As psychiatrists, our stock-in-trade is understanding our patients’ motives—and in general, understanding what makes people “tick.” So, it may seem surprising that when it comes to mass shootings, such as the horrific Thousand Oaks bar massacre, we feel frustrated by the media’s obsession with the shooter’s “motives.” The same goes for investigators of such attacks, who seem fixated on determining the shooter’s “motive.”

To be sure: after such tragedies, it’s simply human nature to ask, “Why did the shooter do it?” And even in the most heinous and difficult to fathom crimes, there is motive. The popular myth that the perpetrator of a mass shooting “just snapped” has been debunked.1 Furthermore, the determination of “motive” is often important in criminal law. Essentially, motive (from the Latin word *motivum*, meaning “moving cause”) is what moves a person to commit a certain act. In US criminal law, there is no

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Mass Shootings

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requirement to prove motive to reach a verdict. However, motive may be shown by the prosecution in order to prove that a defendant had a plausible reason to commit the crime.

Technically, motive is distinct from intent, although the two are often intertwined. (Motive has been defined as “the reason that nudges the will and prods the mind to indulge the criminal intent.”) Thus, a person who knowingly puts a loaded gun to someone’s temple and fires it clearly had the intent to kill or grievously wound the person, but may have done so for a number of motives (eg, revenge, jealousy, racial animus). Motive becomes critical in, for example, the prosecution of hate crimes and acts of terrorism.

Notwithstanding the legitimate role of “motive,” we believe that the ritualized hunt for the shooter’s motive is usually an exercise in fruitless speculation and wasted resources. When pursued by the media, this quest almost always lacks the necessary data to reach a sound determination. Moreover, these exercises rarely yield any useful or actionable information that would help reduce the likelihood of future mass shootings. Almost invariably, we learn little more than what we have known for many years—that mass shooters are typically (though not always) angry, aggrieved, emotionally unstable, or socially isolated males who are seeking retribution or revenge for perceived mistreatment, rejection, or humiliation.

As a society, we must do better than this. We need to focus on:

1. Recognizing the major risk factors that raise the risk of violence in general;
2. Identifying and reporting observable “red flag” behaviors that point toward imminent, directed violence;
3. Reducing the likelihood that would-be killers can easily get hold of lethal weapons.

Is there a “profile” for mass shooters?

The most important risk factor for future violence in general is a previous history of violence. Other prominent risk factors include, but are not limited to:

A history of being abused or bullied
Witnessing violence between parents
A preoccupation with weapons or death; poor control of anger
Social isolation

Unfortunately, these risk factors are far too prevalent in the general population to be of practical use in identifying would-be shooters and may not apply to mass shooters. For mass shooters have been preoccupied with feelings of social persecution and fantasies of revenge for some type of perceived injustice.

While the FBI report did not directly assess the shooters’ motives, it did identify various grievances in 79% of the active shooters, mainly in the realm of interpersonal or employment actions perceived to be directed against the shooter (total of 49%). The report also identified “precipitating events” in 44% of the shooters who had an identifiable grievance such as problematic interpersonal interactions, or communicating their violent intent (leakage)—either through verbal or physical behavior. Those under age 18 demonstrated such behaviors to school peers or teachers, while those over 18 demonstrated the behaviors to spouses or domestic partners. This phenomenon of leaking violent intent is consistent with findings by the US Secret Service that found that over three-quarters of perpetrators made concerning communications and/or elicited concern from others before carrying out their attacks.

It is in the area of paying attention to warning signs and appropriate reporting to authorities that we may make the biggest gains in preventing mass shootings. Indeed, the FBI report suggests that by means of recognizing such red flags we may be able to head off potential shootings. Specifically, in 13 states, initiating an “extreme risk protection order” allows a judge to temporarily restrict a dangerous individual’s access to firearms, possibly preventing an imminent shooting.

The following Case Vignette is an example of “what went right” in averting a potential mass shooting. It involves a 22-year-old international student, here on a temporary visa.

Case Vignette

Mr Z had attempted to buy an AR-15—the semiautomatic weapon of choice for most mass shooters—at a local gun shop. For several reasons—including Mr Z’s inquiring about high-capacity shotguns for hunting—the gun shop owner became suspicious and contacted the sheriff’s office. In doing so, the gun store owner became the hero who appropriately alerted law enforcement. A series of discoveries uncovered Mr Z’s history of alcohol abuse, depression, suicidal thinking, anger problems, and feeling that he might lose control or act violently. This led authorities at the University to fill out the paperwork for New York’s SAFE Act, which bans the sale of most semi-automatic weapons, and prevents people from buying a gun if a mental health professional determines that individuals might harm themselves or others.

Subsequently, fellow students shared screenshots of messages they had seen Mr Z post in a social media group. These revealed that Mr Z felt compelled to buy a gun and a bulletproof vest, and to practice shooting. Police obtained a search warrant for Mr Z’s apartment, where they found
Moving away from motives to preemption and prevention

We hope that cases such as this, in concert with the FBI’s recommendations, will shift the focus of the press and other parties from sensationalizing motives to observing and reporting ominous behaviors. We would include suicidal threats or behaviors in this category, since almost half of the shooters in the FBI study had suicidal ideation or engaged in suicide-related behaviors at some time prior to the attack.11

Through collaboration between the public and responsible authorities, we stand a chance of preempting at least some planned shootings. Indeed, one study of thwarted mass homicide plots found that friends, family members, and acquaintances of threatening individuals—all played an important role in discovering and thwarting homicidal plots.15 To be sure, there is a great deal of room for improvement in this area. For example, the FBI report found that only about 14% of persons reported their concerns about potential shooters to law enforcement authorities.

While solid, evidence-based methods of preventing mass shootings are still lacking, we believe that progress will come through work on a number of fronts. First, better reporting of ominous behaviors and careful use of extreme risk protection orders may avert at least some mass shootings. Second, the use of Threat Assessment and Management (TAM) teams in our schools may also help preempt planned attacks. TAM teams are interdisciplinary groups of professionals that include law enforcement, mental health providers, and other security stakeholders, collaborating in a structured effort to accurately assess and mitigate the risk of violence.16

Finally, we believe—albeit speculatively—that the media can contribute to a reduction in mass shootings by refusing to publicize and sensationalize mass shooters by dwelling on their supposedly resentful, narcissistic motives. There is reason to believe that such notoriety may encourage copy-cat killers, bent on ousting the previous shooter.17,18

Surely, proactively uncovering homicidal plots and removing the lethal means of carrying them out makes far more sense than retroactively speculating on a shooter’s motives.

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FROM THE EDITOR

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uals’ willingness to speak with her about their illness. Having had few such discussions, she was struck by how much the individuals she interviewed were aware of their own mental states. To me, though, it was clear that something about the relationship the writer had developed with those individuals fostered their willingness to share their inner worlds with her.

The experience of learning to know another’s inner self is one of the most difficult, but most gratifying parts of our clinical work, and I’ve written about this in Psychiatric Times and elsewhere and lectured about it, on many occasions. To me, this capacity is at the heart of successful work with our patients and learning about it is the most difficult but important skill for psychiatrists.

One of my first experiences as a third-year medical student during my first rotation, in psychiatry, was learning that it is possible to understand a patient even in the most severe psychotic state. When the chief resident asked a patient with schizophrenia how he was doing, the patient responded with an angry tirade about how Lyndon Johnson was burning and killing defenseless babies in Vietnam. I was taken aback at the patient’s vehemence, but our chief resident calmly asked if our patient felt someone had been mean to him that morning. Yes, the patient replied, he thought the nurse was angry when she gave him his medications. Our chief said that the nurse was very busy and wasn’t angry with him at all. The patient visibly relaxed with this brief reality testing, nonsympathetic interchange.

A few weeks ago, I had a similar experience with being in synchronicity with a patient. I was asked to join a resident in speaking with a young man who had been unsuccessfully treated with medications for an acute onset of depression and anxiety several months following the shooting death of two close relatives. After speaking with him only for several minutes, I felt there was likely something that he hadn’t spoken about that was bothering him.

Was it his body language, open, but holding back at the same time; his affect, the worried expression on his face; or something more? I can’t really say. But I felt something was missing and I asked if he knew why he felt so bad, even beyond the fact that the two deaths were so understandably and horribly upsetting. Yes, he said with no hesitation, he felt guilty.

“Why?” I asked. “Because I should have been able to prevent it,” he responded. This led to a brief conversation in which I began to better understand the origin of his ongoing guilt. As he told me the specific details of what had happened, I thought his guilt was in reality unjustified. His response to my subsequent question about whether he had told anyone about his guilt led to his revealing that he had not because he felt so ashamed.

I’ve been doing clinical work for over four decades, and I still can’t explain how at certain moments with certain patients I feel in tune with them. It’s my and their state of consciousness within our relationship that in some way seems to help them to reveal something about their inner lives to me. When I teach residents and students, I talk about this state as learning to listen not as an external observer but as an empathic listener. I’m not sure, though, that description completely captures what is happening.

I still can’t really explain what allows us to inhabit, even though briefly and incompletely, the hidden self of another person. Is it a finely tuned mirror neuron neural network, or quantum mind and entangled electrons, or something else? I just don’t know, although I do know that we can enhance our ability with time and effort and self-reflection. And, it may be that Heinz Kohut was right when he asserted that empathic connection and understanding, this sharing of souls, this synchronicity, is the curative transmuting component of our psychological treatments. And, that it is likely to affect the outcome of all treatments.

Outside of a science fiction story, we still don’t have an expeditious way to enhance the capacity for developing empathic connections. At present, developing this skill requires lengthy practice. But, who can say what the future holds. Our neuroscience research findings about brain function are growing too fast to keep up with. What the near and distant learning path will be for this and other related and critically important aspects of the curative process is hard to predict. I think there’s a long road ahead, one that may take another generation to travel. I’ll likely not be working, or perhaps not even alive by the time the full understanding is discerned.

There are still many patient populations that have little access to psychiatric care, including children, the elderly, those living in urban core or rural areas, service veterans, and members of minority racial, ethnic, gender, and immigrant groups. Of great concern is that suicide rates continue to appear to be an inexorable rise, including those at both the younger and older ends of the life cycle. And, the CDC just reported that the gun deaths were the highest in the 2017 reporting cycle than in decades, or possibly ever in the US. On the other hand, the government, although not nearly quickly or thoroughly enough, is beginning to take concrete steps to address the opiate addiction and overdose death epidemic.

Over the past years, Psychiatric Times has addressed all these issues and many more. And, I’m proud that during my tenure as Editor in Chief, we’ve begun to implement a number of initiatives to continue improving the quality of the articles you read both in print and on our website. It has been gratifying that the publishing staff have been responsive to a number of ideas from Michelle Riba, our deputy editor who also is stepping down from her editorial leadership position, and me.

We’ve taken steps to diversify the editorial board in keeping with national best practices to

Monarchs and the President

for Lincoln Brower (1931-2018)

Richard M. Berlin, MD

Dr Berlin is Instructor in Psychiatry at the University of Massachusetts Medical School, Worcester, MA.

The Monarch’s cortex, head of a pin, contains maps of Earth and heavens within.

But the brain of our President holds less space to chart a course for the human race.

We bet he didn’t see them go when he choppered down to Mexico.

Butterflies equipped with Nature’s GPS outsmart even Air Force One, we guess.

Flying past Stars and Stripes unfurled, an exodus of migrants in an uncaged world.

There are still many issues we deal with and so many barriers, from too few psychiatrists, to lack of knowledge and inadequate skills, to societal, governmental, and health system matters, that an apparently unending array of work remains to be done. I am honored and appreciative, and fortunate, that I’ve had a chance to highlight some of this ongoing work through my position at Psychiatric Times.
I did my best, it wasn’t much I couldn’t feel, so I tried to touch . . .
I’ve told the truth, I didn’t come to fool you.

Hallelujah, Leonard Cohen

improve equity, diversity, and inclusiveness of historically underrepresented voices. We instituted an editorial advisory board comprised of residents and recent graduates to open editorial access to the newest generation of our colleagues.

We also are quite proud of the formal alliances we’ve formed with a number of important sub-specialty organizations in psychiatry. The expert contributions that have come from these relationships have clearly raised the bar for our content. In addition, we’ve benefitted from regular contributions from psychiatrists with a very diverse array of interests and expertise such as Fuller Torrey, Allen Frances, Harvey Greenberg, Tom Koster, and Ron Pies to name just a few. David Pollack and his colleagues, as another recent example, have begun what will be an ongoing series on the psychiatric issues related to climate change. Ongoing work will assure that Psychiatric Times continues to achieve greater diversity in our regular contributors.

One of the most important collaborations I’ve been fortunate to have over my career has been the one with Michelle Riba. I know that her creativity, diligence, advocacy, and commitment to excellence in every aspect of her work have helped make me a better psychiatrist, scholar, editor, and person that I would otherwise have been. While I know we’ll both miss working together at Psychiatric Times, we also know there will be other collaborations down other roads.

Another important reason my work at Psychiatric Times has been so meaningful to me is not only the opportunity to help advance our field, but also to work with such a terrific and dedicated professional staff. I continue to feel lucky that Susan Kwsien, our former staff leader who I worked with through most of my tenure, convinced me to take the role of Editor in Chief. Although Susan left her position at Psychiatric Times in the spring, we have a connection that is ongoing.

As you may be aware, the ownership of UBM changed recently and that time of transition has seemed to me a good time for me to make my transition from the Editor in Chief role I’ve filled since 2014. In addition to that transition, and Susan Kwsien’s departure, there have been other staff transitions. Guiding the ship through all these changes have been three talented and hardworking people whose behind-the-scenes work rarely gets public notice.

Natalie Timoshin has done an incredible job steering the Psychiatric Times ship as executive editor since Susan’s departure. Heidi Durr has always done an amazing job with our special reports and other major content and now is outgoing herself. And, Laurie Martin has used her magical skills to oversee our website’s incredible array of content, a job which normally would need to be carried out by several people.

The most important acknowledgement and thank you goes to my wife Cathy. My appreciation reflects not only her tolerating the many hours I’ve spent on Psychiatric Times that otherwise would have been spent with her. Cathy has been my most supportive (and critical) editor since I began to write lectures, editorials, and other publications four decades ago. The quality and readability of my work is due to her unflinchingly direct and honest editorial review and advice, well before I submit anything for publication. One of the things I’ll miss the most about stepping aside as Editor in Chief of Psychiatric Times is the time we’ve spent together fine tuning (and sometimes more than that) my monthly editorials.

There’s so much more work remaining for our field, and Psychiatric Times will, I trust, continue to play an important role in both highlighting our progress and reminding us of what still remains unfinished. I have unbounded pride that Psychiatric Times remains the most widely read psychiatric publication by psychiatrists in the US for a good reason.

There are so many of our readers I’ll never meet and benefit from through personal contact, but the relationship with our readers is something I already miss. I’ll simply close with this:

Reference
The Dog That Did Not Bark

Some Thoughts on the Pathogenesis and Persistence of Prevalence of Schizophrenia and Bipolar Affective Disorder in View of Current Discoveries

Nicholas Pediaditakis, MD

The genome consortium studies have established, with a high degree of confidence, that certain loci genes are associated with schizophrenia and bipolar disorder.1 The tempting assumption from this group of genes is directly involved in the development of these disorders. Not so. The aforementioned genes are directly involved in the expression of premorbid personality/traits, since the presence of these traits invariably antedates the disorders. This temperamental configuration, ie, personality, is made up of traits from evolutionary pressures on the individual—albeit of an exaggerated form—such as aloofness, inner directness, autonomy, and an aversion to social interaction. Comprising, according to E.O. Wilson, one part of our human nature from birth, the other from being social creatures.2

Similar to the dog that did not bark is the dearth of the traits (whose presence normally ensures sociality) that creates the vulnerability for schizophrenia. They emanate from evolutionary pressures on social experiences, such as cooperation, empathy, mutuality, friendly competitiveness, and a tendency for social give and take. As E. O. Wilson’ concluded, these traits together, but not amalgamated, with the “selfish” traits, complete our conflictual human nature.

Yet the presence of a group of gene loci associated with the expression of our sociality is not even being considered in current studies. It is important to note that although the lopsided temperament varies somewhat between sufferers, the cardinal symptoms are felt as alienation and a disconnectedness by all of them. The premorbid personality made of “lopsided asocial” traits creates a pool of vulnerable individuals in whom schizophrenia and bipolar disorder may develop by a periodic phase-shift of the overall coordinating faculty of brain function that ensures synchrony.3 This synchrony is an emergent property of complexity. This probabilistic shift heralds the expression of the disorders and redefines what between sufferers, the cardinal symptoms are felt as alienation and a disconnectedness by all of them.

The premorbid personality made of “lopsided asocial” traits creates a pool of vulnerable individuals in whom schizophrenia and bipolar disorder may develop by a periodic phase-shift of the overall coordinating faculty of brain function that ensures synchrony.4 This synchrony is an emergent property of complexity. This probabilistic shift heralds the expression of the disorders and redefines what between sufferers, the cardinal symptoms are felt as alienation and a disconnectedness by all of them.

CRISP and electronic technology also present us with ethical and existential dilemmas that will tax our wisdom and have a bearing on our very survival as a species.

The quickly advancing developments in molecular genetics, evolutionary biology, and gene editing (CRISPR) and the fusion of these disciplines with electronic technology are presenting mind-boggling opportunities for prevention as well treatment of major mental disorders. It also presents us with ethical and existential dilemmas that will tax our wisdom and have a bearing on our very survival as a species as we deal with conundrums such as what constitutes treatment and what constitutes cure. Moreover, we must consider the ramifications of attempting to modify elements of the genome that pertain to human nature (eg, what kind, for whom, by whom, for what purpose) as well as what might the consequences be for the future of humanity.

Dr Pediaditakis retired recently after 63 years of clinical practice. He is a graduate of the Aristotelian School of Medicine in Thessaloniki, Greece. After completing his internship in Cleveland, OH, he obtained a fellowship/residency in psychiatry at the University of Colorado, School of Medicine. After completing his residency, he spent more than 20 years as Director of a major mental health center in the metropolitan area of Wake County in NC as well as private practice and consultation. He is an Affiliate Professor at East Carolina University, Brody School of Medicine in Greenville, NC. He now writes essays and raises black angus as a hobby. He just published the book Chronicles of the Soul, which comprises essays relevant to us all.

Dr Pediaditakis reports no conflicts of interest concerning the subject matter of this article.

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Use of Psychodrama With Adolescents

Donald C. Fidler, MD, FRCP-I, for the Committee on the Arts & Humanities, Group for the Advancement of Psychiatry

For three years, I was medical director of a specialized adolescent inpatient unit at West Virginia University (WVU). All patients were court-ordered for 12-month stays. Three admission criteria were required: (1) criminal charges, (2) substance use disorder, and (3) one or more additional psychiatric diagnoses.

Approximately 90% of our patient population had witnessed people being shot and killed. The majority had been sexually abused. None were known sexual offenders since those adolescents were assigned to a different specialized unit. The majority had experienced people trying to kill them. Approximately 50% reported experiences of being gang members. A minority lived in homes with one or both biological parents.

Some were incapable of withstanding strong and painful emotions launched by self-reflection and requested to be returned to juvenile criminal offense programs. For those who remained, we offered numerous psychotherapies and prescribed medications. These included individual cognitive, behavioral, and insight-oriented psychotherapies, as well as traditional group, family, art, recreation, and physical exercise therapies. In addition, I directed adolescents in psychodrama groups. I trained in psychodrama courses taught at American Psychiatric Association meetings and was an adjunct professor in psychodrama exercises, realizing we did not judge or evaluate.

Mimized, we offered numerous psychotherapies. My sense of contentment was highest when the patients shared their families and friends. Adolescents described themselves in terms of being gang members. A minority lived in homes with one or both biological parents.

Approximately 90% of our patient population had witnessed people being shot and killed. The majority had been sexually abused. None were known sexual offenders since those adolescents were assigned to a different specialized unit. The majority had experienced people trying to kill them. Approximately 50% reported experiences of being gang members. A minority lived in homes with one or both biological parents.

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Psychodrama

In psychodrama sessions, I began by leading patients in simple warm-up exercises such as repeating telephone numbers while displaying varying emotions and making constant eye contact at close proximity while making faces and trying not to laugh. We progressed to complex, traditional exercises of having patients direct other patients and staff members in acting out stories from their own lives. As they became skilled in acting, they elected to perform scenes from Shakespeare’s works (drama therapy) and were especially drawn to Hamlet, finding parallels between Shakespeare’s characters and their own lives.

Adolescents gained trust during simple psychodrama exercises, realizing we did not judge their “pretend” characters, and that the stage was a place where they could experiment. If they didn’t like how they performed, they were free to change what they said and did.

Once the program had been in place for several months, new patients had advantages of observing experienced patient performers, which increased their courage and helped them participate.

The majority of participants were candid and truthful in their responses. Some used humor, helping them to avoid demonstrating strong emotions they did not want to exhibit in front of groups, often revealing even more with their humorous truth.

An advanced technique was interviewing them twice while they imagined and acted out themselves at age eighty. In the first scenario, I asked them to imagine that as teenagers, after being in our program, they never made changes in their lives. I did not specify what “changes” meant, allowing them to use their imaginations as guides.

While interviewing my pretend 80-year-old patients, I prompted them with open-ended, generalized statements and questions, such as the following:

Tell us about the role of alcohol and drugs in your life
Tell us about the role of school and out-of-school education
Tell us about members of your family, including any children and grandchildren; how much contact if any do you have with relatives; how well do you get along?
Tell us about moments you regret in your life
Tell us about moments you treasure in your life
Tell us about the worst action you took that made the world a worse place
Tell us about the best action you took that made the world a better place
Tell us about anything that stood in your way of being a better person
Tell us about your important life lessons
Tell us what you would like your epitaph to read

While portraying 80-year-old people, these adolescents were accurate in describing elderly views of failing to achieve Erik Erikson’s developmental stage of “integrity.” They discussed marked pride and full hearts of living lives of accomplishment, of improving the lives of others, and of feeling joyful and grateful. And again, their affects matched their pretend lives’ stories.

Wrap up

Staff members and I were struck by the amazing health that resided within all of them, despite the severity of psychiatric presenting symptoms. These adolescent patients had never experienced lectures on human development, and yet, with very little prodding, they were markedly capable of telling riveting, detailed stories of successes and failures for all of the various stages of development.

Important in therapy, were the discussions that compared and contrasted the two varying outcomes they created from their fertile imaginations. The brain maps of development were clearly present in their minds. Their performances revealed dreams and aspirations hidden from consciousness.

During subsequent weeks and months, staff members and I reinforced the adolescents’ exposed self-knowledge. We encouraged them to own the capacities for change they had found within themselves. Their smiles and positive energy contiguously spread to the staff. We had connected, and the connections energized us and led to our eagerness to continue to help them.

By conducting psychodrama sessions, building emotional and understanding connections, I was able to more accurately evaluate my patients’ mood patterns, cognitions, attentions spans, recall, and their abilities to deal with challenges and adversity. My diagnoses were more accurate. I was able to more accurately target symptoms for indicated medications and/or indicated psychotherapies. My sense of contentment and effectiveness skyrocketed.

Let’s reintroduce the arts into psychiatry.

(Continued on page 29)
Reduced Gray Matter and Enlarged Ventricles in First-Episode Psychosis

**Brian Miller, MD, PhD, MPH**

There is evidence for abnormal immune system function in (some) patients with schizophrenia.1 Several studies have found associations between peripheral blood levels of cytokines, small proteins that regulate the inflammatory response, and brain structure.2,3 However, relationships between leukocytes, peripheral immune cells, and brain structural changes have not been investigated, despite evidence that under certain conditions these cells can cross a disrupted blood-brain barrier. Outside of schizophrenia, there is evidence that infiltration of neutrophils into the brain following a stroke is associated with larger infarct volumes and worse outcomes.4 Given the evidence for progressive gray matter volume loss in first-episode psychosis (FEP), it is possible that leukocyte infiltration may contribute to brain tissue loss.5

Nunez and colleagues6 looked at: (1) differences in brain volume and leukocyte counts in patients with FEP and healthy controls, and (2) whether any type of leukocyte was associated with gray matter, white matter, or cerebrospinal fluid in these two groups. The researchers recruited 137 patients with FEP and 81 healthy controls in Spain, aged 13 years or older, with a blood sample, T1 structural brain imaging, and demographic and clinical data. Participants with FEP had an illness duration of less than one year. Exclusion criteria for all participants were intellectual disability (DSM-IV criteria), history of head injury with loss of consciousness, and systemic disease with mental health impact. Additional exclusion criteria for controls were past or present psychotic symptoms or MDD, and having a first-degree relative with a history of psychotic disorder.

A high-resolution T1-weighted structural image was obtained for each participant using one of 5 scanners. Total brain volume was obtained from the sum of gray matter, white matter, and cerebrospinal fluid volumes. Fasting blood samples were collected between 8 and 10 AM at baseline and at 2 months. The median difference between the blood sample and imaging was 15 days for FEP and 17 days for controls. In participants with FEP, psychopathology was assessed using the PANSS (Positive and Negative Syndrome Scale). Cumulative antipsychotic exposure was calculated for subjects with FEP, and data on tobacco and/or cannabis use was obtained for all subjects.

Patients with FEP had smaller gray matter volume (including thalamus, entorhinal area, and anterior insula) and larger cerebrospinal fluid volume (including lateral and third ventricles) than controls, but no differences in white matter volumes. Patients with FEP also had significantly higher neutrophils and lower...
Walking Out of the Darkness
Sharing My Story to Help Others

For almost a decade of my life, I hid in the shadows. It was a sheltering shade from the perceptions and realities of personal and professional judgment. Selfishly, I hid away the truest aspects of myself in the desperations of protective darkness. I was ashamed and afraid of the ramifications and repercussions that might come but hoping one day I would be able to walk again in my own semblance of light.

A few years ago, I was still living in the dark when two medical colleagues died from suicide. In the initial moments after one such loss, a few colleagues and I were asked to console professionals with whom we worked. Shattering tears of a quaking heartache—misunderstood, perplexed, and even angry—I felt empty words roll off my tongue, speaking complicit platitudes of the appropriate things to say in such a time of loss. It was a measured professional grieving that could have offered so much more.

In moments of counsel, I was still hiding the truth of my own story. I attempted to provide comfort, while still hiding the depths of my own inner turmoil. The truth is, I have a history of depression, suicidal ideation, and I am ashamed and afraid of the ramifications of protective darkness. I was tempted to provide comfort, while still hiding the depths of my own inner turmoil. The truth is, I have a history of depression, suicidal ideation, and I am a recovering alcoholic. I have spent several years in successful recovery. Modern medicine broke me to the core to reveal a personal identity crisis that spiraled into an apathetic loss of hope. I do not pretend to know any other individual person’s story, but I do have my own story. It is an experience that may help other people process, grieve, and understand. It is also one that may be able to shine a light on the evolving epidemic of caregiver suicide and distress. And out of this tragedy, I found the courage to stand up and start telling my story. I found a way to walk out of the darkness and back into the light.

It was a walk revealing a mental clarity that I had nothing left to lose by sharing my story. I went into medicine to help other people, to walk alongside individuals during their own times of navigating illness. I went into medicine to be a healer, a consoler, and a guide for other people during some of the most difficult times of their lives. Potential ramifications and repercussions were a small price to pay for the opportunity and blessing to help other people in their moments of need. I had a genuine opportunity to live true to the calling of the Hippocratic Oath.

I now live with a newfound perspective for helping other people. Finding meaning helped to reframe the experiences of my own life, not as events to hide in shame or guilt, but as experiences that made me the husband, father, and physician I am today. Recognizing that my own story has a value that can be used to connect other people during their times of need, I learned to open myself up to vulnerability and to embrace the strength revealed in authenticity. The rewards continue to grow day by day by simply being true to myself.

**Overcoming the stigma in the medical workplace**

Indeed, rewards have come through my ability now to have conversations with colleagues about seeking their own mental health assistance and in connecting to medical students about being proactive about their own mental health. They accrue in helping other alcoholics seek out treatment resources while connecting them to a recovery community, sitting empathetically to hear about a friend’s struggle with anxiety, or offering a show of support for someone with a history of diversion in the medical workplace. Living openly has invited me into these spaces to share in other people’s stories, while offering opportunities to help and heal. Living openly has not been about promotion to an ideal; it simply revolves around attraction to a normalization that it is okay to seek out help. It embraces a utopian hope that we will view individuals with mental health conditions the same as anyone else.

Yet, the rewards of being invited into these spaces reveal the sobering chasms of the work we have left to do. A stairwell conversation often includes a colleague’s concerned diatribe about what will need to be disclosed on a state medical licensing form. There is the connection to an Alcoholics Anonymous group, earmarked by questions of reporting this to human resources and insurance malpractice carriers. The quiet conversation about anxiety escalates quickly to disclosures of gaps in med-
An Integrated Care Approach to Identifying and Treating the Suicidal Person in Primary Care

Julie E. Richards, PhD, MPH, Rebecca Parrish, LICSW, Amy Lee, MPH, Katherine Bradley, MD, MPH, and Ryan Caldeiro, MD

Although psychiatrists may be better trained to treat suicidal patients, most patients with suicidal ideation are receiving care outside of specialty psychiatric settings and can benefit from interventions in primary care. Many individuals see their primary care provider in the months leading up to suicide death. Therefore, primary care clinicians may have important opportunities to identify and treat suicidal patients. Recommendations about assessing suicidal risk in primary care settings are mixed, however. The Joint Commission now recommends asking patients about suicidal ideation routinely in ambulatory settings. The United States Preventive Services Task Force (USPSTF) does not make a recommendation for or against screening for suicide risk in a primary care setting due to insufficient evidence regarding the accuracy of screening tests and the effectiveness of suicide prevention interventions. The USPSTF does, however, recommend routine depression screening for adolescents and adults seen in the primary care setting when adequate systems are in place to ensure accurate diagnosis and appropriate follow-up. Depression-assessment instruments such as the nine-item Patient Health Questionnaire (PHQ-9) often include questions about suicidal ideation. Moreover, health care systems are increasingly implementing screening for depression as part of behavioral health integration (BHI) in primary care to provide patients with better access to needed care and address the well-known inefficiencies of siloing care for mental health in specialty settings.

We must pivot from models of punishment and shame toward pathways of acceptance and support.

Safety of the conversational waters. I listened for several minutes and offered a few small words of advice. And then she began to cry.

She shared, “Your story is a lot like my story.” She went on to explain that she was struggling with depression, anxiety, and coping with alcohol at night to help her to sleep, to numb away the feelings in her own life. I could have held up a mirror in those moments. She knew about the programs, the initiatives, and the efforts from her leadership to create supportive programs. Over time, she made several tangential, small inquiries to colleagues about seeking help for her mental health conditions.

She was counseled by colleagues to hide her struggles, to covertly conceal the depths of her own life. I could have held up a mirror in those moments. She knew about the programs, the initiatives, and the efforts from her leadership to create supportive programs. Over time, she made several tangential, small inquiries to colleagues about seeking help for her mental health conditions.

Dr. Hill is Division Chief of Pediatric Palliative Care and Assistant Professor of Pediatrics, Riley Hospital for Children, Indiana University Health, Indianapolis, IN...

LINKS
• Psychiatrists can play key roles in the integration of care for suicidal patients in primary care by providing leadership and consultative support to primary care teams
• Helping primary care clinics develop a team-based approach takes the burden off individual primary care providers (PCPs) and alleviates their fear about identifying suicidal patients and needed resources that they are unable to address alone

SIGNIFICANCE FOR PRACTICING PSYCHIATRISTS

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Nutritional Psychiatry: The Gut-Brain Connection

Umadevi Naidoo, MD

There is truth in the saying, “you are what you eat.” We may often feel better when we eat better, and science has shown that it is in fact true—a healthy diet has an impact on physical health. Now, science is showing us that a healthy diet may have an impact on mental health. The impact that food has on mood and other aspects of mental illness is being researched. Nutritional psychiatry is developing into a real opportunity for clinical intervention for patients who suffer from depression and anxiety.

Clinical practice has shown that psychiatric patients experience increased morbidity and mortality associated with a range of medical illnesses. In addition, lifestyle, psychiatric medications, and inadequate healthcare all contribute to the poor physical health of people with mental illness.

Thus, nutritional interventions may be helpful to patients who want to combat the adverse effects of medications.

Although certain recommendations such as eating a healthy diet of fresh fruits, vegetables, whole grains, and lean proteins seem simple, doctors do not routinely discuss diet with their patients. The gap in nutrition education in our medical schools has left many practicing clinicians without a “language” to discuss dietary interventions with patients.

Helping to fill this void, nutritional psychiatry provides useful action-oriented steps to patients, and it is a potentially powerful tool for clinicians.

What’s the connection?

Anatomically speaking, the vagus nerve connects the gut and brain. This gut-brain axis provides a greater understanding of the connection between diet and disease and is also relevant in psychiatric disease. The human microbiome, which has co-evolved with humans, is a community of different bacteria that inhabit the body and is beneficial to humans. Researchers agree that an individual’s unique microbiome is created within the first 1000 days of life. As clinicians it is useful for us to understand the microbiome.

Nutritional psychiatry

In terms of nutritional psychiatry, we are learning through research that the food we eat impacts how we feel emotionally.1-3 There are some individuals who seek complementary treatments such as food-mood interventions in addition to allopathic medications to boost their chances of improving mood and anxiety. It’s important to note that such complementary treatments may benefit mild to moderate depression and anxiety; however, they are not likely to affect suicidal ideation or a psychiatric emergency. It’s helpful to alert patients to this if you use nutritional psychiatry in your clinical work. Recommendations are not prescriptive but allow the clinician to provide clear guidelines to the patient.

The growing evidence base for nutritional psychiatry in human studies is encouraging. The SMILES (Supporting the Modification of lifestyle in Lowered Emotional States) trial showed that food can improve mood.4 Another study completed a systematic review and meta-analysis of observational studies looking at healthy dietary indices and the risk of depressive outcomes.5 The study concluded that following a healthy diet, particularly a traditional Mediterranean diet, or avoiding an inflammation-producing foods appear to confer some protection against depression. A recent report outlined an Antidepressant Food Scale that listed 12 antidepressant nutrients linked to the treatment and prevention of depression (Table).6

A good resource for clinicians is the International Society of Nutritional Psychiatry Research (ISNPR) website.4

Understanding the microbiome

Diet is thought to be an important factor that can regulate or dysregulate the microbiome. Diseases may occur when the balance between “good” and “bad” bacteria in the gut is altered. Examples of these diseases may include: irritable bowel disease, which is caused by dysfunction in the composition and interactions between microbes, the gut lining, and the immune system; as well as asthma, obesity, metabolic syndrome, diabetes, mood and cognitive problems.

Healthy gut bacteria have a number of functions, including the breakdown of complex carbohydrates and the production of vitamins and nutrients as well as short-chain fatty acids. Moreover, they protect against pathogens, help train the immune system, support detoxification, and help modulate the nervous system.

From a mental health perspective, 90% of serotonin receptors are located in the gut. It is therefore not surprising that when someone is prescribed an antidepressant such as sertraline or fluoxetine, the most common adverse effects are gut related. Most commonly patients experience nausea, diarrhea, dry mouth, and sometimes vomiting. These adverse effects tend to remit after the first 1 to 2 weeks if not sooner. Gut dysbiosis can also be caused by prescription antibiotics. Antibiotics negatively impact the good bacteria that protect the gut. A solution to this is to take a probiotic to protect good gut bacteria and/or to include probiotic rich foods in the diet.

Recently, Zinöcker and Lindseth7 looked at the western diet, the microbiome-host interaction, and its role in metabolic disease. They report that the gut environment (or microbiome) is changed by what we eat and is affected by the western diet that contains ultra-processed foods. The change that occurs leads to inflammation in the gut, and consequently symptoms of disorders. While we know that processed foods are poor nutritional substrates for whole foods such as fruits and vegetables—the authors delve further into the impact that these food additives have on inflammation in the body and possibly contribute to diseases.

Many studies have outlined the connection between processed foods and obesity, diabetes, and heart disease. This study looked at the additional possibility that food processing affects inflammatory processes in the body (and thereby diseases) via diet-microbiome-host interactions. The food industry has continually increased the number of food additives without testing their impact in the microbiome. The findings from this study suggest that reducing processed foods from our diets would help reduce the likelihood of diseases related to inflammation.

A study at the University of Michigan evaluated withdrawal symptoms that people experience when they stop eating processed foods.8 The study looked at data that food addiction (eg, eating highly processed foods) may trigger addictive like symptoms in some people, including withdrawal symptoms. The Highly Processed Food Withdrawal Scale (ProWS) was adapted from self-report measures of drug withdrawal symptoms. The researchers feel that this scale may be a psychometrically sound tool for future research investigating highly processed food withdrawal in humans. The data can inform us of how patients may experience withdrawal-like symptoms when they suddenly stop eating highly processed foods.

Prebiotics and probiotics

Some ways in which we can protect our microbiome balance is to include both prebiotic and probiotic foods in our diets. A prebiotic is a soluble fiber that helps feed the good organisms (probiotics) in our gut. Probiotics already live inside the large intestine. The more probiotics that the probiotics have to eat, the more efficiently they will work. Examples of prebiotic foods include onions, leeks, asparagus, bananas, Jerusalem artichokes, chicory root, garlic, dandelion greens.

Probiotic foods that supply these bacteria include fermented foods such as sauerkraut, yogurt with active cultures, pickles, kefir, kimchi, kombucha.

TABLE. Antidepressant nutrients

- Folate
- Iron
- Long chain omega-3 fatty acids
- Magnesium
- Potassium
- Selenium
- Thiamine
- Vitamin A
- Vitamin B₆
- Vitamin B₁₂
- Vitamin C
- Zinc
Bipolar or Fanatic? The Reluctant Radical

James Phelps, MD

Do you sometimes have trouble continuing your daily work under the shadow of looming climate change? Wonder about chucking your practice and working exclusively on ending our reliance on fossil fuels? Is someone who devotes his life to arresting climate change a fanatic—or may be even manic? Let’s take a brief tour through climate science to the story of such a man who acquired such a diagnosis.

Harvard historian of science Naomi Oreskes’ asserts that science is not simply the result of following “the scientific method” of rigorous hypothesis testing. Rather, she believes that science is a process of arriving at a consensus, a current working understanding.1 This is why a physicist may accept the idea that a vaccine increases one’s safety even without being able to deeply evaluate the epidemiologic data, or a geologist accepts speculation by natural selection without examining all the relevant data: they rely on the consensus of scientists who specialize in epidemiology or evolution. Says Oreskes, we can think of scientific knowledge as the result of “a jury of geeks.”

Science’s current working understanding of climate indicates that the earth is warming rapidly, sufficient to cause social disasters beyond anything humans have ever seen, during most of our patients’ current lifetimes. If you have any difficulty with this assertion, please do listen to Oreskes’ TED talk on science first, then the World Bank report predicting climate-driven migration of 140 million people by 2050.2

Watching humans destroy the very basis of their existence (a stable climate), one man thought “this is insane.” He could not understand how we could persist in our current behaviors. He thought a global awakening to our collective insanity was emergently needed. So he dedicated his life to helping people recognize and respond to the problem of climate change. The result: he was diagnosed as bipolar and given lithium.4

Was this man fanatic, or manic? What is the difference? The literature on this question is surprisingly small: there are no references on Pub Med for a search of fanatic manic, or fanatic bipolar, for example. A more substantial work has examined the boundary of religious and delusional beliefs (some of it reviewed in Iyassu et al).5 A lengthy user post and replies on the International Bipolar Foundation (IBPF) website includes many descriptions of the overlap of manic phases and intense religious thinking.6 Indeed the term “fanatic” has a strong connection etymologically to religion (from fana, a holy place, sanctuary or temple; and the verb fano, to devote).

But not all fanaticism is religious. Perhaps fanaticism itself is a disease, like alcoholism: a Psychology Today post suggests there should be a Fanatics Anonymous.7 Or perhaps fanaticism is like a brain infection, a la the parasite that can infect an ant’s brain and make it climb up a blade of grass where it is more likely to be eaten by the cow that is the parasite’s next life-cycle port of call.8 Perhaps fanaticism is a neurologic problem: combat injury to the frontal cortex is associated with fundamentalist beliefs, according to Zong and colleagues.9

Whatever the etiology, some fanaticism comes very close to the behaviors of bipolar mania: energized devotion to an idea. Sex and money are frequent foci, but also political ideas: see, for example, the complex patterns of bipolar-like behaviors in world leaders, examined by Nassir Ghaemi in his book A First-Rate Madness (narcissism is just the beginning).10 In this territory of highly uncertain boundaries between passion and determination and mental illness lies the story of the man who had a diagnosis of bipolar mania based on his insistence that humankind itself is insane for continuing to mine and burn fossil fuels. It’s an interesting twist, no?

You must see the documentary of this man, The Reluctant Radical, at your earliest opportunity.11 Look for local showings. It is a fascinating tour through fanaticism and its consequences, including bipolar diagnosis (in this case, likely over-diagnosis). It’s a polished production, easy to watch, with a message of the utmost importance: that we ourselves are indeed acting insane and must quickly recognize our own collective “mental illness” with radical behavior change.

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Integrated Care
Continued from page 9

FIGURE. Results of standard primary care workflow designed for suicidal patients during July 2018, Kaiser Permanente Washington Primary Care System

Due for BH screening

“More than half the days” OR “Nearly every day”

“During the past two weeks how often have you been bothered by...”

89% Screened by PHQ-2 (45,235 of 50,733)

6% Frequent Suicidal Ideation (PHQ-9 Item 9=Score 2-3) (332 of 7264)

37% Indicate Need for Same Day Crisis Response Planning (107 of 286) (mean 2.2, SD=2.5)

96% Assessed with PHQ-9 (7,264 of 7,582)

9% Assessed with C-SSRS (286 of 332)

86% Assessed with C-SSRS (286 of 332)

Frequent Suicidal Ideation

6% Assessed with PHQ-2+ (7,582 of 45,235)

“More than half the days” OR "Nearly every day"

"Thoughts you would be better off dead, or of hurting yourself in some way"

#3 “During the past month, have you been thinking about how you might kill yourself...”

3: 17% 2: 16% 1: 37% 0: 9% 1% 1% -24 per 10,000 screening visits

Crisis Response Plan Development

BH, behavioral health.

Note: Prevalence outcomes distinguished from process outcomes in shaded boxes.

*Columbia Suicide Severity Rating Scale (C-SSRS) may have been utilized up to 14 days after the Patient Health Questionnaire-9 (PHQ-9), and in cases with multiple assessments recorded, the score closest to depression assessment was used.

Integrating behavioral health into primary care

Kaiser Permanente Washington, a regional health care system, piloted a BHI program in three primary care clinics in 2015. Rollout across the system’s remaining 22 clinics began in 2016. The BHI program was designed by clinical operations leaders, including a psychiatrist and researchers to support care for depression, suicidality, alcohol, cannabis, and other drug use.

The BHI team used three main implementation strategies:

- Enabling primary care teams by using external practice coaches who partnered with local implementation teams that included providers, medical assistants (MAs), and clinical social workers (trained as integrated behavioral health clinicians).

- Supporting primary care teams with decision-support tools embedded in the electronic health record (EHR) that prompted screening, follow-up assessments, and follow-up care.

- Performance monitoring for site leaders and teams who reviewed routine data reports on screening and assessment during routine quality improvement meetings.

Workflow for depression and suicide care

The process designed and implemented at each clinic included annual screening for adult patients coming into primary care. Following receipt of an electronic reminder for annual screening, MAs or clinic front-desk staff gave patients a seven-item paper screen. The screen included the PHQ-2 for depression, three questions about alcohol use (AUDIT-C), one question about cannabis use, and one question about other drug use or nonmedical use of prescription medication.

Data from the screen were entered into the EHR while patients were roomed by MAs, and additional EHR decision-support tools prompted assessment and follow-up for symptoms that patients endorsed, such as suicidal ideation.

For example, for patients with scores of 2 or higher on either PHQ-2 question, the EHR prompted MAs to ask the patient to complete the PHQ-9 to help assess depressive symptoms (Figure). If patients answered, “more than half the days” or “nearly every day” to the ninth PHQ-9 question about “thoughts that you would be better off dead, or of hurting yourself” in the last 2 weeks, the EHR prompted MAs to give the patient a brief version of the Columbia Suicide Severity Rating Scale (C-SSRS) modified for patients to complete on paper. For patients with C-SSRS scores indicating some level of suicide attempt planning in the past month (eg, “yes” to question 3), an EHR “Best Practice Alert” prompted the provider to initiate a same-day referral to a clinical social worker for crisis response planning. Crisis response plans were developed collaboratively with patients to identify warning signs of a suicidal crisis and coping strategies, reduce access to lethal means (ie, firearms and medications), and create a list of resources available for emergency support. A customizable EHR template, based on prior suicide prevention research, was used to document this plan for patients and care providers.

Psychiatrists were available, via telephone consult service, to provide a “real time” consultation to primary care providers, clinical social workers, and other members of the care team. Psychiatrists either answered the phone directly or returned calls within 30 minutes during regular business hours (Monday–Friday 8 AM–5 PM). Primary care providers often contacted psychiatrists to help make decisions about psychiatric hospitalization, initiating psychotropic medications, or about treatment options for suicidal patients with comorbid substance use disorders and/or serious mental illnesses. Clinical social workers at all primary care clinics were also invited to join a weekly 1-hour conference call with a psychiatrist and social work manager to discuss BHI-related challenges such as best practices for handling difficult encounters with suicidal patients.

Depression screening and suicide risk assessment

Our research team is still evaluating BHI in our health care system. Preliminary results from analyses of a single month of performance metric data, however, show that of 50,703 visits when BH screening was due, the PHQ-2 was completed for 89% and 17% of these scored positive for depressive symptoms (Figure). A full
PHQ-9 was completed for 96% of visits when the PHQ-2 was positive, with 6% indicating frequent suicidal ideation (in the last 2 weeks). Of those with suicidal ideation, the C-SSRS was completed for 86% of visits and 37% of C-SSRS scores prompted a crisis response plan. These preliminary data illustrate the potential reach of BHI, which translated into a need for crisis response planning in 24 per 10,000 screening visits (107 of 45,235 visits with PHQ-2 completed).

Barriers, facilitators, and positive stories
During the pilot phase of this project, the main barrier to implementation of the workflow for depression and suicide care was the fear associated with identifying patient needs without the time or resources to address them. Primary care providers worried that they did not have the capacity to address the needs of suicidal patients without compromising care provided to other scheduled patients. Another important barrier was the initial lack of an EHR alert to prompt the use of the C-SSRS for patients with frequent suicidal ideation, which was later added.

Facilitators of this workflow included familiarity with the PHQ-9, which was previously used in the primary care clinics to monitor patients diagnosed with depression. Another critical facilitator was the focus on team-based care, which included psychiatrist consultants, clinical social workers, primary care providers and their support staff. Primary care providers routinely identified the clinical social workers, who were available for same-day referrals, as key to overcoming their fear of routinely screening for depression and assessing patients with suicidal ideation. They also expressed appreciation for the psychiatrist consultants available by phone for providing supportive care to their patients at the time it was needed.

Another major facilitator of suicide risk assessment, and BHI overall, was the number of positive stories shared about suicidal patients being seen for routine medical needs who were identified and then received needed care. One clinical social worker shared the following brief Case Vignette.

CASE VIGNETTE
A young man came in to seek care for cold symptoms. As the clinical social worker on staff, I was paged to come talk with this patient after he scored high on our behavioral health screening tools. I learned that not only was this patient severely depressed but also that he had attempted suicide twice in the past couple of weeks.

Next, we talked about his immediate safety, and I discovered that he had limited outside supports. Because his safety couldn’t be guaranteed if he went home, we talked about inpatient psychiatric treatment, which he agreed was a good idea. I coordinated his follow-up care, and the patient was authorized for psychiatric admission within 4 hours. I also talked with his parents, who waited with him and later drove him to his psychiatric placement.

Thanks to BHI, we had systems in place that let us know this young man was in immediate danger, and we were able to intervene and help him right away.

Implications for practice
Based on our experiences implementing care for suicidality as part of a behavioral health integration package, our conclusions are:

- Psychiatrists can play key roles supporting real-time care for patients with suicidal ideation by educating primary care providers about the wide range of treatment options available and providing consultative support in the development of tailored plans of care for individual patients.

- Implementing screening for depression followed by suicide risk assessment is feasible in primary care settings, particularly when tools to guide clinical decision making for suicidal patients are embedded into EHR systems. Moreover, the brief, self-administered suicide risk assessment tool we used was highly valuable to primary care clinicians who used the information to guide their decisions about follow-up care.

- Most importantly, developing a team-based approach to providing care for suicidal patients, including psychiatrists, clinical social workers, and other primary care staff, takes the burden off individual primary care providers and alleviates fear about identifying patient needs for which they do not have resources to address themselves.

Limitations
Further research on this model of care is needed to know if the suicide care we implemented as part of BHI in primary care improved patient health outcomes (eg, suicide attempts). Additionally, adaptations may be required to implement this model of care in a fee-for-service environment. For psychiatrists working in these settings, however, it is important to note that team-based care is possible because consultation and care management services are reimbursable by Medicare and other payers as part of a collaborative care program. Finally, it is outside the scope of this article to provide guidance on issues related to legal liability when patients die by suicide, despite their health care providers best attempts to provide high-quality care. We recognize, however, that providers who have lost patients to suicide may make decisions about patient care based on these experiences.2,22 We also recognize that current laws may incentivize “over-hospitalization” and coercive treatment.2,24 A core ethical challenge to working with suicidal patients is that interventions intended to increase short-term safety in the short run may not be the best long-term solution.2,23 The best protection for patients and providers who care for suicidal patients, in primary care and specialty care settings, may be collaborative crisis response planning and documentation.20,21,26

Conclusion
Health care systems are increasingly addressing depression through behavioral health integration in primary care to improve the well-known inefficiencies and inferiority of siloing mental health care in psychiatric specialty settings. Provider stories about the integration of care for suicidality in primary care, including depression screening and suicide risk assessment, indicate that primary care staff value the ability to provide the care to suicidal patients when needed. Integrated social workers trained as behavioral health clinicians, as well as psychiatrist leadership and ongoing consultative support, provide a system to help primary care teams be successful.

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Zero Suicide
The Dogged Pursuit of Perfection in Health Care

David W. Covington, LPC, MBA, and Michael F. Hogan, PhD

It is rational to pursue zero suicide among patients in health care?” This question was posed by Mokkenstorm and colleagues as they addressed objections that the science and published results aren’t yet in. Growing evidence, however, demonstrates remarkable success at reducing the number of lives lost to suicide in health care systems that have committed to the systematic “suicide care” approach known as “Zero Suicide.”

Psychiatric leadership is essential to the success of efforts toward zero suicide. More than a slogan, the approach applies evidence about what works in the detection, treatment, and management of individuals with intense suicidality within a culture determined to learn together and make a dramatic difference. Three essential steps—routinely asking about suicide, developing a collaborative crisis/safety plan including counseling on lethal means, and delivering direct treatment for suicidality for those at elevated risk—have produced exceptional results in several systems.

The concept of zero in quality improvement has been around for more than 50 years, with James Halpin introducing the zero defects movement in 1966. By 1976, the concept of “target zero” had moved to reducing accidents in Japan. In the 1980s, Dr Don Berwick and the Institute for Healthcare Improvement reached out to NASA for a dialogue about applying quality improvement to health care, ie, one small step for quality and one giant leap for health care safety. More recently, “Innovating to Zero” has been called one of the 10 megatrends for innovation.

Efforts by the mental health system to realize zero suicide
Health care in the United States has focused on quality improvement since the 1960s, but it has only introduced the concepts of high-reliability science in the past 20 years. High-reliability organizations aggressively pursue perfection, an approach, for example, that has driven commercial aviation in the US to achieve remarkable levels of safety in air travel. This approach is characterized by a deference to front-line expertise, a preoccupation with learning about failures and “near misses” and a relentless focus on the target of zero defects.

The Henry Ford Health System (HFHS) in Detroit was the first to apply these concepts in behavioral health care, which focused on the relentless assessment of suicidality across their continuum of psychiatric care. The result was an audacious goal to achieve zero suicides in their mental health programs. The effort was labelled “perfect depression care.” In a 2015 National Public Radio story, Silberner wrote: “The story of the health system’s success is a story of persistence, confidence, hope, and a strict adherence to a very specific approach.”

The population served by HFHS includes individuals with acute and serious mental illness whose hazard ratio suggests they are 12 times more likely to die of suicide than are those in the general population. Nevertheless, HFHS reported a 75% reduction in the first 4 years of implementation of their perfect depression care model and zero deaths during all of 2009. Over the period of implementation, the effort succeeded in reducing suicide deaths among a population under psychiatric care to about the level in the general population.

The US National Institute of Mental Health is doing this with a series of research awards. One is a 5-year grant to the HFHS and Brian Ahmedani to conduct a large-scale review of an implementation of Zero Suicide across most of the Kaiser Permanente Health System. Another is a grant to Barbara Stanley to evaluate enhanced versus routine implementation of Zero Suicide in over 160 mental health clinics in New York State.

Results are starting to emerge. In 2015, Centerstone partnered with the Suicide Prevention Resource Center and will soon submit its Zero Suicide results with the aim of publishing in a peer-reviewed journal, although reductions in the death rate at this large multisite nonprofit community mental health provider have been previously reported. Centerstone achieved a 64% reduction in suicide deaths.

This success did not occur in the context of the rigors of a funded research project but as part of an intensive “commitment to radical quality” within usual health care. The results are clearly impressive and demand attention. At the same time, the effort was not a randomized trial. Some have discounted the results, minimizing the approach as “clever sloganengineering” and repackaging. One implication clearly is the need to complete the science and verify the results of applying new knowledge to the care of suicidal individuals.

The task force quickly learned that usual care is disastrous when it comes to preventing loss of life by suicide. By 2010, striking evidence of the impact of good care was starting to emerge, such as the study by Motto and Bostrom’ showing that “caring letters” to individuals who had been hospitalized following an attempt dramatically reduced subsequent attempts and deaths.

In 2010, Forbes magazine published an article asserting that few suicidal patients receive good treatment, a claim no one seemed to contest. Few in the field escaped their criticism, including drug companies, the National Institutes of Health, therapists, and university clinical study review boards. At the time, Dr McKeon challenged our Action Alliance task force: “Over the decades individual clinicians have made heroic efforts to save lives, but systems of care have done very little.” His statement reveals one of the core challenges in suicide care: Individual clinicians (especially psychiatrists, often called on to make medicolegal decisions in the case of suicidal individuals) face great pressures, but institutions have not provided training, care pathways, and access to effective brief treatments and supports such as caring letters.

So, the task force reviewed the specific practices. What did the

National Action Alliance for Suicide Prevention task force
In 2010, when a task force commissioned by the National Action Alliance for Suicide Prevention and Dr Richard McKeon of the Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, studied the HFHS story, comprehensive evaluations of good suicide care were not yet available. The task force quickly learned that usual care is disastrous when it comes to preventing loss of life by suicide. By 2010, striking evidence of the impact of good care was starting to emerge, such as the study by Motto and Bostrom showing that “caring letters” to individuals who had been hospitalized following an attempt dramatically reduced subsequent attempts and deaths.

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So, the task force reviewed the specific practices. What did the
HFHS actually do in their perfect depression care protocol? What did they do that might make care safer and might make it look and feel like care? We published the “Suicide Care in Systems Framework,” and three specific research-informed and evidence-based approaches emerged as central to zero suicide efforts.8

Three approaches to reaching zero suicide
First, we need to routinely ask about suicide risk. In 2013, Simon and colleagues9 concluded that the PHQ-9 question 9 regarding thoughts that you would be better off dead, or of hurting yourself, “identifies outpatients at increased risk for suicide attempt or death.” They added: “This excess risk emerges over several days and continues to grow for several months,” with an accuracy about twice as predictive of future suicide behavior as cholesterol scores are of future heart disease. Thus, a simple screening question (which obviously must be followed by a full clinical evaluation) matches effectiveness of a cardiac care metric widely acknowledged as significant and warranting care throughout the health care industry. Psychiatrists and others engaged in the delivery of mental health services are offered a great opportunity to positively affect the lives of those they serve through a relentless application of this question as part of their standard of care.10

Zero Suicide requires a standardized methodology for screening and assessing risk, and HFHS was relentless in its search of individuals in care who were at risk. Although science leading to better specificity in prediction is needed, we have the information we require to improve care today. Starting the conversation about suicide is a crucial first step. It creates connection, acknowledges the pain and distress individuals experience, and provides a foundation for effective emerging treatments. Second, individuals at risk should complete a collaborative safety/crisis plan that includes counseling to help them reduce and manage access to lethal means. When we reviewed the HFHS practices in 2010, there were few research studies of safety planning. The findings of Bryan and colleagues11 are promising, however. In the largest-scale study of crisis planning to date, the collaborative safety planning intervention by Stanley and Brown12 reduced suicidal behavior by an extraordinary 50%.

Use of this brief intervention for individuals with acute, elevated risk who are able to participate in it should be part of a new standard of care, as has been cited in a recent report from the Action Alliance. Third, individuals at risk should receive direct treatment targeting suicidality and the care should extend into follow-up. The very significant suicide risks for individuals in the immediate aftermath of a psychiatric hospitalization have been carefully described by Olsson,13 providing a clear message for the efficacy of universal and continuing interventions and support following hospital discharge. Yet, even when we know the practice works, HEDIS [Healthcare Effectiveness Data and Information Set] tells us that only about half of US patients receive any outpatient care during the first week after psychiatric hospital discharge and one-third receive no mental health care during the first month.

Let’s rewind into the care itself. When acute or outpatient mental health care is received, the vast majority of individuals at risk do not receive any direct treatment for their suicidality. Dialectical behavior therapy, cognitive behavioral therapy, and the Collaborative Assessment and Management of Suicide have all been shown to reduce suicide risk. As well, new brief treatments are being developed, including the three-session ASSIP [Attempted Suicide Short Intervention Program] which reduced subsequent attempts by 80% compared with usual care.14

Outside inpatient settings, health care systems have simply not been accountable for suicidal. Mental health professionals frequently report a complete lack of training to deliver interventions and care to prevent suicide.15 These standard approaches came under criticism in the New Zealand national media in 2017.16 The Minister of Health’s response after studying Zero Suicide was to change the culture within the mental health workforce and galvanize society around known interventions. As Dr Jonathan Coleman explained: “It does seem that setting a goal, and it may be aspirational... actually just focuses efforts.”17 A 2016 study by Erlangsen and Nordenfelt18 showed a lower risk of deliberate self-harm and general mortality for those who received psychosocial therapy. In fact, direct treatment of suicide is more effective and cost-efficient than statins are for the prevention of heart disease. (One fatal myocardial infarction is prevented for every 83 people treated with statins versus one self-harm episode prevented for every 44 people treated with psychosocial therapy.) When compared to this outcome of a well-established standard of care in the physical health world, we can clearly argue the case for direct care for suicidality becoming a standard practice expectation.

So, if we know that these three practices work and have increased and been repeatedly supported by research, why aren’t they readily available?

The way forward
Zero Suicide attempts to break through these challenges of the status quo and forgotten patients. It states that the logic and the literature base on quality improvement suggest that we need a systematic, leadership-driven quality improvement approach for a “wicked problem” like suicide. The “Suicide Care in Systems Framework” report, recommending a systematic approach, was published at virtually the same time While and colleagues17 were concluding that a systematic implementation of crisis intervention and other recommended steps in England and Wales saved hundreds of lives compared to incomplete implementation. Zero Suicide is also activated by a significant inclusion of the lived experience and expertise of those who have been there—that is, those who have made a suicide attempt but recovered and found some way forward.

The model is being implemented globally. More than 90 organizations and individuals have signed on to the Zero Suicide Alliance in the United Kingdom, including half of the National Health Service Trusts. In Queensland, Australia, 11 of 16 health districts are deploying the toolkit (available at ZeroSuicide.com) following the lead of Gold Coast Health. In 2017, hospitals in Ontario, Canada, published “Strengthening Suicide Prevention in Ontario Hospitals,” which had as its top recommendation implement the Zero Suicide model in hospitals across the province. As well, the fourth Zero Suicide International Summit with more than 100 leaders from nearly 20 countries was recently hosted in Rotterdam by 113 Suicide Prevention and Deloitte. The program also showcased their Super-net and Supranet Zero Suicide initiatives in Holland.

As a scientific matter, we need more data. As a public health and quality-of-care matter, the evidence is already in. The time is now. Together, we can, and must, do this. It is our hope that Zero Suicide motivates health care and other leaders to move from half measures to full measures in suicide prevention and better health care.

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Mr Covington reports that he is CEO and President of Recovery Innovations, Inc, partner in Integrated Health Resources, LLC, and he is one of the founders of the Zero Suicide in Healthcare initiative. Dr Hogan is a consultant to the Zero Suicide Institute.

References
Safe Communication About Suicide in the Digital Age
Harnessing the Role of Media in Youth Suicide Prevention

» Nicole T. M. Hill, MBMSc, Jo Robinson, PhD, and Simon Rice, PhD

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Role of traditional media
The role of the media has been identified as a critical component in suicide prevention.3 Traditional media’s influence on facilitating suicide “contagion” (ie, imitative behavior) has been well document- ed. This phenomenon has been linked to the mechanism of suicide contagion, whereby exposure to suicide facilitates suicidal behavior in another. Increases in suicide following exposure to suicide have been documented following celebrity suicides, news reports, and fictional portrayals of suicide, and the young appear particularly susceptible to this effect.

In an effort to mitigate the potential for suicide contagion, several countries have successfully implemented media reporting guidelines to help facilitate the safe reporting of suicide. These guidelines have been largely shaped by evidence that has linked increased rates of suicide to media content including: prominent and ongoing coverage of a suicide death; sensationalized language; stories glorifying the suicide act; and detailed descriptions of the method of suicide. By contrast, content that promotes help-seeking behavior and includes messages of hope and recovery is believed to be protective.

A recent example of the potential confounding effects of the media on youth suicide prevention was demonstrated following the release of the 2017 Netflix series “13 Reasons Why,” which builds up to the graphic suicide of a 17-year-old student over 13 episodes. Suicide attempts that resembled the suicide in the series were reported in several anecdotal media reports throughout the United States. Additionally, an increase in website searches of suicide methods was observed following the broadcast of the series.4 Critical factors identified in this work include the following:

1. The majority of young people have regular access to the internet and social media, which provides a new and challenging landscape for suicide prevention initiatives.
2. The resource chat-safe, a young person’s guide for communicating safely online about suicide has been developed in collaboration with experts and young people to mitigate suicide risk online and may be an important education resource for clinicians who work with young people and their families.

Role of social media
The growing uptake, influence, and diversity of social media platforms pose new opportunities and challenges for the prevention of suicide and self-harm behavior, particularly in young people who are large consumers of new media. A recent study undertaken by Pew Research Center found that 85% of teens regularly access social media sites such as YouTube, Instagram, and Facebook.6 Moreover, the proportion of teens using social media, of which 83% endorse social media use as acceptable to young people.

Content that promotes help-seeking behavior and includes messages of hope and recovery is believed to be protective of suicide.

SIGNIFICANCE FOR PRACTICING PSYCHIATRISTS
Young people’s lives are becoming increasingly integrated with digital technology and social media. Clinicians involved with the care of digitally expert youth are tasked with educating young people on how to communicate safely online, particularly in the management of suicide risk. Similarly, clinicians who have good awareness of the terminology and dynamics of social networks are likely to benefit in their engagement with youth, but should remain mindful of the potential challenges that social media environments pose.

1. The majority of young people have regular access to the internet and social media, which provides a new and challenging landscape for suicide prevention initiatives.
2. The resource chat-safe, a young person’s guide for communicating safely online about suicide has been developed in collaboration with experts and young people to mitigate suicide risk online and may be an important education resource for clinicians who work with young people and their families.

Although traditional media guidelines have been largely successful in...
promoting responsible conversation about suicide among journalists and other media professionals, these resources are less likely to be relevant to young people who use social media to communicate about suicide online. For example, existing guidelines for media professionals provide little advice in the way of monitoring social media posts for potentially harmful content and ways to safely respond to someone who may be suicidal online. Despite this, few evidence-based resources are currently available to help guide young people through the process of safe peer-to-peer communication about suicide online.

Our team at Orygen recently developed “#chatsafe: A young person’s guide for communicating safely online about suicide.” The #chatsafe guidelines were developed using the Delphi expert consensus method, which involved two panels of experts: one comprised of Australian youth advocates and the second comprised of international media professionals and suicide prevention experts. The expert panels rated recommendations from the peer-reviewed and grey literature for inclusion in the guidelines. A summary of the core components of the #chatsafe guidelines are shown in the Table. (The full guidelines are freely available for download.)

Unlike traditional media guidelines, the #chatsafe guidelines provide evidence-based recommendations that are specific to youth and the social media environment. For example, they advise young people to consider the impact of their post on others who may be vulnerable to suicide, provide information on the permanency of the Internet, and include practical information on how to safely operate memorial pages dedicated to honoring the deceased.

Importantly, the #chatsafe guidelines also provide information on how to respond to someone online who may be at risk of suicide. Given recent evidence that shows young people appropriately recognize, interpret, and endorse a desire to seek support positive use. Provided the experience using social media is primarily positive, time spent using social media has the potential to operate as a preventive or therapeutic medium that may actually complement traditional therapy. As such, clinicians may benefit from taking clients’ social media use as part of their assessment of social history and suicide risk.

In cases in which clinicians recognize that social media use may be impacting mental health, discussions can focus on the importance of privacy, respectful communication, thinking carefully prior to posting, and challenging the assumption that content shared on social media is necessarily true. Clinicians should, however, be cautious about accessing patients’ data online without their consent, as such efforts may be viewed unfavorably by patients and may jeopardize the therapeutic alliance.

There is also value in clinicians being aware of their own digital footprint, including the sharing of unprofessional content, engagement with patients in social media environments, or content posted about them by others. Clinicians must also remain mindful of potential boundary violations when writing about clinical experiences and be aware that some patients and families may be skeptical of clinicians writing publicly. Nevertheless, appropriate use of social media can be an effective tool for advocacy and education. Some key recommendations include: only write things online that you would say in person, don’t publish content that will only benefit yourself, be mindful that clinicians represent the profession in public communication, and be aware that there is a responsibility to care for a patient’s wellbeing even in online settings.

**Recommendations for clinicians/conclusion**

Those involved with the care of our digitally expert youth are tasked with the important responsibility of guiding young people through the process of understanding the risks associated with communicating about suicide online. In particular, clinicians who have good awareness of terminology and dynamics associated with online social networks may engage more easily with their younger clients.

Nevertheless, clinicians are unlikely to affect the ubiquitous role that social media plays in the lives of young people, so their efforts should seek to support positive use. Provided the experience using social media is primarily positive, time spent using social media has the potential to operate as a preventive or therapeutic medium that may actually complement traditional therapy. As such, clinicians may benefit from taking clients’ social media use as part of their assessment of social history and suicide risk.

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**References**


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**TABLE. Contents of #chatsafe: A young person’s guide for communicating safely online about suicide**

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<th>Components</th>
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<td>• Remember that posts can go viral • The permanency of the Internet: “Once posted, always posted” • It can be helpful to monitor your post for harmful content • What to do if monitoring isn’t an option • Some tips on self-care • General safety tips for communicating about suicide online • Posting and sharing images, photos, or video content • Language and safety tips for discussing suicide online</td>
</tr>
<tr>
<td>2. Sharing your own thoughts, feelings, or experience with suicidal behavior online</td>
<td>• Your privacy • Sharing your experience in a safe and helpful way • The use of “trigger” or “content” warnings</td>
</tr>
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<td>3. Communicating about someone you know who is affected by suicidal thoughts, feelings, or behaviors</td>
<td>• When someone has died by suicide • The suicide of celebrities and other public figures</td>
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<td>4. Responding to someone who may be suicidal</td>
<td>• Things to ask yourself before responding to someone who has indicated he or she may be at risk of suicide • How to respond to someone who might be at risk of suicide • Know that it’s OK to ask someone “Are you thinking of suicide?” • Steps you can take if the person indicates he or she is not at immediate risk of suicide • How to respond to a person at immediate risk of suicide or in the process of making a suicide attempt</td>
</tr>
<tr>
<td>5. Memorial websites, pages, and closed groups to honor the deceased</td>
<td>• The terms of use for memorial pages or groups • Responding to comments that indicate a person is struggling or distressed</td>
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**SUICIDE AND SELF-HARM: PART 2**

**JANUARY 2019**

**PSYCHIATRIC TIMES**

**www.psychiatrictimes.com**
Suicide Risk Assessment and Management Tips for Improving Care and Outcomes

CASE VIGNETTE

It is late Friday afternoon and you are about to see your last patient, Mr. G. This morning, as you prepared for your third meeting with him, you jotted down notes about the need to review the benefits and potential side effects related to his new psychiatric medications and a reminder to check back in on the psychosocial stressors that seemed to be escalating for your patient when you saw him a few weeks ago. These stressors, in combination with chronic depression and anxiety, served as the catalysts to why he had come in to see you for the first time 2 months earlier. When you meet Mr. G, you notice that his affect is more dysphoric than his previous presentations, with notable agitation and hopelessness that permeates the rest of your time together. He discloses that things have not gotten better and that he is starting to give up hope that things will ever get better. His marriage is “failing,” he might be laid off from work soon, and is feeling like a burden to others more and more each day.

Despite being a seasoned clinician, you feel a twinge of anxiety as you take in his comments. Your mind is moving quickly, and you know you need to get a suicide risk assessment under way. That natural anxiety does not dissipate. In fact, it becomes more intense when you gather the “results” of your suicide risk assessment.

The data confirm that your patient is positive for many suicide risk factors (eg, demographics, psychiatric diagnoses, chronic suicidal ideation, hopelessness, burdensomeness) and is clearly experiencing several psychosocial stressors that are exacerbating his clinical presentation and contributing to several warning signs (eg, isolation, trouble sleeping, agitation). He also discloses that his suicidal ideation has become more severe and frequent, that he has been thinking more about the plan for suicide he has always had in the back of his mind (overdosing via a highly lethal combination of medications to which he has access), and indicates intent for suicide as 3 out of 10 (0 = no intent; 10 = highest intent).

Although the patient’s current warning signs and suicide risk indicators (ie, ideation, intent, plan, access to means) suggest elevated risk, he is also openly disclosing and seeking support, all good signs. But you cannot ignore that his combination of historical/baseline factors suggests elevated risk for suicide. Your lack of a lengthy therapeutic relationship also complicates the suicide risk formulation. Weighing all of these factors, you eventually arrive at the decision that “moderate risk for suicide” is the best formulation but feel stuck about the optimal way to proceed.

Predicting risk for suicide

When thinking about a case like this, determining how to ensure delivery of excellent care while balancing medico-legal demands may seem to be an impossible task. Recent increased attention to the alarming public health problem of suicide has led to greater discourse and new implementation strategies to prevent suicide. There remains an intimidating gap in empirical knowledge on how to determine, with any certainty above chance, who will die by suicide among those exhibiting risk. This dilemma—the impetus to eliminate suicides and a lack of clearly defined paths for how to arrive at that goal—naturally causes apprehension.

In fact, this issue has caused some suicide researchers to publish their re-examinations of what we know and do not know—an important contribution toward progress in the field. Such publications, however, have translated to clinical confusion. For example, research suggesting that suicide risk assessments are unable to predict who will die by suicide have led to provocative dialogues on whether these approaches should be abandoned, especially given the implied goal that our risk assessment approaches are meant to be predominantly geared toward prediction. The predicament of a goal to eradicate suicide along with unrealized ability to accurately predict suicides have cast doubt on the fact that suicide risk assessment and management are actually critical to improving the very care and outcomes current suicide prevention approaches are striving to achieve.

Of course, along with many clinicians, suicide loss survivors, and those with lived experiences, we are invested in finding the answers to prediction. We argue, however, that until that time arrives, and even when it does, we should incorporate assessment and management approaches that are in and of themselves opportunities to collaboratively work with our patients to help them weather suicidal crises and ultimately create a life worth living.

Risk assessment

Our therapeutic risk management of the suicidal patient (TRMSP) model is structured to achieve these goals. The TRMSP framework is built on and integrates the tenets of prior research and clinical evidence, the ethical principles of autonomy, nonmaleficence, and beneficence, and medicolegal knowledge and awareness. TRMSP consists of three core components: a clinical interview/suicide risk assessment that is augmented by an evidence-based structured instrument, stratification of risk by severity and temporality, and a collaboratively developed safety plan. In his discussion of the TRMSP model, Silverman states that it “provides a way forward and a very nice roadmap not only for better determining level of risk but also for identifying appropriate strategies for intervention and management.”

Every clinician should execute a suicide risk assessment when working with patients who are either at risk for suicide or exhibit warning signs. Listing all the elements to a suicide risk assessment is outside the scope of this article, but the goal behind any risk assessment is analogous to that of an inductive process, that being to gather data about suicide risk indicators, risk and protective factors, and functional patterns to ultimately inform management and intervention approaches in a highly individualized fashion. It is worth stating that the risk assessment is best viewed as an ongoing process, as opposed to an event. Given that the risk assessment process evolves over time, and that there is a potentially endless stream of pertinent and dynamic data to gather, the notion of a complete assessment at any given point in care is rather elusive.

Nonetheless, there are core components that should not be omitted. The addition of a reliable and valid structured instrument to this process is not only medicolegally sound but also affords the opportunity to yield additional information that may be missed during a traditional free-form clinical interview. A more in-depth discussion of considerations when selecting an instrument is provided in Homaifar et al. Selecting an instrument that attends to critical content, or an element of your clinical interview that is not as robust (eg, protective factors), and enables a quantitative element to your data can be especially helpful. This can enhance disclosure and dialogue between the clinician and patient, which may ultimately shape and guide outcome tracking across management and intervention approaches.

For example, a quantitative measure that helps identify reasons for living (eg, the Reasons for Living Inventory) can be used therapeutically to first help Mr. G identify that he does in fact have reasons to keep going and then later to track improvement in this area over time. Similarly, utilizing a measure reflecting the intensity of ideation, intent, and/or desire to die by suicide helps other clinicians (eg, an on-call provider unfamiliar with the patient) recognize changes from the individual’s baseline. Such data help other providers distinguish between modest changes across a chronic baseline versus significant escalations that potentially warrant life-saving interventions, thus facilitating patient-centered, individualized care across both time and clinicians.

Risk stratification

As highlighted in the example, clinicians often grapple with the suicide risk formulation for patients similar to Mr. G, that is, those who are chron-
SUICIDE AND SELF-HARM: PART 2

TRMSP is a framework that we have found to be easy to implement, which can ultimately increase the clinician’s comfort and confidence.

Safety planning
A major component of suicide risk management is safety planning. Before briefly outlining our approach to safety planning, it is critical to note the many pitfalls of the management approach of “no suicide contracts.” These types of contracts, which essentially involve the patient making a commitment to not die by suicide until the next session or that he or she will not enact suicidal behavior without first contacting the clinician, have no evidence base behind their efficacy, afford no medicolegal protection, are not patient-centered, and can have paradoxical effects for both the patient (eg, less disclosure about suicidal desire to not disappoint the clinician) and the clinician (eg, false sense of security which leads to less engagement in appropriate management approaches). In contrast, the safety planning process involves a hierarchical set of strategies designed to help the patient know how to identify and how to cope when in a suicidal crisis. Especially when done in a collaborative way, safety planning can help the clinician better understand risk and targets for intervention (eg, that the patient is unable to identify warning signs and has limited coping skills) professional help if his suicidal intent increased, you would likely need to reconsider how to bolster management approaches as this patient may not be able to independently maintain safety between today’s session and Monday’s check-in call. For a greater discussion on safety planning please see Matarazzo et al. 

Conclusion
Armed with a framework that can optimize the therapeutic benefit of risk assessment, we strongly believe that the real goal of our practice, which is to take care of our patients, can be achieved regardless of the current state of the field. TRMSP is a framework that we have found to be easy to implement, which can ultimately increase the clinician’s comfort and confidence while allowing engagement in work that can be incredibly challenging. The three small additions of using reliable and valid structured instruments to augment a suicide risk assessment, enhancing suicide risk formulation by stratifying risk across severity and temporality, and collaboratively developing a safety plan, are essential ingredients to improving care and guiding the path to optimizing outcomes. Finally, while we must recognize the persisting limitations of current risk assessment techniques in relation to prediction of suicide, we must not forget that these same procedures can, and sometimes do, afford life-saving opportunities.
INTRODUCTION

The Therapeutic Potential of Self-Disclosure

David W. Reid, MD

One gray February morning, I received a distraught phone call from a harried inner-city hospital administrator: “Dr Reid, if we can’t find a child psychiatrist in the next 48 hours, we will need to close down our unit due to lack of accreditation. Can you help us?”

I had not done inpatient psychiatry for a decade and was very busy in my outpatient private practice. I almost declined, but I realized that if I held the job for five months, I could then entice a graduating child psychiatrist in need of a starting salary to our practice (Clinical Associates of Tidewater).

The next morning, after a quick tour and hurried deliberations, I agreed to work as the attending psychiatrist on the 12-bed unit for children and adolescents. In my negotiations, I insisted to be allowed to eat breakfast with the kids every morning and then lead a 45-minute group psychotherapy session with them and the staff. I reasoned that the fastest way to understand and begin to guide the milieu was to regularly share a meal with all involved.

Most of the children and teenagers were victims of physical abuse, sexual abuse, neglect, abandonment, violence, and chaos. Many were depressed and angry at society and themselves; some sought to numb themselves with drugs and alcohol. Talking about their problems, especially with adults listening in, seemed ludicrous to them. So, after a few frustrating weeks, I decided to make an “intervention.”

The previous Christmas, my son Jon had given me a huge, fuzzy brown teddy bear that reminded me of a smaller teddy bear in his arms. He had heard me tell about the cherished stuffed bear of my youth, I called Teddy. I took his picture, present into the group session and told them the following story:

This bear’s name is Rocko. When he was very young and barely able to survive on his own, hunters shot and killed both his mother and father. Rocko escaped and somehow managed to live through the first cold winter all by himself. He grew to maturity and met a very attractive female bear. They mated and had a little cub, named Beara. But soon tragedy struck again. The hunters returned and killed Beara’s mom. Rocko managed to escape with his son and is courageously trying to raise his son in spite of the hardships in his life.

I proposed that at the end of each group, the kids and staff nominate the kid who had tried the hardest in group that day. Everybody would vote, although not for themselves. Whoever won had the honor of keeping Rocko and Beara until the next meeting. Most of the children quickly accepted the mythology of Rocko and Beara and competed to win them for a day. This competition allowed them to open up more and helped them create alliances among themselves in order to be nominated. Everyone on the unit participated in embellishing the story of Rocko and Beara’s lives. The kids hugged and loved Rocko and dressed him in their clothes. Sometimes, an especially angry kid would physically abuse Rocko. More than once, he needed to be returned home for emergency repair surgery.

Invariably, the attacker had been abused earlier in his or her young life.

Rocko’s story was like theirs—tragedy, survival, despair, resilience, family loyalty, and hope. I wanted him to portray the idea that a man can be strong and nurturing. I also wanted to convey that make-believe and playfulness are possible and helpful even in the midst of distress, loss, and turmoil. I give credit to Donald Winnicot (the English pediatrician and psychoanalyst) for showing us the value of play as a metaphor to use in therapy with children. Many of the kids, even the teenagers, expressed considerable affection and protectiveness towards Rocko and Beara and got angry with those who mistreated them.

“Bruce,” an angry, out-of-control 16-year-old, illustrates how Rocko’s transformative power worked. The police escorted Bruce to our hospital. His father called them when Bruce became enraged and combative. At the emergency department, where the police first took him, he threatened to “punch out the doctor’s lights” if he was touched. The hospital staff obtained a temporary detaining order so that Bruce could be involuntarily placed on our unit.

As soon as the police took off his handcuffs, Bruce began threatening the staff and other patients. With a show of force by four male staff, he agreed to go to the seclusion room, cursing and threatening as he went, fists clenched. Before I went in to interview him, I asked a burly childcare worker to wait outside and help me if he attacked. Frankly, I was afraid of Bruce. His right hand was swollen.
from punching the walls in eruptions of anger. He looked like a taut spring ready to go off if anyone irritated him. Seething with rage, he refused to talk with me. I told him every enraged person has reasons for his anger and invited him to tell me about his life, but he remained silent, his back turned.

In his days on the unit, Bruce’s story gradually unfolded. He was the youngest in a large family. The father rarely worked and often verbally and physically abused his wife and the boys. As they grew older, each son in turn put a stop to his beatings by fighting the father. A year ago, Bruce had confronted his father in a struggle for dominance. Then, after his parents separated, Bruce lived with his mother, but she soon demanded that he go live with his father. His mother refused to come to a single family session. After Bruce moved in with his father, he also began to use and sell drugs. He provoked fights wherever he went, taking on a fearless, ferocious identity even though he was only 5’4” tall and 135 lbs. His brothers had smeared toothpaste on him while he slept, which had triggered his rage.

In group sessions, he snarled and scoffed at the idea of talking about his feelings. Mostly, he remained sullenly silent. But slowly, he started taking a leadership role, often to protect some of the younger boys on the unit. As he realized he was safe and did not need to fight to protect himself, he grew less defensive. He began to tell some of his traumatic experiences—the mockery and beatings by his older brothers and school bullies.

During one session, he was nominated for the hardest worker, and won! He acted nonchalant as he took Rocko and Barea to his room, but I could sense he was softening and allowing our care to soak in. Later that day, his father came for a visit. Bruce proudly showed him Rocko and explained how he had won him for the day. Sarcastically, the father said, “Oh how nice, you won a teddy bear?” The father showed distain for everything, including his son.

As soon as he was “no longer out of control,” his HMO insurance company began a drumbeat for us to discharge Bruce. We resisted for as long as possible. In his final group session, Bruce told each kid, one by one, he would miss them, and why. He then apologized for his meanness the day before to the charge nurse, and tearing up, he said that he would miss her the most.

Then a six-year-old boy jumped out of his seat, ran over to Bruce, threw his arms around his neck and said, “Thank you for being my friend. I really mean it.”

Bruce began to cry. When he tried to hide it, I said, “Bruce, don’t hold it back. It’s okay to cry. If you keep it up, you’ll turn into a real human being.”

Bruce continued to cry for about an hour after the meeting. Clearly, he experienced a sense of being appreciated, understood, and respected—and longed for more. Bruce won Rocko that day with no contest and proudly carried him around the unit until his moment of discharge. In doing so, he was embracing Rocko and the value of caring, hope, and the struggle to overcome loss.

When we did not recruit a child psychiatrist in July, I could not bring myself to leave the unit and risk it being shut down. I continued working there for another year until we finally found someone to take over the position.

Bruce and my time with the unit staff taught me to never give up trying to help the most difficult and damaged patients. Showing kindness, respect, and caring often touches the heart of the most troubled patients we try to help. Creating a safe caring environment comes from strong leaders who are free to share their tender feelings.

Dr Reid is a child psychiatrist in private practice in Virginia Beach, VA.

EXCLUSIVE CLIMATE CHANGE COVERAGE

In the Room With Climate Anxiety: Part 2

Part one of this article briefly reviewed the literature on climate anxiety, presented the clinical rationale for moving climate-distressed patients into engaged action in concert with others, and listed numerous varied means of action.1 In this article, particular clinical situations in working with climate anxiety are discussed. The realities of climate change call upon a range of our skills, including our psychotherapeutic skills. Climate is both a public health and a psychological issue and these aspects are intertwined.

Most Americans are worried about climate change, and climate change may come up in various ways in treatment.2 The patient may explicitly make reference to it, or it may be an obvious aspect of their situation, such as having lost a home to wildfire. Sometimes the references are explicit. However, often these references are made by the patient in passing. As with any difficult topic, like sex or spirituality, the patient may be waiting, consciously or unconsciously, to see if the therapist can handle the discussion. It is the job of the therapist to be listening for possible references and to open these subjects for exploration. Patients may reference the state of the world, the news, a friend or relative dealing with fire, flood, or storm, or concern about their children’s future. Sometimes these references may be made quite dismissively or sarcastically, as though the patient is inviting the therapist to collude in ignoring the importance of our collective situation. It is important that the therapist not share in an unspoken assumption that climate is too big to talk about. When such references come up in treatment, the therapist should follow up: “I noticed you joked about the state of the world. Perhaps there are things about it that are frightening, so you don’t want to let yourself take them seriously. What is it like for you?” Then the therapist is in a position to explore the patient’s feelings and help him or her actively engage in response to his or her deepest concerns.

A discussion about climate involves a fresh appreciation of our relationship with the future. British psychoanalyst Rosemary Randall points out that we have defensively tended to split our appreciation for present and future, predicting future catastrophe while wrapping the present in gauze, as though the present is not connected to the future.3 She and Australian cultural researcher Lesley Head4 point out that some of this difficulty might relate to the enormously influential work of Kübler-Ross on grief.

Kübler-Ross was working with people who were dying, and therefore the final stage she described was an acceptance that did not include a future. As Leslie Head describes, in our current climate situation, we enter a
future with necessary coexistence of grief and hope. She distinguishes hope from optimism, noting that optimism tends to push out negative feelings, whereas hope has room for grief also. Popular movements dealing with climate anxiety, the Good Grief Network, and Joanna Macy’s Active Hope Workshops emphasize this coexistence of hope and grief.

Countertransference issues

When therapists find themselves reluctant to discuss climate change, they should reflect on their own feelings about it. Most of us tend to use the defense mechanism of disavowal in dealing with climate, just as patients do.3 Therapists, like patients, have combinations of knowing and not knowing, acceptance and non-acceptance and are in various stages of emergence from disavowal. We may intellectually know that human made climate change is real, but the information has not completely penetrated emotionally, or we haven’t figured out how to best work at social change and how to change our lifestyles, given the social pressures to continue with business as usual.

We are all in the same boat in this regard. What is important is that we are each working on it, individually and together. Climate will require collective change, so none of us individually can have it all figured out. This may be a challenge for the therapist who is accustomed to working from the position of expert. Climate calls us to a more humanistic therapeutic stance, where we are talking with the patient about our shared human situation. “Here is the situation we are in…” An understanding of this humanistic stance can undercut therapists’ feelings of guilt about their own carbon-imperfect lifestyles, which might interfere with their engagement in the topic.

Therapists may fear discussing a topic that has become politicized. The ethics of discussing climate change with patients have been explored in a series of articles in the AMA Journal of Ethics. Given the enormity of climate as a public health crisis, it has been concluded that, in spite of its politicized nature, the benefits of discussing climate change with patients generally outweigh the risks.4

Therapists may avoid discussing climate change because they themselves harbor pessimistic opinions about humanity’s future. We all need to understand that we are part of complex socio-environmental systems and uncertainty is inherent in complex systems. Hopelessness can be a defense stance, an avoidance of uncertainty and of the realities of agency. Clinical situations

Disavowal. While patients are unlikely to use the word “disavowal,” what characterizes much of the distress about climate is the difficulty of coming to terms with the existence of disavowal in oneself and in the world. Patients may express dismay, a feeling of alienation, of unreality, of impotent worry as they find themselves and watch others participating in relatively comfortable fossil-fuel–laden lifestyles while simultaneously knowing about the existing and future suffering wrought by climate change. This experience can be magnified in patients who grew up in circumstances of abuse or neglect, where collective family disavowal may have significantly shaped their development.

For these patients, a discussion of the nature of disavowal can be useful. Patients can be credited for their appreciation of reality, and the therapist should be confirming that the collective enacting of disavowal can be “crazy-making,” in that it is confusing and frustrating. The therapist should clearly lay out the current circumstances, e.g., “Yes, we are in a serious urgent situation that most people are in various stages of waking up to.” “Yes, this is resulting in tremendous suffering.” “What helps people to bear this knowledge of reality is a bit different for different people. We can think about what helps you.”

For patients with histories of abuse and neglect, it is important to also explain that they may be particularly aware of our society’s disavowal because of their own experience with disavowal. For example, you might start the conversation with the following, “Wrong things were happening, but somehow people both knew and did not know; they knew it but didn’t fully appreciate it enough; they knew it but didn’t take it seriously enough to get help; they knew it but didn’t allow that knowledge in deeply enough to change their behavior. So now you are painfully aware of our lack of full awareness about climate change.” Patients can be encouraged to act in concert with others, having allies this time, as they work their own way out of disavowal and take action over what so deeply concerns them.

My children’s future. Parents can be especially distressed over climate and may require extra support.5 Findings suggest that parents may have a psychological need to maintain the illusion of an omnipotent ability to keep their children safe.6 Awareness of climate change is a threat to that illusion. Parents can be assisted to connect with other concerned parents and to shift their activities into arenas that can actually help their children’s future safety.

Parents who wonder about how to address their children’s environmental concerns can be encouraged to engage with their children in pro-environmental activities. In that way the parent and child are given the experience of being able to engage actively together rather than the experience of paralyzed worry.

Patient dealing with disaster or threatened disaster. Psychiatry has a long history of understanding and working with psychiatric effects of disasters. Now, however, both we and our patients have a new larger context, that of climate change. Even in which we are understanding and experiencing individual disasters and threats of disaster. Now the patient dealing with disaster may also be dealing with the knowledge that, given climate destabilization, more disasters may follow. Clinical work with these patients involves a balance between the need for immediate trauma care while not ignoring the reality of future climate anxiety.

The climate denier. When the topic of climate change arises, one might find oneself working with a patient who actively rejects the reality of human-made climate change. One-tenth of Americans are “dismissive” of global warming as an issue and another 11% are “doubtful.”7 We all tend to filter reality through our preexisting beliefs, a process known as confirmation bias.8 When working with a climate change dismissive patient, it is important not to collude with the denial of science while simultaneously affirming the underlying positive values that might be fueling the rejection. Understanding and appreciating the patient’s values can advance the therapeutic relationship.

There is an ongoing discussion within the political science arena about the importance of appreciating underlying worldviews and values. One version of this discussion is “polarity theory” described by McIntosh.9 According to this theory, “value clusters” exist within the political right and left. All value clusters are recognized as having both positive and potentially unhealthy aspects. This theory asserts that our way out of current extreme political polarization involves affirming the positive aspects of those values so that negative aspects can then get “pruned away” within the political camps themselves. This theory may bear some relationship to that of motivational interviewing where resistance is not directly confronted but underlying motivations are clarified.

Positive values that may underlie climate denial are often the “liberty” value cluster described by McIntosh, which can lead to a worry about government overreach. When faced with a climate denying patient, these values can be uncovered with a simple question such as “What worries you about those who want response to climate change? What mistakes do you think they could make?” The clinician can then express genuine appreciation for the positive aspects of these underlying values, such as affirming the importance of personal liberty or small and local governmental heritage.

As psychiatrists, when we work with climate change material clinically, we are both assisting in an urgent public health crisis and meeting our patients where they are. We can promote hope with room for grief. We can provide general recommendations to our patients for dealing with climate distress, including taking a break, having fun, maintaining routines, and focusing on only a few issues while simultaneously encouraging active engagement in response to deep concerns.10

References

6. Alame D, Truong RD. How should clinicians weigh the benefits and harms of discussing politicized topics that influence their individual patients’ health? JAMA Ethics. 2017;11:114-118.
Book Review

Child Psychiatrists: On the Front-lines of Neuropsychiatry

Barbara Schildkrot, MD

In medical publishing, the casebook format has become increasingly popular—and for good reason. A memorable clinical vignette facilitates learning. As clinicians, we assimilate information best from case examples. We can imagine ourselves in the story, especially when the cases are drawn from real life and the authors do not edit out the confusions and uncertainties of actual psychiatric practice—the patient whose history is hard to follow; the individual with multiple diagnoses, or someone with an atypical presentation.

Pediatric Neuropsychiatry: A Case-Based Approach is a new casebook that focuses on the overlap of neurology and psychiatry in child practice. The co-editors, Aaron J. Hauptman and Jay A. Salpekar, two neuropsychiatry colleagues of mine, have called upon 65 contributing scholars to present a comprehensive, clinically relevant, and very readable text.

Psychiatrists are increasingly aware that the boundary between psychiatric disease and neurological disease is arbitrary. This book is written with the goal of presenting an integrated conceptualization of neuropsychiatry and brain/behavior in the realm of pediatric neuropsychiatry practice.

Child and adolescent psychiatrists are on the front lines of neuropsychiatry. Everyday considerations in the practice of child and adolescent psychiatry include: brain development, genetic diseases, the influence of prenatal exposure to alcohol or drugs, nutritional influences on brain health, family dynamics, and educational opportunities that shape neurodevelopment. Many neuropsychiatric diseases that adult psychiatrists treat are first seen in children: autism spectrum disorders, ADHD, lead poisoning, fetal alcohol syndrome, sleep disorders, Tourette syndrome, epilepsy. Pediatric Neuropsychiatry: A Case-Based Approach covers all of these topics and more—pediatric traumatic brain injury, anoxic brain injury, non-epileptic seizures, childhood multiple sclerosis, autoimmune limbic encephalitis, PANS [pediatric acute-onset neuropsychiatric syndrome] and PANDAS [pediatric autoimmune neuropsychiatric disorder associated with streptococcal infection], hypothalamic tumors.

The book contains 26 chapters that focus on case examples. The case descriptions are followed by a discussion of diagnostic impressions, a succinct summary of the relevant neuroanatomy and pathophysiology, treatment strategies, and neuropsychiatric “lessons learned.” An additional chapter discusses the pediatric neuropsychiatric exam.

Throughout the book there are unique features such as: personal reflections written by patients or family members, “Clinical Pearls,” and summaries of educational materials or available resources like rating scales for ADHD. There is a substantial section on complementary and alternative medicine strategies for patients who have epilepsy. It is clear that the authors were writing with the needs of clinicians in mind.

While there are now 33 accredited fellowships open to psychiatrists who seek post-graduate training in Behavioral Neurology & Neuropsychiatry, no such formal programs are available in pediatric neuropsychiatry. For child and adolescent psychiatrists who are interested in learning more about neuropsychiatric thinking, this latest casebook is an excellent resource. There is also much material here that would appeal to psychiatrists with adult patients.

I spoke with Jay and Aaron about their book. Jay Salpekar is a Child and Adolescent Psychiatrist who runs a Neuropsychiatry in Epilepsy Program at Kennedy Krieger Institute, an institution specializing in brain and spinal cord diseases and developmental disabilities in children and young adults. He is also on the full-time neurology and psychiatry faculty at Johns Hopkins University School of Medicine.

When we first came up with the idea for this book, we knew that we wanted it to be different. We wanted to include patient and family stories and also their personal reflections; we think these are as important as the scientific background for enlightening our understanding of cases.

We were so gratified by the reception we got from chapter authors, all experts in their fields. We wanted cases that would illustrate brain and behavior relationships. It didn’t have to be the most rare case or a neat and tidy case. The contributors understood the concept and were totally on-board.

Aaron Hauptman is a Child and Adolescent Psychiatrist at Boston Children’s Hospital who is also in a Behavioral Neurology and Neuropsychiatry fellowship program at Brigham and Women’s Hospital. He works with individuals with developmental and acquired CNS injuries across the lifespan. According to Aaron,

In addition to providing accurate diagnoses, one of our main goals as clinicians is to be able to offer to the children and families who are struggling with neuropsychiatric illnesses an integrated formulation of their experiences. It’s not an either/or situation.

And in fact, to try to pigeonhole what’s going on as either uniquely neurological or psychiatric is both invalidating and often inaccurate. A large part of why we wrote the book was to help give other clinicians a sense of this integrative approach.

A one-to-one correlation between brain and behavior is much less certain in children because they adapt so quickly. Despite the fact that prognosis and localization are so different for pediatric patients, still attention to neuroanatomical correlates of cognition, behavior, and emotion can be tremendously valuable.

Working with these patients and families has been an unparalleled experience. I’m optimistic about shifts in the field toward increasing integration of neurology and psychiatry. We hope that our book helps more clinicians to take part in the discussion.

Dr. Schildkrot is Assistant Professor of Psychiatry, part time, Harvard Medical School, Beth Israel Deaconess Medical Center, Boston, MA. She is the author of two books: Unmasking Psychological Symptoms: How Therapists Can Learn to Recognize the Psychological Presentation of Medical Disorders and Masquerading Symptoms: Uncovering Physical Illnesses That Present as Psychological Problems.

References
Substance Use Disorders in Crisis Settings

Engagement, Assessment, and Intervention Approaches

Individuals with active substance use disorders (SUDs) who present to mental health crisis settings have often been regarded as “unwelcome visitors” who have come to the wrong place. Characterizations of at least some of these individuals (whether they present with substance use as the major complaint or with additional complaints such as suicidality, risk of violence, or active co-occurring psychiatric illness) by staff in many crisis settings are often negative.

Persons with active SUDs may not present in ways that fit our framework of how we can help. He or she may show up with symptoms or in situations that are clearly caused or exacerbated by substance use, but at the same time have no interest in receiving a referral for treatment. Another person may present with true desperation, but what he or she is asking for is not “psychiatric help,” but rather a place to stay, a medication, or something else that we cannot provide. Individuals with active substance use may state that they are suicidal without serious intent, the presence of psychiatric illness. Finally, these individuals may not fit either addiction or psychiatric settings—our usual set of resources—and may be misunderstood and unwelcome.

Since the late 1990s, best practice recommendations emphasize that individuals in crisis with active SUDs, and particularly those with comorbid psychiatric and substance use disorders, should be considered not only as “welcome” but also treated on a priority basis.

Because of a number of factors, including the opioid epidemic, the need to re-think our prioritization of “who is in crisis” and “who needs our help the most” has become more urgent in the past few years. It is critical that the most effective engagement and clinical practice protocols are utilized, especially for patients who have co-occurring medical, psychiatric, cognitive, or significant social challenges (eg, homelessness). Rather than encountering barriers to access and unwelcoming attitudes, these individuals must be prioritized and provided with an organized and effective crisis response.

STEP ONE: Welcoming practice

Implementing “welcoming practice” for individuals with active substance use requires clear policies and procedures that govern the expectations of behavior for all staff and requires monitoring and oversight by clinical and administrative leaders.

Staff need clear instructions about how to treat individuals who may be engaging in behaviors that generate negative reactions. First, the person who needs help is welcomed and our intention to help is explained. The help we
provide is immediate as well as continuing. The person is made to feel safe, and over time we connect the person with services that will help him progress toward achieving meaningful life goals.

Welcoming includes never using disparaging or disrespectful language, even when the individual is not listening. It also includes the ability to empathize with the person who may be displaying challenging or difficult behavior. For example, this might include a person who has frequent episodes of intoxication but continually refuses referral to addiction treatment. He is living a desperate existence and may feel hopeless about being able to get sober. He is at his wit’s end and does not know how to get help. Or, it might be a person who has chronic pain, anxiety, depression, a history of trauma, and poorly managed opioid use presents with what might be considered “inappropriate” demands for pain medication. This individual is someone whose life is falling apart, is at high risk for a lethal outcome but who has no safe or easy way to ask for help other than by requesting medications for pain.

It is important to reframe our perceptions and change our approach. Incorporate a welcoming message in your routine instructions for preparing your patients for what to do when they are in crisis after hours. Let them know that they are always welcome to call for help (whether calling you directly or calling the crisis service that you use for back up), even if they have been using substances. For instance, you can say: “Call for help as soon as possible, so we can help you be safe and stable. It is helpful if you can call for help before you use substances, but substance use is never a barrier to calling for help. Our goal over time is to help you to develop the skills you need to manage these challenges successfully . . . but for right now, it is important that we meet you exactly where you are.”

STEP TWO: Rapid integrated longitudinal assessment

Arbitrary barriers to assessment

Once the individual with active substance use is welcomed for care, we begin the assessment immediately and proceed with a thorough structured and integrated approach to learn best how to be helpful in the moment. Many crisis programs have adopted rules that automatically delay crisis assessment of anyone who is actively “under the influence,” often requiring that the blood alcohol level is below the legal limit of intoxication before crisis assessment can begin.

There is no rational clinical basis for having this rule. Under no circumstances should any provider of crisis services have a formal or informal policy that creates barriers to treatment for individuals with substance use. Note the following language in the current crisis management protocol utilized in Arizona.

Assessment begins at the point of clinical contact, regardless of the client’s [sic] clinical presentation. Initiation of assessment should not be made conditional on arbitrary criteria such as length [sic] of abstinence, non-intoxicated alcohol level, negative drug screen, absence of psychiatric medication, and so on.

The assessment of individuals in crisis needs to begin immediately. If the person is too intoxicated to communicate clearly, we still need to assess for any immediate risk to safety based on medical or behavioral lack of control (including risk of inadvertent falls or self-injury), as well as to rapidly access any available collateral information. The assessment of the individual begins with welcoming engagement and messages of safety and support while the person is intoxicated and proceeds to a more detailed discussion as soon as the person can carry on a conversation.

Some individuals will have their best and most honest conversations when their alcohol blood level is 0.2 (or when they are high on some other substance); some may not. That is part of the assessment. In addition, if the person presents with intoxication and complaints of suicidality, he is treated as potentially more at risk of self-harm than someone who is equally suicidal but sober; it is essential to evaluate the level of suicide risk when the person is intoxicated, not just hope that the person will “change his mind” when intoxication clears.

Guidelines for integrated longitudinal assessment

A frequent barrier to rapid and effective crisis intervention is the belief that assessment cannot proceed quickly because substance use may result in symptoms that mimic those of psychiatric illness. Although there are instances where this may occur, it should never delay beginning the assessment to quickly establish as much information as possible and proceed accordingly.

Guidelines for appropriate diagnostic assessment of individuals with an SUD in crisis have been described in the literature, and include the following:

1. Identify the person’s goals and request for help, to establish connection and reinforce hope.

2. Using the framework of an HPI (history of presenting illness), identify the person’s most recent stable baseline, before the current crisis. Gather information from the patient as well as collateral information from a partner/relative, previous treaters, and health records that include baseline mental status and mental health treatment, health status, SUD treatment efforts during the most recent period of abstinence or controlled use. Carefully describe—chronologically—the sequence of events proceeding from the last period of stability to the current presentation.

The Case Vignette illustrates an approach that rapidly provides information that identifies diagnosis, current baseline treatment, and recommended interventions, even though the patient may still be under the influence.

CASE VIGNETTE

John has a long history of schizophrenia and alcohol use disorder. He lives in supported housing by himself, supported by his case management team who see him one to two times a week. At baseline he is managed on several medications, but even on his best day he has auditory hallucinations, and finds that using alcohol provides him with short-term relief. His team has been working hard to help him reduce or eliminate his alcohol use, and he recognizes that the short-term relief is often followed by exacerbations of voices.

John recently started on oral naltrexone and reports better control of craving. However, today he went out with some friends who offered him alcohol and an unknown substance described as “synthetic marijuana.” John reports that, “The alcohol didn’t do much for me, but the other stuff made me feel pretty good for a while. Then, all of a sudden, the voices got real loud and I started to panic.”

Alternatively, the same approach might yield a different story and imply a different solution. For example, John reports that he stopped his medication three weeks ago and has been responding to increased voices by trying to control them with more and more alcohol and drugs. He is very ambivalent about going back on medication but also knows that the alcohol and drugs are not working. He is scared and feels out of control.

In most cases, history (from multiple sources) will establish the probable diagnosis, baseline state during previous periods of abstinence, reasons for the immediate decoupling or crisis presentation, and recommended intervention. In some instances, assessment may need to be extended, either because more collateral information is needed and/or the person may not be initially coherent enough to provide accurate information.

3. Be cautious about diagnostic assumptions. Many crisis settings utilize the diagnosis of “Substance-induced disorder” for almost every patient who presents with active substance use that has an impact on symptoms. This is very misleading. In most instances, persistent mental illness (which may be exacerbated, or at times masked, by substance use) can be identified by history. A diagnosis of “substance-induced psychiatric disorder” requires that the psychiatric symptoms were initiated only in response to significant substance use and clear up completely within 30 days after substance use is discontinued. Substance-induced psychiatric disorder therefore is a diagnosis of cause—not cause—and should be utilized cautiously; whether the symptoms will in fact clear up quickly is often uncertain. Overuse of “substance induced disorder” may lead to undertreatment of persistent disorders that may be present already or that may be just beginning.

4. Use urine screening judiciously as one piece of potentially corroborating information, along with self-report, collateral reports, and the person’s clinical presentation. Note that some substances (e.g., synthetic cannabinoids, fentanyl) may not be detectable in the urine screen, and, conversely, urine screening may be positive without a commensurate understanding of quantity of use. Each crisis setting should be aware of what substances do not appear in...
its urine screen, as well as the threshold for a positive result, and what medications (including over the counter use) may lead to false positives.

5. Identify any immediate risks due to intoxication, withdrawal, suicidality, violence, or exacerbation of mental illness/medical conditions that require emergent intervention.

6. Once immediate safety is established, assess carefully to determine what is the best next step to engage the individual in ongoing services that will help him increase stability and make progress over time.

STEP THREE: Establish immediate safety and stabilization

Each crisis setting must have clear protocols and medical/nursing resources for addressing intoxication and withdrawal. Note however that even programs with minimal medical support can still safely manage most episodes of intoxication safely. The level of withdrawal severity, measured by tools such as the CIWA-Ar (Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised) for alcohol or COWS (Clinical Opiate Withdrawal Scale) for opioids, determines intervention protocols in the behavioral health crisis setting.1 It is important to note that crisis programs are permitted to provide buprenorphine and are able to perform buprenorphine inductions. Although withdrawal symptoms may not be as specific biologically for other substances, they can lead to significant discomfort and agitation and should be managed consistently and symptomatically.

Naloxone administration

Crisis settings are first responders and are increasingly likely to have exposure to individuals with life threatening overdose. In a psychiatric crisis setting, an individual may have hidden opioids and use them after admission or obtain opioids from a visitor (even with reasonable search protocols). All crisis settings must have naloxone available and capacity to administer naloxone in the event it is needed.

STEP FOUR: Individualized disposition planning and continuity of care

A common frustration of crisis providers is that individuals who present with significant substance use are routinely referred for abstinence-expected treatment (in a detoxification or addiction treatment program), even if that is not an appropriate match for what the individual wants, needs, or is ready for. This results in the person refusing the recommendation, being discharged to no service, and recidivism or accepting the referral and then not following through, leaving AMA (against medical advise), or being administratively discharged. These results are neither clinically appropriate nor a good use of resources.

Crisis standards of care developed by Balfour and colleagues4 include quality indicators that look at issues of repeated psychiatric crisis visits (including SUDs) as an improvement opportunity. The authors recommend that all crisis settings emphasize individually matched engagement and continuity of care (not just referral for an episode of sobriety) as markers of success. As with other chronic conditions, this approach is unlikely to achieve perfect remission, so much as to create the ability for engagement that will lead to improvement and stabilization over time.

The ASAM (American Society of Addiction Medicine) Criteria for patient placement—the gold standard for addiction service matching—helps connect individuals for whom typical addiction treatment programs are not appropriate to other levels of care including proactive community-based case management. These models have demonstrated success for high risk individuals who cannot or will not engage in more conventional services. Crisis services should establish the following guidelines for disposition planning.

Individualized patient needs

Care should be individualized to each person’s crisis presentation and request for help, and should not involve referral for abstinence-expected services. The ASAM criteria can guide connection to levels of care that may include continuing community-based outreach. At the same time, it is important to remember that individuals who present with psychiatric issues (suicidality, psychosis) are at increased risk if there is comorbid substance use.

Tools such as the LOCUS (level of care utilization system) 20 reinforce that additional comorbidity for individuals who demonstrate safety risk can lead to a higher level of care than might be indicated for the MH presentation alone.

Prioritize engagement of high risk individuals

Individuals with substance use disorders (including those who present with frequent intoxication, requesting a place to stay or stating they are suicidal in order to get a bed), should be treated as high-risk and need to be engaged immediately. The crisis system should have a clearly demonstrated mechanism for providing crisis follow up for up to 90 days for these individuals. Intramuscular naltrexone is likely to be of benefit as well as crisis case management.3 These models have demonstrated success for high risk individuals who cannot or will not engage in more conventional services. Crisis services should help them gain control even if at first they continue to use substances.

The importance of engaging high-risk opioid users

Individuals who present with unmanaged pain, requests for opioids or for higher dosages of opioid, or other indications of potentially risky or lethal...
Use of Psychodrama

Continued from page 6

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Dr Fidler is retired from psychiatry in Morgantown, WV; he is also an actor, a playwright, lecturer, and Professor Emeritus, Department of Behavioral Medicine and Psychiatry, West Virginia University, Morgantown, WV.

Reference

First Episode Psychosis

Continued from page 7

cytochromes than controls. In FEP, neutrophils were significantly negatively associated with gray matter volume ($r=−0.17$), and significantly positively associated with cerebrospinal fluid volume ($r=0.19$). None of the blood cell types were associated with white matter volumes. Higher neutrophils were also associated with greater PANSS total ($r=0.17$) and positive subscale ($r=0.17$) scores, including specific items for hallucinations, suspiciousness/persecution, disturbance of volition, and preoccupation. Findings were not confounded by antipsychotic or other psychotropic medication exposure. Importantly, neutrophil counts remained stable 2 years after the initial blood assessment, which argues against an acute infection contributing to these findings. In controls, none of the blood cell counts were associated with gray matter, white matter, or cerebrospinal fluid volumes.

The researchers concluded that theirs is the first study to show associations between blood neutrophil counts, psychopathology, and brain volumes in psychosis. These findings were specific to patients with FEP, who also had higher blood neutrophils than controls. The pattern of reduced gray matter volume was generalized all over the brain rather than localized. Findings further support a role for immune system dysfunction in schizophrenia. Strengths of the study include the relative large sample size, and consideration of multiple potential confounding factors, including antipsychotic medication and acute infection. Limitations of the study include the observational design, use of multiple MRI scanners, blood and imaging were not performed on the same day, and absence of data on anti-inflammatory medications, inflammatory diseases, and sleep problems.

The bottom line
Findings indicate that neutrophil counts are associated with brain volumes and psychopathology in FEP, supporting a role for immune dysfunction in the pathophysiology of this disorder.

References

Tips for outpatient practitioners
If your patient presents in crisis with active substance use, it is important to remember to take a leadership role in developing the follow-up plan after the crisis episode is resolved. Treatment providers are usually ideally suited for helping patients learn from the crisis episode, incorporate information that might help them make better decisions about substance use, decide whether they need additional help, and develop skills to ask for help before becoming intoxicated. It is important not to overreach by demanding abstinence as a condition of continued treatment, or assuming that the patient has “learned his lesson.” The crisis involving substance use is usually a continuing journey, in which the treatment provider helps the patient make progress one small step at a time.

References
10. American Association of Community Psychiatrists (AACP): LOCUS: Level of Care Utilization System for substance use disorders service providers, including provision of proactive consultation and welcoming offers of instant crisis response. This will enable substance use disorders service providers, including provision of proactive consultation and welcoming offers of instant crisis response. This will enable...
CME Events

AACAP’s 2019 Pediatric Psychopharmacology Update Institute
Early Treatment Intervention: When, What, and For How Long?
January 25–26, 2019 - Brooklyn, NY - New York Marriott at the Brooklyn Bridge
Boris Birnholz, MD, and Gabrielle A. Carlson, MD, Co-Chairs
This institute links the latest findings on the treatment of ADHD, substance abuse, depressive disorders, irritability, suicidal/self-injurious behaviors, psychosis and schizophrenia, anxiety, and high-risk mood and psychotic disorders.
Discounted early bird rates are available until December 11, 2018.
Visit: www.aacap.org/psychopharm-2019 for more information!

AACAP’s Douglas B. Hansen, MD, 44th Annual Review Course in Child & Adolescent Psychiatry
March 23–25, 2019 - Baltimore, MD - Hyatt Regency Baltimore Inner Harbor
Tom D. Benton, MD and Gabrielle A. Carlson, MD, Co-Chairs
This course emphasizes the most recent material relevant to the general practice of child and adolescent psychiatry and serves as both an up-to-date review of child and adolescent psychiatry and important clinical research. The course is designed to update practitioners on state-of-the-art standards of diagnosis and treatment.
Visit: www.aacap.org/ReviewCourse-2019 for more information!

AACAP’s 66th Annual Meeting
October 14–19, 2019 - Chicago, IL - Hyatt Regency Chicago
Submissions to the Call for Papers for AACAP’s 66th Annual Meeting will open in December and will be due Thursday, February 14, 2019, or Tuesday, June 4, 2019, for (late) New Research Poster. The online Call for Papers submission form is available at www.aacap.org/AnnualMeeting-2019; all submissions must be made online. Abstract proposals are prerequisites for acceptance of any presentation. Topics may include any aspect of child and adolescent psychiatry.
For information about all of AACAP’s meetings and to register, visit www.aacap.org, email meetings@aacap.org, or call 202.566.7300, ext. 2006.

Jacobi Medical Center (JMC) is a modern, state-of-the-art, Level 1 Trauma Center located in an attractive and safe residential Bronx neighborhood just 20 minutes north of Manhattan. It is a North Bronx Healthcare Network hospital affiliated with North Central Bronx Hospital and a teaching site and academic affiliate of the Albert Einstein College of Medicine. It offers a full continuum of Acute Care Inpatient and Outpatient services in diverse Medical and Surgical Specialties, including Psychiatry. The Department of Psychiatry has 98 Adult Acute Inpatient beds, a Comprehensive Psychiatric Emergency Program (CPEP), a Consultation-Liaison Service, an Adult Ambulatory Practice, and a Community-Based Assertive Community Treatment Program. The department employs evidenced-based best practices in providing the highest quality care to its patients. In a patient-centered approach that is respectful of their individuality, culture, and community.

North Central Bronx Hospital (NCBH) is a modern, state-of-the-art community hospital located in an attractive and safe residential Bronx neighborhood just 20 minutes north of Manhattan. It is a Bronx Healthcare Network hospital affiliated with Jacobi Medical Center and a teaching site and academic affiliate of the Albert Einstein College of Medicine. It offers a full continuum of acute care inpatient and outpatient services in diverse medical and surgical specialties, including Psychiatry. The NCBH Department of Psychiatry has 70 Adult and Geriatric Acute Inpatient Beds, a Partial Hospital Program, Psychiatric Emergency Consultation-Liaison Service, an Adult Ambulatory Practice, and a community-based Assertive Community Treatment Program. The department employs evidenced-based best practices in providing the highest quality care to its patients. In a patient-centered approach that is respectful of their individuality, culture, and community.

Jacobi Medical Center & North Central Bronx Hospital are currently accepting applications and referrals for the following opportunities:
- Inpatient Attendings (JMC and NCBH)
- PI Coordinator
- Attending Psychiatrist ER-CPEP (JMC)
- Inpatient Unit Chief (JMC)
- Attending Psychiatrist ER (NCBH)
- Director of Psych Emergency Services (NCBH)
- Collaborative Care (Psychiatrist within Adult Primary Care Services)
- Moonlighting opportunities also available (JMC and NCBH)

An academic appointment at Albert Einstein College of Medicine is offered. We offer a generous income package along with outstanding benefits, opportunities for advancement, retirement plan, malpractice, and much more!

For immediate confidential consideration, please contact: Carmen Velez – Office of Physician Recruitment: VelezC@pagny.org
646-494-7559

www.pagny.org

Physician Affiliate Group of New York (PAGNY) is comprised of over 15,000 physicians and healthcare professionals who provide services to NYC Health + Hospital, the largest public healthcare system in the United States. Our practitioners are highly skilled professionals with outstanding credentials who deliver the highest level of quality healthcare to patients throughout New York City.

Immediate openings for Psychiatrists

Join the largest, most dynamic medical department in the nation and make the difference that matters the most. We are expanding and have new opportunities for psychiatrists who are ready for a rewarding career. We are recruiting psychiatrists to fill the future we are creating. Opportunities range from full-time or part-time faculty to part-time faculty or part-time or part-time work opportunities.

- Competitive starting annual salary with potential bonuses of $32,000 annually.
- Student loan repayment incentive up to $250,000.
- Reimbursement for eligible relocation up to $15,000.

www.psychiatristjobs.la

Rutgers University Behavioral Health Care (UBHC), the Department of Psychiatry at Rutgers-Robert Wood Johnson Medical School and the Rutgers Institute for Health, Healthcare Policy and Aging are building a clinical research program in addiction (opioid, alcohol and other substances), and are looking to recruit a tenured-track or tenured faculty member at the Associate or Full Professor level.

We are looking to hire an established and productive researcher with active and grant-funded (e.g., NIDA) research programs related to substance abuse/addiction and services and implementation research. The successful candidate will develop new initiatives that integrate research, training, and specialized substance abuse addiction services. Successful candidates will be expected to work with researchers, clinicians, and administration at Rutgers, the RWJ Barnabas Health system, and the State of NJ Division of Mental Health and Addiction Services to position Rutgers to be competitive for large systems-impacting grants such as the one described in NIDA’s recent RFA for the HEALing Communities Study: https://grants.nih.gov/grants/guide/ida-files/RO1-DA-19-016.html. Prior experience working on projects of this type, that includes clinical trial design, a services research perspective, health economics, and learning health care system components will be considered a strong required experience.

Successful applicants will benefit from a wide array of resources including: a productive team of experimental psychopathology researchers (e.g., https://ubhc.rutgers.edu/research); the wide range of clinical services at UBHC, including inpatient, partial hospital, outpatient, residential, Department of Corrections programming, therapeutic school and school-based programs that together serve over 75,000 individuals annually; the large RWJ Barnabas Health system that is currently implementing evidence-based opioid addiction interventions in multiple urban and rural areas in NJ; medical, internship, and post-doctoral training programs at UBHC and in the Department of Psychiatry; programs in Psychology, Neuroscience, Psychiatric Rehabilitation, Social Work, Public Health, Genetics, and other departments and schools that offer opportunities for collaboration; the Rutgers Center for Cognitive Neuroscience Medicine (Rutgers University); the Rutgers Princeton Center for Computational Cognitive Neuropsychiatry (ccnp.princeton.edu); the Rutgers Brain Health Institute (https://brainhealthinstitute.rutgers.edu/); the Rutgers Center of Alcohol Studies (http://alcoholsudies.rutgers.edu/); a developing Addictions Research Center at Rutgers; active collaborations with the New Jersey Division of Mental Health and Addiction Services and the New Jersey Division of Child and Family Services; and competitive support and start-up packages.

Interested applicants should apply using the following link: https://jobs.rutgers.edu/postings/79420

Applicants from minority and under-represented groups are especially encouraged to apply.

Rutgers University Behavioral Health Care (UBHC), the Department of Psychiatry at Rutgers-Robert Wood Johnson Medical School
With the continued growth of our Department of Psychiatry and our New General Psychiatry Residency Programs at Ocean Medical Center and Jersey Shore University Medical Center our vision for Behavioral Health is Bright.

Psychiatry Residency Training Program Director

Ocean Medical Center, Brick, New Jersey

Hackensack Meridian Health is seeking a Residency Training Program Director to lead a unique community-engaged psychiatry residency program.

Located in the heart of one of the largest and fastest growing counties in the state, Ocean Medical Center has become a vital part of the community since its opening in 1984.

Ocean Medical Center has been ranked as the top rated hospital for quality in Ocean County, and among the best in the state of New Jersey. We have been rated as the top hospital in the county for the treatment of heart attack, congestive heart failure, and surgical care improvement. In fact, Ocean Medical Center was named one of the safest hospitals in the state of New Jersey by Forbes Magazine.

Requirements: Candidates must have an MD or DO degree; Completion of an ACGME Accredited Psychiatry residency; Current board certification by the American Board of Psychiatry and Neurology; Three years of experience as a member of a teaching faculty or as an educational administrative leader; and have a strong track record of scholarship.

Hackensack Meridian Health is committed to improving the health and well-being of the residents of New Jersey by providing quality, patient-centered health care services delivered in hospital, community and in-home settings, and to advancing medicine through clinical education and research.

We foster a culture of excellence within a collaborative environment. We actively seek innovative solutions, technologies and partnerships to support sustainable financial growth and to ensure communities we serve have access to a comprehensive continuum of integrated services that meet their present and future health care needs.

In addition to our collegial work environment, we offer a highly competitive compensation package which includes: medical/dental plans, 403(b) retirement plan, and relocation assistance.

For immediate consideration, please contact Renee Theobald, at: Renee.Theobald@hackensackmeridian.org or call: 732 751-3597

HackensackMeridianHealth.org
With the continued growth of our Department of Psychiatry and our New General Psychiatry Residency Programs at Ocean Medical Center and Jersey Shore University Medical Center our vision for Behavioral Health is Bright.

As the area’s premier provider of psychiatric services, Hackensack Meridian Behavioral Health Services has provided comprehensive mental health and substance abuse services to the residents of Monmouth, Ocean, Middlesex, and Bergen Counties for over forty years. Due to continued growth and expansion, we are currently accepting applications for Psychiatrists to join our Mental Health and Addiction Interdisciplinary Teams in the following positions:

- Consultation Liaison Psychiatrists: Jersey Shore University Medical Center (Neptune, NJ) and Riverview Medical Center (Red Bank, NJ) and Hackensack University Medical Center (Hackensack, NJ)
- Staff Psychiatrist for Adult Inpatient Unit: Jersey Shore University Medical Center (Neptune, NJ) and Riverview Medical Center (Red Bank, NJ) and Hackensack University Medical Center (Hackensack, NJ)
- Outpatient Child & Adolescent Psychiatrist: Jersey Shore University Medical Center (Neptune, NJ) and Hackensack University Medical Center (Hackensack, NJ)
- Medical Director/Section Chief, Child & Adolescent Psychiatry: Jersey Shore University Medical Center (Neptune, NJ)
- Outpatient General Psychiatrist: Jersey Shore University Medical Center (Neptune, NJ), Riverview Medical Center (Red Bank, NJ), and Raritan Bay Medical Center (Perth Amboy, NJ)
- Medical Director of Adult Inpatient Unit Riverview (Red Bank, NJ)
- Emergency Psychiatry: Raritan Bay Medical Center (Perth Amboy, NJ)
- Geriatric Psychiatry – Hackensack University Medical Center (Hackensack, NJ)
- Outpatient/Consultation Liaison Psychiatrist – JFK (Edison, NJ)
- Per Diem/Tele-psychiatry – Hackensack Uniervty Medical Center (Hackensack, NJ)
- Staff Consultation Psychiatry – Bayshore Medical Center, (Holmdel,NJ)

In addition to our collegial work environment, we offer a highly competitive compensation package which includes: medical/dental plans, 403(b) retirement plan, and relocation assistance.

For immediate consideration, please contact Renee Theobald, at: Renee.Theobald@hackensackmeridian.org or call: 732 751-3597
Aligned Telehealth, Inc. – California
Our mission is to be the leader in innovative, high quality, accessible behavioral health solutions. Explore opportunities in multiple states.

Hiring MULTIPLE Psychiatrists for Telemedicine and Onsite positions in the following states
CA, TX, NV, AZ, FL, OR, NM, CO and other states. Full time and Part Time positions.

We offer competitive salaries and excellent benefits!

Immediate Need for BC Psychiatrist with Texas medical license for evening tele position.
Immediate Need for BC Psychiatrist with CA license (must reside in CA) for several outpatient sites

Contact Sandra Williams at 818-814-7790 or email me your current CV to swilliams@alignedth.com
To be considered for these great opportunities.

Outpatient Adult and Child Psychiatrists are needed for Stanislaus County Behavioral Health & Recovery Services, in the Central Valley less than two hours from San Francisco and Yosemite. Recovery-oriented treatment provided in a multidisciplinary setting with friendly and dedicated staff members. Recently revised rates with full malpractice coverage and pension plan (PARS) as a Personal Service contractor with an income potential of over $325 K per year for adult psychiatrist and over $355 K per year for child psychiatrist for F/T work.

P/T options and the opportunity to combine Tele-Psych with limited onsite work are also available. Excellent work environment with NO Call Requirement, lower than average case load and comprehensive nursing & ancillary support makes this a very pleasant and rewarding opportunity. J 1 applicants are welcome.

Fax CV to Bernardo Mora, MD at (209) 558-4326 or Email: bmora@stanbhrs.org

Join an exciting and lucrative practice which gives you flexibility to work in inpatient, outpatient, telepsychiatry and research settings. Flexibility to work from home office is possible. For interested individuals, opportunities in teaching medical students, supervising staff, becoming a principal investigator, ECT and TMS are also available. Competitive salary and benefits. Malpractice and license assistance.

J-1 & H-1 visa’s welcome

Locations in Southern California, Nebraska & Florida

CV/Resumes may be submitted via email to HR@asclepes.com or by fax to 747-998-0383.

Exceptional opportunity to earn from 450k to 575k for Psychiatrists to work in State Hospitals, outpatient clinics and Telepsychiatry in CA. Earn $180 to $230 an hr. Contact 707-226-2426 or email Bayareadrs@gmail.com

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**Butte County Behavioral Health Services**

Butte County Behavioral Health Department is seeking a Medical Director based in Chico, California to manage department programs. The incumbent will perform approximately 50% direct services and 50% administration work. In collaboration with the Assistant Director – Clinical Services, evaluates plans, establishes, and implements the medical services component and all clinical services of the department; participates in coordination of services across county departments and agencies; provides medical direction and consultation to all mental health programs and consultation to contracted agencies; particularly in the areas of quality improvement, medication monitoring, and peer review.

Starting salary is dependent on experience and is negotiable. The Department will also consider a Medical Director on a contract basis. Salary for a contracted Medical Director is negotiable. For additional information, please contact Geoff Davis, at (530) 891-2986 gdavis@buttecounty.net for a recruitment packet and appointment to speak with the Behavioral Health Department Director. Please visit the Butte County Human Resources Department website for more information, to review the recruitment packet, and to apply for the opportunity:

http://www.buttecounty.net/humanresources/employment.aspx

**J-1 Visa Opportunity in California**

Imperial County Behavioral Health Services is currently recruiting for a full time psychiatry. Imperial County is located 90 miles by freeway to the city of San Diego to the west, and 90 miles to Palm Springs to the north. Located in a rich farming area, Imperial County has a population of 180,000 and borders with Yuma, Arizona and with the cosmopolitan city of Mexicali, Mexico population 1.2 million. San Diego State University maintains a satellite campus in Calexico and there are a number of private and public universities located in Mexicali, the state capital of Baja California Norte. Imperial County’s location and diversity make it the perfect place for a psychiatrist to relocate under the J-1 Visa program or for any reason.

The position pays a highly competitive salary, including health benefits for you and your family, and requires no hospital work and minimal after hours work freeing you up for more leisurely activities.

The successful candidate diagnoses and treats patients with mental, emotional, and behavioral disorders. Qualified candidate must have CA medical license or ability to obtain.

Send CV to Imperial County Behavioral Health Services, 202 North 8th Street, El Centro, CA 92243.

J-1 applicants welcome.

For additional information, please contact:

Kristen Smith (442)265-1606 kristensmith@co.imperial.ca.us

**Psychiatrist Position**

Imperial County Behavioral Health Services is seeking a Medical Director based in Chico, California to manage department programs. The incumbent will perform approximately 50% direct services and 50% administration work. In collaboration with the Assistant Director – Clinical Services, evaluates plans, establishes, and implements the medical services component and all clinical services of the department; participates in coordination of services across county departments and agencies; provides medical direction and consultation to all mental health programs and consultation to contracted agencies; particularly in the areas of quality improvement, medication monitoring, and peer review.

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http://www.buttecounty.net/humanresources/employment.aspx

**Chief Medical Officer – Community Healthlink**

UMass Memorial Health Care’s Department of Psychiatry and its Community Healthlink (CHL) member institution is looking for a chief medical officer to help lead the largest provider of mental health services in Central Massachusetts.

The position involves supervision of a large group of professionals and participation in the executive team’s strategic, program and organizational development efforts. The ideal candidate will have a demonstrated commitment and passion for community psychiatry and an interest in a leadership role in advocating and promoting the wellbeing of traditionally underserved populations.

CHL has a long tradition of bringing excellent mental health and substance use disorder services to our city and region, from its inception as a community mental health agency to its current role as a key member organization at UMMHC. Its 1300 employees serve over 22,000 individuals each year and its programs assist patients across the life span. Medical staff are faculty members of the UMass Department of Psychiatry and employees of the medical group practice—they are vital contributors to the department’s missions of training, research, and clinical excellence. We believe this position will be a terrific opportunity for individuals committed to serving their community through the provision of high quality psychiatric care as part of mission driven team.

To learn more about our Community Healthlink locations, please visit our website http://www.communityhealthlink.org/chl/:

Interested applicants should submit a letter of interest and curriculum vitae addressed to:

Alan P. Brown, MD
Vice Chairman of UMMHS Department of Psychiatry for BH Integration and Population Health

Clinical Professor of Psychiatry, Family Medicine and Community Health c/o: Jessica Saintelus, Physician Recruiter

Jessica.Saintelus@umassmemorial.org

As the leading employer in the Worcester area, we seek talent and ideas from individuals of varied backgrounds and viewpoints.
Michigan

**MEDICAL DIRECTOR POSITION IN LANSING** — Seeking Psychiatrist for Medical Director position of Sparrow Hospital’s Behavioral Health Service line which consists of an adult inpatient psych unit, geropsych unit, PHP and Outpatient Clinic. The hospital is offering an attractive employment compensation package. Lansing is about an hour from Ann Arbor, Battle Creek, Jackson and Grand Rapids. It is an hour and a half from Detroit.

Please contact Terry Good, Horizon Health, at 804-684-5661.
Email: terry.good@horizonhealth.com; Fax #: 1-804-684-5663.

**Sparrow**

**Psychiatry Position with Sparrow Medical Group**

Sparrow Medical Group (SMG), a multispecialty physician group and the premier physician organization of Sparrow Health System (SHS), located in Lansing, Michigan, is seeking a dynamic BC/BE psychiatrist for an adult inpatient position. Position is hospital-employed and offers excellent compensation and benefits including relocation assistance, 401(k) with matching funds, generous CME benefits and malpractice insurance that includes tail coverage.

Learn more about this position by contacting:
Barbara Hilborn, Manager Provider Recruitment Office: 1-800.968.3225
Email: barbara.hilborn@sparrow.org
Visit our website at www.sparrow.org
More information on the Lansing area can be obtained at www.lansing.org.

If you are interested in working in a dynamic BC/BE psychiatrist for an adult inpatient position available. Be in on the beginning of a new unit helping to mold and develop the program. Open to employment, or independent contractor arrangement. Located in southeast MO near Cape Girardeau, this is a low cost of living, low crime rate area but close to a local airport that has direct flights to Chicago. It’s also only two hours from Memphis and St. Louis. This designated underserved area is also located in the Delta Regional Authority so J1 Waivers can also be obtained through the DRA as well as the state. Position can be inpatient, or outpatient.

Please contact Terry Good, Horizon Health, at 804-684-5661.
Email: terry.good@horizonhealth.com; Fax #: 1-804-684-5663.

New York

**BEAUTIFUL SARANAC LAKE NEAR LAKE PLACID** — Psychiatrist/Medical Director, 12-bed Geropsychiatric Unit – Adirondack Medical Center has an affiliation with the Olympic Training Center in Lake Placid. Saranac Lake, located in the Adirondack Park, is a nature lover’s paradise but the downtown area has an urban vibe. Open to either contracting with a local psychiatrist/group in practice for part-time work, or full-time employment with benefits. Part-time administrative duties such as meeting attendance, UR and policy & procedure questions can be handled while at the hospital.

Please contact Terry Good, Horizon Health, at 804-684-5661.
Email: terry.good@horizonhealth.com; Fax #: 1-804-684-5663.

**Four Winds Hospital**

Four Winds Hospital provides inpatient and outpatient mental health treatment services for children, adolescents and adults.

We are the leading specialized providers of inpatient psychiatric treatment in the Northeast.

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**Duties include:**
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Human Resources at 914-763-8151 ext. 2585, or email resumes to MDjob@fourwindshospital.com
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www.fourwindshospital.com

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Per diem / Part Time / Full Time

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**Division of Behavioral Health Services**

**wellness recovery prevention**

For clinical staff and leadership positions

The State of New Jersey is seeking motivated BC/BE Psychiatrists for full-time inpatient work in our Joint Commission-Accredited state psychiatric hospitals and forensic center. Psychiatrists with management experience are also needed to serve as Medical Director or Associate Medical Directors in some facilities.

• Facilities are in close proximity to metropolitan centers of New York City and Philadelphia/NJ. shore
• Psychiatrists work with a multidisciplinary team
• Primary care physicians provide for patient’s physical health care
• University affiliations/Opportunities to work with forensic fellows and psychiatry residents
• On-site CME activities and paid CME leave time
• 30 hour work week
• Competitive salaries
• Opportunities for voluntary on call available
• 12 paid holidays
• Generous medical and dental benefits and retirement packages for full-time positions

Candidates must possess N.J. medical license.
Interested candidates should send cover letter and detailed resume to:
Evan Feltese, M.D.
Division Medical Director, DMHAS
Evan.Feltese@doh.nj.gov
609-530-1562

**PSYCHIATRISTS**

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January 2019
For consideration, send your CV to: positions are possible. Surate with qualifications. Tenure-track attractive compensation commensurate with basic and clinical science in other neuroscience disciplines across several Penn State campuses. With our clinical partner, the Pennsylvania Psychiatric Institute, the Department staffs several outpatient and partial hospital programs for children and adults, 89 inpatient beds, and other neuromodulation services, specialty sleep and eating-disorders programs, and expanding psychiatric consultation and integrated care programs for Hershey Medical Center. Successful candidates should have strong teaching as well as clinical skills and, optimally, potential for scientific and scholarly achievement. We offer an attractive compensation package commensurate with experience and qualifications. Salary is competitive with funding available through the Medical School and other sources.

ETSU is located in Johnson City, TN, which has the perfect blend of four mild and beautiful seasons, gentle mountains, a local theater, and a symphony orchestra. Come explore this ideal family location with college/urban sophistication surrounded by national forests and beautiful parks. No state income tax, low cost-of-living, low crime rate, golf courses, and lakes.

Apply to the position at https://jobs.etsu.edu. Telephone inquiries should be made at (423) 439-2225 or e-mail at lovedayc@etsu.edu. AA/EOE.

Psychiatrist Opportunity Southwestern Virginia Mental Health Institute is located in Marion, Virginia, sitting in the heart of the Blue Ridge Mountains. Our 179-bed behavioral health facility offers an exciting career in a wide range of interesting pathology in psychiatric treatment while providing a highly desirable work-life balance.

We have opportunities in our inpatient setting for Psychiatrists for our Adult Admissions and Geriatric Units. These positions are employed positions offering a competitive salary with generous state benefits and paid malpractice insurance, loan repayment, CME stipends/leave, sign-on bonus, and relocation allowance. No on-call required, with compensated on-call available.

If you are licensed or eligible for licensure in Virginia, and have completed a psychiatric residency, please send your current CV to kim.sayers@dbhds.virginia.gov or you may contact a member of our Human Resources staff at 276-783-1204 to discuss this opportunity.

We invite you to join a team of dedicated physicians and loyal staff who are committed to promoting a life of possibilities for all Virginians.

For more information, please visit:
www.swvmhi.dbhds.virginia.gov;
www.smythcounty.org;
www.abingdon-va.gov

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Pensyslvania

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Tennessee

EAST TENNESSEE STATE UNIVERSITY
QUILLEN COLLEGE OF MEDICINE
DEPARTMENT OF PSYCHIATRY & BEHAVIORAL SCIENCES
ADULT PSYCHIATRISTS, CHILD PSYCHIATRISTS

Two full-time positions available for Adult Psychiatrists who are BE/BC at time of hire, and/or Child Psychiatrists who are BE/BC at the time of hire in the subspecialty of Child and Adolescent Psychiatry. Positions may include inpatient and/or outpatient. Program activities include clinical care of patients combined with teaching and supervision of residents and medical students. Research and academic activities are strongly encouraged. Salary and academic rank are commensurate with experience and qualifications. Salary is competitive with funding available through the Medical School and other sources.

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Virginia

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We invite you to join a team of dedicated physicians and loyal staff who are committed to promoting a life of possibilities for all Virginians.

For more information, please visit:
www.swvmhi.dbhds.virginia.gov;
www.smythcounty.org;
www.abingdon-va.gov

Wisconsin

CLINICAL PSYCHIATRIST

Clinical excellence and quality living! Winnebago Mental Health Institute (WMHI) is a 280 bed psychiatric facility associated with Medical College of Wisconsin’s North East Wisconsin Psychiatry Residency. We are seeking a Board Certified/Board Eligible Psychiatrist who wants to work with a Multidisciplinary Treatment Team to treat acutely ill Civil Patients and/or Forensic Patients. A strong commitment to excellence in clinical care and education of Residents, Medical Students and students/ interns of all clinical specialties makes WMHI a great place to practice. Excellent fringe benefit package, strong collegial support, paid call, and a beautiful campus enhance your work days.

WMHI is located near Oshkosh, Wisconsin, which is the center of the Fox River Valley, one of the fastest developing areas of Wisconsin. Four seasons with all the outdoor opportunities of each, cultural and sports venues, outstanding public and private schools and three universities in the area make this a great place to raise a family. In 1 1/2 hours you can be in Milwaukee, Madison, the Wisconsin Dells or “up north”.

Information on WMHI can be found at http://www.dhs.wisconsin.gov/WMHI_Winnebago/.

For application instructions, go to www.wisc.jobs and search for Psychiatrist (Job Announcement Code: 17-02966).

EOE
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