AACDP

AMERICAN ASSOCIATION OF CHAIRS OF DEPARTMENTS OF PSYCHIATRY

Chairs' Corner E-Newsletter

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President's Message

Let me first mention that we have a meeting in Boston next month (the last one with AAP) with some very interesting speakers including Gary Gottlieb, MD, the former CEO of Partners Health. Join us if you can and enjoy.

And now, some thoughts on the practice of medicine: I am currently sitting in a Federally Qualified Health Center where I am covering for one of my faculty members who is filling a gap at our student health center, created when one of our hospitals, desperate to keep a unit open, asked us to move a psychiatrist there. This sequence of events should make it clear to anyone that we are desperately short of psychiatrists in our local area. We all know that psychiatry is a huge shortage area nationally. There are a finite number of residency positions and the pipe line is a long one. Consequently, new graduates have their choice of practice sites. It is also my impression that psychiatrists are retiring or at least cutting back on work at earlier ages than in the past. We all know the statistics on physician work satisfaction and the overused term, "burnout".

So we have not enough psychiatrists and working conditions that are also not so great much of the time. The combination is lethal, sometimes, unfortunately, literally so. Given all this, I increasingly think that we need to be more assertive around what we think are reasonable work conditions. I think we need to not be afraid to say 'no'. For example, that one in four call the hospital needs you to pick up? The 15 minute appointments the CFO wants to increase revenue or decrease losses in the outpatient department? I've started to tell people what we can and can't do based on what maintains quality of life for our faculty members. People who like to come to work are more productive. As you may know, there are good studies that demonstrate increased productivity after an organization does away with defined vacation time. Individuals are free to take as much or little time as they like. Unsatisfactory working conditions also drive up turnover. Replacing one psychiatrist on faculty costs between $250,000 and a lot more — depending on what they do. This is largely a hidden cost that does not show up on a balance sheet, but it is a cost.

The systemic nature of the problems we face around shortages and dissatisfied physicians call for systems reforms. I think we all have to set lines in the sand and lobby hard with our health systems. We need allies as well, and many other chairs are likely to be having similar issues and be willing to work with us. We also need to lobby on

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a national level. This is where AACDP as an organization can be helpful. We plan on meeting a year from now in Washington at APA headquarters and will work with the APA to organize a lobbying day aimed at our respective congressional delegations. Topics are going to include research and GME funding at the very least. The more chairs the better and so I hope you will join us in Washington, September 2020.

Jed Magen

Summary of the May, 2019, Scientific Program

David Kupfer, MD, Distinguished Professor Emeritus of Psychiatry, University of Pittsburgh School of Medicine
Keynote Address: A Jog in the Sun

From the start of his talk Dr. Kupfer reminded us all that having a sense of humor, persistence, and optimism; being a risk-taker; being passionate; and, yes, being a bit "lucky", are all important qualities for a Chair. It should be considered a basic tenet that change is a constant, that the unexpected happens frequently, that progress is non-linear, that it always "takes longer", and that -- if you try to please everybody -- you will ultimately fail. Some of the challenges are that it is lonely at the top, where do you seek mentoring, how do you develop a shared vision and shared pride, how do you stick with the mission and the journey, and how do you maintain appropriate negotiation styles with those above, equal, and below. Negotiation styles are: competitive, avoidance, compromising, collaborative, and accommodating. Negotiating skills are: assertive, empathic, creative, and flexible. Each of us must find our own most adaptive profile of skills that best matches our style.

The Department of Psychiatry at the Western Psychiatric Institute and Clinic at the University of Pittsburgh was presented as a 36-year-old "case study" in point. The goals set out were to develop expertise in clinical research and translational science conducted by faculty (primary and joint); to promote interdisciplinary research, to improve clinical care; to provide first-class education (medical school) and residency (post-doctoral training); and to succeed as an entrepreneurial department. The tactics were to recruit young faculty – clinical and research (M.D.'s and Ph.D.'s) and to develop a reward structure based on effort and success. A similar system was anticipated for researchers and clinicians with 12-month salaries, the co-existence of clinical activity and research activity, and equity balance in compensation (easier in a low-paying clinical department like psychiatry). Given that promotion has largely depended on recognition within one's discipline, how do we facilitate interdisciplinary research and training? What structures are necessary to improve interdisciplinary efforts? The answer includes underwriting interdisciplinary training, creating a climate in which interdisciplinary research is in each Department's best interest, pressuring funding agencies to create opportunities, rewarding interdisciplinary efforts, and evaluating continuously. More specifically, one must get cross-disciplinary stakeholders signing on to smaller efforts, e.g., small R01's and foundation grants (like NARSAD), initiating a training program, obtaining one or two K (career development) awards, using post-doctoral fellows and young investigators as "bridges", and combining top-down strategies with bottom-up tactics. In recruiting post-doctoral fellows and faculty, one must remain degree-blind, look for an interdisciplinary mind-set, look for a collaborative spirit, and educate the leadership. They will be happy in the end.

There must be a departmental infra-structure with a Research Review Committee; creation of a research career pipeline; development and implementation of T32 training grants in an array of areas; and educational opportunities to assist young investigators in their career transitions (e.g., a Survival Skills Workshop and K award program). Most importantly, one must try to achieve a departmental culture of mentoring – complete with role models, facilitators of professional socialization and networking, advisors on goals and career paths with sufficient specificity for each mentee, and promoters of scholarly values and scientific integrity. The successful mentor must be a nurturer – e.g., on facing disappointments; a teacher of rules

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and skills, and an advocate – e.g., saying "no". It is recommended that we build a "research culture" with an emphasis on mentoring, that we utilize a Research Review Committee, that we have an Annual Research Day, that we provide research survival skills training, and that we set up a research "Career Development Institute". This institute should incorporate career planning, mentoring circles, oral platform presentations, asking an expert, and negotiation skills training. Dr. Kupfer also reminded "us to not take ourselves too seriously, to work with people brighter than ourselves, to bring together people who have different areas of expertise;" to be gender and degree blind; to start learning from people younger than ourselves; to downplay our notions of self-importance; to use new techniques and new strategies; to be able to change; and to stay flexible and keep learning lifelong.

Altha Stewart, MD, Former President of the American Psychiatric Association
Title: Mental Health Services in Correctional Institutions

Former APA President, Dr. Altha Stewart, delivered her presentation speaking extemporaneously. She noted that the prevalence of serious mental illness in the United States prison system is significantly higher than in the general population and that the statistics are proportionately alarming and have been for some time now. She discussed her work in Memphis at the Center for Health in Justice Involved Youth and its mission to identify and keep at-risk youth from entering the juvenile justice system. She discussed the need to focus on schools and her work with the Shelby County School system in terms of prevention. She also discussed the significant amount of stigma that continues to be involved in this area of psychiatry. She emphasized that community involvement, engagement, and education on mental illness (and specifically trauma) as well as adverse childhood experiences and the social determinants of health are required to address this national problem.

Susan Azrin, PhD, Unit Chief of Early Psychosis Prediction and Prevention Unit at the NIMH
Title: Rapid Science-to-Service Translation in First Episode Psychosis Treatment

Dr. Azrin began her presentation by stating that schizophrenia affects approximately 2.5 million U.S. citizens with a typical onset of its symptoms from ages 16 to 30 -- including altered perceptions, thinking, and disorganized behavior. She noted that it frequently results in unemployment, homelessness, and incarceration and that people with schizophrenia die 8 to 20 years earlier than others do. Treatment delays are common. The time between the onset of psychotic symptoms and initiation of treatment is typically 1 to 3 years in the U.S. Lengthy treatment delays are associated generally with negative outcomes -- poorer response to antipsychotic medications as well as specifically with poorer symptomatic and functional outcomes. Dr. Azrin emphasized that early intervention matters, as it results in a rapid remission of positive symptoms, lower rates of psychiatric re-hospitalization, decreased substance use, improved social and vocational functioning, and increased quality of life. Recommended FEP (first episode psychosis) practices are to employ research-supported interventions -- including low-dose antipsychotic medications, cognitive and behavioral psychotherapy, family education and support, and educational and vocational rehabilitation. Team-based and person-centered care, collaborative decision-making, and assertive outreach to the community are also recommended.

The NIMH launched the Recovery After an Initial Schizophrenia Episode (RAISE) project in 2008. RAISE began with two studies examining different aspects of Coordinated Specialty Care (CSC) treatments for people who were experiencing FEP. One study focused on whether or not the treatment worked better than care typically available in community settings. The other project studied the best way for clinics to start using the treatment program. CSC places the service user/client at the center of care and involves medication geared to FEP; primary care coordination; recovery-oriented cognitive behavioral psychotherapy; family education and support; case management; and supported employment and education. A CSC team requires sufficient staff to cover a number of key roles and associated functions. Three of these – pharmacotherapy, psychotherapy, and family therapy – can usually be reimbursed via private and public insurance. Two others -- case management and supported employment -- are not generally covered by commercial insurance but may be reimbursed by Medicaid, if the state's Medicaid waiver includes those services. Another function, team leadership, is critical for CSC success; yet, this role is not typically reimbursed by private or public insurance plans. Mental Health Block Grant set-aside

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funds for early serious mental illness can be used to cover reimbursement gaps in care management, supported employment, and team leadership. The RAISE Early Treatment Program clinical trial which involved 34 community clinics, found that after two years, CSC was superior to usual community care on engagement in treatment; quality of life; symptomatic improvement; involvement in work or school; and cost-effectiveness. In addition, CSC did work better for patients with a shorter duration of untreated psychosis.

In the Specialized Treatment Early in Psychosis (STEP) Program clinical trial, it was found after one year that STEP was superior to usual care on the likelihood of hospitalization; the number and length of inpatient episodes; vocational and academic engagement; and symptomatic improvement. The STEP public-sector model also supports the feasibility and effectiveness of CSC. From 2008 to 2018, there was a 20-fold increase in the number of CSC programs for FEP in U.S. community settings. NIMH is launching the Early Psychosis Intervention Network (EPINET), which establishes a national learning healthcare network among U.S. early psychosis clinics and utilizes standard measures of FEP/CHR (Clinical High Risk) characteristics and key outcomes across CSC sites. EPINET employs a unified informatics approach to monitor the delivery, quality, and impact of CSC and cultivates a culture of collaborative research participation in academic and community early psychosis clinics. The anticipated scope of EPINET is five regional CSC networks that comprise about 50 CSC programs in 8 states, with 75% of them being community clinics. About 400 patients at Clinical High Risk for Psychosis and 2,300 FEP patients are currently enrolled in these clinics, and an anticipated 5,000 FEP patients will enroll in EPINET over the 5-year project. Future challenges for CSC programs will be: how to reduce the duration of untreated psychosis (DUP) to the international standard of < 3 months in U.S. communities; how to effectively mitigate risks for early mortality; how to enhance social, academic, and work outcomes; how to extend recovery beyond the initial episode of care; and how to increase the person's prospects for long-term physical health and psychological well-being.

Anita Everett, MD, Director of Center for Mental Health Services (CMHS), SAMHSA
Title: The Role of Academic Medical Centers in Leading, Teaching and Delivering Suicide-Specific Interventions

Dr. Anita Everett of SAMHSA began with some background about SAMHSA -- as one of the HHS family of agencies (including CMS, FDA, NIH, and HRSA). SAMHSA's general organization follows: CMHS (Center for Mental Health Services); CSAT (Center for Substance Abuse Treatment); CSAP (Center for Substance Abuse Prevention) and CBHSQ (Center for Behavioral Health Statistics & Quality). Examples of "Discretionary" Services CMHS Grants are: Integrated Care; HIV/AIDS and Hepatitis in Underserved Populations; Assisted Outpatient Treatment; Circles of Care for Children; National Strategy for Suicide Prevention; and Grants to Expand Substance Abuse Treatment Capacity in Adult Treatment Drug Courts. SAMHSA's Director, Dr. Elinore McCance-Katz, has re-focused the agency on developing a system to disseminate research findings and evidence-based practices (EBPs) to service providers to improve prevention and treatment services. Per Dr. Everett, SAMHSA is a "small agency with a small budget but a big job". Its current priorities are: (1) combating the opioid crisis through the expansion of prevention, treatment, and recovery support services; (2) addressing serious mental illness and serious emotional disturbance; (3) advancing prevention, treatment, and recovery support services for substance use; (4) improving data collection and analysis, dissemination, and program and policy evaluation; and (5) strengthening health professional training and education. Further, the SAMHSA Evidence-Based Practice Resource Center provides communities, clinicians, policy-makers and others in the field with scientifically-based information, resources, and tools to incorporate EBPs into their communities or clinical settings.

A new resource [https://www.samhsa.gov/ebp-resource-center] is "The SMI Adviser" by Drs. Tristan Gorrindo and Stephanie Slowly. Duration of untreated psychosis is too long with treatment-as-usual. We need treatment alternatives to the status quo, such as Assertive Community Treatment (ACT); school-based treatment; in-home services; and "RAISE" (from NIMH). SAMHSA is also addressing other problems: overdose deaths, suicide, and the opioid crisis. Strategies for the opioid crisis are: improved access to effective treatment; more accurate data; more evidence-based pain management practices; greater availability of medications for overdose; and more and improved research.

Suicide is another major problem-- with 47,173 deaths in 2017. When the overdose and suicide rates are aligned side-by-side, the state-by-state maps for both problems overlap highly. Suicide rates rose across the U.S. from 1999 to 2016, with suicide rates increasing in almost every state. SAMHSA's suicide-related program efforts and initiatives include the

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Garrett Lee Smith (GLS) state/tribal youth suicide prevention and intervention program and campus suicide prevention grant program; "Zero Suicide" in health systems; a suicide prevention resource center; a national strategy for suicide prevention grants; native connections (tribal behavioral health); a national suicide prevention lifeline; crisis center follow-up grants; a mayor's and governor's challenge; a family tool kit; an updated *after-an-attempt* brochure; a national strategy for prevention implementation; the addressing of suicide clusters within American Indian and Alaskan native communities; and lifeline warning-sign wallet cards. Examining data in high-risk communities is useful for planning purposes.

It is also anticipated to expand the number and types of systems that engage with "Zero Suicide" and to train specialized professionals. The design is around what the suicidal patient needs: someone to talk to for a "safe landing"; talk line capacity; trained personnel with knowledge of resources; and follow-up capacity until the patient has, in fact, "safely landed". Moreover, there needs to be engagement with the organizational entity, a safety plan, documentation of resolution of the provoking circumstances, a place to go for a "safe landing"; ED-based Specialty Mental Health Crisis Center services; and someone to respond or be dispatched for a "safe landing". Police Departments need to be professionally staffed with a crisis response team. Community data should be used to target high suicide-risk communities – just as is currently done nationwide by CDC and NIAID for HIV/AIDS. Primary care providers need to identify high suicide-risk patients, restrict access to means for suicide, create a viable suicide safety plan, and, very importantly, program for follow-up care. This effort dovetails with specialty care providers delivering suicide-specific interventions, such as Dialectical Behavior Therapy (DBT), Collaborative Assessment and Management of Suicidality (CAMS), Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), and medications that mitigate suicide potential (such as clozapine, esketamine/ketamine, and lithium). The underlying condition must also be treated. Other professionals are also needed to support this process, including teachers, school nurses, case managers, and home visitors.

Robert Caudill, MD, Associate Professor and Director of Telemedicine and Information Technology Programs in the Department of Psychiatry and Behavioral Sciences of the University of Louisville School of Medicine in Kentucky
Title: Telemedicine and Information Technology Programs

Telepsychiatry was originally geographically driven by patient isolation and the need to access care. It has become technically easier to use over time. Convenience and cost encourage its use. It will likely increase in use, given the shortage of psychiatrists nationally. Changing expectations include differences across the patient age range and the large number of patients now in forensic facilities. Telepsychiatry saves patients and professionals travel time, wait time, lost time from work, and lost productivity. The multiple research studies that have now been conducted on patient satisfaction, reliability, and treatment outcomes of telepsychiatry services represent a major advance for the field. There are now secure cloud-based technologies as well as appropriate guidelines established. Best practices involve administrative, technical and clinical considerations. Program development involves legal and regulatory issues, including licensure and malpractice, scope of practice, prescribing, informed consent, and billing and reimbursement procedures. Standard Operating Procedures and protocols must be established for patient and provider identification as well as for emergency situations. Videoconferencing requirements for integration into other technology and systems must be worked through -- including privacy and security issues as well as HIPAA regulations. Physical location and room requirements need to be planned as well. Clinical issues involve patient and setting selection, management of patients accessing both in-person care as well as telepsychiatry, establishing provider relationships, ethical considerations, and cultural issues.

A psychiatry department-based telemedicine program can offer solutions to staffing issues, increase the availability of on-site staff for the more intensive involvement required for a less stable patient group, provide university-caliber physician group care overall, and establish access to independent additional assessments as well as to sub-specialty focused areas of psychiatric clinical expertise. It can also include provision of psychiatry leadership to multidisciplinary treatment teams, physician and psychiatric ARNP collaborations, development of telepsychiatry rotations for residents in psychiatry; and an ongoing relationship with the university. Training in video presentation skills, camera awareness, lighting, and "framing" are helpful as well. Moreover, the American Telemedicine Association (ATA) has contributed to identifying multiple clinical champions -- providing a basis for knowledge sharing and supporting business sustainability.

The future of telepsychiatry continues to move forward. Virtual reality (VR) is at the leading edge and provides a full

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immersion of human sensorimotor channels into a vivid and global experience. VR allows a more intuitive mode of interacting and a flexible environment -- enhancing the sense of "being there". This sense experienced by clinicians and patients is a component of the efficacy of telepsychiatry. In addition, high definition and 3D telepsychiatry offer a compelling milieu by which to achieve a full sense of immersion and to enhance the quality of telepsychiatric care. The thought about having a "body double" is appealing in psychiatry to expand the efficiency of meeting one's work load. In a real sense this is now possible under the auspices of an "avatar". For example, an avatar might be a nurse who speaks to the patient to elicit health information. Technology in the home can be used to create an avatar as a combination of speech, gestures, and augmented reality. Patients then relay their psychiatric symptoms and queries to the automated avatar, who, in turn, prompts them to provide relevant information to monitor their psychiatric symptoms. The avatar does not "replace" the psychiatrist. In contrast, the goal is to help patients maintain a personal relationship with their psychiatrist while receiving the personalized attention to which they are accustomed – but without the inconvenience of travel, wait time, and lost productivity.

Karl Goodkin, MD, PhD