

# PSYCHIATRIC NEWS

*The First and Last Word in Psychiatry*

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"Making the transition from military service to life at home remains an enduring challenge," said psychiatrist and retired Army general Loree Sutton, M.D. (right), as she was named commissioner of New York City's Office of Veterans' Affairs by Mayor Bill de Blasio. See story on page 6.

## SAMHSA Uses Recovery Event To Report Rise in Substance Abuse

**The Substance Abuse and Mental Health Services Administration observes National Recovery Month and releases data that officials find troubling on the prevalence of substance abuse.**

BY VABREN WATTS

Last month, the Substance Abuse and Mental Health Services Administration (SAMHSA) celebrated the 25th anniversary of National Recovery Month, an observance emphasizing that mental health services can enable those with a mental illness, including substance use disorders (SUDs), to live healthy and rewarding lives.

"[For] a quarter of a century we have been illuminating, defining, validating, and shaping a concept into a fact that people do recover from addiction and mental illness," said SAMHSA Administrator Pamela Hyde, J.D., at a press conference at the National Press Club in Washington, D.C. "Understanding that treatment works . . . is a critical component. [Today] we acknowledge and celebrate that reality."

As part of the event, SAMHSA released some of the data from its 2013 National Survey on Drug Use and Health (NSDUH). "An estimated 24.6 million Americans 12 years and older were current drug users," Hyde reported, emphasizing that means more than 9 percent of

see **Substance Abuse** on page 30

## APA Urges Revisions to Proposals On Medicare Payment Reform

**The "G" code for chronic care management proposed by CMS does not cover the intensity of work required to treat individuals with serious mental illness, two or more chronic medical conditions, and multiple providers.**

BY MARK MORAN

APA is seeking revisions to a number of payment reform proposals—especially those concerning payment for care of patients requiring chronic care management—included in a proposed rule issued by the Centers for Medicare

and Medicaid Services (CMS).

Specifically, APA is urging the agency to include two codes (99490 and 99487) formulated by the AMA and incorporated in the *Current Procedural Terminology (CPT)* manual to pay for non-face-to-face, collaborative care of patients.

In its proposed rule, CMS offers just one so-called "G" code (analogous to the

CPT 99490 code) to use for reimbursement for care of patients with chronic illness. But Irvin "Sam" Muszynski, J.D., director of APA's Office of Healthcare Services and Financing, told *Psychiatric News* that the "G" code proposed by CMS would appear to cover care coordination services akin to disease management—identifying and assisting patients with two or more chronic illnesses in managing specific disorders such as diabetes and/or hypertension and depression.

But it would not cover the intensity of work described in the 99487 CPT code, see **Payment Reform** on page 24

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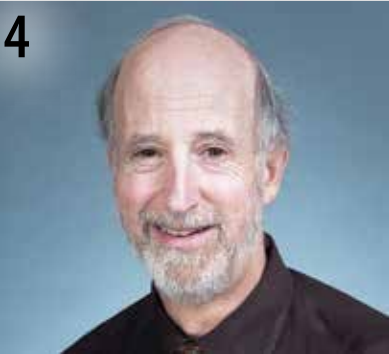
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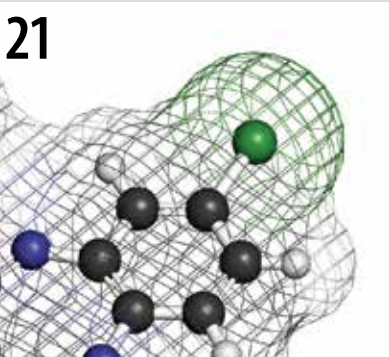
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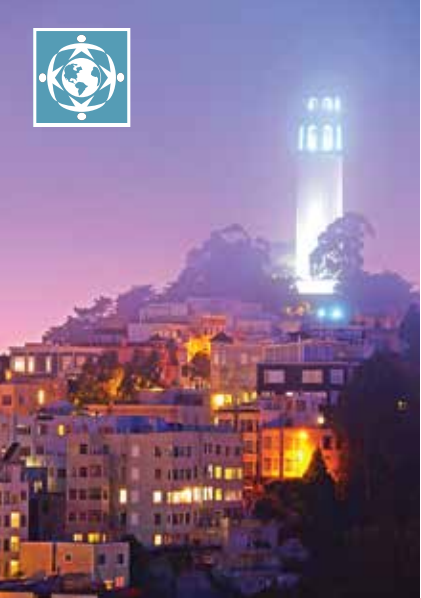
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Register Now for APA's Fall Institute



Registration is open for APA's 2014 Institute on Psychiatric Services, which is being held October 30 to November 2 in San Francisco at the San Francisco Marriott Marquis. The theme of this year's institute is "Integrating Science and Care in a New Era of Population Health." More information on the program, registration, and housing can be accessed at [psychiatry.org/IPS](http://psychiatry.org/IPS).

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## FROM THE PRESIDENT

## IPS: Learn About Integrating Care and Expanding Partnerships

BY HUNTER MCQUISTION, M.D., AND PAUL SUMMERGRAD, M.D.

Psychiatry is in the midst of dramatic change, both as a medical specialty and as part of a broader transformation of health care. With those changes come many possibilities to improve the way we provide care that leads to better patient outcomes.

APA's 2014 Institute on Psychiatric Services (IPS) will address many of the challenges and opportunities facing psychiatrists and mental health clinicians in today's evolving health care system. The theme we have chosen for the IPS, which will be held in San Francisco October 30 to November 2, is "Integrating Science and Care in a New Era of Population Health."

The Scientific Program Committee, led by one of this column's authors, Hunter McQuiston, M.D., has prepared an outstanding program showcasing the latest in scientific research and emerging clinical topics in psychiatry and mental health. Attendees will recognize features that have been popular in the past, as well as enjoy new programming and APA partnerships.

We are especially honored that former U.S. Surgeon General David Satcher, M.D., Ph.D., will present the keynote address at the opening session. Dr. Satcher has long focused attention on improving access to quality health care for diverse and underserved populations and has been an early advocate for integrating behavioral health into health care. As part of those efforts, in 2006 he established the Satcher Health Leadership Institute at Morehouse School of Medicine.

Helping to organize important topics, particularly as they reflect the importance of integrated care, the program presents six overlapping tracks: Clinical;



cal; Collaborative Care; Chemical Misuse; Leadership and Advocacy; Lesbian, Gay, Transgender, and Questioning; and Professional Development.

The 2010 Affordable Care Act (ACA) has offered unprecedented opportunity for Americans to access health care, and as a result, we are beginning to see greatly increased demand for psychiatric services. There is now a critical mass of evidence demonstrating the value of integrating general medical care with psychiatric care, providing higher-quality care to larger numbers of patients, and lowering health care costs. Psychiatry is already undergoing rapid shifts in practice, including new ways of working with our primary care colleagues. As we learn more about delivery models and embrace emerging public health opportunities, psychiatry is poised to make key contributions in health at both the individual and population levels.

To help APA members learn more about integrated care, IPS's Integrated Care Track will address clinical approaches and evolving health care policy issues particularly relating to the ACA. Just a few of these sessions are "ACA and APA: Yes We Can," chaired by Anita Everett, M.D.; Lori Raney, M.D., on "Primary Care and Behavioral Health: Advanced Practical Skills for the Consulting Psychiatrist"; a session on "Risk Management and Liability Considerations in the Integrated Care Setting"; and a presidential symposium on the current state of primary care and psychiatry integration. Moreover, IPS's Professional

Development Track will enable meeting participants to identify sessions that provide tools to cope with a changing practice landscape, for example "Finding Your Ideal Job in Psychiatry."

Another focus concerns addictive disorders. In response to many requests by past IPS attendees, the Chemical Misuse Track has been added to the program. The role of psychiatrists in tobacco cessation will be discussed by Jill Williams, M.D., in "Smoking and Mental Illness: A Wake-Up Call for Psychiatrists," and there will be a symposium on approaches to smoking cessation led by Steven Schroeder, M.D., a former president of the Robert Wood Johnson Foundation and a distinguished leader in this area. Considering the current public debate on the risks and benefits of cannabis, IPS will offer a presentation on Colorado's experience with medical marijuana and a workshop on prenatal exposure to cannabis. There also will be sessions on nondrug behavioral addictions, such as gambling.

Reflecting the integrative nature of our work and our desire to create strong bridges with allied professions, APA has teamed up with the National Association of Social Workers (NASW) to create a special series of sessions for social workers.

APA and NASW share the same person-centered objectives, striving to provide the best possible care and outcomes. As part of this series, APA CEO and Medical Director Saul Levin, M.D., M.P.A., and NASW CEO Angelo McClain, Ph.D., L.I.C.S.W., will facilitate a dialogue among a panel of psychiatrists and social workers.

We are also building on APA's initiative with the faith community through the newly formed Mental Health and Faith Community Partnership (*Psychiatric News*, August 1; <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1891983>) with a special interdisciplinary symposium, "At the Intersection of Spirituality and Mental Health: Psychiatrists and Faith Leaders Working Together." The symposium, chaired by Altha Stewart, M.D., will be a constructively provocative session that exemplifies IPS's eclectic and explorative character.

APA's Division of Diversity and Health Equity (DDHE) will spotlight the LGBT community in its "On Tour" disparities education program track, with two poignant sessions co-organized

see **From the President** on page 16

## Advertisement

### Are You Coming to the IPS? Be a Mentor!

The National Minority Mentors Breakfast for APA's Minority Fellowships Programs (MFP) will be held at the Institute on Psychiatric Services (IPS) in San Francisco (see above article) on Thursday, October 30, from 8 a.m. to 10 a.m. This event provides an opportunity for residents and medical students to network with senior psychiatrists about issues related to the field, the Association, and career opportunities.

APA members of all backgrounds are encouraged to join the National Minority Mentors Network and become mentors to their younger colleagues. Mentors play an important role in the professional growth and development of new psychiatrists and receive great satisfaction from sharing their hard-earned wisdom and experience.

APA members who plan to attend the institute and who would like to be mentors are invited to attend the breakfast. More information is available from Marilyn King at [mking@psych.org](mailto:mking@psych.org) or (703) 907-8653. APA members who cannot come to the IPS but are interested in joining or obtaining additional information about the network should contact King as well.

The National Minority Mentors Breakfast is hosted by the MFP and APA's Division of Diversity and Health Equity.

## PROFESSIONAL NEWS

# Collaborative Depression Care in OB-GYN Benefits Disadvantaged Patients

**For many uninsured or publicly insured women, the only contact they may have with a health care provider occurs when they are going to have a baby.**

BY MARK MORAN

**C**ollaborative depression care adapted to an obstetrics-gynecology (OB-GYN) setting appears to have a greater impact on depression outcomes for socially disadvantaged women with no insurance or with public coverage than for women with commercial insurance, according to a report published online in *AJP in Advance* August 26.

The study extends the evidence of the benefits of collaborative care beyond the insured populations in which it has largely been tested to uninsured and pub-

licly insured patients with multiple medical, psychiatric, and social problems.

"It's a really important finding," said lead author Wayne Katon, M.D., of the University of Washington. "Many of the original collaborative care studies have been done in HMO settings with insured patients. Some people have thought that although the model worked in those settings, it won't help disadvantaged patients because they have too many other challenges—housing, transportation, domestic violence, or other social adversities. But the fact is that it appears from this study that it does help and works even better. More vulnerable populations need even more support to really help them with their illnesses," Katon said.

In the study, 205 women who screened positive for depression with a score of at least 10 on the Patient Health Questionnaire-9 and met criteria for major depression or dysthymia were randomized to a 12-month intervention program or to usual care, with blinded assessments at six, 12, and 18 months. Of these patients, 120 had no insurance or relied on public coverage, and the rest had commercial insurance.

The collaborative care model designed for the OB-GYN population included an initial engagement session with the care manager, choice of initial treatment (psychotherapy or medication), proactive outreach for patients who did not follow through with appointments, help for uninsured patients with charity care

for medications, choice of in-person or telephone visits, and use of social workers as care managers to help alleviate barriers to care. Two depression care managers provided training on issues related to women's mental health, such as domestic violence and sexual assault.

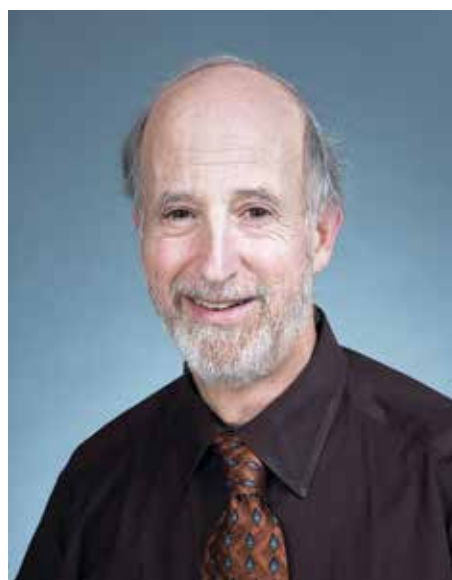
The care managers followed patients in-person and by telephone every one to two weeks for up to 12 months.

Patients assigned to usual care were informed of their depression diagnosis by the research assistant and received an educational depression pamphlet. All patients had an opportunity for referral to social work and psychiatric consultations.

Katon and colleagues found that the treatment effect was significantly associated with insurance status: patients with no insurance or with public coverage had greater recovery from depressive symptoms than patients with commercial insurance over the 18-month follow-up period with the intervention than with usual care.

Women with commercial insurance tended to improve sooner (at the six-month follow-up) with the intervention than with usual care compared with women with no insurance or with public coverage. However, patients with no insurance or with public coverage tended to have greater improvements with the intervention than with usual care at 12 and 18 months on these measures (see chart on page 29).

For patients in both insurance categories, the intervention was associated see **Depression Care** on page 29



Wayne Katon, M.D., says this study is one of the first to look at collaborative care in an OB-GYN setting, where one-third of women say they get their primary care.

## Key Points

- Patients with no insurance or with public coverage had greater recovery from depressive symptoms over the 18-month follow-up with the intervention than with usual care, compared with those with commercial insurance.
- Women with commercial insurance tended to improve sooner with the intervention than with usual care, compared with women with no insurance or with public coverage. However, patients with no insurance or with public coverage tended to have greater improvement with the intervention than with usual care at 12 and 18 months.
- For both insurance groups, the intervention was associated with a higher percentage of patients receiving four or more mental health visits, compared with usual-care patients. Similarly, for both insurance groups, patients receiving the intervention were more satisfied with the quality of depression care than were usual-care patients.

**Bottom Line: Collaborative depression care adapted to OB-GYN settings is effective in improving quality of mental health care and depression outcomes in socially disadvantaged populations; this contradicts the belief that depression in socially disadvantaged women is recalcitrant and difficult to manage in any setting.**

## Teens With Depression Benefit From Collaborative Care Model

**An intervention based on the IMPACT model was adapted for teens, using age-appropriate education materials and an "engagement" session with the adolescent and his or her parent.**

BY MARK MORAN

**A** collaborative care intervention for adolescents with depression who are being treated in primary care resulted in greater improvement in depressive symptoms at 12 months than that seen in a comparable group of adolescents treated in a usual-care model.

The findings, reported in the August 27 *JAMA Psychiatry*, suggest that mental health services for adolescents with depression can be integrated into primary care. The study is one of the first to

look at collaborative care for adolescents and, along with an *AJP in Advance* study looking at collaborative care for disadvantaged OB-GYN patients with depression (see article above), helps expand the potential for collaborative care beyond the insured adult populations in which it has been largely studied.

From April 2010 to April 2013, 101 adolescents aged 13 to 17 seen at nine primary care clinics in the Group Health Cooperative system in Washington state were randomized to a collaborative care model for depression care or to usual care. All subjects screened positive for depression on the nine-item Patient Health Questionnaire (PHQ-9) on two separate occasions or screened positive on one occasion and met criteria for major depression. Exclusion criteria included alcohol/drug misuse, having recently planned or attempted suicide, bipolar disorder diagnosis, developmental delay, and currently being in

treatment with a psychiatrist.

Study co-author Wayne Katon, M.D., director of the Division of Health Services and Psychiatric Epidemiology at the University of Washington, told *Psychiatric News* that participants in the treatment arm received the Reaching Out to Adolescents in Distress (ROAD) model, a collaborative care intervention based on the IMPACT Team Care model (*Psychiatric News*, November 2, 2012) and adapted for adolescents.

The lead author of the study was Laura Richardson, M.D., of the Department of Pediatrics at the University of Washington.

Adaptations for the study included developmentally sensitive materials and structured involvement of both the adolescent and parent in the initial education and engagement session, the choice of treatment, and follow-up contacts.

Intervention components were delivered by depression care managers, who were master's level clinicians employed by the study. The education and engagement session included eliciting the youth's perspectives on their symptoms, provid-

*continued on facing page*



# PROFESSIONAL NEWS

## Shift to Population Health Called Critical to Psychiatry's Future

The high cost of treating patients with psychiatric disorders and chronic physical illnesses are driving the push to replace "complaint-driven" care with population-based collaborative care.

BY MARK MORAN

**"P**opulation health" is the future.

So say the leaders and champions of the emerging models of collaborative care. While there will always be a place for solo private-practice medicine—and a need for clinicians who know how to deliver one-on-one clinical care for the patient's complaints—those champions argue that the traditional model of ad hoc, individualized care must give way to one that personalizes care by data-driven, evidence-based decisions, in addition to the wisdom of the clinician and the doctor-patient relationship.

"Population health is a conceptual framework for thinking about why some populations are healthier than others and what kinds of policy development, research agenda, and resource allocation should flow from the [fact that] some populations are healthier than others," said psychiatrist Joseph Parks, M.D.,

*continued from facing page*

ing depression education, and encouraging active treatment participation of the adolescents and their parents. During the session, the care manager helped the teen and the parent decide to pursue treatment with antidepressant medication, brief cognitive-behavioral therapy (CBT), or both.

Adolescents randomized to receive usual care and their parents received a letter summarizing their PHQ-9 results and encouraging follow-up to initiate depression care. Their primary care clinicians received letters summarizing the results and recommending treatment.

Katon, Richardson, and colleagues found that adolescents receiving the collaborative care intervention had significantly greater improvement in depression than those randomized to usual care; they also had significantly more mental health visits and were significantly more likely to adhere to the antidepressant treatment regimen.

When patients were asked to report their satisfaction with the treatment, those in the intervention group were significantly more likely to say they were



Joseph Parks, M.D., director of Medicaid in Missouri, says many Medicaid directors are turning to psychiatrists for help with high-cost patients who have psychiatric disorders and chronic medical conditions.

director of Missouri's Medicaid program, in comments to *Psychiatric News*. "At a more operational level, it is the health of a population as measured by health status indicators, but as it is also influenced by social, economic, and environmental fac-

"moderately to very satisfied" with care at six months.

Overall, 86 percent of patients in the intervention group received either psychotherapy or medications that met study quality standards, compared with 27 percent of the control group. Youth in the intervention group were significantly more likely than control youth to receive four or more psychotherapy sessions in the first six months of the study.

In an interview with *Psychiatric News*, Katon said the study is one of very few to look at collaborative care for adolescents with depression. "Of the 80 some trials at NIMH [National Institute of Mental Health] on collaborative care, only one or two have looked at teenagers," he said. "In this study it was shown to work very well with teenagers, who experienced improved quality of care, received more counseling visits, and demonstrated a very robust finding showing improvement in depression symptoms." **PN**

**2** "Collaborative Care for Adolescents With Depression in Primary Care: A Randomized Clinical Trial" is posted at <http://jama.network.com/article.aspx?articleid=1899203>.



tors; personal health practices and behaviors; individual capacities; human biology; and of course, the health services that people get.

"Population health can be thought of as the intersection and combination of clinical care and public health," he explained.

As medical director for Missouri's Department of Mental Health, and now as director of Medicaid, Parks has been a national leader in integrating psychiatric and general med-

ical care for the state's publicly insured patients. He will be speaking about population health and how it applies to psychiatrists working in integrated, collaborative care models later this month at APA's Institute on Psychiatric Services in San Francisco. He previewed his talk in an interview with *Psychiatric News*.

Parks believes the biggest weakness of the current delivery model is that it is "complaint driven"—that is, it depends on the individual patient to come to the system with a complaint. "So we are depending on the sick person who is least educated about health care to figure out what he or she needs and when," he said. "This is particularly problematic in psychiatry, when the illnesses

we deal with interfere with concentration, executive function, persistence on task," and other factors that may hinder the ability to even recognize that one is ill, let alone to seek out timely, evidence-based treatment.

In contrast to this individualized, complaint-driven model, population health is data driven, Parks said. "We use data to try to predict before illness happens, or at least pick out people who have known care gaps—people we know should be getting treatment—and try to reach out to them before they get sicker and need the emergency room. That's the process of what's called 'risk stratification'—figuring out the patients who are at higher and lower risk so you can target the limited resources toward the people who need them."

Health systems that are invested in collaborative care use "registries" to risk stratify the patients within the population they serve. These are databases listing patients and their important health indicators and conditions, as well as evidence-based treatments to address those conditions, so that clinicians working on the collaborative team know which patients need which kinds of tests, treatments, or interventions.

Registries can also be used to benchmark the performance of clinicians in providing those tests and interventions. "Population health management, through the use of registries, gives the individual practitioner constant feedback about what their peers are doing and how what they are doing compares with those peers," Parks said.

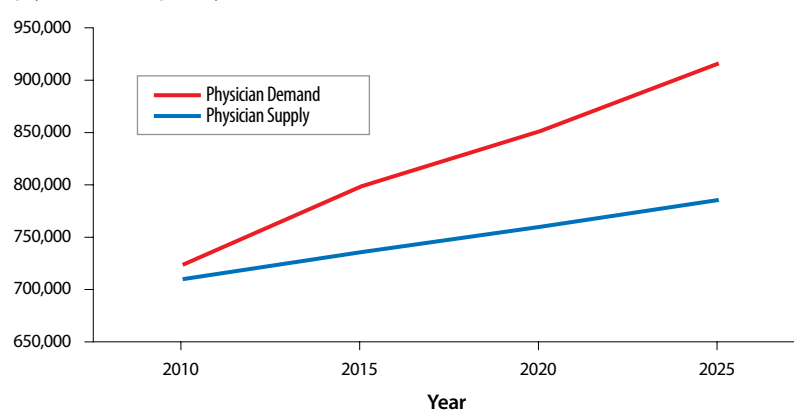
Ultimately, he said, it "takes medicine and psychiatry from being a 'cottage industry' where we do what we guess is best, to a quantifiable, data-driven science."

If it sounds visionary, Parks is confident that two realities—data on costs showing that mental illness and substance abuse are the main drivers of high utilization and a shortfall

see *Population Health* on page 28

### Projected Supply of Physicians to Fall Short of Demand

The graph shows the expected gap between supply and demand for physicians across all specialties over the next 15 years. Psychiatrist Joseph Parks, M.D., says the shortfall in psychiatrists is especially acute.



Source: AAMC Center for Workforce Studies, June 2010

## PROFESSIONAL NEWS

## Psychiatrist and Retired General Named Head of N.Y. Vets' Office

**Psychiatrist Loree Sutton, M.D., new head of the Mayor's Office of Veterans' Affairs in New York, vows to provide veterans with the best services available to help them transition successfully to civilian life.**

BY AARON LEVIN

New York City Mayor Bill de Blasio has appointed psychiatrist Loree Sutton, M.D., a retired U.S. Army brigadier general, to be commissioner of the Mayor's Office of Veterans' Affairs. She will advise the mayor on veterans' issues and undertake initiatives affecting the city's veterans.

Sutton retired from the Army in 2010 after more than 25 years in uniform, serving last as the founding director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE).

"With General Sutton at the helm of this office, I'm confident our city will continue to serve our veterans with the compassion and care they deserve," said de Blasio.

Sutton entered the Army following graduation from medical school at Loma Linda University in California. During her career, she served in the Sinai Desert with the U.S. supervision force, in Germany, and in Kuwait and Iraq during the first Gulf War in 1991.

Ultimately, she rose to command the Carl R. Darnall Army Medical Center at Fort Hood, Texas, until she took on the job as the first director of the DCoE in 2007.

"The Mayor's Office of Veterans' Affairs plays a pivotal role in ensuring our city's veterans receive the support they need, and I'm honored to work alongside our mayor and the federal government to provide our veterans with the highest quality services," said Sutton at the same event.

De Blasio connected the needs of today's veterans to his own family's experience with the aftermath of war.

The mayor's father lost a leg fighting in the Pacific in World War II and suffered physically and mentally for many years until he died by suicide in 1979, he said.

"New York City is home to thousands of veterans who have selflessly volunteered to serve and have protected our fellow Americans from harm, abroad and on the home front—and they deserve a commissioner who is equally committed to protecting our service men and women when they return home and transition back into civilian life," said de Blasio.

"From finding housing to seeking earned health benefits to securing a job, the transition from military to civilian life can be extremely challenging, and I look forward to helping our city's veterans navigate this path together in a way that maximizes their potential," said Sutton. **PN**



Photographer/Mayoral Photography Office

Loree Sutton, M.D.: "Community partnerships within New York City organizations are critical to meeting the needs and harnessing the strengths of our city's veterans."

Information about the Mayor's Office of Veterans' Affairs in New York City is posted at <http://www.nyc.gov/html/vets/html/home/home.shtml>.

## RESIDENTS' FORUM

### Never Let Your Colleagues Worry Alone

BY LARA COX, M.D.

Never worry alone. As residents, we've all heard it, whether in med school, from our program directors or chiefs, or from our attendings when we start a new rotation. And it sounds easy. All of us in medicine can recall the first patient who died despite our best efforts, the family member who got under our skin, the supervisor whose comments cut a little too deep. We also recall those moments of identification with a profoundly ill patient who made us wonder why we were spared; we know the weight of letting a patient walk out of our office and feeling simultaneously responsible and helpless to protect the patient until the next time he or she walks back through the door.

So it should be easy not to worry alone. After all, we have these experiences in common. We know that a career in medicine, even with all the rewards and the fulfillment it offers, has incredibly difficult moments—and that training is especially hard. As psychiatrists, we have been

doubly reinforced that becoming depressed is not a character flaw. We know that depression is an illness, not a weakness—that regardless of triggers, it has a biological basis and that there are effective treatments.

But it is easy to forget these things in the whirlwind of training. We get caught up in the rush of multiple admissions in a day, of trying to take time to teach medical students and to learn ourselves. There is often no time to stop and think. It can feel like constantly playing catch-up, and it's easy to attribute exhaustion to never quite getting enough sleep, to feel like disillusionment is just a little bit of compassion fatigue, to find yourself constantly irritable or down or overwhelmed and think that it's just this job.

The other issue is that depression lies. You may have been told never to worry by yourself and that to be depressed doesn't make you weak or incompetent. You may have learned everything we know about



the biological underpinnings and memorized all of the treatments. When depression weaves its insidious way into your mind, none of that knowledge matters. It will tell you that you are stupid and that you are barely holding together the façade of knowing what you are doing. It will say that you are letting everyone down—when your patients don't get better, it's your fault; when you miss your family's holidays for work, you are selfish; when you cancel dinner with friends at the last minute, you've failed them yet again. And it can make you believe that there is no hope, that none of the exhaustion or the seemingly insurmountable obstacles will ever go away. These lies make you feel completely and utterly alone.

When it comes to depression, there is a lot of evidence that we as physicians do worry alone. Our rates of depression, suicidal thoughts, and suicide are higher than those of the general population, and this increase in depressive symptoms is particularly notable early in our careers. Depression early in one's career as a physician predicts ongoing risk for depression. Among physicians with depression, more than half avoid seeking treatment due to perceived stigma, and among physicians who die by suicide, few are in treatment at the time of their death.

But depression is treatable. And suicide is preventable. So, perhaps an equivalently important instruction is "never let your colleagues worry alone." If you notice someone struggling, ask what is wrong. Maybe the intern on your service has started coming in late every day or is at the hospital far later than everyone else each night. Or your co-resident is drinking more than usual at social functions—or has stopped attending at all. Perhaps someone seems anxious or irritable, or it feels as though they're putting in less effort than before. If you are a supervisor, maybe you notice that a resident's performance has plateaued, or even dropped.

It would be easy to get frustrated with these changes, to notice only their impact on your work. But depression doesn't always look like sadness, especially in those who are trying desperately to keep it together. So ask. Ask them how they're doing and what is going on. And listen. Offer support. Know what resources are available at your institution and help colleagues in distress access them. Because if we each worry with each other, then no one has to worry alone. **PN**

References for this article are posted at <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1905377>.



# PROFESSIONAL NEWS



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## AHA Urges Caution on E-Cigarettes, Citing Lack of Good Data

**The American Heart Association will not support e-cigarettes as a primary smoking cessation aid due to their lack of demonstrated efficacy.**

BY NICK ZAGORSKI

**S**ince their introduction a little over a decade ago, electronic cigarettes have exploded onto the marketplace, quickly evolving from a novelty item to a ubiquitous presence. The popularity of these products, though, is far outpacing related research and regulation.

On August 25, the American Heart Association (AHA) provided some needed information and guidance through the organization's first policy statement on e-cigarettes.

While scientific studies into e-cigarettes are limited, the AHA panel went through the evidence to develop recommendations in several key areas of e-cigarette control such as clean indoor air laws, taxation, regulation, targeting of products to youth, surveillance, and smoking cessation.

One of the key conclusions was that the AHA does not support e-cigarettes as a primary aid in smoking cessation. The statement noted a lack of empirical evidence that e-cigarettes are more effective or safer than other available options. Some observational and survey studies have suggested that e-cigarettes can improve quit rates, but the one large randomized study completed to date found them to be only as effective as a nicotine patch after six months, with a similar rate of side effects.

The AHA policy did add that in cases in which repeated efforts with conventional treatments fail, are not well-tolerated, or rejected by a patient, clinicians should not discourage e-cigarettes if the patient requests them. The message that e-cigarettes are a contingency plan for quitting gained traction in the media, but as Douglas Ziedonis, M.D., M.P.H., chair of the Department of Psychiatry at the University of Massachusetts Medical School, believes, it does muddle the issue of what e-cigarettes are.

"Obviously, if a patient comes to you and says 'I want to use e-cigarettes,' which are available over the counter, you can't say no," Ziedonis told *Psychiatric News*. "However, it's important to remember that e-cigarette manufacturers are not making any therapeutic claims, nor is the Food and Drug Administration aiming to classify them as a medication."

In April, the FDA proposed to extend its regulatory authority over tobacco products to include e-cigarettes and some other devices (*Psychi-*

*atric News*, May 29), but these rules are not scheduled to be finalized until June 2015.

The better take-home message from the current knowledge of e-cigarettes, Ziedonis suggested, is one that stresses dialogue. "We need to make sure to ask patients about e-cigarettes. 'How

often do you use e-cigarettes? In what settings? Do you use them in addition to other tobacco products?' We can then integrate that knowledge into a cessation strategy that makes use of approved medications and social support," he said.

The AHA stated that this policy is provisional; the organization will continue to monitor the e-cigarette landscape and evolve its position as new data become available. In the meantime, the current statement offers a resource for people to educate themselves about numerous e-cigarette topics beyond just their role in a smoking-cessation strategy, including their design, toxicology, and health impact.

"Given the high prevalence of tobacco use among people with mental illness, especially teens and young adults, I believe these guidelines are worthwhile reading for any psychiatrist," Ziedonis said. **PN**

**▶** The AHA policy statement on electronic cigarettes was published in *Circulation* and is posted at <http://circ.aha.org/content/early/2014/08/22/CIR.000000000000107.full.pdf+html>.

### CDC Reports E-Cigarette Use Growing Among Youth

In addition to the AHA policy statement, late August saw the Centers for Disease Control and Prevention (CDC) publish the results of a survey in *Nicotine and Tobacco Research* highlighting a pervasive rise of e-cigarette usage among teens. More than 263,000 adolescents or teens who had never smoked a cigarette used e-cigarettes in 2013, compared with only 79,000 who had done so in 2011. The youth who tried e-cigarettes were also twice as likely to say they would try a regular cigarette. This trend could undermine the gains made in reducing teen smoking; this same CDC survey reported that overall teen smoking in 2013 had dropped to 15.7 percent, the lowest on record. An abstract of the CDC report is posted at <http://ntr.oxfordjournals.org/content/early/2014/08/18/ntr.ntu166.abstract>.

## Advertisement

# Costs Higher for Mental Health Court Participants

Higher costs incurred by detainees participating in mental health courts may mask other benefits of these diversion programs.

BY AARON LEVIN

**S**aving money is one of the big selling points for mental health courts, but a six-year study finds that participants in mental health courts cost an average of \$4,000 a year more than a matched group of jail detainees who received jail-based psychiatric services. The additional costs were due to the treatment received through the mental health court system and were not offset by criminal justice cost savings.

"The findings presented here call into question some of the assumptions of mental health court advocates who argue that participation in these courts will result in more cost-effective and efficient interventions for jail detainees who have a serious mental illness," concluded Henry Steadman, Ph.D., of Policy Research Associates in Delmar, N.Y., in the September *Psychiatric Services*.

"There may be cost shifting, but there may not be cost savings," added Steadman in an interview with *Psychiatric News*.

However, the increase in costs may not be a bad thing, said APA President-

elect Renée Binder, M.D., a professor and director of the Psychiatry and the Law Program at the University of California, San Francisco.

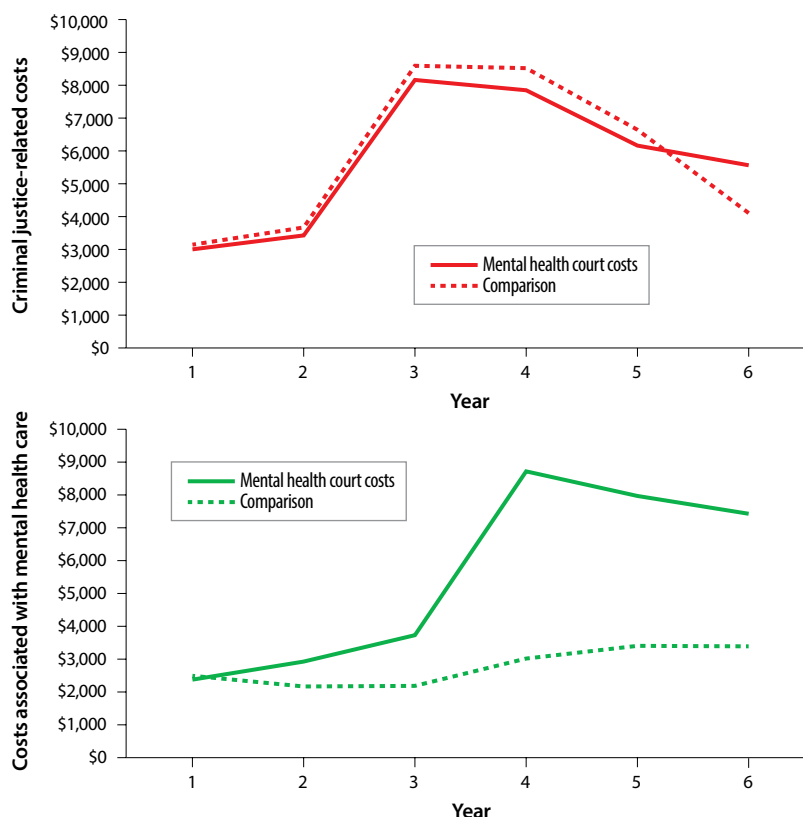
"That reflects increased mental health care utilization, especially for people with co-occurring substance abuse disorders and a criminal history," Binder told *Psychiatric News*. Prior research (including Binder's) has shown that mental health court participation decreases recidivism, jail days, new arrests, and violence. "So beyond the cost issue, the outcomes of mental health courts are valuable for public safety. It's a good thing from the patient's point of view and from a public-safety point of view."

Mental health courts are a type of voluntary diversion program that allows some people with mental illness facing criminal charges to accept court-monitored, community-based treatment instead of going to trial or jail.

Steadman and colleagues tracked 296 mental health court participants and 386 matched jail detainees for three years prior to a target arrest and then followed them for three years *see Courts on page 30*

## Increased Costs in MH Courts Driven by MH Care

Criminal justice-related costs for mental health court participants remain similar to those for controls (top), but costs associated with mental health care are higher in the three years following arrest (bottom).



Source: Henry Steadman, Ph.D., et al., *Psychiatric Services*, September 20, 2014



Paul Davis

## St. Elizabeths Emerges From Federal Oversight

A long list of improvements to ensure that patients receive quality care leads the federal government to end civil-rights monitoring of Washington, D.C.'s historic psychiatric hospital.

BY AARON LEVIN

**S**t. Elizabeths Hospital in Washington, D.C., is finally free of the federal monitoring put in place seven years ago to ensure that the rights of patients were enforced.

"This is the last of several cases and gets the Department of Behavioral Health completely out from under any federal oversight," Stephen Baron, L.C.S.W., director of the District of Columbia Department of Behavioral Health (DBH), told *Psychiatric News*.

On August 28, the Department of Justice (DoJ) asked the U.S. District Court in Washington, D.C., to dismiss the injunction against the city, which owns the psychiatric hospital. The department said that the District of Columbia had sufficiently improved the care and treatment of patients at St. Elizabeths Hospital, which has served as a training ground for generations of psychiatrists.

Reforms undertaken by the city agency "have resulted in important improvements in integrated treatment planning, psychological and psychiatric services, nursing care, and protection from assault," said the DoJ in a statement. The reforms also improved discharge planning and the community placement process.

The case began in 2005 when the DoJ investigated 400 hospitals nationwide under the Civil Rights of Institutionalized Persons Act and the Americans With Disabilities Act and concluded that 75—including St. Elizabeths—needed closer monitoring.

Based on its review, the DoJ cited St. Elizabeths for a lack of individualized treatment and quality treatment,

poor treatment planning, too few discharges, and excessive use of seclusion and restraint. It issued its report in May 2006, a month after Baron arrived to lead the DBH.

"We then sat down and negotiated a five-year settlement agreement containing 224 performance benchmarks, which was finalized in June 2007," said Baron.

Among other provisions, the hospital moved to increase to 50 percent the proportion of direct-care staff who are R.N.s. An electronic medical records system and other changes were put in place to support discharge planning. And the opening of a new hospital building in 2010 addressed environmental issues (*Psychiatric News*, May 21, 2010).

Involuntary civil admissions were reduced from about 150 a month 10 years ago to between 15 and 20 a month today, largely by increasing the number of inpatient beds in four community hospitals devoted to involuntary acute care.

"If individuals need an inpatient stay longer than 14 days, then they are transported to St. Elizabeths," he said. "It functions now as a way station."

*see St. Elizabeths on page 22*



## GOVERNMENT NEWS

# CMS Revises ‘Meaningful Use’ Criteria For Electronic Records

**APA and the AMA maintain that the performance thresholds and timeline for meeting meaningful use criteria are too rigid to account for variability in physician practices.**

BY MARK MORAN

The Department of Health and Human Services (HHS) published a final rule in August that gives health care providers a longer adoption timeline and more flexibility in the certified electronic health record technology (CEHRT) that they use to meet “meaningful use” criteria for the 2014 EHR Incentive Program reporting.

The incentive program, created in the 2009 Health Information Technology Act, provides physicians and hospitals with stimulus funding to encourage them to implement electronic health records (EHRs).

The new rule pushes back the beginning of the third stage of meaningful use for the first cohort of adopters from January 1, 2016, to January 1, 2017. Also, some providers struggling to adopt 2014 certified EHRs will now have an extra year to use 2011 Edition software. (The government has certified certain software products that can be used for each phase of implementing EHR systems in a physician practice; information about those products is available on the CMS website. Deadlines for implementing the software products have been established for each phase of the incentive program.)

By providing this flexibility, more providers will be able to participate and

meet important meaningful use objectives such as checking for drug-drug and drug-allergy interactions, providing clinical summaries to patients, prescribing electronically, and reporting on key public-health data and quality measures, according to the Centers for Medicare and Medicaid Services (CMS).

“We listened to stakeholder feedback and provided CEHRT flexibility for 2014

EHRs can be widely adopted throughout the health care system.

Earlier this year, APA joined the AMA, the College of Healthcare Information Management Executives, and 45 other physician and hospital organizations in calling on the federal government to add more time and flexibility in the Medicare and Medicaid EHR Incentive Program.



Psychiatrist Laura Fochtmann, M.D., says CMS’s revised criteria for meaningful use are a step in the right direction but do not go far enough in making the criteria more flexible to account for variability in physician practice.

to help ensure that providers can continue to participate in the EHR Incentive Programs forward,” said CMS Administrator Marilyn Tavenner on the CMS website.

APA, the AMA, and other medical groups have consistently expressed concern about the EHR criteria and urged the government to adjust them to ensure an orderly transition so that

## Key Points

- The revised rule pushes back the beginning of the third stage of meaningful use for the first cohort of EHR adopters from January 1, 2016, to January 1, 2017.
- Some providers struggling to adopt 2014 certified EHRs will now have an extra year to use the 2011 Edition software.

**Bottom Line: According to CMS, the revised criteria should mean more providers will be able to participate and meet meaningful use objectives such as checking for drug-drug and drug-allergy interaction, providing clinical summaries to patients, prescribing electronically, and reporting on key public-health data and quality measures.**

too rigid to account for the variations in typical clinical activities across differing clinical specialties and types of physician practices.

For example, Fochtmann said, the standards include having patients use a “patient portal” so they can check on lab reports, office appointments, and other data from their home computers. “But not all patients are able to use computers or wish to use them to communicate with their physicians,” she pointed out.

Also, some states have regulations about parental access to information about children or adolescents, she noted, making it impossible for some child and adolescent psychiatric practices to meet the criteria on patient portal use. Other criteria, such as implementation timetables, have been challenging to meet for solo practitioners and those in small-group, office-based practices, which are common in psychiatry, due to the significant start-up costs and training required to adopt an EHR.

Fochtmann said that the newly revised criteria are a step in the right direction. “My primary concern is that the criteria still don’t go far enough in making meaningful use more flexible,” she said. “Overall, the meaningful use program has driven EHR use, but it is much more cumbersome and confusing than it has needed to be to achieve the ultimate goal of enhanced patient care.” **PN**

**2** Information about the revised criteria and timeline are posted at <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms> and <http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-08-29.html>. APA’s Committee on Mental Health Information Technology has posted information for psychiatrists at <http://www.psych.org/home/search-results?k=electronic+health+records>.

## New System Will Monitor Emergence of Illicit Drugs

The National Institutes of Health has awarded the University of Maryland’s Center for Substance Abuse Research (CEASAR) five years of funding for the creation of the National Drug Early Warning System (NDEWS), a system that monitors emerging drug trends across the United States.

“NDEWS will generate critically needed information about new drug trends in specific locations around the country so rapid, informed, and effective public health responses can be developed precisely where needed,” said National Institute on Drug Abuse Director Nora Volkow, M.D.

The system will scan social media and Web platforms—as well as conventional data resources—to respond to potential outbreaks of illicit drugs such as heroin and to identify increased use of designer synthetic compounds.

The NDEWS network, which will consist of addiction experts and researchers, will assess the outbreak and examine anonymous urine samples—provided by the criminal justice drug testing programs—for enhanced analysis that includes testing for synthetic drug metabolites, and quickly disseminate information to the public using traditional and social media outlets.

Information on the NDEWS is posted at <http://www.center-for-addiction-recovery.com/blog/?p=4818>.

In a February 21 letter to then Health and Human Services Secretary Kathleen Sebelius, the organizations noted that “additional time and new flexibility are vitally important to ensure that hospitals and physicians continue moving forward with technology to improve patient care. By making such changes, HHS would be demonstrating needed flexibility to maximize program success, without compromising momentum toward interoperability and care coordination supported by health information technology” (*Psychiatric News*, March 21).

In comments to *Psychiatric News*, Laura Fochtmann, M.D., a former member of APA’s Committee on Mental Health Information Technology, explained that “meaningful use” is the term developed by the government to describe criteria for implementation of electronic records that would qualify clinicians, hospitals, and health systems to receive the incentive payments established under the government’s program for providers of Medicare and Medicaid services.

But she said the standards—including both the performance thresholds and the timelines for meeting them—are considered by many in the medical field as

## APA INSTITUTE



## Culture, Diversity Issues in Mental Health Major Focus of IPS Program



**Former U.S. Surgeon General David Satcher, M.D., will give the keynote address at APA's 2014 Institute of Psychiatric Services, to be held October 30 to November 2 in San Francisco.**

BY RUTH SHIM, M.D., M.P.H.



Culture counts. These words capture the overall theme of the landmark publication "Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General"

issued by former U.S. Surgeon General David Satcher, M.D., Ph.D., in 2001. In the years since, considering culture and addressing cultural competence remained challenges in the field of psychiatry.

Psychiatrists and mental health clinicians from diverse racial and ethnic backgrounds are still grossly under-

represented in the field. Although most members of minority populations in the United States do not have a disproportionate prevalence of mental illness, they often have poorer access to services and greater disease severity and chronicity. When minority populations do seek mental health treatment, they often receive poorer quality of care than their white counterparts.

Although these facts paint a bleak picture, sessions at the APA Institute on Psychiatric Services (IPS) in San

Francisco October 30 to November 2 will not shy away from these complicated issues and topics. First, the keynote address at this year's meeting will be delivered by Satcher. His speech will spotlight the importance of culture in mental health and will challenge providers to take action to improve clinical outcomes for diverse and vulnerable populations.

Several workshops, lectures, forums, seminars, and symposia will also examine issues of culture and mental health among diverse populations. An entire track is devoted to lesbian, gay, bisexual, and transgender mental health issues, with each session designed to help increase clinicians' cultural competence in this area.

Several sessions highlight mental health issues among African Americans, including the Solomon Carter Fuller Award Lecture, being given this year by William Lawson, M.D., Ph.D., an expert in disparities and mental health issues affecting African Americans. Also, to commemorate the 50th anniversary of the Civil Rights Act, APA President Paul Summergrad, M.D., and former American Psychiatric Foundation President Altha Stewart, M.D., will present a forum on the civil rights movement and African-American mental health concerns. These presentations (and others) will help provide a cultural framework

see *Institute* on page 14



### VIEWPOINTS

## Capitol Hill Fellowship Gives Resident Insider's View of Legislative Process

BY ELLYN JOHNSON, M.D.

It's been a pleasure and a privilege to serve as the 2014 APA Jeanne Spurlock Congressional Fellow the last six months. The fellowship provides psychiatry residents, fellows, and early career psychiatrists an opportunity to work in a congressional office on federal health policy.

The fellowship was created in honor of the late Jeanne Spurlock, M.D., who was an APA deputy medical director and head of the Office of Minority and National Affairs, as well as a staunch advocate for children and minorities.

My fellowship experience gave me the opportunity to serve on the House Armed Services Committee (HASC) Subcommittee on Personnel.

The fellowship started with lots of background reading on the current reorganization of the military health system, which culminated in a hearing on this topic. I wrote the educational background material for the committee members, the opening remarks of the subcommittee chair, and many of the questions posed to the witnesses. I served as the subject-matter expert during meetings with medical special-interest groups pursuing a relationship with the Department of Defense (DoD) or seeking TRICARE coverage of specific therapeutic modalities.

I was surprised at how often I was called on to review the evidence base of therapeutic modalities that had grabbed the attention of members of Congress. This showed me the importance of a well-organized political action strategy to get your issues taken seriously by elected officials.



Although my recommendations weren't always accepted, lawmakers appreciated the presence of a neutral physician able to translate the medical literature into lay terms, especially in the area of mental health treatment. In light of the committee's oversight function, we had many briefings with DoD and the military services' leaders around their efforts on suicide prevention, improvement of the Armed Forces' mental health overall, sexual-assault response and prevention, the opening of combat positions to women, and more efficient collaboration with the Veterans Administration, among other topics.

Each fiscal year, the HASC is responsible for passing the National Defense Authorization Act, which sets DoD policy as a companion to the annual appropriations bill that releases funding for defense spending. As the bill cycle heated up, I focused on reviewing and

giving recommendations on proposed health care legislative provisions, many of which focused on military mental health. I received a priceless education in diplomacy as I discussed my concerns and recommendations with House members' staffs and sought compromises that stayed as true as possible to the medical literature in the setting of complex political considerations. My time on the HASC really challenged my clinical and research interpretation skills in ways I did not expect. I also wrote many health-related parts of the bill, including spotlighting the forward-thinking suicide and resilience research that the Army is currently conducting. The bill recently passed the House.

The mentoring and guidance I received during my fellowship was unmatched. Working under the direction of committee staff, I fully participated in all subcommittee activities and was accepted as a member of the team.

see *Viewpoints* on page 30

Ellyn Johnson, M.D., was a resident at the Medical College of Georgia at Georgia Regents University when she began her fellowship and is now on active duty in the U.S. Air Force.



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BY NICK ZAGORSKI

## Family Meals Can Reduce Effects of Bullying

**S**pending some time together as a family, such as at a dinner table, may help protect adolescents from the negative effects of cyberbullying, reports a study in *JAMA Pediatrics*.

The study, led by researchers at McGill University, surveyed more than 18,000 adolescents in Wisconsin to identify the risk of various mental health consequences following exposure to cyberbullying. About 18 percent of adolescents surveyed experienced some form of online bullying, and victims of cyberbullying showed increased risk for all 11 outcomes measured, which included internalizing problems (anxiety, depression, self-harm, suicidal ideation, and suicide attempt), externalizing problems (fighting and vandalism), and substance abuse (frequent alcohol use, binge drinking, prescription drug

misuse, and abuse of over-the-counter drugs).

The researchers also found that these effects related more strongly to cyberbullying victims who had fewer family dinners together. Though the connection is only correlational, the authors noted that family dinners, or other shared family time, offer a period of communication and social support that is beneficial to adolescents' mental health.

"Many adolescents use social media, and online harassment and abuse are difficult for parents and educators to monitor, so it is critical to identify protective factors for youth who are exposed to cyberbullying," commented lead author Frank Elgar, Ph.D., of McGill's Institute for Health and Social Policy.

**E**lgar F, Napoletano A, Saul G, et al. "Cyberbullying Victimization and Mental Health in Adolescents and the Moderating Role of Family Dinners." 2014. *JAMA Pediatrics*. Sep. 1. <http://archpedi.jamanetwork.com/article.aspx?articleid=1900477>

## Institute

continued from page 10

for addressing mental health in the African-American population.

Increasing diversity in the psychiatric workforce remains a major priority in the United States and internationally. A forum titled "Training Experiences of Minority Individuals in Psychiatry: Then, Now, and How to Create the Best Future" will highlight the importance of a culturally diverse workforce.

Also, culture and the mental health of American-Indian populations will be addressed, and Russell Lim, M.D., editor of the *Clinical Manual of Cultural Psychiatry*, will lead a seminar on clinical

Ruth Shim, M.D., M.P.H., is a member of the IPS Scientific Program Committee and vice chair for education and faculty development in the Department of Psychiatry at Lenox Hill Hospital in New York.

cal applications of the *DSM-5* Cultural Formulation Interview.

These are just a sample of the many IPS sessions that will focus on culture and psychiatry.

There also are numerous informal networking events that help increase individuals' understanding of culture in psychiatry. And the Caucus of Black Psychiatrists will also be meeting at the IPS.

Finally, the venue for this year's IPS meeting also affords a great opportunity to experience a wealth of cultural diversity. The streets of San Francisco are teeming with cultural experiences, from an international lineup of cuisine choices to distinct architecture to unique musical and art experiences. Consider a visit to Chinatown, catch a show at the Fillmore, or take a walk down Lombard Street. There are endless opportunities to discover and embrace culture in all its many forms. **PN**

## Xenon Gas Impairs Reconsolidation of Fear Memories

**T**he unwanted reactivation of negative memories in the form of flashbacks or nightmares is a key event in posttraumatic stress disorder (PTSD), and scientists are looking for ways to block such painful memories from surfacing. Now, researchers at McLean Hospital have found that a dose of xenon gas given right after a traumatic memory surfaces can help erase that memory. The study, published in *PLoS One*, analyzed xenon exposure in a rat model of fear conditioning, but the approach could hold promise for humans, since xenon is already used in anesthesia and imaging.

Rats exposed to xenon gas for an hour immediately after exhibiting a memory-triggered fear response (freezing in response to a tone) displayed a significantly reduced fear response in subsequent tests given 48 hours, 96 hours, or 18 days later. This reduction was not observed if the xenon was administered two hours after the traumatic memory surfaced, and xenon did not have any effect if given before any fearful memories surfaced. These results support the notion that xenon inhibits memory reconsolidation—a process in which reactivated memories temporarily become labile.

The researchers will continue probing xenon's effects, such as testing whether lower doses and a shorter exposure time can also erase negative memories. Such data will be important if xenon therapy can progress to human studies.

**M**eloni E, Gillis T, Manoukian J, Kaufman M. "Xenon Impairs Reconsolidation of Fear Memories in a Rat Model of Post-Traumatic Stress Disorder (PTSD)." 2014. *PLoS One*. Aug. 27. <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0106189>

## Autoantibodies Identified In Patients With Narcolepsy

**M**any scientists believe narcolepsy has an autoimmune component, though attempts to pinpoint definitive autoantibodies have not been fruitful. A new study published in *Proceedings of the National Academy of Sciences* may have found a promising candidate, however.

The research team tested the sera of 89 narcolepsy patients along with that of 52 people with other sleep disorders and 137 healthy controls. They found that 27 percent of the narcolepsy samples exhibited distinct staining patterns when tested on slices of rat brain, which was a much higher proportion than the other two groups.

Purified antibodies taken from narcolepsy patients could induce sleep disturbances when injected into rats, whereas

antibodies from healthy subjects could not, further supporting the presence of autoantibodies.

Further analysis of stained neurons identified the likely autoantigen as a short motif found on the peptides neuropeptide glutamic acid-isoleucine (NEI) and  $\alpha$ -melanocyte-stimulating-hormone ( $\alpha$ MSH). The exact effects of disrupted NEI/ $\alpha$ MSH aren't known, but the authors noted that these peptides were found in close proximity to neurons containing hypocretin, the neurotransmitter that regulates wakefulness, which is lacking in many cases of narcolepsy.

**B**ergman P, Adori C, Vas S, et al. "Narcolepsy Patients Have Antibodies That Stain Distinct Cell Populations in Rat Brain and Influence Sleep Patterns." 2014. *PNAS*. Aug 18. <http://www.pnas.org/content/111/35/E3735.abstract>

## Stem Cells Reveal Signaling Patterns In Schizophrenia Neurons

**R**esearchers at the University of California, San Diego, used induced pluripotent stem cell (iPSCs) technology to uncover some of the chemical changes occurring in the neurons of people with schizophrenia. The researchers created functional neurons from human iPSCs generated from the skin cells of both healthy individuals and schizophrenia patients and then triggered the neurons to release neurotransmitters using potassium chloride.

What they observed was that neurons derived from schizophrenia patients secreted significantly more dopamine, norepinephrine, and epinephrine, which are known as the catecholamine neurotransmitters since they are synthesized from the amino acid tyrosine.

In addition, many of the schizophrenia neurons were producing tyrosine hydroxylase, the enzyme that initiates the synthesis of this neurotransmitter family. These findings, published in *Stem Cell Reports*, suggest that people with schizophrenia may be preprogrammed to secrete more catecholamine neurotransmitters than normal.

The researchers believe that these iPSC-derived neurons could have many applications, including being able to evaluate the severity of someone's disease, prescreen patients for drug responses, and even test the efficacy of new drugs. **PN**

**H**ook V, Brennand K, Kim, Y, et al. "Human iPSC Neurons Display Activity-Dependent Neurotransmitter Secretion: Aberrant Catecholamine Levels in Schizophrenia Neurons." 2014. *Stem Cell Reports*. Sep. 11. <http://www.cell.com/stem-cell-reports/abstract/S2213-6711%2814%2900245-8>



## CLINICAL &amp; RESEARCH NEWS



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## ED Visits for Drug-Related Suicide Attempts on Rise

The troubling rates of suicide attempts and completed suicides among middle-aged adults generate calls for intensive preventive interventions with this population.

BY VABREN WATTS

Two new reports from the Substance Abuse and Mental Health Services Administration (SAMHSA) suggest that suicide attempts are increasing—particularly among certain age

groups—and that a substantial number of these events are associated with prescription and over-the-counter drugs.

SAMHSA's Drug Abuse Warning Network (DAWN), a public surveillance system that monitors drug-related emergency department (ED) hospital visits, conducted a comparative analy-

sis on the number of visits to an ED for drug-related suicide attempts from 2005 to 2011.

"Suicide continues to take lives without regard to age, income, education, . . . race, or gender," commented SAMHSA Administrator Pamela Hyde, J.D. "It is a growing risk in far too many segments of our society."

The first report showed that ED visits for drug-related suicide attempts among individuals aged 12 and older increased by 51 percent, rising from 151,477 visits in 2005 to 228,227 in 2011. Middle-aged patients—those aged 45 to 63—had the largest increase in suicide-related ED visits, jumping from 28,802 in 2005 to 58,776 in 2011, a 104 percent increase. A 58 percent increase in ED visits was observed in young adults aged 18 to 29.

The second report from SAMHSA focused on identifying medications that may have contributed to the high prevalence of ED visits by middle-aged adults. The study results showed that of the ED visits made by this population in 2011, approximately 96 percent of those linked to medication overdoses involved nonmedical use of prescription drugs and over-the-counter medications. Medicines intended to treat anxiety and insomnia accounted for nearly half of all ED visits for medication-related suicide attempts among this age group, followed by pain relievers (29 percent) and antide-

pressants (22 percent).

"Along with the continued rise in rates of suicide in the U.S. reported by the [Centers for Disease Control and Prevention] for 2011, SAMHSA's new report on the rise in emergency department visits from 2005 to 2011 due to drug-related suicide attempts is alarming," said Christine Mourtier, M.D., chief medical officer for the American Foundation for Suicide Prevention.

Mourtier told *Psychiatric News* that the findings reported by SAMHSA also correlate with other analyses showing that middle-aged individuals have the highest rates for completed suicide in the United States. "[This] warrants a call to action. When we attend to suicide risk, as we have with youth and the elderly, we have been able to stem the tide and . . . even reduce suicide risk. It is time to pay close attention to middle-aged Americans . . . and know that we [as mental health professionals] do have the potential to save lives," concluded Mourtier. **PN**

▶ "Emergency Department Visits for Drug-Related Suicide Attempts Have Increased" is posted at <http://www.samhsa.gov/data/spotlight/spot150-suicide-attempts.pdf>. "Emergency Department Visits for Drug-Related Suicide Attempts Among Middle-Aged Adults Aged 45 to 64" is posted at <http://www.samhsa.gov/data/2K14/DAWN154/sr154-suicide-attempts-2014.pdf>.

## DEA Tightens Restrictions on Hydrocodone Combinations

With a 300 percent increase in overdose-related deaths paralleling the dramatic rise in prescriptions for opioid pain relievers, experts say that the new ruling to reschedule hydrocodone combination products was urgent.

BY VABREN WATTS

The Drug Enforcement Administration (DEA) has ruled that as of October 6, hydrocodone combination products (HCPs) will no longer be classified as Schedule III drugs, but rather as Schedule II substances.

"This has been a long-awaited and very welcome change in rescheduling hydrocodone combination products," said Petros Levounis, M.D., M.A., chair of psychiatry at Rutgers New Jersey Medical School. Levounis, a member of APA's Council on Addiction Psychiatry, told *Psychiatric News* that the HCPs

should have "always" been classified as Schedule II products for their high potential to be abused.

Under the Controlled Substances Act, drugs and other substances with accepted medical uses are placed into one of four schedules based on their abuse potential. Drugs with highest harm and abuse potential are placed in Schedule II, whereas substances with progressively less potential harm are placed in schedules III through V. Among Schedule II drugs are cocaine, methamphetamine, and methylphenidate. (Schedule I is reserved for

controlled substances with no currently accepted medical use and lack of accepted safety for use, including heroin, LSD, and marijuana.)

HCPs are drugs that contain both hydrocodone, which by itself is categorized as a Schedule II drug, and specified amounts of other substances, such as acetaminophen or aspirin.

"The large amounts of acetaminophen in hydrocodone combination products gave the first impression that hydrocodone combination products were relatively safe drugs, which led the government to consider the drugs as Schedule III [in 1970]. Now we know, because of the high prevalence of prescription painkiller abuse and its associated deaths, that hydrocodone and high doses of acetaminophen can be very toxic to patients," said Levounis.

The current analysis of HCPs by the DEA and the Department of Health and Human Services, which led to the final ruling issued August 21, showed that HCPs may lead to severe psychological or physical dependence and that adding nonnarcotic substances like acetaminophen to hydrocodone does not diminish its abuse potential.

Data leading up to the issuance of the

rescheduling rule were gathered from studies conducted by both federal and private agencies, including the Monitoring the Future surveys, which showed that Vicodin, an HCP that is a Schedule III drug, was twice as likely to be used nonmedically by 12th graders from 2002 to 2011 than was OxyContin, a Schedule II substance.

"Almost 7 million Americans abuse controlled-substance prescription medications, including opioid painkillers, resulting in more deaths from prescription drug overdoses than auto accidents," said DEA Administrator Michele Leonhart. "[The current] action recognizes that these products are some of the most addictive and potentially dangerous prescription medications available."

Levounis agreed. "We live in the age in which prescription opioid abuse is an epidemic, and we should not let our guard down. We [as psychiatrists] applaud these efforts and partner with the federal government to continue our efforts to reduce prescription opioid addiction . . . and combat the calamities that have been associated with such addiction." **PN**

▶ The DEA's final ruling is published in *The Federal Register* at <http://go.usa.gov/mc8d>.



# Schizophrenia Symptoms Reduced By Combination of ECT and Clozapine

**An innovative combination of electroconvulsive therapy and antipsychotic medication passes an early but rigorous test in a small clinical trial.**

BY AARON LEVIN

Combining two existing therapies for treatment-resistant schizophrenia appears to reduce symptoms effectively, although the duration of the effect remains an open question, according to researchers from Zucker Hillside Hospital in Glen Oaks, N.Y.

When treatment with second-generation antipsychotic medications fails to relieve symptoms of schizophrenia, psychiatrists may turn to clozapine. However, half of such patients may be resistant to clozapine treatment, leaving both physicians and patients with few alternatives.

"The treatment of this subgroup of patients remains an enormous challenge, with significant public-health implications," said Georgios Petrides, M.D., an adjunct associate professor of psychiatry and behavioral sciences at Zucker Hillside, in a study published August 26 in *AJP in Advance*.

Petrides and colleagues augmented clozapine with electroconvulsive therapy (ECT) in a randomized, single-blind study of 39 patients. All patients continued receiving clozapine, but 20 also received an ECT treatment three times a week for four weeks, then twice a week for another four weeks.

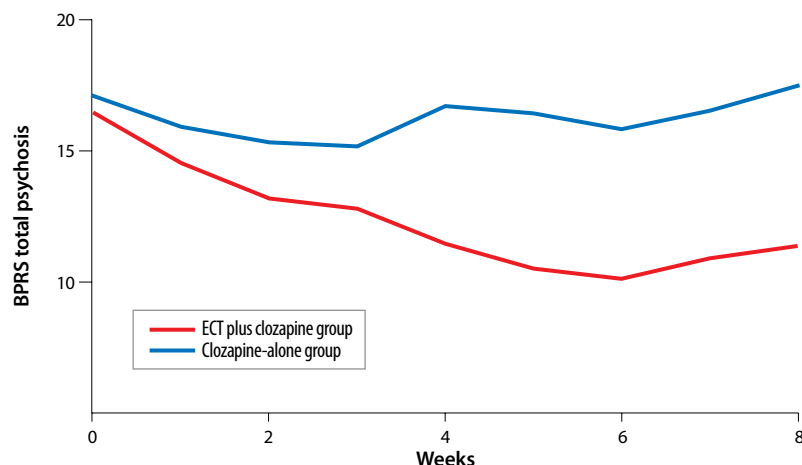
The researchers had conducted pilot studies on several patients and were sufficiently encouraged by the response to move ahead with a clinical trial. ECT was often used to treat people with schizophrenia before the introduction of antipsychotic medications in the 1950s.

The absence of a placebo arm may have helped recruitment, since the study design meant that some patients were randomized to immediate ECT treatment while the others were offered it later, said study co-author Alan Mendelowitz, M.D., an associate professor of psychiatry at Hofstra North Shore-LIJ School of Medicine and unit chief on the resident training research unit at the Zucker Hillside Hospital.

Informed consent in this study population required close attention, Mendelowitz told *Psychiatric News*. "Every time you do research in a population whose psychosis reduces their capacity to consent, it's a challenge."

## ECT Plus Clozapine Cuts Psychosis Symptoms

A combination of electroconvulsive therapy (ECT) and clozapine significantly reduced symptoms of schizophrenia as measured on the Brief Psychiatric Rating Scale more than did use of clozapine alone.



Source: Georgios Petrides, M.D., et al., *AJP in Advance*, Aug. 26, 2014

So they created a questionnaire carefully explaining what the patients were consenting to.

"If they didn't get it all correct, they did not enter the research protocol," he said. "Sometimes that ruled out the sickest of the sick."

Family support was also an important criterion, he said. "You have to find the right patient with the right family, because there is a great burden on them to get the patient to the hospital for treatments and follow-up."

Response to the combined treatment was defined as a 40 percent reduction in symptoms, twice the standard typically used in medication trials, the researchers noted. Ten of the 20 patients in the clozapine-plus-ECT group achieved that response, compared with none in the clozapine-only cohort. As part of the study's crossover design, the 19 patients in the control group later received ECT treatment, and nine of them responded.

"These are among the highest response rates ever recorded in this patient population," Petrides and colleagues said. "The augmentation of clozapine with ECT for the treatment of clozapine-resistant schizophrenia is a safe and effective treatment option."

The high response rate and blinded rating process used were encouraging and justify looking at this approach in a larger, longer-term study, said William McDonald, M.D., a professor of psychiatry and behavioral sciences and head of the neuromodulation and ECT group at Emory University School of Medicine, in an interview with *Psychiatric News*.

Several elements of the study's design

enhanced its validity, said McDonald, who was not involved in this study. For instance, the researchers used videotapes from which any spontaneous mention of ECT had been deleted to maintain blinding for the raters.

The researchers included extensive neurocognitive testing throughout the trial to track problems that sometimes crop up with ECT. However, they noted, "Clinically, the degree of cognitive burden shortly after the trial was

felt to be consistent with the clinical experience with ECT."

Significantly, the treatment had no effect on negative symptoms, noted McDonald. "This demonstrates a true response to the schizophrenia and not just to underlying depression."

Mendelowitz did sound a few cautionary notes at this stage in the research. For example, even with the strong response in this trial, the combination treatment would be hard to replicate in ordinary practice, because in many communities there is no access to ECT and many clinicians do not use clozapine, he said.

Clozapine also requires weekly blood monitoring, and there are significant risks of adverse effects with the medication (see page 21). The initial ECT treatment may require follow-up maintenance sessions, as it does with depression. More significantly, while the researchers have clinically followed some of the patients since the trial ended, they did not receive funding from the National Institute of Mental Health to formally track longer-term outcomes.

"Our clinical impression—and I stress 'impression'—is that the robust response we saw does not last as long as we had hoped," said Mendelowitz. "But we are pleased with our findings and hope that this study will lead to further research, and ultimately, to treatment." **PN**

➤ "Electroconvulsive Therapy Augmentation in Clozapine-Resistant Schizophrenia: A Prospective, Randomized Study" is posted at <http://ajp.psychiatryonline.org/article.aspx?articleID=1900625>.

## From the President

*continued from page 3*

by the Association of Gay and Lesbian Psychiatrists: "Care of the Transitioning Transgender Patient," which will be held Friday, October 31, at 3:30 p.m., and "Wrestling With the Angel: Psychotherapy, Struggle, and Faith in Lesbians and Gay Men," which will be held Saturday, November 1, at 1:30 p.m. DDHE is also hosting a community event on Thursday, October 30, from 5:30 p.m. to 8:30 p.m. at the San Francisco LGBT Community Center (1800 Market Street). Psychiatrists, mental health providers, and community leaders will discuss behavioral health concerns of the LGBT community in the Bay Area; refreshments will be served. A brochure listing these and more diversity-related sessions at IPS, including the John Fryer Award Lecture by Dee Mosbacher, M.D., Ph.D., on Saturday, November 1, at 10 a.m., is posted at [www.psychiatry.org/File%20Library/Learn/Scientific\\_Programs/2014%20IPS/20140909-IPS-](http://www.psychiatry.org/File%20Library/Learn/Scientific_Programs/2014%20IPS/20140909-IPS-Diversity-Track-Flyer.pdf)

Diversity-Track-Flyer.pdf.

Finally, 2014 marks the 50th anniversary of the 1964 Civil Rights Act, and we will feature a timely discussion titled "The Civil Rights Movement and African-American Mental Health" in a presidential forum. Other sessions, such as the Solomon Carter Fuller Award Lecture by William Lawson, M.D., will also examine issues related to accessing services and providing clinical care to people of African origin.

This is an unusually robust program that offers intellectual stimulation, relevance, and collegiality. As always, we appreciate IPS's longtime support from the American Association of Community Psychiatrists. We look forward to seeing you in San Francisco and helping in the effort to provide education about how we can reach more people with our skills, expertise, and dedication to personal recovery. **PN**

➤ For registration and housing information, see the box on page 2.



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## CLINICAL &amp; RESEARCH NEWS

# Genetic Variants Linked to Rare But Serious Clozapine Side Effect

**An international collaboration identifies rare variants in two human leukocyte antigen (HLA) genes associated with agranulocytosis risk in people taking this antipsychotic.**

BY NICK ZAGORSKI

It almost sounds like a Zen riddle: if a medication is effective, but no one uses it, is it really a good drug? That is the conundrum facing the schizophrenia drug clozapine.

"Clozapine is the single most effective antipsychotic available, yet it is used by less than 5 percent of people with schizophrenia," said Jeffrey Lieberman, M.D., the Lawrence C. Kolb Professor and chair of psychiatry at Columbia University and immediate past-president of APA. "To use this drug in such a limited basis is such a shame."

The problem lies in the range of potential adverse effects associated with the drug, particularly clozapine-induced agranulocytosis (CIAG), a rare but sometimes fatal loss of white blood cells.

In a major initiative to try and enable safe and widespread clozapine use, Lieberman joined with numerous other researchers worldwide to identify genetic factors that might predispose people to CIAG. As reported September 4 in *Nature Communications*, this research consortium screened 163 people with CIAG—the largest CIAG cohort ever assembled—and uncovered variants in two genes, HLA-B and HLA-DQB1, associated with CIAG risk.

The two HLA genes make proteins that are part of the human leukocyte antigen complex, a series of proteins on the cell surface that act as a barcode so the immune system can distinguish friendly cells from intruders.

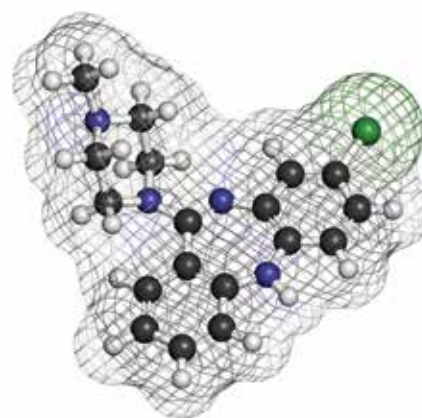
"These are very plausible candidates," said lead author Fred Jarskog, M.D., a professor of psychiatry at the University of North Carolina School of Medicine and research director at the North Carolina Psychiatric Research Center. "HLA proteins have been tied to numerous adverse drug reactions, and their involvement would be consistent with an immune system-related response like CIAG."

These findings also confirm an earlier genetic study in a small population of Jewish people with schizophrenia, led by Lieberman, which had first postulated the connection between HLA types and agranulocytosis.

Despite the massive effort, Jarskog cau-

tioned that the relatively small sample size and low frequency of the two risk variants would preclude applying these findings to any diagnostic test. Less than one-third of the CIAG cases carried one of the risky HLA variants, while only 4 percent had both. "So at the moment a genetic test could not provide guidance for more than a handful of people," he said.

A predictive test would be a long-term goal, as it would overcome two obstacles to widespread clozapine use. To try and detect CIAG as early as possible, people who are prescribed clozapine undergo weekly blood tests to monitor their white-cell counts, a process that burdens both patients and physicians. By identifying a person's risk, both the threat of CIAG and the need for continual monitoring could be reduced.



molekulbe/Shutterstock

Until that time, Jarskog believes, these genetic findings could serve in a different capacity. "We cannot predict CIAG yet, but maybe we can prevent it, or minimize the damage."

He suggested taking cell samples

from people with CIAG who have the risk variants and have experienced the most severe drops in blood cell counts. These cells could be analyzed in a lab setting to try and deduce the molecular mechanism behind the adverse drug response. "If we can figure out how the cells react to clozapine, we might also find ways to block that reaction."

Both of the risk variants altered the sequence of the protein, and the research group carried out computer modeling that suggested that the subtle protein changes may increase the affinity of clozapine to dock to the HLA proteins, which could affect how HLA "barcode" is read.

The research was supported by the National Institute of Mental Health as part of the American Recovery and Reinvestment Act of 2009. **PN**

**2** An abstract of "Clozapine-induced Agranulocytosis Is Associated With Rare HLA-DQB1 and HLA-B Alleles" is posted at <http://www.nature.com/ncomms/2014/140904/ncomms5757/full/ncomms5757.html>.

## Happiness Can Be Part of Life For People With Schizophrenia

**Happiness for people with schizophrenia is a complex phenomenon, but not an unattainable one, and can be encouraged.**

BY AARON LEVIN

Having schizophrenia brings a host of daunting problems, but it does not preclude happiness, concluded researchers at the University of California, San Diego (UCSD).

As one might expect, compared with 64 healthy control subjects, 72 outpatients with nonremitted chronic schizophrenia were not as happy as measured with four items of the Center for Epidemiologic Studies Depression Scale, which the researchers used as a scale to measure happiness (CESD-H). But that didn't mean that all of the schizophrenia subjects were unhappy.

"[T]here was considerable heterogeneity in levels of happiness among people with schizophrenia," reported lead author Barton Palmer, Ph.D., a professor in UCSD's Department of Psychiatry, and colleagues online August 14 in *Schizophrenia Research*.

In fact, 37.5 percent of the people with schizophrenia had CESD-H scores in the

upper third of the range, as did 82.8 percent of the controls. Another 15.3 percent had scores in the lowest third of the range, while none of the controls' scores were that low.

There were no significant correlations in the group with schizophrenia between levels of happiness and positive, negative, or anxiety symptoms, or

**"Happiness is affected by, but not incompatible with, chronic schizophrenia. . . ."**

between happiness and physical health or cognitive functioning, the researchers said. Nor was happiness correlated with age, education, or duration of illness.

Happier people with schizophrenia did have lower perceived stress, higher levels of trait and event resilience, optimism, and personal mastery.

In short, "happiness is affected by, but not incompatible with, chronic schizophrenia and is strongly correlated with a number of positive psychosocial traits or factors," they wrote.

So if more than 1 in 3 people with a highly heritable illness like schizophrenia say they are happy, then perhaps "happiness may be a viable goal for many individuals with this disorder," said

Palmer and colleagues. "An important follow-up question is whether happiness among people with schizophrenia can be improved through intervention."

Such interventions might include techniques like cognitive reframing, grateful thinking, and mindfulness training, they noted.

"People with schizophrenia are clearly less happy than those in the general population at large, but this is not surprising," said Palmer. "What is impressive is that almost 40 percent of these patients are reporting happiness and that their happiness is associated with positive psychosocial attributes that can be potentially enhanced."

"People tend to think that happiness in schizophrenia is an oxymoron," said study co-author and former APA President Dilip Jeste, M.D., a professor of psychiatry and

neurosciences and the Estelle and Edgar Levi Chair in Aging at UCSD, in a statement. "Without discounting the suffering this disease inflicts on people, our study shows that happiness is an attainable goal for at least some schizophrenia patients. This means we can help make these individuals' lives happier."

The research was funded, in part, by the National Institute of Mental Health and the Center for Healthy Aging and the Sam and Rose Stein Institute for Research on Aging at UCSD. **PN**

**2** An abstract of "Wellness Within Illness: Happiness in Schizophrenia" is posted at <http://www.ncbi.nlm.nih.gov/pubmed/25153363>.

# School Starts Too Early for Teens, Pediatricians Agree

The country's largest pediatrician organization joins those who want middle and high schools to start the school day at 8:30 a.m. or later.

BY LYNNE LAMBERG

**S**leep-deprived adolescents have a powerful ally: the American Academy of Pediatrics (AAP). In a policy statement published in *Pediatrics* in September, the AAP urged the nation's middle and high schools to start classes at 8:30 a.m. or later—30 to 60 minutes later than most do now. An accompanying technical report details causes and consequences of insufficient sleep in teenagers.

"The evidence strongly implicates school start times of 8:30 a.m. or earlier as a key modifiable contributor to insufficient sleep as well as circadian rhythm disruption in middle- and high-school students," the AAP said.

Calls for later school start times have prompted debates—sometimes contentious—since the 1970s, when researchers first documented a pubertal delay in the timing of the biological clock that makes it hard for teenagers to fall asleep before 11 p.m. and to arise before 8 a.m. This finding has been affirmed in adolescents worldwide. Naysayers still contend, how-



ever, that delaying start times "coddles" students.

The 8:30 a.m. start time would give most adolescents the opportunity to sleep from about 11 p.m. to 7 a.m. on school nights, Judith Owens, M.D., lead author of both publications and chair of the AAP's Adolescent Sleep Working Group, told *Psychiatric News*.

Ideally, she said, they would be able to sleep even later, as most adolescents need 8.5 to 9.5 hours of sleep for optimal alertness and performance.

In supporting the 8:30 a.m. start time, Owens added, "the nation's premier health advocacy organization for children and adolescents has strongly endorsed a public-health initiative that is somewhat controversial."

Owens' group collaborated with the AAP Committee on Adolescence and its Council on School Health to produce both reports. A professor of pediatrics at George Washington University School of Medicine, Owens directs sleep medicine at Children's National Medical Center in Washington, D.C.

## There's an 'Epidemic' of Insufficient Sleep

Most U.S. adolescents currently average less than eight hours sleep on school nights, the AAP reported. High school seniors responding to a nationwide poll conducted for the National Sleep Foundation reported they averaged less than seven hours' sleep on school nights.

"Chronic sleep loss has increasingly become the norm," the AAP said, noting that the average adolescent regularly experiences levels of sleepiness equal to those of patients with sleep disorders such as narcolepsy. Many teenagers report falling asleep in class or while doing homework one or more times a week.

Sleeping late on weekends may help offset the weekday sleep deficit, the AAP said, but also may worsen circadian dis-

ruption and morning sleepiness on school days.

While naps and caffeine consumption may temporarily counteract sleepiness, they do not replace missed nighttime sleep.

Academic performance improves when students average eight hours of sleep or more. After a delay in school start times for about 9,500 public-school students in grades 6 to 12 in three states, students earned better grades in core subjects and scored higher on state and national standardized achievement tests. Auto crashes related to students' drowsy driving declined.

## St. Elizabeths

*continued from page 8*

The connections with other area hospitals mean that St. Elizabeths is now part of an integrated community mental health system, said Baron. "We're not just a hospital; we're a whole system of care."

"The leadership of the Department of Behavioral Health and of St. Elizabeths Hospital has made significant and often difficult decisions to change the clinical culture at St. Elizabeths Hospital and ensure that persons confined to hospital were appropriately discharged and integrated into the community with adequate supports," said Acting Assistant Attorney General for Civil Rights Molly Moran, J.D., in a statement. "They strongly supported the required changes and provided the time, energy, and resources necessary to achieve reform."

A second lawsuit, filed by the advocacy group University Legal Services (ULS), was settled in 2011. That litigation

## Early Starts the National Norm

According to U.S. Department of Education statistics, about 43 percent of the nation's 18,360 public high schools now start before 8 a.m., including nearly 10 percent that start before 7:30 a.m. Only 15 percent start at 8:30 a.m. or later. And some schools hold preschool sports practice, classes, and other activities. The median middle-school start time is 8 a.m. More than 20 percent of middle schools start at 7:45 a.m. or earlier.

In Fairfax County, Va., the state's largest school system, where high schools start at 7:20 a.m., students begin boarding school buses at 5:45 a.m. and may need to arise at 5 a.m. or earlier. The Fairfax County School Board will vote this month on a plan developed by Owens and colleagues to start classes later.

Secretary of Education Arne Duncan has in tweets and interviews endorsed delaying school start times for adolescents. "Mornings are very difficult. You know, they're not awake. They're groggy," he said on "The Diane Rehm Show" in 2013. "If we were able to start later, and if they were able to be more focused, if they were able to concentrate in class, that's a really good thing."

Duncan's department does not have an official position on school start times, however. "Education is a state and local matter, and districts are free to explore options in the best interests of their students," his office told *Psychiatric News*.

The AAP work groups focused on the need to optimize adolescents' health, safety, and academic performance. *see Teens on page 27*

## Child Psychiatrists Back Conclusions of Sleep Report

The American Academy of Child and Adolescent Psychiatry (AACAP) regards the American Academy of Pediatrics policy on delaying school start times as comprehensive and compelling, AACAP President Paramjit Joshi, M.D., told *Psychiatric News*.

"Sufficient sleep is essential for good mental health," said Joshi, an endowed professor and chair of psychiatry and behavioral sciences at Children's National Medical Center in Washington, D.C. Adolescents who get sufficient sleep report fewer symptoms of depression and anxiety and lower suicidal ideation than those who sleep less, she pointed out. They have more energy and are less likely to overeat and become obese.

Getting adequate sleep is especially important for adolescents with depression, bipolar disorder, or anxiety disorders or with a genetic predisposition to develop these disorders, she added, as insufficient sleep can exacerbate such illnesses.

also covered "blatant violations of the individuals' rights and a disturbing lack of respect for the individuals served, . . . practices resulting in abuse and neglect."

ULS will continue to play a monitoring role under federal law, said managing attorney Mary Nell McGarity Clark, J.D.

"We have had an open cooperative relationship with the management since our settlement, and we are at the hospital at least once a week visiting clients and making presentations," Clark told *Psychiatric News*. "Because of the settlement agreement in our case, reinforced by the agreed dismissal of the Department of Justice litigation, we are able to advocate more effectively for the patients." **PN**

**2** The Department of Justice's statement on the St. Elizabeths case is posted at <http://www.justice.gov/opa/pr/2014/August/14-crt-912.html>. More on St. Elizabeths is posted on the DBH website at <http://dbh.dc.gov/page/saint-elizabeths-hospital>.



## CLINICAL &amp; RESEARCH NEWS

# Novel Suicide-Prevention Treatment Targets Poor Sleep

**More than 60 epidemiologic studies show that poor sleep raises the risk of suicide, but sleep-focused treatment may lower that risk.**

BY LYNNE LAMBERG

Improving disturbed sleep may curb suicide risk in people with depression and other psychiatric disorders, said speakers at a symposium at the annual meeting of the American Academy of Sleep Medicine and Sleep Research Society in Minneapolis.

Trouble falling asleep and staying asleep and poor-quality sleep predict increased risk for suicidal thoughts and behaviors, said Rebecca Bernert, Ph.D., symposium chair and director of the Suicide Prevention Research Laboratory at Stanford University School of Medicine. Unlike many other suicide risk factors, sleep complaints are amenable to treatment, said Bernert, an instructor in psychiatry and behavioral sciences at Stanford.

At the symposium, Bernert and others described what she said are the first outpatient suicide-prevention trials to focus on sleep as a therapeutic target and to use suicide risk as a primary outcome measure.

Developing an infrastructure to sup-

port an outpatient suicide-prevention trial poses many challenges, Bernert said. Researchers must show institutional review boards they have devised procedures to assure informed consent, confidentiality, and patient safety; will provide 24-hour on-call clinical coverage; and can manage possible emergencies.

The sensitive nature of suicidal symptoms, and the stigma surrounding them, present obstacles to subject recruitment, Bernert said. Researchers need a large population sample to study behaviors that occur rarely, she noted, and typically screen far more people than they enroll. The transient nature of a suicidal crisis adds complexity to both treatment and assessment.

Bernert and her colleagues at Stanford developed a manualized behavioral insomnia trial for suicide prevention. For an open-label feasibility study now in progress, they use clinic-based referrals, community flyers, and print advertising to recruit subjects with depressive symptoms, including suicidal ideation. Treatment consists of five weekly individual sessions that focus on insomnia symptoms and poor sleep quality.

Preliminary findings look promising, Bernert said. The researchers have



In June, San Francisco's Golden Gate Bridge board of directors approved a \$76 million, 20-foot-wide steel net to deter potential jumpers. Rebecca Bernert, Ph.D., who directs the Suicide Prevention Research Laboratory at Stanford University School of Medicine, is a member of the board of the Bridge Rail Foundation, which has long advocated for the suicide barrier.

Norbert von der Groeben/Stanford School of Medicine

found significant posttreatment reduction in suicidal ideation and insomnia, with treatment gains maintained at one-month and three-month follow-up. Subject recruitment will continue through 2014.

## Study Targets Veterans With Depression

Brief behavioral sleep interventions may help depressed veterans with insomnia and suicidal ideation, according to another symposium speaker, Wilfred Pigeon, Ph.D., research director of the Center of Excellence for Suicide Prevention at the Canandaigua Veterans Affairs (VA) Medical Center in New York.

His team provided either cognitive-behavioral treatment for insomnia (CBT-I) or basic sleep education to veterans in a primary care setting. Therapists saw veterans in the CBT-I group individually for two 30- to 40-minute sessions and spoke with them by phone in two 15- to 20-minute sessions. Veterans in the control group received one in-person and one phone session focusing on healthy sleep habits.

While both approaches proved helpful, the number of participants was too small to show significant differences, Pigeon said. The study aimed mainly to assess feasibility of brief sleep interventions in a VA primary care setting. Upcoming studies will focus specifically on reduction of suicidal risk.

## Pharmacotherapy Used in Other Studies

A four-year, randomized, controlled clinical trial using the hypnotic medication zolpidem to treat suicidal, depressed outpatients with insomnia is under way, W. Vaughn McCall, M.D., M.S., Case Distinguished University Chair of Psychiatry and Health Behavior at the Medical College of Georgia at Georgia Regents University, reported at the symposium.

McCall, who is the study's principal investigator, and colleagues at the medical schools of Duke University, the University of Wisconsin, and Wake Forest University debated the level of severity of suicidal ideation to include. People who are overwhelmingly suicidal need to be in a hospital, McCall told *Psychiatric News*. The researchers did not, however, want to exclude people who potentially could benefit from the planned treatment.

They eventually included in their recruitment criteria scores on the Columbia Suicide Severity Rating Scale, which incorporates clinical judgment. They accept people with varying degrees of suicidal severity, but exclude those with imminent suicide intent. While defining inclusion/exclusion criteria is not a trivial task, McCall stressed, studies like this can be done without putting participants at undue risk.

By June 1, the research team had screened more than 525 people by phone, selecting about 1 in 15 for randomization into the study.

The researchers had planned to use a 12.5 mg dose of zolpidem as the hypnotic. In January 2013, just as the study was about to begin, however, the Food and Drug Administration (FDA) reduced the recommended starting dose of zolpidem to 6.25 mg, while allowing an increase to 12.5 mg if the lower dose is ineffective. The FDA's action improved the study, McCall said, enabling the researchers to assess the impact of flexible dosing.

All study participants receive an open-label serotonin reuptake inhibitor and also take zolpidem-CR 6.25 mg or 12.5 mg or a placebo in tablet form at night 15 minutes before going to bed for eight weeks, wearing a wrist activity monitor throughout the study. Among the initial 35 patients followed for eight weeks, McCall said, suicidal ideation fell, and no patients made a suicide attempt or had to leave the study to be hospitalized. The study is scheduled to run through 2016. **PW**

➤ "A Sleep-Oriented Intervention for Suicidal Behaviors" is posted at <http://clinicaltrials.gov/ct2/show/NCT01770587>. "Reducing Suicidal Ideation Through Insomnia Treatment" is posted at <http://clinicaltrials.gov/ct2/show/NCT01689909>.

## Suicide Risk Peaks at Night



Suicide risk rises nearly fourfold between midnight and 6 a.m., said Michael Perlis, Ph.D., an associate professor of psychiatry at the University of Pennsylvania School of Medicine.

Previous studies had found suicide occurs most often in daylight hours. In absolute numbers, that is true, Perlis

noted, but a different picture emerged when he and colleagues calculated suicide rates according to the proportion of people awake across the day.

Surveillance data from the Centers for Disease Control and Prevention's 2010 National Violent Death Reporting System provided the estimated time of fatal injury recorded for 35,332 suicides from 2001 to 2010 in 18 states.

Perlis's team adjusted these data to the number of adults awake at each hour, drawing on nearly 125,000 responses to the Department of Labor's 2003-2011 American Time Use Surveys.

The researchers found the frequency of suicides was 3.6 times higher at night than would be expected by chance. Suicides peaked between 2 a.m. and 4 a.m., a finding that evokes F. Scott Fitzgerald's assertion, "In a real dark night of the soul it is always three o'clock in the morning."

Both circadian and social factors may contribute to the increased risk of suicide at night, Perlis said. Decision-making skills decline at night, even in regular night workers.

In people who can't sleep because of depression, insomnia, or nightmares, lower impulse control at night may give rein to catastrophic thinking and suicidal ideation, Perlis suggested. Lack of both social constraints and social supports and easier access to alcohol and substances at night, he added, also may exacerbate suicidal thoughts and behavior.

Helping people sleep better may reduce their suicide risk, Perlis said. "If there is one requirement for suicide," he observed, "it is that you must be awake to do it."

## Payment Reform

*continued from page 1*

which covers collaboration in services for patients having, for instance, severe mental illness, two or more chronic medical conditions, and multiple care providers.

“The new CPT code and our recommendations, if adopted, will begin to enable key evidence-based integrated care efforts with the psychiatric/substance use disorder population and persons with primary medical conditions and mental health comorbidities to move forward in very important ways,” Levin wrote in comments submitted to CMS Administrator Marilyn Tavenner. “There are other essential psychiatric physician non-face-to-face functions that will need to be recognized, about which we will be communicating further with CMS.”

The CMS proposal was included in the Proposed Rule for Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, and Other Revisions to Part B for calendar year 2015, issued in July.

APA President Paul Summergrad, M.D., told *Psychiatric News* that the U.S. health care system will not achieve quality and equity goals, and patients won’t get the care they need, unless the role of psychiatrists is recognized by all payers of care. “The comorbidities between general medical and psychiatric illness are too frequent and associated with premature death, lifetimes of disability, and high cost,” he said. “We are urging CMS to include the codes that will fully allow psychiatrists to play their essential role in chronic disease management and collaborative care.”

The proposed rule does not address the sustainable growth rate (SGR) formula or the conversion factor used to determine overall physician payment under the Medicare program. A number of proposals are pending in Congress for reform of the payment formula and elimination of the SGR, but Muszynski explained that all of those proposals also call for some form of value-based payment, adoption of electronic medical records, incorporation of performance measures, coordination of care for patients with chronic conditions, and other delivery-system and reporting reforms.

While legislative proposals continue to be debated in a divided Congress, many of these reforms are being driven by regulatory requirements included in the CMS proposed rule, he said.

Coding for reimbursement of collaborative care is a principal concern of APA as public and private health systems move, however slowly, toward integration of care. “Management of mental health conditions is a carefully coordinated effort,” Levin wrote. “There is a substantial evidence base that shows that psychiatric involvement at critical junctures results in better

outcomes. A large number of Medicare beneficiaries eligible for such services—those who have two or more chronic conditions—are patients who have serious mental health and/or substance use disorders. There needs to be a mechanism for reimbursement for these types of services that will improve access to care for these often vulnerable patients.”

Levin also highlighted concerns about

the agency’s proposals for measures that will be included as part of the Physician Quality Reporting System (PQRS). The PQRS is a program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals.

Levin pointed out that two critically important measures—one addressing use of antidepressant medication during the

acute phase for patients with major depressive disorder and another addressing preventive care and screening for unhealthy alcohol use—appear to be omitted from the list of available measures for 2015, yet are not included on a list for removal following public comment.

“APA supports these measures being included in the PQRS program for 2015,” Levin wrote. “If these measures were

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selected for removal, APA would strongly object, since they are valuable measures in an underrepresented domain and can be used by a wide variety of physicians, including psychiatrists, family practice physicians, primary care physicians, and geriatricians. We ask that CMS clarify their intent on these measures and either include them for [calendar year] 2015 or put them on the list for removal and

allow public comment.”

Additionally, Levin urged CMS to increase the number of cross-cutting measures available for psychiatrists and amenable to psychiatric care to increase participation in the PQRS program and to reconsider several measures that are pertinent to psychiatric practice and slated for removal from the PQRS measure set.

APA's letter addresses a range of other proposals in the CMS notice. Among these are the following:

- **Value-based modifier.** The value-based modifier (VBM) is a formula for reimbursing physicians based on quality of care and the value of services they provide, rather than according to volume of services provided. The formula will

be applied to all physicians and alternative payment models in 2017 and will be based on 2015 performance. But in its comments letter, APA expressed concerns both about the formula itself and the speed with which it is being implemented. Levin urged CMS to slow down the phase-in schedule for the VBM implementation and allow more leeway  
*see **Payment Reform** on page 26*

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# Payment Reform

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for small or solo practices, which may have difficulty meeting the deadlines and the thresholds in the proposed rule.


- **Physician Compare website.** Physi-

cians and other health care professionals participating in Medicare so they can make informed choices. Yet APA and other medical groups have expressed concern about many aspects of the website and the kinds of information that may be publicly available, as well as the ability of physicians to review and correct information on the website. In its letter, APA urges CMS to expand the

preview period to 90 days at a minimum and delay posting contested information until problems are resolved.

- **Opt-out policy.** APA has joined the AMA in urging CMS to amend its opt-out policy to allow physicians to opt out of Medicare indefinitely, as opposed to requiring reaffirmation every two years. The current require-

ment, in which every physician who opts out of Medicare must refile an affidavit every two years to maintain his or her opt-out status, is unnecessary and is not required by law. [PN](#)

 APA's comments to CMS are posted at <http://www.psychiatry.org/advocacy--newsroom/advocacy/medicare-medicaid-and-public-health>.

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## Teens

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mance, Owens said. Communities that already have delayed school start times, she noted, have found ways to deal with bus schedules, teacher retention, athletic-event scheduling, after-school jobs, and child care for younger siblings.

Delaying school start times alone is not a panacea for adolescent sleep deprivation, the AAP cautioned. Adolescents need to learn to make sleep a priority and to manage competing demands for their time, including homework, sports and other extracurricular activities, social networking, and jobs. The AAP suggested that families develop a home media use plan, with a media curfew.

Electronic media use near bedtime may not only prove stimulating, but also may delay sleep via blue-light exposure that suppresses melatonin levels.

"We hope AAP's action will inspire pediatricians and other physicians to educate students, parents, educators, athletic coaches, and others about healthy sleep habits," Owens said, "and advocate in their communities for school

start times that allow adolescents to get sufficient sleep." **PN**

 An abstract of "School Start Times for Adolescents" is posted at <http://pediatrics.aappublications.org/content/134/3/642>. An abstract of "Insufficient Sleep in Adolescents and Young Adults" is posted at <http://pediatrics.aappublications.org/content/134/3/e921>.

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# Population Health

*continued from page 5*

of psychiatrists necessary to meet the demand for services—are causing payors to recognize that the “cottage industry” doesn’t work and that psychiatric expertise is essential in a reformed, collaborative care model.

“I recently went to a national meet-

ing of Medicaid directors, where all of them were asked what they most wanted to talk about,” Parks recalled. “Two-thirds of them indicated they wanted to hear about behavioral health. And that’s because they’ve been running the data, and when you run the data, it is the patients with behavioral health conditions who are the highest utilizers of not only behavioral

health services but of general medical care. They have more hospitalizations; more admissions for asthma, diabetes, and heart disease; and more use of the ER for all medical causes.

“So the payors in the commercial and public sectors have come to realize that patients with behavioral health conditions are the expensive ones driving the total spend,” he said. “[Payors] want to

control the total spend, so they are looking to us now for answers.”

But that raises another problem and another reason why there is a certain inevitability to population-based, collaborative care—there are not enough psychiatrists to meet the demand for mental health services. Parks has data showing that the current and future projected numbers of psychiatrists falls short—

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and will continue to fall shorter—of the need for services.

“Our current delivery model will fail because we can’t possibly provide services to everyone who needs or wants our services,” Parks stated (see chart on page 5).

But the collaborative care model—as exemplified, for example, by the IMPACT model implemented at the

University of Washington—repositions the psychiatrist as a consultant advising primary care physicians, care managers, psychologists, and social workers about best practices for an entire population. In this way, as Jürgen Unützer, M.D., one of the founders of the IMPACT model, has said, it exponentially increases the clinical reach of the psychiatrist—and her or

his value to the health system.

“Population health means thinking of your patients not just as the people you are seeing face to face in the clinic, but as everyone that the clinic serves, and everyone trying to get into that clinic,” Parks said. “We will never meet the demand with our current numbers. That’s why psychiatry should care about population health—because it is

the only way we can improve the health of all the people who need and want our services.” **PN**

To listen to an interview of Parks by *Psychiatric News*, go to [http://www.psychnews.org/update/audio/joe\\_parks.mp3](http://www.psychnews.org/update/audio/joe_parks.mp3) or scan the QR code with your smartphone.

## Depression Care

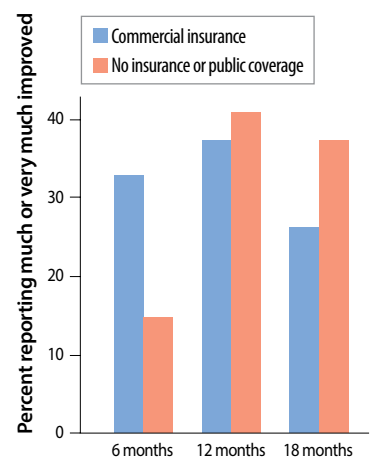
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with a higher percentage of patients receiving four or more mental health visits, compared with usual care. Similarly, for both insurance groups, patients receiving the intervention were more satisfied with the quality of depression care than were usual-care patients.

Katon said the study is one of the first to look at collaborative care in an OB-

### Disadvantaged Women Show Greater Improvement With Collaborative Care in Ob-Gyn

Women with commercial insurance tended to improve sooner (at 6 months) with the intervention than with usual care compared with women with no insurance or with public coverage. But the latter tended to have greater improvements with the intervention than with usual care at 12 and 18 months.



Source: *AJP in Advance*, August 26

GYN setting. That’s important, he said, because a third of women identify their OB-GYN as their primary care physician. “For many economically and socially disadvantaged women who are publicly insured or uninsured, the only time they may have contact with a health care provider is around having a baby,” he said. **PN**

“A Randomized Trial of Collaborative Depression Care in Obstetrics and Gynecology Clinics: Socioeconomic Disadvantage and Treatment Response” is posted at <http://ajp.psychiatryonline.org/Article.aspx?ArticleID=1900629>.

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SAMHSA Administrator Pamela Hyde, J.D., announces data from the 2013 National Survey on Drug Use and Health at a press conference celebrating the 25th anniversary of National Recovery Month and expresses concern about attitudes on marijuana use.

## Substance Abuse

*continued from page 1*

the U.S. population of adolescents and adults acknowledged drug use at the time of the survey. Marijuana was the most commonly used illicit drug, with 19.8 million individuals saying they used it in the month prior to the survey. The next most common example of illicit drug use was nonmedical use of prescription pain relievers, used by 4.5 million individuals.

Alcohol use was estimated to be prevalent in about half (52.2 percent) of the U.S. population aged 12 and older, with 60.1 million individuals acknowledging that they engaged in binge drinking. SAMHSA reported that of the people who needed treatment for a substance use disorder or alcohol use disorder, only 11 percent received help for the problem.

"This proves that substance use in our country still poses a significant public-health risk," said Michael Botticelli, acting director of the White House Office of National Drug Control Policy, who was a panel speaker. "We should keep in mind

that the work to reduce substance use in America is not in vain . . . [and that] we have made significant progress."

During an interview with *Psychiatric News*, Botticelli, who openly discusses his recovery from alcohol abuse over the past 25 years, said that by intensifying efforts to reduce stigma associated with mental health and substance use disorders, more people will be encouraged to access mental health care services. He told conference attendees that the time has come to rally for more community-based recovery support services and ensure that laws, policies, and practices do not continue to perpetuate barriers to recovery. "We need all your help to engage broader community stakeholders and policymakers at every level."

According to the 2013 NSDUH report, drug use is up slightly from 2012. Hyde stated that the alarming rates of drug use in adolescents and adults, particularly marijuana use, may be a result of a growing perception that one particular drug may be less harmful than others, a finding reported by prior NSDUH studies. "Social norms have to change, or else we are going to keep meeting here every fall and sharing the same problem. Understanding that treatment works and prevention works are critical components. We will be watching [trends in drug and alcohol use] closely over the next few years."

A full report of the 2013 NSDUH findings is scheduled to be released by the end of year, according to Hyde. **PN**

**2** Available data from the 2013 National Survey on Drug Use and Health are posted at <http://store.samhsa.gov/product/NSDUH14-0904?from=carousel&position=1&date=09032014>.

## Courts

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after that point.

Both total and criminal justice costs for both groups rose in the three years prior to the arrest, with 86 percent of the average criminal justice costs coming in the year just before the arrest.

### Findings Contradict Earlier Study

One of Steadman's earlier studies found an increase in costs in the first 18 months after entry into a mental health court program (reflecting an acute need at the start for housing, employment, and other services, as well as treatment) followed by declines. But that's not what happened in this study, which covered a longer time period.

In the current study, the mental health court participants incurred an average of about \$4,000 annually in additional total charges over the three years following their arrest.

"We were very surprised," said Steadman. "We thought we'd get the same pattern."

The difference was attributable to higher treatment costs: \$6,000 more than the control group in year 4, \$5,000 in year 5, and \$4,500 in year 6, said Steadman and colleagues. These higher costs were not offset by criminal justice costs, which were slightly lower in years 4 and 5 but higher in year 6.

Participants with a co-occurring substance abuse disorder and those who spent more time in jail following arrest were the costliest to care for, they said.

The results may seem counterintuitive: if offenders stay out of jail and in treatment, they should incur fewer costs.

"I think you do get reduced criminal justice involvement, but the people who get enrolled in mental health courts don't need just short-term treatment around some high-acuity issues," he suggested. "They're going to need long-term intensive services."

### Better Evaluation of Candidates Urged

Courts must do a better job of knowing what services are available in the community and then matching offenders to them, he said. If evidence-based services are not available, then perhaps offenders should not be enrolled in mental health court programs.

"Or maybe the court has to stimulate development of those services in the community," he said.

A second study in the same issue of *Psychiatric Services* compared 198 criminal offenders with mental illness enrolled in a mental health court program with a similar number who were processed through the usual criminal court system in Florida.

"Mental health court assignment pre-

dicted a lower overall rate of recidivism and longer time to rearrest for a new charge compared with assignment to traditional court," wrote Joye Anestis, Ph.D., an assistant professor of clinical psychology at the University of Southern Mississippi, and Joyce Carbonell, Ph.D., a professor of psychology at Florida State University.

They noted that increased attention and supervision provided by the mental health court process are probably not the mechanism of action that explains the differences between the two cohorts.

"One might conclude from both studies that spending more on mental health treatment for these individuals is a non-essential luxury when the court intervention itself seems to reduce recidivism with no measurable mental health benefit," said Marvin Swartz, M.D., a professor of psychiatry and behavioral sciences at Duke University, in an accompanying commentary. "Such conclusions would be vastly premature."

In fact, longer studies of mental health courts are needed to "assess the mental health functioning of court attendees, the appropriateness of the treatment they receive, and the extent to which the treatment comports with evidence-based models," wrote Swartz. **PN**

**2** An abstract of "Criminal Justice and Behavioral Health Care Costs of Mental Health Court Participants: A Six-Year Study" is posted at <http://ps.psychiatryonline.org/article.aspx?articleid=1878687>. Swartz's commentary, "How Do Mental Health Courts Work?," is posted at <http://ps.psychiatryonline.org/article.aspx?articleid=1900281>.

## Viewpoints

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Congressional staff are far more accessible and interested in their constituents than they receive credit for. We had meetings and gave professional recommendations regardless of political affiliation or personal views. My eyes were opened to how powerful special-interest lobbies can be, not from the backroom deals seen on television, but by organized grassroots efforts energized by a common issue.

There is no excuse for psychiatrists, and all mental health care providers, to be politically inactive on the local, state, and national levels. Lawmakers need mental health care experts to inform policymaking, and our patients need political advocates. I challenge you to become politically active through APA, your district branch, and the APA Political Action Committee (APAPAC).

I want to give special thanks to the staff in the Department of Government Relations and my subcommittee staff leader for her generous mentorship and teaching. **PN**



Michael Botticelli, acting director of the White House Office of National Drug Control Policy, describes his personal story of recovering from alcohol abuse and the importance of National Recovery Month.