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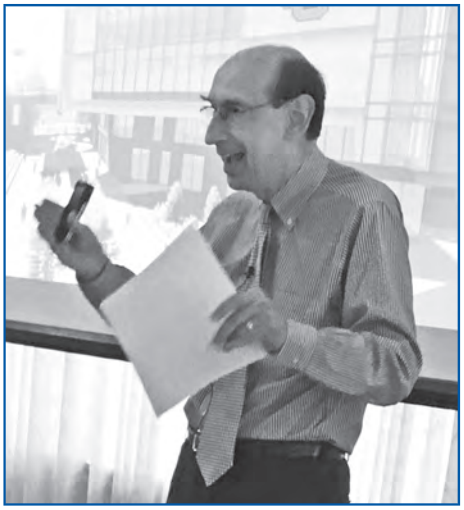
2016 Annual Meeting

On April 27, 2016, the members gathered at the Quinnipiack Club in New Haven for the Annual Meeting. The evening began with a reception where members enjoyed the hospitality of the Quinnipiack Club while catching up with their colleagues. After the reception "The Colorado Batman Murder Massacre: Delusion, Disinhibition or Depravity?" was presented by Phillip Resnick, M.D. Dr. Resnick, an internationally known forensic psychiatrist, is noted for his expertise in the assessment of violence risk and the detection of malingered mental illness.

When Dr. Resnick's presentation adjourned, the business meeting and awards ceremony were held. During the business meeting outgoing president Reena Kapoor highlighted the progress made by the organization over the past year, including the diligent work CPS is doing with the legislature to assist in improving conditions for psychiatric practice for the members and access to care for patients. Following Dr. Kapoor's remarks, the incoming CPS President, Dr. Caren Teitelbaum, was introduced. Dr. Teitelbaum spoke about her goals for the coming year.

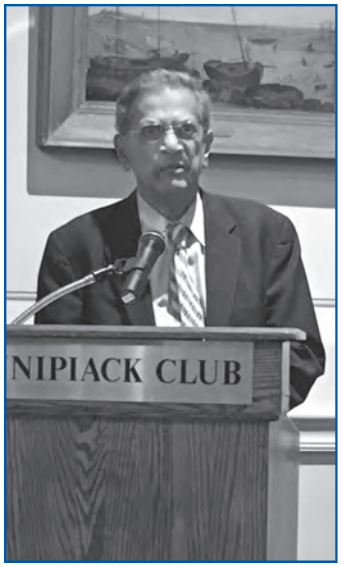
Two awards were given for outstanding achievements in the past year. The first award of Service to Patients was presented to Dr. Paul Desan for his participation at the Pharmacy and Therapeutics Committee of the Department of Social Services. Dr. John de Figueiredo was awarded Service to CPS for his many contributions to the CPS and his long time involvement in the APA Assembly as one of the CPS representatives.

At the conclusion of the business meeting was the election of the 2016-2017 slate of officers. The following members were approved: President-Elect: Melissa Welby, M.D., Secretary: Shaukat Khan, M.D., Treasurer: Sherrie Sharp, M.D., Councilor-at-Large: Tobias Wasser, M.D., Representative to the APA Assembly: Reena Kapoor, M.D.

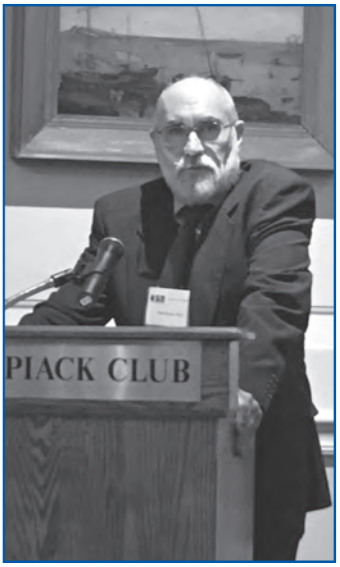


Keynote Speaker Dr. Phillip Resnick

From L-R: Drs. Sherrie Sharp, Tobias Wasser, Reena Kapoor, Caren Teitelbaum, Shaukat Khan and Melissa Welby



Award recipient Dr. John De Figueiredo



Award recipient Dr. Paul Desan

2016 Media Awards:
Honoring Connecticut's Best Mental Health Journalism

A Message from the Executive Office

For the twenty-eighth year, the CPS, along with the National Alliance on Mental Illness – Connecticut Chapter (NAMI-CT) and the Department of Mental Health and Addiction Services (DMHAS), sponsored a Media Awards event. On March 3, psychiatrists and legislators gathered in the Legislative Office Building in Hartford to honor the work of journalists who put the spotlight on mental illness in an effort to reduce stigma. Articles that originated in Connecticut were eligible for awards in print and broadcast categories. The three sponsoring organizations chose winners based on excellence in exploring the topic of mental illness.

This year's first and second place winner in the print category was Arielle Levin Becker. Arielle's article "Mental Health Agencies Take on Larger Role in Coordinating All Care," was awarded first place. In this article she explains the statewide effort to bring together mental and physical health care for thousands of people with serious mental illness, chronic medical conditions and high health care costs. Arielle reports that 15 local mental health agencies now serve as "behavioral health homes," designed to play a larger role in their clients' overall health. That means coordinating their medical and behavioral health care, offering wellness programs, tracking things like diabetes and blood pressure, and addressing barriers such as past experiences with trauma that can keep clients from getting the care they need.

Second place was given to Ms. Levin Becker for her article "Childhood Trauma Tied to Later Problems". In this article she informs us that decades of research have linked childhood trauma with a greater likelihood of developing both mental and physical health problems later in life. Studies suggest that the risks of health problems are particularly pronounced among those with four or more different types of adverse childhood experiences known as ACEs. She goes on to explain that policymakers in Connecticut are now trying to target that stress more directly, hoping that preventing exposure to trauma or identifying and treating it early can lead to better health, education and social outcomes. State social service officials are looking to expand or introduce parenting programs and other early childhood interventions, while in New Haven, there are several initiatives underway to reduce exposure to trauma, with the goals of improving health care outcomes while lowering cost. More projects in New Haven aim to improve access to mental health service early on by placing mental health clinicians and consultants in a pediatric primary care clinic, Early Head Start and elementary schools as well as focusing on addressing stress and depression in low-income mothers as a way to prevent ACEs in their children.

Honorable Mention in the print category was awarded to Mackenzie Rigg of the News-Times. In her article Mackenzie profiles Ed Noe who has been homeless for 25 years, the last 10 years in New Milford. Mr. Noe's behavior recently took an erratic turn and his mental state began deteriorating. He was diagnosed with Schizophrenia. With the help of a group of townspeople including a priest, social services director and members of the Danbury Hospital's community care team and medical professionals Mr. Noe received the help he needed and was evaluated and admitted to the psychiatric unit. Mr. Noe's sister Laura was interviewed for the story and was quoted as saying "He's been kept alive by the kindness of these people. He has survived because of people being able to see beyond a dirty homeless man."

This year we were pleased to announce that there were two first place winners in the broadcast category. Allan, Mike and Mary in the Morning was awarded for their podcast on WRCH "Maintaining Good Mental Health." In conjunction with Mental Health Awareness month, May of 2015 the morning show welcomed local psychologist Dr. Elaine Ducharme who educated the audience with facts and research on mental illness. Dr. Ducharme also reviewed signs of depression and shared tips on

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2016 Media Awards

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maintaining good mental health.

Also receiving first place in the broadcast category was the Colin McEnroe Show on WNPR for their presentation of "Unlocking the Mysteries of Alzheimer's Disease." During the hour show Mr. McEnroe speaks to Dr. Stephen Strittmatter and Dr. Christopher van Dyck, two researchers on the cutting-edge of research. Dr. Stephen Strittmatter is Professor of Neurology and Professor of Neurobiology, Director of Cellular Neuroscience, Neurodegeneration and Repair, and Director of the Memory Disorders Clinic at Yale. Dr. Christopher van Dyck is Professor of Psychiatry, Neurology, and Neurobiology and Director of the Alzheimer's Disease Research Unit at Yale University.

The Second place winner in the broadcast category was Where We Live for "Living with Autism Spectrum Disorder" on WNPR. During this broadcast they discussed Autism access, research and treatment. They welcomed several guest including healthcare reporter Arielle Levin Becker, Deborah Fein, Professor of psychology at the University of Connecticut, Donna Swanson, Executive Director at FOCUS Center for Autism, Dan Lenois, team leader for Spectrum Unplugged Panel and Mentoring Program at FOCUS and Rajesh Anandam, Co-Founder of Ultra Testing.

In addition to the award presentations, the event featured remarks by CPS Past President Dr. Brian Keyes and Mary Kate Mason, Director of Government Relations at DMHAS.

The event concluded with a reception where CPS members were afforded the opportunity to discuss issues of importance to the organization with legislators.

For copies of the award-winning articles, please contact Kristin Loney at the CPS Executive Office by telephone at 860-243-3977 or by email at cps@ssmgt.com.

Immediate past President Dr. Brian Keyes

Mary Kate Mason, DMHAS Government Relations

2016 Award Winners

L-R: Velandy Manohar, M.D., Brian Keyes, M.D., Jacquelyn Coleman, Paul Desan, M.D., Shaukat Khan, M.D.

2016 CPS Legislative Report

Melissa Dempsey and Jacquelyn Coleman

The General Assembly adjourned May 4. It was forced to reconvene to approve a highly contentious budget. Connecticut residents are feeling the effect of that budget through cuts to services and layoff of government workers. Bills of particular importance to CPS are reviewed below.

Senate Bill 67 - An Act Concerning the Authority and Responsibilities of Advanced Practice Registered Nurses. This bill attempted to update the state statutes to conform to the law granting APRNs independent practice. However, the strategy seems to have been to insert "and APRN" whenever the statutes referred to physicians. That was objectionable for many reasons. There were several amendments to the bill, all varying in length between 80 – 100 pages. CPS was pleased to see that provisions allowing APRNs to determine incapacitation for purposes of enacting a will or invoking a power of attorney were dropped. Our testimony pointed out that independent practice of nursing did not mean practice of medicine, and we cited potential civil liberties problems. Our position was supported by NAMI, CLRP and MHA. The bill as amended passed. The State Medical Society was very effective in negotiating this difficult bill.

Senate Bill 131 – An Act Concerning the Working Group on Behavioral Health Utilization. The bill was submitted by Senator Edward Kennedy, Jr. It proposed that the Working Group established by statute in June 2015 be reconvened to research the number of prior authorization requests for behavioral health services and the number of denials for such requests compared with the number of prior authorization requests for other health care services and the number of denials for such requests. It also adds that data be collected on the percentage of paid claims for out-of-network behavioral health services compared with the percentage of paid claims for other types of out-of-network health care and surgical services. As psychiatrists are aware, there are many reasons to believe that significant disparities between mental and physical health coverage still exist in Connecticut despite the passage of mental health parity. CPS is grateful to Senator Kennedy, for submitting the bill. It is now being implemented by the Insurance Commissioner.

Senate Bill 373 – An Act Limiting Changes to Health Insurers' Prescription Drug Formularies. This bill would have prohibited insurers and HMOs from removing a drug from a formulary (i.e., a list of covered prescription drugs) or reclassifying any covered drug into a higher cost sharing tier during a health insurance policy's term, unless the drug is deemed unsafe. The bill did not pass.

Senate Bill 372 – An Act Concerning Clinical Review Criteria for Utilization Review and Adverse Determination Notices. This bill expands the clinical review criteria that health carriers (e.g., insurers and HMOs) may use for utilization reviews. Under the bill, these may include criteria intended to address technological or treatment advances not covered in certain professional medical society treatment criteria publications. The bill also repeals a health carrier's disclosure requirement specific to clinical review criteria for (1) substance use disorders, (2) child or adolescent mental disorders, and (3) adult mental disorders. It replaces these specific requirements with a general disclosure applicable to all clinical review criteria. It passed with amendments.

House Bill 5517 –An Act Concerning Cost-Sharing for Prescription Drugs. This bill attempted to limit coinsurance, copayments, deductibles or other out-of-pocket expenses imposed on insureds for prescription drugs but was not voted on by the Insurance and Real Estate Committee by its committee deadline.

Senate Bill 134 - An Act Concerning Severe Mental or Emotional Impairment and Workers' Compensation Coverage. This bill makes police officers and firefighters eligible for workers' compensation benefits if: 1. while engaged in the line of duty, they see a person's death or its "immediate aftermath" (the scene of the death within six hours after law enforcement officers secure it) and 2. a licensed and board certified mental health professional diagnoses the officer or firefighter with post-traumatic stress disorder (PTSD) and determines that it originated from seeing the death or its immediate aftermath. While CPS supported the bill, we advocated that the bill did not go far enough in that we believe it is time for Connecticut to acknowledge that it is not just a police officer, firefighter or ambulance worker witnessing a death or maiming caused by the actions of another that should be compensable. This bill died as have all the others like it submitted in the past many years.

Senate Bill 433 – An Act Concerning Standards and Requirements for Health Carriers' Provider Networks and Contracts between Health Carriers and Participating Providers. This bill requires health carriers (e.g., insurers and HMOs) to establish and maintain adequate provider networks to assure that all covered benefits are accessible to covered individuals without unreasonable travel or delay. Carriers must ensure that emergency services are available at all times. Additionally, it requires a carrier to provide benefits at the in-network level of coverage when a nonparticipating provider performs covered services for a covered individual if a participating provider is not available in the network. The bill passed with amendments and we are awaiting the issuance of regulations for its implementation.

House Bill 5531 – An Act Concerning the Care and Treatment of Persons with a Mental Illness or Substance Use Disorder. The bill would have provided a Probate Court with the authority to appoint a conservator of the person who may consent to the administration of medication on behalf of a conserved person who has a mental illness or substance use disorder but was not approved by the Judiciary Committee by its committee deadline.

Melissa Dempsey is the Government Relations Director and Jacquelyn Coleman is the Executive Director of the Connecticut Psychiatric Society

A Message from the CPS President

Caren Teitelbaum, M.D.

I am delighted and honored to be your new president and to follow the thoughtful leadership of Dr. Reena Kapoor. Prior to my becoming an active member of CPS, the value of my membership wasn't clear to me. Recalling that time has made me recognize that it may not be clear to you what a CPS membership offers. Having attended CPS meetings for several years, I have seen how we are frequently bombarded with legislation and other policy initiatives that can have deleterious consequences for our patients' ability to receive proper care and for our members to deliver it. If we do not monitor these issues and devise thoughtful responses, then, by default, we allow our patients' lives and the way we practice to be at the complete mercy of others. As your representative in Connecticut, CPS provides crucial advocacy for your patients and for your continued ability to practice safe and gratifying psychiatry. An example is a bill recently proposed in the legislature which would have allowed non-physicians to evaluate the fitness of physicians. CPS had an important lobbying role in preventing the passage of this bill.

Last October I attended the State Advocacy conference sponsored by the APA, where I received public policy advocacy training. A central tenet of that conference was that we cannot allow complexity to paralyze us. A recent example of how complexity can lead to paralysis concerns mental health parity legislation. Although enacted into law at both the local and federal level, such parity is far from a reality throughout the country, including in Connecticut. As one Executive Director at the conference explained, it took him eighteen months to understand the federal mental health parity law, and it may well be the case that almost no one, including its drafters, fully understands it.

However, this complexity notwithstanding, several states have made significant inroads into parity enforcement. CPS has within the last few years begun to join this effort and in the last year in earnest. Those of you who filled out the survey we sent played a crucial role in defying the notion that complexity necessitates paralysis. One of the reasons cited for not enforcing the federal and local parity laws is the absence of data demonstrating that such laws are being violated. By filling out the survey, you provided necessary data that CPS can use to make clear to those responsible for enforcement that parity between mental health and other medical specialties is far from a reality. Your contribution has been crucial.

"As your representative in Connecticut, CPS provides crucial advocacy for your patients and for your continued ability to practice safe and gratifying psychiatry."

In addition to the work concerning parity, a core group of members are doing their best to advocate thoughtfully in several other complex domains—including the needs of patients who are homeless, safe prescribing by psychiatric and non-psychiatric prescribers, the appropriate implementation of new models of care, and other areas as well. The more members actively involved the more CPS can influence the very real forces that have a profound impact on our patients. I know that most of us are overcommitted, but the time that it took to fill out that recent survey was likely less time than it takes to obtain a prior authorization. So, if you can take a few moments to fill out brief surveys or to e-mail form letters to congressional representatives, you can make a genuine contribution to the work CPS is trying to do for everyone. I also encourage you to spread the word and encourage your colleagues to contribute what they can. Please remind them a few minutes of time can genuinely help to effect change.

We also need to provide our organization with a future. We have close to eight hundred members with different talents and needs. For those of you who mentor early career psychiatrists, please bring them with you to meetings and encourage them to become involved. For those of you who are mid-career or have been in the field for many years, I welcome your expertise and experience. For those of you who are in retirement, you bring essential perspectives and experience, and I very much welcome your involvement in CPS initiatives.

I look forward to an exciting and productive year.

2017 MENTAL ILLNESS MEDIA AWARDS

Entries in the Twenty-ninth Annual Mental Illness Media Awards competition are sought by sponsoring organizations, the Connecticut Psychiatric Society (CPS), the National Alliance on Mental Illness (Connecticut NAMI), and the Connecticut Department of Mental Health and Addictions Services (DMHAS). The Media Awards honor journalists who put the spotlight on mental illness and mental health, promoting greater understanding of mental illness, and of the great potential for treatment, rehabilitation and recovery. Winning articles or presentations on mental illness that originate in Connecticut between January 1, 2016 and December 31, 2016 in print and broadcast will receive "Awards for Excellence" at our Mental Illness Media Awards ceremony held in the Spring at the LOB in Hartford. **The deadline for submission is January 31, 2017**. Anyone can make a nomination for this award. A panel of judges from the sponsoring organizations will select the winners in early 2017. Entry forms can be obtained at 860-243-3977 or cps@ssmgt.com.

Talk (Radio) Therapy in Sierra Leone

Ayana Jordan M.D., Ph.D.

My studies and travel throughout Africa have been driven by my interest in global mental health. So when a former medical school classmate of mine started an organization called Wellbody Alliance, which provides free medical care to people in the Kono District of Sierra Leone, I seized the opportunity.

In 2011, I applied for a grant that enabled me to work in Sierra Leone for three months, chronicling the types of mental disorders seen in the Kono population. The people I worked with included victims of the civil war in Sierra Leone, namely child soldiers, amputee civilians and female rape victims, who are not only shunned by the community at large but also have essentially no access to mental health care services,

With certainty, the need for mental health services in Sierra Leone, a country recovering from civil war, is dire. In 2009, it was estimated that 442,000 people in Sierra Leone struggled with a mental disorder; of these only 2,058 received formal treatment. Based on these numbers, the estimated treatment gap for mental illness in Sierra Leone is an astounding 99.5 % (WHO, 2012). Although the College of Medicine and Allied Health Services (COMAHS), the first medical school opened in Sierra Leone, graduated its first class of 21 psychiatric nurses in 2012, these graduates have yet to be incorporated into the formal health system. The goal of my work, and the work of so many other, has been to help develop innovate strategies to address Sierra Leone's growing mental health care crisis.

Since 2011, I have since returned to Sierra Leone three additional times–in 2012, 2013, and most recently in January of 2014. I was awarded a global mental health grant from the Association of Women Psychiatrists' to continue my work studying the link between mental illness, substance use, and associated stigma in the Kono District of Sierra Leone, West Africa.

Unfortunately, given the Ebola outbreak in West Africa, I was unable to return in 2015 to continue my research as planned, however I felt obliged and passionate about helping Sierra Leoneans in the midst of their crisis. I began to think about how I could be most helpful to people of Sierra Leone, while remaining here in the US. I brainstormed possible projects with Sierra Leonean-born psychiatrist, Dr. Mandy Garber, who I met during my initial visit to Sierra Leone. (Dr. Garber currently practices in my hometown of Pittsburgh, Pennsylvania.) We settled on the radio show idea, a platform that proved successful in reaching Haitians following the catastrophic earthquake of 2010.

I'm happy to report that so far, four one-hour programs have aired live on Star Radio in Sierra Leone, and thousands of people tuned into this particular radio network, where the shows aired. The shows were broadcasted in the four largest cities in the country—the capital city of Freetown, as well as nearby cities Bo Town, Kenema, and Makeni. All shows were broadcast in Krio, the common language spoken in Sierra Leone, and featured mental health providers speaking about Ebola, how the disease is spread, and the mental distress that is being caused by the crisis. Listeners called-in with questions, and we also shared local mental health resources, so that individuals knew where to go for counseling and assistance with coping.

Due to the overwhelmingly positive response to the radio program, I was able to obtain funds from the Yale Global Mental Health Program to continue more radio programs; specifically addressing the unique mental health concerns in the community.

This radio movement is now a collaborative project led by the Sierra Leone Mental Health Initiative (SLMHI), a group of mental health professionals (including Dr. Garber and myself) in the African diaspora committed to addressing mental health needs in Sierra Leone, along with Enabling Access to Mental Health, the Mental Health Coalition of Sierra Leone, Yoga Strength, and the Bellevue/NYU Program for Survivors of Torture. In a population of people that have already gone through a horrendous civil war, with many survivors of torture, and unheard atrocities, my goal is for listeners to not only have access to accurate, culturally relevant mental health information, but also feel supported.

Given the low literacy rate in Sierra Leone, coupled by the fact that many do not have access to the internet, and listen to the radio for information, the use of the radio to broadcast information has proven to be a crucial platform for sharing much needed information. Through the course of this radio intervention, SLMHI has learned of the following lessons:

(i) Sierra Leoneans are eager to engage with "experts";
(ii) Listeners are keen to share their concerns and want their experiences validated;
(iii) In a country where cellular phone fees are quite exorbitant, texting is a preferred form of communication.

Based on the lessons learned and the positive response to the radio show, SLMHI believes that an ongoing national radio show focusing on mental health in Sierra Leone is timely. Also, we plan to arrange for listeners to text in questions after the show that can be addressed on air, or in subsequent radio programs, a way to ensure and tailor the intervention to the wants of the people.

In February 2016, Dr. Garber and I launched the first radio program of the next series, LIVE in Freetown, the capital of Sierra Leone. Over the next year, SLMHI and its partners will launch monthly radio broadcasts to focus on the following major categories of mental health: grief and loss, substance use disorders, mood disorders, psychoses, and childhood mental Illnesses. The overall message of the program is this: You are not alone. Please do not feel abandoned. There are local and global mental health communities that are dedicated to helping you cope and ease the suffering of trauma and disease, while providing information on local mental health resources.

World Health Organization. (2012). Mental health in development: Sierra Leone. Retrieved from http://www.who.int/mental_health/policy/country/sierra_leone_country_summary_2012.pdf

Substance Abuse in Adolescent Bariatric Surgery Patients

Caitlin Tillberg, PGY-4, Frank H. Netter School of Medicine, Quinnipiac University

As of 2012, 1 in 5 children between ages 12 and 19 met criteria for childhood obesity, defined as weighing at or above the 95th percentile of sex-specific CDC body mass index-for-age growth charts (CDC 2014). Obese youth are more likely than non-obese children to suffer from a variety of health complications, including but not limited to diabetes, hypertension, fatty liver disease, and sleep apnea; over 80% of obese children will be obese in adulthood as well. (Hsia et al. 2012)

Bariatric surgery, also known as weight loss surgery, performed in adolescence is one of the few effective ways to decrease the likelihood of remaining obese into adulthood. To be eligible, adolescents must have a BMI at or above 35 with a major comorbidity (Type 2 diabetes mellitus, moderate or severe obstructive sleep apnea, pseudotumor cerebri, or severe nonalcoholic steatohepatitis), or a BMI at or above 40 with other comorbidities (Kindel et al. 2015). The 1991 National Institutes of Health (NIH) consensus criteria stipulated that treatment of obesity with bariatric surgery is limited to adults but as obesity rates have increased among adolescents, the procedures have become more accepted for use in this age group. (Mechanick et al. 2013) Since 2004, about 1,000 adolescents per year have undergone bariatric surgery in the United States; most were 17 or older at the time, with a mean age of 18. (Kindel et al. 2015; Steele 2013)

Many factors influence the determination of eligibility for surgery, and assessing for pre-existing substance use disorders (SUDs) in adult surgery candidates is standard. However, the American Society for Metabolic and Bariatric Surgery (ASMBS) pediatric committee's 2012 best practice guidelines do not address SUDs at all. (Michalsky et al. 2012)

Substance use disorder screening, prevention, and treatment are important for the health of all adolescents, but they are particularly important for obese adolescents who will undergo or have undergone bariatric surgery. While any still-developing adolescent faces greater risks from substance abuse than an adult would, adolescent bariatric surgery patients (BSPs) must also contend with potential risks of intra- and post-operative adverse events, as well as poor pre- or post-operative adherence to treatment plans. Post-operative BSPs of any age are also vulnerable to increased direct harm from alcohol use in particular, due to post-operative physiological changes in alcohol's absorption and metabolism. (Klockhoff et al. 2002)

An active SUD, including alcohol use disorder, is a contraindication for bariatric surgery. (Spadola et al. 2015). In fact, history of any illicit drug use up to five years prior to surgery may be grounds for denial of the surgery, depending upon the particular surgery program. (Rummell & Heinberg 2014) Therefore, bariatric surgery candidates of any age have a strong incentive to downplay or deny problematic substance use during the approval process.

Adolescents have particularly strong motivations to deny substance use, as consuming alcohol under age 21 and smoking under age 18 or 19 are illegal in the US. In addition to the usual consequences adults face upon admitting to substance abuse, such as discord with family or partners, adolescents who admit substance use must anticipate negative consequences from parents or other authority figures as well, such as facing curtailed privileges at home or disciplinary action at school.

Like adults, teenagers are forced to make small decisions constantly, and they will eventually face the cumulative, long-term consequences of those decisions, whether they relate to food choices, smoking, drinking, or other substance use. Adolescents are thought to have comparatively poor impulse control due to the differential development of certain brain structures and pathways. An important factor that could contribute to impulsivity and risk-taking is the elevation of activity in teenagers' dopaminergic pathways, particularly in the ventral striatum, which leaves them more sensitive to rewards than younger or older people. At the same time, the association areas that underlie cognitive control mature more slowly than other regions. Although there are obviously many biological and psychosocial factors affecting adolescent behavior, it is plausible that the combination of those first two factors leaves teenagers with a biological incentive for reward-seeking behaviors without an adult-level counterbalance. (Geier 2013, Romer 2010) A manifestation of this setup is the phenomenon of "delay discounting," which describes how future rewards pale (are "discounted") in comparison to immediately available ones, in proportion to duration (the delay) between the decision and the reward. (Daniel et al. 2015) Predictably, delay discounting has a greater magnitude in youth than in adults, and notably, delay discounting is particularly pronounced in obese youth facing decisions about food. (Daniel et al. 2013)

Evidence is mixed regarding the prevalence of substance use among obese adolescents. Lanza et al. (2015) suggest increased risk, with the explanation that the teenagers may seek out additional social interaction but be embraced only by these already-marginalized, delinquent peer groups. Furthermore obesity in adolescence is also associated with increased depressive symptoms, so obese teenagers may be more likely to self-medicate with illicit substances in order to cope with social difficulties. However, for extremely obese teenagers in particular (≥99th percentile) there is evidence that the risk of substance use may be similar to that of normal weight peers. (Ratcliff 2011)

For adolescent BSPs, age group alone is an additional risk factor for development of new SUDs post-operatively. For example, people are most at risk for developing alcohol use disorder between ages 18 and 20. (Brown et al. 2008) This is in contrast to the situation of adult BSPs, who would have already passed the peak age for new-onset SUDs at the time of surgery.

Adolescent BSPs must navigate not only the usual challenges of maturation

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Personal Perspectives on Psychiatry

Serena Spruill
Prepared by Swapnil Gupta, M.D. and Rebecca Miller, Ph.D.

This is the first of a series of essays on personal experiences with psychiatry. Ms. Spruill currently works in Peer Support at Connecticut Mental Health Center where she provides education to new employees and fellows on what is helpful in treatment. In this piece she talks about what was helpful to her in her work with psychiatric providers.

Ms. Spruill's piece helps us return to the fundamentals of practice: listening deeply, offering hope, inspiring action, providing validation, and using knowledge to empower and heal. These are key elements of our work but may at times be overlooked in the time-pressured environment of today's practice. Her story calls to mind the findings on the therapeutic alliance accounting for the highest percentage of variance in outcomes [1], and the importance of 'common factors' [2] in the doctor-patient relationship.

"He gave me hope…"
Things that were helpful to me, one of the biggest things was to be truly listened to. I know I was being truly listened to when I began to feel hopeful and when I was offered solutions. One doctor, he gave me hope, he reminded me to think of my passions in life, either past or ones that I wanted to do in the future. He helped my self-esteem by making me feel capable even with my mental illness. He read some of my writings, even though he was swamped with work and was so busy himself. He felt my need for somebody to look at my writings from a clinical perspective. He helped me to make sense of what I was writing and he saw different themes, which helped me understand what I was trying to say.

"I needed that to feel validated"
At first I wasn't really writing and then I started doing automatic writing, like a spirit came through me and the writings were the spirit's writings, totally separate from mine, two distinct essences in the same body at that time. He read some of those writings so he knew where I was coming from, and where I was at with my mental illness. It left me feeling great, because I was listened to and heard. I needed that to feel validated and understood about what I was going through at the time, and he helped me understand it, with comments about what he noticed about the writing. When he gave the writings back to me, I could see he made little notations next to certain sentences and so I knew he had really gotten something out of the writing.

"He told me I could try"
When I found out I had mental illness, I thought all I was going to be was a vegetable, a blob and a zombie who sat around all day. I thought I would be hospitalized for the rest of my life, and I didn't think I would have a life outside an institution at all, because I didn't feel capable. I had a sister who had mental illness and I saw it first hand and I thought I was going to end up being a ditto. But the doctor told me I didn't have to live my life that way, and that the first thing was to find the right medication, and I did that. He told me I could try.

"I can do it if he did it."
I also saw this guy who was worse than I was, he would leave the hospital every day 2-3 times a week, for a few hours, and I used to always wonder what he was doing. And one day, he said he was going to school. And I was like, wow, that gave me incentive to try because if he can do it, then I know I can at least try. And years later I saw him again and I said I remember you, and are you still going to school? And he said, "I finished!" and I said wow now I know I can do it if he did it.

"My life built from there on."
The medication took away the voices and I began to work on my recovery process. But until then I was stuck. The doctor said take a look at some of your interests from the past and things that you wanted to do. I said I always wanted to go back to school, to become a midwife. So I went back to Gateway Community College, I took one class just to see if my brain would work, and even if it didn't work, I would have tried and done something productive and spent time not just at the hospital. So I did that, and my life built from there on.

"Now I know myself."
I had to get to know myself because sometimes the voices would make it hard for me to work. Before I found the medication that worked best for me, I was having difficulty studying and I had to work through those and learn how to study so I could get the grades to pass the tests. I learned how to work around myself, sometimes when I wanted to study because of the illness I couldn't do it so I had to wait a while. I had to gauge myself and anticipate when it would be a good time. I would get sleepy, some of it was my pills and some of it was just me. I had to work toward being a responsible student. Now I know myself, what works and what doesn't work and I just go on from there. I'm not passive, I have a voice and I know how to advocate for myself. I wear my emotions on my face, and need to work on it sometimes.

"You don't want to be talking to a stone wall."
I had pretty good experiences overall with doctors, but when I first came through the doors the person I was talking to, he had no affect, no animation, no nothing. I thought I was talking to a robot, I didn't know if he was really hearing me or what I was saying. I didn't want to deal with him anymore. I didn't even feel like I was talking to a human being. I just remember that. And when I came back the third time they had somebody else there who I felt was connected and I felt listened to. You feel connected if you're having a one on one about this serious stuff, you need to know that it's getting through. I mean you don't want to be talking to a stone wall, you want to be talking to a living breathing person, someone that responds to you and has empathy and cares.

"People don't feel listened to."
The main thing that keeps coming up is people don't feel listened to, they would say what's been going on with them and then it's like dismissed, like it's not valid, and they don't feel like they need to act

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Depression, Shame and Stigma in Therapists: To Share, or Not to Share – That is the Question

John S. Tamerin, M.D.

Let me begin by presenting some data on the prevalence of depression in physicians and the problem physicians have in dealing with the reality of this illness which is rather different than the reality of dealing with any other illness including cancer.

An article was published in JAMA last year titled *"Prevalence of Depression and Depressive Symptoms Among Resident Physicians."* It was based on a massive compendium of 50 studies of 18,000 physicians in training and found the prevalence of depression was 29% (close to 1 in 3). We all know that medical training is highly stressful and might be a precipitating factor. However, depression does not disappear among physicians once their training is completed.

Studies have revealed that depression remains more common in the medical profession than in the general population, affecting an estimated 12% of male and 18% of female physicians. This is impressive since so much of the current epidemiologic research connects depression with poverty and unemployment. Yet, the average physician in America earns from $239,000 a year in the Northeast to $258,000 in the Great Lakes region.

The high prevalence of depression among physicians is not only true in the United States. A 2011 survey of 50,000 practicing physicians in Australia demonstrated a dramatically increased incidence of severe psychological distress and a twofold increased incidence of suicidal ideation in physicians compared with the general population. Sadly, although physicians globally have a lower mortality risk from cancer and heart disease relative to the general population (presumably related to self-care and early diagnosis), they have a significantly higher risk of dying from suicide: the end stage of an eminently treatable disease process – depression.

Indeed, although physicians seem to have generally heeded their own advice about avoiding smoking and other common risk factors for early mortality, they are decidedly reluctant to address depression, a significant cause of morbidity and mortality that disproportionately affects them.

A number of studies have revealed that over 60% of physicians with suicidal ideation indicated they were reluctant to seek help due to concern that it could affect their medical license. To some extent, physicians' reluctance to reach out may be self-imposed. Physicians feel an obligation to appear healthy, perhaps as evidence of their ability to heal others. They may feel this is what their patients expect of them.

The consequence of all of this is that on average the United States loses as many as 400 physicians to suicide each year, the equivalent of at least three entire medical school classes. The physician suicide rate cited in most studies has been between 28 and 40 per 100,000 compared with the overall rate in the general population of 12.3 per 100,000. Overall, then, physicians are more than twice as likely as the general population to kill themselves. Female physicians appear to be especially vulnerable. Suicide rates for women physicians are approximately four times that of women in the general population.

A major impediment preventing physicians from being able to honestly face depression is that physicians who have reported depressive symptoms to their licensing boards, potential employers, hospitals and other credentialing agencies have experienced a range of negative consequences, including repetitive and intrusive examinations, licensure restrictions, discriminatory employment decisions, practice restrictions, hospital privilege limitations, and increased supervision.

Even if disability insurance has previously been procured, its use may subject physicians to repeated humiliating and invasive examinations by detached and dubious "independent medical examiners" for the insurer, whose motivation is to cut company losses.

Many physicians affected by mental illness feel that insurers expect them to adhere to the standard prescription: "Physician, heal thyself!" (i.e. solve your own problems or keep them to yourself). Sharing this reality with others can be hazardous to your health! This may help to explain the reluctance on the part of physicians to step forward and serve as role models either via public statements like those made by Kay Jamison or Marsha Linehan or by a private disclosure to a colleague.

A U.S. study found that half of all psychiatrists with a depressive illness would prefer to self-medicate rather than risk having their illness recognized by another physician. A recent study of Canadian psychiatrists found that one third of respondents admitted to a mental illness. What is equally significant is that only 10% would disclose a mental illness to a colleague because of career implications and sense of stigma. Furthermore, for the same reasons, three-quarters indicated that if they required hospitalization they would choose to go out of area. Twice as many physicians cited confidentiality as being more important than the quality of care they might receive in their own community. How different this is than when a physician searches for the best surgical care he or she might receive for cancer.

In the simplest terms, one female physician put it this way: "People reach out when you have breast cancer. They hug you and send cards. When you have depression they withdraw and send no cards."

What I found striking as I started researching this topic both on my own and with the assistance of a medical librarian was that there were so few articles on this very important subject. There is limited research, limited prevalence data, even less advice to doctors with this problem and virtually nothing to be found about the value of self-revelation, of sharing, of "coming out." Simply stated, there are huge negative consequences associated with "coming out."

So the trend among depressed psychiatrists is certainly denial and

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Personal Perspectives

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upon what was being expressed. They're not listening to me, I told them and they still won't listen. The stress of whatever is making their symptoms worse, like a bad roommate situation or red tape with social security, and it feels like nothing is happened and what they said is being dismissed, "Staff doesn't care about me." It's still going on, they're still not listening to me.

"I had to do my part too."
They can only do it up to a certain point, but I had to do my part too. They can only do as much as you let them. At the same time you have to want it, you have to have the drive yourself. No one can do it for you. Basically when you get mental illness you're just that person with mental illness. If you never learn to live your life properly then you won't take off. Once you learn about these things and see how you can do things then you do it. You learn before you get mental illness, and then you can kick back in after you have mental illness. If you never learned how to live before mental illness then you need more help getting able to live.

"Not afraid to be a rogue."
The qualities of a good doctor in my mind are somebody that knows their stuff and knows how to use it to benefit everyone, the clients and the staff. Not afraid to be a rogue if needed, because sometimes you have to be the one that starts things that aren't in place already, things that you care about that you know will make a positive difference in everybody's lives that you come in contact with on the job. The people that learned what they were supposed to have learned in school, and then have learned what they can on the job, they're open to learning any way they can, through clients, peer support, other staff members, books or whatever it is that might come across their plate, they keep up with things and are educated.

"Plant the seed."
Know how to use it – you have to have good communication skills across the board, to everyone, staff and clients. You need to have expert communication skills and know when to use them. Don't keep talking to someone to whom you know you're not getting through to, leave it, maybe you'll have a better time at a later date, plant the seed and keep on going. You have to meet them where they are at, you can't talk over somebody's head, not using jargon when you can say it in a different way. Sometimes we think we're connecting with them on their level, using their language, but we're already behind the times, the words have been on the streets for years, phrases that we're just learning. Just being aware of it is enough, because you can date yourself and joke about it and that's enough. Because psychiatric jargon is so different in how you talk to a client, with a client you might use street talk so they can understand you.

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A MESSAGE FROM THE UNITED STATES SURGEON GENERAL
Vivek H. Murthy, M.D., M.B.A.

Dear Colleague,

I am asking for your help to solve an urgent health crisis facing America: the opioid epidemic. Everywhere I travel, I see communities devastated by opioid overdoses. I meet families too ashamed to seek treatment for addiction. And I will never forget my own patient whose opioid use disorder began with a course of morphine after a routine procedure.

It is important to recognize that we arrived at this place on a path paved with good intentions. Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do so safely. This coincided with heavy marketing of opioids to doctors. Many of us were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain.

The results have been devastating. Since 1999, opioid overdose deaths have quadrupled and opioid prescriptions have increased markedly – almost enough for every adult in America to have a bottle of pills. Yet the amount of pain reported by Americans has not changed. Now, nearly 2 million people in America have a prescription opioid use disorder, contributing to increased heroin use and the spread of HIV and hepatitis C.

I know solving this problem will not be easy. We often struggle to balance reducing our patients' pain with increasing their risk of opioid addiction. But, as clinicians, we have the unique power to help end this epidemic. As cynical as times may seem, the public still looks to our profession for hope during difficult moments. This is one of those times.

That is why I am asking you to pledge your commitment to turn the tide on the opioid crisis. https://psychiatry.org/psychiatrists/end-the-opioid-epidemic Together, we will build a national movement of clinicians to do three things:

First, we will educate ourselves to treat pain safely and effectively. A good place to start is this pocket guide available at http://turnthetiderx.org/treatment/#, with the CDC Opioid Prescribing Guideline. Second, we will screen our patients for opioid use disorder and provide or connect them with evidence-based treatment. Third, we can shape how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing.

Years from now, I want us to look back and know that, in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way. I know we can succeed because health care is more than an occupation to us. It is a calling rooted in empathy, science, and service to humanity. These values unite us. They remain our greatest strength.

Thank you for your leadership.

Substance Abuse

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but also dramatic changes in their appearance and daily life, which will affect their concept of their own identity as well as their family and social relationships. Once weight loss is underway, adolescent BSPs may feel that they have access to social circles or activities, such as clubbing or "hooking up," that were previously less available to them, whether due to others' disapproval or simply their own discomfort or low self-esteem. Post-op adolescent BSPs' restrictions on food consumption will also set them apart during the many social situations that involve eating (e.g. birthday parties, watching sports, or simply friends going out to eat together) and may cause them to feel that they are "missing out" on new experiences; participating in substance use provides an avenue to become more fully integrated into social gatherings.

Although substance-related decision-making is challenging for adults as well, teenagers are at increased risk of long-term negative outcomes related to substance use because of the effects of substance abuse on the ongoing development of their brains and bodies. Given their still-developing decision-making capabilities, adolescents may be less likely than adults to appreciate the reasons why bariatric surgery is contraindicated with SUDs: namely, the risk of adverse surgery outcomes and the risk of treatment failure. Adolescents may view the prohibition on substance use as an administrative obstacle to be circumvented rather than a precaution intended to maximize the likelihood of success.

There are a variety of substance-related adverse effects after bariatric surgery. Obesity is a risk factor for venous thromboembolism (VTE) in general; as BMI increases, so does the risk. Undergoing surgery also increases the likelihood of VTE for patients of any weight, and the effects of surgery and obesity together on VTE risk are synergistic. (Parkin et al. 2012) If a BSP is a smoker, current smoking contributes another risk factor for VTE in general and post-operative VTE in particular. Current smoking at the time of surgery is also associated with increased risk of post-operative pneumonia, post-operative infections at the surgical site, and mortality. (Hawn et al. 2011, Musallam et al. 2013, Sweetland et al. 2013) As a result, extremely obese patients undergoing any type of surgery are particularly discouraged from smoking.

Thromboembolism is only one of the substance-related adverse effects that can occur in the short-term or long-term following bariatric surgery. Smoking can also interfere with recovery, as it is associated with increased incidence of post-operative marginal ulcers (at the anastomosis site in Roux-en-Y gastric bypass), pneumonia, and infections, and smokers often have more difficulty with post-operative pain management (Rummell & Heinberg 2014).

Post-operative substance use has the potential to interfere specifically with weight loss. Alcohol is calorically dense, and one or two alcoholic drinks can comprise a significant percentage of the recommended daily calorie intake, which is set considerably lower for BSPs than for the average person. Marijuana provides another example, as its active ingredient of tetra-hydrocannabinol can increase subjective feelings of hunger. Additionally, intoxication with illicit substances, such as heroin, can impair executive function and decrease motivation for strict adherence to treatment plans. Some patients may also turn to smoking or cocaine, in attempts to increase their weight loss or energy (Moser et al. 2015).

An alcohol use disorder is the SUD most likely to develop post-operatively. Metabolism of alcohol also changes after bariatric surgery. Indeed, anything that a patient consumes enterally will be metabolized differently post-operatively (Spadola et al. 2015) Furthermore, for a patient who has lost a large amount of weight, the same amount of ethanol consumption results in a higher amount of ethanol per kilogram of body weight. Alcohol use can therefore be particularly dangerous in post-operative adolescent BSPs, given adolescents' propensity for binge-drinking. (Klockhoff et al. 2002)

Aside from the general health benefits of detecting and treating substance abuse, treatment of SUDs prior to bariatric surgery is actually associated with greater post-operative weight loss, when compared to people who had never had a SUD. A history of SUDs (but not current substance use) is more common among bariatric surgery candidates than in the general population, and having recovered from an SUD prior to bariatric surgery can give patients experience and tools to make major behavioral changes. (Kalarchian et al. 2007) This may in turn improve their adherence to post-operative treatment plans for diet and exercise, leading to more weight loss. (Mechanick et al. 2013) Encouragingly, most patients who were already in recovery for SUD prior to surgery did not relapse during the time period studied afterwards. (Ivezaj et al. 2015)

Including substance abuse screening as part of the formal guidelines for adolescent bariatric surgery would be a straightforward way to increase the likelihood of being able to identify and treat pre- and post-operative SUDs, before they result in significant harm to patients. As a large percentage of post-operative patients undergoing treatment for SUDs indicate that they had not had a SUD prior to undergoing surgery, it would be important to continue this screening at post-operative visits indefinitely. (Spadola et al. 2015; Ivezaj et al. 2015)

In conclusion, extremely obese adolescents are in a position to benefit greatly from bariatric surgery. However, they are also vulnerable to developing SUDs, which in turn can have more deleterious effects on them and their health and development than might be the case for adult BSPs. In the context of bariatric surgery, SUDs can be associated with significant morbidity and even mortality. As a result, it is imperative to screen for and treat these disorders as they arise.

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Depression

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concealment and, even if, by some chance, a depressed physician or therapist were aware of the existence of a support group for people suffering with depression, there would be a huge reluctance to attend such a group where, God forbid, they might run into one of their patients! Presumably, this might be analogous to a physician's reluctance to attend an AA meeting in his or her community.

Though, I should comment that there is perhaps less stigma in 2016 in going for rehab and/or attending an AA meeting than in attending a support group for major depression or bipolar disorder. In this context, it may surprise some of you to learn that there actually is an organization that can easily be found online called the idaa.org, International Doctors in Alcoholics Anonymous. The organization has existed since 1949. We have nothing like this for doctors or therapists suffering with depression.

What about the prevalence of depression among psychiatrists as compared with other physicians? A study from Johns Hopkins of 1,300 of their graduates found that psychiatrists had the highest rate of suicide of any of the medical specialties. In another study, Blachly and his colleagues gathered data on 249 physicians listed in JAMA obituary columns and made extrapolations to determine which specialties had the highest risk of suicide. They interpreted their data to show that psychiatrists had the highest suicide rate and pediatricians had the lowest. Further support for the notion that psychiatrists might be at higher risk is found in the work of Rich and Pitts who found that psychiatrists committed suicide at twice the expected rate.

Now I would like to shift the focus from prevalence, shame and concealment to the value of people who have suffered with depression acknowledging their illness and then utilizing this experience as an opportunity to meet with peers, share their pain and both receive and offer help.

"Who then can so softly bind up the wound of another as he who has felt the same wound himself."

This quote, attributed to Thomas Jefferson, the father of the Declaration of Independence, serves as the symbol of the Greenwich Depression and Bipolar Support Alliance (DBSA) support group.

DBSA was started thirty years ago in Chicago to provide support for people with depression and bipolar disorder through establishing support groups in many communities in the United States. There are now 1,000 support groups in our fifty states. Our chapter in Greenwich was started fifteen years ago. It was the first chapter in Connecticut, and there are now five additional chapters in the state.

Of course, as a prerequisite to participating in peer support – whether as a layman, a lawyer, a physician, a psychiatrist, a psychologist, a social worker or a minister, all of whom have been members of our Greenwich DBSA support group at one time or another – the individual must find the courage to self-identify as currently having or having had depression or bipolar illness in themselves or in a loved one.

"Who then can so softly bind up the wound of another as he who has felt the same wound himself."

Permit me to further personalize this subject of depression by inviting you to ask yourself the following questions:

Have you ever been depressed or had a family member with depression?

1. If you answered YES:
   a. Have you ever told a member of your family about it?
   b. Have you ever told a friend about it?
   c. Have you ever told a professional colleague?
   d. Have you ever shared it with someone in your hospital or in your department of psychiatry?
   e. Have you ever shared it with a patient?

2. How would you feel if a patient knew that you or a family member were or had been depressed?

3. Have you ever felt ashamed of having depression?

4. Do you believe that having had depression or a family member having had depression has had a negative impact on your ability to work with depressed patients?

5. Or has it in any way been beneficial – enabling you to be more understanding, more compassionate or perhaps more authentic in working with a depressed patient?

6. If you felt it would benefit a patient, would you ever share your having had depression and/or any of the details associated with your experience?

7. What factors would you consider in deciding whether or not to discuss your having had depression with a patient?

8. Have you ever referred a depressed patient to a peer support group like the Depression and Bipolar Support Alliance?

9. Would you consider attending a meeting to explore its usefulness for your patients?

10. Would you consider attending a DBSA meeting for your own personal support? Or would you refer a member of your family to a DBSA support group meeting?

I would like to conclude by saying that in the intervening 14 years, although many well-known actors, athletes, artists, musicians, entertainers, prominent public figures, politicians, and even astronaut Buzz Aldrin have come forth and have acknowledged being depressed, very few physicians and/or psychiatrists have followed their example and have written or spoken about their personal experience of being depressed.

There has been one recent exception. On May 15th of this year, an article appeared in the Hartford Courant titled: "Damaging Secrets: Breaching Wall Of Silence About Mental Health," written

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by Charles Atkins, a member of the Yale Voluntary Faculty. Dr. Atkins had the courage to acknowledge his own depression and concluded his article by saying: "So as I think about how we'll ever make inroads past the negativity and discrimination concerning mental health, a good place to start is among the professionals, such as me. That artificial wall of us and them must come down…" and he ends with saying "…how nice it would be if we could ever get to the point where acknowledging things that are a common part of the human condition could be freely discussed without fear and the threat of negative consequences."

Perhaps it is time for other psychiatrists to discover the power that results from being both authentic and vulnerable. I suspect that if they find the courage to "come out" as Dr. Atkins has done, they might even have the experience that Martin Buber famously identified: "When people relate to each other authentically and humanly, God is the electricity that surges between them."

Dr. Tamerin is a Clinical Associate Professor of Psychiatry at the Weill/Cornell School of Medicine. He is a member of the Board of Directors and the Scientific Advisory Board of the Depression and Bipolar Support Alliance. (To read Dr. Tamerins own personal experience with depression and bipolar disorder visit the Greenwich DBSA website www.dbsagreenwichct.com click on the Founder's Statement)

Connecticut BHP
Supporting Health and Recovery

We are all hearing every day about the opioid crisis that impacts every community in America. Given your area of expertise and practice, it is likely that you strive daily to help address this epidemic of addiction. Despite all the clinical effort being made so far, the statistics below shed some light on where things stand in Connecticut:

- There were 434 deaths from drug overdoses involving opioids in CT last year;
- Rates of opioid related deaths are increasing.
- Approximately 70% of 911 responses last year involved caring for a person who overdosed.
- More than 50% of those who overdose die at the scene—they are not making it to the hospital.
- Of those who make it to the hospital, more than 33% arrive too late to be saved.
- Highest per capita incidence of overdose deaths are occurring in rural settings/small towns.
- Per capita death rates from heroin overdose are higher in suburbs rural settings than urban.

On behalf of Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT) Connecticut BPH is reaching out to you to be sure you are aware of the program and to invite you to become involved. They are establishing a group of MAT experts in Connecticut to be able to mentor other providers in Connecticut through the PCSS-MAT program.

Given your expertise in treating substance use disorders, you are uniquely qualified to assist in combating this community wide epidemic. *They need you*. Please apply to become a CT state PCSS-MAT mentor and mentor a colleague. http://pcssmat.org/mentoring/become-a-mentor

They also invite you to sign up for a state specific list-serve and participate in the conversations supporting the treatment of patients with opioid use disorders and their families.

Beacon Health Options is currently seeking a full-time psychiatrist to join our team at our office in Rocky Hill. The candidate will be responsible for assisting the Chief Medical Director in providing quality, cost-effective utilization management for mental health and alcohol/drug rehabilitation, through the use of the care authorization and utilization management processes for mental health and drug/alcohol rehabilitation services.

Position Responsibilities:

- Assists in the development, implementation, and evaluation of utilization management policies and procedures to support medical management objectives.
- Educates peer physicians and care managers about utilization management policies and procedures. Works with medical/clinical staff on outlier management issues and corrective actions.
- Assists in developing and evaluating the collection and analysis of data and formulation of clinical utilization.
- Provides medical leadership to the clinical provider network and clinical and Intensive Case Management staff.
- May assist in and coordinating the development and design of performance standards, clinical policies and procedures and utilization management clinical criteria.

Position Requirements:

Education: M.D. or D.O. degree from an accredited medical school with Board certification in Psychiatry by the American Board of Psychiatry and Neurology.

Licensure: State of Connecticut Medical License (active and unrestricted).

Relevant Work Experience: Position requires five years of clinical practice in mental health. Experience providing treatment for patients diagnosed with substance abuse is desired, as well as, experience delivering care in inpatient and outpatient settings. Position requires familiarity with medical care delivery systems and experience with utilization management, quality improvement, and peer review is an advantage. Demonstrates skills suitable to working with contracts, provider relations, and member services and interpreting benefits. Knowledge, experience and demonstrated success in medical/clinical management operations in a managed care environment is preferred.

Please contact Dr. Sherrie Sharp, Chief Medical Director-Connecticut, Beacon Health Options at 860-331-3943 with your interest or referrals. Thank you!

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