The Residents' JOURNAL

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Inside

In This Issue

This issue of the *Residents' Journal* features articles on the theme of advocacy in psychiatry. Nina V. Kraguljac, M.D., M.A., and Sourav Sengupta, M.D., M.P.H., discuss the role of advocacy in residency training and provide information on opportunities for residents to engage in advocacy efforts. Joanna Quigley, M.D., presents the results of a survey on residents' perceptions, knowledge, and practices related to advocacy. John O. Lusins III, M.D., and Kavara S. Vaughn, M.D., discuss the role of the chief resident as advocate. Alik S. Widge, M.D., Ph.D., outlines the importance of advocacy to the career of the aspiring academic psychiatrist. Last, Annemarie Mikowski, D.O., shares with us the eye-opening experience of a group of residents who participated in a suicide prevention community walk.

Editorial

Reflections and Transitions

Sarah M. Fayad, M.D.
Editor-in-Chief

The academic year is nearing an end, and with that, my year of serving as Editor-in-Chief is coming to a close. It has been a wonderful privilege to serve in this capacity, and I have thoroughly enjoyed working with authors, reviewers, and guest section editors from around the country to build strong issues of the *Residents' Journal*. It has been an honor to work with the editorial staff of the A*merican Journal of Psychiatry* as well.

I would like to express my gratitude to Dr. Joseph Cerimele, who served as Senior Editor this academic year. He has also served as a mentor over the past 2 years and worked diligently to make each issue of our journal better than the last. He even graciously stepped seamlessly into my role as Editor when I was out on maternity leave. His term at the *Residents' Journal* is coming to a close as well, and while we will miss his presence and innovative ideas, we wish him the best in his future endeavors.

Dr. Monifa Seawell, this year's Associate Editor and an incoming forensic fellow at Case Western Reserve University, will be moving into the role of Editor-in-Chief. She will be joined by our new Associate Editor, Dr. Arshya Vahabzadeh, who will be a PGY-3 resident at Emory University. I will continue working with the *Residents' Journal* in the position of Senior Editor.

This has been a year of growth for the *Residents' Journal*. We are happy to see the interest that has been generated in the Journal this past year. This has resulted in a large number of high-quality manuscripts, with an increasing number of articles authored not only by residents, but by medical students as well. We have seen residents build their skills as peer reviewers as well as guest section editors. A new feature, Point-Counterpoint, was introduced this year. This feature allows residents to present opposing scholarly discussion about a particular clinical situation or question. We plan to continue this feature on a quarterly basis in the coming academic year. It is our hope that the skills trainees build in working with the *Residents' Journal* will help to prepare them to make contributions to the scientific literature throughout their careers. I would like to express my gratitude to the authors, reviewers, and guest section editors who have worked to make this an excellent year at the *Residents' Journal*.

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The Resident as Advocate in Psychiatry

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The role of the physician has not only been defined as that of medical expert, but also as communicator, collaborator, manager, scholar, professional, and health care advocate (1). Residency is a time to prepare us for these roles.

The Accreditation Council for Graduate Medical Education has defined six core competencies that are assessed during residency (2). We are expected to 1) act professionally, 2) be skilled in interpersonal communication, 3) demonstrate medical knowledge, 4) provide effective patient care, 5) show awareness of the system of care in which we are practicing, and 6) display commitment to practice-based life-long learning. While core competencies match up with most of the roles we fulfill in our professional lives, notably, advocacy is not explicitly listed as one of them.

The Alliance for Justice has defined advocacy as any action that "speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others" (3). The American Medical Association declaration of professional responsibilities states that physicians must "advocate for the social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being"(4). However, the general concept of advocacy remains problematic because it is undefined in both scope and practice (5).

Both practicing physicians and residents generally acknowledge a health-advocate role as part of their social responsibility to society as physicians (6, 7). However, 74% of residents polled in one survey reported that they were not engaged in health advocacy activities (8). Lack of time, insufficient rest, and high-stress environments were cited by residents as barriers to engage in such activities (8). Another study found that residents who felt that health advocacy would play a significant role in their future practice were more likely to have had formal training during residency as well as a role model or mentor (9). However, many residency programs do not offer any formal training or allow protected time to engage in advocacy. The burden of advocacy training often lies within professional societies.

Advocacy Within Professional Societies

As the oldest medical specialty society in the United States, the APA was founded in 1844 by 13 physicians specializing in the treatment of mental and emotional disorders. The APA constitution from 1892 states that "the object of this association shall be the study of all subjects pertaining to mental disease, including the care, treatment and promotion of the best interest of the insane" (10). The essence of this continues to live on in APA's current objectives. The organization has always relied on its membership to carry out this mission. Today, several opportunities are open to residents interested in becoming involved in advocating for patients and the profession.

Residents can seek opportunities with their local chapter, district branch, or area branch in the APA. These opportunities not only help residents gain valuable experience, but also expose them to mentorship by senior leaders at the local, district, and/or national level. Many training programs have resident liaisons with their local chapter. District branches have resident representative positions or residents as members on their executive councils. Residents can get involved in the APA Assembly, APA's legislative body, by representing one of seven large geographical areas via the Assembly Committee of Members-in-Training. APA also has nationally elected resident positions on the Board of Trustees and several fellowships that place residents on national APA committees (Table 1).

There are also numerous psychiatric subspecialty organizations that are active in advocacy, including the American Academy of Child and Adolescent Psychiatry, the American Association of Community Psychiatrists, and the American Association for Geriatric Psychiatry, each with opportunities for residents to become directly involved. Similar opportunities are offered by the American Medical Association, America's largest medical professional society.

Advocacy Outside Professional Societies

Residents can work in a more local capacity to organize their advocacy-oriented colleagues and utilize opportunities in their own communities. Simply inviting colleagues to discuss a challenging or topical issue or attending a community mental health event (e.g., participating in a National Alliance on Mental Illness or American Foundation for Suicide Prevention walk) can be the seed of a fruitful advocacy collaboration. Many residents across the country are directly involved in advocacy within their own communities by working at free clinics for the underserved, engaging civic and community leaders, and educating the public about important mental health issues.

By meeting regularly, setting goals, reviewing successes and strategies, educating each other, and engaging colleagues in action, residents can build on the success of smaller, more manageable advocacy projects to be better prepared to tackle larger mental health issues. These activities can be incorporated into a new or existing resident interest group or in-

continued on page 4

continued from page 3

corporated directly into the structure of the house-staff organization.

Examples of Advocacy Efforts

In the recent national debt crisis debate, residents became directly involved in advocating for protection of graduate medical education funding from projected cuts to Medicare. Proposals were on the table to drastically and disproportionately reduce graduate medical education funding, which may have made it unsustainable for smaller residency programs to survive and could have further reduced the supply of physicians the nation will need to provide access to quality medical and mental health care (11). Residents nationwide contacted their senators and congressmen, via telephone and letters, to voice their concerns, and many met with legislative staff in person to advocate for sustained funding during advocacy days on Capitol Hill. While drastic cuts to graduate medical education have been avoided, no long-term solution has been agreed upon, and it is essential that residents remain actively involved in the process.

The Assembly Committee of Members-in-Training advised APA to monitor recent policy changes of the National Resident Matching Program, which will no longer allow residency programs to offer contracts outside of the regular match to nontraditional applicants. While the practices of offering "prematches" has been subject to substantial controversy,

continued on page 5

TABLE 1: Opportunities for Residents Within APA[a]

Program	Description	Eligibility
Member-in-training trustee	A member-in-training trustee elect is elected at large and serves on the Board of Trustees for 1 year without a vote. At the end of the year, he or she advances to member-in-training trustee and serves on the Board for 1 year with voting privileges. The Board's primary function is to formulate and implement policies of the Association.	PGY-2, or PGY-3 if a 5-year program[b]
Assembly Committee of Members-in-Training	Committee members are elected by one of the seven area councils and serve two sequential 1-year terms in the APA Assembly, the legislative body of the APA. The first year as deputy representative (nonvoting), the second year as representative. The Assembly advises the APA via the Board.	PGY-1 or PGY-2, or PGY-3 in 5-year program[b]
Member-in-training district branch representative	Members-in-training at the local district branch. Responsibilities include attending district branch meetings, informing the district branch about resident issues, and communicating with member-in-training area representatives.	Contact district branch
APA fellowship in public psychiatry	Public psychiatry fellows are active participants in selected APA components and the Institute on Psychiatric Services. Based on expressed interests, fellows are assigned to an APA component and take part in all deliberations, projects, and initiatives.	PGY-3, or PGY-4 in 5-year program[b]
APA child and adolescent psychiatry fellowship	This fellowship is design to promote interest among residents in pursuing careers in child and adolescent psychiatry. Fellows will learn about clinical research, treatment for children with mental disorders, and issues associated with child and adolescent mental health.	PGY-1 to PGY-3
American psychiatric leadership fellowship	This is a 2-year fellowship that offers residents many opportunities to prepare them for leadership roles. Fellows participate in a component, attend the annual and fall component meetings, present a workshop at the APA annual meeting, and receive leadership training.	PGY-2, or PGY-3 in 5-year program[b]
APA/Substance Abuse and Mental Health Services Administration minority fellowship	This fellowship is designed to provide recipients with an enriched training experience through participation in the APA September and annual meetings as well as to develop leadership skills to improve the quality of mental health care among ethnic minority groups.	PGY-2
APA/ Substance Abuse and Mental Health Services Administration substance abuse fellowship	Substance abuse is a major public health concern, and the negative influence of substance abuse has a greater cost to people in minority communities. Fellows participate in component meetings and receive leadership training.	PGY-5, addiction fellow
Jeanne Spurlock, M.D. congressional fellowship	Offers an opportunity to work in a congressional office on federal health policy, particularly related to child and/or minority issues. Fellows help develop legislative proposals, track and analyze legislative initiative, arrange hearings, and brief members of Congress and their staff	All residents

[a] Data are from the American Psychiatric Association (13) (http://www.psychiatry.org/residents).

[b] Refers to residency with additional fellowship training.

continued from page 4

these changes may increase disparities for international medical graduates and thereby result in unintended negative consequences for many prospective residents (12). As a result of these efforts, APA communicated with the National Resident Matching Program concerns about policy changes and is now implementing a program to monitor possible negative effects to the physician workforce as a result of implemented changes.

In the future, residents will no doubt be integrally involved in the many important policy debates facing psychiatry over the next few years. We will need to advocate in order to avoid or to minimize drastic cuts in state mental health budgets. We will need to help define the essential mental health benefits that insurers in each state must provide as required by the Patient Protection and Affordable Care Act. In emergency departments and inpatient units and community clinics across the country, psychiatry residents understand the realities of providing mental health care and will need to be actively involved in influencing the future of our nation's mental health system.

How to Stay Informed

Residents must stay informed of issues affecting their patients and profession. Keeping track of mental health issues in the news can be daunting, but there are strategies to digest all this information. Several prominent news websites allow you to set "alerts" to send to you via e-mail when an article on a topic on which you have expressed interest is published (e.g., an article on mental health parity). All APA members-in-training can receive *APA Headlines,* the daily news clipping service focusing on mental health-related news (to subscribe, go to the members corner on APA's website at www.psych.org or call 888-35-PSYCH). All APA members receive *Psychiatric News,* which has a new format and a fully redesigned website (psychnews.psychiatryonline.org). *Psychiatric News* also has a new weekly e-newsletter, *Psychiatric News Update* (subscribe via e-mail at PNUpdate@psych.org), and a daily news blog through which you can read about the latest developments in the legislative, regulatory, and clinical arenas. Additionally, APA's Division of Government Relations publishes regular health policy updates in their weekly RushNotes (subscribe via e-mail at advocacy@psych.org).

Conclusions

Many residents are hesitant to engage in advocacy, often because of perceived lack of time during their training or lack of familiarity with the process or of fully developed expertise in the field. At its core, residency training is based on the challenge of learning new skills, practicing them, and eventually mastering them.

Advocacy requires the same process. Residents need to stay informed about current issues and educate patients, families, other health care professionals, and the public about mental illness and important mental health issues. More formal opportunities to engage in advocacy efforts are offered by medical specialty societies for residents to become active at the local, regional, and national levels.

There is no substitute for learning by doing. Getting involved in health care advocacy is not as daunting as it may seem, and the rewards can be substantial. Once residents begin to engage in advocacy, the next steps will be much easier. Residents will quickly find themselves developing a skill set that can greatly influence the lives of patients, communities, and the profession.

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Advocacy: What Do Psychiatry Trainees Know and Do?

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Advocacy is an integral aspect of medical practice, especially in psychiatric practice. Many professional organizations, including APA, the American Medical Association, and the American Academy of Child and Adolescent Psychiatry, consider advocacy to be a professional responsibility (1, 2). Advocacy takes many forms, ranging from individual work done on behalf of a patient to activities that aid specific populations (2–4). While the definition of advocacy is broad, at a basic level, it consists of fostering engagement with patients and the community, educating others, and convincing others to support positive change (4).

Producing physicians who are effective advocates requires adequate exposure to and training in this arena. Inclusion of an advocacy curriculum in residency training is a growing requirement across specialties (5). However, little is known of physician engagement in and education about advocacy activities at the resident/training level (6). While there is some literature on advocacy curricula for residents, there are little data specific to psychiatry, and no standard advocacy curriculum exists (4, 7). Information regarding current resident advocacy activities will aid program directors as they develop and implement such curricula.

In the present study, we obtained data from current residents in psychiatry and child and adolescent psychiatry on their perceptions, knowledge, and practices related to advocacy. The objectives were to understand residents' perceptions of advocacy training, assess residents' comfort with the inclusion of advocacy practices in their clinical and professional lives, learn about current advocacy behaviors, and gauge interests in advocacy education.

Methods

The study was approved by the institutional review board of the University of Kentucky. In October 2010, program directors and coordinators at the 308 accredited psychiatry and child and adolescent psychiatry programs in the United States and Puerto Rico were e-mailed a description of the study and provided with a link to the electronic survey (survey monkey). Directors and coordinators were asked to distribute the e-mail to their trainees. Approximately 5 weeks later, an e-mail was sent via the chief resident e-mail list service with the same request. Telephone calls were made to representative programs from each geographic area to confirm receipt of the original e-mail. The survey was made available for 8 weeks.

The survey design was guided by the literature and feedback from psychiatric educators and residents. Trainees reported demographic information, educational profile (type of training program, year in training, location of medical school and residency program), professional organization memberships, and media utilization. Advocacy knowledge and behavior were measured in terms of patient and community activities. Responses to attitudes and perceptions about advocacy were measured using a five-point Likert scale (0=strongly disagree to 5=strongly agree), while advocacy behaviors were ranked as follows: never=0, occasionally=1, and frequently=2. Mean scales were created for advocacy attitudes (13 items, alpha=0.88) and patient advocacy behaviors (nine items, alpha=0.79) to support bivariate analyses including t tests, analyses of variance (ANOVAs), and Pearson's correlations between measures. The survey was not validated.

Results

We received surveys from 155 trainees. According to the Accreditation Council for Graduate Medical Education (ACGME), there were 5,759 residents in general and child and adolescent psychiatry programs during 2010 and 2011 (8). The demographic and descriptive data of the respondents are summarized in Table 1. Most trainees felt that patient advocacy activity was important. Few respondents felt that they had sufficient time or training to perform advocacy well (Table 2). Assessment of resident behavior related to patient advocacy demonstrated a wide range of participation.

Bivariate analyses assessed relationships

continued on page 7

TABLE 1: Characteristics of Residents in Medical Schools Accredited by the Accreditation Council for Graduate Medical Education

Characteristic	N	%
Demographic		
Age 25–39 years	138	90
Female	85	56
Program type		
General psychiatry	109	70
Child and adolescent psychiatry	32	21
Combined general/child and adolescent psychiatry	8	5
Triple board	6	4
Year in program		
PGY-1 and 2	55	36
PGY-3 and 4	79	52
Location of training		
Midwest	35	23
Northeast	30	20
South	49	32
West	38	25
Citizenship		
U.S. citizen/permanent resident	143	94
Professional membership		
APA	121	86
American Academy of Child and Adolescent Psychiatry	47	34
News sources used		
At least three types (print, television, radio)	73	47

continued from page 6

between demographic and training factors with scales of patient advocacy behaviors. This included community advocacy. Age was associated with patient advocacy (ANOVA: F=4.71, df=2, 134, p<0.05), with respondents in the age range of 30–39 years (mean=0.91 [SD=0.42]) reporting more advocacy activity than those in the 25–29 years range (mean=0.70 [SD=0.40]). Child and adolescent psychiatry residents (mean=1.00 [SD=0.35]) demonstrated more advocacy activity than psychiatry residents (mean=0.73 [SD=0.43]; t=3.63, p<0.001). Trainees reporting more memberships in professional organizations also reported greater patient advocacy (r=0.25, p<0.01).There was a positive association between the use of a greater number of news sources and patient advocacy (r=0.20, p<0.05).

TABLE 2: Resident Attitudes, Knowledge, and Behavior Toward Advocacy

	N	%
Measure: respondent strongly or somewhat agrees		
I have a responsibility to advocate for my patients	133	95
It is important for psychiatrists to be involved in advocacy	122	87
Learning about advocacy is important to my residency training	117	84
I feel comfortable advocating for my patients	109	78
It is important for psychiatrists to be politically involved	97	69
I have a responsibility to advocate for my local community's needs	90	65
I believe that I am an effective advocate for my patients	73	52
I believe that I am an effective advocate for my own professional needs	64	46
I am sufficiently aware of local advocacy resources	55	39
I frequently teach younger residents and medical students about advocacy issues related to patient cases we review	51	36
I believe that I am an effective advocate for my profession's needs	51	36
I have received sufficient training in advocacy during my residency	41	29
I have enough time to address advocacy issues with my patients and their families	38	27
Patient advocacy: respondent has occasionally or frequently performed action		
Submitted a prior authorization form for medications	111	80
Referred a patient to a social/case worker related to an advocacy issue	109	78
Submitted a letter to an employer to request accommodations for a patient or their family member	103	74
Referred a patient to the services of a nongovernmental organization focusing on mental health care	84	61
Submitted a letter in support of a Social Security Insurance/ Disability claim	84	60
Submitted a report to Child Protective Services	84	60
Submitted a letter to an insurance company on behalf of a patient	76	55
Submitted an application for medications from a patient assistance program	77	55
Referred a patient to a lawyer or legal aid organization	44	32

Discussion

Experiences during residency training ensure that physicians develop familiarity with and acquire expertise in certain practice areas. The importance of physician advocacy for quality patient care and effective systems of care has been increasingly recognized, as evidenced by its inclusion in ACGME program accreditation standards. One challenge is creating an adequate environment for advocacy training in residency given the multiple competing curricula and clinical demands as well as the discomfort among many practicing physicians with this area of practice. This study summarizes a number of these difficulties. Residents considered advocacy knowledge and skills to be important but reported minimal exposure to advocacy education. Most respondents believed that they had a responsibility to advocate on behalf of their patients, and approximately 50% felt that they were effective in doing so; however, less than one-third of respondents felt that they had time to engage in these activities. This disparity between the level of interest in advocacy and the actual degree of engagement is noted in the literature (1). Few residents interacted with public or private agencies. While respondents expressed interest in learning about advocacy, concern was expressed about adding to existing activities. Residents with more experience and training reported higher participation, suggesting that time spent as a physician supported appreciation for the practice of advocacy. Not surprisingly, advocacy interest and activity were positively associated with behaviors indicating involvement in broader communities through membership in professional organizations and attention to news sources.

Our study has several limitations. It is not clear how many residents actually received the survey, and thus an accurate response rate could not be calculated. We also could not compare the demographic profile of respondents with that of their respective trainee cohorts, since much of these data are not routinely collected. The limited number of responses may reflect the unfamiliarity and discomfort that

continued on page 8

continued from page 7

psychiatry trainees have with advocacy. Furthermore, residents may have underreported their participation in advocacy by simply not realizing that certain activities are a component of such work (6). Respondents also may have had difficulty accurately categorizing their activities, especially activities that were clinically related into the survey categories. Our data may overestimate resident interest, since the residents most interested in the topic may have been more likely to respond.

Conclusions

The importance of advocacy as an essential, basic skill of physicians is becoming increasingly clear. This study provides evidence that psychiatry trainees agree that this area of practice is important, but significant challenges exist with regard to teaching advocacy skills. Additional research is needed, but clearly residents would benefit from exposure to a systematic curriculum for this area. Developing systematic and comprehensive curricula resources and a curriculum for residency programs would be highly beneficial.

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The Chief Resident as Advocate

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Many paths of advocacy can be tread by a psychiatry resident; however, there is one resident role in which advocacy is part of the job description. This position is that of the chief resident. As chief resident, one must serve as an advocate for fellow residents, patients, faculty, staff, and administration, although varying situations may call for the balance of focus to be tilted toward one particular group. That being said, those of us who serve as chief residents consider ourselves first and foremost to be representatives of residents. Thus, even when advocating on behalf of other groups, we strive to be mindful of how residents could be affected by proposals at every level. Patient care is the overarching focus of our work, and we believe that advocating on behalf of our residents leads to better patient care.

As advocates for residents, we regularly bring their concerns and suggestions to the attention of the administration. For example, a resident in our department informed us of a problem with the proposed outpatient clinic schedule for the next year. The proposed schedule indicated that residents rotating on our dual-diagnosis unit were to be in the outpatient continuity clinic and the opioid treatment groups on the same afternoon. The residents were to alternate between outpatient appointments and opioid treatment groups throughout the afternoon. Knowing that outpatient clinics are unpredictable, such a schedule could create unnecessary time stress for residents and compromise patient care. Thus, we approached our department chairperson, who readily agreed to move the residents' continuity clinics to another day, which alleviated the problem.

It could be argued that the most important moments of advocacy involve day-to-day interactions with residents.

continued on page 10

continued from page 9

This is the type of advocacy in which we take the most pride because it provides unexpected opportunities for us to make the days a little kinder to residents. For example, on one occasion, there was a misunderstanding between hospital staff and a resident, and I perceived the situation to be unfair to the resident. The nursing staff had told our attending that they were looking for a resident but could not find him. The attending brought this concern to my attention. However, the resident was in an interview room with a patient during the entire time the nursing staff was trying to locate him, and they did not check there for him, nor did they page him. When I learned of the details, I went with the resident to address the situation with all parties involved in order to ensure a good resolution. Such misunderstandings can unnecessarily degrade the reputation of a competent resident, and therefore I consider the simple act of advocating on behalf of the resident to be more than just serving as a mediator.

The chief resident is also a liaison between the faculty, staff, administration, and the residents and must work toward ensuring that the needs of all parties are being met. This role brings to mind the duality or "middle man" existence of the chief resident (1). We still work "in the trenches" as residents and thus share the same concerns as residents. However, we must be mindful of the needs of other groups and make difficult decisions based on administrative needs. This type of juggling can cause an inner struggle, and a chief must remain mindful in order to stay honest and respected by all parties.

In summary, as chief residents, we view ourselves as advocates because when we act, our deeper purpose is often to promote the interest of a party, most often our residents. Furthermore, our responsibilities go beyond that of simple, neutral negotiation.

Drs. Lusins and Vaughn are both fourth-year residents in the Department of Behavioral Medicine and Psychiatry, Morgantown University Hospital, Morgantown, WV.

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Advocacy and the Aspiring Academic Psychiatrist

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As psychiatrists we are advocates whenever we speak on behalf of others, whether representing our profession to policy makers and the media or developing clinical and ethical standards or working to reallocate resources to better serve patients (1–3). Academic psychiatrists are well equipped to do all of this, but at a time when we are advised to focus on excellence in a single domain (i.e., research or teaching), why would we? What reason is there to spend more time away from our loved ones and add to our long to-do list?

The answer is the same as for everything else we do: because we must. Advocacy is our duty as physician-scholars, and it can advance our careers. It is our duty because as psychiatrists working in discovery and education, we have expertise beyond clinical training, and policy makers need to be informed as they struggle to understand new technologies and an increasingly complex health economy. Policy makers need us to be proactive in bringing our knowledge into their process. Furthermore, our future departments and funding agencies expect it. The psychiatric residency requirements by the Accreditation Council for Graduate Medical Education (4) call for us to "advocate for quality patient care and optimal patient care systems [and also] advocate for…assisting patients in dealing with system complexities, including disparity in mental health care." University promotion and tenure policies expect professional service, most forms of which fall under the definition of advocacy. Finally, in an era of low pay lines, when grant agencies must decide which young investigator to support, they will look for those who show leadership potential. Service to your patients and profession can give you an edge over your peers.

But where does one start? I can recommend my own path, which began with simply showing up at local meetings while still in medical school. The APA and local psychiatric societies are actively seeking participation from young psychiatrists, as well as the subspecialty psychiatric organizations. Most chapters hold monthly dinner meetings, often led by the same psychiatrists who teach and supervise us during the daytime. These faculty are usually willing mentors, and you may find yourself (as I did) joining them at your state capitol for advocacy days, or perhaps making connections that may help you with national opportunities and fellowships (including numerous awards sponsored by the APA and APA Foundation). Such meetings offer a boost to your CV and an education not found in your residency program, and they are also excellent venues for early research presentations.

I have found a synergy between each aspect of my residency training, in which my time in organized medicine brings me into contact with program directors, department chairs, and senior scientists, who might otherwise not be aware of my scientific endeavors, and my time in the lab enables me to be a better advocate by bringing an active junior researcher's perspective into the board room.

None of us who hope to work in a university setting and advance the art and science of psychiatry can afford to ignore advocacy. It is a vital part of our future portfolios and one that each of us must start building early in residency.

Dr. Widge is a third-year resident in the Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle.

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Residents Take an Advocacy Role in Suicide Prevention

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Last summer, the residents at the University at Buffalo, the State University of New York, decided to take a different approach to suicide prevention. Some residents took an advocacy position by participating in a local *Out of the Darkness* Community Walk, which benefitted the American Foundation for Suicide Prevention. At the time of its inception, 25 years ago, the American Foundation for Suicide Prevention provided $11,000 to fund three research studies. Today, it is a national nonprofit organization that has almost $4.5 million invested in suicide research and efforts to increase national awareness about depression and suicide through outreach and education. Additionally, the organization provides support for families and individuals affected by suicide.

Psychiatry residents are often involved in the process of discussing suicide as part of a comprehensive lethality risk assessment or addressing risk modification as part of a treatment plan. Each assessment we do includes asking questions to stratify risk and evaluate protective factors before balancing all of these considerations to determine steps for intervention. Participation in the walk as a volunteer offered a uniquely different perspective.

Understanding the effect of suicide on families and the community was one reason residents felt compelled to walk. Those who participated were walking side-by-side with family members who had lost loved-ones; many of whom were wearing t-shirts memorializing those lives cut short. The process was both eye-opening and humbling. As residents, we tend to think in terms of our individual patients. During the walk, one could not help conceptualizing the effect of suicide on the community, an effect that is both vast and terrible. Listening to a father's grief when describing the son who impulsively ended his life was a distinctly different rally to commence the walk, relative to that for the typical charity or 5K walk. The pain was palpable.

And yet, despite feeling a sense of deeply rooted sympathy, the experience also provided an important reminder that we do not practice in a vacuum, that our work aimed toward minimizing lethality is supported, and that we are part of a community working toward suicide prevention. Family and friends began the day formed as teams of remembrance and were swathed in color-coordinated shirts with photographs of a happy loved-one now gone, a uniting emblem across their chests. What began as a patchwork quilt of color gradually melted together as we walked, a confetti of color celebrating individual lives. Most of all, the walk seemed to provide hope.

For residents, it was an opportunity to reflect on the larger picture of suicide prevention and extend their view beyond that of the individual to that of the family and community. This reflection will hopefully continue to influence the residents as they move forward in their careers, extending the concept of physicians as advocates for their patients outside of the clinical roles they have been accustomed to.

The walk consisted of over 1,000 participants, and more than $77,000 was raised. *Out of the Darkness* Community Walks are between 3 and 5 miles and take place in more than 200 communities across the country (www.outofthedarkness.org).

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Back to Maslow's Hierarchy: A Federal Disability Benefits Primer

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It is your first clinic visit with "Ms. K," a 50-year-old female patient. The patient has cancelled several prior intake appointments. In the waiting room, you note that her hands are visibly shaking, her eyes are wide, and she is leaning toward the younger woman sitting beside her, as though for protection. She insists that the younger woman, who is her daughter, accompany her into your office. She describes her first panic attack, which took place at work 5 years prior. She felt humiliated when she found out that there was nothing "really" wrong with her and feared the embarrassment of another public attack. She started staying home whenever she felt anxious. She quickly ran out of sick days at work and was fired. Her resulting feelings of failure worsened her anxiety, and she began having panic attacks when she would even think of leaving home. Things have gotten so bad now that she only leaves the house rarely and only accompanied by her daughter. She has been living on her savings, but the money is running out. She tearfully confesses that she does not want to be a burden to her daughter and wonders whether she will end up homeless.

As resident psychiatrists, we encounter many patients who are "on disability." Often, our idea of what this constitutes is unclear; however, disability benefits are integral to the lives of many of our patients. In fact, psychiatric illness is the most common reason for a person to receive disability benefits (1). Despite this, many patients, such as Ms. K in the above case, have little knowledge of the programs available to help them. Indeed, about 20% of individuals with serious mental illnesses who are unable to work have not applied for disability benefits (2). With a basic knowledge of disability benefits, we can better understand many of our patients' lives as well as guide them to appropriate resources.

TABLE 1: Social Security Administration Disability Evaluation Criteria for Disability Due to an Anxiety Disorder[a]

Criteria
Medical documentation of at least one of the following:
Generalized, persistent anxiety with at least three of the following: Motor tension Autonomic hyperactivity Apprehensive expectation Vigilance and scanning
Persistent, irrational fear of an object, activity, or situation that results in a desire to avoid the object, activity, or situation
Severe panic attacks with sudden and unpredictable onset at least once a week
Recurrent, distressing obsessions or compulsions
Recurrent, intrusive, distressing recollections of a traumatic experience
The anxiety results in a complete inability to function independently outside of the home or results in at least two of the following:
Marked limitation in activities of daily living
Marked limitation in social function
Marked difficulty maintaining concentration, persistence, or pace
Repeated episodes of extended decompensation

[a] Data are from the U.S. Social Security Disability Evaluation (see reference 6).

Social Security Disability Insurance and Supplemental Security Income

The Social Security Administration manages the two main federal programs that provide benefits to disabled individuals: Social Security Disability Insurance and Supplemental Security Income. The medical requirements are the same for both, but eligibility varies with employment history.

Social Security Disability Insurance benefits are available to those who become disabled after working enough to be "insured." Currently, a worker receives one credit for each $1,130 earned, up to four credits yearly (3). The number of credits needed to be insured depends on the age of the person when he or she becomes disabled. For example, a person who becomes disabled at age 60 needs 38 credits, whereas someone who becomes disabled at age 40 needs only 20 credits (4). The amount of money a person receives through Social Security Disability Insurance is variable and depends on the individual's lifetime earnings history.

Those who have not worked enough to qualify for Social Security Disability Insurance may be eligible for Supplemental Security Income. This program is designed for those who are disabled (or who are age 65 or older) and have little or no income. To receive Supplemental Security Income, a person also must have less than $2,000 in resources, which includes money in bank accounts, real estate, and vehicles. However, general household goods, one vehicle, and the person's home are excluded from the tally of resources. At present, an individual can receive up to $698 monthly from Supplemental Security Income, although this amount can be reduced due to income received from

continued on page 14

continued from page 13

other sources, including other federal benefits (5).

If the applicant qualifies for one or both of these programs, the next step is to determine whether he or she is disabled. The Social Security Administration defines disabled as "the inability to engage in any substantial gainful activity…by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (6)." Generally, employment that enables a person to earn over $1,010 monthly is considered substantial gainful activity. To simplify the process, the Social Security Administration maintains a list of conditions that qualify a person as disabled without a lengthy review. For mental illnesses, the listings describe the symptoms (generally based on DSM-IV criteria) and level of functional impairment required to be considered disabled (Table 1). An individual with a less severe illness can also qualify if he or she is unable to work in a previous profession and unable to adjust to other work. There is some flexibility here, since the person's age, education, and skills are considered when deciding whether an adjustment to other work is possible.

The privacy implications of a disability application cannot be overlooked. When an individual applies, he or she signs a form allowing for the release of virtually his or her entire medical record, including substance abuse history and HIV and genetic testing results. Detailed psychotherapy notes are protected, although information such as modality of treatment, frequency of therapy, treatment plan, and prognosis may be required. The same form also gives consent for the Social Security Administration or its representatives to obtain educational records and information from teachers and even to speak to the applicant's friends, family, and neighbors.

Representative Payees

Some beneficiaries are so impaired that they are unable to successfully manage their own finances. In such cases, the Social Security Administration appoints a representative payee to ensure that the person's benefits are spent first for basic essentials, such as rent, electricity, and groceries. Money that is left over can then be given to the recipient as spending money or put into a savings account. Approximately 30% of individuals receiving benefits as a result of mental illness have a payee (7). The payee is often a family member or friend but can also be someone like a case manager or social worker. If a person does not have an individual who is appropriate and willing to act as a payee, organizations that will act as the payee exist (sometimes solely for this purpose) and are permitted to collect a reasonable fee for doing so. Perhaps surprisingly, regardless of the type of payee, the trust levels and overall satisfaction of the beneficiaries are high (7).

Medicare and Medicaid

The aforementioned programs are distinct from Medicare and Medicaid, which help pay for medical care. Medicare is a federally-based program, and individuals who have received Social Security Disability Insurance for 2 years are automatically enrolled. Medicare is also available to those aged 65 or older. Individuals receiving Medicare are allowed some choice in selecting a plan that is right for them and may have to pay a premium, similar to private health insurance.

Medicaid is a state-based program. Federal law sets certain guidelines regarding who and what services must be covered, but individual states are free to go above these minimums. In most states, Supplemental Security Income recipients automatically qualify. In return for a state's Medicaid program meeting the minimum requirements, the federal government helps to fund it. Since Medicaid is state-based, factors such as eligibility, benefits, and premiums or copays vary depending on the state.

The Downside of Disability

Approximately 27% of Social Security Disability Insurance and 34% of working age Supplemental Security Income beneficiaries are disabled as a result of primarily psychiatric causes, and those impaired by psychiatric conditions tend to be younger when disabled and therefore receive benefits for longer periods (8). However, many of these disabled individuals feel that they could work in some manner (2). Indeed, working appears to improve self-esteem and perhaps overall quality of life, suggesting that helping those who are able to return to work should be a priority (9). The Social Security Administration has enacted measures to ease the transition back to work, such as trial work periods and temporary continuation of benefits. Additionally, the administration recently completed the 4-year long Mental Health Treatment Study, which demonstrated improved employment rates with expanded employment and treatment services (10). The model used in the study, individual placement and support, focuses on the beneficiary's preferences, integrates mental health and employment services, and provides personalized and ongoing support. The individual placement and support model has demonstrated great promise in this and other research studies in helping individuals return to work (11).

Where to Start?

The plethora of information on disability benefits can be overwhelming, both to you and your patients. There are numerous special circumstances (beyond the scope of this article) that alter a person's eligibility for benefits. It is easy to see how someone already burdened by a difficult illness might give up on the process as a result of not knowing where or how to start. One way to begin is with the Benefit Eligibility Screening Tool on the Social Security Administration's website (http://www.benefits.gov/ssa). This screener consists of about 20 simple questions (depending on one's answers), takes just a few minutes, and could be easily completed with your patients during an office visit. The Social Security Administration may also be contacted directly at any of their local offices (or by calling 1-800-772-1213).

As psychiatrists, we focus on our patients' mental and emotional health. However, it

continued on page 15

continued from page 14

should be apparent that we cannot begin to succeed in helping patients with their mental and emotional needs unless their physical needs are sufficiently met. By helping to guide our patients toward appropriate resources, we are helping them take the first steps toward total health.

Dr. Coffman is a first-year resident in the Department of Behavioral Medicine and Psychiatry, West Virginia University Hospitals, Morgantown, WV.

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Assisted Outpatient Treatment: Preventive, Recovery-Based Care for the Most Seriously Mentally Ill

Gary Tsai, M.D.
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Mental health systems are struggling to provide care for the seriously ill, with conservative estimates reporting that approximately 30% of the homeless (1) and 20% of the prison population (2) are severely mentally ill . An important contributing factor to these poor outcomes is that almost 50% of those with severe mental illness (defined in this article as schizophrenia, schizoaffective disorder, bipolar disorder, and depressive disorder with psychotic features) in the United States are untreated (3). Although this population only comprises about 4.5% of the general population, this still amounts to a substantial 13 million Americans affected (4).

Not surprisingly, the percentage of untreated severely mentally ill individuals closely mirrors the 40%–50% of individuals in this population who suffer from anosognosia and possess significant deficits in self-awareness (5). While intensive case management practices, such as Assertive Community Treatment/Full Service Partnerships, have been successful in providing care for clients who are amenable to voluntary services, individuals who lack insight remain difficult to engage. Studies have shown that these individuals possess deficits in the frontal lobe and in executive functioning, which impairs their capability for objective self-reflection (6). Research has also revealed a clear link between lack of insight and treatment nonadherence (7), which has been associated with poorer clinical outcomes in terms of illness relapse, response to treatment, hospitalizations, and suicide attempts (8, 9). Without the capacity to recognize their need for help, this subset of the mentally ill frequently declines care, resulting in revolving-door hospitalizations as well as incarceration and victimization or violence (10). While voluntary care is clearly ideal, the difficult reality is that the mentally ill are a heterogeneous group with varying needs.

Assisted Outpatient Treatment

Assisted outpatient treatment programs, also known as outpatient commitment, arose in response to the challenges of caring for the severely mentally ill. To date, versions of outpatient commitment laws have been enacted in 44 states, most notably in New York via Kendra's Law. These court-ordered programs are community-based, recovery-oriented, multidisciplinary services for seriously ill individuals who have a history of poor adherence to voluntary treatment and repeated hospitalizations and/or incarcerations. Despite regional differences, the challenging patient population receiving services from assisted outpatient treatment and the goals of treatment are generalizable. In most states, mentally ill individuals who decline treatment must meet strict criteria for involuntary treatment; i.e., they must be deemed a danger to themselves, others, or gravely disabled. Rather than waiting until these outcomes are imminent, assisted outpatient treatment engages high-risk individuals through earlier and less restrictive treatment in the community.

Establishing flexible and therapeutic relationships with clients within the evidence-based paradigm of assertive community treatment is the foundation of effective assisted outpatient treatment. In California, comprehensive outpatient services are offered 24/7 at a client-to-clinician ratio of 10:1. Service plan goals are concrete and individualized, and every effort is made to involve patients in their care, empowering their sense of self-worth and independence. The assisted outpatient treatment team is a mobile unit, and the location of services varies depending on client needs. Provided services include psychotherapy, medication management, crisis intervention, nursing, and substance abuse counseling as well as support for housing, benefits, education, and employment. Providers often maintain contact with clients on a daily basis, and any member of the treatment team, including psychiatrists, psychologists, nurses and case workers, can provide services and support.

In 2008, Nevada County became the first and only county in California to fully implement an assisted outpatient treatment program in order to promote ongoing treatment adherence in the community. Although the procedural process varies slightly between states, Nevada County's treatment process begins with a referral submitted to mental health agencies by family members, cohabitants, treatment providers, or peace officers. If the individual meets the eligibility criteria (Figure 1), the treatment team develops a preliminary care plan, which is strategically revised throughout the process to meet the needs and desires of the client. If the individual voluntarily engages with court-supervised treatment, a petition is no longer necessary. However, if the client contests the petition, a public defender is assigned and the court proceeds with a hearing. If granted, the assisted outpatient treatment order is valid for up to 180 days. Regular status hearings, held at least every 60 days, enable the court to both ensure that the client is engaged in treatment and that the treatment team is providing necessary support and services. Importantly, assisted outpatient treatment does not affect existing laws regulating the administration of involuntary medications. If patients decline to engage with the treatment team, they are assessed for the appropriateness of a 72-hour hold for further evaluation and care at a local hospital.

While all assisted outpatient treatment programs involve interactions with law enforcement and the court system, a

continued on page 17

continued from page 16

unique feature of Nevada County's program is its degree of systemic integration. During planning, the behavioral health department held meetings with various stakeholders, including representatives from the mental health board, superior court, county counsel, public defender's office, law enforcement, advocacy groups (such as the National Alliance on Mental Illness), and members of the community. As a result of this collaboration, the assisted outpatient treatment team works closely with all involved parties, enhancing the efficiency and impact of these intensive, wrap-around mental health services.

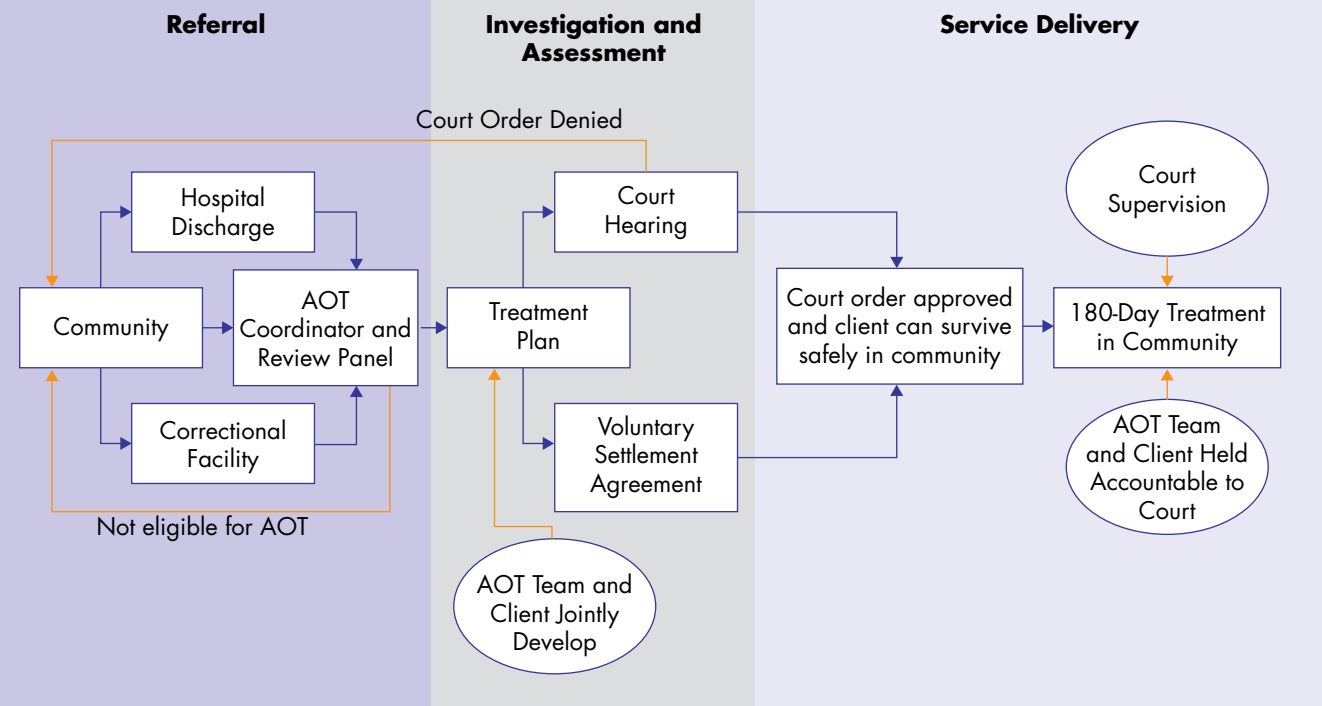
Results From the Nevada County Assisted Outpatient Treatment Program

Given the difficult target population, one of the most compelling measures of success for Nevada County's assisted outpatient treatment program is the number of people who voluntarily engage in treatment and avoid court-ordered intervention. Between 2008 and 2010, with a county population of 97,000, there were 24 referrals to the program, and 19 met eligibility criteria (11). The vast majority of referrals (15 out of 19) voluntarily engaged with their care team, and a majority remained in treatment even after their court order expired. The Milestones of Recovery Scale was used to assess markers of mental health recovery. Because of out-of-county incarceration or an inability to locate individuals, Milestones of Recovery Scale data were only available for 16 of the 19 individuals who received services. Of these clients, 14 had pre-assisted outpatient treatment scores in the "struggling" category, compared with only eight individuals posttreatment. While five of the 19 clients engaged in treatment were employed prior to treatment, six were employed following treatment.

Assisted outpatient treatment also produced significant cost savings for Nevada County as a result of decreased hospitalizations and incarcerations (Figure 2). The year prior to assisted outpatient

continued on page 18

FIGURE 1: Eligibility Criteria and Procedural Process of Assisted Outpatient Treatment (AOT) in California[a]



AOT Eligibility (California):

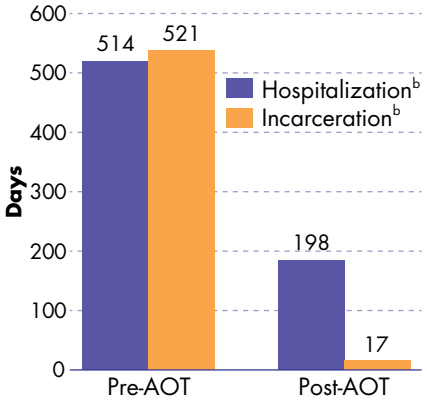
1. Be mentally ill and at least 18 years old.
2. Have a history of poor treatment compliance leading to at least two hospitalizations or incarcerations in the last 36 months, or violent behavior at least once in the last 48 months.
3. Have been offered and to have declined voluntary in the past.
4. Clinical determination needs to indicate that they are unlikely to survive safely in the community without supervision.
5. Participation in AOT needs to be the least restrictive measure necessary to ensure recovery and stability.
6. Condition needs to be substantially deteriorating and must likely benefit from treatment.
7. Not being placed in AOT must likely result in the patient being harmful to self/others and/or gravely disabled.

[a] Data are drawn from criteria as described by the California Psychiatric Association (www.sdcounty.ca.gov/hhsa/programs/bhs/documents/Lauras_Law_AB1421.pdf) and New York State Office of Mental Health (http://bi.omh.ny.gov/aot/files/AOTReport.pdf).

continued from page 17

treatment implementation, the 19 participants who received services accounted for 514 days of psychiatric hospitalization. After initiation of treatment, the number of inpatient days for these individuals decreased to 198 days, representing a 61% drop in hospitalization days. Similarly, 521 days of pre-assisted outpatient treatment incarcerations fell to just 17 days posttreatment, representing a 97% reduction in incarceration days. With estimated daily hospitalization costs of $675 and incarceration costs of $150 per day, the assisted outpatient treatment program resulted in a 45% net savings for Nevada County during the 31-month period of this assessment and saved $1.81 for every $1 invested.

FIGURE 2: Outcomes of Nevada County Assisted Outpatient Treatment (AOT) Program[a]



[a] Data are drawn from statistics as reported by the Nevada County Behavioral Health Department.

[b] Data represent number of days.

Conclusions

The unfortunate irony of psychiatric care today is that oftentimes the patients who are most in need of services are too disorganized and ill to seek assistance themselves. Subsequently, these high-risk clients frequently only receive treatment after they are involuntarily hospitalized or placed in other restrictive settings of care, including the criminal justice system.

The Nevada County assisted outpatient treatment program takes a patient-oriented, multidisciplinary approach to provide community-based services for the severely mentally ill who are historically the most difficult to engage. Objective measures of the program demonstrate that it is cost-efficient and has resulted in overall improvement in clinical functioning, as well as fewer hospitalization and incarceration days. These findings are attributable to effective collaboration between county systems, evidence-based clinical practices, and comprehensive and individualized care management.

In an era of health reform and decreased medical spending, ensuring treatment for the most vulnerable mentally ill individuals is instrumental in maximizing the efficient use of limited resources. Nevada County's assisted outpatient treatment program provides an innovative example of an efficacious and cost-effective model of service delivery for seriously ill individuals that is preventive, recovery-oriented, and evidence-based care.

Dr. Tsai is a fourth-year resident in the San Mateo County Psychiatry Residency Training Program, San Mateo, Calif. *The author thanks Carol Stanchfield, Program Director of Turning Point Providence Center, and the Nevada County Behavioral Health Department.*

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TEST YOUR KNOWLEDGE

In preparation for the PRITE and ABPN Board examinations, test your knowledge with the following questions.
(answers will appear in the next issue)

This month's questions are courtesy of Monifa Seawell, M.D., Associate Editor. Please see the accompanying article by Tracy Serge Coffman, M.D., from West Virginia University Hospitals, Morgantown, WV, in this issue.

Question #1
Which of the following statements is true?

A. Social Security Disability Insurance and Supplemental Security Income have different medical requirements but similar eligibility requirements.
B. The amount of money dispersed through Social Security Disability Insurance varies depending on age.
C. Supplemental Security Income requires the recipient to have less than $500 in resources.
D. Under Social Security Disability Insurance, the number of credits required to be insured correlates with the age at which the disability occurred.

Question #2
Which of the following statements is most accurate?

A. Mental illness is the primary disability in 51% of working age Social Security Disability Insurance recipients and 48% of working age Supplemental Security Income recipients.
B. Mental illness is the primary disability in 27% of working age Social Security Disability Insurance recipients and 34% of working age Supplemental Security Income recipients.
C. Mental illness is the primary disability in 10% of working age Social Security Disability Insurance recipients and 15% of working age Supplemental Security Income recipients.
D. Mental illness is the primary disability in 5% of working age Social Security Disability Insurance and 36% of working age Supplemental Security Income recipients.

ANSWERS TO MAY QUESTIONS

Question #1.
Answer: **D. Stimulation of 5-HT_2 and 5-HT_3 receptors**
Sexual dysfunction caused by selective serotonin reuptake inhibitors is related to serotonergic stimulation of 5-HT_2 and 5-HT_3 receptors but likely has a complex origin. The effect of serotonin on nitric oxide production and other systems may also be involved, and mechanisms involving dopamine, anticholinergic effects, and prolactin have been proposed (1). Sexual side effects have not consistently been reported with 5-HT_{1A} agonists, and animal studies have shown that 5-HT_{1A} receptors may facilitate sexual behavior (2).
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Question #2
Answer: **C. Discontinue venlafaxine and start bupropion**
All the options are strategies that have been suggested for the management of sexual dysfunction secondary to a serotonergic agent. However, changing from a serotonergic medication to bupropion has the strongest evidence base and is supported by randomized controlled trials and therefore is the best choice (1).
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We are currently seeking residents who are interested in submitting Board-style questions to appear in the Test Your Knowledge feature. Selected residents will receive acknowledgment in the issue in which their questions are featured.
Submissions should include the following:
1. Two to three Board review-style questions with four to five answer choices.
2. Answers should be complete and include detailed explanations with references from pertinent peer-reviewed journals, textbooks, or reference manuals.
***Please direct all inquiries and submissions to Dr. Seawell; mseawell@med.wayne.edu.**

Author Information for *The Residents' Journal* Submissions

The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; manuscripts authored by members of faculty cannot be accepted.

1. **Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
2. **Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure.
3. **Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure.
4. **Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures.
5. **Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure.
6. **Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in *The Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
7. **Book Review:** Limited to 500 words and 3 references.

Abstracts: Articles should not include an abstract.

Upcoming Issue Themes

Please note that we will consider articles outside of the theme.

August 2012
Section Theme: International Health
Guest Section Editor: Nicole Zuber, M.D.
nicajean@gmail.com

September 2012
Section Theme: Psychosomatics
Guest Section Editor: David Hsu, M.D.
david.hsu@ucdmc.ucdavis.edu

October 2012
Guest Section Editor: David Hsu, M.D.
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November 2012
Section Theme: Transitions
Guest Section Editor: Nina Kraguljac, M.D.
nkraguljac@uab.edu