



# Community Psychiatrist

September 2013

Volume 27, Number 2

## President's Column

### *View from (near) the Navy Yard*

And yet another shooting possibly associated with mental illness. Rick and Kay Warren talking with Piers Morgan about their son with borderline personality disorder who committed suicide. Newtown, Connecticut. Military suicide. Virginia Tech, Columbine, Paduca Kentucky, Nickel Mines Amish School, and the Batman premier. A national media spotlight is focused on mental illness. Who are these perpetrating people? What can we do? Maybe spotlight is not the right term; rather searchlight might be more fitting. Many of us in many ways are searching for answers.



We are the general public; we are searching for a sense of safety. How could this happen, could my neighbor or that new co-worker unexpectedly turn into a killer? Is that shy librarian at my local branch really shy or is this a person who is quietly plotting an attack. A classmate had a psychiatric hospitalization, should I limit social interactions so that I don't become a target? I am part of a civil society and I need a sense of safety. That is my right as a citizen. Right?

We are elected officials; we want to do something to fix America's problems with mental illness. Our constituents want us to help with this; we want to do something good. We know Americans are very unhappy with all the partisan conflict. Show us the way. We understand that mental illness has its complexities; most of us are lawyers so we know about civil rights, the second amendment and also about treatment. Just tell us what we need to do, make it simple, how can we fix this? We will draft the legislation. Sponsor the bill. We need action. We are searching for a way to provide a sense of safety.

We are persons with mental illness. We are consumers or patients, and some of us are survivors. We never asked to have a mental condition. We get what stress is all about. Been there done that, we illness manage every day. We are on a road to recovery and we know how to work our recovery plans and stay well. Except when we don't, and that is why most of us have a safety net. We know we need people. Please don't associate us with those that are not in recovery, don't have a wellness plan and plot to kill other humans. We are not that. We too are searching for a sense of safety.

We are community psychiatrists; we are searching for way to help. We work with mental illness every day. We hate the adverse impact that untreated mental illness can have on a person's life and we want to support recovery. We hate the painful path associated with suicide. We help individual people get on a recovery road and we also help families, our co-workers and the sometimes-nebulous systems we work in. We are intrepid warriors on the front lines of mental illness. Sometimes we

have answers and often not. The answers often cost money and resources, which we are not accustomed to wielding. We know patient care and sometimes we can contribute meaningfully to broader public policy. We ourselves also want a safe world for the consumers we work with as well as for our own lives in the communities we all live in.

So where are the answers? A rhetorical question. Should we continue to be incremental in our national mental health policy, or are we ready to take a leap forward? How many navy yards does it take? What if we divided our thinking into two parts: 1. those who seek treatment, and 2. those who need a special path for potential public safety reasons.

Part 1. Treatment on demand for those who seek treatment. Every person in America who seeks treatment has a path to effective treatment within a reasonable timeframe. One week. Catchment areas or local government is accountable to set up plans that provide this goal for all Americans. Feds help out if the locals or state cannot do it. How far are we, is each catchment area from this goal? (Note, emergency evaluation in ED that is only assessment and triage does not count as treatment.)

Part 2. Special paths for the small number of individuals who are not readily able to seek treatment and may have public or personal safety risks. This would be the high cost-high risk minority of individuals.

The effort and detailed planning involved with approaching these two groups are not so simple, however if we don't leap forward with a commitment to better access and management of special high risk persons in US mental health policy, we will continue to live or die by gradual and incremental changes. Now is a time to leap as far as we can. Treatment on demand.

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When something is polarizing, there is usually validity to be found on both sides with the truth somewhere in the middle. Robert Whitaker's book *Anatomy of an Epidemic* has sparked such a debate about the role of psychiatric medications in recovery – the return to well being as a functional member of the community over the long-term. On the one hand, there is an evidence base of both old and new long-term follow-up studies suggesting that medications impede the achievement of recovery outcomes, on the other hand there are voluminous placebo-controlled double blind studies, FDA indications, and testimonials from consumers and their treating psychiatrists describing how medication saved their lives. This debate has carried over into many forums including online venues such as the AACP listserv (which in and of itself is worth the AACP membership dues – join now!) and Whitaker's Mad In America online community. This edition of the newsletter addresses this topic with two insightful articles from our members. In "Why Wunderink Matters," Dr. Sandy Steingard, one of the few psychiatrist bloggers at [madinamerica.com](http://madinamerica.com), summarizes the literature and concludes that there are some who benefit from medications and others who do not, but currently we have no way of predicting who will ultimately fall into which group. The accompanying article "A More



Comprehensive Approach to Ethical and Effective Prescribing" by Dr. Mark Ragins begins to tackle the issue of how to integrate this unsettling uncertainty into our clinical practice. As we struggle with these complex issues, it is encouraging to see our field poised to take on this challenge. Tom Insel's recent NIMH Director's Blog column "Antipsychotics: Taking the Long View" affirms this.

However, the debate has brought to light another difficult question. One frequent criticism of Whitaker is that he is not telling us anything new, that many the studies and data he cites are decades old, and his book should have been a sleeper. However, it wasn't a sleeper, and the idea that medications may actually have a negative impact on long-term recovery outcomes was surprising news to many psychiatrists, myself included. We should ask ourselves: why is that?

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## Why Wunderink Matters

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In August, an important paper was published in *JAMA Psychiatry*. Wunderink and colleagues (1) published results of a follow up to a study he had completed several years ago. In the initial study of first episode psychosis, subjects were randomized to one of two treatment strategies: maintenance treatment (MT) in which they were maintained on drugs for the two year study or drug discontinuation (DR) in which the drugs were stopped and then restarted if symptoms recurred.



In their initial report (2), they found that the DR group had a higher rate of relapse. They found no advantages to DR. This study supported the standard practice of recommending that individuals remain on these drugs continuously for at least two years.

In this new study, they tracked these individuals seven years after they had first entered the study. They defined three categories of recovery: symptomatic remission were those who had few or no psychotic symptoms, functional remission were those with good function (self-care, relationships, work), and full recovery were those who met criteria for both symptomatic remission and functional recovery.

At seven years, there was a clear difference between the MT and DR groups: while both had similar rates of symptomatic

remission (~67%), the DR group had a much higher rate of functional remission (46%) and full recovery (40%).

Also of note, at seven years the MT group had the same number of relapses, they just occurred a bit later than in the DR group.

Martin Harrow's longitudinal study (3) showed a correlation between neuroleptics and worse functional outcome but since this is a naturalistic study, one could not know if the drug dose caused the worse outcomes. Wunderink and colleagues randomized their subjects to each treatment approach yet they also found that higher drug doses were correlated with worse functional outcome.

Wunderink also found that total dose had an impact on outcome. Less exposure to neuroleptic was associated with better functional outcome without diminishing symptomatic improvement.

Timothy Crow, a prominent British psychiatrist and researcher, conducted a somewhat similar study in the 1980s. In his study, he randomly assigned 120 subjects who had recovered from a first episode of psychosis with neuroleptics to maintenance treatment with drug or placebo. In an initial paper published in 1986 (4), his group reported a higher rate of relapse in the placebo group. However, in a later paper (5)

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reporting on outcomes at 30 months, they reported a higher rate of employment in those randomized to placebo. As they wrote in that paper, "It suggests the disquieting conclusion that the benefits of active neuroleptics in reducing relapse may exact a price in occupational terms."

More recently, Gleeson and colleagues (6) reported on the effects of an intensive experimental intervention that was designed to improve adherence to neuroleptic treatment in a group of individuals with first episode psychosis. Their intervention was effective - more individuals remained on drug - and at 12 months the relapse rate in experimental group was lower. But similar to Wunderink and Crow, they report that at 30 months, there was no advantage with regard to relapse rate for the experimental group and their vocational outcomes were worse.

This is how I am currently making sense of this.

First of all, there is a wide variability in outcome and response. I continue to believe that there are those who benefit from these drugs in both the short and long term. However, there are others for whom the response is not so great and there are those who recover without taking them. Unfortunately, we have no way of knowing who these people are.

In the Wunderink study, ~ 40% of individuals did not relapse - and this includes those who stopped the drugs completely. Outcome is highly variable. I would argue for an attitude of active shared decision making between the individual and her support system. "Relapse" is a construct that varies from individual to individual. The risk, therefore, needs to be considered on an individual basis.

Secondly, dose matters. We have known for at least twenty years, that low doses are as effective as higher ones (7). Many of the most troubling side effects are dose related. Wunderink found that those in the discontinuation group had overall less

exposure to these drugs. It may have been this lower exposure, rather than the targeted dosing strategy, that had the greatest impact. We need to treat these drugs with caution. We should start low and go slow. We need to regularly consider dose reductions.

This does not need to be a polarized discussion for or against the use of these drugs. I doubt there is one correct answer. However, it is important that psychiatrists are open in acknowledging the import of these studies and work hard to understand how to incorporate these findings into clinical practice.

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# A More Comprehensive Approach to Ethical and Effective Prescribing

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Like most doctors, I feel like I prescribe medications ethically and effectively. The basic foundation for that confidence is three things: 1) Knowing that my primary motivation is almost always to help my patients. I believe that my prescribing isn't substantially impacted by other motivations like my own financial gain, decreasing my own workload, or countertransference, for example. 2) I try to defend myself as best I can from being too influenced by the profit seeking motivations of the pharmaceutical industry. And 3) I try to resist responding to various self destructive motivations of my patients (hopefully without becoming too judgmental and pejorative of their "medication abusing", "manipulative", "sabotaging" desires). Prodded by Robert Whittaker's books, I feel the need to build a more comprehensive approach to ethical and effective prescribing than I was taught or modeled or even than is expected of me. Here are four more foundations I'm building: 1) Individualized prescribing, 2) Recovery based prescribing, 3) Trauma informed prescribing, and 4) Toxicity informed prescribing.



## 1) Individualized Prescribing

I was first taught to prescribe based upon people's diagnoses. I was taught a rapid, highly simplified, reliable, syndromic checklist method of differentiating a handful of diagnoses that have associated research driven flow charts of medications to treat them. Within this system a variety of people, for example a speed using, foster care childhood, homeless person, an emotionally labile rape victim, a person with a strong family history and clear episodes of highs and lows, and an emotionally immature teenager are all diagnosed with Bipolar disorder and treated with mood stabilizers and atypical antipsychotics. Even this system is often considered too time consuming and replaced with symptom based prescribing. I was taught to treat depression with antidepressants, anxiety with anti-anxiety medications, psychosis with antipsychotics and mood instability with mood stabilizers. Chart notes are supposed to reflect targeted symptoms.

I don't find either of these approaches to be generally ethical or effective. Fortunately I have the time and support to actually get to know my patients well and to understand as well as empathize with them. We build a shared story of what their difficulties are and how they developed them. Sometimes it's a medical model, DSM story and sometimes it's not. We develop a shared treatment plan that often, but not always, includes medications as part of how their life is going to get back on track. I may or may not prescribe to help overcome family conflicts, attachment disorders, violent urges from childhood beatings, the stress of a battle between God and the Devil within them, or any of a multitude of highly individualized formulations.

I believe this method increases effectiveness both by incorporating well known "nonspecific treatment factors" and by increasing engagement and medication usage. It reduces

"drop outs" and "non-compliance", arguably two of the most important mediators of ineffective treatment.

## 2) Recovery Based Prescribing

It has been a good deal of my life's work to develop and practice a comprehensive approach to recovery based prescribing. Key values have been embedded into key practices with every patient I see including:

- Collaborative, client-driven prescribing instead of professional driven
- Shared decision making, and shared responsibility instead of informed consent and professional responsibility
- Quality of life, goal driven prescribing instead of symptom relief prescribing
- Pursuing resilience instead of cure
- Shared journey of learning from successful and failed attempts instead of risk aversion
- Growth oriented instead of caretaking—including transitional relationships with me instead of lifelong commitments
- Basing hope on their strengths instead of mine
- Taking the long view of recovery

I have discussed each of these in detail elsewhere. In my view, developing these practices has protected the people I work with for a great deal of the damage commonly included in our prevalent medical model prescribing.

## 3) Trauma Informed Medications

There is a great deal of trauma and suffering associated with mental illnesses. There is also, unfortunately, a great deal of trauma associated with psychiatric treatment including medications. While consumer / survivors used to confront us with traumatic stories of involuntary hospitalizations and confinement, of being locked up and tied down and physically assaulted, today's stories far more commonly revolve around traumatic medication stories – medicated after inadequate evaluations, mis-medications, overmedication, polypharmacy, difficulties in functioning on medications, difficulty in getting off medications, etc. While trauma informed approaches have been developed, though not nearly widely enough used, for hospital practice, I've never seen trauma informed approaches to medications articulated.

When there was a large conflict over whether antidepressant prescribing to depressed teenagers was causing an increase in suicidal thoughts and behavior, the discussion focused on the biological factors not the traumatic factors. I never heard the hypothesis that suicidal thoughts and behaviors increased because it was traumatizing to be diagnosed with a mental illness and give a prescription, even if you never took it.

When we do think about trauma and medications we tend to conceptualize it as internalized self stigma and then see the remedy as destigmatizing education, especially emphasizing the shame and blame reducing aspects of illness based formulations. Rarely do we linger over understanding the individualized traumatic impact of each prescription we write. Which of our patients feel degraded, dehumanized, discounted,

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pressured to conform, misunderstood, controlled, drugged up, physically harmed, over sedated, creatively inhibited, racially persecuted, personally devalued, etc. by their prescriptions? I've tried to develop a plausible list to explore with people as I prescribe to try to be trauma informed. Sometimes I won't prescribe as a result of the likely trauma I'll induce. Sometimes I'll help them work through the trauma to be able to use medications less painfully.

#### **4) Toxicity Informed Prescribing**

I was taught that the way to deal with toxic aspects of our medications was to learn the side effects of each medication and balance symptom relief and side effects, including attempting to share my decision making process with my patients through a discussion of risks and benefits and informed consent. I wasn't really taught that even though I was usually urged to prescribe "for the rest of your life" that all of the studies of effects and side effects were short-term studies, generally 6-12 weeks. I also wasn't taught that pharmaceutical companies routinely hide the side effects to increase their profits. The Zyprexa / diabetes story was my personally traumatic lesson in "real life".

I also didn't notice that the side effects included in the FDA studies and the PDR systematically exclude "subtle" psychological and emotional side effects that are often very important to the people I work with including things like "I don't feel like I can cry anymore even when I need to", "I was able to remember more of my past and felt more alive when my medications were decreased," "I'm less creative on my medications and I just don't feel like writing poetry as much," or "I'm not as quick-witted and funny as I used to be."

Whitaker's main contribution to my thinking is his biological hypothesis that feedback responses to medication induced "positive" biochemical changes may be far more pervasive and damaging than we realized and that we often mistakenly identify them as re-emergence of underlying, still existing illnesses. I was certainly aware of this possibility with addictive medications and with tardive dyskinesia, but I'd never applied that model to "my antidepressants poop out after about 9 months and I need to change what pill I'm on" let alone to cognitive declines with schizophrenia, chronic depression and

generalized anxiety, rapid cycling and mixed state bipolar, or stimulant induced chronic mood instability. On a gut level his hypothesis fits my clinical observations.

Taking this hypothesis seriously has led me to two prescribing changes. Firstly, I think I have to take the same precautions I do for medications known to create either tolerance or withdrawal based problems like benzodiazepines and stimulants and that I take with those known to cause hypersensitivity feedback syndromes like tardive dyskinesia for all medications. "If you have no side effects now, you're never going to get any. You can keep taking this medication with minimal monitoring indefinitely" is probably not an effective and ethical approach even though it's very common.

Secondly, as I read the long term studies that have gotten more recent exposure and Andreason's unique work, I've come to the conclusion that neither the pro-medication nor the anti-medication sides are correct. It isn't a question of figuring out whether untreated psychosis is damaging to your brain or long term medications are damaging to your brain. The most likely answer is that both are damaging. The prescribing recommendations of both sides of the "or" argument - aggressive preventative prescribing to people at high risk of developing psychosis versus avoiding medications while pursuing holistic, interpersonal, or social interventions while the psychosis persists and grows - are both narrow minded. The "and" approach says that it's harmful both to medicate and not to medicate.

I've long suspected that "Do no harm" was a fantasy. I have to come to terms with the likelihood that I'm doing harm when I do prescribe and when I don't prescribe, regardless of my motivations. Perhaps I can apply some of the harm reduction principles I've learned to use with substance abuse. But I know how humbling and powerless and uncomfortable using harm reduction feels. I have some emotional work to do if I'm going to approach all of prescribing that way.

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# Suicide and the Community Psychiatrist

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Did you happen to forget that it was our nation's 39th Annual Suicide Prevention Week, September 8-14? Well, I did, and expect many community psychiatrists did, given the lack of list-serve chat talk about what to do approaching that week.



I found out myself in an unexpected but most meaningful way that might be of interest to my fellow community psychiatrists, whether you are Jewish or not. In the middle of the recent Jewish High Holy Days, the Rabbi at our reform synagogue asked me if I would serve on a study session planned on Yom Kippur. Yom Kippur is a day to pray to be put in "The Book of Life" for next year. It was to be September 14th, the same day as the last day of suicide prevention week. Tragically, those who commit suicide do not want to be put into that book, which should evoke concern on the part of any community.

I agreed to participate, thinking this would be quite easy. As a community psychiatrist and administrator for over 40 years, I knew much about suicide, didn't I? And, hadn't I spoken to the public on many occasions? Just to be sure, I asked colleagues for their recommendations. Soon, I realized there would be more of a challenge ahead than I realized, but at least I thought I would be more prepared.

Here's what happened and how I used what I learned from other community psychiatrists. In a religious sense, I found the entire process to be almost "miraculous".

I decided to focus my part of the presentation on my own professional direct experiences with suicide. Why? One reason is that I did not have any family suicide to talk about personally. Therefore, if I wanted to model about the necessity of talking more publicly about this stigmatizing topic, I had to share something personal. That something personal was the two suicides in my career.

I still felt pretty confident as I stepped up to talk to the audience of about 200 people. I began to tell them about one of my first patients in my first year of residency when I was learning how to be a psychiatrist. He was an elderly man who came in somewhat reluctantly for depression related to job loss and a loveless marriage. After the first session, I began an older antidepressant and made plans to add some psychotherapy. At the second visit, he seemed a bit better.

It was just then during the presentation that I started to tear up and sob. And sob. I looked to my wife, secretly hoping she might come up to comfort me, but at the same time too embarrassed to ask her to do so. Then, a man on the aisle near the front softly said toward me: "take your time, relax". And I did. And I was able to go on to say that the patient's wife called a few days later to say that he had walked into Lake Michigan and drowned, an apparent suicide.

At that time, 40 years ago, I had panicked and I told the audience that. What would my supervisors say? Was I not cut out to be a psychiatrist? Most fortunately, they were kind, gentle, supportive, and educational, all the things that would help anyone reacting to a suicide. They told me I probably wasn't taught yet that a transition to apparently doing better

could be a high risk time, when the patient had the energy and resolve to end their life. That is one reason why people were often surprised by a suicide. They said I would learn from this and be a better psychiatrist. I never did have another patient to commit suicide.

Still retaining my composure, I went on to the second suicide. This time, 15 years later, it was a staff member. I had been the Medical Director of a large community mental health center. One of the staff was whispered to have AIDS. When he didn't come to work for 3 days, we started to be concerned. Maybe he was in a hospital. Confidentiality about AIDS at that time was a big concern. Just to be sure, a staff member and I decided to go to his house. There we found him on the bed, dead, with a gunshot wound to the head. After some days, we processed this with our grieving staff. I think I had some of what is called suicide grief, that grief complicated by a combination of guilt, anger, shock, relief, and intermittent intrusion of traumatic memories. Maybe, I told the audience, given my sobbing, some of that grief was still with me.

As a staff, we realized that maybe we were taking suicide assessment in too routine away. Perhaps, too, we weren't paying enough attention to our own mental health. After all, psychiatrists and mental health professionals were thought to have high rates of suicide. We soon did much continuing education on suicide and also became closer as a staff.

I went on to tell the audience that we now know how to prevent most suicides, provided that the person comes to treatment in a comprehensive system using the best practices. They were reassured. How did I know that? First, from Mark Ragins, M.D. of The Village in Long Beach. He had reminded us of the importance of the therapeutic alliance in preventing suicide and to be very cautious about rushing to hospitalize a suicidal patient. Second was a system and practice that I did not know of before. That was from Karen Chaney, M.D., Medical Director of Adult Services for Magellan Behavioral Health (see [www.magellanofaz.com](http://www.magellanofaz.com) and click on Suicide Prevention). Their goal was to get to "zero" suicides in their system. After canvassing best practices elsewhere, they developed a protocol. Essential seemed to be a brief screening questionnaire. One provider found at least 155 out of 2400 screens were positive for high risk. Here, too, there was no rush to hospitalize, but to pull together all the resources: psychotherapy, medication, home visits, family involvement, and telephone checks, among them. Now, it is crucial to remember that these positive screens were in patients not necessarily thought to be of risk by their caregivers. The conclusion is that most suicides should be thought of as a system failure.

I would probably add that suicides are also a community failure, for we need the public to watch for suicide risk and help get people into good systems of care. In our study session, another presenter talked about a new public education on suicide prevention through the local university. So far, though, I couldn't tell if there were any psychiatrists involved. I offered to be.

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The "miraculous" part to me happened right after the presentation was over. I walked up to the gentleman who had calmed me and thanked him. As I found out, he was the father of a young lady who had committed suicide only two months before. Her suicide was so traumatic to the community that her funeral had an overflow attendance. Now, he, in all his suicide grief, was able to comfort me!? What an example of how the

community and community psychiatrists can work together and comfort one another.

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## Depression and Danger to Others

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Depression is not generally associated with dangerousness to others. In "worst case" situations, however, depression and resultant suicidal thinking/suicide attempts/suicide can be dangerous to others.

The clearest examples of situations where a depressed person is a danger to others are in those instances where a depressed individual kills someone, sometimes followed by suicide. Homicide-suicide is a worldwide problem, although the percentage of homicides accounted for by homicide-suicide varies widely amongst countries. There are several situations where depression precipitates murder, and then sometimes suicide:

- Infanticide and postpartum depression: The murder of a child under one year old by his mother. Fifty percent of infant homicides occur within the first four months, with a prominent form being "altruistic" or murder out of love, i.e., the suicidal parent does not want to leave the child "alone" and acts in what she thinks is the best interest of the child.
- Filicide: The killing of a child by a parent, which accounts for 60% of all child homicides. Depressed women who committed filicide report thinking about their own death and the death of their child(ren) for days or weeks before the event.
- Adolescent parricide, whereby a shamed and humiliated son (usually) kills a parent based on a belief this will result in a "relief of dysphoric feeling."
- Domestic homicide and homicide-suicide perpetrated by members of an older (over 65 years-old) couple include depression as one of the more frequent psychiatric disorders -- a global finding.
- Mass murder followed by suicide is the all-too-common example of extra-familial killing followed by suicide. Depression is the leading diagnosis found in these cases.

There are other ways a parent's suicide is dangerous or damaging to children. Thoughts of harming their infant occur in 41% of depressed mothers (six times the rate compared to non-depressed mothers) and these thoughts lead mothers to withdraw from their infants. Children of women with postpartum depression experience poor physical developmental outcomes.

Children bereaved by parental suicide have more depressive symptoms, disproportionate rates of suicidality and hospitalizations for suicide attempts; more psychiatric referrals, PTSD-like symptoms with guilt and self blame, higher

rates of personality disorders, increased rates of convictions for violent crimes, and a substantially greater risk of suicide themselves.

Depression can be a contributing factor in a number of other situations where a suicide causes harm to others. "Suicide epidemics" have been a quagmire since long before organized psychiatry began to try to untangle its nuances. Such epidemics are known to occur sporadically, but repeatedly, in certain populations such as American Indians and in certain sites such as psychiatric inpatient units.

Suicide by car crash is an effective way to disguise a suicide: Driver suicide was ranked in the year 2000 by the WHO/Euro Multicentre Study on Para-suicide as the twelfth most common method of attempted suicide, but there is currently wide variance amongst countries in reported driver suicide. Suicide by motor vehicle is dangerous to others because the driver has no control of the actual outcome.

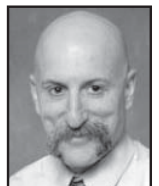
Some people who are intent on killing themselves set up a scenario to use another person as the lethal agent, and that other person is often a policeman/policewoman, thus "suicide by cop." In such cases, there may well be bullets flying in all directions.

Depression can be a contributing factor to pathological fire setting, and any fire setting is dangerous to the proximate population. Fire setting is frequently used in filicide. Patients with pyromania have a higher number of previous depressive episodes as compared to patients with other impulsive control disorders.

Death by self-immolation in western and developed countries is an uncommon event, and is usually a suicide in a depressed person. In eastern and developing countries, setting oneself on fire is multifactorial, but here tradition often masks suicide rooted in depression. In self-immolation, the fire setter is the sole target, but once the fire is set, the individual who set the fire has no control over the fire's course or its destruction.

Suicidality, secondary to depression, can be a danger to others. People who commit such acts predominantly suffer from mood disorders, and the most prevalent mood disorder is major depression.

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## What's New in DSM-5 for Cultural Psychiatry?

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The publication of the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) in 1994 by the American Psychiatric Association was a watershed moment for cultural psychiatry with its glossary of culture-bound syndromes, Outline for Cultural Formulation (OCF), culturally relevant diagnostic categories, and cultural considerations in the narratives introducing each chapter. DSM-5 advances the practice of cultural psychiatry with the Cultural Formulation Interview (CFI). Based on the OCF, it is a 16-question interview, with 12 additional supplementary modules (Explanatory Model, Level of Functioning, Psychosocial Stressors, Social Network, Cultural Identity, Spirituality, Religion, and Moral Traditions, Coping and Help-Seeking, Patient-Clinician Relationship, Immigrants and Refugees, School-Age Children and Adolescents, Older Adults, and Caregivers). DSM-5 also includes an updated Glossary of Cultural Concepts of Distress, the new name for culture bound syndromes. The CFI, CFI Informant Version, and supplementary modules are available online at <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>.

This column will highlight the most useful of the 16 questions. The clinician who would like to perform a culturally appropriate assessment on any individual, not just patients from other countries or ethnic groups, now has sample questions from which to choose to collect the clinical data for the OCF.

### **Cultural definition of the problem and Perceptions of Cause, Context, and Support:**

The CFI's second question is an extremely effective way of determining how the patient's community sees their illness: *Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?* The next questions (3-5) ask the patient to identify their concerns, why do they think it is happening and what are the causes: *What troubles you most about your problem? Why do you think this is happening to you? What do you think are the causes of your problem? What do others in your family, friends, or others in your community think are the causes of your problem?*

### **Social Network:**

Questions 6 and 7 ask the patient how they derive support or experience stress from their family, friends, or ethnic or religious community: *Are there any kinds of support that make your problem better/worse, such as support from family, friends, or others?* Questions 9 and 10, which ask the patient to explain

how they see their cultural identity is making their problem worse or better, explore the role of cultural identity in the patient's illness: *Are there any aspects of your background or identity that make a difference to your problem? Or are causing other concerns or difficulties for you?*

### **Help-seeking:**

The last six questions focus on how the patient has gotten help in the past, and where they will get help in the future. Not only do these questions show interest in the patient, but it also gives the clinician information about their health beliefs that can be used during the discussion of their treatment plan. Questions 11-12 ask the patient what have they tried in the past: *Sometimes people have various ways of dealing with problems like your problem. What have you done on your own to cope with your problems? Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your problem?* Question 14 asks the patient what they think would be helpful for them, while Question 15 looks at what others have advised, further putting the clinician's advice to the patient in context with the patient's health beliefs: *What kinds of help do you think would be most useful to you at this time for your problem? Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?* The final question (#16), asks the patient if they have concerns about the therapist patient relationship, completing the fourth part of the OCF.

The 16 questions of the CFI and its 12 supplementary modules equip any clinician with sample questions to perform a culturally appropriate assessment and create a cultural formulation that will engage the patient in their treatment, and are an important advance in the practice of cultural psychiatry.

Russell F. Lim, MD, MEd.

Dr. Lim is a Health Sciences Clinical Professor at the University of California Davis School of Medicine, Department of Psychiatry and Behavioral Sciences. He is the editor of the Clinical Manual of Cultural Psychiatry. The second edition is scheduled for release next year, and will include the Cultural Formulation Interview, three new chapters on women, gay, lesbians, transgender individuals, and religion, and over 15 video vignettes to illustrate teaching points from the text.





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## The START Program

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The Vermont State Hospital was flooded in August 2011 and overnight a hospital was shuttered. The hospital had lost its CMS certification in 2002 and the state had spent the intervening time debating the future of the hospital. There were those who argued that a state hospital was not needed and those who argued that we needed a newer, bigger, state-of-the-art facility, but the opposing factions could never agree. But with one major storm, there was no choice; the state hospital was closed and engineers determined that it would never re-open again.

This began a remarkably complex process that continues to evolve.

As the Medical Director of the largest community mental health center in the state, I was in what I will likely look back on as a once in a lifetime opportunity to make proposals for program development that were funded and then up-and-running within less than a year.

One of these programs is called START - STabilization And Recovery Team. This is a group of professional and peers who go to peoples' homes and offer a variety of support to help them through a crisis. The mission of program developed post-Irene was to reduce hospitalization so we work primarily with individuals who would otherwise be hospitalized.

My agency HowardCenter already had a crisis service in place which is staffed 24/7 by at least two master level clinicians. We have a phone line, we go out to the community, and we cover the local emergency room. We also already had a 6 bed hospital diversion program located adjacent to the home base of our Crisis program. This unit functioned as an adjunct to Crisis. Some people are admitted from the ER in lieu of hospital admission and some are referred by a Crisis clinician who has done an evaluation in the field. Others may be referred by other clinicians who work in our agency.

START was intended to offer people in crisis the option of remaining at home with the support of our team.

This program has proven to be very popular and well

received and its benefits have gone beyond what we initially anticipated. We are made up of professionals and peers. The peers have had a variety of trainings including Intentional Peer Support. The professionals include a part-time psychiatrist, and full time psychologist and a case manager. All of the professional staff is fairly seasoned in a variety of aspects of community mental health work. Our operating philosophy can be described as social network based and pragmatic. We believe it is less disruptive to get help in the community and that utilizing one's natural supports are helpful since those are the supports that a person can use even after we are no longer involved in their lives. We offer supportive listening, assistance in obtaining housing, referral for treatment and introduction to community supports. Several members of the team have begun training in dialogic practice and we embed this into the work we do with patients and their families.

One of the unplanned benefits of this program is the impact it has had throughout the agency. Nothing teaches recovery as well as seeing someone who we have known for many years through multiple crises rise to the occasion of being able to function consistently and responsibly as a peer support. It has been quite moving and has almost immediately effected a subtle culture change. Long-term clients of the agency seem more receptive to the idea of working and it has raised the general level of awareness that people who have experienced extreme states can recover and contribute to their communities in meaningful ways.

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## Preparing for ICD-10-CM

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On October 1, 2014 clinicians and administrators throughout the country will be expected to complete a switch in coding medical conditions, including psychiatric conditions, from ICD-9-CM to ICD-10-CM. In this article we would like to share some thoughts about key points of the change to help them in the transition.

Clinicians will not fail to notice the biggest change. The codes used on ICD-10 are quite different from those we have been using until now. They begin with a letter, not a number, and most of the psychiatric conditions begin with the letter "F." Examples:

F33.2 = "Major Depressive Disorder, recurrent, severe without psychotic features."

F43.21 = "Adjustment Disorder with mixed anxiety and depressed mood."

F68.3 = "Borderline Personality Disorder"

We found relief in that the nomenclature used in ICD-10-CM is virtually the same one used on DSM-IV-TR. ICD-10-CM does not have any Disorders that clinicians have not been using since DSM-IV-TR was published in 1994.

There will be differences in the degree of change that providers will have to make by the time of implementing ICD-10-CM, depending on whether the service provider also expects a change to DSM-5.

Changing to DSM-5 will include:

1. Stop using the multiaxial system. The clinician will have to simply list the Disorders in order of clinical importance, as the rest of medicine have been doing for decades.
2. Changing the name used for 89 Disorders, e.g., "Dysthymia" is replaced with "Persistent Depressive Disorder."
3. Realizing that there have been 15 combinations of Disorders, e.g., the subtypes of "Schizophrenia - Paranoid, Catatonic, Disorganized, and Undifferentiated" - have all been folded into just "Schizophrenia," without any subtypes
4. Accounting for an increase of the V-codes from 22 to 88.
5. Actualizing an increase in the number of Abuse codes from 5 to 44.
6. Noting that there are over 400 changes in criteria-sets of Disorders carried over from DSM-IV-TR. Luckily, most of these criteria-set changes are very minor and are unlikely to lead clinicians to changing their patient's ongoing diagnosis.

In general, clinicians should welcome the switch from ICD-9-CM to ICD-10-CM. The new version of ICD is more specific the one it is replacing. In ICD-9-CM there is a huge sharing of codes. One code, for example, 292.89, is shared by 31 distinct Disorders in ICD-9-CM. With the adoption of ICD-10-CM, each of those 31 Disorders will have its own unique code.

Roger Peele, MD, DLFAPA  
Gustavo Goldstein, MD, DFAPA

# The Role of Psychiatry in Healthcare Reform: Partnerships in the Service of Recovery and Wellness

Elinore F. McCance-Katz, MD, PhD, Chief Medical Officer, SAMHSA

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With health coverage under the Affordable Care Act (ACA) beginning in 2014, psychiatry is positioned to become more integral to the delivery of mental health and substance abuse treatment services in multiple sectors of the healthcare system. Health reform and insurance parity for behavioral health disorders have laid the groundwork for essential collaborations among psychiatrists and primary care providers. The efficacy of integrated care is increasingly recognized and the establishment of health homes and accountable care organizations are signaling a dramatic shift from individual treatment settings to coordinated care approaches that address the holistic needs of those served. As these changes rapidly take place, psychiatrists will need to prepare for new roles in integrated practice settings.

With this shift also comes a conceptual shift in expectations and outcomes for psychiatry. The treatment of mental and substance use disorders have generally been underfunded in the current healthcare system. Individuals with these disorders are often marginalized leading to systems of care in which psychiatric services are delivered in isolation from necessary medical services. Clinical services delivered by psychiatrists have been narrowed and often limited to psychopharmacology, frequently constrained by managed care reimbursement practices. The availability of psychotherapy has steadily declined over the last decade. At the same time, rates of comorbidity and early mortality for individuals with mental and/or substance use disorders are alarmingly high--and highly costly--particularly when considering that these factors are primarily due to preventable medical conditions and modifiable risk factors. These conditions have contributed to challenges in accessing high quality psychiatric and primary care services.

Health reform brings a new opportunity for psychiatry based on an emphasis on integrated care with a person-centered orientation. Research shows that people with behavioral health conditions have improved outcomes in integrated care settings where they can effectively coordinate their medical and behavioral healthcare and easily access primary care services. Person-centered approaches are also known to lead to improved treatment outcomes when all of an individual's medical and psychiatric issues can be addressed in one clinical setting. Holistic and person-centered approaches incorporate the concepts of wellness and recovery, and represent opportunities for psychiatrists to expand their repertoire of effective clinical services.

Increasingly, psychiatrists will be incorporated into primary care and, in some instances, specialty medical settings to provide evaluation and treatment for mental and substance use disorders. Similarly, traditional mental health settings, while still focused in providing services to those with mental disorders, will start to transition to programs in which primary

care will be available in addition to psychiatric and other treatment services. Moving forward, psychiatrists will become important and integral members of a treatment team dedicated to providing integrated care to those who often have complex medical and psychiatric issues. Psychiatrists can expect to work in a multidisciplinary environment likely to include other primary providers, nursing, social work, case management, and peer recovery supporters.

The Substance Abuse and Mental Health Services Administration ([SAMHSA](#)) has spent several years supporting programs and projects designed to advance this new approach to mental health care and has partnered with psychiatry, specifically the American Psychiatric Association and the American Association of Community Psychiatrists, to advance these concepts in the field. SAMHSA defines [recovery](#) from behavioral health problems as a process where individuals improve outcomes related to their health and wellness. The goal is for people with behavioral health problems to lead their recovery journeys with the support of allies--including psychiatrists and other providers. [Wellness](#) is identified as a state of well being that includes multiple aspects of a person's life including emotional, physical, social, and spiritual. The ACA supports these concepts with a focus on wellness and prevention strategies along with the encouragement of outcomes-driven reimbursement approaches.

SAMHSA's [Recovery to Practice](#) (RTP) program incorporates the vision of recovery and wellness into the concrete and everyday treatment practices of behavioral health professionals in all disciplines--including psychiatry. Since 2009, RTP has partnered with the APA/AACP and other national behavioral health care provider associations to prepare for the implementation of the ACA and transform how behavioral health care is provided. The APA and AACP have created and pilot-tested nine training modules that target both psychiatrists in training as well as those already established in the field.

The Primary and Behavioral Healthcare Integration (PBHCI) grant program builds partnerships and infrastructure needed to provide primary healthcare services for people with behavioral health disorders served in community mental healthcare settings. Psychiatry has played a key role in this effort including identifying [clinical practice tools](#) for successful integration. Moving forward, SAMHSA plans to work to encourage further integration of psychiatry into primary healthcare settings.

Shared decision making is an additional ACA-supported recovery-based practice innovation. This includes a [shared-decision making tool](#) developed by SAMHSA--along with psychiatric consultants--designed to help psychiatrists and clients make informed choices about the use of antipsychotic

*Continued on Page 12*

medications. Additional tools are being developed including an on-line guide on Medication Assisted Therapies for those with opioid addictions.

For the past 40 years, SAMHSA has partnered with the APA and other groups on the [Minority Fellowship Program](#) (MFP) in order to reduce health disparities and improve health care outcomes of racially and ethnically diverse populations by increasing the number of culturally competent behavioral health professionals--including psychiatrists--available to underserved populations in the public and private nonprofit sectors. The MFP closely aligns with the ACA by addressing the current and projected behavioral health workforce shortages and the need

to train providers on recovery-based practices.

Finally, SAMHSA, through its [BRSS TACS](#) initiative, is working with psychiatry to bring to scale a range of recovery-based approaches including the development of peer providers as important team members to expand service access, recovery, and wellness. Peers can benefit psychiatrists by serving as treatment extenders to more fully engage clients beyond the treatment encounter and into wellness activities.

SAMHSA stands ready to build on these efforts and to continue to work alongside psychiatry to transform behavioral health practice to foster recovery and wellness.



### **AACP Events at IPS**

The Board will meet at the IPS at the Philadelphia Marriott Downtown Hotel

Wednesday, October 9 at 1 p.m. - 8 p.m., Grand Ballroom C, Level 5

Thursday, October 10 at 8 a.m. - 12 noon, Grand Ballroom C, Level 5

#### **Membership Forum**

Friday, October 11 at 5 p.m. - 7 p.m., Franklin 1, Level 4

#### **Membership Reception**

7:15 p.m. - 9 p.m., Pine Building Great Court, The Pennsylvania Hospital

### **Public Psychiatry Fellowship Events at IPS**

There are approximately 15 public and community psychiatry fellowship training programs throughout the country, almost all of which have been developed in the past seven years. A list of these programs with contact information appears on the AACP website at <http://www.communitypsychiatry.org/training/fellowships.aspx>. One new program started this year is at Nassau University Medical Center on Long Island, New York. For information about that program contact Rajvee Vora at [<rvora@numc.edu>](mailto:rvora@numc.edu).

The meeting of Public and Community Psychiatry Fellowship Directors is scheduled in Franklin 3 in the Marriott Downtown on Thursday, 10/10 from 3:30 to 6 pm. Prospective applicants to such fellowships are invited to attend the meeting.

Directors of Public and Community Psychiatry Departments that don't have fellowship programs have been invited to attend the above meeting this year, and the last hour of this meeting will be devoted to a discussion led by Pat Runnels amongst that group.

### **APA Public Psychiatry Fellows Presentations at IPS**

Friday, October 11, 2013

8:00 am to 9:30 am

Psychiatry in the Storm: Issues of Public Psychiatry During Hospital Evacuations

Rooms 401/402, Level 4

Chair: Wil C. Berry, MD

10:00 am to 11:30 am

Does One Size Fit All? Three Psychiatric Health Home Models, Their Patients, and the Residents who Work in Them

Room 404, Level 4

Chairs: Tauheed Zaman, MD & Elizabeth Horstmann, MD

1:30 pm to 3:00 pm

Recovery through the Continuum of Care: A Look at Pre-Hospital, Hospital, and Outpatient Recovery-Based Interventions

Room 307, Level 3

Chairs: Rowena Cabigon Mercado, MD, MPH & Ana T. Turner, MD

3:30 pm to 5:00 pm

Smart Phones in the Clubhouse: An Exploration into the Influences of Mobile Technology on Psychosis, the Therapeutic Alliance, & Recovery

401/402, Level 4

Chair: Neisha D'Souza, MD