CHANGES...

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Digital Mental Health: How to Engage With Innovation, Part 1

Psychiatric Times

Digital mental health was a popular topic at this year's American Psychiatric Association (APA) Annual Meeting. Over a dozen sessions focused on new technologies ranging from smartphone apps to voice analytics, virtual reality to social media. While it was impossible to attend every session, we asked the presenters from one session to share some in-depth comments and thoughts with the readers of Psychiatric Times. Their session was entitled "Revitalizing Psychiatry Through Engaging with Innovation to Increase Access and Inclusion with Care."

In the first article of this two-part series, the presenters discuss social media use for youth, and app privacy and efficacy claims that clinicians and patients must evaluate daily. Topics that will be covered in Part 2 are voice analytics for detecting and monitoring mood, and smartphone and web-based passive data as a digital biomarker for mental health disorders.

Dr Bridianne O'Dea addresses "Does Social Media Impact Mental Health in Youth?"

Social media has become ubiquitous among young people, with up to 85% of those aged 12 to 17 years using one or more platforms. YouTube, Instagram, Snapchat, and Facebook are the most popular social media platforms among Western teens. As young people have quickly adapted to sharing their life online, parents have become increasingly concerned about problematic use. Teens who report that social media has a positive impact on their lives favor its ability to connect and stay in contact with others, to provide entertainment, and to increase the ease of finding news and information. However, many teens admit to concerns about bullying, relationship damage, unrealistic nature of online sharing, and time wasting. These concerns are echoed by parents who report being more concerned about their child's technology use than drugs and alcohol.

While many studies have examined the associations between mental health outcomes and social media use, followed by systematic reviews and meta-analyses, results remain inconclusive. Most studies are cross-sectional, with only small effect sizes found. Despite an unclear causal link

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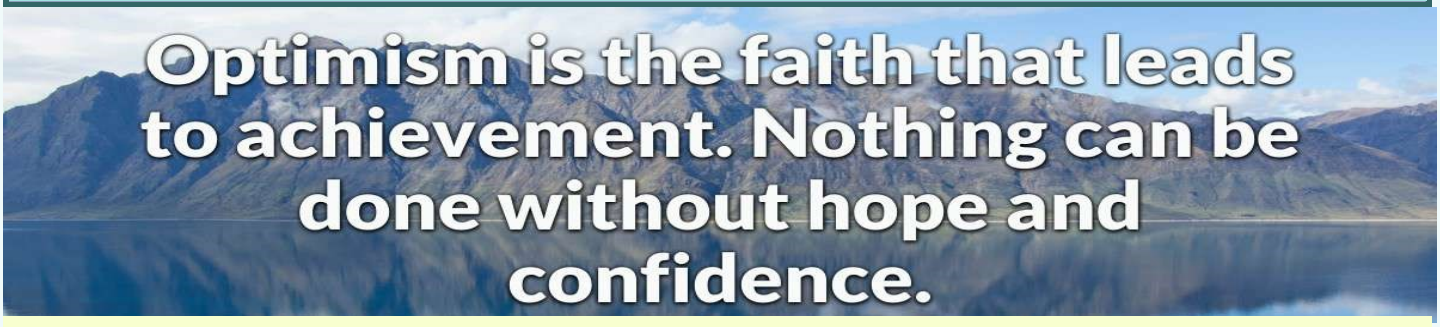
Our Mission To continually improve the provision of behavioral health services for residents of Caroline, Dorchester, Kent, Queen Anne's and Talbot counties through effective coordination of care in collaboration with consumers, their natural support systems, providers, and the community at large.

Our Vision A rural behavioral healthcare delivery system that is clinically and culturally competent. This system will ensure access, have a community focus, be cost-effective, and be integrated to serve the community as a whole.

Mid Shore Behavioral Health is located at 28578 Mary's Court, Easton, MD 21601. MSBH invites community members, agencies and local advocates to participate in the Behavioral Health Services Network, which are workgroups that seek to address issues pertaining to behavioral health services specific to adults, youth, aging, homeless people, and individuals involved in the criminal justice system. See https://www.midshorebehavioralhealth.org/bhsn for more information or call 410-770-4801.



We need to stop focusing on the mental health of mass shooters

In the two decades since the massacre at Columbine High School, digging into the psychology of mass shooters has sadly become an all-too-familiar habit — now something we seem to do almost weekly.

After the Virginia Tech shooting in 2007, media coverage pointed to the shooter's odd behavior as a child and his near-mutism as a college student. After the mass shooting at Sandy Hook Elementary School in Newtown, Conn., in 2012, newspapers described the shooter as "withdrawn and meek" and suggested that he might have had Asperger syndrome. The two people responsible for the shooting at STEM School Highlands Ranch in Colorado on May 7 are already the subjects of forensic investigation of their presumed troubled pasts.

This practice is not just a phenomenon of the post-Columbine era of mass shootings. It has its roots in the early 20th century, and it represents an effort to shift blame and find an area of consensus after massacres that could otherwise force uncomfortable conversations. In the process, this practice fosters stigma against one of the most vulnerable groups of Americans: the mentally ill.

In the late 19th century, reports of mass shootings were typically very brief. But by the turn of the century, coverage grew more detailed, often describing how the shooter had gone "suddenly insane" as a result of financial losses or a romantic mishap.

Read full article at https://www.washingtonpost.com/outlook/2019/05/20/we-need-stop-focusing-mental-health-mass-shooters/?utm_term=.5830a5951ee4

Gun Ownership Practices Linked to Soldier Suicide Risk

U.S. soldiers who own firearms, store a loaded gun at home, or carry a gun publicly when not on duty are at significantly greater risk of suicide death, a case-control study of 135 U.S. Army soldiers who died by suicide shows.

"Our findings concurred with earlier studies by showing that factors beyond ownership of a firearm were associated with an increased risk of suicide," wrote Catherine L. Dempsey, PhD, MPH, and her coauthors.

Since 2004, the rate of suicide deaths among Army soldiers has exceeded the rate of combat deaths each year, which prompted Dr. Dempsey, of the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences, Bethesda, Md., and her coauthors to investigate whether increased access to firearms might be associated with an increased risk of suicide. The study was published by JAMA Network Open.

In the study, the researchers interviewed the next of kin or supervisors of 135 Army soldiers who had taken their own lives while on active duty between 2011 and 2013, 55% of whom used firearms to do so. They compared those findings with those 137 controls matched for suicide propensity based on sociodemographic and Army history risk factors, and 118 soldiers who had experienced suicidal ideation in the past year.

This analysis showed that soldiers who had stored a loaded gun with ammunition at home, or who had carried a personal gun in public had nearly fourfold higher odds of suicide (odds ratio, 3.9; P = .002), compared with propensity-matched controls.

Similarly, those who owned one or more handguns, stored a gun loaded with ammunition at home, and carried a personal gun in public had a greater than threefold odds of suicide.

The study found that soldiers who died by suicide were 90% more likely than matched controls to own at least one gun, four times more likely to store that gun loaded with ammunition at home, and three times more likely to carry a gun in public, compared with controls.

There was the suggestion that the use of safety locks at home was protective, but this did not reach statistical significance.

However, the study did not find significant differences in firearm accessibility characteristics between the soldiers who died by suicide, and the controls with suicidal ideation.

"Some current theories of suicide (eg., the interpersonal theory of suicide) suggest that fatal suicidal behavior results require not only the presence of suicidal desire but also a developed capability or capacity for suicidal behavior," the authors wrote. "According to the interpersonal theory of suicide, this capability for lethal self-injury is acquired through repeated exposure to painful and fear-inducing experiences, thus habituating an individual to the pain and fear required to enact a fatal suicide attempt."

Dr. Dempsey and her coauthors argued that their study supported a continued focus on "means restriction" counseling; limiting or removing access to lethal methods for suicide; and "motivational interviewing."

They cited the fairly small sample size and relatively small response rates to surveys as limitations. However, they wrote, the response rates "were high for multi-informant interviews conducted within a military population."

The study was supported by the U.S. Department of the Army, U.S. Department of Defense, U.S. Department of Health & Human Services, National Institutes of Health, and National Institute of Mental Health. One author declared grants from the Military Suicide Research Consortium outside the submitted work, and one author declared support, consultancies, and advisory board positions with the pharmaceutical industry, and co-ownership of a mental health market research firm. No other conflicts of interest were declared.

Article Courtesy of MD Edge Psychiatry

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between social media and poor mental health, clinicians and parents have found themselves needing to address problematic use among youth. While there are no clear diagnostic frameworks, clinicians are encouraged to examine the domains of excessive use, withdrawal symptoms, tolerance, and negative repercussions. Identifying any underlying mental illness is key. A range of self-report measures have been developed to assist in the measurement of problematic Internet and technology use.

Although no gold-standard treatments exist, cognitive-behavioral therapy adapted for Internet use has shown some promise among adults.3 Ultimately, clinicians and parents are encouraged to implement strategies that include behaviour modification (ie, non-screen time), cognitive restructuring (ie, challenging negative thoughts associated with use), and harm reduction to address co-morbidities. Parents are encouraged to promote self-regulation and autonomy, model the behaviors they wish to see in their children, and create regular time for open and honest discussions about online activities with their children.

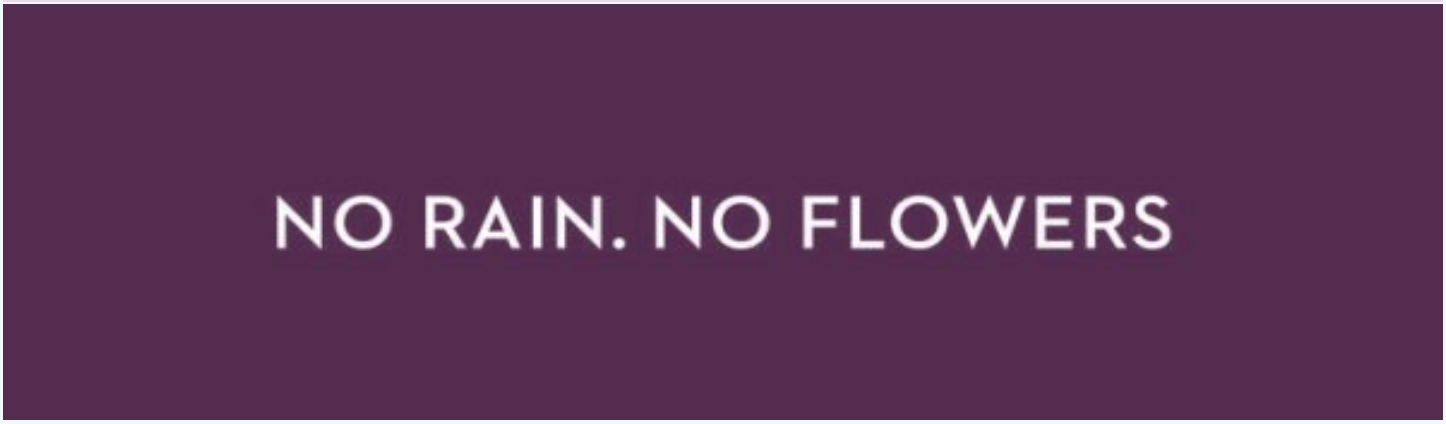
Dr Mark Larsen addresses "Is That Mental Health App Safe and Effective?"

More than 10,000 mental health apps may be available for immediate download today, but what do we know about their safety and effectiveness? In a recent study, we intercepted the traffic from mental health smartphone apps and found that over 50% are sending data to destinations not disclosed in the privacy policy.4 In essence an app may promise not to send or share data—but it seems the majority are not keeping their word. This does not mean we should not use mental health apps but rather that caution should be exercised, especially if the app comes from a source or developer you do not recognize and trust.

Many apps are making claims on the app store that tout how effective their app is. We explored the veracity of these claims by comparing what the app is telling consumers and what has been studied and published in the peer-reviewed literature. We found that while many apps make claims, fewer than 2% can back up those claims with actual evidence using their app.5 One point to be aware of is that many apps say they are designed with "evidence-based CBT" but fail to show how well that evidence-based, derived from face-to-face interaction, translates directly into the app in question.

The takeaway lesson is that there are good apps out there, but if you rely on chance, you may not find a great one. One useful tool to consider that takes in account these concerns about privacy and evidence is the APA app evaluation model, which you can access here: https://www.psychiatry.org/psychiatrists/practice/mental-health-apps/app-evaluation-model. To learn more about Dr Mark Larsen's work, please visit https://research.unsw.edu.au/people/dr-mark-larsen

Courtesy of Psychiatric Times



June 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
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2	3	4	5	6	7	8
9	10	11 Roundtable on Homelessness 1:30 Consumer Council 3-4 @ CVI	12	13 C&A Workgroup 11-12	14	15
16	17	18 Aging Workgroup 11am	19	20	21 Forensic Workgroup with CIT 9-11	22
23 30	24	25 MD Commitment to Veterans Conference	26 SUD Resources/ Nalaxone Training 8-12:30	27	28 Human Trafficking Training 12:30-4	29

July 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3		5	6
7	8	9 Roundtable on Homelessness 1:30 Consumer Council 3-4 CVI	10	11 C&A Workgroup 11-12	12	13
14	15	16 Aging Workgroup 11am	17	18 CVI 10th Birthday BBQ 6-8	19 Forensic Workgroup 9-11	20
21	22	23	24 BHSN Quarterly Meeting 10-11	25	26	27
28	29	30	31 MD Handle With Care Summit 9-4			

August 2019

Sun	Mon	Tue	Wed	Thu	Fri	Sat
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4	5	6	7	8 C&A Workgroup 11-12	9	10
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18	19	20 Aging Workgroup 11am	21	22	23	24
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September 2019

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