WWW.PSYCHNEWS.ORG | NEWSPAPER OF THE AMERICAN PSYCHIATRIC ASSOCIATION | VOLUME 48, NUMBER 23, DECEMBER 6, 2013

PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

ISSN 0033-2704

David Hathcox

To standing ovations, former member of Congress Patrick Kennedy gives an impassioned speech on the rights of people with mental illness and the importance of parity at the APA Assembly meeting last month in Washingon, D.C. See story on page 4.

Final Rule Clarifies Regulations For Parity Law

The final rule offers critical guidance on the status of intermediate-care benefits, transparency and disclosure of criteria by health plans, and provider reimbursement.

BY MARK MORAN

Five years after passage of the Mental Health Parity and Addiction Equity Act, the federal government at last released a long-awaited final rule to provide regulatory guidance for implementing the landmark law.

The final rule, issued just one day after a Senate Judiciary subcommittee hearing into the delay, clarifies several important concerns that APA and other mental health advocacy groups have had about the law.

At that hearing, former member of Congress Patrick Kennedy, one of the sponsors of the 2008 law, told committee members that despite an interim final rule that was issued in 2010, weak and inconsistent application, insurance company manipulation of the regulations, and outstanding issues the rule did not address have negated the substantial strides made in providing treatment equity for those suffering from mental illness or addiction.

Chief among the issues clarified by the final rule is the status of intermediate levels of care—such as intensive outpatient, partial hospitalization, and residential care—and issues around transparency and disclosure by health plans of medical necessity criteria they

*see **Final Rule** on page 19*

Three Candidates Vie to Become APA's Next President-Elect

Election season is under way at APA as the names of candidates who will be running for several Board of Trustees positions are announced. Two Areas will be choosing their representatives as well.

BY KEN HAUSMAN

APA members will be able to choose among three president-elect candidates in the upcoming APA election who specialize in different areas of psychiatry but share extensive involvement in APA—Renée Binder, M.D., James Nininger, M.D., and Mark Rapaport, M.D.

Binder is professor and director of the Psychiatry and the Law Program at the University of California, San Francisco, and associate dean for academic affairs for the School of Medicine and former interim chair of psychiatry. She is chair of the APA Committee on Advocacy and Litigation Funding and a former trustee at large and Area 6 representative.

Nininger is a clinical associate professor of psychiatry at Weill/Cornell Medical College and in private practice with a subspecialty in geriatrics. He is

*see **Candidates** on page 20*

Renée Binder, M.D.

James Nininger, M.D.

Mark Rapaport, M.D.

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Psychiatric News, ISSN 0033-2704, is published bi-weekly on the first and third Friday of each month by the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Periodicals postage paid at Arlington, Va., and additional mailing offices. Postmaster: send address changes to *Psychiatric News,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Online version: ISSN 1559-1255.

SUBSCRIPTIONS
U.S.: individual, $130. International: APA member, $177; nonmember, $195. Single issues: U.S., $24; international, $41. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or e-mail institutions@psych.org.

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Back to Big Apple in '14!

For APA's 2014 annual meeting, the Association returns to one of its most popular hosting locations, New York City. Register now while early-bird rates are still in effect and have first crack at the hotel where you'd most like to stay.

Registration information can be accessed at annualmeeting.psychiatry.org. (If you don't have your log-in information, call [703] 907-7300.) To reserve your first-choice hotel, reserve through the annual meeting website (above) or call Travel Planners at (800) 221-3531 or (212) 532-1660. Watch *Psychiatric News* for important meeting announcements.

Departments

FROM THE PRESIDENT

Training the Psychiatrist of the Future

BY RICHARD SUMMERS, M.D., AND JEFFREY LIEBERMAN, M.D.

Whether the Affordable Care Act and mental health parity laws result in a major system transformation or a minor pivot of the health care system is anyone's guess and everyone's worry. But we do know that the roles that psychiatrists play are changing and will continue to change. Training the psychiatrist of the future will require continued commitment to the essential skills and attitudes we all hold dear while developing new learning objectives, venues, and experiences to prepare our trainees for the times ahead.*

There are five areas that will require particular attention, focus, and creativity for educators, faculty, and trainees to train the psychiatrist of the future. Each demands innovation from medical schools, residency training programs, and continuing medical education programs. We will sketch out the needs and some possible responses.

Doctor-Patient Relationship

The essential importance of the doctor-patient relationship and the need for trainees to develop their rapport-building, history-taking, and collaboration skills will be ever more important in the future collaborative and technology-driven health care environment. The psychiatrist of the future will likely have less regular face-to-face contact with patients (like our colleagues in other medical specialties), making the ability to develop an effective therapeutic alliance for assessment and treatment even more important. We will have to do more with less.

Training programs will need to focus intensively on these skills and help trainees adapt the essential elements to new settings—for example, communicating with patients while accessing electronic medical records, telepsychiatry, and other forms of telephonic or Internet-based contact with patients and other clinicians, and team-based care such as Assertive Community Treatment.

Diversity, Broad Range of Treatments, Broad Range of Roles

Psychiatry encompasses a broad range of illnesses and a particularly broad range of treatments. We practice in a variety of care levels and provide treatment in the form of psychopharmacology, neuromodulation, psychotherapy, and other psychosocial treatments, including individual, family, and group. Our work has a broader social context, not infrequently involving the legal and educational systems and the social safety net. There will always be a diversity of treatments and approaches in our field, and maintaining the psychiatrist's familiarity with the full range of treatments is a challenge for training programs. The tension between the need to provide generalists to take care of many and subspecialists to advance knowledge and provide expertise on specific problems will continue and increase. We will need to support both general and subspecialty training as psychiatric medicine continues to diversify.

Training programs will need to balance training psychiatrists who will practice in traditional roles, such as general psychiatry outpatient provider, with fellowship training for subspecialty experts, as well as potential new roles like clinical neuroscientist and behavioral health specialist integrated with primary care practice.

Integrated Behavioral Health Care

The momentum for patient-centered care, the medical home, and integration of behavioral health with primary care creates a new role for psychiatrists. Many are doing this now, but the roles are evolving as the systems are changing. We do know that this role, which will expand in the coming years, involves increased knowledge and comfort with primary care medicine, understanding of chronic illness and how people adapt, a population-based approach, as well as strong skills in interpersonal communication and collaboration and knowledge about systems of care.

A number of centers have an established track record of training their medical students and residents in such knowledge, skills, and attitudes. The rest will need to find the best rotation venues, didactics, faculty mentoring, and other training opportunities to make this happen.

Neuroscience Education

The neuroscience explosion and its application in psychiatry have led to advances in our field that are not always captured in residency training. Many outstanding training programs do not have adequate access to neuroscience faculty members with sufficient time to teach and mentor. Recent discussions about the role of *DSM-5* and the Research Domain Criteria being developed by the National Institute of Mental Health have helped bring awareness to the exciting developments in this area.

see ***From the President*** *on page 19*

*Yager J. (2011) The Practice of Psychiatry in the 21st Century: Challenges for Psychiatric Education, Academic Psychiatry 2011;35:283-292

Richard Summers, M.D., is a clinical professor of psychiatry and codirector of residency training at the Perelman School of Medicine of the University of Pennsylvania. Jeffrey Lieberman, M.D., is professor and chair of psychiatry at Columbia University and president of APA.

EXCLUSIVE ONLINE CONTENT

APA Members Win Prestigious Sarnat, Gralnick Awards

The Institute of Medicine's 2013 Rhoda and Bernard Sarnat International Prize in Mental Health has been awarded to William Carpenter, M.D. , and Vincenzo De Luca, M.D., is the winner of the 2013 Alexander Gralnick Award. The Gralnick Award is sponsored by the American Psychiatric Foundation.

Destructive Mining Practice Worsens Depression in Appalachia

Removal of entire mountaintops to extract the coal beneath impacts more than the environment. It also appears to raise the risk of mental health problems, particularly depression.

To access the articles above, go to http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1785972 or scan the QR code with your smartphone.

PROFESSIONAL NEWS

Parity Law Just One Stop on Long Journey, Kennedy Says

The parity law's chief architect says that psychiatrists can help determine how the law changes the state of mental health care in this country.

BY KEN HAUSMAN

The long-awaited final rule on implementing the federal mental health parity law was issued last month, "but the final word on mental health is not yet written." That was a point emphasized by the law's chief sponsor, former member of Congress Patrick Kennedy, during a speech last month to the APA Assembly in Washington, D.C.

To what extent the parity law changes the lives of people with mental illness for the better will in large part have to be determined by psychiatrists "on the front lines," who battle to make mental health care as routine as the rest of medical care, he told Assembly members.

Kennedy lamented the stubborn stigma that still attaches to mental illness as well as the thousands of suicide deaths that could be prevented every year if people weren't ashamed of having an illness affecting the brain rather than other organs of the body. With the implementation of the parity law, the brain is "no longer left out of medicine," he said.

He added that in the battle against stigma, it is appropriate to adopt the slogan that AIDS activists used in their fight against a highly stigmatized illness a couple of decades ago: "Silence = Death."

Kennedy, who fought for 12 years to get the mental health parity law passed, said that the battle against mental illness discrimination "is part of the march toward progress embodied in the civil-rights movement in our country and in the historic human-rights movement that occurred in South Africa." (The government of South Africa, he noted, bestowed its highest civilian honor on his father, the late Sen. Edward Kennedy, for his support in the antiapartheid movement including imposition of U.S. sanctions against the South African government.)

"What you're fighting for at APA," he declared, "is giving a connection to human beings who feel marginalized because their illness is so shamed and stigmatized, much like Americans who are marginalized because of the color of their skin, their gender, their sexual orientation, or their religious ethnicity."

He also described the long journey from the parity bill's introduction in Congress to its passage in 2008 and the issuance of a final rule to implement it last month. He cited in particular his disappointment with several congressional colleagues who took him aside to reveal how mental illness had affected them or a family member but then voted against the bill, afraid about voter reaction. "The biggest enemy we have is secrecy," he stated.

He ended by describing how receiving mental health treatment changed his life for the better, allowing him to experience the joy of seeing the parity law enacted, its final rule issued, and of being a father able to give his children the foundation in life that all children need. Kennedy now serves as a senior advisor to APA. PN

David Hathcox

Patrick Kennedy tells Assembly members that the battle against mental illness discrimination "is part of the march toward progress embodied in the civil-rights movement in our country and in the historical human-rights movement that occurred in South Africa."

Listen to Kennedy's remarks to the Assembly at http://www.psychiatry.org/advocacy--newsroom/newsroom/video-news/patrick-kennedy-2013.

PSYCHIATRY & INTEGRATED CARE

Three Decades of Working in Integrated Care

At a recent meeting in the United Kingdom, Wayne Katon, M.D., was introduced as the "grandfather of collaborative care." He was the first to adapt the chronic care model to depression and other common mental disorders, and he continues to be at the forefront of researching new ways to integrate behavioral and physical health care. Wayne has been a wonderful mentor, colleague, and friend to many of us, and as we continue this new column on integrated care in Psychiatric News, *I have asked him to share his perspective on 30 years of work in the field.*

—Jürgen Unützer, M.D., M.P.H.

BY WAYNE KATON, M.D.

I began working as a consultation psychiatrist in primary care in 1979 during my chief residency year. One of my initial surprises was the high prevalence of mental illness among patients, later documented to be 20 percent to 25 percent in mixed-income populations and as high as 50 percent in low-income populations. The majority of these patients presented with somatic complaints or worsening of a chronic illness such as diabetes, rather than with psychological complaints. I often evaluated patients who had never seen a mental health professional or had resisted referral to specialty mental health care either for financial reasons or stigma. I realized that psychiatrists could have a much greater public-health impact working with primary care physicians, who typically have a panel of 1,500 patients, rather than treating patients in a specialist's office where only 30 to 35 patients are seen each week.

In my early experience in primary care, I hoped that educating family doctors about diagnosis and treatment of common mental illnesses would improve both recognition and outcomes of these illnesses. Accurate recognition in primary care of common mental disorders such as depression improved from about 25 percent in the early 1980s to 60 percent in later decades. However, persistent gaps in quality of care for depression in primary care continued to be documented. In most systems of care, once accurate diagnosis occurred, patients weren't adequately educated about their illness and had few follow-up contacts with their physician, leading to poor treatment adherence and outcomes.

At the same time that my research group was developing research ideas about improving quality of care and outcomes for patients with depression and anxiety in primary care, several national leaders emerged in Seattle to emphasize the large gaps in quality of care for all chronic illnesses. Ed Wagner and Michael Von Korff from Group Health Cooperative began publishing papers on the deficits in quality of care for chronic illnesses, developing influential ideas about changing the primary care system to improve these deficits, and building a chronic illness model that shaped our thinking about how to improve depression care. A key part of this model is how to activate and educate patients to participate in their own care and how to provide improved education, greater frequency of contacts, and flexible ways to deliver patient care—such as use of telephone or secure messaging—while improving adherence and medication management.

see ***Integrated Care*** *on page 20*

Wayne Katon, M.D., is professor and vice chair of the Department of Psychiatry and Behavioral Sciences at the University of Washington Medical School. Jürgen Unützer, M.D., M.P.H., is an internationally recognized psychiatrist and health services researcher. He is a professor of psychiatry and behavioral sciences at the University of Washington School of Medicine, where he directs the Division of Integrated Care and Public Health and the AIMS Center, dedicated to "advancing integrated mental health solutions."

AMA Acts on Medicare Payment As Congress Considers Legislation

Without reform of the Medicare payment formula, physicians will face very steep across-the-board payment cuts in January.

BY MARK MORAN

In response to news from Capitol Hill that a legislative proposal was in play to end the much-derided sustainable growth rate (SGR) component of the Medicare payment formula, the AMA voted during its recent Interim Meeting in Washington, D.C., to continue advocating for repeal of the SGR, while upholding the AMA's principles of pay-for-performance, which were adopted in 2005 (*Psychiatric News*, July 15, 2005).

Legislation under consideration in the Senate Finance Committee and House Ways and Means Committee would end the SGR and replace it with a "value-based performance (VBP)" payment program containing a set of incentives to encourage physician practices to adopt quality measures and integrated care. The measures appear to have bipartisan support.

Without repeal of the SGR, physicians are facing a staggering 24 percent across-the-board cut in Medicare reimbursements in January.

Repeal of the SGR has been one of APA's and the AMA's leading legislative priorities, and at the AMA's November meeting there was a widespread sense of anticipation that the goal was in sight. Importantly, however, at press time the legislation on the Hill called for a 10-year freeze of physician Medicare pay. That's because every year for close to a decade, Congress has stepped in at the end of the year to avert increasingly severe physician payment cuts mandated by the SGR—adding to an accumulating Medicare program debt.

The AMA's resolution opposes the 10-year payment freeze and directs the AMA to advocate with the Centers for Medicare and Medicaid Services and Congress for "alternative payment models, developed in concert with specialty and state medical organizations, including private contracting as an option."

An amendment was added to the resolution during the meeting that asks the AMA to continue to advocate for "positive updates"—that is, increases in Medicare physician payment. Said one physician on the floor of the House of Delegates, "We are at an uncommon time when we have a chance to do something really important, to speak with a unified voice and see the SGR ended. What this [amendment] tells our constituents is that the SGR fix will not end our advocacy efforts."

AMA/Ted Grudzinski

In her opening address at the Interim Meeting last month, AMA President Ardis Hoven, M.D., urges delegates not to reject the legislative proposal on the sustainable growth rate while it was still in draft form. "To walk away now before we know what modifications may be made would be ill advised," she said.

In a November 15 letter to the Senate Finance Committee and House Ways and Means Committee, APA CEO and Medical Director Saul Levin, M.D., M.P.A., said, "APA believes that the proposal's framework is consistent with what Congress has voiced regarding a repeal and replacement of the SGR: a strong emphasis on policy reforms that reward quality . . . and encouragement of integrated care."

He added, "APA supports the framework's call for significant and ongoing stakeholder collaboration on the development of quality, resource use, clinical practice improvement, and electronic health record meaningful-use measures under the proposed Value-Based Performance program. APA has urged lawmakers in recent communications regarding SGR repeal to include new funding to support quality measure and quality initiative development. . . . "

Levin expressed serious concern about the possibility of a 10-year freeze on physician payments, noting that "APA recommends some form of positive update as physicians work to transition fully into the VBP."

John McIntyre, M.D., chair-elect of the AMA's Council on Medical Services, which drafts much policy with regard to quality measures, integrated care, and Medicare payment, said a recent estimate by the Congressional Budget Office (CBO) showing that repeal of the SGR would be far less costly than previously projected provided a strong impetus to legislators in both parties that now was the time to repeal it. The CBO estimate put the cost at $147 billion. "Obviously that's a lot, but its 50 percent less than what had been projected in 2012," McIntyre said.

He described the proposed 10-year freeze as "infuriating," but he echoed the sense of relief at the AMA meeting that an end to an exhausting multiyear legislative battle was in sight.

"Over the last decade, there has been a growing fatigue among physicians in regard to the amount of effort that has gone into trying to repeal the SGR," he told *Psychiatric News*. "What has been particularly frustrating for physicians is that there has appeared to be uniform support for ending the SGR, and there is almost no one in Congress who thinks it's a rational or workable formula. Yet it hasn't happened."

McIntyre also noted that the draft legislation in Congress would sunset penalties under the Physician Quality Reporting System, Value-Based Payment Modifier, and "meaningful-use" electronic health record programs at the end of 2016. So even if payment levels overall would be flat for the next decade, ending these penalty programs would, at least theoretically, effectively increase physician payments.

He emphasized that the legislation effectively takes the $147 billion "off the table" so that future negotiations with Congress about updates to Medicare payment become much easier.

At press time, the fate of the congressional legislative proposals was uncertain and subject to intense negotiation. In her opening address at the Interim Meeting last month, AMA President Ardis Hoven, M.D., urged delegates not to reject the legislative proposal while it was still in draft form. "To walk away now before we know what modifications may be made would be ill advised." PN

The text of the APA letter to the congressional committees is posted at http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/APA%20on%20the%20Issues/Government%20Affairs/11-15-2013-APA-SGR-feedback-WM_Finance.pdf.

APA Recognized for CPT Code Education

Rebecca (Becky) Yowell, assistant director of the APA Office of Healthcare Systems and Financing, has been honored with the Staff Liaison Excellence Award from the AMA for her extensive work to support APA's representatives to the AMA CPT Editorial Panel.

The award is designed to recognize "outstanding specialty society staff members who provide extraordinary support to advisors, AMA staff, and the CPT Editorial Panel." Yowell was cited for her efforts to help APA respond to CPT coding proposals and to ensure that APA members have the tools they need to apply correct coding for the services they provide.

In their letter nominating Yowell, David Nace, M.D., and Jeremy Musher, M.D., advisor and alternate advisor, respectively, to the CPT Editorial Panel from APA, pointed out that over the last three years, APA was immersed in the multiyear review of CPT codes for psychiatric illnesses and that Yowell "has been at the center of the entire process, working not only in the best interests of APA and the APA advisors to the CPT, but also, frequently assisting the other specialty societies. . . ."

APA was also honored by the AMA, which bestowed the Educational Excellence Award on APA for its efforts to help members learn the CPT coding system after extensive changes were implemented earlier this year. The award is given to a medical specialty society "whose educational program and materials serve to inspire the expansion of educational programs for its membership." As then-APA Medical Director James H. Scully Jr., M.D., explained, "Since many [APA] members had little familiarity with the evaluation and management codes that became part of coding for a psychiatrist's patient encounters in 2013, it was essential that we undertook a major educational effort to introduce them to these codes and their documentation requirements."

APA submitted its nomination jointly with the American Academy of Child and Adolescent Psychiatry (AACAP), with which it partnered in developing materials to inform psychiatrists about the CPT coding changes.

Also winning recognition for his service in assisting the CPT Editorial Panel was Illinois psychiatrist Benjamin Shain, M.D., who received honorable mention for the Burgess Gordon Memorial Award for his work as an advisor from AACAP. PN

Information about changes to the CPT codes in psychiatry that took effect in January are posted at http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1487337.

PROFESSIONAL NEWS

Safety Is Key to Use of Electronic Health Records

Careful use and an abundance of caution have to follow the adoption of electronic health records by psychiatrists.

BY AARON LEVIN

Electronic health records (EHRs) have many real or potential advantages, but those need to be balanced against equally real and potential opportunities for breaches of privacy, confidentiality, and security, said speakers at the APA Institute on Psychiatric Services in Philadelphia in October.

Done right, EHRs could help physicians coordinate a patient's care, reduce prescribing errors and drug interactions, and speed administrative tasks and claims processing, said U.S. Air Force Col. Daniel Balog, an assistant professor of psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Md.

EHRs could also help patients fill out forms, answer screening protocols such as the PHQ-9, and monitor their health information.

Special issues arise for psychiatrists, Balog noted. On which servers will psychotherapy notes reside, and who will be authorized to access them? How will patients' concerns about EHR vulnerabilities affect their sense of trust and influence how psychiatrists record diagnostic details?

"*Privacy* is the patient's right," said Zebulon Taintor, M.D., a psychiatrist in private practice in New York. "*Confidentiality* is what the doctor does to keep the patient's information between doctor and patient. *Security* is what others do."

And security is the most problematic area for Taintor. Outsiders, he maintained, want to break into EHRs for three reasons: to steal money, identity, and patient data.

To get money, thieves go after credit-card information and bank-account numbers.

Others look for insurance identification numbers. A stolen Medicare card is worth $100 these days, he said. Identity theft can cause the patient to lose insurance coverage, be asked to pay for health care someone else received, or have their credit rating downgraded.

Less often, adverse medical data about a patient may fuel custody battles, employment background checks, or landlord-tenant feuds, he said.

"Technology is getting ahead of protection, and theft gets easier as data are connected in a chain," said Taintor. "When doctors connect with a hospital system, for instance, it puts all their data at risk."

The clinical process may also be affected if a patient fears security breaches. Patients may not disclose previous diagnoses such as cancer, mental illness, or sexually transmitted diseases, for example, worried that such medical information could eventually harm them.

Ellen Dallager

Adoption of electronic health records is inevitable, but needs to be mixed with caution, says Col. Daniel Balog, an Air Force psychiatrist.

Protecting medical information calls for action by patients, physicians, and organizations, said Taintor.

"Patients should look carefully at their Explanation of Benefits for services they did not receive and should protect their health insurance ID cards," he stated. "If security is breached, they should notify doctors, insurers, hospitals, the police, and the Federal Trade Commission and then check their credit reports."

Physicians' offices must institute good computer security practices, such as cancelling passwords once an employee leaves the job, he pointed out. "Think as if you are an organization."

That's what Taintor does. When he works with an actual organization, he follows all its health information policies and procedures. In his private practice, he files patient data in a computer that is never connected to the Internet. He uses different passwords when possible and turns off all computers when not in direct use.

And perhaps the field missed another alternative, he said. At a panel on EHRs at the APA annual meeting in 2012, Taintor asked who in the audience would prefer adopting an old tried-and-true system for ensuring medical-record security like that used by the Department of Veterans Affairs. Everyone in the room applauded. PN

Information from APA about electronic health records is posted at http://www.psychiatry.org/practice/managing-a-practice/electronic-health-records.

Data Mining Prescription Info: APA Member Tells a Cautionary Tale

One psychiatrist questions whether the existence of data mining will alter what physicians tell their patients about confidentiality.

BY MARK MORAN

Psychiatrists and their patients should know that the "blanket authorizations" signed by insurance company beneficiaries for release of medical information may include release of sensitive prescription drug use history.

And there is evidence that such information can be "data mined" for use in insurance underwriting.

APA member Charles Portney, M.D., of Los Angeles, alerted *Psychiatric News* to the case of a patient who came to him seeking treatment but who was especially concerned about confidentiality. "He was a health care professional himself, and he was concerned about psychiatric care impacting his career," Portney told *Psychiatric News*. "I assured him of the confidentiality of his treatment with me. I don't have an electronic medical record, and I told him that pharmacies can't release information without a signed release."

Two months later, a life insurer contacted Portney with a request for the patient's entire medical file. The patient had applied for life insurance before beginning treatment and had signed an authorization for release of medical information; when Portney informed the patient of the request, the patient did some investigating and discovered that the insurer was contracted with a company called ScriptCheck—which is a subsidiary of Quest Diagnostics—that mines prescription data so that life insurers can use the information in underwriting.

Sergey Ivanov

Portney was shocked at the level of intrusion and told *Psychiatric News* that psychiatrists and their patients need to know that the authorizations signed by patients in insurance contracts—which are often signed with little scrutiny and are not always specific about the kinds of information that may be affected—significantly alter what psychiatrists should tell their patients about the confidentiality of their treatment.

"My colleagues and the public need to look at these blanket releases, and we need to inform patients about what they may cover," he said. "And we have to alter what we are saying to patients when we reassure them about confidentiality."

A spokesperson for Quest Diagnostics, when contacted by *Psychiatric News*, issued the following statement: "Before issuing a policy, life insurance

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PROFESSIONAL NEWS

CBT Gets Citywide Rollout In Philadelphia's MH System

With lots of planning and plenty of strategic feedback, cognitive-behavioral therapy travels from the outpatient clinic to the public mental health system.

BY AARON LEVIN

One key to making a large mental health system more recovery oriented is using empirically supported, evidence-based treatments, and that was the premise that brought one big city and the godfather of cognitive therapy together.

A few years after Arthur Evans, Ph.D., took over in 2004 as commissioner of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), he had a conversation with Aaron Beck, M.D., the man who developed cognitive-behavioral therapy (CBT) in the 1960s.

"We know that CBT works, but it is not widely practiced in the field, so let's use Philadelphia as a laboratory to work on implementation issues," Evans recalled Beck saying in 2006.

The benefits of CBT are by now well known, but it is closely associated with individual outpatient therapy. Evans saw a partnership with Beck as a means to get an evidence-based treatment into a wide range of settings within a public mental health system, especially for the benefit of people with serious mental illness.

Clinicians in England had used CBT to treat psychosis-related distress but not negative or cognitive symptoms, said Paul Grant, Ph.D., a research assistant professor of psychology in psychiatry at the Aaron T. Beck Psychopathology Research Center in the Perelman School of Medicine at the University of Pennsylvania. He spoke at the APA Institute on Psychiatric Services in October on behalf of Beck, who was unable to attend.

Research by Beck and colleagues showed a correlation between negative symptoms and defeatist beliefs, such as an unwillingness to take risks or a fear of rejection, said Grant.

"Our theoretical framework for therapy now sees low functionality not as being about neurological deficits, but about those beliefs," he said. "Our goal is to turn negative symptoms into problems to be addressed and translating problem behaviors into underlying feelings that can be addressed in therapy."

Aaron Levin

The Beck Initiative in Philadelphia was a collaborative clinical, educational, and administrative partnership, said Torrey Creed, Ph.D, at the Institute on Psychiatric Services.

Beginning in 2007, instructors from the Beck center undertook a six-step strategy to train personnel from 27 DBHIDS agencies in the use of CBT.

First, the instructors spent time learning about the agency and its operations by talking to supervisors and therapists in order to adapt the CBT program to the setting.

Next, they conducted 22 hours of intensive workshops over several days using materials specifically tailored to the agency's clientele.

"The goal was not to get the staff ready to use their knowledge, but to give them the tools they'd need," said Torrey Creed, Ph.D., a research assistant professor of psychology in psychiatry at the Beck Psychopathology Research Center and a faculty member at the Beck Institute. "Workshops alone are not enough."

The next step came as training cases were selected from the trainees' existing caseloads. The Beck instructors met with groups of six agency therapists once a week for six months, Creed noted. Together, they reviewed audiotapes of the clinicians using CBT. "The instructors actively made treatment suggestions at first but steadily phased themselves out as clinical colleagues in the agency built skills, gave more support, and combatted program drift," said Creed.

The instructors also reviewed samples of audiotapes at three and six months after the training began to measure adherence. A total of 245 clinicians at 27 agencies began the first round of training, and 185 completed it. Of those, 133 trainees met competency goals at six months, and the rest received more intensive feedback on how to improve their use of CBT.

"We're building in an ongoing expectation that people will stay on board," said Creed, adding that "network and agency support are critical."

To sustain the program and its quality, the agencies maintain their own internal consultation process, the Beck center provides support as needed, web-based training is available, review meetings are held as "booster" sessions, and clinicians must be recertified every two years.

"The Beck Initiative created a context in which evidence-based practice can be adapted so it can move into the community quickly," said Creed.

The group has now completed one year of a similar training program in a rural area of southwestern Georgia.

The Beck Initiative shows that patients with serious mental illness can have residual symptoms but can still function and have more productive and fulfilling lives, said Evans.

"The big challenge in the field is not what works but how to get it to work in real-world settings," he stated. "We found that you need to work at multiple levels simultaneously—including the organizational and system levels—and not just with practitioners." PN

Information about the Aaron T. Beck Psychopathology Research Center is posted at http://aaronbeckcenter.org.

Brain Injury Medicine Gains Subspecialty Status

The new subspecialty is to focus on prevention of brain injuries and the evaluation, treatment, and rehabilitation of those who have suffered such injuries.

BY KEN HAUSMAN

The American Board of Psychiatry and Neurology (ABPN) has announced that the first examination to obtain subspecialty certification in brain injury medicine (BIM) will be held October 6, 2014.

The new subspecialty was approved by the American Board of Medical Specialties in September 2011, after it evaluated a joint application from the ABPN and the American Board of Physical Medicine and Rehabilitation.

According to the ABPN, the BIM subspecialty "will focus on the prevention, evaluation, treatment, and rehabilitation of individuals with acquired brain injury. BIM physicians provide a high level of care for patients with brain injury and their families in both the hospital and the post-acute setting, and over the continuum of care to facilitate the process of recovery and improve medical and functional outcomes."

Candidates wanting to achieve this certification through the ABPN must have a certification in psychiatry or neurology by December 31 prior to taking the exam, complete the requisite practice experience or formal training, meet all training requirements (if applying based on training) by July 31 of the year of the examination, and meet all of the ABPN's medical licensure requirements.

A "grandfathering" option will be available from 2014 to 2018 as an alternative to completing one year of fellowship training in brain injury medicine in a program approved by the Accreditation Council for Graduate Medical Education (ACGME). To use this option, applicants can qualify to take the examination in BIM through a "temporary pathway" involving a choice of two options.

The first option is "attestation of a minimum of 25% practice time in the United States devoted to brain injury medicine beyond completion of residency training in the primary specialty for a minimum of three years (within the last five years). The practice should be adequately broad to reasonably reflect the full scope of brain injury medicine."

The second option is "successful completion of 12 months of fellowship training in an ACGME- or non-ACGME-accredited brain injury medicine fellowship program affiliated with an ACGME-accredited psychiatry, neurology, or child neurology residency training program. Training must be completed by July 31 of the year of the examination." PN

Information about BIM certification, including applications and information booklets, is posted at http://www.abpn.com/ifas_bim.html.

LEGAL NEWS

Drug Firm Pays Billions For Misbranding Antipsychotics

Johnson & Johnson was sued for failing to report data suggesting increased risks for stroke and diabetes associated with the antipsychotic Risperdal.

BY VABREN WATTS

Bloomberg/Getty Images

Johnson & Johnson misbranded Risperdal to treat other psychiatric disorders.

Pharmaceutical giant Johnson & Johnson (J&J) announced November 4 that it will plead guilty to a single misdemeanor charge that it misbranded the atypical antipsychotic drug Risperdal for uses not approved as safe and effective by the Food and Drug Administration (FDA).

A part of one of the largest health care fraud settlements in U.S. history, the pharmaceutical company has agreed to pay $2.2 billion to resolve criminal and civil investigations, the U.S. Department of Justice announced.

Risperdal (risperidone)—a dopaminergic antagonist—was FDA approved to treat schizophrenia in 1993 and approved in 2003 to treat mixed episodes associated with bipolar I disorder. A complaint filed by the U.S. Court for the Eastern District of Pennsylvania alleged that Janssen Pharmaceuticals, a J&J subsidiary and Risperdal's developer, began to market the drug from 1999 through 2005 to remedy agitation associated with dementia in the elderly and psychiatric disorders in children—indicating to physicians and other prescribers that Risperdal was safe and effective for these unapproved indications and populations.

According to the FDA, J&J received several warnings regarding its misleading marketing tactics targeted to physicians and consumers. After a whistleblower complaint was filed, the FDA Office of Criminal Investigations initiated a probe concerning J&J's alleged misconduct.

"When pharmaceutical companies ignore the FDA's requirements, they not only risk endangering the public's health but also damaging the trust that patients have in their doctors and their medications," said FDA Commissioner Margaret Hamburg, M.D. "The FDA relies on data from rigorous scientific research to define and approve the uses for which a drug has been shown to be safe and effective. . . . Pharmaceutical manufacturers that ignore the FDA's regulatory authority do so at their own peril."

The Department of Justice further alleged that J&J was aware that Risperdal posed serious health risks, including increased risks for the onset of diabetes, breast development in boys, and strokes in elderly patients.

During the investigation, a physician who worked on a J&J study claimed that the company was "purposely withholding the findings" that showed that Risperdal increased risk for stroke in elderly patients after the company combined negative data with other studies to make it appear that there was an overall lower risk for adverse events. In addition, the company promoted Risperdal as "uncompromised by safety concerns (does not cause diabetes)," ignoring data that indicated otherwise.

As a result of its practices and misconduct, the company has agreed to submit to stringent requirements under a corporate integrity agreement with Department of Health and Human Services Office of the Inspector General. The agreement is designed to increase accountability and transparency and prevent future fraud.

Psychiatric News contacted J&J to ask how the company plans to regain trust among clinicians and consumers. Michael Ullmann, J&J vice president and general counsel, replied in a statement saying, "This resolution allows us to move forward and continue to focus on delivering innovative solutions that improve and enhance the health and well-being of patients around the world. We remain committed to working with the U.S. Food and Drug Administration and others to ensure greater clarity around the guidance for pharmaceutical industry practices and standards."

Though J&J acknowledged that it improperly marketed Risperdal to older adults for unapproved uses, the pharmaceutical firm admitted to no wrongdoing for accusations that it promoted drug use in children and the developmentally disabled and that it provided kickbacks to doctors and pharmacists in exchange for writing more prescriptions.

The agreement will also resolve similar misbranding accusations for the company's heart failure drug, Natrecor, and newer antipsychotic drug, Invega. PN

RESIDENTS' FORUM

Leading Forensic Psychiatrist Relishes Role as Educator

BY ALEXANDRA JUNEWICZ

Before I began my rotation in forensic psychiatry with Dr. Phillip Resnick, I had heard of the admiration he had earned from colleagues in his field, as well as the reputation for excellent teaching he had earned from his fellows and students. My own experience working with Dr. Resnick deepened my respect for him as a mentor and educator. I was amazed to find that despite the many demands on his time, he regularly spends hours examining and critiquing the work of his students, residents, and fellows. He not only encourages meticulous attention to detail, but also uncompromising integrity. Indeed, the high standards to which he holds his students, residents, and fellows demonstrate his true devotion to teaching.

While working with Dr. Resnick, I was fortunate to have the opportunity to talk with him about his life and career. After graduating from Case Western Reserve University (CWRU) with a degree in psychology and from CWRU School of Medicine, Dr. Resnick served as a captain in the U.S. Army. While directing a women's psychiatric ward during that time, he became fascinated with the cases of two women who had murdered their children and who inspired him to write about child murder and coin the term "neonaticide." This experience sparked his interest in forensic psychiatry, and Dr. Resnick describes a genuine passion for his work as the greatest motivator in his career. "I find the idea of applying psychiatry to legal issues intellectually more challenging than practicing psychiatry," he said.

Driven by his passion for this field of work, Dr. Resnick rose to prominence in the specialty of forensic psychiatry. He became director of the Court Psychiatric Clinic of Cleveland in 1976, founding director of the CWRU Forensic Psychiatry Fellowship in 1979, president of the American Academy of Psychiatry and the Law in 1984, and founding president of the Association of Directors of Forensic Psychiatry Fellowships in 1986.

He has consulted on many cases of national interest, including those of Jeffrey Dahmer, Timothy McVeigh, Ted Kaczynski, Andrea Yates, Casey Anthony, and Scott Peterson. In addition, he has written 113 articles and delivered 165 major presentations throughout the world.

As his many accomplishments suggest, Dr. Resnick works hard. However, through my conversations with him, I have discovered that he also has interests in reading, travel, and impressionist art. His recent reading selections include *Far From the Tree* by Andrew Soloman, which discusses how parents cope with having children who are different than they are. He also recently read *Claude and Camille* by Stephanie Cowell, which tells the story of artist Claude Monet's romance. Though Dr. Resnick says he does not Tweet, he does use Facebook to stay in touch with his children and grandchildren.

see ***Residents' Forum*** *on page 18*

Alexandra Junewicz is a fourth-year medical student at Case Western Reserve University who plans to begin a psychiatry residency next year.

COMMUNITY NEWS

Ellen Dallager

Van Yu, M.D. (right), accepts the Gold Award for Community-Based Programs from Clifton Tennison Jr., M.D., chair of the Psychiatric Services Achievement Awards Selection Committee, on behalf of Janian Medical Care.

Ellen Dallager

Patricia Deegan, Ph.D., and James Schuster, M.D., M.B.A., accept the Gold Award for Academically or Institutionally Sponsored Programs on behalf of the Community Care Behavioral Health Organization, UPMC, Pittsburgh.

APA Honors Innovative Programs

The Psychiatric Services Achievement Award winners this year feature integrated and patient-centered care, as well as outreach to returning veterans.

BY MARK MORAN

Four programs that provide services for people with mental illness were honored at APA's Institute on Psychiatric Services in October. Each year APA awards two Gold Awards—one for a community-based program and one for an institutionally based program—and two programs with a Silver and a Bronze Award.

Gold Achievement Award Winners

- **Janian Medical Care** is the primary provider of psychiatric services for the Center for Urban Community Services (CUCS), employing 40 full- or part-time psychiatrists at more than 55 locations throughout New York City. In 2012, Janian began offering primary care to CUCS clients. The program had its origins in 1986 when a group of New York City psychiatrists began voluntarily offering services at dilapidated single-room-occupancy hotels and at parks and shelters where they knew they would find people struggling with homelessness and treatable mental illness. Within a decade, their efforts, known as the Project for Psychiatric Outreach to the Homeless (PPOH), had attracted the support of funding agencies, and by 2005 PPOH was providing services at 32 programs in the city. In 2005, PPOH was acquired by CUCS, a comprehensive human services agency that serves over 25,000 people each year and is the nation's largest provider of supportive-housing social services. Despite all the changes since 1986, Janian Medical Care has remained true to its roots. CUCS Janian Medical Care was selected to receive APA's 2013 Gold Achievement Award in the category of community-based programs.

- **Community Care Behavioral Health Organization** (CCBHO) is a nonprofit managed care company that is part of the University of Pittsburgh Medical Center. CCBHO has implemented peer-run Decision Support Centers (DSCs) at 12 sites in its provider network since 2009. The DSCs provide people with severe mental illness with tools to prepare for their psychiatrist visits and make informed shared decisions. DSCs use CommonGround, a software program designed by Patricia Deegan, Ph.D., that helps people organize and express their treatment concerns clearly. Even people with low literacy and no computer skills can use the program's interactive touch screens.

  CCBHO began a collaboration with Pat Deegan and Associates (PDA) in 2007 to develop a replicable version of CommonGround and design a standard implementation process. CCBHO sponsored implementation of the second DSC in the United States to use CommonGround and was the first of PDA's partners to take the program to scale, playing a crucial role in the migration of Common Ground into medical practice. CCBHO received APA's 2013 Gold Achievement Award in the category of academically or institutionally sponsored programs.

Silver Achievement Award

- **The Veterans Outreach Program at the City College of San Francisco** has helped veterans since 2010 adjust to college by providing comprehensive specialty on-campus mental health care from the San Francisco VA Medical Center. Veterans of the wars in Iraq and Afghanistan increasingly are enrolling in college, but many have difficulty adjusting to college life. Up to 25 percent have a psychiatric diagnosis, and many have cognitive disorders associated with a traumatic brain injury.

Bronze Achievement Award

- **The Hasbro Children's Partial Hospitalization Program**, a joint program of the Department of Pediatrics and the Division of Child Psychiatry at Hasbro Children's Hospital, Rhode Island Hospital in Providence, serves youth who have co-occurring general medical and psychiatric disorders. Patients for whom conventional approaches have failed receive individualized, intensive, integrated care in a day-hospital setting. The program has treated more than 2,200 patients since it was established in 1998. Its innovative program has become a model of integrated care for children and adolescents and their families. PN

Information about the award winners is posted at http://ps.psychiatryonline.org/issue.aspx?journalid=18&issueid=927776 by scrolling down to "APA Achievement Awards."

Hospital Calls BERT to Calm Agitated Patients

A hospital musters resources from several of its departments as part of a strategy to prevent minor crises from escalating into larger ones.

BY AARON LEVIN

A Missouri hospital revamped its emergency response protocol to prevent agitated patients from becoming violent, but it took comprehensive planning and training—and some help from a squeaky yellow squeeze toy—to get the program off to a good start.

The goal was to create a group of skilled experts who could deescalate situations in which patients are in a behavioral crisis, said Lawrence Kuhn, M.D., medical director for behavioral health with SSM Health Care, a Catholic hospital system with seven campuses around St. Louis. The pilot site was SSM St. Mary's Health Center in Richmond Heights, Mo.

Aaron Levin

Goofy? Maybe. But an attention-getting device like a squeeze toy that says, "Have a stress-free day!" helps spread the word about one hospital's new plan to calm agitated patients.

Their goal was to establish rapport early, set limits for the patient's choices, and minimize calling security officers to subdue the patient, he said at the APA

COMMUNITY NEWS

Institute on Psychiatric Services in Philadelphia in October.

So St. Mary's adapted a model from the Crisis Prevention Institute of Milwaukee to form the hospital's Behavioral Emergency Response Team (BERT). "BERT is a three- or four-person collaboration between security, nursing, behavioral health, administration, and the hospital phone operators," explained Sarah Lohse, R.N., B.S.N., the director of inpatient services.

The service is used only for patients. Visitors and other nonpatients in escalating crises are the responsibility of the security department alone.

The BERT goes into action when a patient is exhibiting verbal symptoms of anxiety or is in a defensive state, said Lohse. Physical acting out still calls for a security response.

The telephone operators are the system's linchpins, she said. Once a special extension number is dialed, the operators send word over the staff paging system to BERT members on duty.

One team member grabs the "go bag," filled with everything from pens and involuntary tracking forms to restraints, the latter rarely used, but always at hand.

"Behavioral health takes the lead, building rapport with the patient and documenting the encounter," said Lohse. "We use security guards from the emergency department, so often they already know the patient, which also helps."

The administrator on the team helps arrange the next steps for patients, linking them with services or admitting them, as necessary.

The need for some new thinking about how to handle patients in escalating crises began in 2010 when smaller psychiatric units in the region began to close and the county shut its sole psychiatric hospital.

As training for the BERT program began, clinicians, security officers, and administrators were joined by personnel from the emergency, information technology, and marketing departments. The marketing department developed a full package to spread the word about the new program: flyers, posters, screen savers, badge cards, and key chains.

Perhaps the biggest help was the odd little squeezable "stress doll" with the hysterical laugh—immediately named "BERT"—who swiftly became a favorite with everyone in the building and helped promote his namesake program (see photo). Little BERT even appeared as an icon on the telephone operators' computer screens, to make clicking on him easier to start a team call. But the squeeze doll was just the symbol for a broader process within the hospital.

"We first trained the primary team responders, and then we educated the rest of the employees," said Lohse, who led the training program.

So far, 166 BERT interventions have been called since the operation started in August 2012.

"Over that time, we've changed the culture from a power struggle to a therapeutic intervention," said Kuhn. Restraints have been required on only six occasions.

Challenges remain, he noted. Fielding a full team when the whole staff is contending with a heavy patient load is not always easy. And employees have tended to wait too long to call for the BERT, said Lohse. "We continue to encourage them to call sooner rather than later."

"Qualitatively, though, employees say they feel better and safer with BERT in place," said Kuhn.

Ultimately, the BERT isn't designed to solve every escalating crisis, Lohse explained, but it does provide an additional level of support to existing resources and helps create a culture that binds together hospital employees and departments to solve a common problem. PN

Information about SSM Behavioral Health Services is posted at http://www.ssmhealth.com/behavioralhealth.

Genome Studies Open Window On Schizophrenia Etiology

Scientists are steadily building a knowledge base to explain the relationship between the genetics of schizophrenia and the symptoms that characterize the disorder.

BY JUN YAN

This is the second in a two-part series on advances in research on the contributions of the genome to the development of mental illness. The first installment appeared in the November 15 issue.

Genomewide association studies (GWAS) have in recent years identified genetic variants linked to development of schizophrenia, part of a series of rapid advances that have energized the field of psychiatric genetics.

Based on multiple analyses of data from the international collaboration known as the Psychiatric Genome Consortium (PGC)—some of which have been published, and more are soon to be in press—the genetic architecture of schizophrenia is fast emerging, Patrick Sullivan, M.D., a professor of genetics and psychiatry and director of the Psychiatric Genomics Department at the University of North Carolina School of Medicine, told *Psychiatric News*.

Genetic architecture describes the correspondence between phenotypes (e.g., symptoms) and underlying genotypes (e.g., disease-causing genetic variants), particularly how many different loci are involved and the effects of these loci.

The earlier search for genetic variations with a strong, large effect has turned up only a few significant findings. Although more work is being done, scientists have "looked pretty hard" for variants with large effects and should have found them, according to Sullivan. Rather, it appears that schizophrenia is partly caused by "hundreds of variations in hundreds of different genes, where the effects of each variation are very subtle," he noted.

Jonathan Sebat, Ph.D., an associate professor of psychiatry and the chief of the Center for Molecular Genomics of Neuropsychiatric Diseases at the University of California, San Diego (UCSD), explained the genetic causes of schizophrenia in a somewhat different way. (Sebat coordinates the copy-number variation [CNV] group in the PGC, which is finishing a separate study on schizophrenia and anticipates its publication within a few months, he told *Psychiatric News*.)

Previous research has shown that CNVs, which includes deletions or duplications of large chunks of DNA, contribute to schizophrenia as well as to autism and bipolar disorder, and specific CNVs have been located. However, the extent of CNVs' contribution to psychiatric disorders remains a subject of debate. Sebat estimated that de novo CNV mutations, which are usually seen in only one person in a sample population, contribute to from 4 percent to 5 percent of all schizophrenia cases. "So far all the CNVs associated with schizophrenia [that we know of] are rare variations, none is common," he explained.

Sebat said that in one patient with schizophrenia, a rare CNV or a few variants could account for the total cause of his or her disease; another patient, also diagnosed with schizophrenia, may have different genetic variants and different biological mechanisms. Do they have the same disease or different diseases that look similar? Often the underlying pathology may fundamentally differ. Therefore, the complexity of psychiatric genetics also lies in the heterogeneity in a symptom-based classification system.

"Symptoms alone have turned out to be not very reliable for predicting the causes of the disorders," Sebat said. "A constellation of similar symptoms can come from lots of different genetic and biological errors. Until we understand the underlying causes of mental disorders, we cannot correctly reclassify them."

Progress Made With Other Disorders

Since 2010, PGC groups have published meta-analyses on attention-deficit/hyperactivity disorder (ADHD), bipolar disorder, major depressive disorder (MDD), and cross-disorder overlaps. The progress is dependent on the contribution of more genotyping data from researchers.

The MDD genetic architecture is more challenging, Sullivan acknowledged, as the disorder is very heterogeneous, more common, and less heritable than, say, schizophrenia. In an analysis of 9,000 cases and as many controls, the group found hints of risk genes but none of statistical significance. "We need larger samples," Sullivan said, which are currently accumulating. "By the end of the year we may have 30,000 to 40,000 cases in the database."

He believes the progress in schizophrenia can be a model for other psychiatric disorders. "Using relatively inexpensive and standard tools, we will be able to learn a lot about the [underlying genetics] of any psychiatric disorders," he said.

In studies published this year, the cross-disorder group demonstrated risk loci associated with all five disorders (schizophrenia, bipolar disorder, MDD, autism, ADHD), with strong evidence implicating the calcium channel signaling system, which is important for neuronal communications, as a pathway conferring broad genetic risks to psychiatric disorders, according to Jordan Smoller, M.D., Sc.D., a professor of psychiatry at Harvard Medical School and director of psychiatric and neurodevelopmental genetics at Massachusetts General Hospital.

Thomas Lehner, Ph.D., says the Psychiatric Genome Consortium "organizes the field around common goals with a team-science approach and vastly increases the scale of experiment."

Smoller coordinates the PGC's cross-disorder analyses. He said that the group is extending the analyses to include new datasets on anorexia nervosa, OCD, and Tourette syndrome.

"Our findings show that genetic risk variants do not necessarily respect the boundaries of our diagnostic criteria," Smoller said. "The genome hasn't read the *DSM*." He hopes that soon the causes of psychiatric disorders gleaned from genomic studies will be incorporated into the classification and definitions of psychiatric disorders rather than the classification relying solely on clinical symptoms.

"The PGC represents a sea change in the way research is done in psychiatry," said Smoller. "In the last five years, in part as a result of the PGC, we have gone from having almost no confirmed genetic risk loci [in psychiatry] to having 150 to 200 of them. It's dramatic progress."

He believes that the success has convinced more investigators to join the consortium, which led to accelerated success.

Researchers in the consortium also benefit from state-of-the-art tools and technology. For example, several PGC coordinators emphasized that the consortium has engaged top-notch genetic statisticians to develop sophisticated tools to ensure that analyses are performed correctly and consistently.

Genotyping data from each individual, recorded with microarray "chips," routinely contain 500,000 to 1 million single-nucleotide polymorphisms (SNPs). In GWAS, patients and controls are compared on these SNPs to identify significant differences that may be associated with a disease. Because of the large number of comparisons, the statistics are more complex than clinical or epidemiological research, and the standard for drawing conclusions is therefore much higher.

The PGC receives funding from many public and private sources on both sides of the Atlantic. The National Institute of Mental Health (NIMH) is one of the founding members and has continued to be a funding source.

Thomas Lehner, Ph.D., M.P.H., chief of the Genomics Research Branch at NIMH, told *Psychiatric News* that the institute is "thrilled to support the effort and watch the field advancing so rapidly."

"What we find so attractive about the PGC is that it organizes the field around common goals with a team-science approach and vastly increases the scale of experiment," said Lehner. "It puts together very smart people to think about the problems and come up with effective solutions, including experts inside and outside the field of psychiatry. Without the PGC, progress would have been much delayed."

Moving Discoveries From Lab to Clinic

One of the promises of genetic research is to reveal the pathophysiology of the illnesses. In psychiatric as well as nonpsychiatric illness, genomic research has turned up multiple risk loci previously unknown or unsuspected. These discoveries uncover underlying etiology of various brain dysfunctions and provide directions for research into gene-environment interactions and brain biochemistry. They also suggest potential targets for developing new drug treatments.

Genetic findings also guide personalized diagnosis and treatment. For example, known CNVs in autism can help stratify the disorder into different subtypes, and at UCSD, genetic testing for autistic patients is routinely used in clinical diagnosis, according to Sebat. He believes the same can and should be done for schizophrenia.

"For the first time, we actually have traction in understanding the genetic architecture of mental disorders, and the PGC is one of the driving forces behind the progress, said Lehner. PN

CLINICAL & RESEARCH NEWS

ktsdesign/Shutterstock

Dopamine in Area of Brainstem Linked to Late-Life Depression

Late-life depression is common and often resistant to therapy, but pharmacologic enhancement of dopamine transmission may help in some cases of the illness.

BY JOAN AREHART-TREICHEL

For some time, there has been reason to believe that the brainstem might play a role in late-life depression. Now, Robert Wilson, Ph.D., a professor of neurological sciences and behavioral sciences at Rush University Medical Center, and his colleagues have tested the hypothesis. And as they reported online October 16 in *JAMA Psychiatry,* dopaminergic neurons in the ventral tegmental area of the brainstem seem to be implicated in development of late-life depression.

The study sample consisted of 124 older individuals from a parent study called the Rush Memory and Aging Project.

These individuals had undergone extensive annual clinical evaluations that included a structured medical history, a neurological examination, and neuropsychological tests. None of the subjects was diagnosed with dementia on the basis of these evaluations. During each annual evaluation, these individuals were also tested for depression with the Center for Epidemiological Studies Depression Scale. The cohort lived on average five years after entry into the study, and their depression scores over these years were averaged.

After the subjects died, their brains were autopsied. The researchers then used the subjects' depression evaluation material and brain autopsy material to see whether there were any links between late-life depression and four brainstem areas—the dorsal raphe nucleus, the locus ceruleus, the substantia nigra, and the ventral tegmental area.

Specifically, they measured dopamine neurons in the substantia nigra and in the ventral tegmental area. A lower density of dopamine neurons in each nucleus was related to a higher level of depressive symptoms when each nucleus was modeled separately. In contrast, when the two nuclei were modeled together, the effect for the substantia nigra was no longer significant, but the effect for the ventral tegmental area remained so. As for the locus ceruleus, the researchers measured noradrenergic (not dopaminergic) neurons, and for the dorsal raphe nucleus, the researchers measured serotonergic (not dopaminergic) neurons. Neither of these neuron measures was related to depressive symptoms.

Thus it appeared that the dopamine system in the ventral tegmental area of the brainstem might play an important role in late-life depression, Wilson and colleagues concluded.

The results have clinical implications, Wilson said in an interview with *Psychiatric News*. "Late-life depression is common and often resistant to therapy. These findings suggest that pharmacologic enhancement of dopamine transmission may be helpful in some cases."

The research was funded by the National Institutes of Health and the Illinois Department of Public Health. PN

An abstract of "Brainstem Aminergic Nuclei and Late-Life Depressive Symptoms" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=1756815.

Targeting Specific Factors Might Improve Bipolar Disorder Outcomes

More research is needed on the clinical course of bipolar disorder throughout the lifespan.

BY JOAN AREHART-TREICHEL

A prospective study on bipolar disorder in youth, led by Boris Birmaher, M.D., has identified a number of factors associated with the development of stable mood over the long term.

Birmaher, a professor of psychiatry at the University of Pittsburgh, reported the study results at the 25th Annual New York Mental Health Research Symposium of the Brain & Behavior Research Foundation in New York City in October. While there, he was also honored for outstanding achievements in childhood-onset bipolar disorder research.

Birmaher and his coworkers followed 367 children with bipolar disorder for an average of eight years to determine their prognosis. At the end of the period, about 45 percent were doing "relatively well"—that is, had had a stable mood for most of the follow-up period.

The findings by Birmaher and his team also showed that youth whose illness started later in adolescence; who at intake had less severe depressive and manic symptoms, less suicidality, and less substance abuse; and who lived in families with a higher socioeconomic status were more likely to do well. These findings suggest that treatments that could delay the onset of the illness or target the other factors might be able to increase the chances of achieving a lasting stable mood, Birmaher and his coworkers contended.

Birmaher and his group would also like to determine whether youth with bipolar disorder are going to have the disorder for the rest of their lives. Some of the subjects in their study have been off bipolar medications for several years now and are doing well, he said. But whether that will continue to be the case is not known, he admitted. It could be that "the illness will again kick in, especially under stress."

Boris Birmaher, M.D.: "Bipolar disorder is terribly difficult to diagnose in children. For instance, what is the difference between normal elation and mania in a youngster of 9 or 10 years?"

An audience member asked Birmaher how bipolar disorder can be differentiated from ADHD in children. It can be difficult, he replied, since symptoms such as impulsivity, hyperactivity, and excessive talking can indicate either bipolar disorder or ADHD. But if the symptoms tend to be episodic rather than chronic, and the typical manic symptoms cluster together, it may be a sign that a child has bipolar illness instead of ADHD, he said. PN

To watch a video interview with Birmaher, go to http://bbrfoundation.org/brain-matters-discoveries/watch-dr-boris-birmaher%E2%80%99s-video-2013-colvin-prize-for-outstanding.

MED CHECK

BY VABREN WATTS

Extended-Release Hydrocodone Gains FDA Approval

On October 25, the Food and Drug Administration (FDA) approved the first single-entity extended-release (ER) formulation of ***hydrocodone bitartrate*** (***Zohydro ER***) for management of severe pain that requires daily around-the-clock treatment.

Safety and efficacy findings for Zohydro ER were based on clinical trials including more than 1,600 participants with chronic and severe pain. Those given Zohydro ER reported a significant improvement in chronic pain compared with those receiving placebo. The most common side effects reported were constipation, nausea, drowsiness, headache, dizziness, dry mouth, and itching.

The FDA warns that "because of the greater risks of overdose and death with ER/LA opioid formulations, Zohydro ER should be reserved for use in patients for whom alternative treatment options are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. Zohydro ER is not approved for as-needed pain relief."

The approved labeling for Zohydro ER is the first to conform to the updated labeling requirements for all extended-release/long-acting opioid analgesics that were announced by the FDA this summer. The new hydrocodone formulation is classified as a Schedule II substance under the Controlled Substance Act—indicating that it can only be dispensed by prescription and cannot be refilled.

Zohydro ER is manufactured by Zogenix Inc.

Rule Would Require Generic-Drug Makers To Change Labeling

Two years ago, the U.S. Supreme Court ruled that generic drugs—unlike branded drugs—were not required to have updated safety labels, even after discovery of new side effects associated with the medications.

Last month, the FDA proposed a rule that will challenge the 2011 Supreme Court ruling in that it will require makers of generic drugs to quickly update their warning labels with new safety information for doctors and patients.

"More than 80 percent of prescriptions filled in the U.S. are for generics. . . . This proposal will help ensure that health care professionals and consumers have access to the latest safety information for the medications they use," said Janet Woodcock, M.D., director of the FDA's Center for Drug Evaluation and Research.

The proposed mandate means that generic-drug manufacturers would face the same kind of liability over product labeling as brand-name companies do and would lose the shield given them by the Supreme Court ruling.

Displeased with the FDA's proposal, the Generic Pharmaceutical Association (GPhA) said in statement that "the Supreme Court has repeatedly held that generic pharmaceutical manufacturers must duplicate the language on the brand pharmaceutical manufacturer's labels. . . . Multiple versions of critical safety information would lead to unnecessary confusion and uncertainty for prescribers and other health care professionals, with harmful consequences for patients." The GPhA plans to advocate against the new proposal.

Phase 3 Clinical Trials Begin for Potential Alzheimer's Drug

Lundbeck and Otsuka have announced the continuation of their development program for the Alzheimer's disease (AD) drug ***Lu AE58054 (Lu)***.

The program, which will consist of four phase 3 clinical trials, will include about 3,000 patients with mild-to-moderate AD who will receive ranging doses of Lu in combination with ***donepezil*** to assess the effectiveness of Lu as an adjunctive therapy to acetylcholinesterase inhibitors.

Results from phase 2 trials, presented at the Alzheimer's Association International Conference in July, showed Lu and donepezil to be effective in improving cognitive function in patients over a six-month period compared with placebo.

Lu is a selective serotonin receptor 6 (5-HT6) antagonist with a proposed mechanism of action that is different from that of currently available AD medications, which target beta-amyloid and tau-associated mechanisms.

FDA Strategizes to Reduce Drug Shortages

The FDA announced October 31 that it is implementing strategies to further enhance the government's efforts to prevent and reduce medication shortages—a significant public-health threat that can delay critical care for patients.

Since President Obama's 2011 executive order to reduce such shortages, the number of new shortages decreased by more than 50 percent from 2011 through 2012. The FDA plans to further reduce these numbers by improving its approach to addressing the underlying causes of these shortages and requiring all manufacturers of certain critical drugs to notify the FDA of any interruption in manufacturing likely to disrupt drug supply.

"Early notification is a critical tool that helps mitigate or prevent looming shortages," said Janet Woodcock, M.D., director of the FDA's Center for Drug Evaluation and Research. "The FDA continues to take all steps it can within its authority, but the FDA alone cannot solve shortages. Success depends upon a commitment from all stakeholders."

Currently there are seven psychiatric drugs on the shortage list including ***lorazepam injection***, ***prochlorperazine injection***, ***methylin chewable tablets***, various forms of ***methylphenidate hydrochloride***, and various forms of ***fluphenazine hydrochloride***.

Varenicline Appears Ineffective in Methadone-Maintained Smokers

Previous studies investigating nicotine-replacement therapy in methadone-maintained (MMT) opiate-dependent smokers have shown low quitting rates. Researchers from Brown University investigated whether ***varenicline***—the key ingredient in the smoking-cessation drug Chantix—could be successful in treating this difficult-to-treat population.

see ***Med Check*** *on page 18*

DSM-5 SELF-EXAM

Dissociative Disorders

Major changes in dissociative disorders include that (1) derealization is included in the name and symptom structure of what previously was called depersonalization disorder; (2) dissociative fugue is now a specifier of dissociative amnesia rather than a separate diagnosis; and (3) the criteria for dissociative identity disorder are changed to indicate that symptoms of disruption of identity may be reported as well as observed, and gaps in the recall of events may occur for everyday and not just traumatic events. Also, experiences of dissociative identity disorder in some cultures are included in the description of identity disruption.

The questions below are from *DSM-5 Self-Exam Questions: Test Questions for the Diagnostic Criteria,* which may be preordered from American Psychiatric Publishing at http://www.appi.org/SearchCenter/Pages/SearchDetail.aspx?ItemId=62467. The answers and rationales are posted at http://www.psychnews.org/pdfs/DSM-5_Self_Examination_QandA_17.pdf. The book, available in February 2014, contains 500 questions for all the categories of psychiatric disorders and includes Section III. The questions were developed under the leadership of Philip Muskin, M.D., a professor of clinical psychiatry at Columbia University College of Physicians and Surgeons. APA members may purchase the book at a discount.

1. Dissociative disorders involve disruptions or discontinuity in the functioning and integration of several psychological capacities. Choose the psychological functionality that is NOT involved in dissociative disorders.

a) memory
b) consciousness
c) perception
d) delusional beliefs
e) emotional responses

2. Which of the following statements correctly identifies important clinical aspects and associated symptoms of depersonalization/derealization disorder, as it is now described in *DSM-5?*

a) Half of all adults have experienced depersonalization and/or derealization
b) Women are 1.5 times more likely to develop depersonalization/derealization disorder than men
c) Most common onset of the disorder is between the ages of 25 and 35
d) Suicide thoughts and behaviors are rare compared with other psychiatric diagnoses
e) The most common childhood traumatic experiences in persons with depersonalization/derealization disorder are physical and sexual abuse

3. Choose the one statement that accurately identifies a change in dissociative fugue from *DSM-IV-TR* to *DSM-5*.

a) In *DSM-5* but not in *DSM-IV-TR*, a fugue event is diagnosed as dissociative identity disorder, if it takes place in conjunction with the symptoms of that disorder
b) In *DSM-5* but not in *DSM-IV-TR*, a fugue event secondary to temporal lobe epilepsy can be diagnosed as dissociative fugue
c) In *DSM-5* but not in *DSM-IV-TR*, fugue states are diagnosed only as a specifier of dissociative amnesia (that is, dissociative amnesia with dissociative fugue)
d) *DSM-5* but not *DSM-IV-TR* recognizes that fugue states are more common in dissociative amnesia than in dissociative identity disorder
e) In *DSM-5* but not in *DSM-IV-TR*, fugue states are seen primarily as pathology of identity continuity PN

Residents' Forum

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Asked if he could meet anyone, from the past or present, he said he would choose to sit down for a conversation with Benjamin Franklin, whom he admires for his wisdom.

Yet Dr. Resnick also harbors considerable wisdom of his own, developed over the course of a long career in which he has observed many of the recent transformations in psychiatry in general and forensic psychiatry in particular. Since he began his residency in 1966, he has seen general psychiatry shift away from psychoanalysis in favor of biological treatments, and forensic psychiatry gain respectability in academic circles.

Given his widely admired teaching style and highly regarded fellowship, it may come as no surprise that Dr. Resnick considers his role in education to be his greatest career accomplishment. Though training with Dr. Resnick is rigorous, he said that his high standards stem from the realities of what it takes to succeed in forensic psychiatry. He recommends that interested students and residents perform a self-assessment prior to entering the field, noting that "forensic psychiatrists must be able to tolerate close scrutiny and be careful to not be influenced by which side employs them."

Not only has Dr. Resnick trained 77 fellows, but many of these fellows have themselves become forensic psychiatry fellowship directors. Moreover, countless medical students have decided to pursue careers in psychiatry after experiencing his clinical rotation. I once asked Dr. Resnick whether there was anything he would change about his work, and he told me that there was not. "I really have the best of both worlds. I have the opportunity to see fascinating cases and the pleasure of being an educator." PN

Med Check

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In more than 300 MMT opiate-dependent smokers, the researchers evaluated the efficacy of varenicline compared with placebo and nicotine replacement therapy (NRT) over six months.

Results showed that varenicline was 50 percent less effective in achieving smoking cessation than was NRT. There was no significant difference in abstinence rates for varenicline versus placebo.

Michael Stein, M.D, a professor of medicine and health services at Brown University, told *Psychiatric News* that quit rates across all tested medication options—which now include varenicline—have been low for MMT smokers. Stein concluded that future studies should focus on "novel behavioral interventions combined with medication" to achieve smoking cessation in this population.

Stein M., Caviness C., Kurth M.: "Varenicline for Smoking Cessation Among Methadone-Maintained Smokers: A Randomized Clinical Trial." 2013. Drug Alcohol Depend. December 1. http://www.sciencedirect.com/science/article/pii/S0376871613002706

Anticonvulsant May Be Effective in Treating Alcohol Dependence

Researchers from the Scripps Research Institute conducted a study showing that ***gabapentin***, an anticonvulsant medication, may serve as a potential therapy to alleviate alcoholism.

The study—funded by the National Institute on Alcohol Abuse and Alcoholism—included evaluations of 150 alcohol-dependent patients who received moderate to high doses of gabapentin or placebo.

After 12-weeks of treatment, 43 percent of the patients who received the drug were able to refrain from heavy drinking days, compared with 23 percent in the placebo group. In addition, the gabapentin group was four times more likely to stop drinking altogether than those given placebo. The medication appeared to be well tolerated with few side effects and alcohol withdrawal symptoms.

Researchers concluded that because of gabapentin's demonstrated ability to reduce drinking days and relapse-related symptoms, it can serve as a treatment option for alcohol dependence in primary care settings. PN

Mason B., Quello S., Goodell V., et. al.: "Gabapentin Treatment for Alcohol Dependence: A Randomized Clinical Trial." 2013. JAMA Intern Med. Nov 4. [Epub ahead of print] http://www.ncbi.nlm.nih.gov/pubmed/24190578

Final Rule

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use in determining coverage of services.

The final rule spells out that the law was never intended to exclude intermediate levels of care. And plan participants or those acting on their behalf will now be able to request a copy of relevant documents used by the health plan to determine whether it will pay a claim. And the Obama administration has also used the final rule to invite comments from advocacy groups and the public on how to improve accountability and transparency.

"APA is pleased to see the emphasis in the final rule on transparency on the part of health plans as well as the request by the Department of Health and Human Services and the Department of the Treasury for further input on what steps, if any, should be taken to assure accountability under the parity rules," said APA CEO and Medical Director Saul Levin, M.D., M.P.A.

The final rule is effective for plan years beginning on or after July 1, 2014. In practice, the bulk of plan years end December 31, so the effective date for most insured will be January 1, 2015.

The rule is a critical step toward eliminating barriers that people with mental and substance use disorders have typically faced. As with every regulatory rule, "final" is actually just a beginning—there will be disagreements over how to interpret the language, and APA will continue to analyze the rule and will be working with other mental health advocacy groups to ensure compliance with the law.

Monitoring, Enforcement Will Be Crucial

"People with mental illness have long faced discrimination in health care through unjust and often illegal barriers to care," said APA President Jeffrey Lieberman, M.D., in response to the release of the rule. "The final rule provides a crucial step forward to ensure that consumers receive the benefits they deserve and are entitled to under the law. In addition to providing equal benefits for mental illness as physical illness, I am hopeful that there will be strong monitoring and enforcement at both the state and federal levels.

"People with mental and substance use disorders have long suffered and fought hard for treatment coverage commensurate to that for medical and surgical care," Lieberman continued. "Despite passage of the 2008 legislation, many insurance companies have manipulated its intent and purpose through vague medical-necessity standards, lengthy approval procedures, bureaucratic delays in service requests, and complicated appeals processes. These maneuvers have unfairly denied patients the care they need, have paid for, and are due.

"As we review the final rule, we look forward to a new chapter in mental health care that delivers on the promise of the parity law. APA will remain vigilant and continue working toward full equity for people with mental illnesses and substance use disorders."

Four Core Areas Clarified

Since the interim final rule was established in 2009, APA has focused on four core areas in which some insurance providers have acted improperly: scope of service; nonquantitative treatment limits; disclosure and transparency; and parity in Medicaid managed care, Children's Health Insurance Program (CHIP), and alternative benefit plans.

The final rule clarified the scope-of-service issue by stating that the six classifications of benefit schemes (inpatient in and out of network, outpatient in and out of network, emergency care, and prescription drugs) were never intended to exclude intermediate levels of care (intensive outpatient, partial hospitalization, residential care). And although neither the interim final rule nor the final rule mandates specific services required to be offered by plans under the six-classification scheme, the final rule clarifies that plans must assign intermediate services in the mental health/substance use area to the same classification that plans or issuers assign to intermediate levels of services for medical/surgical conditions.

For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as an inpatient benefit, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

Nonquantitative treatment limits (NQTLs) refer to restrictions a health plan may use to substantially limit treatment beyond limits on such quantifiable restrictions as inpatient hospital stays or lifetime dollar limits on care; NQTLs can include, for instance, certain kinds of managed care and utilization review practices. The law stipulates that health plan policies for general medical care and mental health and substance abuse treatment must be comparable with regard to how they apply NQTLs.

But unclear in the law was whether provider reimbursement rates would constitute a form of NQTL. Last month's final rule confirms that they do. The preamble clarifies that plans and issuers can look at an array of factors in determining provider payment rates such as service type, geographic market, demand for services, supply of providers, provider practice size, Medicare rates, training, experience, and licensure of providers, but the rule reconfirms that these factors must be applied comparably and no more stringently on MH/SUD providers.

Moreover, under the final rule, parity requirements for NQTLs are expanded to include restrictions on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services (including access to intermediate levels of care). The net effect of this is that plans will no longer be able to require patients to go to an MH/SUD facility in their own state if the plan allows plan members to go out of state for other medical services.

Especially critical to enforcing the law is regulatory guidance requiring health plans to disclose their medical-necessity criteria in how they apply NQTLs. Disclosure requirements in the final rule will require plans to provide written documentation within 30 days of how their processes, strategies, evidentiary standards, and other factors used to apply an NQTL were imposed on both medical/surgical and MH/SUD benefits.

Also at issue has been how the parity law applies to Medicaid managed care, CHIP, and alternative benefit plans. Even though the final rule states that the parity law applies to Medicaid managed care organizations, CHIP, and alternative benefit plans (that is, Medicaid expansion plans under the Affordable Care Act), the final rule itself does not apply. The Parity Implementation Coalition, on APA's behalf, will be requesting that a Medicaid guidance be issued within 180 days. PN

APA members can access the final rule and APA's initial analysis of the rule on APA's website at http://www.psychiatry.org/parity.

Join the conversation by following @APAPsychiatric and #mhparity.

From the President

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The ACGME Psychiatry Milestones, set for implementation in July 2014, include an ambitious set of developmental expectations for residents in this area.

There is clearly an appetite for learning about neuroscience and an increasing requirement for providing it. This will become increasingly important as the gap between neuroscience knowledge and psychiatric practice closes.

A nationally developed, shared, and disseminated set of resources to support improved neuroscience education would help to meet these goals. The American Association of Directors of Psychiatric Residency Training's Neuroscience Education Initiative is taking on this challenge and is supported by our APA Council on Medical Education and Lifelong Learning. Grant funding may be required to achieve this goal.

Systems of Care and Quality Improvement

The increased awareness that errors reside in systems and that outcomes are determined by processes as much as individuals provides an extraordinary opportunity to improve care. But this will only occur if we learn how to effectively and efficiently study our systems and change them appropriately. Quality improvement has traditionally been an afterthought in medical school and residency training, regarded as a necessary but "back office" function. However, the transformation of the health care system has catalyzed greater attention to this area, and regulatory requirements from the ACGME, at the institutional and program levels, buttress the need to make it a more central aspect of training. In order for this to happen, however, progress in metrics and measures of care quality and outcomes will be required.

Training programs need to enliven and invigorate this aspect of the curriculum and help trainees be part of genuine efforts at self-study and quality improvement. Programs that already have made robust commitments to quality improvement report both improved system functioning and great enthusiasm from trainees.

Conclusion

The psychiatrists of the future will certainly need to know how to connect with and relate to others, and they will also need experience in the breadth of assessments and treatments our field will have to offer. To prepare them for the next 40 to 50 years, our junior colleagues will also need training in integration with primary care practice, application of clinical neuroscience, and an appreciation for systems of care and quality improvement. As the health care system changes, so must our training programs to effectively prepare the next generations of psychiatrists for the future. PN

You can follow Dr. Lieberman on Twitter at @DrJlieberman. To do so, go to https://twitter.com/DrJlieberman, log in or register, and click on "Follow."

Candidates

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APA's Area 2 Trustee, on the American Psychiatric Foundation Board, vice-chair of the APA Steering Committee on Practice Guidelines, a past speaker of the Assembly, and served on the *DSM-5* Clinical and Public Health Committee.

Rapaport is the Reunette W. Harris Chair of Psychiatry and the Behavioral Sciences at Emory University School of Medicine and chief of psychiatric services for Emory Healthcare System. He is the founding co-editor in chief of the APA journal *Focus: The Journal of Lifelong Learning in Psychiatry* and a member of the Council on Medical Education and Lifelong Learning.

The treasurer's post, which is for a three-year term, is also up for election, and in that race Frank Brown, M.D., of Atlanta will face James Greene, M.D., of Memphis.

One of the Board's trustee-at-large positions will also be contested in this election cycle, with Anita Everett, M.D., vying with Stephen McLeod-Bryant, M.D. Everett is from Glenwood, Md., and McLeod-Bryant is from Old Hickory, Tenn. At-large trustees also serve three-year terms.

Two of APA's seven Areas will vote for trustees in the next election. In elections for Area trustee, the Area Council rather than the APA Nominating Committee chooses the candidates.

Facing off for Area 2 trustee are Jack Drescher, M.D., and Vivian Pender, M.D. Area 2 includes all of the district branches in New York state.

Area 5—which includes the Southern states, Puerto Rico, and the military district branch—will also be electing a trustee. The candidates in that race are R. Scott Benson, M.D., of Pensacola, Fla., and Gary Weinstein, M.D., of Louisville, Ky.

Members-in-training (MITs) will also have three candidates from whom to choose as they vote for the Board position of member-in-training trustee-elect. Competing for that position are Vittoria DeLucia, M.D., a resident at the University of Maryland/Sheppard Pratt Program; Heather Liebherr, D.O., a resident at the University of Pittsburgh Western Psychiatric Institute and Clinic; and Ravi Shah, M.D., a resident at New York Presbyterian Hospital Memorial Sloan Kettering Cancer Center.

APA announced the slate of candidates November 1, and while it is considered public, it is not official until the Board approves it at its meeting this month.

All members for whom APA has a valid e-mail address on file will receive an electronic ballot. Other members will receive a paper ballot along with instructions on how to vote online if they so choose. All candidates and their supporters should review APA's updated Election Guidelines. PN

Election information is posted on APA's website at http://www.psych.org/network/board-of-trustees/apa-national-elections. The election guidelines are posted at http://psychnews.psychiatryonline.org/newsarticle.aspx?articleID=1754317.

Integrated Care

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The first trials of collaborative depression care began in 1995 and 1996. We developed and tested two initial models in patients diagnosed with depression and started on an antidepressant. In the first trial, a psychiatrist was integrated into primary care and provided two to three visits to help the patient and primary care physician improve patient education about the patient's illness and pharmacologic management. In the second, a mental health professional supervised by a psychiatrist provided brief cognitive-behavioral treatment and enhanced pharmacologic management. Both trials provided enhanced educational materials to the patient to improve depression self-management, ongoing measurement of depression symptoms, monitoring of adherence to and side effects from medication, and proactive tracking to ensure patients did not miss visits and to facilitate return visits.

These initial trials showed that collaborative care could improve the rate of significant clinical depression response from approximately 40 percent to 70 percent. Today, there are more than 80 trials of collaborative depression care that have been completed in multiple countries, and the model has shown robust evidence of effectiveness.

Because many patients with depression have comorbid chronic medical conditions—and epidemiologic studies have shown that depression is associated with poor adherence to medical regimens, increased complications of medical illness, and increased mortality—we recently developed and tested a multicondition collaborative care approach. The goal is improving both medical and depression disease control for patients with comorbid depression and poorly controlled diabetes and/or heart disease and includes training and supervision of a medical nurse by a psychiatrist and primary care provider. This model of care improved the quality of both mental and physical health care; improved depression, glucose, blood pressure, and LDL cholesterol outcomes; and reduced costs (see teamcarehealth.org). We are currently involved in a large Center for Medicare and Medicaid Innovation project that is adapting this model of care to several thousand patients in eight health care systems.

Today, I still spend one half day each week consulting in primary care, with the first hour supervising a collaborative depression care manager and the next three hours providing psychiatric consultations. I still value this experience of working with family physicians and the ability to improve the quality of mental health care in a large population of patients. PN

Data Mining

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companies receive written authorization from applicants to access and use medical information including prescription histories as part of the underwriting process.

"ExamOne, a Quest Diagnostic company, offers its ScriptCheck service through a third-party vendor that sends existing prescription data from pharmacy records to life insurance companies for use in their underwriting processes. The production of these prescription records is based on the life insurance applicant's completion of an authorization that directs health care providers, including pharmacy benefits managers, to send their health information to the life insurance carrier."

Portney also told his story to the *Los Angeles Times*, which published an article October 21 under the headline, "Your Prescription History Is Their Business," and a line that read "A secretive, for-profit service called ScriptCheck keeps track of all your prescriptions, even those you pay for with cash. Life insurers pay for the data."

In that article, *Times* consumer reporter David Lazarus wrote that "48 states, including California, maintain databases that monitor people's prescription-drug use, although access to this information is generally limited to doctors, pharmacists, and government officials."

Lazarus quoted one insurance company representative as saying, "From the consumer's perspective, you may want to keep certain things under wraps. But when you buy a policy, an insurer will want to pull all information about you."

Steven Daviss, M.D., chair of the APA Committee on Electronic Health Records, told *Psychiatric News* that health information exchanges (HIEs), which connect different sources of patient health care data for the use of practitioners caring for patients, can also be an unexpected source of sensitive information. In Maryland, for example, the HIE contains information on hospital treatments, laboratory and radiology data, diagnoses, and medications. "This is valuable information that improves the continuity of care, but states have different policies regarding access to these data beyond treatment purposes," he said. "Most states have mechanisms that allow one to opt out of the HIE and to see who has accessed your information."

> "We have to alter what we are saying to patients when we reassure them about confidentiality."

Portney wonders what other information might be accessed and how it will affect medical and psychiatric treatment. "Are there also databases of lab tests performed, hospital stays with diagnosis, medical billing, that will be the next information accessed by some commercial entity that is similar to ScriptCheck? Will this change the psychology and expectations of privacy and disclosure in medical treatment, particularly psychiatric treatment? And will this result in patients being more hesitant or resistant to getting prescriptions filled or actually taking the medications?" PN

The *Los Angeles Times* article is posted at http://www.latimes.com/business/la-fi-lazarus-20131022,0,1491023.column?page=1#axzz2kXLUzjJi.

APA Offers Manual on HIPAA Privacy Rule Compliance

APA has issued its updated *HIPAA Privacy Rule Manual, a Guide for Psychiatric Practices*. Members may access it free at http://www.psychiatry.org/hipaa/. The manual includes step-by-step instructions, checklists, template forms, patient notices, frequently asked questions, a thorough explanation of the regulations, and cross-references to useful APA-developed materials on issues including treatment of psychotherapy notes and "minimum necessary" disclosure standards. Other HIPAA resources can be found at the same website.