There thus appears to be ample evidence that smoking cessation is associated with improvements in depression, anxiety, and stress. And the strength of the association, the researchers found, appears to be similar for both the general population and clinical populations, including those with mental disorders.

"We believe that the data are valid and propose three possible explanations for the association," the researchers said. "The first is that smoking cessation causes the improvement in mental health, the second is that improving mental health causes cessation, and the third is that a common factor explains both improved mental health and cessation."

The researchers indicated that they preferred the first explanation. One reason is that "in some but not all of the studies we could calculate the change in mental health in quitters and continuing smokers. . . . We calculated the weighted mean change for both groups, though formal statistical analysis was not possible to compare groups. . . . These data indicate little change in mental health from baseline to follow-up in continuing smokers, while smokers who quit showed reductions in adverse mental health symptoms and improvements in positive affect and quality of life."

"This study illustrates the importance of providing tobacco-cessation treatment to individuals with behavioral health conditions, to help with both improvement in symptoms of mental

*see **Smoking Cessation** on page 30*

Cardiovascular Fitness May Help Prevent Early-Onset Dementia

Active efforts to maintain cardiovascular and cognitive fitness through the lifespan, starting at a young age, offer some promise of preventing or delaying the onset of dementia later in life.

BY JOAN AREHART-TREICHEL

Mandav/Shutterstock

In a large population-based study, researchers have found a link between poor cardiovascular and cognitive function at age 18 and early-onset dementia.

The lead researcher was Jenny Nyberg, Ph.D., of the Center for Brain Repair and Rehabilitation at the University of Gothenburg in Sweden. Study results were published March 6 in *Brain.*

The researchers noted that since individuals with early-onset dementia—that is, before age 65—are an underrecognized patient group, and since modifiable risk factors for the illness are unknown, they wanted to assess whether physical fitness might be such a factor.

Their study included more than 1 million Swedish men. At age 18, the men had mental and physical exams as part of their military conscription process. They were then followed for up to 42 years (26 years on average) to see which ones developed early-onset dementia. Such information was available via the Swedish National Hospital Discharge Register. The researchers then used the data to see if there was any association between cardiovascular and cognitive function at age 18 and early-onset dementia.

The researchers found that such an association was evident, with their data showing that poor cardiovascular function as well as poor cognitive performance at age 18 were associated with an increased risk of early-onset dementia, but the highest risks were found for individuals who had both. The men with poor performance in both realms were seven times more likely to develop early-onset dementia than men who had neither.

A surprising finding, they noted, was that high cardiovascular fitness in individuals with low cognitive performance reduced the risk of early-onset dementia by 48 percent. And high cognitive performance in individuals with low cardiovascular fitness reduced the risk of early-onset dementia by 74 percent.

The researchers also assessed whether one domain of cognitive performance correlated more with early-onset dementia than others did. They found, however, that low performance in all four domains of interest—logic cognition, verbal cognition, visuospatial cognition, and technical cognition—resulted in a significantly increased risk for early-onset dementia.

But how might cardiovascular fitness at a young age influence the risk for early-onset dementia? By enhancing neuroplasticity in the young brain, the researchers speculated, and this neuroplasticity in turn might have a protective or disease-slowing effect on dementia.

"This technically well-executed study is among the first to link cardiovascular fitness and cognitive functioning at a young age with early-onset dementia," Constantine Lyketsos, M.D., chair of psychiatry at Johns Hopkins Bayview Medical Center and a geriatric psychiatrist, told *Psychiatric News*. "As the study is observational, high confidence in a causal link is not possible. However, the findings are consistent with other research linking cardiovascular health or disease and cognitive functioning or reserve with late-onset dementia decades later. Much research is needed to translate this finding into a specifically actionable preventative intervention. For now, active efforts to maintain cardiovascular and cognitive fitness through the lifespan, starting at a young age, offer some promise at preventing or delaying the onset of dementia at mid or later life."

The research was funded by several Swedish foundations and research organizations. PN

An abstract of "Cardiovascular and Cognitive Fitness at Age 18 and Risk of Early-Onset Dementia" is posted at http://brain.oxfordjournals.org/content/early/2014/03/06/brain.awu041.abstract.

Depression, Gene Variant Combine To Affect Cognitive Decline

Since there appears to be a synergistic interaction on cognitive decline between depression and the APOE e4 gene variant, could depression treatment reduce risk of cognitive decline?

BY JOAN AREHART-TREICHEL

Depressive symptoms and the APOE e4 gene variant are known to be independent risk factors for cognitive decline. Now a prospective study of a large population-based sample of older individuals has found that when a person is not only depressed, but has one or two copies of the APOE e4 gene variant, the risk of cognitive decline is even greater than if he or she had either depression or the variant alone.

The study was headed by Kumar Rajan, Ph.D., an assistant professor at the Rush Institute for Healthy Aging at Rush University Medical Center in Chicago, and the findings were published in the February-March *Psychosomatic Medicine.*

The study included 4,150 participants aged 65 and older from either an African-American or European background who were interviewed at three-year intervals. Depressive symptoms were measured using the 10-item version of the Center for Epidemiologic Studies Depression scale. The APOE genotype was evaluated by DNA samples collected during follow-up. Cognitive function was evaluated at the initial and follow-up interviews—follow-up was approximately nine years—using a standardized global cognitive score.

About one-third of the cohort had one or more copies of the APOE e4 variant. In participants with no depressive symptoms, cognitive function decreased by 0.0412 unit per year among those with no copies of the APOE e4 variant and 0.0704 unit per year among those with one or more copies of the variant. For each additional symptom of depression, cognitive decline increased by 0.0021 unit per year among those with no copies and 0.0051 unit per year among those with one or more copies of the APOE e4 variant. The three-way interaction of depressive symptoms, the APOE e4 variant, and time was significant.

That is, the researchers found that the deleterious effect of depressive symptoms on cognitive decline was magnified by the presence of the APOE e4 variant.

"This finding has important implications for older adults, health care practitioners, scientists, and public-health experts—further demonstrating the complex interplay of mental health and genetic markers on late-life cognitive health," Rajan and colleagues concluded.

"Given that our study was based on a population-based sample with a fairly large number of participants being genotyped from two different population structures (European and African American), we feel confident that these results are generalizable and verifiable by other longitudinal population-based studies of older persons."

In an accompanying editorial, Michelle Luciano, Ph.D., of the Center for Cognitive Aging and Cognitive Epidemiology at the University of Edinburgh, said, "Given that the APOE genotype is fixed in an individual, one of the questions that the research of Rajan et al. raises is the potential to curb cognitive decline through interventions targeting depression."

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

An abstract of "Gene-Behavior Interaction of Depressive Symptoms and the Apolipoprotein e4 Allele on Cognitive Decline" is posted at www.psychosomaticmedicine.org/content/76/2/101.

CLINICAL & RESEARCH NEWS

Gender-Related Differences Found In Depression Etiology

Intrapersonal loss and failures to achieve expected goals may be factors that characterize gender-based differences in the onset of depression.

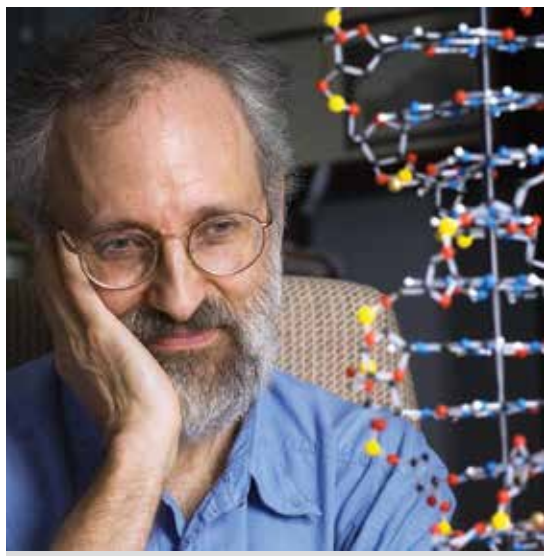
BY VABREN WATTS

Because depression rates for women and men differ, researchers have been trying to determine whether etiologic pathways for the disorder differ across gender lines.

Kenneth Kendler, M.D., a professor in the departments of Psychiatry and Human and Molecular Genetics at Virginia Commonwealth University School of Medicine, led a study identifying factors that distinguish the onset of major depression between men and women. The study was published February 14 in *AJP in Advance*.

Kendler noted that previous studies comparing the etiology of depression between men and women only examined single risk factors, such as marital status or quality, stressful life events, or prior anxiety disorders. Kendler explained to *Psychiatric News* that his current study differs from the previous ones in several ways.

"First, we explored a very wide array of risk factors organized developmentally. Second, we used a path model approach, which can show 'the pathways' of risk over time. Third, we studied twins of opposite sex to get the best control for genetic backgrounds and family environment and rearing experiences."



Virginia Commonwealth University School Medicine

Kenneth Kendler, M.D., used a twin study to investigate etiological differences in depression between men and women.

Kendler and colleagues assessed 1,057 adult opposite-sex twin pairs born between 1940 and 1974 for the incidence of major depression within a given year, as well as 20 risk variables that may contribute to such incidences. The patients were interviewed on risk variables associated with five developmental periods: childhood, early adolescence, late adolescence, adulthood, and past year. Major depression was diagnosed according to *DSM-III-R* criteria.

The results showed that 11 of the 20 risk variables differed across gender lines as they related to development of major depression. Parental warmth, neuroticism, divorce, social support, and marital satisfaction had the strongest impact on development of depression in women, whereas childhood sex abuse, conduct disorder, drug abuse, history of major depression, and distal and dependent proximal stress life events had the largest impact in men.

"The developmental pathways to depression in men and women share some important elements, but on average differ from each other in some important ways," Kendler said.

In characterizing their findings, the researchers pointed out that "deficiencies in caring relationships and interpersonal loss" played a stronger etiologic role in major depression for women, while "failures to achieve expected goals, with lowered self-worth" were more important in the etiologic pathway to major depression for men."

According to Kendler, the current findings are consistent with previous studies that suggest differing subtypes of etiologies for major depression in women and men.

Kendler told *Psychiatric News* that whether the findings from this study can translate into differences in psychotherapeutic treatment responses between men and women is a question that remains to be answered.

He is preparing to initiate a large-scale study investigating molecular genetic factors underlying depression in women.

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

"Sex Differences in the Pathways to Major Depression: A Study of Opposite-Sex Twin Pairs " is posted at http://ajp.psychiatryonline.org/article.aspx?articleID=1831622&resultClick=1.

Premorbid Depression Associated With Poor Anorexia Prognosis

Someone with both anorexia and depression can be ill for longer and less likely to recover than someone with anorexia alone, suggesting that depression is a severity marker for anorexia.

BY JOAN AREHART-TREICHEL

Premorbid depression is associated with a poor prognosis in anorexia nervosa, European and American researchers reported in the March *International Journal of Eating Disorders.*

The lead researcher was Anna Keski-Rahkonen, M.D., Ph.D., an assistant professor in psychiatric epidemiology at the University of Helsinki in Finland.

Out of 2,881 women from the 1975 to 1979 birth cohorts of Finnish twins, the researchers identified 55 with a lifetime *DSM-IV* diagnosis of anorexia nervosa. Of these women, who were age 26 on average at the time of assessment, 39 had recovered from their eating disorder, and 16 had not. Recovery was defined as restoration of weight, menstruation, and the absence of binging and purging for at least one year prior to assessment. Among the women classified as recovered, the average duration of recovery was seven years.

The unrecovered women were significantly more likely to suffer from depressive symptoms prior to eating-disorder onset, to be unemployed, to be dissatisfied with their current partner or spouse, and to report a high level of perfectionism than were women who had recovered. When age at onset and illness duration were accounted for in the analyses, however, premorbid depression was the sole prognostic factor significantly associated with a decreased likelihood of recovery.

Anna Keski Rahkonen, M.D., Ph.D.

Anna Keski-Rahkonen, M.D., Ph.D.: "I think we should accept that anorexia patients with psychiatric comorbidities will be some of our most challenging patients."

"While our theoretical understanding of the factors that may contribute to the unusual persistence of anorexia nervosa has evolved over the years, our ability to predict and manage chronicity among those who suffer from this devastating illness remains limited," said Michael Devlin, M.D., co-director of eating disorders research at the New York State Psychiatric Institute, in an interview with *Psychiatric News*. "This important study brings us a step closer by underscoring the negative impact of depressive symptoms on the goal of full long-term behavioral recovery."

Commenting on the implication of their findings for psychiatrists, Keski-Rahkonen said, "Major depressive disorder is a severity marker for anorexia nervosa. This means that someone with both anorexia and depression can be ill for longer and is less likely to recover than someone with just anorexia.

"We psychiatrists often look for simple solutions to complex problems. Many psychiatrists hope that a single treatment approach—say, cognitive-behavioral therapy [CBT] or an antidepressant—would relieve both anorexia and depression. Unfortunately, it seems that antidepressive medication does not alleviate symptoms of anorexia, and many patients with anorexia drop out of CBT."

She noted that she and her colleagues are conducting a study of adolescents with anorexia nervosa and are finding that "if they also have depression, they seem to need more inpatient treatment and more outpatient and emergency room visits; the overall length of treatment appears to be almost four times longer if depression is involved.

"So I think we should accept that anorexia patients with psychiatric

see ***Anorexia*** *on page 30*

Defendants With Mental Illness Diverted to Social Security System

Social Security disability benefits ease the way back into the community for defendants and prisoners with mental illness in Miami.

BY AARON LEVIN

Aaron Levin

Cindy Schwartz, M.S., and Judge Steven Leifman meet in Leifman's chambers in Miami.

Court officials in Miami have expanded a federal support program for homeless people with disabilities to help those with mental illness who are involved with the criminal justice system return successfully to the community.

The use of the SSI/SSDI Outreach, Access, and Recovery (SOAR) program is appropriate because many people with mental illness who are in jail facing charges or are to be released from prisons are likely to become homeless without some initial support.

"SOAR is a tool for people to move toward recovery," said Cindy Schwartz, M.S., M.B.A., who runs the Miami SOAR program, in an interview with *Psychiatric News*. "You can't move ahead without a roof over your head and some money in your pocket."

Nationally, only 29 percent of first-time applicants are granted Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI), but 65 percent of SOAR-assisted initial applications nationwide are approved within 100 days, according to information covering 2006 to 2013 from the Substance Abuse and Mental Health Services Administration (SAMHSA), which funds technical assistance for the program.

The Miami SOAR program does even better, however, racking up a 94 percent record of approvals in an average of 27 days, in part because it is integrated with the Eleventh Judicial Circuit Mental Health Project (CMHP) in Miami-Dade County. Since 2000, the project has diverted people with serious mental illness from the criminal justice system to community-based treatment and other services.

"Miami's success comes from a dedicated staff who follow through from beginning to end," said Dazara Ware, M.P.C., a senior project associate at the SAMHSA SOAR Technical Assistance Center, run by Policy Research Associates in Delmar, N.Y., which trains SOAR workers. "They are a model for all localities."

In the Miami program, all incoming misdemeanor or felony candidates for diversion are screened for eligibility for federal entitlement benefits. Project staff members then help those who are eligible gather and present needed documentation.

"Once I spoke with the head of the Social Security Administration office in Miami, we were able to collaborate closely," said CMHP founder Steven Leifman, J.D., the Eleventh Circuit's associate administrative judge and a member of the board of the American Psychiatric Foundation (*Psychiatric News*, March 7).

Over the last three years, the program has screened 445 people of whom 220 were eligible and 207 were approved, said Schwartz.

More recently, SOAR has been expanded to include people reentering the community after they finish their jail sentences.

Psychiatrists and doctoral-level psychologists play an important role in the process, said Schwartz. "We need clear, well-documented information about the patient's diagnosis," she said. "That includes the illness, symptoms, medications, and prognosis."

Once the patient is approved for benefits by the Social Security Administration, the evaluating doctor can bill for services rendered as much as three months prior to the application date, she said.

"Our goal is to do [the applications process] right the first time," she said. "We may ask them to drop their own

see ***Defendants*** *on page 30*

Miami

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the National Superintendent of the Year by the American Association of School Administrators in February.

The program originated as a collaborative pilot program in Denver involving the foundation and the Colorado Psychiatric Society following the 1999 Columbine High School shooting in that state.

"Overall, it's been well received in Miami," said Ava Goldman, M.Ed., administrative director of exceptional student education and student support in the Miami-Dade system. "The goal is helping our staff people to know when and how to get help for students."

The target audience extends beyond classroom teachers to include custodians, bus drivers, cafeteria workers, and clerical personnel, she said. In mid-March, two students selected from each school began a one-year training course to learn the same principles. Next year, the school system will begin including parents in the program.

Aaron Levin

The American Psychiatric Foundation's "Typical or Troubled?" program can help teachers and students overcome the myths and stigma around mental illness, said Miami-Dade County Public Schools Superintendent Alberto Carvalho. "This is one world, and we ought to be compassionate, smart, accepting, and sensitive."

"We will have a counseling team in each school to work on risk assessment," said Goldman. "They will see if the student's issues can be managed with resources within the school or if referral to system counselors is needed."

Adoption of "Typical or Troubled?" by a district the size of Miami-Dade, with its 350,000 students in 450 schools, marked a major step for the program. Previously, the largest system to incorporate the program was Albuquerque, N.M, with 93 schools. Overall, the program has been implemented in more than 500 urban, rural, and suburban schools or districts in 38 states.

"We didn't do this because we wanted to be nice," said Carvalho. "We did it because we had significant problems and wanted a solution that was the right thing to do from an educational, humanistic, and economic perspective."

Miami-Dade County has an unusually high proportion (9 percent) of residents with a mental illness, noted Miami-Dade County Judge Steven Leifman, J.D., a member the foundation's board, who originally brought "Typical or Troubled?" to Carvalho's attention.

Leifman developed the Eleventh Circuit Criminal Mental Health Project to divert defendants with mental illness out of the criminal justice system and into community treatment. "Typical or Troubled?" was one way to recognize early possible symptoms of mental illness and intervene before young people ended up in social or legal trouble, he said.

"Mythology and stigma set people with mental illnesses apart from people with other illnesses," said Carvalho. "But mental illness ought to be seen and treated like any other illness. There is no tolerance without understanding and no understanding without education." PN

Information about the American Psychiatric Foundation's "Typical or Troubled?" program is posted at http://www.americanpsychiatricfoundation.org/what-we-do/public-education/typical-or-troubled.

Match

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numbers will exceed the total number of first-year positions offered in the 2014 match—26,678.

"With the number of residency positions funded by Medicare capped, we will see an increasing number of U.S. seniors unable to obtain residency positions," Weissman told *Psychiatric News*. "If we are to effectively expand the number of practicing physicians at a time of growing shortage, it is critical that government funding be made available to support growth in the number of residency positions.

"While the total number of U.S. medical students is increasing, it is not likely that the total number of psychiatry residency positions will be altered significantly without major changes in government policy," Weissman said. "This is the time for psychiatry to reassess what the core or basic training in psychiatry should be for all medical students. This is critical for our recruiting new psychiatrists as well as in the training of other physicians, all of whom provide essential mental health care."

Weissman is not alone in his concern about the future of residency and federal funding for graduate medical education. In a statement issued with the release of the match numbers, Darrell Kirch, M.D., president and CEO of the Association of American Medical Colleges (AAMC), said that a preliminary analysis of this year's data shows that several hundred U.S. medical students did not match to a first-year residency training program.

"As a result, with a serious physician shortage looming closer, we remain concerned that the 17-year cap on federal support of new doctor training will impede the necessary growth in residency positions that must occur to ensure that our growing and aging population will receive the care it needs," Kirch said. "According to the most recent AAMC Survey of Medical School Enrollment Plans, U.S. medical school enrollment will increase to 21,349 students by 2018. Combined with the larger number of graduates from osteopathic schools, which also are expanding to address the shortage, as well as increasing numbers of international graduates entering the match, there may be too few residency positions for all the newly graduated doctors in the not-too-distant future." PN

Preliminary data from the NRMP are posted at http://ww1.prweb.com/prfiles/2014/03/19/11682006/2014%20NRMP%20Main%20Residency%20Match%20Advance%20Data%20Tables%20FINAL.pdf.

Bryan McLamara

Representatives of the ANA and APA's Minority Fellowship Program pose during the Intensive Winter Institute sponsored by the two organizations.

Cooperation

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laborative advocacy effort from all mental health organizations.

She added that by making the needs of patients the primary focus of interdisciplinary meetings by organizations in the mental health field, mental health professionals will become more effective—benefitting patients in all stages of treatment and recovery.

Annelle Primm, M.D., M.P.H., APA deputy medical director and director of the Division of Diversity and Health Equity, agreed. "I think it is important for mental health care professionals to learn about the great benefits of team-based care, particularly in the context of the Affordable Care Act, which values interdisciplinary work," she said.

Primm noted that this is the first year that that APA and the ANA have co-sponsored the Intensive Winter Institute—usually it is hosted solely by the ANA.

"Hopefully, there will be some sustained contact and opportunity for research and joint policy work," said Primm. "When mental health care organizations work collaboratively, it can only mean great things for the field of mental health and for mental health care delivery. People are now equipped with the knowledge that they need to be on top of cutting-edge issues in today's changing health care environment." PN

Smoking Cessation

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illness and overall physical health," Lori Raney, M.D., said in an interview with *Psychiatric News*. "Psychiatrists have an important role to play in assisting in this treatment and can provide guidance and support to patients and in helping our colleagues in other medical settings." In addition to being medical director of Axis Health System in Durango, Colo., Raney has a special interest in smoking cessation and mental health.

The research was funded by the United Kingdom Center for Tobacco and Alcohol Studies. PN

The article "Change in Mental Health After Smoking Cessation: Systematic Review and Meta-analysis" is posted at www.bmj.com/content/348/bmj.g1151.

Anorexia

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comorbidities will be some of our most challenging patients, and their treatment may require a combination of different approaches and a lot of patience."

The researchers also noted that other studies have found that depressive disorders sometimes precede anorexia nervosa and that depressive disorders are "cross-transmitted" in families with eating disorders. Asked about possible genetic connections between depression and anorexia nervosa, Keski-Rahkonen said, "Major genetic collaborations have to date failed to find susceptibility genes for both depression and anorexia. There is, however, some previous evidence from twin studies that anorexia and depression might share a genetic link."

The study was funded by the U.S. National Institutes of Health, the European Union, the Academy of Finland, and private foundations. PN

An abstract of "Factors Associated With Recovery From Anorexia Nervosa: A Population-Based Study" is posted at http://onlinelibrary.wiley.com/doi/10.1002/eat.22.168/abstract.

Defendants

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cases or appeals because otherwise we have no control over the timing of the decision. We just can't afford to wait and support them until a final disposition."

SSI provides a basic income for the claimants, income that gets them quickly out of shelters or jails or hospital forensic units and into real housing, an important first step for community reintegration. That allows other funds to be used for treatment at area clinics.

> "You can't move ahead without a roof over your head and some money in your pocket."

"Most recidivism occurs within 25 days of release so we need to get them into the system as soon as possible," said Schwartz. "With SOAR, the numbers of rebookings and jail days after the approval of benefits were statistically significantly lower than in the one- and two-year period before the approval of benefits."

However, she was careful to note that other factors in addition to SOAR—like treatment, housing, or care management—may also contribute to that outcome.

Five employees run the program in Miami. Funding comes from several sources, including a share of a statewide one-cent tax on drinks at large restaurants and a three-year reinvestment grant from the state. That grant will run out in July, but the funding will be picked up by the South Florida Behavioral Health Network.

Schwartz practices what she preaches about recovery. The program employs two part-time peer counselors and three full-time employees. Two of the three full-timers are people who were once disabled by mental illness, she noted.

"They're doing a fabulous job," said Schwartz of the latter. "Their background helps them be more sensitive to stigma, trauma, and the human experience." PN

Information about SAMHSA's SOAR Technical Assistance Center is posted at http://www.prainc.com/soar. Information about the Eleventh Judicial Circuit Criminal Mental Health Project is posted at http://www.jud11.flcourts.org/scsingle.aspx?pid=285.

University of Massachusetts

Douglas Ziedonis, M.D., M.P.H., says that the scientific community is finally beginning to question the safety and long-term effects of electronic cigarettes.

Cigarettes

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and emerging tobacco products—within the prior 30 days.

The analysis showed that e-cigarette use among the students doubled within one year, from 3.1 percent to 6.5 percent. One troubling finding was that the use of e-cigarettes was associated with an increased risk of beginning to smoke conventional cigarettes. In addition, many of the e-cigarette users indicated that they were using regular cigarettes along with the new products.

Ziedonis said that the study's findings illustrate that once an individual begins using nicotine products and becomes addicted to nicotine, that person is likely to desire the "full range" of effects, which are provided by regular cigarette smoking.

Jill Williams, M.D., director of the Division of Addiction Psychiatry at Rutgers University Robert Wood Johnson Medical School and an expert in nicotine addiction, told *Psychiatric News* that these findings are particularly concerning since the rates of conventional smoking have been declining to record lows over the last several years.

"Behavioral health professionals, including psychiatrists, should do more to assess and treat their adolescent and adult patients for tobacco dependence, just as they would for any other substance use disorder," said Williams, who emphasized that e-cigarettes should not be used as a cessation aid, since they have not been evaluated with the same level of rigor as evidence-based approaches to smoking cessation. "The exact chemical components of the vapor are largely unknown and can vary among devices and manufacturers. . . and we should remain skeptical" of their value in smoking-cessation programs.

Williams stressed that if e-cigarettes continue to go unregulated, their growing popularity has the potential to undo decades of progress in reducing tobacco use by making smoking more attractive to youth and those with nicotine addiction.

The UCSF study was funded by the National Cancer Institute. PN

An abstract of "Electronic Cigarettes and Conventional Cigarette Use Among U.S. Adolescents" is posted at http://archpedi.jamanetwork.com/article.aspx?articleid=1840772.

Rutgers University Robert Wood Johnson Medical School

Jill Williams, M.D., believes that physicians should be skeptical of defining electronic cigarettes as a smoking cessation aid, since these claims have not been approved by the Food and Drug Administration.