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PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

ISSN 0033-2704

David Hathcox

APA President Renée Binder, M.D., opens IPS: The Mental Health Services Conference with the traditional bell-ringing ceremony last month in New York City. The bell was given to APA by Mental Health America; it is the organization's "symbol of hope" against the chains of mental illness. See articles related to the IPS at right and on pages 15, 16, and 17. Coverage will continue in the next issue.

Expert Discusses Team-Based Care For Survivors Of Torture

According to the United Nations, the number of forced migrants grew from 37.5 million in 2005 to nearly 60 million at the end of 2014. A program at Bellevue/NYU offers support to those who come to the United States.

BY MARK MORAN

When it comes to caring for refugees and asylum seekers, "unfortunately, business is booming," said Adeyinka M. Akinsulure-Smith, Ph.D., during the Opening Session of the 2015 IPS: The Mental Health Services Conference, which was held last month in New York City.

Akinsulure-Smith, a program psychologist at the Bellevue/New York University Program for Survivors of Torture, delivered a poignant talk about a topic that is dominating the headlines, striving to put a human face on the refugees and asylum seekers who have sought solace in the United States from African countries torn by war and on the Syrian refugees who are likely to arrive soon.

Originally from Sierra Leone, Akinsulure-Smith is a licensed psychologist and an assistant professor in the Department of Psychology at City College of the City University of New York. She is also the cofounder of Nah We Yone Inc., a nonprofit organization created in 1997 to proactively respond to war victims from the various communities within the African diaspora. From 1997 to 2010, Nah We Yone served

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APA Receives Federal Grant to Train Psychiatrists in Integrated Care

This major milestone is in recognition of APA's commitment to integrated care. The training that psychiatrists receive will enable them to expand their psychiatric expertise to larger populations of primary care patients.

BY MARK MORAN

APA is one of just 39 health care organizations selected by the Centers for Medicare and Medicaid Services (CMS) to participate in the Transforming Clinical Practice Initiative, a grant program in which APA will receive $2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices that are implementing integrated behavioral health programs.

APA will train psychiatrists in collaboration with the AIMS (Advancing Innovative Mental Health Solutions) Center at the University of Washington and will offer both online learning modules and in-person training at APA meetings. Ultimately, it is expected that psychiatrists will be able to join ongoing learning communities designed to continuously share information and advice about how to implement the skills of integrated care into their practices and to transform clinical practice.

"We hope to leverage APA's district branches to create local learning communities dedicated to changing clinical practice," said Anna Ratzliff, M.D., Ph.D., associate director for education at the AIMS Center and director of the University of Washington Integrated Care Training Program.

The award is a milestone for APA, a high-profile recognition of APA's commitment to integrated care and to

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PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

GOVERNMENT NEWS

APA Joins in Push to Advance MH Legislation Through Congress

Important mental health legislation awaits Congressional action, and APA wants to be sure it continues to move along toward passage.

BY AARON LEVIN

Leaders of major mental health advocacy organizations including APA joined together on October 1 for a visit to Capitol Hill to stress the need for significant reforms in the U.S. mental health system.

Officials from the National Alliance for Mental Illness and Mental Health America, along with executives from the National Council for Behavioral Health and the Kennedy Forum, joined APA CEO and Medical Director Saul Levin, M.D., M.P.A., to urge early action on

*see **Legislation** on page 6*

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Legislation

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bipartisan legislation already introduced in both houses of Congress.

They met with members of the House of Representatives concerned with mental health issues and also with several members of the Senate, which was scheduled to hold hearings on mental health legislation at press time.

A number of bills have been proposed, including the Helping Families in Mental Health Crisis Act of 2015 (HR 2646), put forth by Rep. Tim Murphy (R-Pa.) and Rep. Eddie Bernice Johnson (D-Texas), and the Mental Health Reform Act of 2015 (S 1945), introduced by Sen. Bill Cassidy (R-La.), and Sen. Chris Murphy (D-Conn.). Tim Murphy is a psychologist, and Cassidy is a physician.

The leaders pointed out the fragmented approach to identifying and caring for people in the United States with mental illness. They argued that adoption of new legislation would improve federal coordination of mental health resources, expand access to community and inpatient integrated treatment, and enhance mental health services for children and adolescents. The bills would also address psychiatric workforce shortages by fixing barriers to loan repayment for child and adolescent psychiatrists through the National Health Service Corporation. Proposals also address increasing funding for the National Institute of Mental Health.

In a separate but parallel effort, 23 mental health advocacy organizations

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led by APA addressed the issue in a letter sent to the heads of the House Energy and Commerce Committee, whose responsibilities include mental health.

"The need for comprehensive reform is urgent, and you have the opportunity to improve the lives of tens of millions of Americans, their families, and our communities," they wrote to committee Chair Fred Upton (R-Mich.), and ranking member Frank Pallone (D-N.J.).

New legislation would tighten up enforcement of parity rules and have the Government Accountability Office investigate compliance of the parity law by health insurance plans, said the letter.

"The Congress and your committee regularly act to ensure that Americans with heart disease, cancer, or any other medical illness have access to care," wrote the mental health groups. "The same should be true for those with schizophrenia, bipolar disorder, and other serious mental illness."

Both efforts were aimed at keeping mental health reform on the agenda of members of both bodies by urging them to proceed with the internal committee work necessary to advance legislation forward toward final passage. PN

More information about comprehensive mental health reform legislation is posted at http://www.psych.org/psychiatrists/advocacy/federal-affairs/comprehensive-mental-health-reform. The letter to Upton and Pallone is posted at http://www.psychiatry.org/newsroom/news-releases/mh-organizations-call-for-comprehensive-mental-health-reform.

PROFESSIONAL NEWS

Addiction Society Releases National Practice Guideline on Opioid Medications

The American Society of Addiction Medicine has created a comprehensive guideline for treating people with opioid use disorders, including those with special needs.

BY NICK ZAGORSKI

Over the past decade, the misuse and abuse of opioid drugs—both prescribed and illegal—has risen dramatically, prompting the Centers for Disease Control and Prevention to classify the current situation as "an epidemic."

Several groups have developed guidelines in the past few years aimed at helping providers evaluate and manage this growing problem, but they typically have been incomplete, noted Margaret Jarvis, M.D., medical director of the Marworth Alcohol and Chemi-

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cal Dependency Treatment Center in Waverly, Pa.

"While national data on the opioid problem has been around for a while, people have awakened to this situation only in the past few years," she told *Psychiatric News*. "As can happen when people scramble in response to a crisis, expediency can preempt thoroughness. So many of the guidelines out there may not include all the available treatment options or may only be relevant to a particular state or health care system."

To address the lack of a comprehensive, national guideline, the American Society of Addiction Medicine (ASAM) developed the National Practice Guideline for the Use of Medications to Treat Opioid Use Disorders.

The ASAM guideline provides evidence-based guidance on the appropriate use and follow-up for all three major medications currently approved to treat opioid use disorders—methadone, buprenorphine, and naltrexone—as well as for the opioid blocker naloxone, which can be used to treat opioid overdose.

The guideline also recommends clonidine as a treatment option for opioid withdrawal, though the medication has yet to be approved by the Food and Drug Administration for this use.

"At the moment, there is no clear first-line treatment for opioid abuse," said Jarvis, who served as chair of ASAM's Quality Improvement Council, which oversaw the selection of the independent guideline committee.

"What is clear is that a combination

see ***Guideline*** *on page 10*

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Guideline

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of medication and psychosocial intervention provides the most significant change," she continued. "They should always be used together."

The guideline also features sections related to patient populations with special needs, including people who have accompanying psychiatric disorders, people with chronic pain, adolescents, pregnant women, and people in the criminal justice system.

"I think that ASAM provided a comprehensive and detailed view of what we know about opioid treatment, particularly as it relates to treating the addiction itself," said Thomas Kosten, M.D., the Jay H. Waggoner Chair at Baylor College of Medicine and director of Baylor's Division of Alcohol and Addiction Psychiatry.

"Where the guideline falls a little short is in not providing a lot of detail on how you manage patients with significant psychiatric comorbidities."

As an example, he described the challenging situation of a veteran dealing with mild traumatic brain injury, posttraumatic stress disorder, and opioid misuse—a triple play of cognitive, behavioral, and substance use problems. "You get into some very tricky pharmacological decisions in such scenarios," Kosten said.

Managing patients with multiple mental issues can be complicated, and definitive research guiding how best to treat such patients can be hard to come

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by, Kosten said. Still, he noted that he believes there is enough clinical knowledge in the psychiatric community that some consensus could be reached, and ASAM or other guidelines could benefit from including consensus-based information in addition to evidence-based recommendations.

Whether the ASAM guideline will incorporate such changes in the future is uncertain, but some changes will be forthcoming, as ASAM plans to review and revise the guideline annually as new evidence emerges.

As more and more people focus on treating people with opioid use disorders, Jarvis said that she is hopeful that information on best treatments will continue to emerge.

"Depending on the discoveries, it's possible the practice guideline will see many new additions next year," she said.

"If there is a message that I believe will remain constant through the years, however, it would be that opioid abuse is not a one-and-done problem; this is a chronic disease that needs chronic treatment," she continued.

The ASAM practice guideline was developed by a multidisciplinary committee consisting of 10 experts representing the fields of addiction psychiatry, general psychiatry, pharmacology, internal medicine, and family medicine. PN

"The National Practice Guideline for the Use of Medications to Treat Opioid Use Disorders" is posted at http://www.asam.org/practice-support/guidelines-and-consensus-documents/npg.

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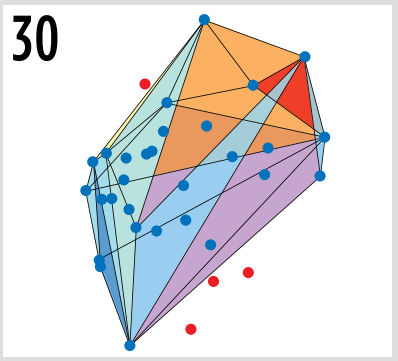

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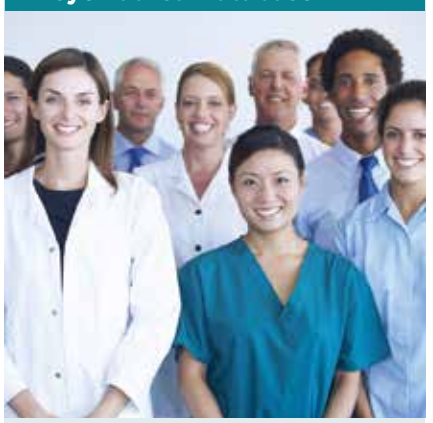

APA is offering a new member benefit for psychiatrists practicing in the United States and Canada. They are invited to join a new database that will enable individuals seeking psychiatric care to locate psychiatrists practicing in their area. To join the database, go to http://apps.psychiatry.org/optinfap/Login.aspx. To review the functionality of the database, go to http://finder.psychiatry.org.

Departments

FROM THE PRESIDENT

Gun Violence Restraining Orders: One Tool to Prevent Gun Violence

BY RENÉE BINDER, M.D.

When we hear about the lost lives after mass shootings in the United States, one of our responses is to think about whether these tragedies could have been prevented. One strategy to consider is whether a gun violence restraining order (GVRO) would have made a difference. California recently became the first state to have a GVRO statute. It enables a concerned family member and/or law enforcement officer to remove guns from individuals who are at risk of being dangerous to themselves or others before a tragedy occurs. As such, it is an important mechanism for temporarily removing firearm access on a case-by-case basis.

The right to keep and bear arms is granted by the Second Amendment. The U.S. Supreme Court has affirmed this right in two recent decisions (*D.C. v. Heller* [2008] and *McDonald v. Chicago* [2010]). Both cases involved statutes that prohibited ownership of handguns (in D.C. and in Chicago). The Court ruled that such prohibitions were unconstitutional and that individuals have a constitutional right to possess firearms in the home for self-defense, unless they fit into certain prohibited categories such as being convicted felons or having been civilly committed.

However, many people who might be dangerous are not included in the prohibited categories. GVROs expand the categories for gun-ownership restriction and can be lifesaving. The idea of a GVRO is based on research showing that there are times when individuals are at a heightened risk of violence. For example, this may be when a person has untreated mental illness and is paranoid. It may be when a person is depressed and thinking about suicide. It may be when a person makes threats to hurt others or stalks another person. At these times, it is important to remove access to guns. GVROs are a mechanism to do so.

Part of the impetus for the GVRO law in California came after Eliot Rodgers killed six people and injured 14 others in 2014 in Isla Vista (a college community near the University of California, Santa Barbara). Mr. Rodger's mother had been very concerned about her son and asked the police to go to his house and evaluate him. The police did not feel that Mr. Rodgers met the criteria for transport to a hospital on an involuntary hold—in part because he denied being a danger to himself or others. Unknown to the police, however, Mr. Rodgers had an arsenal of guns in his home, subsequently used for the mass shooting. The police had no authority to search the home for weapons, even though his mother thought that he was dangerous. A similar scenario happened in Tucson, Ariz. Jared Loughner killed six people and injured 12 others including Congresswoman Gabby Giffords. Mr. Loughner's parents were so worried about their son that they would take his car keys from him at night so that he couldn't harm anyone. However, neither the parents nor law enforcement had any mechanism to take his guns away from him.

A GVRO law might have also saved the life of Laura Wilcox. Laura was a 19-year-old student at Haverford College who was working as a receptionist at the front desk of a mental health clinic during her winter break when she and three other people were murdered. The assailant had been stalking one of the women who worked

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PROFESSIONAL NEWS

Outcomes From AOT Studies Show Benefits of Program

Amid controversy, one researcher lays out the evidence for the use of involuntary outpatient commitment in the community.

BY AARON LEVIN

Does involuntary assisted outpatient commitment work?

The answer is, "it depends," Marvin Swartz, M.D., a professor of psychiatry and behavioral sciences at Duke University School of Medicine, told an audience gathered at IPS: The Mental Health Services Conference in New York last month.

Swartz, who was the 2015 recipient of APA's Isaac Ray Award, which recognizes outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence, has spent over 25 years studying assisted outpatient treatment (AOT). As he described during the lecture given in connection with receiving the award, examining the effectiveness of AOT presents methodological challenges and the results have been mixed.

As Swartz explained, AOT is "a treatment plan wrapped in a legal order." It extends the state's civil commitment authority from the psychiatric hospital to a community-based mental health system. A court order requires a patient to comply with treatment and receive services but also implicitly requires that the mental health system treat the patient.

Ellen Dallager

Doing assisted outpatient treatment right means providing the funds, the expertise, and the commitment to make it work, says Marvin Swartz, M.D., a professor of psychiatry and behavioral sciences at Duke University.

Failure of a patient to stick to the treatment plan violates the court order and typically results in a patient being transported to a hospital or other psychiatric facility for a mental health evaluation. However, it does not call for incarceration or "forced drugging in the community," as some opponents have charged, said Swartz.

Critics of AOT have suggested that instead of mandating that patients receive treatment—which they say implicitly blames the patient for failures of the mental health system—the focus should be on improving the system itself and increasing outreach to patients in need. However, evidence suggests AOT can lead to improvements for some patients.

Swartz led the first randomized, controlled trial of AOT commitment in North Carolina, which compared the outcomes of patients with severe mental illness who received community mental health services through AOT with those who received comparable services without AOT.

The team found that individuals in AOT had fewer readmissions to the hospital and spent fewer days in the hospital if they received AOT for six months or more and they were provided consistent and frequent community services during the commitment period; they were also less likely to be violent or to be victimized.

Individuals who received AOT for less than six months, however, saw no benefit, even when combined with other outpatient services.

The introduction of an AOT program in New York in 1999—known as Kendra's Law—brought with it a significant amount of funding to support AOT infrastructure and implementation. Investments were made in enhanced community services, intensive care management, assertive community treatment, and a single point-of-access program. Funds were also

see **AOT** on page 34

ACLU Brings Lawsuit Against Two Psychologists Who Ran CIA's Post-9/11 Interrogations

The two psychologists trained and supervised other CIA personnel in their methods, and founded a company with which the CIA contracted to run its interrogation program.

BY MARK MORAN

The American Civil Liberties Union (ACLU) announced last month that it has filed a lawsuit against two psychologists who designed and implemented the Central Intelligence Agency (CIA)'s post-9/11 program of "enhanced interrogation" on behalf of three victims of the program.

Gul Rahman, Suleiman Abdullah Salim, and Mohamed Ahmed Ben Soud—three of more than 100 victims and survivors of the CIA program—are suing psychologists James Mitchell and John "Bruce" Jessen, who helped convince the CIA to adopt as official policy the use of harsh and extreme interrogation techniques, which the ACLU in its suit refers to as "torture."

"Mitchell and Jessen conspired with the CIA to torture these three men and many others," said Steven Watt, a senior staff attorney with the ACLU Human Rights Program, in a statement. "They claimed that their program was scientifically based, safe, and proven, when in fact it was none of those things. The program was unlawful and its methods barbaric. Psychology is a healing profession, but Mitchell and Jessen violated the ethical code of 'do no harm' in some of the most abhorrent ways imaginable."

Under Mitchell and Jessen's interrogation program that was adopted by the CIA in 2002, the plaintiffs were subjected to severe physical and psychological conditions including sleep deprivation, starvation, sensory deprivation, extreme temperatures, and waterboarding, according to the ACLU. One of the victims, Gul Rahman, died in his cell while being detained by the CIA; his family is bringing the suit on his behalf.

Mitchell and Jessen trained and supervised other CIA personnel in their methods, according to the ACLU. In 2005, they founded a company named Mitchell, Jessen & Associates with which the CIA contracted to run its interrogation program, including supplying interrogators and security for black sites and rendition operations.

The lawsuit was filed in federal court in Washington state, where Mitchell, Jessen & Associates was based and where Jessen currently lives. The plaintiffs are suing Mitchell and Jessen under the Alien Tort Statute, which allows federal lawsuits for gross human rights violations.

In July, a report commissioned by the Board of Directors of the American Psychological Association found that key officials at the American Psychological Association colluded with Department of Defence (DoD) officials to have the association issue "loose, high-level ethical guidelines that did not constrain DoD in any greater fashion than existing DoD interrogation guidelines" (*Psychiatric News*, August 21). The report concluded that the psychological association's "principal motive in doing so was to align [the association] and curry favor with DoD. There were two other important motives: to create a good public-relations response, and to keep the growth of psychology unrestrained in this area."

The report also found that "[American Psychological Association] officials engaged in a pattern of secret collaboration with DoD officials to defeat efforts by the American Psychological Association Council of Representatives to introduce and pass resolutions that would have definitively prohibited psychologists from participating in interrogations at Guantanamo Bay and other U.S. detention centers abroad."

In 2006, the American Psychiatric Association approved a policy strictly prohibiting psychiatrists from participation in interrogations. That position was reaffirmed by the Board of Trustees and Assembly in 2014. PN

The ACLU suit is posted at https://www.aclu.org/legal-document/salim-v-mitchell-complaint. The "Report to the Special Committee of the Board of Directors of the American Psychological Association: Independent Review Relating to APA Ethics, Guidelines, National Security Interrogations and Torture" is posted at http://www.apa.org/independent-review/APA-FINAL-Report-7.2.15.pdf.

ASSOCIATION NEWS

APA Honors Outstanding Achievements In Mental Health Services at IPS

The 2015 Psychiatric Services Achievement Awards recognized innovative programs that offer services to diverse and typically underserved populations, support integrated care, and promote early intervention and prevention.

BY MARK MORAN

Four programs providing unique and innovative services for people with mental illness were honored last month during the Opening Session of APA's IPS: The Mental Health Services Conference in New York. Each year, APA awards two Gold Awards (one for an institutionally based program and one for a community-based program), a Silver Award, and a Bronze Award.

Accepting the Gold Award for an Institutionally Based Program are Lisa Murphy, M.A., and J. Paul Federoff, M.D.

Accepting the Silver Award is Ben Harrington, M.A.

Accepting the Bronze Award are Joel Streim, M.D., and David Oslin, M.D.

• **Gold Award for Institutionally Based Program:** *Sexual Behaviours Clinic, Integrated Forensic Program, Royal Ottawa Mental Health Centre, Ottawa, Ontario.*

The Sexual Behaviours Clinic (SBC), first established in 1983, seeks to protect communities by preventing sex crimes and improve patient well-being so that sex offenders can go on to lead successful and productive lives in the community.

Through partnerships with community agencies that monitor and support sex offenders in the community, such as the Ottawa Police, the Circles of Support and Accountability, the Children's Aid Society, and Probation and Parole, the clinic treats about 175 new patients each year, mostly with a combination of medication and individual and group-based psychotherapy.

Treatment in the SBC can include a combination of medications, group therapy, couples therapy, and individual therapy. Pharmacologic treatment offered by the clinic helps to reduce sexual impulses that might normally preoccupy the patient, including selective serotonin reuptake inhibitors, which are particularly effective at controlling abnormal sexual impulses, and antiadrenergic medications, which reduce—and, in some cases, completely suppress—sex drive. The use of these medications is completely voluntary, as is all treatment offered by the SBC.

• **Gold Award for Community-Based Program:** *Missouri Community Mental Health Center Health Home Program, Jefferson City, Mo.*

The premature mortality associated with serious mental illness is largely preventable. There is strong evidence that access to high-quality, integrated care can improve the health of individuals with serious mental illness.

In 2011, the state of Missouri made a commitment to its citizens to focus on prevention efforts. Using an integrated care approach, Missouri's Department of Mental Health (DMH) collaborated with the state's Medicaid system (MO HealthNet) and community mental health system to establish "health homes" throughout the state's 29 community mental health centers. All adults enrolled in Missouri's Community Mental Health Center (CMHC) Health Home Program have a serious mental illness, and all children and youth in the program have a serious emotional disorder.

The health home approach allows eligible Medicaid enrollees to receive health care for targeted chronic conditions such as diabetes, chronic obstructive pulmonary disease, hypertension, and asthma, as well as mental health care. Health homes either strengthen linkages to community primary care providers (PCPs) or bring PCPs in house.

Missouri's investment in integrated care has resulted in improved care coordination and has placed Missouri on a national stage as a model in integration.

Photos: David Hathcox

Accepting the Gold Award for a Community-Based Program are Tara Crawford, M.S., Joseph Parks, M.D., Kim Yeagle, L.C.S.W., and Jaron Asher, M.D.

• **Silver Award:** *Student Outreach and Teacher Training to Ensure Prevention, Early Recognition, and Treatment of Mental Health Problems, Mental Health Association of East Tennessee, Knoxville.*

For the past 15 years, the Mental Health Association of East Tennessee (MHAET) has been working in schools to promote the mental and emotional well-being of students. MHAET has implemented a two-pronged integrated approach to reach both students and teachers: Mental Health 101 for middle and high school students and in-service training for teachers, including Typical or Troubled?, a program of the American Psychiatric Association Foundation. In the 2014–2015 school year, these programs had a direct impact on 23,928 students in 83 middle and high schools in the MHAET catchment area, which includes the urban areas of Chattanooga, Knoxville, Johnson City/Kingsport, and surrounding rural areas—a population of 2.5 million residents in 35 counties.

Mental Health 101 was associated with several positive outcomes during the 2014–2015 school year: an increase of 325 percent in the number of high school students who could identify a sign of mental illness, a 191 percent increase in the number of high school students who could identify a warning sign of suicide, a 175 percent increase in the number of middle school students who could identify a warning sign of suicide, and a 50 percent increase in the number of middle school students who could identify the correct duration of symptoms before seeking help.

• **Bronze Award:** *SUSTAIN (Supporting Seniors receiving Treatment And Intervention), a program of the Department of Psychiatry at the University of Pennsylvania's Perelman School of Medicine, and the Pennsylvania Department of Aging (DoA).*

This program is recognized for its private-public partnership to deliver population-level integrated care to low-income seniors in Pennsylvania.

SUSTAIN has two broad goals: to identify community-dwelling elders at risk of poor health outcomes, including nursing home admission, and to support those patients and their primary care prescribers to manage their mental health care, consistent with evidence-based guidelines, across the state.

The innovation embodied in SUSTAIN

see **Achievements** on page 18

ASSOCIATION NEWS

IPS: The Mental Health Services Conference

October 8-11, New York City

More than 1,500 people gathered in New York City last month to learn the latest on clinical care, service delivery, integrated care, and issues that impact the mental health of diverse communities. While taking a break to peruse the Exhibit Hall and APA Central, attendees were invited to show their pride for their profession by having their picture taken for posting on a photo wall and sharing on social media.

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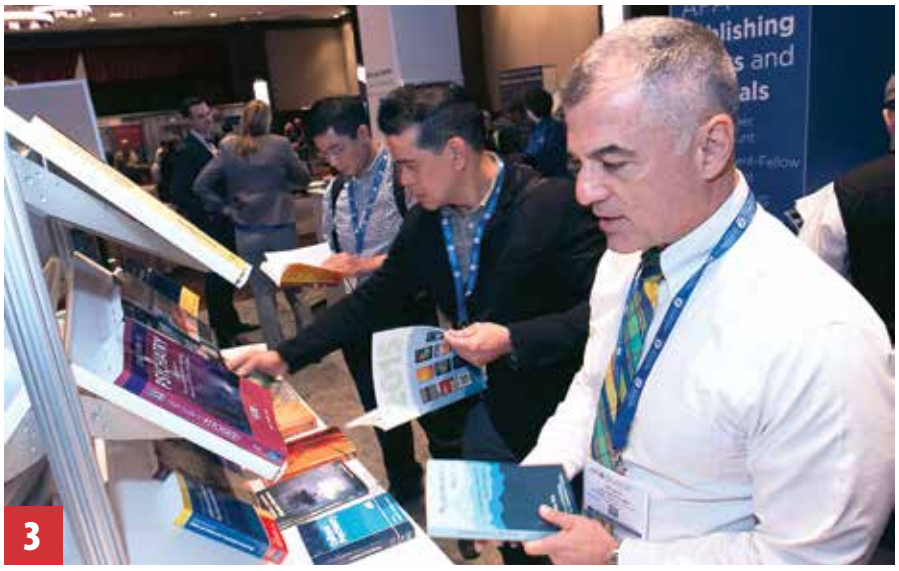

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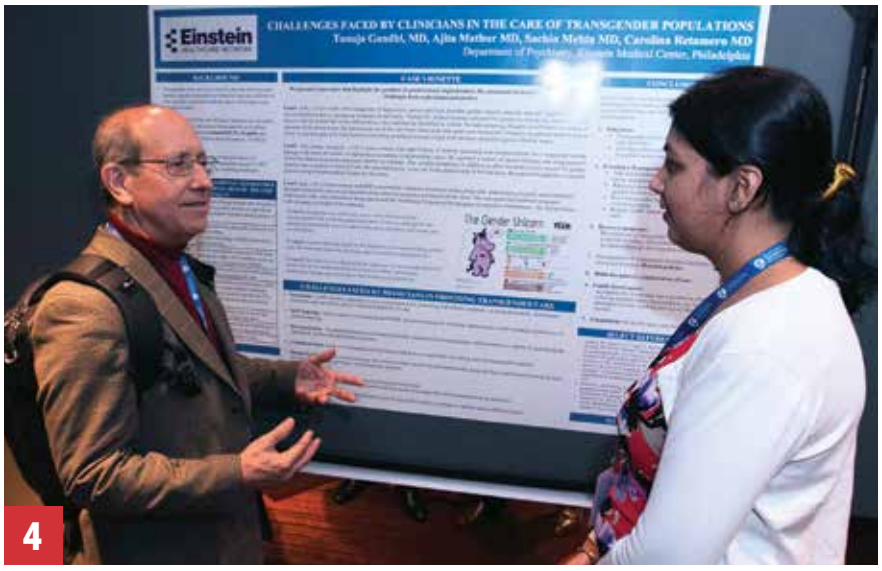

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1 Posing for a photo as part of #iampsychiatry wall are Ramneesh Baweja, M.D., Onaiza Anees, M.B.B.S., Houssam Raai, M.D., and Kavita Kothari, M.B.B.S., and 6 Tracy Collins, M.D.

2 APA staff were on hand in APA Central to answer questions and provide information about the Association's programs, services, and benefits. It was a central attraction in the Exhibit Hall.

3 Petros Levounis, M.D., looks over the book selection at the booth of American Psychiatric Association Publishing.

4 Lawrence Real, M.D., discusses a poster presentation with Tanuja Ghandi, M.D.

5 Zahid Islam, M.D., and Muhammad Iqbal, M.D., enjoy a snack as they visit the booths in the Exhibit Hall.

Photos: David Hathcox

COMMUNITY NEWS

Clinicians Support Oregon Town's Resilience After College Shooting

Roseburg is looking for a few good mental health practitioners of any kind who can spend some extended time helping the community recover.

Photos: Daniel Bristow, M.D.

BY AARON LEVIN

As the immediate tragedy of the shooting at Umpqua Community College that left eight students and one professor dead in Roseburg, Ore., receded last month, the longer-term needs of the small rural community began to emerge.

"This is a tightly knit community, so the impact was greater," said family practice doctor Christine Seals, M.D., medical director of the Umpqua Health Alliance and president of Community Health Alliance, the local mental health provider in Roseburg.

"Everyone knew someone at that college," said Seals in an interview. "There is not a single person or patient I have seen since the shooting who was not linked in some way to someone who lost their life or was injured."

Access to mental health care in rural Oregon can be difficult enough without a mass casualty event.

There are just five psychiatrists in the community, plus several more at the Department of Veterans Affairs Medical Center in the town. The VA medical center was able to provide some short-term, humanitarian help during the initial community response.

However, what is needed now are not short-term visits by outside clinicians but a longer commitment by mental health professionals of any stripe who can deliver trauma-informed care to those who need it.

"Most people can give a day, but not three or four weeks," said Seals.

Through Laurence Colman, M.D., M.P.H., chief medical officer at Greater Oregon Behavioral Health in Portland, Seals requested help from the Oregon Psychiatric Physicians Association (OPPA) and the Oregon Council of Child and Adolescent Psychiatry.

"Dr. Seals approached me looking for clinicians with particular training in acute cognitive-behavioral therapy, cognitive-processing therapy, and other trauma-focused training and experience to help out as the initial two weeks of support from the Red Cross and the federal government ran out," Colman told *Psychiatric News.* The U.S. Public Health Service sent a team. Its members offered support to local practitioners and some assessment help but not clinical services.

"It's unfortunate that many people coming into the county to offer a one-time clinical service meet the community's needs far less than one or a few clinicians who can dependably be available on an ongoing, weekly basis," said Colman.

OPPA is also thinking about the longer term. Daniel Bristow, M.D., the organization's public information chair, drove to Roseburg on the Friday night following the tragic shootings.

"I soon found out that simply being there, meeting people, sharing stories, and finding out how to go forward would be the most valuable contribution," wrote Bristow, a psychiatrist with Kaiser Permanente in Portland, Ore., in an email.

Bristow emphasized the need to engage the news media to help educate the public about the psychological consequences to the community. OPPA already had in place an outreach and media protocol for responding to public events with psychiatric implications. That plan served to educate members of the media and the public about depression after Robin Williams' suicide and about addiction following the legalization of recreational marijuana in Oregon.

After the Roseburg tragedy, Bristow and other members of OPPA provided media interviews by phone or in person, offering the public useful information and avoiding sensationalism or speculation, he said.

Risk for the traumatic aftereffects of the Roseburg shooting may be heightened because so many people have connections to the event, as Seals noted.

"But the healing process may also go better because of the support of the community as well," she said.

Even before the tragedy, Seals said that she was trying to recruit one general and one child psychiatrist to the area. She noted the positive professional opportunities in a smaller medical system that is receptive to innovation.

A clinician in any field looking to make engaged, integrated care a reality might do worse.

"We have had a tragedy here whose impact will be felt for 10 or 20 years," she said. "I want psychiatrists who will play a role in an innovative, open-minded, creative way. This is a place where you can make a difference." PN

Information on the Umpqua Health Alliance is posted at http://www.umpquahealthalliance.org/.

Law enforcement officials brief reporters at the Public Safety Center in Roseburg, Ore., following the October 1 shooting at Umpqua Community College.

Achievements

continued from page 16

is a merger of two existing powerful tools—a large pharmacy benefits database maintained by the DoA and a software-supported collaborative care program developed by the University of Pennsylvania.

The DoA database provides real-time information about new prescriptions for psychotropic and anti-dementia medications for low-income Pennsylvania residents aged 65 and older. In this population, more than 90 percent of prescriptions for psychotropic medications are written by primary care physicians.

SUSTAIN staff uses the DoA database to identify geriatric patients with newly diagnosed behavioral health problems and their primary care providers across the state. These patients are then contacted by the SUSTAIN staff, who provide telephone-based clinical assessments and deliver a variety of behavioral health services, including therapy support, education, and support services for caregivers. PN

Full descriptions of the Achievement Award winners appear in the October issue of *Psychiatric Services* at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.661013, http://ps.psychiatryonline.org/doi/10.1176/appi.ps.661010, http://ps.psychiatryonline.org/doi/10.1176/appi.ps.661011, and http://ps.psychiatryonline.org/doi/10.1176/appi.ps.661009.

COMMUNITY NEWS

Conference Examines Cultural Histories Leading to Unrest in Ferguson

To fully understand African-American patients, their cultural history must be taken into account.

BY VABREN WATTS

An individual's emotional responses are often rooted in the historical events and experiences of his or her culture, some mental health experts say in speaking about the civil unrest in African-American communities where unarmed African-American males have died at the hands of law enforcement.

This was the takeaway message from a recent conference led by the Missouri Psychiatric Association, which gave psychiatrists, psychologists, and other mental health professionals an opportunity to engage in a dialogue on some of the underlying psychosocial factors that may have resulted in uprisings in multiple cities across the United States in the past few years related to race, socioeconomic disadvantages, and discriminatory practices of some municipal criminal justice systems.

"Everybody remembers August of last year in Ferguson, Mo., which was at the center of national and international news after the shooting death of Michael Brown," James Fleming, M.D., told *Psychiatric News*. Fleming, a psychiatrist at Holistic Psychiatry Kansas City, Mo., was one of the moderators of the conference, "Addressing the Psychiatric Impact of Economic Disparity, Societal Stress, and Racial Profiling," which was held in Columbia, Mo., less than two hours from Ferguson.

Brown was an unarmed 18-year-old African American who was shot on August 9, 2014, by Darren Wilson, 28, a white on-duty Ferguson police officer, during an altercation between the two men. A series of protests and civil disorder erupted in the city shortly after the shooting, sparking a national dialogue about race and the relationship between law enforcement officers and African Americans, in particular those African Americans living in impoverished areas.

Collins Lewis, M.D., says that due to the events involving deadly interactions between African Americans and law enforcement, more mental health professionals must step up and talk about the mental health impact of racism and poverty in the United States.

"We know that the economic conditions and racial inequalities in the inner city have been very poor for many years," said Fleming. "This has clearly had an adverse impact on the African-American community as witnessed in such places as Baltimore and New York."

In response to the series of shootings of unarmed African-American males and civil unrest throughout the nation, the Black Caucus of the APA Assembly passed an action paper last spring calling for the education of APA members about the need to provide community-based and culturally sensitive mental health services to those who may have been affected by these events. The current meeting was inspired by that mission and focused heavily on cultural history.

Marva Robinson, Psy.D., president of the St. Louis Association of Black Psychologists, talks about historical factors that may have led to an "explosive situation" in Ferguson, Mo., after the death of Michael Brown. At left is Amina Avion, a graduate student at Washington University.

"Past circumstances perpetuate today's issues," said Marva Robinson, Psy.D., a clinical psychologist and president of the St. Louis Association of Black Psychologists, as she explained to conference attendees how historical trauma has had an impact on many African-American communities.

"Looking over the past 400 years that African Americans have been in this country, we have been enslaved both physically and psychologically," said Robinson. She told *Psychiatric News* that psychological enslavement persisted after slavery was made illegal in the United States: African Americans were denied voting rights, first-class education, access to certain establishments, and opportunities available to whites, and they were the victims of violence and hatred and many forms of overt and covert discrimination.

"Any form of enslavement sends the message that you are not an individual and that your life is not important," Robinson explained.

According to an ongoing study by Robinson, historical trauma that is linked to racism is associated with numerous physiological and psychological outcomes. These outcomes include low volumes in the prefrontal cortex, hippocampus, and the amygdala (areas related to memory and emotions); and increased risk for diabetes and hypertension. Psychological outcomes include increased risk of posttraumatic stress disorder, oppositional defiant disorder, attention-deficit/hyperactivity disorder, depression, and aggression. The data also show that people who are subjected to some forms of racism are more willing to engage in criminal behaviors.

Economic disparity also can play a role in psychological and physiological distress, said Deanna Barch, Ph.D., chair of the Department of Psychology at Washington University. She presented data from the Preschool Depression Study, which measured the neurobiological and psychological effects of poverty on 246 preschool-aged children up to their teenage years. "Poverty has a clear effect on the development of brain structure and brain function," Barch told *Psychiatric News*.

"Looking at MRI scans, impoverished children showed a steeper decline in gray mater volume over the course of the study compared with children who were not impoverished," explained Barch. Poverty-related stress was also negatively associated with children's hippocampal volume and functional brain activity. In addition, poverty was associated with the onset of childhood depression.

According to Amina Avion, a graduate student at the Early Emotional Development Program at Washington University, many African Americans in Ferguson are affected by both racism and poverty. The unemployment rate for African Americans living in the city is 20 percent compared with 7 percent for whites. Though the city is 67 percent African American and 29 percent white, there is very little representation of

Psychiatric Aftermath of Ferguson

No civil unrest in a community goes without mental health consequences, said Marva Robinson, Psy.D., a clinical psychologist and president of the St. Louis Association of Black Psychologists.

Robinson along with researchers from the University of Missouri, St. Louis, led a study assessing the prevalence of mental health disorders among 600 Ferguson, Mo., residents and local active-duty police officers in the three to six months following the death of Michael Brown. Preliminary findings showed that 34 percent of the community and 14 percent of police officers met *DSM-5* criteria for posttraumatic stress disorder (PTSD); the national prevalence of PTSD is 7.8 percent. About 43 percent of the community sample and 33 of the police sample met criteria for depression; the national average is 6.7 percent. Anger expression was prevalent in 32 percent of the community and 23 percent in law enforcement; the national average is 7.3 percent.

"These data demonstrate the amount of mental health intervention that is needed or warranted in Ferguson," said Robinson. "However, efforts to evoke meaningful change is going to be impacted by the level of distress that was already in the community before the unrest. Therefore, we must address those emotions displayed prior and after the [Michael Brown] incident in Ferguson."

COMMUNITY NEWS

African Americans in leading positions within the local government—including the police force, which is 11 percent African American and 83 percent white.

In an investigative report released this year by the U.S. Department of Justice, the Ferguson Municipal Court system was found to have disproportionately targeted African-American citizens—through citations and arrests—for financial gain for the city from 2012 to 2014. Within that period, African Americans accounted for 93 percent of arrests made by Ferguson police and were 68 percent less likely to have their cases dismissed than were whites.

"Those of us who have studied issues of race and inequality—and, in particular, African-American relations with law enforcement, could have predicted that an uprising in Ferguson was soon to happen," Karen Curls, Ph.D., chair of the Social Sciences Division at the Metropolitan Community College Penn Valley Campus, told *Psychiatric News*.

James Fleming, M.D., talks to attendees about the Black Caucus of the APA Assembly action paper "Improving APA Support of the Mental Health of African-American Males," which calls for more training opportunities for psychiatrists to provide culturally competent therapeutic interventions for African-American communities.

Photos: Vabren Watts

Karen Curls, Ph.D., chair of social sciences at the Penn Valley Campus of the Metropolitan Community College, talks about the evolution of militarized policing in African-American communities.

Curls, who was one of the conference speakers, said that policing and its racial and social construct date back to the 1700s with slave patrols and night watchers. These were white men who were hired by slave owners to monitor the behavior of blacks and maintain social and economic order.

"This resulted in setting a foundation and a belief as they relate to groups of people in this country," said Curls, "which was to protect whites and control and criminalize blacks." To reverse this belief system, this country's history of racism, race relations, and the criminal justice system must be addressed, she emphasized.

Speaking with *Psychiatric News* after the conference, Fleming said that on the basis of attendees' evaluations of the conference, he is hopeful that participants will better understand the plight of many African Americans.

"There was an appreciation of the knowledge base of historical roots of racism in this country, the impact of institutionalized racism, and various aspects of mental health among minority communities," said Fleming. "For many of us in attendance, this was new information and will allow us, as mental health professionals, to be more culturally sensitive to all patients. We hope to continue this dialogue in future programs." PN

PSYCHIATRY & INTEGRATED CARE

Improving the Reach and Effectiveness of Integrated Care

BY JÜRGEN UNÜTZER, M.D.

It has been two years since I began editing this column on integrated care, and I suspect many readers are familiar with the broad themes associated with this new approach. Integrated care effectively incorporates good mental health care with the rest of health care, leveraging psychiatrists and other mental health specialists to reach more patients in need. The Centers for Medicare and Medicaid Services and other major health care payers are considering establishing new payment methods for evidence-based collaborative care, and this could dramatically increase access to this effective model of care over the next few years. To realize this opportunity, we will need to dramatically expand the availability of psychiatrists and other mental health care professionals who are

trained in evidence-based collaborative care. We also need to continue to look for new ways to leverage the skills of psychiatric consultants to reach more people in need.

One of the most promising approaches to further improve the reach and effectiveness of behavioral health care is the systematic involvement of family members, peers, community health workers, and community-based organizations in care. The ability to share some of the important tasks of evidence-based collaborative care with family members, peers, or community health workers has the potential to dramatically increase access to high-quality treatment and to effectively leverage mental health services provided in primary care and other health care settings.

Examples of such task sharing include the award-winning Center for Health Services and Society, which works to improve depression care across diverse health care and community programs in Los Angeles. The center was pioneered by Ken Wells and colleagues at UCLA.

In a similar effort and with support from the Archstone Foundation's Late-Life Initiative, researchers at the University of Washington and the University of California, Davis, are testing ways to expand collaborative primary care for depressed older adults by engaging family members or health workers in community-based organizations in care teams. For example, Ladson Hinton, M.D., a professor and director of geriatric psychiatry, is leading an effort to implement a family partnership intervention at the McClellan Outpatient Clinic, a clinic of the U.S. Department of Veterans Affairs.

Another promising approach to improve the reach and effectiveness of integrated behavioral health care is through the use of technology. Mobile technologies, such as smartphone apps, can allow patients to check in and communicate with their collaborative care team at any time. In addition to facilitating efficient check-ins, such apps can provide timely reminders and information to help patients, family members, and caregivers understand their conditions and tools for taking good care of themselves and their loved ones.

Technology can also be used to help deliver evidence-based psychosocial treatments such as problem-solving treatment (PST) to patients in home and community settings. For example, in the Bridging Research Innovations in Greater Health through Technology, Emotion, and Neuroscience Study (BRIGHTEN), over 1,000 people received app-based mental health care in the course of five months, including iPST, an app based on basic problem-solving therapy. After two weeks of regular use, participants showed marked improvement in mood and self-reported function. The VA's Moving Forward program is also based on basic PST principles, offering returning veterans web-based and app-based interventions to help them reintegrate into society.

The field of integrated care is young, and there is still much work to do if we want to better leverage the skills of psychiatrists to reach the millions of individuals who are suffering from untreated mental health and substance use problems each year. New partnerships and new technologies are offering us important opportunities to reach this ambitious goal. PN

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

VIEWPOINTS

Remembering Alies Muskin, ADAA Executive Director

BY MARK POLLACK, M.D.

All of us at the Anxiety and Depression Association of America (ADAA) deeply mourn the loss of our executive director Alies Muskin, who died on September 22 at the age of 59 from complications of breast cancer.

Alies began her career at ADAA in 2001, serving as chief operating officer before being named executive director in 2010. She worked tirelessly to offer hope and to improve the quality of life for the millions of children and adults who suffer from anxiety, depression, obsessive-compulsive disorder, posttraumatic disorder, bipolar disorder, and other related disorders.

She strongly believed that the sense of shame and stigma about mental health issues that prevent so many from accessing the care they need could change for the better with input from patients, families, loved ones, clinicians, and researchers. "So many people tell us that just knowing that they are not alone is empowering," she said.

She positioned ADAA as the leading organization in this country dedicated to the prevention, treatment, and cure of these illnesses through education, training, and research, and she never wavered in promoting the message that mental illness is treatable.

Her commitment to improving the lives of affected individuals extended to ensuring that over the years ADAA supported numerous research projects from young and established investigators. "Understanding the basic science," she said, "gives us hope that advances in neuroscience can impact how we diagnose and treat anxiety and mood disorders."

In Alies' eyes, a key element of the ADAA mission was helping improve patient outcomes by promoting scientific innovation, encouraging translation and implementation of research into practice, and providing continuing education of evidence-based treatments across disciplines.

Alies truly wanted to make the world a better place—to make sure that affected individuals had access to the best treatment possible—and she was relentless in her commitment to doing the hard work necessary to make it happen. She was a masterful administrator and advocate, an optimist with a clear-eyed understanding of people and systems, and she moved the organization and the field forward with her incisive intelligence, keen sense of humor, warmth, and boundless energy.

Emily Rosenberger

Alies Muskin and her daughter Emily Rosenberger.

Like all great leaders, Alies raised the game of those around her, and we were all the better for knowing her. The ADAA remains committed to realizing Alies' vision and following the path she set forth for the future.

Loving survivors in her immediate family include her husband, Alfie Rosenberger; daughters Emily (and her husband Matt Geramita) and Melanie; her brother Philip Muskin, M.D., and his wife, Marlene, and their son, Matthew; and her sister, Marci Muskin, and her husband, Richard Geisenberger, and children, Dana and Harry. PN

You can honor the legacy of Alies Muskin by contributing to a memorial fund in her name to support the work of the organization that she led so passionately at http://tinyurl.com/alies-donate.

Mark Pollack, M.D., is the chair of the Department of Psychiatry at Rush University Medical Center and president of the Anxiety and Depression Association of America.

RESIDENTS' FORUM

Resident as Advocate: Extending Your Commitment

BY LUMING LI, M.D.

As a resident committed to improving the well-being of people with mental illness through local, state, and federal action, I encourage you to consider joining me in this work. Why get involved in advocacy? Mental health services are poorly funded, with low reimbursements to clinicians and financial loss to many outpatient clinics. Even integrated mental health practices with clinical efficacy are difficult to support financially after initial research demonstration funds end. Advocacy is needed to expand mental health access and continue research. Hopefully, sustained advocacy efforts can collectively bring about systemic changes that improve care.

There are several ways to be involved in advocacy, and they are not time consuming. One way is through direct participation in the political process. For example, several of my co-residents and I went to Hartford, Conn., earlier this year to testify at a public hearing against budgetary cuts to our premier community mental health centers in Connecticut. We sent out emails to organize the event and drove about 45 minutes to Hartford. At the event, we waited in a large caucus room until our names were called. We read our prepared statements in front of a camera and members of Congress. Our testimony was broadcast on local television. Afterward, the department featured our advocacy efforts at Grand Rounds.

Similarly, attending conferences can offer insight on current issues in psychiatry. This year, I attended a conference by the National Association of Psychiatric Health Systems, where I met Sen. Chris Murphy (D-Conn.), who is the cosponsor of comprehensive mental health reform legislation in the Senate. The bill allows for patients to partner with providers and their families to gain better access to care. Last year, I went to APA's Institute on Psychiatric Services, where I first learned about evidence-based integrated care models that improve access to care. These opportunities allow for resident engagement in national discussions on policy ideas and changes.

Just last month, APA launched its Congressional Advocacy Network (CAN), whose goal is to amplify the voice of psychiatry in Congress through an intensive program matching psychiatrists in every state and Congressional district with a member of Congress. You can join in this effort by becoming a Congressional Advocate. Congressional Advocates will serve as key contacts when important issues come before Congress, so that psychiatry can quickly deliver its message to Congress through direct, personal communication. The CAN program will also complement the efforts of the district branches and state associations (DBs/SAs) and be used as a resource for both the DBs/SAs and APA when federal issues arise that require a quick response. If you are interested in the program, contact Ashley Mild at amild@psych.org or Adam Lotspike at alotspike@psych.org of APA's Division of Government Relations. More information is posted at www.psychiatry.org/CAN.

Writing can also be a powerful way to participate in the political process. Members of Congress want to hear from constituents (particularly physicians, because they are thought to offer a unique voice as a group). The email addresses of senators and representatives are posted online, and their offices are a phone call away. Either emailing or calling works well. I've had responses within 24 hours using both methods. You can often email your message directly or can schedule an appointment to speak to your representative at a time that works for you (for example, an afternoon off from clinic). This can occur at the state or national level. To make it easy for you to contact your federal members of Congress, just visit APA's advocacy website, where you can send pre-composed letters to members of Congress and learn about new mental health legislation. Check out http://cqrcengage.com/psychorg/home.

You can also become an advocate at your home institution by creating a forum for discussion. I worked with other residents from my program to create a discussion group among those interested to learn more about models for psychiatric services and policy implications for mental health reforms. We were able to recruit faculty mentors to help suggest local experts and discussants who could give brief, informal presentations to facilitate conversation. The monthly group gathering is an opportunity for social engagement that has strengthened participants' knowledge about parity laws and other

see **Residents' Forum** on page 30

Luming Li, M.D., is a PGY-2 in adult psychiatry at Yale School of Medicine.

JOURNAL DIGEST

BY NICK ZAGORSKI


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Gene Polymorphisms Identified In Methadone Clearance

While methadone is an important opioid addiction medication, accidental overdose is a major concern. Overdoses occur in part because there is much variability in how quickly methadone clears from an individual's system, so dispensing the right dose remains tricky.

Cytochrome P oxidases (CYPs) are key metabolizers of foreign chemicals, and a group at Washington University in St. Louis examined whether variations of the enzyme CYP2B6 contribute to methadone metabolism.

Compared with those without the polymorphism, volunteers with at least one copy of the CYP2B6*6 polymorphism showed lower methadone metabolism and clearance, with oral S-methadone clearance being the most reduced, followed by oral R-methadone, and lastly, methadone delivered intravenously.

The authors noted that genetic testing might be useful to identify subjects with lower metabolic profiles who are thus at a greater risk for methadone toxicity. In particular, the CYP2B6*6 variant is more prevalent in African Americans, they noted.

This study was published in *Anesthesiology*.

Kharasch E, Regina K, Blood J, Friedel C. Methadone Pharmacogenetics: CYP2B6 Polymorphisms Determine Plasma Concentrations, Clearance, and Metabolism. *Anesthesiology.* Sep 19, 2015 [Epub ahead of print] http://anesthesiology.pubs.asahq.org/article.aspx?articleid=2444105


Image Point Fr/Shutterstock

Light Therapy Reduces Depression In People With Cystic Fibrosis

Depression is a common symptom of cystic fibrosis, and it leads to worse outcomes when patients with the disease are hospitalized. Previous studies have shown the benefits of bright-light therapy in improving mood and reducing the length of stay of hospitalized patients, but it was unknown if these benefits would extend to patients with cystic fibrosis.

Researchers at Ohio State University examined the effects of light therapy on 30 patients with cystic fibrosis who were hospitalized following a pulmonary exacerbation (80 percent of whom had at least mild symptoms of depression upon admission). The patients used a light box for 30 minutes each day for seven consecutive days.

At the end of the week, the patients showed a significant decrease in their depressive symptoms as well as improvements in other quality-of-life indicators, including vitality and emotion. The light treatment was well tolerated and seemed to produce a shorter hospital stay—though the authors noted that length of stay was compared with that of a previous cohort of patients with cystic fibrosis.

The authors also cautioned that this pilot study, published in the *Journal of Affective Disorders*, had no control groups so the exact effects of light therapy as opposed to other aspects of the hospital stay remain unknown.

Kopp B, Hayes D Jr, Ghera P, et al. Pilot Trial of Light Therapy for Depression in Hospitalized Patients With Cystic Fibrosis. *J Affect Disord.* Sep 28, 2015;189:164-168. http://www.jad-journal.com/article/S0165-0327(15)30574-7/abstract


Csehak Szabolcs/Shutterstock

Naltrexone Offers Limited Benefit For People With Gambling Problems

Naltrexone is an approved medication for both alcohol and opioid addiction, and there is some evidence to suggest that it may also offer a viable option for treating behavioral addictions such as problem gambling.

To evaluate the effectiveness of naltrexone on gambling, researchers in Finland carried out a randomized, double-blind, placebo-controlled trial in 101 problem gamblers. The study participants received either 50 mg of naltrexone or placebo to use as needed when they felt an urge to gamble, along with psychosocial support for 20 weeks. The researchers then assessed the severity of the problem gambling, including money spent, gambling frequency, gambling urges, and emotional well-being.

They uncovered no significant outcome differences between the two groups, though they found a potential improvement with naltrexone on well-being in a subgroup of participants with a variant of the opioid receptor *OPRM1*. They suggested that larger studies are warranted to further evaluate the role of *OPRM1* in problem gambling and possibly other behavioral addictions.

This clinical study was published in *European Addiction Research*.

Kovanen L, Basnet S, Castrén S, et al. A Randomised, Double-Blind, Placebo-Controlled Trial of As-Needed Naltrexone in the Treatment of Pathological Gambling. *Eur Addict Res.* 2016;22(2):70-9. Epub Sep 5, 2015. http://www.karger.com/Article/Abstract/435876


Miriam Doerr/Shutterstock

Some First-Time Fathers May Experience Antenatal Depression

While the prevalence and risk of depression in pregnant women has been well documented, less is known of the risk of depression in expectant fathers.

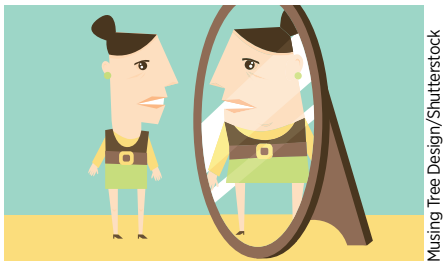
A new study appearing in the *American Journal of Men's Health* provides some of the first epidemiological details of antenatal paternal depression, finding that about 13 percent of first-time expectant fathers experienced elevated levels of depressive symptoms during their partner's pregnancy.

These findings were based on a survey of 622 men in Quebec who completed online questionnaires measuring such factors as mood, physical activity, sleep, financial stress, and more during their partner's third trimester.

The surveys revealed that depression rates were higher in men who experienced problems sleeping, had a family history of psychological difficulties, lower perceived social support, poorer marital satisfaction, and financial stress and whose partner was experiencing depressive symptoms.

"These are important signals because some of these factors may worsen in postpartum; certainly sleep will be compromised in the first years," said study author Deborah Da Costa, Ph.D., an associate professor in the Department of Medicine at McGill University in a press release. "Antenatal depression is the strongest predictor for postnatal depression. So teaching fathers and screening … early on can be beneficial in terms of decreasing the risk or the continuation of depression postpartum."

Da Costa D, Zelkowitz P, Dasgupta K, et al. Dads Get Sad Too: Depressive Symptoms and Associated Factors in Expectant First-Time Fathers. *Am J Mens Health.* Sep 18, 2015 [Epub ahead of print] http://jmh.sagepub.com/content/early/2015/09/16/1557988315606963.abstract


Musing Tree Design/Shutterstock

Diversity of Intestinal Microbiome May Be Linked to Anorexia Nervosa

The intestinal microbiome has been linked with weight regulation, and new research published in *Psychosomatic Medicine* has now linked gut bacteria with extreme weight dysregulation.

A group from the University of North Carolina School of Medicine analyzed the fecal samples of 16 women with anorexia nervosa taken at admission to and discharge from an eating disorders clinic.

They found that the gut bacteria populations were far less diverse at admission than at discharge (intestinal bacterial diversity is a sign of good health). Patients that demonstrated the greatest improvement in mood over the course of their time at the clinic tended to have the most diverse gut microbiota.

However, the researchers did note that even at discharge, the bacterial diversity of the fecal samples of the anorexia patients was still lower than those taken from 12 healthy controls.

"We're not saying that altering gut bacteria will be the magic bullet for people with anorexia nervosa," said lead author Ian Carroll Ph.D., in a press release. "Other important factors are at play, obviously. But the gut microbiota is clearly important for a variety of health and brain-related issues in humans. And it could be important for people with anorexia nervosa."

Kleiman S, Watson H, Bulik-Sullivan E, et al. The Intestinal Microbiota in Acute Anorexia Nervosa and During Renourishment: Relationship to Depression, Anxiety, and Eating Disorder Psychopathology. *Psychosom Med.* Oct 1, 2015 [Epub ahead of print] http://journals.lww.com/psychosomaticmedicine/Abstract/publishahead/The_Intestinal_Microbiota_in_Acute_Anorexia.99043.aspx

CLINICAL & RESEARCH NEWS

More Than Words: Automated Speech Analysis May Offer Clinical Insight

Subtle changes in semantics and syntax can differentiate which individuals are at greatest risk of developing psychosis, offering a powerful and objective diagnostic tool.

BY NICK ZAGORSKI

More and more, computer algorithms are being used by humans to assist them in filtering language—educators use them to quickly identify plagiarized text, human resources use them to screen resumes, and advertisers tailor their pitches to the content of our daily emails.

Using computers to analyze language could also prove valuable in the psychiatric arena, where language is an essential part of the evaluation and treatment process.

"Speech is an incredibly complex and rich form of data in terms of clinical information," said Gillinder Bedi, D.Psych., an assistant professor of clinical psychology at Columbia University. "In addition to the information someone is telling you, facets such as inflection, acoustics, rate of speech, or pauses carry substantial information that we interpret as listeners."

Subtle changes in a person's speech can also serve as an early indication of a problem in the brain, Bedi said, including both acute conditions such as alcohol intoxication and chronic disorders such as dementia or psychosis.

According to Bedi, automated speech processing software might be able to identify changes in speech at their earliest stages, complementing a clinician's subjective insight with an objective analysis and leading to more accurate diagnoses.

In a recent paper, Bedi and Cheryl Corcoran, M.D., an assistant professor of clinical psychiatry at Columbia, along with colleagues at Columbia, IBM's T.J. Watson Research Center, Brazil, and Argentina described how automated speech analysis can be used to identify individuals who will go on to develop psychosis.

For the study, which was published in *NPJ Schizophrenia*, the researchers used an algorithm to evaluate transcripts from interviews with 34 youth considered to be at risk for schizophrenia (five of whom would eventually develop a psychotic episode), conducted every three months for up to 2.5 years. Using automated analysis, the transcripts from the interviews were analyzed for their average phrase length, the frequency of determiner words such as "that" and "which," and the semantic coherence.

As Corcoran explained, semantic coherence refers to a narrative flow—the extent to which subsequent phrases or sentences in speech are related to one another in terms of meaning. "Automated speech analyses estimate semantic coherence by assigning meaning to every word in the language—much as humans do—by considering prior experience with the word in many different contexts," she said.

According to Corcoran, in automated analysis, every word is assigned a semantic value based on its co-occurrence with every other word in the language; the value is represented as a directional vector. In turn, the semantic vector for a sentence is the average or sum of all the semantic vectors of the constituent words; these sentence vectors can be lined up to see if meaning flows naturally from one sentence to the next.

If someone is speaking coherently on a topic, then the phrase vectors will line up, Corcoran, senior author on the study, told *Psychiatric News*. However, if the vectors of successive phrases point in very different directions, this indicates semantic incoherence.

When each participant was plotted on a 3D graph based on his or her scores for each speech component, the researchers found that all five individuals who developed psychosis demonstrated speech patterns that were clear outliers from the other 29 youth.

"Now discrimination is not the same as prediction, but this does show there are distinct semantic differences in someone who will develop psychosis up to two years before it happens," said Bedi. "Our goal now is to predict, at the level of the individual, who will go on to develop psychosis and who will not."

Corcoran already has data from a second cohort of at-risk individuals, as well as healthy participants and people who have experienced psychosis. She has applied for funding to carry out the analysis.

"Our 100 percent record will not persist, but if we can get an algorithm that predicts with 90 or even 80 percent accuracy the people most likely to develop psychosis, it would still outperform the current clinical ratings," Corcoran said.

She is also exploring whether the technology can detect changes in speech patterns in people with mild cognitive impairment (MCI), a risk state that precedes Alzheimer's disease.

"In both Alzheimer's and MCI, there is a decrease in semantic fluency, which is the generation of different words that have to do with a single topic. This can be easily assayed with automated speech analysis," Corcoran said.

Bedi, meanwhile, is exploring whether these methods can be applied to identify drug and alcohol abuse. Her first efforts, published last year in *Neuropsychopharmacology*, compared the speech patterns of people on MDMA (ecstasy) or methamphetamine with placebo. She found that the semantics of speech changed depending on drug condition, and the analysis program could discriminate the drugs taken by the participants with over 80 percent accuracy.

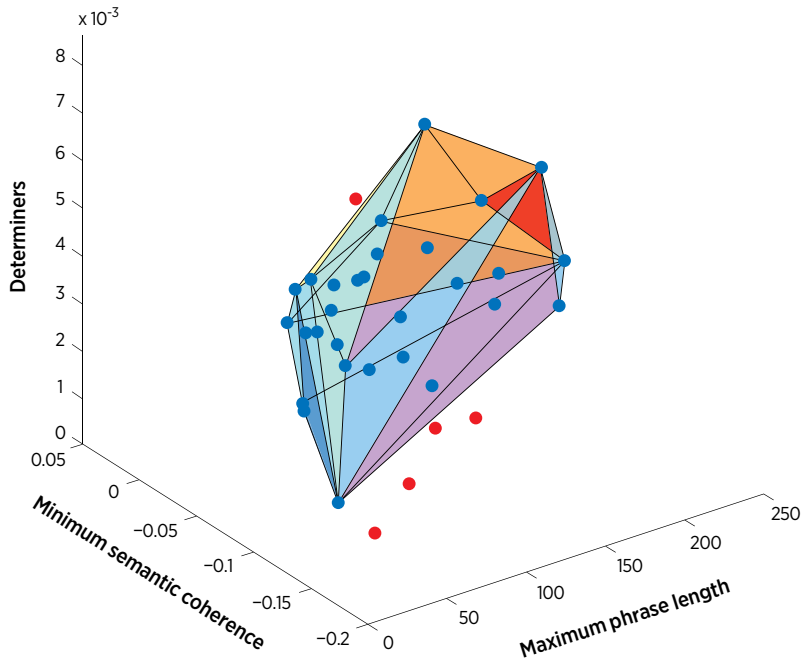
More broadly, both researchers believe that the results from automated speech analysis studies should encourage more collaboration between psychiatrists and computer scientists. Psychiatry has much to gain from advancements in computing power used in other areas of science and industry, they suggested.

The research by Corcoran and Bedi is supported in part by the National Institute of Mental Health, National Institute on Drug Abuse, National Center for Advancing Translational Science, and New York State Office of Mental Hygiene. PN

"Automated Analysis of Free Speech Predicts Psychosis Onset in High-Risk Youths" is posted at http://www.nature.com/articles/npjschz201530. "A Window Into the Intoxicated Mind? Speech as an Index of Psychoactive Drug Effects" is posted at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4138742/.

Speech Processing Can Discriminate Those Who Develop Psychosis

When plotting three semantic variables—the frequency of determiner words, coherence between phrases, and phrase length—high risk individuals who developed psychosis (red) were clear outliers compared to those high risk individuals who did not transition (blue).



Source: Gillinder Bedi, D.Psy., et al., *NPJ Schizophrenia*, August 26, 2015

Residents' Forum

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reforms in the context of patient struggles. We were fortunate to have our state's deputy commissioner, Miriam Delphin-Rittmon, who oversees all mental health and substance abuse services in Connecticut, come and talk about state-level approaches to mental health challenges. After making the connection, she invited us to help with active projects such as working on recovery-model patient and family-driven research collaborations and participating in advocacy issues around opiate addiction.

As a trainee, you deserve the opportunity to learn about advocacy and discover innovative strategies for change. There are many ways to be engaged beyond the ones that are listed. Find what works for you. The process can really help you grow as a clinician and provide new opportunities for personal and professional development. I know it has for me. PN

CLINICAL & RESEARCH NEWS

Early Engagement Is Key To Preventing CBT Dropout

Early improvements in well-being may be more responsible for CBT discontinuation than the therapy not working, so therapists should work with patients to ensure a long-term plan for progress.

BY NICK ZAGORSKI

Although cognitive-behavioral therapy (CBT) has been shown to be effective at treating a range of psychiatric disorders, many patients discontinue therapy prematurely. Withdrawing from therapy early can increase a patient's risk of symptom relapse or, in the case of group therapy, compromise the dynamic of the group.

"Unfortunately, there is no simple answer that explains CBT dropout," psychologist Joshua Swift, Ph.D., head of the Psychotherapy Process and Outcome Research Lab at Idaho State University, told *Psychiatric News*. "There are many factors that stem from both the nature of talk therapy and the nature of the patient's disease."

Swift and colleagues recently completed a meta-analysis on dropout data collected from over 100 CBT clinical studies (including over 20,000 patients) for a range of mental health problems. The analysis was published online in September in the *Journal of Consulting and Clinical Psychology*.

They found that dropout rate was associated with diagnosis, with depression having the highest dropout rate (36 percent) and anxiety disorders the lowest (19 percent). CBT format and the setting in which it was delivered also played a role: e-therapies had higher dropout rates (34 percent) than either individual or group sessions (25 percent), and the number of outpatient dropouts (26 percent) exceeded that of inpatient dropouts (19 percent).

Why are patients ending CBT before the recommended course of treatment is complete? While a natural inclination would be to think it's related to a lack of improvement, some recent research suggests that the opposite is true and that patients who improve the fastest may be at the greatest risk of discontinuation.

A group at the University of Houston (UH), led by Partha Krishnamurthy, M.D., at UH's Institute for Health Care Marketing, monitored 139 people enrolled in a 12-week CBT program for anxiety, assessing each participant's anxiety levels during each session.

"Our approach was to view the patients through a different lens and consider them as customers," Krishnamurthy told *Psychiatric News*. "What are the market forces that are driving their decisions?"

The researchers found that, among patients with mild or moderate anxiety, there was a correlation between reduced symptoms and stopping treatment early; patients who improved quickly were more likely to drop out in the first few sessions.

"So it is the speed of improvement, rather than the level of improvement, that affects dropout rate," said Krishnamurthy.

He and his team are hoping to continue their marketing-style analysis and test whether certain interventions, such as altering payment structures to incentivize patients to stay in therapy longer, might reduce the dropout rate.

Judith Beck, Ph.D., president of the Beck Institute for Cognitive Behavior Therapy and an associate professor of psychology in psychiatry at the University of Pennsylvania, agreed that improvement can be a dropout factor, but believes that the underlying causes that lead a patient to withdraw from treatment are more complex.

Judith Beck, Ph.D., suggests a key element of retention and positive outcomes in CBT is keeping motivation high by having patients look forward in the therapy process.

"In anxiety, particularly, as patients get better and can expose themselves to their fears, their motivation to stay in treatment decreases," she said. "As an example, if someone is deathly afraid of bridges, they may seek treatment. But as they improve, they start to rationalize, 'As long as someone else is in the car with me, I'm OK, so I don't need therapy anymore.'"

To maintain a patient in therapy, Beck said therapists must help their patients to recognize that progress is an important part of the therapy process. According to Beck, studies show that outcomes for CBT are better when therapists regularly ask patients to assess the progress they have made as well as the areas for improvement.

The first couple of CBT sessions are most important, said Swift. "The biggest thing early on for a therapist is to get the client invested in the process and develop that relationship. Don't worry about getting results early on, as the initial progress has more to do with the patient's overall well-being as opposed to a reduction in symptoms."

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Psoriasis Severity Does Not Appear To Increase Depression Risk

Patients with a history of psoriasis showed twice the prevalence of depression as those without, but the severity of the skin problems did not influence the severity of depression.

BY NICK ZAGORSKI

While previous studies have identified a link between psoriasis—a debilitating skin condition that affects about 4 percent of the population—and depression, a study published September 30 in *JAMA Dermatology* suggests that the severity of psoriasis does not influence the risk of depression.

The findings suggest that "[t]he degree of depression may be more tied to patients' perception of how society views their physical appearance, as opposed to how severe the psoriasis is objectively," lead author Roger Ho, M.D., M.P.H., of the Ronald O. Perelman Department of Dermatology at New York University School of Medicine, said. "This should encourage physicians to screen all psoriasis patients for depression, regardless of how mild the skin problems may appear."

Ho, along with his NYU dermatology colleagues Brandon Cohen, B.S., and Kathryn Martires, M.D., examined patient data available as part of the National Health and Nutrition Examination Survey. They compiled information on more than 12,000 patients collected from 2009 to 2012, which included 351 cases of psoriasis and 968 cases of depression.

The prevalence of depression was about twice as high among psoriasis patients (16.5 percent) compared with people without a history of psoriasis (8.9 percent). This twofold risk increase remained the same even when factoring in other potential risk factors, such as cardiovascular problems.

Psoriasis is an autoimmune disorder, and it has been linked to an increased risk of heart attacks and strokes—both of which also increase the risk of depression. Yet the psoriasis patients with a history of heart attacks or strokes had no increased risk of depression compared with psoriasis patients with no such history, suggesting that psoriasis' depression risks are independent of its cardiovascular interactions.

Also, psoriasis patients were divided into two groups: those with limited psoriasis and those with extensive psoriasis; there was no significant difference in depression rates between these groups (18.4 percent for limited psoraiasis and 23.1 percent for extensive).

"Overall this was a very well-designed study that considered a lot of variables, with the exception of testing whether psoriasis medications had any effect on depression," James Bourgeois, O.D., M.D., a clinical professor of psychiatry at the University of California, San Francisco, told *Psychiatric News*. He was not involved in the study.

"It is also nice to see some attention paid to an illness that is chronic but not necessarily life-threatening, and highlighting that such conditions also have a strong psychiatric burden," he continued.

Moving forward, Bourgeois thinks that some prospective studies would be worthwhile, as researchers continue to recognize the bidirectional relationship between mental and physical health problems.

"We see it frequently in chronic pain; the pain leads to depression, which in turn exacerbates the level of pain," Bourgeois said. "It would be interesting to see if depression may likewise influence psoriasis and also test whether actively treating depression might reduce the severity of psoriasis." PN

An abstract of "Psoriasis and the Risk of Depression in the U.S. Population: National Health and Nutrition Examination Survey 2009-2012" is posted at http://archderm.jamanetwork.com/article.aspx?articleid=2443350.

CLINICAL & RESEARCH NEWS

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He added that providers should not worry about trying to do too much too quickly, as one of the other interesting trends he found in his meta-analysis was that dropout rates decreased as the number of CBT sessions increased.

If the patients do end up discontinuing CBT, therapists should not be discouraged, as they are not alone, Swift noted. Swift's meta-analysis suggests an overall 20 percent discontinuation rate for CBT, which is lower than earlier work examining CBT dropout had suggested. PN

"Meta-Analysis of Dropout From Cognitive Behavioral Therapy: Magnitude, Timing, and Moderators" is posted at http://www.researchgate.net/publication/281226304_Meta-Analysis_of_Dropout_From_Cognitive_Behavioral_Therapy_Magnitude_Timing_and_Moderators. An abstract of "Survival Modeling of Discontinuation From Psychotherapy: A Consumer Decision-Making Perspective" is posted at http://onlinelibrary.wiley.com/doi/10.1002/jclp.22122/abstract.

Childhood Adversity Linked to Social Outcomes, Not to Course of Psychosis

Being a victim of child abuse was associated with greater likelihood of being single among patients with psychosis, and childhood adversity was also linked to outcomes related to service use and medication compliance.

BY MARK MORAN

There does not appear to be any significant association between a history of childhood adversity and the course of psychotic illness during the first year after presentation to mental health services, according to a report published online in *Schizophrenia Bulletin*.

However, childhood adversity was associated with several outcomes that the authors of the study suggest could impact service use and social functioning among psychosis patients.

Researchers at King's College London investigated associations between childhood adversity and one-year outcomes in 285 first-presentation psychosis patients. Exposure to childhood adversity prior to 17 years of age was assessed using the Childhood Experience of Care and Abuse Questionnaire. Data on illness course, symptom remission, length of psychiatric hospitalization, compliance with medication, employment, and relationship status were extracted from clinical records for the year following first contact with mental health services for psychosis.

The sample was drawn from patients who participated in the Genetics and Psychosis Biomedical Research Centre (GAP-BRC) study from the Lambeth, Southwark, Lewisham, and Croydon adult inpatient and outpatient units of the South London and Maudsley Mental Health NHS Foundation Trust.

A total of 71 percent of patients reported exposure to at least one type of childhood adversity (physical abuse, sexual abuse, parental separation, parental death, disrupted family arrangements, or being taken into care). Despite the high prevalence of childhood adversity in the sample of patients, the researchers found no evidence that a history of adversity impacted either remission from psychotic symptoms or global functioning scores at one-year follow-up. There was no robust evidence of a dose-response effect for exposure to multiple adverse experiences on clinical course of psychosis, symptomatic remission, or global clinical functioning over one-year follow-up.

However, psychosis patients who reported a history of physical abuse were almost three times more likely to be single at follow-up compared with patients who did not report this type of adversity. Moreover, there was evidence of an association between parental separation in childhood and a longer admission to a psychiatric ward during one-year follow-up, with cases reporting such adversity being approximately twice as likely to have longer hospital stays compared with those without such a history. Psychosis patients reporting a history of parental separation were also more likely to be noncompliant with medications one year after first contact with psychiatric services compared with those who did not have this experience.

The authors noted that previous studies have shown that patients with psychosis who reported a history of childhood abuse are more likely to avoid intimacy.

"Given the high prevalence of childhood adversities reported by first-presentation psychosis cases in this sample, routine assessment of adversity history and psychotherapies focused on adverse childhood experiences should be considered by services providing treatment to psychosis patients," the researchers wrote. PN

"Impact of Different Childhood Adversities on 1-Year Outcomes of Psychotic Disorder in the Genetics and Psychosis Study" is posted at http://schizophreniabulletin.oxfordjournals.org/content/early/2015/09/14/schbul.sbv131.full.

Refugees

continued from page 1

over 500 African refugees and asylees and their families in New York City, offering them direct services and referrals to legal, mental health, and social services.

According to data presented by Akinsulure-Smith during her talk, the United Nations estimates the number of forced migrants grew from 37.5 million in 2005 to nearly 60 million in 2014—numbers that fail to capture the floodtide of refugees that have since left Syria. Among refugees coming to the United States, some 1.8 million are asylum seekers, according to Akinsulure-Smith.

"Asylum" is a legal term referring to the protected status granted by a nation to people who have left their country due to fears of persecution on account of race, religion, nationality, political belief, or membership of a particular social class. While asylum in the United States confers on people a range of benefits, the legal process for being granted asylum can be lengthy, rigorous, and intimidating; individuals must be able to prove that the persecution from which they are fleeing actually occurred and their fear of persecution if returned is legitimate.

To offer support to refugees and asylum seekers, the Bellevue/NYU program takes an integrated, team-oriented approach toward each individual referred to their care, Akinsulure-Smith said. "Our focus is to rebuild and heal from a holistic interdisciplinary way that focuses on individuals' resilience, drawing on an integrated model of care to help people use the resources they have to rebuild their lives," she said.

David Hathcox

Adeyinka M. Akinsulure-Smith, Ph.D., keynote speaker at this year's IPS: The Mental Health Services Conference, said the numbers of individuals forced to migrate from their country of origin because of war or fear of persecution has grown dramatically in recent years.

During the talk, Akinsulure-Smith described "Ms. X," a 26-year-old refugee from Albania who had fled the country with her husband and small child after repeated threats and a sexual assault related to her family's political affiliations. The attorney for her asylum petition had repeatedly tried to talk to her about her experiences, but Ms. X had broken down in tears trying to recount her traumatic experiences; that was when she was sent to Bellevue.

"We do a lot of grounding exercises and recovery work," Akinsulure-Smith said. "She was also referred for psychiatric services; she had a baby and was nursing at the time and wasn't sure she wanted to be on medication. The family had little or no money—her husband was working under the table—so we provided her Metro Cards to help her get back and forth. Our legal team worked with her attorney to help him understand the limits of what could be expected in questioning her in preparation for the asylum hearing."

Ms. X was eventually granted asylum in 2007, after a protracted legal proceeding. According to Akinsulure-Smith, her case is typical of the burdens many refugees are bearing: traumatic memories, shame and stigma, fear and uncertainty about the future, and the anguish of being a minority in a strange country.

After reflecting on the angry political rhetoric being used by some presidential candidates and others with regard to undocumented people and Syrian refugees who will be potentially entering the United States, Akinsulure-Smith closed her lecture with a brief slide show of familiar faces, all of whom were refugees: Albert Einstein, Madeleine Albright, Victor Hugo, Sigmund Freud, Ayan Hirsi Ali, Marlena Dietrich, Henry Kisssinger, the Dalai Lama, and Elie Wiesel, among others.

She concluded: "No one chooses to be a refugee." PN

Addition of Aripiprazole May Reduce Depressive Symptoms in Older Adults

Previous studies show that 55 to 81 percent of older adults with major depressive disorder fail to remit with SSRIs and SNRIs.

BY VABREN WATTS

A recently published study in *The Lancet* suggests that adding a low dose of the antipsychotic aripiprazole to an antidepressant regimen in older adults with treatment-resistant depression may help them achieve and sustain remission.

The multisite study coordinated by Charles Reynolds III, M.D., an endowed professor of geriatric psychiatry at the University of Pittsburgh School of Medicine, tested the effectiveness and safety of aripiprazole as an adjunctive therapy to the antidepressant venlafaxine in 468 adults aged 60 to 75.

"About half of older adults with major depression show incomplete response to antidepressant pharmacotherapy, in particular to selective serotonin reuptake inhibitors [SSRIs] or serotonin-norepinephrine reuptake inhibitors [SNRIs], with or without psychotherapy," Reynolds told *Psychiatric News*. "Yet there are few data from controlled clinical trials [involving this population and second-line pharmacotherapy] to guide decision making by patients and clinicians."

Prior research in younger patients—averaging 30 years of age—with major depressive disorder showed that adding aripiprazole to an antidepressant regimen helped relieve symptoms of depression when an antidepressant alone was not effective. However, data concerning a combination of aripiprazole and antidepressants in older adults were lacking.

"It's important to remember that older adults may not respond to medications in the same way as younger adults," Eric Lenze, M.D., a professor of psychiatry at Washington University in St. Louis and lead author of the *Lancet* paper, said in a press release. "There are age-related changes in the brain and body that suggest certain treatments may work differently, in terms of benefits and side effects, in older adults. Even when a strategy works for patients in their 30s, it needs to be tested in patients in their 70s before it can be considered effective in older patients."

This was of particular concern with aripiprazole after studies evaluating the medication in younger adults with major depressive disorder suggested it increased risk of neurological and cardiometabolic adverse effects.

To test the effectiveness and safety of aripiprazole in older patients with major depressive disorder and no history of cognitive decline, each study participant received an extended-release formulation of venlafaxine—ranging from 150 mg a day to 300 mg a day—for 12 weeks. Of the 181 patients whose symptoms did not remit after 12 weeks of treatment, 91 were randomly assigned to receive venlafaxine for another 12 weeks with the addition of 10 mg to 15 mg of aripiprazole and 90 received placebo in addition to venlafaxine each day. Remission was defined as a Montgomery Asberg Depression Rating Scale score of 10 or less (and at least 2 points below the score at the start of the randomized phase) at both of the final two consecutive visits. The researchers chose venlafaxine as a lead-in antidepressant, in part, to avoid adverse drug interactions that have been known to occur between aripiprazole and some widely prescribed antidepressants (such as paroxetine and duloxetine).

University of Pittsburgh School of Medicine

Charles Reynolds III, M.D., believes that with appropriate medical monitoring, aripiprazole may serve as an effective and safe adjunctive therapy to some antidepressant therapies in older patients with major depressive disorder.

The results showed that combined venlafaxine and aripiprazole therapy led to remission of depressive symptoms in 44 percent of treatment-resistant patients compared with 29 percent of participants who received venlafaxine and placebo.

Akathisia and Parkinsonism were the most common adverse events reported by participants in the aripiprazole adjunctive therapy group, occurring respectively in 26 percent and 17 percent of those patients. The groups showed no differences in changes in percentage of body fat, total cholesterol, HDL, LDL, triglycerides, glucose, or insulin concentrations.

"This study is a major advance in support of evidence-based care for older adults with depression," said Reynolds. "By publishing our findings, … we hope particularly to reach primary care physicians, who provide most of the treatment for depressed older adults. The excellent safety and tolerability profile of aripiprazole as well as its efficacy should support its use in primary care, with appropriate medical monitoring."

Reynolds told *Psychiatric News* that although the study provided evidence for aripiprazole to be safe and effective in adults aged 60 to 75, further research on augmentation strategies in adults above the age of 75 is needed.

The study was funded by the National Institute of Mental Health. PN

AOT

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allocated for medication, drug monitoring, prison and jail discharge managers, and other services for people in the AOT program.

New York's AOT program also created an opportunity for Swartz and colleagues to evaluate how a comprehensively implemented and well-funded program of AOT performed. Using an observational model with statistical controls, Swartz and colleagues analyzed data from Medicaid claims, case manager reports, and AOT to assess the program's effectiveness (*Psychiatric News*, August 2, 2013).

Studying the New York state program was not easy, he said. For one thing, the people who were selected for AOT were a heterogeneous group and thus hard to match with controls. Additionally, a large number of cases came from New York City, creating potential geographic and cultural biases.

Swartz and colleagues also found that 80 percent of the people in AOT started in the program as they were released from psychiatric hospitals. Essentially, the program served as a stepdown from hospitalization for many—a form of conditional release and possibly a way for patients to get out of the hospital, Swartz explained.

Nevertheless, the increased access to services in the New York state program did improve a range of outcomes for enrollees, said Swartz. "We find consistent evidence that during AOT there is a substantial reduction in the number of psychiatric hospitalizations and in days in the hospital if a person is hospitalized," Swartz and colleagues wrote in a report evaluating the New York program. "We also find that AOT recipients are far more likely to consistently receive psychotropic medications appropriate to their psychiatric conditions."

In addition to its effects on patients, the program also influenced service provider behavior. The state monitored clinicians and phoned them if they were not meeting the prescribed standards of care, thus injecting an additional layer of accountability into the system.

"The question is not *if* AOT is effective, but *can* it be effective?" said Swartz. "It is a complex intervention that must be carried out in the community and is not easy to evaluate in a randomized, controlled trial. It can be effective if implemented well, provided with the necessary services, and given sufficient time to work." PN

"A Randomized Controlled Trial of Outpatient Commitment in North Carolina" is posted at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.52.3.325. "New York State Assisted Outpatient Treatment Program Evaluation" is posted at https://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/#sum.

SSRIs for Depression in Elderly: Are They Associated With Falls?

Treatment of depression in frail older adults is complex and good clinical care requires that a health care provider consider many factors associated with the risk for falls.

BY MARK MORAN

Is the treatment of major depression in the elderly with selective serotonin reuptake inhibitors (SSRIs) associated with falls and injuries from falls?

A recent review of literature suggests that there is insufficient evidence of such an association and that—despite current recommendations from the American Geriatric Society warning physicians from prescribing SSRIs to the elderly—physicians should not be deterred from prescribing the medications to patients experiencing late-life depression.

"The field of geriatric psychiatry has for a long time been calling for more inclusion of older adults in RCTs [randomized, controlled trials] of antidepressant drugs," Yeates Conwell, M.D., director of the geriatric psychiatry program and director of the University of Rochester Medical Center Office for Aging Research and Health Services, told *Psychiatric News*. "It is a problem that one cannot rely on existing clinical trial data to answer this question—and many other unanswered questions regarding treatment of depression in later life—because so many trials [have] excluded people over age 65 or with the conditions that are comorbid with depression in later life and that put the patient at increased risk for falls."

In a paper appearing in the October issue of the *American Journal of Geriatric Psychiatry*, Marie Ann Gebara, M.D., of the Department of Psychiatry at the University of Pittsburgh and colleagues describe how they systematically searched PubMed/MEDLINE, EMBASE, the Cochrane Library, PsycInfo, and ClinicalTrials.gov for studies that explored the associations between SSRIs and falls in the elderly.

Among the 26 studies they found, only one was a randomized, controlled trial. The rest were observational studies that offered no evidence of a temporal association between use of medication and falls—that is, whether the use of SSRIs preceded falls or whether falls were experienced by individuals with untreated major depression who were later treated with SSRIs.

Yeates Conwell, M.D.

Yeates Conwell, M.D., director of the University of Rochester Medical Center Office for Aging Research and Health Services, says randomized, controlled trials of treatments for depression need to include older adults.

The one randomized, controlled trial that Gebara and colleagues did identify suggested that patients who took sertraline were no more likely to fall than those who took placebo, but the fact the study was "underpowered"—having too few participants—made it difficult to rule out the possibility that such a relationship might exist.

Of the nine observational studies that found a positive association between SSRI use and falls, the researchers noted that those who took SSRIs also had other risk factors that may have contributed to increased frailty, including being among the oldest participants in the study and/or having multiple comorbidities, higher numbers of medications, and baseline higher rates of falls.

"We conclude from our systematic review that there is insufficient evidence to support clinical guidelines or policy changes recommending the avoidance of SSRI use in older adults based on fall risk," Gebara and colleagues wrote. "Given the available evidence, we do not think that clinicians should be deterred from using SSRIs in late-life depression."

Yet their findings fly in the face of the 2012 American Geriatrics Society Updated "Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." For falls and a history of falls among elderly people, the Beers criteria lists SSRIs as potentially inappropriate (along with anticonvulsants, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, and tricyclic antidepressants), stating that "these drugs can cause fainting and falls, and make it hard

see ***SSRIs*** *on page 37*

Timing Is Everything in Diagnosis At Overlap of ADHD and ASD

When symptoms of attention-deficit/hyperactivity disorder intersect with those of autism spectrum disorder, a crucial delay in care may result.

BY AARON LEVIN

A percentage of children ultimately diagnosed with autism spectrum disorder (ASD) were previously diagnosed with attention-deficit/hyperactivity disorder (ADHD), an error that may delay the correct diagnosis and appropriate treatment, according to a study by Amir Miodovnik, M.D., M.P.H., and colleagues.

Symptoms like inattention, hyperactivity, and impulsivity can appear in children with either disorder. One Canadian study found that ASD was diagnosed 1.29 years after a comorbid ADHD diagnosis but did not address the question of age, said Miodovnik, a developmental pediatrician at Boston Children's Hospital.

The American Academy of Pediatrics recommends that screening for ASD occur between 18 and 24 months, but diagnosis often comes much later than that, they wrote in the October *Pediatrics*. If ADHD is diagnosed before ASD, clinicians might be inclined to stick with the former because its symptoms appear dominant. ASD would then go untreated for several years until the correct diagnosis was made.

The researchers looked at a sample of 1,496 children with a current diagnosis of ADHD, drawn from the 2011-2012 National Survey of Children's Health. Of those, 705 also had been diagnosed with ASD, including 313 who were diagnosed with ADHD before ASD. On average, there was about a three-year delay in the age of diagnosis for this latter group, compared with children whose ADHD was diagnosed at the same time as or after their ASD, or those with ASD only.

The ADHD-before-ASD group exhibited fewer speech problems than the other two groups, a factor that may have contributed to delays in ASD diagnosis.

Also, the children with ADHD before ASD were 16.7 times more likely to be diagnosed with ASD after their sixth birthday than the ASD-only cohort and 29.5 times more likely than the ADHD same/after group.

Part of the problem may be that pediatricians usually see their patients for short clinic visits, during which the typical social and behavioral deficits that characterize autism may not appear. Any problematic behavior may be ascribed to a more familiar condition.

"[G]eneral practitioners may be inclined to attribute maladaptive behaviors to ADHD, the most common neurobehavioral disorder of childhood," wrote Miodovnik. "Our study supports the hypothesis that receiving a diagnosis of ADHD before ASD may delay the diagnosis of ASD, and that this delay persists across age and severity of the ASD."

The longer the delay before an autism diagnosis, the worse patient outcomes are likely to be, they concluded.

More work is needed to define how and when the symptoms of ADHD and ASD overlap and how that knowledge can be best applied to screening and diagnosis.

"For now, clinicians should consider ASD when evaluating young children presenting with ADHD symptoms," they said. PN

An abstract of "Timing of the Diagnosis of Attention-Deficit/Hyperactivity Disorder and Autism Spectrum Disorder" is posted at http://pediatrics.aappublications.org/content/early/2015/09/08/peds.2015-1502.abstract.

LETTERS TO THE EDITOR

Asylums: Back to the Future?

Reading the column by APA President Renée Binder, M.D., titled "Return to Asylums? NEVER!" in the August 21 issue, I was dismayed by the lack of definition of "asylum." Instead, we should be debating how people with serious and persistent mental illness ought to be cared for, given our inhumane, costly, and morally irresponsible status quo. By creating alternatives, we will begin to shift the expectations of our patients and the public debate about the scope of such possibility.

As an early career psychiatrist working in a public hospital with involuntary severely persistently mentally ill (SPMI) patients and consulting for medically underserved populations, I do not know firsthand the abuses of the state psychiatric hospitals, though they have a history of brutality, victimization, and other excesses with little emphasis on recovery. Many of my hospitalized SPMI patients have told me they prefer jail to the involuntary treatment they receive in the hospital, which is indeed a damning indictment.

Letters Invited

Readers are invited to submit letters up to 500 words long for possible publication. *Psychiatric News* reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be emailed to cbrown@psych.org.

However, this need not be the case. Asylum could be defined by open, voluntary, accessible, recovery-oriented residential treatment for many of those now cycling through hospitals and jails and prisons. Such models existed at the intersection of deinstitutionalization and the nascent community treatment that was meant to replace it in the 1960s and are contemporary in the few remaining Soteria model houses in the United States and Northern Europe. It is in large part because of the habituation to violent and involuntary treatment that today's chronically institutionalized and incarcerated patients are disengaged and hostile to care.

It is only through our own vision and leadership that a new generation of mentally ill patients can have different experiences and expectations of the care offered to them and that alternative models of community care and asylum, rather than involuntary detention (whether hospital or prison), can become viable. Community care will provide part of the solution, but it cannot serve the needs of our most vulnerable patients.

TAYLOR MAC BLACK, M.D.
Seattle, Wash.

Response from APA President Renée Binder, M.D.:

Thank you for taking the time to share your comments on my column. I define "asylum" as an institution that provides long-term treatment and housing to people with mental illness. As we all know, asylums in this country were built to separate people with mental illness from the rest of the community and have a long history of providing inadequate or even harmful care, severely limited by a lack of understanding of the etiology of mental illness as well as resources. During the era of asylums, people with mental illness were locked away and warehoused; today, they are warehoused in jails and prisons—a situation that I am addressing through initiatives this year as APA president. However, I don't think we are far apart in our thinking, because I do believe that this country would benefit from new models of residential treatment that respect autonomy. We also need other models of care and alternatives that include diversion programs, collaborative courts, and increased community treatment with wraparound services, housing, substance abuse programs, and early intervention and prevention services. I appreciate your input and your suggestions. PN

From the President

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in the clinic. Laura's parents became spokespersons for GVRO legislation as well as for Laura's Law, the assisted outpatient treatment law in California that was named after their daughter. I had the opportunity to speak with Mr. and Mrs. Wilcox when we were giving input about a proposed GVRO statute. They told me that Laura's Law would not have saved their daughter's life but a GVRO might have. Law enforcement had gone to the home of the perpetrator to evaluate him for an involuntary hold on the basis of dangerousness. He did not meet the criteria for a psychiatric hold, and the police did not have the authority to remove guns from him.

The process for a GVRO in California is that a law enforcement officer or family member can request that a civil court issue a GVRO through a written application and hearing in front of a judge. If the judge agrees, a GVRO is in effect for 21 days. Guns can be removed from individuals for the duration of the order, and they will be temporarily prohibited from purchasing a firearm. Before the GVRO expires, a subsequent hearing will be held in which the person identified as dangerous will have the opportunity to request restoration of gun rights. If the GVRO is upheld, the order prohibiting the purchase and possession of firearms will be extended for up to one year. GVROs are based on the long-standing infrastructure and procedures of emergency protective orders to protect victims of domestic violence. Both include due process protections.

In addition to advocating for GVROs, there are other actions that we can take to decrease gun violence. We should advocate for strategies to increase responsible gun ownership including background checks and waiting periods before gun purchases, closing gun-show and Internet sales loopholes, product-safety regulations, safe-storage requirements, and gun-free college campuses and hospitals. We also should be able to talk to and educate our patients about the dangers of having guns in the home (especially in the presence of children, adolescents, people with dementia, people who abuse children or partners, people with mental illnesses including substance use disorders, and others who are at risk of harming themselves or other persons). Currently, a number of states prevent physicians from asking questions about guns, and such prohibitions need to be ended.

GVROs will not prevent gun violence. However, they may serve as a useful tool that will temporarily keep guns out of the hands of high-risk individuals during periods when they are a danger to themselves or others. PN

SSRIs

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to coordinate movements."

So what is good advice for clinicians treating major depression in older adults? In their paper, Gebara and colleagues offered three recommendations:

- In cases of mild depression or subclinical depressive symptoms, cognitive-behavioral therapy and problem-solving therapy are some of the evidence-based psychosocial approaches for treatment in older adults that may be considered as first-line treatment. In cases of at least moderately severe depression, however, antidepressants have adequate evidence for efficacy.
- Clinicians and policymakers should be mindful of the hazard of shifting prescribing toward agents with less evidence for efficacy in older adults and less information regarding potential risk, as is the case with serotonin-norepinephrine reuptake inhibitors and the conflicting data with respect to falls.
- The literature does not address the question of falls and SSRIs given the limitations of observational studies; thus, there is a need for large, long-term, and appropriately powered RCTs similar to those seen in other fields of medicine; the high public health importance of this question justifies their cost.

Davangere Devanand, M.D., direc-

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tor of geriatric psychiatry at Columbia University Medical Center, applauded the methodological rigor of the analysis by Gebara and colleagues and broadly agreed with their recommendations. "The authors did an exceptionally careful analysis," he said. "There are really no good prospective, randomized, controlled trials that would give us much better evidence than we have now."

Devanand said that though the Beers Criteria represent consensus opinion based on the available evidence, however weak or strong, most clinicians will heed the Food and Drug Administration, which has not indicated that SSRIs should not be prescribed because of the risk of falls.

He added that a host of comorbid medical conditions, as well as dementia, can contribute to falls, and these need to be factored into the calculus of risk associated with medication. Additionally, the risk of falls can be affected by the absence of health aides and other social supports for an elderly person living alone.

"My advice is to avoid medication to the extent possible, but when there is clear evidence of major depression, clinicians who prescribe SSRIs should 'start low and go slow' in increasing the dose," he said.

Conwell concurred. "Treatment of depression in frail older adults is complex and good clinical care requires highly individualized judgments in any event," he said. "How at risk for falls is the older person due to all other causes? What alternatives are there to an SSRI? How

acceptable are they to the patient? How able is the person to take added precautions against falls while the time passes necessary for the antidepressant response to kick in? These are not black and white decisions. But [Gebara and colleagues'] point is an important one—drugs do have a place and previous reports of falls' risk should not preclude their use, especially since the evidence is weak."

An editorial accompanying the Gebara analysis in the *Journal of Geriatric Psychiatry* by Carl Salzman, M.D., of the Department of Psychiatry at Massachusetts Mental Health Center, concluded, "Given the destructive nature of late-life depression on duration and quality of life as well as physical health, withholding treatment of a true late-life depression for fear of antidepressant side effects is probably more harmful both acutely and over time than antidepressant side effects, especially when doses are low and carefully prescribed to avoid drug interactions." PN

"Cause or Effect? Selective Serotonin Reuptake Inhibitors and Falls in Older Adults: A Systematic Review" is posted at http://www.ajgponline.org/article/S1064-7481(14)00345-5/abstract. "Late-Life Depression and Antidepressants," by Carl Salzman, M.D., is posted at http://www.ajgponline.org/article/S1064-7481(15)00135-9/abstract. The 2012 American Geriatric Society Updated Beers Criteria are posted at http://www.americangeriatrics.org/files/documents/beers/BeersCriteriaPublicTranslation.pdf.

Grant

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the goals of its so-called "Triple Aim": improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations. Of the 39 health care organizations, there are 29 health care networks, and just 10 "Support and Alignment Networks" (SAN), of which APA is one.

According to the CMS website for the initiative, the SANs will provide a system for workforce development utilizing national and regional professional associations and public-private partnerships that are currently working in practice transformation.

"Research shows that integrating behavioral health care into primary care settings improves patient outcomes and reduces health care spending," said APA President Renée Binder, M.D. "This grant will allow APA to expand the number of psychiatrists who are trained to provide evidence-based integrated mental health care to people throughout the United States."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., said APA members who participate in the training will be part of the transformation of American health care. "This award is an important recognition of the vital role of psychiatry in integrated care that treats mind, brain, and body," Levin said. "APA members who avail themselves of training with our colleagues at the AIMS Center will develop skills allowing them to extend their psychiatric expertise to larger populations of primary care patients."

In the grant proposal to CMS, APA stated the following: "We propose to train 3,500 psychiatrists during the four years of the program. Psychiatrists trained in the earlier years will participate in a learning network and serve as trainers for later cohorts. We assume that trained psychiatrists will spend at least 20 percent of their practice time providing evidence-based integrated care consultation. During this time, each of the consulting psychiatrists will support as many as 50 primary care providers and consult on the care of about 400 patients a year.

"When fully implemented, psychiatrists will be able to support approximately 150,000 primary care providers and consult on the care of well over 1 million patients each year. Research shows that as much as $1,000 per patient in health care costs can be avoided each year when primary care patients receive well-implemented, evidence-based integrated mental health care, resulting in potential health care savings in excess of $1 billion."

Ratzliff told *Psychiatric News* that training, which is free, will be accessed through two main avenues: seven online training modules available through APA and in-person training at APA annual meetings and district branch meetings.

The grant period is four years. Ratzliff said psychiatrists who complete the training program will be recognized by APA for their commitment to learning and implementing the skills of integrated care.

Levin said APA is committed to educating members about new modalities for delivering care, as well as supporting them in their current practices. "Receiving this grant compliments the other policy objectives APA is looking to achieve such as payment for these new deliveries, increased quality measures for reimbursement, and ensuring mental health parity for patients," he said.

APA members interested in receiving training in the collaborative care model should email san@psych.org. PN

Information about the Transforming Clinical Practice Initiative is posted at http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/.