The Massachusetts Psychiatric Society will celebrate its 50th anniversary on April 30, 2014 and I hope that you will join us! As with all Golden Anniversary’s, this event has much meaning and requires thoughtful planning with the hope that all will attend and enjoy the celebrations. The three primary plans to achieve are: the date, the place, and the keynote speaker. The date is always easy as it is pre-determined by the anniversary. The next task is to find a place to celebrate that has special meaning to most members and a significant link to the organization. The final task is the selection of a speaker, preferable someone who has made major efforts to promote the interests of the organization through public service or organizational leadership, or someone who knows deeply the suffering and needs of those who have had or recovered from mental illness and/or substance use disorders through his or her personal experience or family life.

The location for our 50th anniversary is the John F. Kennedy Presidential Library and Museum in Columbia Point, Boston. This selection recognizes that the birth of MPS came in the same year as President Kennedy’s Community Mental Health Centers Construction Act or more commonly called the Community Mental Health Act that heralded a new era in mental health care delivery. Celebration of two significant events that impacted the practice of psychiatry in Massachusetts will be blended with our 50th Annual Meeting celebration.

The John F. Kennedy Library as the venue pays tribute to the dream that President Kennedy articulated for those suffering mental illness and mental retardation (now referred to as intellectual disabilities). His vision, presented to the nation on February 5, 1963, described a society that strove to move institutionalized patients to a meaningful lifestyle in the community. This eloquent speech set the stage for two bills that were to forever change the approach to helping people with mental illness and intellectual disabilities, the Maternal and Child Health and Mental Retardation Planning Amendment to the Social Security Act (October 24, 1963) and the Mental Retardation and Community Mental Health Centers Construction Act (October 31, 1963) (1,2). These bills began the evolution of a series of subsequent federal and state bills to address the inequities in care for citizens with behavioral health (the umbrella term for the expanded focus on psychiatric disorders and substance use disorders) and intellectual disabilities.

In this pivotal speech President Kennedy defined the plight of people with mental illness and intellectual disabilities. Selected quotes reflect not only his eloquence but his compassion and commitment to care of these marginalized citizens (see Reference 2 for the complete speech).

“mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single condition.” “Most of them are confined and compressed within an antiquated, vastly overcrowded, chain of custodial State institutions. The average amount expended on their care is only $4 a day--too little to do much good for the individual, but too much if measured in terms of efficient use of our mental health dollars.” “But the anguish suffered both by those afflicted and by their families transcends financial statistics.” “This situation has been tolerated far too long. It has troubled our national conscience--but only as a problem unpleasant to mention, easy to postpone, and despairing of solution.” “Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release.”

(from the President...Continued on page 3)
Four years ago I found out that I was moving to Massachusetts. Aside from the change in weather, it did not seem that daunting at the time to think of “jumping the puddle”, as we say back home. One of the issues that were pressing in my mind, was the fact that I always thought I would become a doctor to help people in this “new” island. But, seeing the diversity of cultures, and ethnicities that UMass attends, particularly the Latino community, made me feel like I would still have a chance to serve a piece of my country from far away. As a Latino resident fellow member, working with Latino patients, and listening to their views on their cultural differences, and expectations for treatment, has been eye opening, and thought provoking. Many, even after living in the states for many years, believe that having a clinician from their ethnic group would make it easier for them to be understood and better served. I have thought a lot about this perception, and believe that it is a complicated issue for both the patients, and for the people trying to care for them.

At first, feeling that extra connection with Latino patients was a blessing, but I have realized the big responsibility it is. I also believe that it can be unfair for other doctors with different cultural backgrounds who are capable, and interested in taking care of these patients. On the other hand, even though Puerto Rico is a territory of the United States, and we are raised with plenty of access to American culture, there are multiple ways in which my customs and beliefs are different, so I experience how this affects communication and relationships for me. I can see where these patients are coming from.

Multiculturalism continues to grow in the United States. In Massachusetts there is approximately 25% of non-white population, so it is fair to say that during our training and career we will be faced with the situation of having to care for a patient of a different ethnic and cultural background. As mental health providers we need to consider how a patient’s own beliefs, traditions, and understandings affect the presentation of their symptoms, and attitude towards treatment. This topic should be an ongoing conversation and for this reason I am very excited to announce that the Massachusetts Psychiatric Society has opened a new Multicultural Psychiatry Committee, to be chaired by Dr. Astrid Destriers.

The purpose of this group is for psychiatrists in Massachusetts to have a place to discuss issues that we face when treating diverse populations, learn from each other’s experiences, and promote cultural competence. This would be a great way for us, resident fellow members interested in multicultural psychiatry, to pair up with mentors that can help us foster our ideas. This group would also be a good way to advocate for improved access to care, and parity for all patients.

I am very enthusiastic about the opportunity to get together with a diverse group that shares an interest in serving, and better understanding the broad range of patients we serve.

Please join us in a “Meet and Greet” at the MPS headquarters in Wellesley on April 9th at 6:30PM. I look forward to seeing you.

RESIDENT FELLOW MEMBER CORNER

Auralad Padilla, M.D.

MPS IS PLEASED TO WELCOME THE FOLLOWING NEW MEMBERS

General Members:  
Andrea Stone, MD

Resident Fellow Members:  
Shahdwat Pandhi, MD  
Shreeshad Paudel, MD  
Ouadie Fawehmilah, MD  
Anthony Rocco Giovannone, MD  
Sushruta Arjau, MD  
Carrie Melissa Cunningham, MD  
Kimberly Leventhal, MD  
John M. Teal, MD  
Jennifer Leah Goetz, MD  
Vanessa Marie Myles, MD  
Jose Rengifo, MD  
Genny J Feinberg, MD  
Rajgan Gosain, MD  
Jinjun Johnson, MD  
Neeta Sharma, MD

Transfer In:  
Lilijana Markovic, MD

March 11  
Methadone and Buprenorphine: Clinical Impact of Drug Interactions  
Elinore McCance-Katz, MD, PhDChief Medical Officer, Substance Abuse and Mental Health Services Administration  
www2.gotomeeting.com/register/800461818

April 8  
The Psychology of AA and Its Role in Clinical Care  
Marc Galanter, MD  
Director of the Division of Alcoholism and Drug Abuse, NYU  
www2.gotomeeting.com/register/809088138

May 13  
Managing Pain in Patients With An Addiction History  
Jonas F. Kauffman RN, MPH, LADC, CAS  
Vice President, Addiction Treatment Services North Charleston Foundation, Inc.  
Assistant Professor of Psychiatry, Harvard Medical School  
www2.gotomeeting.com/register/566094882

June 10  
Assessment and Management of Opioid Use Disorders in the General Hospital Setting  
Joji Suzuki, MD  
Assistant Professor of Psychiatry, Harvard Medical School  
www2.gotomeeting.com/register/412848618

July 8  
Treatment Options for Opioid Dependence: A Role for Agonists vs. Antagonists  
Maria A. Sullivan, MD, PhD  
Associate Professor of Clinical Psychiatry  
Division on Substance Abuse and Addiction  
Columbia University and NYSPI  
www2.gotomeeting.com/register/744246234

2014 Webinar Schedule
FREE sessions are scheduled from noon to 1 p.m. Eastern CME and Certificates of Participation Available

ARCHIVED WEBINARS
Accessible at www.APAseducation.org and www.pcsomat.org

DMS-5: Substance Related and Addictive Disorders
Charles P O’Brien, MD, PhD  
Center for Studies of Addiction  
Professor, Department of Psychiatry  
University of Pennsylvania School of Medicine

Using Medication Assisted Treatment with Veterans for Opioid, Alcohol, and Tobacco Use Disorders
Andrew J. Saxon, MD  
Professor of Psychiatry, University of Massachusetts Medical School

MPS Bulletin – March 2014

www.psychiatry-mps.org
Interested candidates should send a Letter of Interest and CV to: William Pariseau @ william.pariseau@state.ma.us

As public sector intermediate care facilities, HPP/Polaris psychiatrists do not experience the pressures of managed care. This provides a unique opportunity can also be admitted through the Massachusetts court system. All staff psychiatrists are board-certified or pursuing board certification.

President Kennedy proposed a three prong program to achieve his vision that included resocialization of the ill, ensuring the care or prevention of these illnesses, education and training of providers and teachers, and community based treatment with goal of rehabilitation and recovery (2,3). The first act, Maternal and Child Health and Mental Retardation Planning Amendment to the Social Security Act was signed on October 24, 1963 with two major funding components to update education and treatment programs and for prevention through prenatal and infant medical care. The Community Mental Health Centers Construction Act of October 31, 1963 funded facility construction funds for clinical, education, and research centers for prevention, care, and treatment of people with community based centers for the care of people with intellectual disabilities and with mental illness. At the Inauguration Ceremony President Kennedy posited, “It was said, in an earlier age, that the mind of a man is a far country which can neither be approached nor explored under present conditions of scientific achievement, it will be possible for a nation as rich in human and material resources as ours to make the remote reaches of the mind accessible. The mentally ill and the mentally retarded need no longer be alien to our affections or be beyond the help of our communities” (4).

President Kennedy’s dream captured the psychiatric nation, patients, and families to seek better outcomes for those with mental illness through research and education and the continued construction of welcoming centers within communities to care for those shunned by society. The shortened title the Community Mental Health Act appeared in 1962, the community health centers, as a part of a system of care, appeared to be well-functioning. I was assigned to the North Central Unit at Worcester State Hospital that was linked to its Catchment area community mental health center. The North Central Unit provided psychiatric care, day programs, and resources to move patients to recovery in the community. Community based patients would be referred to us if they were not needed from the community mental health center to the acute unit, once stabilized and then transitioned back to the community. New patients were similarly sent to this seamless system of community care. This system was knit together by the two team psychiatrists, Dr. Pilette on the North Central Unit at Worcester State Hospital and Dr. Honner at the North Central Unit at the Worcester Psychiatric Center; the linkage completed with a day exchange at each treatment center. Patients with a diagnosis of schizophrenia or other illnesses identified both psychiatrists as their psychiatrists and all staff shared the goal of recovery to community mental care. My experience in those weeks of this system of care, albeit in an overburdened, smoke filled state hospital, was a draw to psychiatry for me as I witnessed the need of patients with serious and persistent mental illness receiving humane care focusing on providing the best quality of life in the community.

As a resident in early 1986, I saw that in this city system, the.seemingly less evident as more patients were homeless and, as such, the community, more potherless. Despite this, case managers were available to help patients keep appointments, have necessary medications, and bring them to emergent treatment, if a t a difficulty to self care was established. The state hospital was the center of the catchment area; the community psychiatrist less evident to me, because of the distance was due to eroding sources of support for the continuity of care with the passage of the 1985 Omnibus Budget Reconciliation Act that changed federal support to the community mental health centers. State block grants, which allowed states to alter funding support to the community mental health centers (10).

During the 1990’s the Commonwealth of Massachusetts enacted legislation aimed at closing state hospitals to reduce state
As a person with lived experience, Attorney General Coakley brings a family per-sonal perspective to the personal cost of mental illness to her office. The death of her brother by sui-cide, whose bipolar disorder was untreated, is a poignant story. As Attorney General, she has used the power of the office to fight for parity and to ensure that people with be-havioral health disorders will be protected in having access to care. Soon, she will be distributing grants worth $8 million for programs for mental health and substance use disorders with funds from a suit of a pharmaceutical company. Attorney Gen-eral Coakley holds the distinction of being one of the most active Attorney Generals in protecting psychiatric patients’ rights to treatment.

The 50th anniversary celebrates not only the fact that MPS, as a district branch of the American Psychiatric Association, was created 175, but to note the dedication and tradition of psychiatrists in Massachusetts advocating for our profession, our patients. Our celebration, its venue, and its speaker will ensure a vibrant annual meeting. I look forward to seeing you on April 30th!


THE MASSACHUSETTS PSYCHIATRIC SOCIETY OFFERS MENTAL HEALTH LEGAL CONSULTATION PROGRAM TO ITS MEMBERSHIP

The PROGRAM will consist of telephone consultation and advice to the MPS membership on practice issues limited to personal practice issues for individual members in the area of risk avoidance, risk management and medical malpractice. The PROGRAM will operate during regular business hours, Monday through Friday 8:00 A.M. to 5:00 P.M. The number to call 508-734-3003 that will access Attorney James Hilliard and associates of the Law Firm of Connor & Hilliard whose practices are concentrated in the are in the mental health law. The PROGRAM will provide consultation and advice that will include but not be limited to the following areas:

1. Board of Medicine regulations, physician licensure requirements and disciplinary procedures.
2. What to do when you have received a subpoena or court order for the records of a current or former patient.
3. What to do when served with a subpoena demanding that you appear and testify at a deposition or trial regarding a current or former patient.
4. Notifying police about a patient who has stolen or altered a prescription.
5. Do you need consent to treat a minor from both parents despite a divorce.
6. Legal parameters of signing a “pink paper” when you have little knowledge of the patient.
7. A psychiatrist’s obligation to notify the police of a past crime of a current Patient.
8. A psychiatrist’s legal duty to report another physician to the Board of Medicine and its exceptions.
9. Mandatory reporting statutes in Massachusetts and their exceptions.
11. The statutory “Duty to Warn” and its exceptions.
12. Prescribing practices: what not to do and what you have to do.
13. Termination with a troublesome patient; the “write” and wrong procedure.

Consults on issues will be limited to a reasonable length of time and each MPS member will be afforded up to two [2] hours of telephone consults per year. In the event a response to an inquiry is not available at the time of the call, every effort will be made to provide a response within twenty-four [24] hours.

As the PROGRAM is limited to telephone consults that are capable of being resolved within a reasonable telephone discussion, office visits, court appearances or legal work requested by the MPS member over and above a telephone consult may be arranged with Connor & Hilliard on a private pay basis.

Gratitude to the members of the APA Committee on RBRVS, Codes and Reimbursement.

I am writing to MPS members this month with a somewhat different column from usual: this is more of an op-ed than my usual straight forward reporting of updates and changes. I hope that you will indulge me in something a bit different this month.

Over the past two years, I have reported on changes in the CPT coding system for psychiatrists that went into effect in January 2013. Although these codes are not without problems both in the documentation requirements and implementation by insurers, we in the Managed Care Committee have argued that they are more reflective of the complexity of work that psychiatrists perform in caring for patients and provide the possibility for greater remuneration and incentives for taking care of patients with a higher degree of medical risk and complexity.

MPS nominated Ronald Burd, MD, a colleague in clinical practice from Fargo, ND and Chair of the APA Committee on RBRVS, Codes and Reimbursement for an APA award due to his work on advocating for this positive change. He ultimately was chosen for the award and accepted it on behalf of the work of the Committee. An acknowledgement he well deserved.

I didn’t know the half of it, however. I recently accepted an appointment to this APA Committee and was invited to attend two AMA meetings in February, as an observer and possible future active participant on behalf of APA. These meetings were the AMA CPT (the forum for creation of new codes and changes in existing codes) and AMA RUC (the forum for the valuation and reimbursement of existing codes). These two meetings are highly structured and apply to all physicians of all specialties and to all other providers of healthcare services. There is a “firewall” between them; the creation of new codes is separate from the valuation of codes, although issues with the codes might bounce back and forth to the two committees. CMS is a participant and advisor in both meetings. AMA is a CMS contractor to create the codes via the CPT meeting. However, the valuation of codes via the RUC are merely recommendations, with CMS free to disregard, which they did last year with the new psychiatric codes, and corrected this year after a lengthy “survey” process that Dr. Burd and the APA Committee directed.

Why am I going into all this minute detail about these meetings? I feel that we are updates on APA and our psychiatric colleagues for their unsung work in advocating on behalf of psychiatrists and the complex practice of psychiatry to our colleagues in the rest of the “house of medicine”. That’s neurosurgeons, orthopedists and every other specialty. The previous codes that psychiatrists used were inconsistent and unstructured compared to other medical coding that they were slated for devaluation. Our APA colleagues successfully argued for the true complexity of psychiatric practice and were able to produce a workable new coding scheme to describe the issues of risk and medical necessity that psychiatrists face taking care of patients. They then successfully argued that these codes should be created and funded in two huge meetings, where a gain for one specialty potentially means a loss for another. As I sat in on both of these meetings I truly understood just how daunting a process this actually is and how fortunate we are to have such strong advocates sent to this meeting by APA and representing us. I listened to proposals by surgeons, radiologists and other specialists and for advocates of scores of new laboratory and radiological tests. Every advocate feels their services are essential. Our advocates were able to successfully convince all of these colleagues and competitors that psychiatric services were under-valued due to the structure of our codes and that these codes should be changed to better match up with those of other medical specialties and to allow a higher reimbursement rate based on medical risk and complexity. A monumental effort and a major victory that might bounce back and forth to the two committees of the legislature and impacts to all psychiatrists and their patients.

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So, I’d like to conclude this column by expressing my gratitude to our APA colleagues:

APA ANNOUNCES WINNERS OF THE 2014 ELECTIONS

The Committee of Tellers approved the following results for the 2014 APA National Election.

President-Elect - Renee L. Binder, MD

Treasurer - Frank W. Brown, MD

Trustee-At-Large - Anita S. Everett, MD

Area 2 Trustee - Vivian B. Pender, MD

Resident-Fellow Member Trustee-Elect (RFMETE) - Ravi N. Shah, MD

Becky Yowell is APA staff to the committee, which could not function without her.

APA Committee members who attended these meetings in February and previously:

Ronald Burd, MD & Allan Anderson, MD are our advocates to the AMA RUC

Jeremy Musher, MD & David Nace, MD are our advocates to the AMA CPT.

Thanks to all of them for all their hard work on our behalf.

Remember, all are welcome at the Managed Care Committee Meetings, which occur on the third Tuesday of the month (from 7-9 PM; dinner served!) at the MPS offices in Wellesley. Check the MPS website for details or contact me at gregoryharris@sprynet.com
At its December meeting, the APA Board of Trustees approved establishment of a Psychotherapy Task Force. The Task Force, once again psychiatrists interested in psychotherapy, have a place within the organizational structure of the APA. And it is a powerful symbol of the theory and empirical, biologically reductionistic stance of the field.

Psychotherapy has sometimes been on tenuous ground as psychotherapy’s focus has shifted toward pharmacotherapy. In the late 1990s the ACGME Psychiatry Residency Review Committee (RRC) realized that, given the biological emphasis of psychiatric training and treatment, the field was in danger of losing its validity as part of the identity, training and skill set of psychiatrists. Because of this, the RRC required that residency training include teaching several schools of psychotherapy to a measurable level of competence during residency. Training in supportive, cognitive behavioral and psychodynamic psychotherapy is now a mandated part of every residency curriculum.

Concurrent with this, the APA also recognized that psychotherapy was dwindling as part of the practice of psychiatrists, and established a Commission that later became a Committee on Psychotherapy by Psychiatrists (COPP) within the Components of the APA. Over the roughly dozen years of its existence, this committee promulgated evidence for the efficacy of psychotherapy and its association with brain change, organized psychotherapy related programs for the annual meeting and Institute on Psychiatric Services, developed a curriculum for teaching psychotherapy across schools in an integrated, evidence based way, produced APA Position Statements and information documents on psychotherapy that were adopted by the APA, and conducted a survey of psychotherapy practice patterns among US and Canadian psychiatrists.

Because of financial concerns, COPP was sunset in 2008 along with many other components of the American Psychiatric Association. Efforts to reconstitute psychotherapy were unsuccessful. However, in 2012 an Assembly Action Paper authored by Roger Plakum, MD of Wright State University, Randon Welton, MD of California at Irvine, Allison Cowan from Wright State University, Randon Welton, MD of Wright State University, Andrew Cappel from The University of Columbia, Donna Sudak from Drexel, Eve Caligor from NYU School of Medicine and Evan Leib, a resident at Mount Sinai in New York.

As determined by the Action Paper that established it, and using no APA resources, the Task Force shepherded development of a revised position statement on psychotherapy by psychiatrists. The Task Force also realized that, if a top-down APA committee on psychotherapy was not going to be formed, then it could use APA operational bylaws to develop a Psychotherapy Caucus. The Group was formally approved in December 2013.

It seems particularly auspicious that a Psychotherapy Caucus exist at this moment in time when, ironically, even as the evidence for the efficacy for psychotherapy grows, there is evidence that the provision of psychotherapy by psychiatrists is declining. In 2008 Mojtabai and Olsson reported that over the ten-year period from 1996 to 2004, the percentage of psychiatry office visits involving psychotherapy declined from 44% to 29%. In 2010 by the American Psychological Association (APA) and (replied by COPP member J. Christopher Perry and Joyce West, PhD of APIE) were reported at the Institute for Supportive Psychotherapy in Boston. By the end of 2010 there was a 20% decrease in provision of therapy to psychiatrists from 68% to 48% of office visits involving psychotherapy in 2010. The decreased use by 394 psychiatrists of involving therapy to their patients tended to be over 65, white, U.S. medical graduates, and half their patients were self-pay or uninsured. Obligations to provision of psychotherapy cited by psychiatrists included significant debt burden, lower compensation for psychotherapy compared to other services, and intrusive and time consuming utilization review burdens. Concurrent with this decline, a growing body of evidence demonstrates that multiple kinds of psychotherapy are effective for a range of single disorders and complex comorbid disorders, and that the efficacy of some medications has been overestimated by as much as a third, as in the case of anti-depressants (Turner et al 2001), and much of their effect is placebo effect (Kirsch et al 2008).

The Psychotherapy Caucus offers psychiatrists interested in psychotherapy an opportunity to communicate with one another, to network and transfer knowledge across generations. It is designed to develop symposia and workshops on psychotherapy, and learn about emerging evidence of the efficacy of psychotherapy. A Caucus meeting is planned at the APA Annual Meeting in New York, Monday, May 5th from 2-4 PM in the Riverside Suite 3rd Floor at the Sheraton New York Square Hotel.

Contact Eric Plakum at Eric.Plakun@Aus
tenRiggs.net for further information.

Establishing a Psychotherapy Caucus: MPS members lead the way
By Eric Plakum, MD

The Psychotherapy Caucus offers psychiatrists interested in psychotherapy an opportunity to communicate with one another, to network and transfer knowledge across generations. It is designed to develop symposia and workshops on psychotherapy, and learn about emerging evidence of the efficacy of psychotherapy. A Caucus meeting is planned at the APA Annual Meeting in New York, Monday, May 5th from 2-4 PM in the Riverside Suite 3rd Floor at the Sheraton New York Square Hotel.

Contact Eric Plakum at Eric.Plakun@Aus
tenRiggs.net for further information.

Save the Date
Wednesday April 30th, 2014
MPS 50th Anniversary and Annual Meeting
John F Kennedy Library Boston, MA

Our keynote speaker will be The Honorable Martha Coakley, Attorney General of the Commonwealth of Massachusetts, and

Tewksbury Hospital - Unique full time opportunity for psychiatrist comfortable with treating medically complex behaviorally challenged patients. Full time, 40 hours per week in a Medically En
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Tewksbury Hospital is looking for a full time inpatient psychiatrist. The position is on a physician supervised DIME intermediate care unit working with a highly trained and supervised interdisciplinary team. The unit is dedicated to the treatment of seriously ill, motivated patients with a psychotic illness. No managed care or after
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Bay Cove Human Services, a non-profit Hu
mans Services Provider is seeking a board eligi
ble/ board certified psychiatrist for 24-40 hours per week. Position includes serving as the psy
chiatrist for the PACT (Program for Assertive Community Treatment) program for intensive outreach for individuals with serious mental illness in the community. They are searching for a collaborative environment. Opportunity for our increasingly busy Psychiatric Emer
da Service and outpatient Addictions Re
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Full-time, salaried position for psychiatrist to join our active general hospital Department of Psychiatry. Primary responsibilities include consultation-liaison treatment of patients admitted to 24 hour psychiatric inpatient unit, consultation on psychiatrically ill patients on the medical units and collabora
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In Transitional Space: The Bereavement Exclusion and DSM-5
Ronald Pies, MD

Each month, I highlight an aspect of the DSM-5 that has undergone notable change. For January, I wrote about the elimination of the Bereavement Exclusion. Exception from an informational rather than a diagnostic perspective led me to write about the elimination of the Bereavement Exclusion. Exception from a diagnostic perspective is called for if one with an overall suicide rate of about 4%. Disqualifying a patient from a diagnosis of major depression simply because the clinical picture emerges after the death of a loved one risks closing the door on potentially life-saving interventions. The “exclusion” principle also fails to recognize that MDD can occur in a person who is highly over-smiling and non-verbal, interacting with someone who develops a major depressive symptom a few weeks after a loved one’s death may also be depressed owing to hypothyroidism, pancreatic cancer, marital problems, or a recent setback in business. It is true that the DSM-IV criteria provided a way to “overrule” or “override” the index exclusion; for example, if the depressed, bereaved patient were psychotic, suicidal, somatically ill, or had another condition (such as with feelings of worthlessness, or functioning very poorly in daily life. Unfortunate-ly, only studies with fewer features of depression, those bereaved patients whose depressive symptoms were indeed severe, but who did not meet the criteria for major depression were specified participants in an ongoing contentious debate. Sometimes fueled by sensational or misleading news reports, the clinical significance—and a reduced tendency to recur does not necessarily mean a person was depressed. In truth, the DSM-5 criteria for major depression are no longer simply based on the subset of all persons with major depression. Hamdan et al9 studied a cohort of patients with depression who were not matched for severity, duration, or age. Under the DSM-IV “rules”, these seriously depressed individuals probably would not have received a diagnosis of MDD and appropriate treatment. It is sometimes argued that bereaved, suicidal patients would not have been excluded from an MDD diagnosis, using the DSM-IV override “rules.” In theory, that was true. But not every depressed patient openly acknowledges suicidal ideation or intentions to die. Put another way: bereavement does not immunize the patient against major depression and, frequently precipitates it. Indeed, grief and depression—despite some overlapping symptoms, like sadness, sleep disturbance and decreased appetite—are distinct constructs, and one does not preclude the other. The bereavement exclusion was eliminated from the DSM-5 for two main reasons: (1) it had never been adopted in any other psychiatrically rigorous and well-timed, clinical studies showing that major depressive syndromes following bereave-ment might be regarded as a normal grief reaction (as defined by DSM-5) but rather, as a major depression—likely a potentially lethal disorder, with an overall suicide rate of about 4%. Disqualifying a person from a diagnosis of major depression simply because the clinical picture emerges after the death of a loved one risks closing the door on potentially life-saving interventions. The “exclusion” principle also fails to recognize that MDD can occur in a highly over-smiling and non-verbal, interacting with someone who develops a major depressive symptom a few weeks after a loved one’s death may also be depressed owing to hypothyroidism, pancreatic cancer, marital problems, or a recent setback in business.

neither factor was specifically included in the DSM-IV’s list of features that allowed one to receive an override to the bereavement exclusion. The preponderance of data suggest that, compared to other MDD cases in any other psychiatrically rigorous clinical studies, such as job loss or recent divorce—or to MDD arising “out of the blue”—the bereavement-related depression (BRD) differs very little in symptom picture, course, outcome, or response to treat-ment. Thus, there is no justification for or “privileging” BRMD for exclusion.

As Dr. MacMillan noted, there have been some recent epidemiological studies that appear to show lower risk of recurrence for some types of BRMD, compared with “standard” (non-bereavement) MDD.7,8,9 These data—derived from ECA (Epide-mic Catchment Areas) and National Epidemiologic Survey on Alcohol and Related Conditions surveys of community residents—were obtained by lay interviewers; and, as with all surveys, are subject to recall bias on the part of participants. More important, subjects in the two groups (BRMD vs. “standard” MDD) were not matched for severity, duration, or age. Under the DSM-IV rules, those bereaved-related depression had “clinically significant depressive episode(s)”—i.e., episodes that “qualify” for major depression, with feelings of worthlessness, or functioning very poorly in daily life. Unfortunately, only studies with fewer features of depression, those bereaved patients whose depressive symptoms were indeed severe, but who did not meet the criteria for major depression were specified participants in an ongoing contentious debate. Sometimes fueled by sensational or misleading news reports, the clinical significance— and a reduced tendency to recur does not necessarily mean a person was depressed. In truth, the DSM-5 criteria for major depression are no longer simply based on the subset of all persons with major depression. Hamdan et al9 studied a cohort of patients with depression who were not matched for severity, duration, or age. Under the DSM-IV “rules”, these seriously depressed individuals probably would not have received a diagnosis of MDD and appropriate treatment. It is sometimes argued that bereaved, suicidal patients would not have been excluded from an MDD diagnosis, using the DSM-IV override “rules.” In theory, that was true. But not every depressed patient openly acknowledges suicidal ideation or intentions to die. Put another way: bereavement does not immunize the patient against major depression and, frequently precipitates it. Indeed, grief and depression—despite some overlapping symptoms, like sadness, sleep disturbance and decreased appetite—are distinct constructs, and one does not preclude the other. The bereavement exclusion was eliminated from the DSM-5 for two main reasons: (1) it had never been adopted in any other psychiatrically rigorous and well-timed, clinical studies showing that major depressive syndromes following bereave-ment might be regarded as a normal grief reaction (as defined by DSM-5) but rather, as a major depression—likely a potentially lethal disorder, with an overall suicide rate of about 4%. Disqualifying a person from a diagnosis of major depression simply because the clinical picture emerges after the death of a loved one risks closing the door on potentially life-saving interventions. The “exclusion” principle also fails to recognize that MDD can occur in a highly over-smiling and non-verbal, interacting with someone who develops a major depressive symptom a few weeks after a loved one’s death may also be depressed owing to hypothyroidism, pancreatic cancer, marital problems, or a recent setback in business.
rental loss; and (3) a non-bereaved control group with depression (n = 30). The study found that bereavement-related depression was similar to LBD and CD, with respect to number of symptoms, severity, functional impairment, duration, and risk for recurrence. While the study population was small and limited to youths, the authors concluded that their findings “support the removal of the bereavement exclusion.”

It is important to understand that the DSM-5 criteria merely allow the diagnosis of MDD when the recently bereaved person meets all required symptom, severity, duration, and impairment criteria for MDD. Nothing in the manual compels a diagnosis of MDD after bereavement. The DSM-5 clearly states that “...periods of sadness are inherent aspects of the human experience. These periods should not be diagnosed as major depressive episodes unless criteria are met for severity...duration...and clinically significant distress or impairment.” (DSM-5, American Psychiatric Association, 2013 p. 168)

Indeed, if the clinician’s best judgment—and, as Dr. MacMillan wisely noted, sound judgment in medicine points to normal, bereavement-related grief, the “V” Code of “Uncomplicated Bereavement” (V62.82) may be used. (The “V” codes, of course, are not “mental disorders”). The DSM-5 provides useful guidance on when to apply MDD in the post-bereavement period; e.g., the footnote on p. 161 of the manual lists several features that help differentiate ordinary grief from a major depressive episode. For example, in bereavement-related grief, self-esteem is usually preserved; in MDD, feelings of worthlessness and self-loathing are common. In ordinary grief, the emotional pain is usually accompanied by positive emotions and fond recollections of the deceased; in MDD, pervasive misery and unhappiness are typical. Another important difference noted by Dr. Coryell was Dr. Kay R. Jamison in her book, Nothing Was the Same—is that the normally grieving person is “consolable” by friends, family, and even literature; the person with MDD usually is not.

To be sure, the two week minimum duration for diagnosing MDD is often too brief to reach a confident diagnosis, particularly in the post-bereavement period. But this 2-week duration criterion has applied to all instances of MDD (e.g., after job loss, divorce, etc.) since the DSM-III appeared in 1980. (Curiously, few critics of the DSMs objected to the two-week period until the matter of bereavement arose, in advance of the DSM-5). Moreover, in clinical practice, it is quite rare for a patient with “normal grief” to seek professional treatment within two weeks of the death of a loved one. When medical treatment is sought so soon after a death, the patient usually has “self-selected” treatment, owing to profound distress or incapacity; or (b) has been referred by family members, who believe the patient is suicidal, psychotic, or unable to carry out the activities of daily living. Under such dire circumstances, the DSM-IV bereavement exclusion would not have applied anyway. As for the fear that removal of the bereavement exclusion will lead to hospitalization of bereaved patients being inappropriately diagnosed with MDD, the epidemiological data do not support this view. For example, in the overall NÉSARC sample, only 0.5% of subjects met criteria for “bereavement-excluded depression.”

Finally, nothing in the DSM-5 will prevent the prudent clinician from undertaking a period of “watchful waiting” during the first few weeks after a bereaved patient presents with depressive symptoms, in order to ascertain the “trajectory” of the patient’s condition. Some patients will show a normal marked improvement in their depressive symptoms, even though their grief—quite understandably—may persist for weeks, months, and even years. (Note to frequent misrepresentations in the press, the DSM-5 sets no pre-ordained “time limit” on normal grief). Even if post-bereavement MDD is diagnosed, nothing compels the psychiatrist to begin antidepressant treatment. For mild-to-moderate, non-melancholic presentations of MDD, “talk therapy” alone may suffice. As for concerns that primary care doctors will be induced by the new criteria to prescribe antidepressants inappropriately, my colleagues and I believe the hypothetical concern is best addressed through continued medical education and enhanced psychiatric consultation with PCPs—not by preemptive guidelines in our diagnostic criteria for MDD.2,18

In sum: while the data are not conclusive, the best available evidence suggests that the DSM-5 was justified when it eliminated the bereavement exclusion. No, we must not “medicalize” normal grief—but even if we should “normalize” the serious disorder of major depression, simply because it occurs in the context of bereavement.

Dr. Pies is a member of MPS, and is Clinical Professor of Psychiatry at Tufts University School of Medicine. He wishes to thank Dr. MacMillan and Bev Dunbar for the opportunity to provide this guest column.

References


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Each month, I highlight the aspect of the DSM-5 that has undergone notable changes. I wrote about the elimination of the Bereavement depression. Exclusion from an informational rather than editorial perspective was noted because I hear from MPsy member Dr. Ronald Pies that as someone with expertise in the area of bereavement, he was providing
members with an editorial perspective in favor of the exclusion being eliminated. I encourage other MPS members to contact me if they would like to participate in future columns or have suggestions regarding an area that is of interest to them in the context of a future column. Please welcome Dr. Pies as a guest columnist this month!- Carole Macmillan, MD, cmacmillan@partners.org

In her recent “Transitional Space” column, Dr. Carole Macmillan nicely summarized many of the controversies surrounding the removal of the so-called “bereavement-depression” (BD), in DSM-5. Without question, this was one of the most contentious decisions the DSM-5 Task Force struggled with, and by some lights, the most controversial decision by the APA since homosexuality was removed from DSM-I. While I was not directly involved with the DSM-5 mood disorders work group, I was specifically involved in some contentious debate about BD (2), sometimes fueled by sensational and misleading claims in the media; for example, by claims that “psychiatrists want to make normal grief a mental disorder,” or that, “DSM-5 medicalizes mourning.” It is true that the DSM-5 criteria provide a definition of bereavement depression that is somewhat narrower than the DSM-IV criteria. For example, if the depressed, bereaved patient was psychotic, suicidally preoccupied, or subject to feelings of worthlessness, or functioning very poorly in daily life, then major depression was carried out; whereas, many patients whose depressive symptoms were severe but, who did not meet specific criteria for MDD. However, for bereaved persons whose depressive symptoms were moderate in severity, the DSM-IV criteria did not allow the diagnosis of “bereavement depression.” Thus, the DSM-5 criteria for “bereavement depression” are, in my view, more consistent with the clinician’s experience that after the death of a loved one, many depressed individuals individuals probably would not have received a diagnosis of MDD and appropriate treatment.

In truth, the DSM-5 criteria for major depression differ in nature, course, or outcome for some types of BRMD, compared with “standard” MDD. Moreover, the risk of suicide in bereaved persons was found to be lower than the general population. However, one recent study used rigorous methodological approaches to determine whether bereaved individuals were subject to recall bias on the part of participants. More important, subjects in the bereaved groups were assessed for symptoms, severity, and mortality. Participants in the bereaved group were also assessed for symptoms, severity, and mortality.

The preponderance of data suggests that, in general, bereaved individuals probably would not have received a diagnosis of BRMD or “standard” MDD. However, the DSM-5 criteria do provide a definition of bereavement depression that is somewhat narrower than the DSM-IV criteria. For example, if the depressed, bereaved patient was psychotic, suicidally preoccupied, or subject to feelings of worthlessness, or functioning very poorly in daily life, then major depression was carried out; whereas, many patients whose depressive symptoms were severe but, who did not meet specific criteria for MDD. However, for bereaved persons whose depressive symptoms were moderate in severity, the DSM-IV criteria did not allow the diagnosis of “bereavement depression.” Thus, the DSM-5 criteria for “bereavement depression” are, in my view, more consistent with the clinician’s experience that after the death of a loved one, many depressed individuals probably would not have received a diagnosis of MDD and appropriate treatment.

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Estabishing a Psychotherapy Caucus: MPS members lead the way
By Eric Plakum, MD

At its December meeting, the APA Board of Trustees approved establishment of a Psychotherapy Caucus. The APA’s interest in psychotherapy has diminished over time and once again psychiatrists interested in psychotherapy have a place within the organizational structure of the APA. And it is a step in the right direction that the APA, in its biennial report, has recognized the biologically reductionist stance of the field.

Psychotherapy in psychiatry has sometimes been on tenuous ground as psychiatry’s focus has shifted toward pharmacotherapy. In the late 1990s the ACCME Psychiatry Residency Review Committee (RRC) realized that, given the biological emphasis of psychiatric training and treatment, the field was in danger of losing its identity as a part of the identity, training, and skill set of psychiatrists. Because of this, the RRC required that residency training include teaching several schools of psychotherapy to a measurable level of competence during residency. Training in supportive, cognitive behavioral and psychodynamic psychotherapy is now a mandated part of every residency curriculum. Concurrently the APA also recognized that psychotherapy was dwindling as part of the practice of psychiatrists, and established a Commission that later became a Committee on Psychotherapy by Psychiatrists (COPP) within the Components of the APA. Over the roughly dozen years of its existence, this committee promulgated evidence of ineffectiveness of psychotherapy and its association with brain change, organized psychotherapy related programs for the annual meeting and Institute on Psychiatric Services, developed a mission to train psychiatrists in becoming psychotherapy across schools in an integrated, evidence based way, produced the APA Position Statements and information pamphlets on psychotherapy that were adopted by the APA, and conducted a survey of psychotherapy practice patterns among psychiatrists and residents. Because of financial concerns, COPP was sunset in 2008 along with many other components of the American Psychiatric Association. Efforts to save COPP and preserve psychotherapy were unsuccessful. However, in 2012 an Assembly Action Paper authored by Roger Peele led to the creation of a Psychotherapy Task Force in the APA Assembly. The 12 member Task Force includes 4 Massachusetts psychiatrists: Eric Plakum, MD, Stoneham; Stephen Vladyk and Elizabeth Weinberg, all medical staff members at Austen Riggs. Other members include Paul Lieberman from New York, Bart Blinder from the University of California at Irvine, Allison Cowan from Wright State University, Randon Welton from the APA system, Andrew C. Weil from Columbia, Donna Sudak from Drexel, Eve Caligor from NYU School of Medicine and Evan Lieb, a resident at Mount Sinai in New York.

As determined by the Action Paper that established it, and using no APA resources, the Task Force prepared and presented a revised position statement on psychotherapy by psychiatrists. The Task Force also realized that, if a top-down APA committee on psychotherapy was not going to be formed, then it could use APA operational bylaws to develop a Psychotherapy Caucus. Two sets of draft letters were gathered and mailed to APA president elect and MPS member Paul Summergrad, who took the request to the APA Board of Trustees, where a Psychotherapy Caucus was formally approved in December 2013.

It seems particularly auspicious that a Psychotherapy Caucus exist at this moment in time when, ironically, even as the evidence for the efficacy of psychotherapy grows, there is evidence that the provision of psychotherapy by psychiatrists is declining. In 2008 Mojtabai and Olfson reported that from 2002 to 2010 there was a 20% decline in provision of therapy to patients by psychiatrists from 68% to 48% of office visits involving psychotherapy. As determined by the Action Paper that established the APA Psychotherapy Caucus, psychiatrists interviewed reported that significant burden debt, lower compensation for psychotherapy compared to other services, and intrusive and time-consuming utilization review burdens. Concurrent with this decline, a growing body of evidence demonstrates that multiple kinds of psychotherapy are effective for a range of single disorders and complex comorbid disorders. The APA also realized that, if a top down APA committee on psychotherapy was not going to be formed, then it could use APA operational bylaws to develop a Psychotherapy Caucus. The Psychotherapy Caucus offers psychiatrists interested in psychotherapy an opportunity to communicate with one another, to network and transfer knowledge across genera.
THE MASSACHUSETTS PSYCHIATRIC SOCIETY OFFERS MENTAL HEALTH LEGAL CONSULTATION PROGRAM TO ITS MEMBERSHIP

The PROGRAM will consist of telephone consultation and advice to the MPS membership on practice issues limited to personal practice issues for individual members in the area of risk avoidance, risk management, and medical malpractice. The PROGRAM will operate during regular business hours, Monday through Friday 8:00 A.M. to 5:00 P.M. The number to call 508-734-3003 that will access Attorney James Hilliard and associates of the Law Firm of Connor & Hilliard whose practices are concentrated in the area in the mental health law. The PROGRAM will provide consultation and advice that will include but not be limited to the following areas:

1. Board of Medicine regulations, physician licensure requirements and disciplinary procedures.
2. What to do when you have received a subpoena or court order for the records of a current or former patient.
3. What to do when served with a subpoena demanding that you appear and testify at a deposition or trial regarding a current or former patient.
4. Notifying police about a patient who has stolen or altered a prescription.
5. Do you need consent to treat a minor from both parents despite a divorce.
6. Legal parameters of signing a “pink paper” when you have little knowledge of the patient.
7. A psychiatrist’s obligation to notify the police of a past crime of a current Patient.
8. A psychiatrist’s legal duty to report another physician to the Board of Medicine and its exceptions.
9. Mandatory reporting statutes in Massachusetts and their exceptions.
11. The statutory “Duty to Warn” and its exceptions.
12. Prescribing practices: what not to do and what you have to do.
13. Termination with a troublesome patient; the “write” and wrong procedure.

Consults on issues will be limited to a reasonable length of time and each MPS member will be afforded up to two [2] hours of telephone consults per year. In the event a response to an inquiry is not available at the time of the call, every effort will be made to provide a response within twenty-four [24] hours.

As the PROGRAM is limited to telephone consults that are capable of being resolved within a reasonable telephone discussion, office visits, court appearances or legal work requested by the MPS member over and above a telephone consult may be arranged with Connor & Hilliard on a private pay basis.

Gratitude to the members of the APA Committee on RBRVS, Codes and Reimbursement:

I am writing to MPS members this month with a somewhat different column from usual: this is more of an op-ed than my usual straightfoward reporting of updates and changes. I hope that you will indulge me in something a bit different this month.

Over the past two years, I have reported on changes in the CPT coding system for psychiatrists that went into effect in January 2013. Although these codes are not without problems both in the documentation requirements and implementation by insurers, we in the Managed Care Committee have argued that they are more reflective of the complexity of work that psychiatrists perform in caring for patients and provide the possibility for greater remuneration and incentives for taking care of patients with a higher degree of medical risk and complexity.

MPS nominated Ronald Burd, MD, a colleague in clinical practice from Fargo, ND and Chair of the APA Committee on RBRVS, Codes and Reimbursement for an APA award due to his work on advocating for this positive change. He ultimately was chosen for the award and accepted it on behalf of the work of the Committee. An acknowledgement he well deserved.

I didn’t know the half of it, however. I recently accepted an appointment to this APA Committee and was invited to attend two AMA meetings in February, as an observer and possible future active participant on behalf of APA. These meetings were the AMA CPT (the forum for creation of new codes and changes in existing codes) and AMA RUC (the forum for the valuation and revaluation of existing codes). These two meetings are highly structured and apply to all physicians of all specialties and to all other providers of healthcare services. There is a “firewall” between them; the creation of new codes is separate from the valuation of codes, although issues with the codes might bounce back and forth to the two committees. CMS is a participant and advisor in both meetings. AMA is a CMS contractor to create the codes via the CPT meeting. However, the valuation of codes via the RUC are merely recommendations, with CMS free to disregard, which they did last year with the new psychiatric codes, and corrected this year after a lengthy “survey” process that Dr. Burd and the APA Committee directed.

Why am I going into all this minute detail about these meetings? I feel that we are indebted to APA and our psychiatric colleagues for their unsung work in advocating on behalf of psychiatrists and the complex practice of psychiatry to our colleagues in the rest of the “house of medicine”. That’s neurosurgeons, orthopedists and every other specialty. The previous codes that psychiatrists used were not consistent and unequally compared to other medical coding that they were slated for devaluation. Our APA colleagues successfully argued for the true complexity of psychiatric practice and were able to produce a workable new coding scheme to describe the issues of risk and medical necessity that psychiatrists face taking care of patients. They then successfully argued that these codes should be created and funded in two huge meetings, where a gain for one specialty potentially means a loss for another. As I sat in on both of these meetings I truly understood just how daunting a process this actually is and how fortunate we have to have such strong advocates sent to this meeting by APA and representing us. I listened to proposals by surgeons, radiologists and other specialists and for advocates of scores of new laboratory and radiological tests. Every advocate feels their services are essential. Our advocates were able to successfully convince all of these colleagues and competitors that psychiatric services were under-valued due to the structure of our codes and that these codes should be changed to better match up with those of other medical specialties and to allow a higher reimbursement rate based on medical risk and complexity. A monumental effort and a major victory that will indulge me in something a bit different this month.
As a person with lived experience, Attorney General Coakley brings a family profile to the personal cost of mental illness to her office. The death of her brother by suicide, whose bipolar disorder was untreated, is a poignant story. As Attorney General, she has used the power of the office to fight for parity and to ensure that people with behavioral health disorders will be protected in having access to care. Soon, she will be distributing grants worth $8 million for programs for mental health and substance use disorders with funds from a suit of a pharmaceutical company. Attorney General Coakley holds the distinction of being one of the most active Attorney Generals in protecting psychiatric patients’ rights to treatment.

The 50th anniversary celebrates not only the fact that MPS, as a district branch of American Psychiatric Association, was created in, but to note the dedication and tradition of psychiatrists in Massachusetts advocating for our profession, our patients. Our celebration, its venue, and its speaker will ensure a vibrant annual meeting. I look forward to seeing you on April 30th!


Respectfully,

Janet E. Osterman, M.D., M.S.
President
Mass Psychiatric Society

2014 RISK AVOIDANCE & RISK MANAGEMENT UPDATE
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8:30am - 3:30pm

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EOE
President Kennedy spoke of “a bold new approach” that envisioned a collabora-
tion of federal, state, and local govern-
ments working with private foundations and other groups to continue to implement and improve the care for these vulnerable citizens to return them to the family, community, and workplace of life, whenever possible, or more humane care if the person needed hospitalization, acute or chronic (1,2). He stated, “When carried out, the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and empathy.Bias on prevention, treatment, and rehabilitation will be withdrawn for a duty serous in inferring patients in an institution to wither away” (2,3).

President Kennedy proposed a three prong program to achieve his vision that included residually ill citizens, treatment of these illnesses, education and training of providers and teachers, and community based treatment with goal of rehabilitation and recovery (2,3). The first act, Maternal and Child Health and Mental Retardation Planning, Amendment to the Social Security Act was signed on October 24, 1963 with two major funding compo-
ents to update education and treatment programs and for prevention through pre-
natal and infant medical care. The Commu-
nity Mental Health Centers Construction Act of October 31, 1963 aided fared facility construction funds for clinical, education, and research centers for prevention, care, and case management, community based centers for the care of people with intellectual disabilities and with mental illness. The 1963 presidential ‘Great Society’ Presi-
dent Kennedy passed, “It was said, in an earlier age, that the mind of a man is a far country which neither can be approached nor explained in under prevailing conditions of scientific achievement, it will be possible for a nation as rich in human and mental resources as ours to make the remote reaches of the mind accessible. The mentally ill and the mentally retarded need no longer be alien to our affections or be-
hind the help of our communities” (1,2).

President Kennedy’s dream captured the psychiatric nation, patients, and families to seek better outcomes for those with men-
tal illness through research and education and a commitment to the improvement of welcoming centers within communities to care for those shunned by society. The shortened
title the Community Mental Health Act ap-
peared in 1962, the community health centers, as a part of a system of care, appeared to be well-functioning. I was assigned to the Community Mental Health Center (CMHC) in Worcester, MA that was linked to its Catchment area community mental health center. The Massachusetts community center provided psychi-
atrie care, day programs, and resources to move patients to recovery in the commu-
nity. Community based patients would be treated in the catchment area, not necessarily from the community mental health center to the acute unit, once stabilized in treatment, patients would then transition back to the community. New patients were similarly sent to this seamless system of community care. This system was knit together by the two team psychiatrists, Dr. Pilette on the North Cen-
tral Unit at Worcester State Hospital and Dr. Dr. Bonner at the community mental health cen-
ter, the linkage completed with a day ex-
changed at each treatment center. Patients with a diagnosis of schizophrenia, as illness, had consistently identified both psychiatrists as their psychi-
artists and all staff shared the goal of re-
covery and continuity of mental health care. My work with these patients with serious and persistent men-
tal illness receiving humane care focusing on providing the best quality of life in the community.

As a resident in early 1986, I saw that in the midst of a city system, the needlessness and less evident as more patients were home-
less and, as such, the community, more poor and isolated. In this regard, case man-
ergists were available to help patients keep ap-
pointments, have necessary medications, and bring them to emergent treatment, if a danger to self or others. At the established time state hospital was the center of the catch-
ment area; the community psychiatrist less evident and the potential for this difference was due to eroding sources of support for the continuity of care with the passage of the 1985 Omnibus Budget Re-
conciliation Act that changed federal sup-
port to the community mental health cen-
ters to state block grants, which allowed states to alter funding support to the commu-
nity health centers (1,2,5).

During the 1990’s the Commonwealth of Massachusetts enacted legislation aimed at closing state hospitals to reduce state (continued on page 1)
RESIDENT FELLOW MEMBER CORNER
Auralyd Padilla, M.D.

Four years ago I found out that I was moving to Massachusetts. Aside from the change in weather, it did not seem that daunting at the time to think of “jumping the puddle”, as we have back home. One of the issues that were pressing in my mind, was the fact that I always thought I would become a doctor to help people on this island. But, seeing the diversity of cultures, and ethnicities that UAMSS attends, particularly the Latino community, made me feel like I would still have a chance to serve a piece of my country from far away. As a Latino resident fellow member, working with Latino patients, and listening to their views on their cultural differences, and expectations for treatment, has been eye opening, and thought provoking. Many, even after living in the states for many years, believe that having a clinician from their ethnic group would make it easier for them to be understood and better served. I have thought a lot about this perception, and believe that it is a complicated issue for both the patients, and for the people trying to care for them.

At first, feeling that extra connection with Latino patients was a blessing, but I have realized the big responsibility it is. I also believe that it can be unfair for other doctors with different cultural backgrounds who are capable, and interested in taking care of these patients. On the other hand, even though Puerto Rico is a territory of the United States, and we are raised with plenty of respect to access American culture, there are multiple ways in which my customs and beliefs are different, so I experience how this affects communication and relationships for me. I can see where these patients are coming from.

Multiculturalism continues to grow in the United States. In Massachusetts there is approximately 25% of non-white population, so it is fair to say that during our training and career we will be faced with the situation of having to care for a patient of a different ethnic and cultural background. As mental health providers we need to consider how a patient’s own beliefs, traditions, and understandings affect the presentation of their symptoms, and attitude towards treatment. This topic should be an ongoing conversation and for this reason I am very excited to announce that the Massachusetts Psychiatry Society has opened a new Multicultural Psychiatry Committee, to be chaired by Dr. Astrid Dessoriers.

The purpose of this group is for psychiatrists in Massachusetts to have a place to discuss issues that we face when treating diverse populations, learn from each other’s experiences, and promote cultural competence. This would be a great way for us, resident fellow members interested in multicultural psychiatry, to pair up with mentors that can help us foster our ideas. This group would also be a good way to advocate for improved access to care, and parity for all patients.

I am very enthusiastic about the opportunity to get together with a diverse group that shares an interest in serving, and better understanding the broad range of patients we serve.

Please join us in a “Meet and Greet” at the MPS headquarters in Wellesley on April 9th at 6:30PM. I look forward to seeing you.

MPS IS PLEASED TO WELCOME THE FOLLOWING NEW MEMBERS

Resident General Members: Andrea Stone, MD

Resident Fellow Members:
\- Shadhwat Pandhi, MD
\- Shreedhar Paudel, MD
\- Olaide Fawehinmi, MD
\- Anthony Rocco Giovanone, MD
\- Supritha Arjaul, MD
\- Carrie Melissa Cunningham, MD
\- Kimberly Leventhal, MD
\- John M. Teal, MD
\- Jennifer Leah Goetz, MD
\- Vanessa Marie Myles, MD
\- Jose Rengifo, MD
\- Genny J Feinberg, MD
\- Rajan Gosain, MD
\- Justin Johnson, MD
\- Neeta Sharma, MD

Transfer In:
\- Lilijana Markovic, MD

March 11
Methadone and Buprenorphine: Clinical Impact of Drug Interactions
Elinore McCance-Katz, MD, PhD,Chief Medical Officer, Substance Abuse and Mental Health Services Administration www2.gotomeeting.com/register/800461818

April 8
The Psychology of AA and Its Role in Clinical Care
Marc Galanter, MD
Director of the Division of Alcoholism and Drug Abuse, NYU www2.gotomeeting.com/register/809088138

May 13
Managing Pain in Patients With An Addiction History
Janice F. Kauffman RN, MPH, LADC , CAS
Vice President, Addiction Treatment Services North Charles Foundation, Inc.
Assistant Professor of Psychiatry, Harvard Medical School www2.gotomeeting.com/register/56690482

June 10
Assessment and Management of Opioid Use Disorders in the General Hospital Setting
Joji Sato, MD
Director, Division of Addiction Psychiatry
Instructor in Psychiatry, Harvard Medical School
Director of the Division of Alcoholism and Drug Abuse, NYU www2.gotomeeting.com/register/412846618

July 8
Treatment Options for Opioid Dependence: A Role for Agonists vs. Antagonists
Maria A. Sullivan, MD, PhD
Associate Professor of Clinical Psychiatry
Division on Substance Abuse and Addiction
Columbia University and NYSPI www2.gotomeeting.com/register/744246234

2014 Webinar Schedule
FREE sessions are scheduled from noon to 1 p.m. Eastern
CME and Certificates of Participation Available

- March 11
- April 8
- May 13
- June 10
- July 8
- August 26
- September 9
- October 14

ARCHIVED WEBINARS
Accessible at www.APAeducation.org and www.pcssmat.org

DSM-5: Substance Related and Addictive Disorders
Charles P. O'Brien, MD, PhD
Center for Studies of Addiction
Professor, Department of Psychiatry
University of Pennsylvania School of Medicine
Using Medication Assisted Treatment with Veterans for Opioid, Alcohol, and Tobacco Use Disorders
Andrew J. Saxon, MD
Professor of Psychiatry, University of Pennsylvania School of Medicine

Providers’ Clinical Support System for Medication Assisted Treatment is funded by the Substance Abuse and Mental Health Services Administration
Consult www.pcssmat.org for an array of clinical resources

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Fax: 781-237-7625 ♦ Email: mps@psychiatry-mps.org ♦ www.psychiatry-mps.org

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781-237-8100 ♦ Fax: 781-237-7625 ♦ Email: mps@psychiatry-mps.org ♦ www.psychiatry-mps.org
The Massachusetts Psychiatric Society will celebrate its 50th anniversary on April 30, 2014 and I hope that you will join us! As with all Golden Anniversary’s, this event has much meaning and requires thoughtful planning with the hope that all will attend and enjoy the celebrations. The three primary plans to achieve are: the date, the place, and the keynote speaker. The date is always easy as it is pre-determined by the anniversary. The next task is to find a place to celebrate that has special meaning to most members and a significant link to the organization. The final task is the selection of a speaker, preferable someone who has made major efforts to promote the interests of the organization through public service or organizational leadership, or someone who knows deeply the suffering and needs of those who have had or recovered from mental illness and/or substance use disorders through his or her personal experience or family life.

The location for our 50th anniversary is the John F. Kennedy Presidential Library and Museum in Columbia Point, Boston. This selection recognizes that the birth of MPS came in the same year as President Kennedy’s Community Mental Health Centers Construction Act or more commonly called the Community Mental Health Act that heralded a new era in mental health care delivery. Celebration of two significant events that impacted the practice of psychiatry in Massachusetts will be blended with our 50th Annual Meeting celebration.

The John F. Kennedy Library as the venue pays tribute to the dream that President Kennedy articulated for those suffering mental illness and mental retardation (now referred to as intellectual disabilities). His vision, presented to the nation on February 5, 1963, described a society that strove to move institutionalized patients to a meaningful life in the community. This eloquent speech set the stage for two bills that were to forever change the approach to helping people with mental illness and intellectual disabilities, the Maternal and Child Health and Mental Retardation Planning Amendment to the Social Security Act (October 24, 1963) and the Mental Retardation and Community Mental Health Centers Construction Act (October 31, 1963).

These bills began the evolution of a series of subsequent federal and state bills to address the inequities in care for citizens with behavioral health (the umbrella term for the expanded focus on psychiatric disorders and substance use disorders) and intellectual disabilities.

In this pivotal speech President Kennedy defined the plight of people with mental illness and intellectual disabilities. Selected quotes reflect not only his eloquence but his compassion and commitment to care of these marginalized citizens (see Reference 2 for the complete speech).

“mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single event. ‘Most of them are confined and compressed within an antiquated, vastly overcrowded, chain of custodial State institutions. The average amount expended on their care is only $4 a day--too little to do much good for the individual, but too much if measured in terms of efficient use of our mental health dollars.’ “But the anguish suffered both by those afflicted and by their families transcends financial statistics.”

This situation has been tolerated far too long. It has troubled our national conscience—but only as a problem unpleasant to mention, easy to postpone, and despairing of solution. “Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release.”

(continued on page 3)