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AMERICAN PSYCHIATRIC ASSOCIATION

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David Hathcox

Thomas Frieden, M.D., M.P.H., tells Annual Meeting attendees that understanding how societal influences impact behavior and taking steps to apply that knowledge can lead to a reduction in the incidence of mental disorders and other medical conditions.

CDC Director Calls for Collaboration Of Mental Health and Public Health

BY MARK MORAN

"With a reciprocal revolution bringing together psychiatry and public health, we can affect deep societal change," said Thomas Frieden, M.D., M.P.H., director of the Centers for Disease Control and Prevention, as he presented the William C. Menninger Memorial Convocation Lecture at APA's 2016 Annual Meeting in Atlanta.

Frieden said depression and severe mental illness, alcoholism, opioid addiction, suicide, HIV/AIDS, and a host of other conditions are amenable to population-based solutions that look at how societal influences affect individual behavior and individual health.

"Broad and deep change is possible at the individual and societal levels when psychiatry and public health work together," Frieden said.

Frieden was appointed CDC director by President Barack Obama in 2009. As CDC director, he led the nation's response to the 2009 H1N1 influenza virus pandemic, and he launched the first-ever national paid anti-tobacco media campaign, "Tips From Former Smokers," projected to help more than 100,000 smokers quit.

Prior to coming to the CDC, he was commissioner of the New York City Health Department from 2002 to 2009, where he directed the city's anti-tobacco effort that led to the reduction in the number of smokers by 350,000 and cut teen smoking in half. Also, New York City became the first place in the United States to eliminate trans fats from restaurants, resulting in more than 50 national chains taking that step, and to require certain restaurants to post calorie information prominently.

From 1992 to 1996, as a CDC assignee, he led New York City's program that rapidly controlled tuberculosis, including reducing the number of cases of multidrug-resistant tuberculosis by 80 percent. While working in India for five years as a CDC assignee to the World Health Organization, he assisted with national tuberculosis control efforts.

In his Convocation lecture, Frieden said the opioid abuse epidemic has required physicians to rethink how they manage and treat chronic pain, since many heroin addicts today began their addiction

*see **CDC** on page 11*

Oquendo Urges Senate Passage Of Mental Health Reform Bill

The bill will benefit patients and their families for generations to come, say senators and psychiatrists.

BY AARON LEVIN

APA President Maria A. Oquendo, M.D., and other mental health experts went to Capitol Hill in late May to generate support for passage of the bipartisan Mental Health Reform Act of 2016 (S 2680).

"As a nation, we have failed to meet the needs of Americans with mental illness," Oquendo told senators and advocates gathered for the event in the Hart Senate Office Building. "We have a fragmented delivery and reimbursement system, we deal with workforce shortages and obsolete regulations, and we face the enduring stigma surrounding mental illness. We must do better, and we can do better." (See page 7.)

The Mental Health Reform Act would improve access to care by increasing the number of providers, disseminating the best scientific research, integrating physical and mental health care, and bolstering coordination among federal mental health agencies, said bill coauthor Sen. Bill Cassidy, M.D. (R-La.).

His colleague and coauthor from across the aisle, Sen. Chris Murphy (D-Conn.), described the step-by-step process of gathering support among fellow senators, including eight Democratic and eight Republican cosponsors, to move the bill closer to passage.

*see **Reform** on page 38*

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Five Key Steps Need to Be Taken Now to Improve MH Access

BY MARIA A. OQUENDO, M.D.

It was one of those D.C. spring mornings, jam-packed with sunshine and steamy. We sped past the Capitol dome encased in scaffolding, toward the Senate Hart Building. In the cab, we discussed the Mental Health Reform Act (MHRA) of 2016 (S 2680) and how many more iterations we might yet see. We were headed to the Senate Summit on Mental Health, organized by the bill's sponsors, Sens. Bill Cassidy and Chris Murphy. As APA president, I was to give a provider's viewpoint about the bipartisan legislation, sponsored also by Sens. Lamar Alexander and Patty Murray. I wanted to be supportive yet forceful about what was needed, and the senators had given me excellent material with which to work (see page 1).

Entering the room, I saw representatives of many different organizations: the National Alliance for the Mentally Ill, foundations focused on mental health, National Institutes of Health, and, of course, APA. About 200 people filled the room, listening attentively. Called to the podium by Sen. Cassidy, I thanked him and Sen. Murphy for their excellent work and talked about five key issues that require attention to resolve the mental health crisis in this country.

I began by talking about the wide prevalence of mental illness in this country, with over 68 million people experiencing a psychiatric (including substance use) disorder in the past year. That number represents more than 21 percent of the total U.S. population, and lifetime rates are much higher, with estimates approaching 50 percent. More striking, the latest data, from 2013, show that more than 41,000 people died by suicide, 20 percent more than by motor vehicle accidents—this despite promising gains in medical research and public awareness. As a nation, we continue to fail people with mental illness every day.

There are several contributors to this failure. Fragmented delivery and reimbursement systems, limited funding for research, a lack of coordination in both Washington, D.C., and state capitals, obsolete regulations, workforce shortages, and the enduring stigma surrounding mental illness all pose barriers to appropriate, effective treatment. Of course, we can do better, but we need to act on several fronts.

First, federal mental health initiatives must be overseen by a psychiatrist. Because psychiatric/substance use disorders are fundamentally brain disorders, leadership with biological training is key. This medical leadership must ensure greater coordination between federal departments and agencies that oversee mental health initiatives, spanning research, mental health care delivery, and workforce training.

Second, we must increase support for the National Institute of Mental Health, National Institute on Drug Abuse, and National Institute on Alcohol Abuse and Alcoholism. The only way to gain traction in the prevention and treatment of psychiatric/substance use disorders is through research into their neurobiological causes and identification and testing of treatments that work. As precision medicine marches forward, so must psychiatric science, such that we might identify interventions tailored to the needs of the individual patient.

Third, we must train more mental health professionals, especially psychiatrists. The Organisation for Economic Cooperation and Development has determined that, in terms of psychiatrist availability, the United States is below the mean for developed countries, at 14.5/100,000, and shrinking. Some counties have only 3.5 psychia-

see ***From the President*** *on page 16*


12


28


29

IN THIS ISSUE

Departments

PROFESSIONAL NEWS

Marine Corps Commandant Seeks Cooperation From U.S. Psychiatry

Civilian or military, American psychiatrists can help ease the transition home for U.S. Marines and fellow service members.

BY AARON LEVIN

Gen. Robert Neller, the commandant of the U.S. Marine Corps, came to APA's 2016 Annual Meeting in Atlanta with the same request he makes of all his Marines—to recognize when you need help and ask for it.

The Marine Corps trains its recruits to be tough, resilient, and adaptable in overcoming obstacles, and, most of all, to be members of a team, he told a large audience. When something happens, that sense of cohesion usually sustains them. But not always. Sometimes that culture works against them.

Talking about their internal stresses or anxieties doesn't come easy for Marines, but it's essential. Neller was especially concerned about suicides among current and former members of the Marine Corps. Surviving battle may be a risk factor, but the majority of Marines who die by suicide never saw combat, he said.

Robert Ursano, M.D., is a principal investigator on the Army Study to Assess Risk and Resilience in Servicemembers (STARRS) and spoke in the same session with Neller.

"Historically, military suicide rates were half that of the nation as a whole, but in the last 10 years, they rose above civilian levels," noted Ursano, a professor and chair of psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Md.

"We know for sure that being deployed is not the full answer," he said. "However, half the soldiers coming into the Army today have had a traumatic brain injury [TBI]. That is not surprising considering the high prevalence of TBI in the nation."

Superficially, there may seem to be a continuum from suicide ideation to planning to attempts to completed suicide, but these may be different disorders, he suggested.

"Most people with suicidal ideation have depression, but severity of depression does not predict suicide," he said. "It does predict the presence of an anxiety disorder. So when trying to predict suicide, look at anxiety."

How can civilian psychiatrists help?

"Ask all your patients if they have served in the military," said Ursano. "Screen for any life-threatening events. There's a 12-year gap between the onset of PTSD and diagnosis. The military is pushing that to months, and civilians can do the same."

Too often, outside clinicians don't ask their patients about prior military service, agreed Harold Kudler, M.D., chief consultant for mental health at the VA.

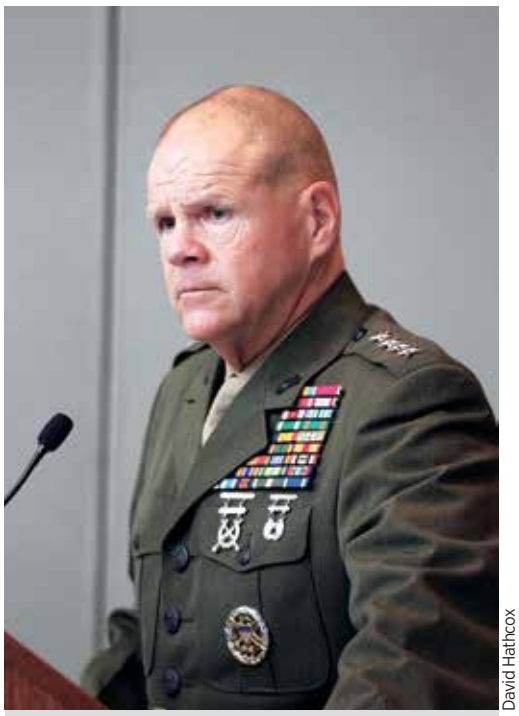
"If they are not asked, vets think you don't care," he said. "If you don't ask, you won't know what you need to know to care for them."

There are 22 million U.S. veterans, but only 9 million receive care in the VA health system, said Kudler. "The vast majority of vets don't use the VA."

Men and women with prior military service don't appear to be different from other patients. "These people aren't visible, but they deserve to be visible."

Kudler offered additional suggestions for practitioners who are unfamiliar with treating former or current service members.

"The best way to show that you care is to listen and ask questions when you don't understand something," he said. "Ask when they served—it makes a difference—and what their military occupational specialty was," he said. "Ask if their military experience affected their physical or mental health, their family life, or their work."



David Hathcox

The commandant of the U.S. Marine Corps, Gen. Robert Neller, tells Annual Meeting attendees about the mental health needs of his Marines, especially after leaving active duty.

Beyond those suggestions, the VA can offer concrete assistance to civilian clinicians, said Kudler. VA facilities can provide technical services like brain scans, free PTSD consultations, a pocket card to guide the conversation, and a community provider toolkit.

Like Kudler, he urged psychiatrists and other mental health clinicians to help out wherever they live. More than 30,000 Marines complete their service and return home each year. Most will receive their health care in their home communities, so all practitioners should routinely ask their patients if they have ever served in the military. That can open a door to a critical part of a patient's life, one that doesn't end on the day the person stepped out of uniform, said Neller.

"We as leaders say to anyone who has served in the military: Your team needs you, your family needs you, your country needs you," he said. "So if you're struggling, tell someone, and that someone is obligated to get you help. The only way to solve anything is to talk about it.

"We need your help," Neller told APA members. "Come and look at our programs. Help us build greater resiliency. Learn about our culture."

"Someone once said that the military is a part of and apart from our nation," concluded Ursano. "Gen. Neller is a leader and he asked us for help—one of the hardest things to do. Now we need to develop ways in primary care to aid people in learning how to ask for help." PN

The Department of Veterans Affairs military health history card is posted at http://www.va.gov/oaa/archive/Military-Health-History-Card-for-print.pdf. The Community Provider's Toolkit is posted at http://www.mentalhealth.va.gov/communityproviders/.

Kitty Dukakis, Veterans Share Personal Stories About ECT

To date, approximately 49 percent of the Veterans Health Administration facilities offer ECT, on both an inpatient and outpatient basis.

BY VABREN WATTS

Clinician scientists and patients came together at APA's 2016 Annual Meeting in Atlanta to discuss the effectiveness of electroconvulsive therapy (ECT) and the need for greater access to ECT in Veterans Health Administration (VHA) facilities.

"We are underutilizing ECT—the most effective therapy for depression—in the United States and especially in our VA hospitals," said session chair Peter Hauser, M.D., a clinical professor of psychiatry at the University of California, Irvine.

As of October 2015, Houser told the audience, 140 of the VHA's facilities—approximately 49 percent—offer ECT to patients, on both an inpatient and outpatient basis. He noted that a 2014 study by the Department of Veterans Affairs observed that veterans with major depressive disorder and comorbid posttraumatic stress disorder (PTSD) who received an average of 6.5 ECT treatments were almost twice as likely to be alive in the eight years following treatment than their counterparts with the same diagnostic profile who did not receive ECT.

"Studies such as this and others," said Houser, "provide evidence that we really need to devote more effort in enhancing the use of ECT for our veterans who are at high risk for suicide and who are really seeking rapid relief from depressive symptoms."

"ECT became an option for me 21 years ago," said the session's special guest, Kitty Dukakis, former first lady of Massachusetts and wife of former Democratic presidential nominee Michael Dukakis. Years before treatment, Dukakis suffered from severe symptoms of depression and alcohol use, which she candidly described in her 2006 book *Shock: The Healing Power of Electroconvulsive Shock Therapy*. "After ECT therapy, I felt better. I was able to live life," she told the audience.

Dukakis was joined on the panel by veterans who also spoke about their experiences with ECT.

continued on next page

Alternative Payment Models Aim To Reward Value-Based Care

The third article in this series on value-based payment looks at alternative payment models.

The American health care system is moving from paying physicians for the volume of services they perform to the value of care they provide. This movement toward "value-based payment" has greatly accelerated in recent years to address the high level of Medicare spending and has been furthered by advances in technology—especially the proliferation of electronic health records (EHRs) and payer incentive programs to encourage the use of EHRs. The goal of this evolution is summed up in the Triple Aim: better patient experience of care, better population health, and lower per capita cost of health care.

This article focuses on alternative payment models.

CHANGING PRACTICE CHANGING PAYMENT

Q *What are Alternative Payment Models (APMs)?*

A APMs are systems of care and models for payment specifically designed to deliver value-based care by rewarding high-quality, low-cost care. APMs include, among other models, accountable care organizations (ACOs), patient-centered medical homes, and bundled payment models for specific conditions and procedures.

Q *What is driving the creation of APMs?*

A The Affordable Care Act (ACA) has played a key role. The ACA created the Medicare Shared Savings Program (MSSP), a program designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

The ACA also established the Center for Medicare and Medicaid Innovation, or CMMI, to encourage and evaluate new models of care for Medicare, Medicaid, and even private payers.

For Medicare, the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, encourages psychiatrists and other physicians to participate in new models of care. The Centers for Medicare and Medicaid Services (CMS) has issued a proposed rule implementing MACRA, and a final rule is due out in November. APA has delivered comments to CMS in response to the proposed rule.

Q *How does MACRA affect the payment of physicians working in APMs?*

A Many details of this program are very technical and subject to revision in the final rule and in coming years. But here is what is known so far.

- MACRA creates a new pathway within Medicare for physicians to earn substantial bonuses for participating in certain new "advanced" APMs. From 2019 through 2024, "qualifying" physicians with a substantial percentage of revenue (or patients) tied to services received through these "advanced" APMs can earn a 5 percent annual bonus. They are also exempt from reporting under the Merit-Based Incentive Payment System, or MIPS, a payment system that replaces the current Medicare quality programs. The percentage of revenue or patient percentage ranges from 25 percent the first year to 75 percent in later years. Bonuses will be based on participation two years earlier, so 2017 participation will determine 2019 bonuses. These APMs, for which the government has set very stringent standards, focus only on Medicare in the early years, but there is an all-payer APM option later on.

- Physicians with slightly less revenue or patients in "advanced" APMs are not eligible for the bonuses, but they can opt out of MIPS reporting. For those who wish to qualify for MIPS bonuses, CMS plans to develop a reporting mechanism that could automatically transfer relevant APM data into the MIPS reporting system to avoid double reporting.

- Physicians who do MIPS reporting can also receive credit for APM participation. Physicians who report under MIPS (and do not qualify for APM bonuses) can receive credit for their APM participation in the MIPS "clinical practice improvement activity" performance category.

- MACRA also established a new Physician-Focused Payment Model Technical Advisory Committee to advise and support physicians in developing new models of care and to review proposals. The committee has held two public meetings to date.

Q *Are there APMs specifically focusing on mental illness and substance use disorders?*

see **Payment Models** on page 28

continued from previous page

"I had been on medication after medication, pill after pill," said Diana Weathers, a former member of the U.S. Navy who spoke about living with bipolar disorder. Weathers said that she was advised to undergo ECT after she told her physician that she was contemplating suicide. "After receiving ECT once every two to three days for eight weeks, I felt lighter, ... started reading again, ... and started to enjoy life again," she said.

When asked by audience members about whether her family backed her decision to undergo ECT, Weathers replied that her husband was a supportive advocate. However, not all ECT recipients get such support because of the stigma commonly associated with the treatment.

"My wife was not an advocate; she still is not," said Jim Bush, a Marine veteran who had served in Vietnam. "She dislikes the short-term and long-term memory loss. However, I don't know whether my memory loss was due to my mental health condition or ECT."

According to Richard Weiner, M.D., interim chair of psychiatry and behavioral sciences at Duke University, anterograde and retrograde memory loss are common side effects of ECT. "The severity and persistence vary," he said. Other side effects include confusion, delirium, and pain at the site of electrode stimulation.

David Hathcox

Kitty Dukakis relates how ECT was key to her regaining her life after suffering from years of alcohol use and depression. With her are veterans Diana Weathers and Jim Bush.

"Of course, I had headaches after ECT and pain in my mouth," said Weathers, "but that all subsided relatively quickly. The progress that I made with ECT was worth the side effects, at least for me."

The scientific presenters of the session mentioned that although research has shown ECT to be a more rapid and effective therapy than any antidepressant, the therapy is strategically used, in most cases, as a secondary treatment option for major depressive symptoms and other psychiatric conditions such as PTSD.

"Because ECT has such a rapid onset of effectiveness for major depressive disorder and comorbid posttraumatic stress disorder," said Hauser, "we really need to consider and offer ECT earlier after onset of these conditions, and not just as a last line of treatment." PN

PROFESSIONAL NEWS

APA Study Reveals Network Inadequacy in DC Exchange Plans

"Narrow" or "phantom" networks are a nationwide problem whereby health plans advertise specialists, including psychiatrists, in their networks who may in fact not be taking appointments, may have moved out of the area, or may even have retired or died.

BY MARK MORAN

The majority of network psychiatrists listed as practicing in the Washington, D.C., area by three major health plans in the District of Columbia health exchange are either not able to schedule an appointment or are not even reachable at the telephone numbers listed for enrollees to call.

That's one of the findings by a team of researchers with the APA Foundation who telephoned a randomly selected sample of psychiatrists publicly listed as network psychiatrists for the three largest health insurance carriers on the DC Health Link Health Insurance Exchange. The study and its results were presented at APA's 2016 Annual Meeting last month in Atlanta during the session "Constrained Access to Psychiatrists in Washington, D.C. Among the Largest Health Insurance Exchange Carriers' Networks."

Among the presenters were past APA President Steven Sharfstein, M.D.; Steven Epstein, M.D., chair of the Department of Psychiatry at Georgetown University School of Medicine; James Griffith, M.D., chair of the Department of Psychiatry at George Washington University; Joyce West, Ph.D., M.P.P., policy research director of the APA Foundation; Irvin "Sam" Muszynski, J.D., director of the APA Office of Reimbursement Policy; and Maureen Bailey, associate director of APA's Office of Parity Implementation and Enforcement Policy.

The analysis revealed that close to a quarter of the phone numbers for the listed psychiatrists were either nonresponsive or were nonworking numbers. And only 14 percent of psychiatrists were able to schedule any appointment at all; in one plan, only 4 percent were able to schedule an outpatient appointment.

The findings highlight a problem with "network adequacy" that has hindered access to care and the implementation of parity nationwide: the use by health plans of "narrow" or "phantom networks" that seem to advertise to enrollees an ample selection of psychiatrists, but which in fact offer very few real options for timely care. In many cases, listed providers are not accepting new patients and others have moved out of the geographic area; in some reported cases, listed psychiatrists are retired from practice or deceased.

"The passage of parity legislation is not enough," said Sharfstein in an interview with *Psychiatric News*. "Patients need real access. But in the real world, patients' experience of trying to access mental health treatment belies what health plans are telling their enrollees. There is no access when there are no clinicians who can provide treatment, and there is no parity when there is no one in the network."

"Our investigation revealed that 86 percent of the psychiatrists listed in the network directories were either unreachable or not actually taking new outpatients," Colleen Coyle, M.D., APA's general counsel, told *Psychiatric News*. "The callers had to call several times in many cases to get a response, and in the end only 14 percent of those listed as being

PROFESSIONAL NEWS

available to patients were able to schedule new outpatient appointments, but with very long wait times in most cases."

In the study, the research team compiled lists of all the psychiatrists who were publicly listed as being network psychiatrists in the online directories of the three largest health insurance carriers participating in the DC Health Link Health Insurance Exchange. Fifty psychiatrists were randomly selected from the psychiatrist network lists of each carrier.

Team members assessed whether the listed phone numbers were working, whether the psychiatrists practiced at the location, and whether someone at each of the offices could be contacted during a seven-day period from February 22 to March 21. At least three calls were placed to contact unreachable physicians' offices.

These are the key findings:

• **23 percent of the phone numbers were nonworking or nonresponsive.** For all the network psychiatrists studied, 23 percent of the listed phone numbers were either nonworking or nonresponsive, and no calls were returned over seven days.

• **Only 51 percent of the psychiatrists were practicing at the listed phone numbers.** 64 percent of Plan C's network psychiatrists were not currently practicing at the listed phone numbers.

• **Only 14 percent of the callers were able to schedule appointments.** Among the listed Plan A network psychiatrists, only 4 percent were able to schedule appointments.

• **Wait times for appointments were long.** The average wait time for new outpatient appointments was nearly three weeks (19.1 days). Specifically, only 7 percent of the listed network psychiatrists were able to schedule a new outpatient appointment within two weeks, 3 percent were able to schedule an appointment within 15 to 28 days, and 4 percent had appointments only available for longer than three weeks. The rest of the listed psychiatrists were either not reachable or not accepting new patients.

"As the Affordable Care Act theoretically expands access to mental health and substance use disorder care, networks are shrinking both because psychiatrists are dropping out of the networks citing unreasonable administrative burden and low payment rates as reasons and because plans are narrowing their networks while providing robust directories of providers to attract purchasers to the plan," Coyle said. "The net impact is that mental health patients are paying for care they cannot access, and those who are able to access care pay for that care out of pocket. Consumers are not getting the benefit of the mental health coverage they have paid for." PN

CDC

continued from page 1

with prescription pain killers.

He also lamented the criminalization of people with mental illness. "It is simply unacceptable that prisons and jails are the largest institutions caring for the mentally ill in America," Frieden said.

He was preceded at the podium by former First Lady Rosalynn Carter, a pioneering advocate for mental health and addiction treatment during her days in the White House. Carter described the work of the Carter Center, which is located in Atlanta, to decrease stigma and increase access to quality mental health care. PN

LEGAL NEWS

Justice Breyer Gives Insider's Peek Inside the Supreme Court

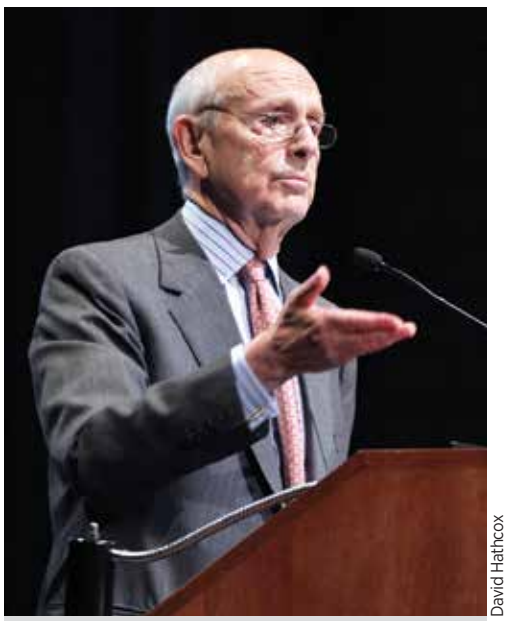
The Supreme Court justice gives a lively and colorful description of the inner workings of the highest court in the land.

BY MARK MORAN

"You have to know something about what goes on beyond our shores in order to answer certain questions of law here in the United States," said U.S. Supreme Court Justice Stephen Breyer last month at APA's 2016 Annual Meeting in Atlanta. "If you don't know at least something about international law, the answer to a question of law here will not be fully informed. And the number of those kinds of cases is growing."

Breyer was speaking about his latest book, *The Court and the World: American Law and the New Global Realities.* His comments on the book were in response to a question from friend and past APA President Alan Stone, M.D., who was instrumental in bringing Breyer to the APA meeting.

But the bulk of Breyer's comments gave a lively, engaging, and impromptu—and frequently funny—description of the work-a-day life of the highest court in the land. "People have arguments, some people don't get over their arguments, they go to lawyers who are supposed to help people get over their arguments—that's called 'settling out of court.' When they can't settle, they wind up in a courtroom."



David Hathcox

Justice Stephen Breyer describes a remarkably orderly process by which the Supreme Court deliberates on cases ranging from the mundane to the momentous.

From there, court decisions can be appealed—many times—through district and circuit courts, state supreme courts, or federal appeals courts until they come to the Supreme Court. Some 7,000 to 8,000 cases a year request hearings before the Supreme Court, and only some 80 cases are heard.

"The criterion for whether cases get heard by the court is whether there is a division of opinion in the lower courts," Breyer said. That is, the court primarily takes cases to resolve a conflict among the lower courts on important questions of federal law.

He described a remarkably orderly process by which the justices read, debate, and eventually decide cases—many of them mundane and unremarkable, and many others momentous in their consequences. He quoted Justice Anthony Kennedy as telling Breyer when he joined the court, "It's much more like an express train than you have ever imagined."

Breyer, who was appointed to the court by President Bill Clinton in 1994, is known for his pragmatic approach to constitutional law. Introducing Breyer before his remarks, outgoing APA President Renée Binder, M.D., called Breyer a "champion of the Constitution as a 'living document' that needs to take into account contemporary issues."

Breyer said the relationship among the justices—despite abiding differences in outlooks on law and the Constitution—are without rancor. "I have never heard a raised voice or a derisive comment from anyone about another justice," Breyer said. "We have lunch together, sometimes we play bridge together. It's not 'slap on the back, let's go to the bar,' but it's cordial, respectful, and professional."

Breyer said the orderliness of the court, along with its processes, is one of the great achievements of the United States. He noted that some highly controversial decisions by the court may have had large segments of the population angry or even furious (he cited, for instance, the 2000 case in which the court's decision effectively decided the contested 2000 presidential election).

"Sometimes you may hear a decision and wish there were riots in the streets," Breyer said. "But before you wish that, I'd ask you to turn on your television set and see what happens in other countries where questions of law are not decided as we do. That is a treasure of the United States—that we do decide our differences of opinion about questions of the law, under the law. That's a very, very good thing, and it works very well." PN

APA Weighs In on Cases Where Law Intersects With Psychiatry

APA has filed legal opinions in cases that involve some of the most hotly contested public issues, including the right of physicians to ask patients about gun ownership.

BY MARK MORAN

What are the rights of pregnant women seeking treatment for substance use disorders and mental illness? Should physicians be allowed to ask patients about firearms in their homes? What kind of accommodations should police officers make for individuals they encounter who have serious mental illness?

Those are three questions to which APA's Committee on Judicial Action has lent its expertise in court cases that represent compelling challenges for psychiatry.

Committee Chair Marvin Swartz, M.D., and committee members Paul Appelbaum, M.D., and Howard Zonana, M.D., presented facts and background information on three cases in which APA submitted friend-of-the-court briefs in a session titled "Psychiatry in the Courts: APA Confronts Legal Issues of Concern to the Field" at APA's 2016 Annual Meeting in Atlanta.

Appelbaum, director of the Division of Law, Ethics, and Psychiatry at Columbia University, discussed the case *New Jersey Division of Child and Family Services v. Y.N.*

"Yvonne" had a history of substance use disorder, including use of painkillers bought on the street. During a medical visit, she learned that she was four months pregnant. A physician urged her to enter a treatment program for addiction, in which she participated through the end of her pregnancy. Upon delivery, the baby went through several days of withdrawal in the neonatal intensive care unit. Subsequently, the Division of Child and Family Services filed an abuse and neglect allegation on the basis of Yvonne's drug use during pregnancy. The charges, upheld in appellate court, were appealed to the state Supreme Court.

Mark Moran

Twenty-nine women in 19 states have been prosecuted on charges related to seeking treatment for substance use disorder during pregnancy, says past APA President Paul Appelbaum, M.D. He pointed out that women should not in effect be punished for entering a treatment program for an addiction that predated pregnancy.

Applebaum noted that a review of such cases found that 29 women in 19 states have been prosecuted on similar charges (although the charges have been

continued on next page

LEGAL NEWS

Correctional Psychiatry Textbook Wins Manfred Guttmacher Award

Correctional psychiatry, a much-needed but greatly underresourced field, gets recognition as the subject of a new textbook.

BY AARON LEVIN

The 2016 Manfred Guttmacher Award given to the *Oxford Textbook of Correctional Psychiatry* (Oxford University Press, 2015) at APA's 2016 Annual Meeting in Atlanta served as a tribute not only for the book but also for the entire field of correctional psychiatry, said its coeditors, Kenneth Appelbaum, M.D., Jeffrey Metzner, M.D., and Robert Trestman, M.D., Ph.D.

"The award is recognition of this growing subspecialty with its increasing complexity," said Appelbaum, a clinical professor of psychiatry at the University of Massachusetts Medical School and director of correctional mental health policy and research at Commonwealth Medicine.

APA presents the award annually for "an outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, paper, or other work published or presented at a professional meeting" over the previous year. It honors the late Manfred Guttmacher, M.D., a forensic psychiatrist and chief medical adviser to the Supreme Bench of Baltimore for 36 years.

This is the first time the award has gone to a work on correctional psychiatry.

Creating the textbook was another step in the development of correctional psychiatry, said Trestman, a professor of medicine, psychiatry, and nursing at the University of Connecticut. He also heads UConn Health Correctional Managed Health Care, which provides all health care in Connecticut's prisons and jails.

The textbook is intended as a tool for training psychiatry residents and forensic fellows, psychologists, social work interns, and administrators, said Trestman. Such a structured curriculum of study can help guide training, research, patient care, and ethical decision making.

David Hathcox

From left: Robert Trestman, M.D., Ph.D., Jeffrey Metzner, M.D., and Kenneth Appelbaum, M.D., receive the Manfred Guttmacher Award for their book on correctional psychiatry.

Appelbaum noted that there is now an order of magnitude difference between the number of people with serious mental illness in jails and prisons and those in civilian psychiatric facilities. He praised outgoing APA President Renée Binder, M.D., for recognizing and addressing the overrepresentation of individuals with mental illness in the criminal justice system. In that light, Appelbaum expressed hope that the low number of sessions at APA meetings or articles in APA journals on correctional psychiatry might soon increase, given that many APA members work in the correctional field.

More work needs to be done on expanding the research and evidence base for psychiatric work in corrections, improving opportunities for rehabilitation, and raising standards of mental health care, said Appelbaum.

Too often, clinicians working in prisons must talk with prisoners through the food slots in their cell doors, denying privacy from guards or other prisoners within earshot, he said. "You can't do psychiatry without confidentiality any more than you can do surgery without sterility."

Correctional mental health clinicians can work through their professional organizations to raise standards, said Metzner. In 2012, for instance, the APA Board of Trustees approved a position statement saying that a prisoner with serious mental illness should not be held in "prolonged segregation" (solitary confinement).

"If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted," continued the APA statement.

The National Commission on Correctional Health Care (NCCHC) issued a 17-point position statement in April, saying, among other things, that solitary confinement longer than 15 consecutive days is "cruel, inhuman, and degrading treatment and harmful to an individual's health. … Juveniles, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration."

Furthermore, said the NCCHC, health care professionals should not be involved in pre-segregation evaluations because doing so condones the use of segregation.

Ironically, prisoners make up the only population group in the United States with a constitutional right to health care and the right to sue the state if it is not provided,

see **Award** on page 15

continued from previous page

upheld in only two states). "So this is not an insignificant issue," he said.

APA entered a brief in the case, urging that adherence to a treatment plan recommended by a physician can never constitute neglect or wanton abuse or misconduct; that Yvonne should not be punished for entering a methadone treatment program for an addiction that predated her pregnancy; and that pregnant women should not be discouraged from entering methadone maintenance, the most effective treatment for opioid dependence.

When the state Supreme Court ruled, the APA opinion prevailed. "We believe that even the threat of proceedings against a pregnant woman for entering treatment can discourage women from seeking treatment, which leads to adverse events for both mother and offspring," Appelbaum said. "From our view, the New Jersey Supreme Court decision represents a common-sense approach to statutory law and to a serious public health problem."

Zonana, a professor of psychiatry and professor of law at Yale University, described the case *Wollschlager v. Florida*, an ongoing case involving a proposed state law, Firearm Owner Protection Act, which would bar physicians from asking patients about firearms in their homes. A three-judge panel of a circuit court upheld the law, and the full panel of the Circuit Court will hear an appeal.

APA, along with the AMA and numerous other medical groups, filed an amicus brief against the law, stating that discussion of gun safety is a legitimate public health concern and the law violates physician and patient First Amendment rights.

According to the brief, "the Act inhibits physicians from communicating with their patients about issues which may become relevant to their patients' health and safety. It also inhibits physicians from making a reasonable, inoffensive notation in their patients' medical records, even though such notation would cause no legally recognized harm to the patient (or anyone else). … Any benefits that might be attributable to the Act, to the extent they may exist at all, are far outweighed by the burdens the Act imposes on the First Amendment rights of physicians and their patients."

Swartz, a professor of psychiatry and behavioral sciences at Duke University School of Medicine, described *City and County of San Francisco v. Sheehan,* which involved a mentally ill patient who lived in a group home and threatened to kill her social worker. The police were called, and the woman was shot several times and subdued. The patient later filed suit, claiming that the police infringed her rights under the Americans With Disabilities Act. After several court appeals, the case was sent to the U.S. Supreme Court.

The court remanded the case, and Swartz said it will likely resurface. He noted that there was a wide range of opinion—within the committee and APA—and it continues to be a difficult and challenging issue: what kind of accommodations should police officers make in encounters with individuals who are seriously mentally ill?

"We will continue to follow this case," Swartz said. "We continue to think the right position is that there ought to be some reasonable accommodations in terms of using Crisis Intervention Teams and training officers about mental illness." PN

LEGAL NEWS

Psychiatrist Reports Inside View Of Fort Hood Killer's Evaluation

A former Air Force psychiatrist relates his experience on the team that determined Nidal Hasan's competency to stand trial.

BY AARON LEVIN

It took a year of investigation, but members of a military sanity board ultimately found that the U.S. Army psychiatrist who shot and killed 13 people at Fort Hood, Texas, on November 5, 2009, was not mentally ill and was able to stand trial, said Kaustubh Joshi, M.D., who chaired the board, at APA's 2016 Annual Meeting in Atlanta.

Maj. Nidal Hasan, M.D., also wounded 32 other people on that November day before he was shot by two police officers and paralyzed. Most of the dead and injured were fellow members of the U.S. Army, preparing to deploy overseas. Hasan was tried and convicted in 2013 for the crimes, and his case is undergoing a mandatory appeals process.

Joshi said he could finally discuss the case publicly now that the trial was over and a verdict rendered.

Sanity boards are appointed by the military convening authority or the judge in charge of a court martial, not by the prosecutor or defense, said Joshi, then an Air Force psychiatrist and now an associate professor of clinical psychiatry at the University of South Carolina School of Medicine. Failure to cooperate with the sanity boards bars the defendant from introducing psychiatric witnesses later in the legal process.

An Army psychiatrist and a Navy neuropsychologist joined Joshi on the board. Together, they had to decide whether Hasan understood the nature of his actions and was competent to stand trial.

Joshi and his colleagues reviewed 10,000 documents, interviewed witnesses, and evaluated Hasan directly for about 13 hours over a three-day period in December 2010.

"This was the only time in my professional life I got everything I wanted," said Joshi about what became his primary job for an entire year.

The investigation revealed a quiet man whose life spiraled downward inexorably after a series of personal and national tragedies: the deaths of his father in 1998 and of his mother in 2001, followed by the September 11 terrorist attacks. By then he was a student at the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Md. Hasan had struggled in medical school but was granted a leave of absence to take care of family affairs, he told Joshi.

Collectively, those events led Hasan, the American-born child of Palestinian immigrants, to a deeper involvement with religion. "Islam became more of *the* focus, not simply *a* focus, of his life," said Joshi, who speculated that religion came to fill the void created by his parents' death.

Then, after the United States invaded Afghanistan and Iraq, Hasan concluded that the country was fighting an unjust war against Islam and trying to force democracy on Muslims. He said that he had been on the wrong side as a U.S. soldier and that he had switched sides.

"He could not balance being a Muslim with his obligations as an American military officer," Joshi said. "But that never translated into overt behaviors regarding that conflict up until November 5. Although he may have made verbalizations about his beliefs on Islam, he never verbalized a threat to harm others."

Nevertheless, no matter how extreme his views of his religion may have been, then or later, they could not be considered delusional, said Joshi.

Hasan graduated from USUHS in 2003 and entered residency at Walter Reed

see ***Fort Hood*** *on page 32*

RESIDENTS' FORUM

The Forgotten Island

BY HÉCTOR COLÓN-RIVERA, M.D.

As a child, I visited my family in Vieques, a municipality of Puerto Rico. My mother grew up on this small island, and somehow I knew it was a different place with different needs. Getting there from San Juan is a two-hour adventure. And while Vieques is a social microcosm of mainland Puerto Rico, it also mirrors the profile with a common denominator: geographic isolation. Intuitively, I realized that mental health and poor education were impacting the dynamic of entire families, but it was not until I was a medical student that I began to understand Vieques's lack of accessibility to education and health care resources.

Vieques has no full-time psychiatrists on the island, leaving the quality and quantity of mental health care to be minimal at best. Island-based health professionals—who include approximately four primary care providers (PCPs), a neurologist, two dentists, and an emergency doctor—lack well-defined outreach programs to facilitate the delivery of mental health services. Despite these limitations, mental health treatment is accessed through PCPs and emergency services, with the exception of individuals who attempt suicide. They are transferred via helicopter to a hospital on the mainland.

I observed firsthand how Vieques's isolation and lack of support from the main island impedes islanders from leading a dynamic and fulfilling life. With the support of APA, we visited Vieques as part of our second APA Mental Health Awareness Tour. We also coordinate an educational program called Salud a Flote. It provides an extra communication mechanism that promotes awareness of mental health and addiction issues in the community.

Over the last several years, we have learned that to make an impact, the following steps were necessary:

- **Include the community.** Meeting with community leaders and learning about their needs in their own words were critical to exploring the principal necessities for the communities. We needed to be realistic, listen, and ask specific questions, as well as create an atmosphere that communicates "we are part of a team."

- **Tailor educational activities that fit the residents' needs.** For an effective delivery and evaluation of the interventions, we needed to establish a community typology that provides a balanced and cost-effective approach. We needed to be careful not to promise what we could not deliver.

- **Use technology to help build educational activities.** Technology is helping education expand beyond linear, text-based learning. We identified already established organizations and groups in the community with the capacity to expand educational projects. We wanted to be more accessible, more affordable, and more efficient at delivering basic education to more people.

We were fortunate to have the support of community leaders in Puerto Rico and APA. I have come to realize that an educational intervention is not enough if it is not integrated into a good public health system. Our results indicate that a greater understanding of communities may enhance our ability to increase prevention, awareness, and effective management of mental health and substance use conditions.

A promising change is coming with broader acceptance of the integrated care model and the increase in educational activities to decrease stigma in vulnerable communities such as Vieques. It is important for us to return often to Puerto Rico and continue adding resources with the goal of addressing mental health services inequities, which creates life-threatening outcomes and poor quality of life. In my experience, the use of media, technology, and the support of the community are required to develop future projects. We call for your support of the Puerto Rico APA Mental Health Awareness Tour as we continue to face the challenges of mental health care delivery and public policy development in Puerto Rico. PN

Héctor Colón-Rivera, M.D., is the chief resident in psychiatry at Boston University Medical Center and an APA SAMHSA/Diversity Leadership Fellow.

Award

continued from page 13

said Trestman. "[Yet] we have ignored to the point of absolute intentional indifference the plight of people with mental illness who become incarcerated." PN

Information on the *Oxford Textbook of Correctional Psychiatry* is posted at https://global.oup.com/academic/product/oxford-textbook-of-correctional-psychiatry-9780190224059?q=trestman&lang=en&cc=us#. The National Commission on Correctional Health Care's position statement on solitary confinement is posted at http://www.ncchc.org/solitary-confinement.

ASSOCIATION NEWS

The Fight for Women's Equal Rights Embroils APA in Long Controversy

Articles and letters to the editor in *Psychiatric News* testify to a long-ago battle over tactics to ratify the Equal Rights Amendment.

50 YEARS

BY AARON LEVIN

In the 1970s and 1980s, APA found itself embroiled in the same controversies swirling around in the rest of American society, including the major shifts in the roles of women.

The most visible aspect within APA of that social change may have been the struggle of how best to encourage ratification of the Equal Rights Amendment (ERA), a struggle that consumed much ink in the pages of *Psychiatric News.*

Versions of the ERA had been proposed since 1923 but had been defeated over and over in the U.S. Congress. Its history seems a remarkable inversion of present-day politics. The Republican Party included the ERA in its platform from 1940 to 1980. New Dealers, Eleanor Roosevelt, the American Civil Liberties Union, and labor unions opposed it on the grounds that it would take away special workplace protections for women.

Led by Rep. Martha Griffiths (D-Mich.), the ERA of the 1970s was passed by the House in 1971 and the Senate in 1972. The deadline set for ratification was 1979. By 1977, 35 states had ratified the amendment, three short of the 38 needed for adoption. A legally questionable three-year extension of the ratification deadline was passed in 1978, but no additional states voted to ratify and the amendment failed.

APA went on record in 1974 and again in 1977 in support of the ERA and urged ratification. Trying to exert more pressure for ratification, APA's Board of Trustees voted to cancel the 1981 Annual Meeting in New Orleans because Louisiana had not ratified the amendment. However, a group of members successfully petitioned the Board to hold a referendum stating that APA would "not prohibit the holding of meetings in a state which has not passed the Equal Rights Amendment."

The statement on which members were asked to vote in the referendum appeared in the January 18, 1980, issue of *Psychiatric News,* and later issues published many letters arguing for and against the measure.

The referendum, wrote Elaine Hilberman, M.D., and Brenda Solomon, M.D., chair and vice chair of APA's Committee on Women, respectively, "has the potential for creating extraordinary divisiveness in APA."

Supporters of the Equal Rights Amendment (ERA) picket in support of a boycott of APA's 1981 Annual Meeting, which was scheduled to be held in Louisiana, a state that had not ratified the ERA. The protest occurred in San Francisco outside the auditorium where the Opening Session of APA's 1980 Annual Meeting was being held.

"The divisiveness was created by those who sought to use APA to support their political interests," countered a letter from Henry Brackin Jr., M.D., of Nashville. "No small pressure group should be a spokesman for all the members on such political issues."

It wasn't only politics, said former APA President Judd Marmor, M.D. "Anyone who assumes the issue of discrimination has no mental health implications either has never experienced such discrimination or is seriously lacking in the capacity to empathically identify with those who have," wrote Marmor.

The April 18, 1980, issue of *Psychiatric News* reported that 5,679 members voted not to boycott nonratifying states, with 4,461 voting to maintain the boycott.

The controversy didn't stop with the referendum. A group called Psychiatrists for the ERA (PFERA) invited journalist Gloria Steinem to the 1980 San Francisco meeting. Steinem's celebrity status ensured wide coverage of the issue inside and outside APA.

Boycott advocates also looked beyond ratification to point out significant disparities in psychiatry.

"About 88 percent of APA members were men, and two-thirds of our patients were women," said Jean Shenoda Bolen, M.D., in a recent interview. (The ratio today is about 60/40, male/female among APA members.) In 1980, Bolen was the West Coast chair of Psychiatrists for the ERA. PFERA vowed to inform women contemplating psychotherapy about the likely sexist views of the male psychiatrists who were likely to treat them. They asked that more women be appointed to the APA Board and the editorial board of the *American Journal of Psychiatry.*

Exchanges continued in the pages of *Psychiatric News* about the boycott, the restricted professional opportunities for women psychiatrists, and the treatment of women patients.

The 1981 Annual Meeting was ultimately held in New Orleans, although some members chose not to attend.

"The ERA episode served a major consciousness-raising role, and that was a good thing," Bolen said. "Sometimes you lose, but you still persevere to make a point. We raised equal rights as an issue for every psychiatrist in APA, and they had to decide if they would go to New Orleans."

The battle of the ERA was not in vain, she said. It contributed to psychiatry by demonstrating that women were not treated as equal to men and had been kept from achieving their full potential.

Change would come, however. In 1985, Carol Nadelson, M.D., became the first woman president of APA.

"I think that every woman psychiatrist who got involved in this effort at the national level, and those who spoke about the reasons behind the boycott of New Orleans in her district branch, found her voice—after the years of training and being in hierarchal situations, where maintaining silence on issues related to sexism was a survival skill," said Bolen. PN

From the President

continued from page 7

trists per 100,000. Given that 21 percent of the population had a psychiatric disorder in the last year, let's do a thought experiment. Consider that out of 100,000 persons, 21,000 need psychiatric care each year,and 4,200 have serious mental illness. Can you imagine that three or four psychiatrists could serve such a patient base, even with collaborative care models and use of physician extenders?

Fourth, we must enforce the Mental Health Parity and Addiction Equity Act. Much time has elapsed since this landmark legislation became law and regulations were put in place, yet insurers creatively continue to discriminate against patients with mental illness, especially by failing to maintain adequate provider networks and using multiple strategies including more onerous preapprovals for psychiatric care than for other types of medical care. We simply must expand federal efforts to enforce compliance with parity regulations.

Finally: prevention. We need not wait until disease and suffering unfold. We can develop tools to identify those at risk before any symptoms emerge through the use of genetic, molecular, and other markers. Research is essential to developing such tools. We can develop strategies to prevent untoward environmental risk factors such as child abuse or maternal depression, known to increase risk for behavioral problems, including suicide, later in life. In fact, preventing mental illness should be the fundamental goal driving research and treatment and be at the core of all federal mental health initiatives.

As APA members, we should be encouraged that these five components of meaningful mental health reform are addressed in the bill being moved through the Senate. I look forward to Congress's enactment of this legislation during this session. PN

Possible Pathway Discovered for Ketamine's Antidepressant Effects

New research suggests that the rapid antidepressant effects of ketamine may be associated with a ketamine metabolite that works independently of NMDA glutamate receptors.

BY VABREN WATTS

National Institute of Mental Health

Carlos Zarate, M.D., believes that discovery of a ketamine-like therapy that lacks the potential adverse risks associated with ketamine use could lead to the burgeoning of a new era for psychopharmacology.

Numerous studies have suggested that a single dose of the anesthetic ketamine can reduce symptoms of depression within a matter of hours, but the medication's dissociative and euphoric properties have raised questions about its viability as a long-term depression medication. A study published last month in *Nature* has now found that treating animals with a metabolite created when the body breaks down ketamine is able to reverse depression-like behaviors without the side effects commonly associated with ketamine.

"This discovery fundamentally changes our understanding of how this rapid antidepressant mechanism works and holds promise for development of more robust and safer treatments," Carlos Zarate, M.D., chief of the Experimental Therapeutics and Pathophysiology Branch and Section on the Neurobiology and Treatment of Mood Disorders at the National Institute of Mental Health, said in a press statement.

While researchers believed that ketamine produces its antidepressant effects by blocking N-Methyl-D-aspartic acid (NMDA) glutamate receptors, other NMDA receptor antagonists have failed to produce ketamine's rapid and sustained antidepressant effects.

To determine whether NMDA receptor inhibition is the main mechanism underlying the antidepressant effects of ketamine, Zarate along with other scientists and clinicians from the National Institutes of Health, University of Maryland School of Medicine, and University of North Carolina School of Medicine compared the antidepressant effects of two enantiomers (2S, 6S)-hydroxyketamine (HNK) and (2R, 6R)-HNK, which are byproducts of metabolized ketamine.

For the study, the researchers measured acute (one hour) and sustained (24 hour) antidepressant response in mice that were administered a single 10 mg/kg dose of ketamine, (2S, 6S)-HNK, or (2R, 6R)-HNK. Antidepressant response was measured by the mouse forced swim test and learn helplessness test.

The researchers found that administration of (2R, 6R)-HNK elicited acute and sustained antidepressant-like effects similar to that of ketamine, whereas (2S, 6S)-HNK did not. The antidepressant actions induced by (2R, 6R)-HNK were found to be independent of NMDA receptor inhibition, but were associated with early and sustained activation of α-amino-3-hydroxy-5-methyl-4-isoxazole propionic acid (AMPA).

"These findings reveal that production of a distinct metabolite of ketamine is necessary and sufficient to produce the ketamine antidepressant actions," the researchers noted.

Additional analysis revealed (2R, 6R)-HNK did not induce changes in locomotor activity and motor coordination in the mice, nor did the animals self-administer (2R, 6R)-HNK, as was seen in the animals given access to ketamine.

"The current findings are encouraging and exciting news," Zarate told *Psychiatric News*.

"Hopefully these findings will open the gate for other researchers trying to tap into AMPA activation for creation of new compounds for depression."

This research was supported by the National Institutes of Health. PN

An abstract of "NMDAR Inhibition-Independent Antidepressant Actions of Ketamine Metabolites" is posted at http://www.nature.com/nature/journal/vaop/ncurrent/full/nature17998.html.

Bupropion May Be Best Choice for Overweight Patients With Depression

While the mechanism of the weight-reducing effect of bupropion has yet to be determined, researchers suspect that the dopaminergic and noradrenergic effects of the medication may play important roles in the regulation of appetite, satiety, craving, and feeding behavior.

BY MARK MORAN

Gregory Simon, M.D.

Psychiatrist Gregory Simon, M.D., says assessing the effect of antidepressants on weight gain can be difficult in a clinical setting since weight gain is gradual and most people gain some weight as they age.

Obesity and its relationship to antipsychotic medication is a concern now well known to physicians treating patients with schizophrenia. But what about the relationship that exists between depression, antidepressant treatment, and weight gain?

The association between antidepressant therapy and long-term weight gain may not be as pronounced as in the case of antipsychotics, but any weight gain attributed to antidepressants should be of concern—particularly when prescribing to patients who are overweight, David Arterburn, M.D., an internist and an expert in obesity with the Group Health Research Institute (GHRI) in Seattle told *Psychiatric News*.

"As many as two-thirds of Americans are overweight, and a significant number of those are individuals with depression," Arterburn said in an interview. "We don't need to add even a few more additional pounds that will increase their risk for obesity-related diseases if we can help it. So if we are able to treat depression and at the same time promote even modest weight loss, it would be a win-win."

Arterburn was the lead author of a study published online April 13 in the *Journal of Clinical Medicine* that suggests bupropion may be the best first-line antidepressant for patients with weight issues.

Together with GHRI psychiatrist Gregory Simon, M.D., and colleagues, Arterburn examined the relationship between antidepressant medication and weight change over a two-year period among adult patients with a new antidepressant treatment episode between January 2006 and October 2009 in the Group Health Cooperative—a large health system in Washington state.

Medication use, diagnoses, height, and weight were collected from electronic databases. Antidepressants included in the analysis were fluoxetine, citalopram, bupropion, paroxetine, sertraline, trazodone, mirtazapine, venlafaxine, and duloxetine. (During the study years, the second-generation antidepressant medications escitalopram, fluvoxamine, and nefazodone were not on the Group Health formulary and so were not included.)

The reference medication against which other antidepressants were measured for effect on weight was fluoxetine, the most commonly prescribed antidepressant at Group Health.

Aterburn, Simon, and colleagues found that nonsmokers who initiated bupropion

see ***Bupropion*** *on page 34*

Child Psychiatrists Look at Specialty From Both Macro, Micro Perpectives

Big-picture approaches to system change and close attention to therapeutic detail can help improve the care of young patients.

BY AARON LEVIN

Children are not just small adults, and clinical practice and the overall health care system need to take notice of that reality, said speakers at APA's 2016 Annual Meeting in Atlanta in a session on child and adolescent psychiatry in the 21st century.

Mental disorders are the most expensive elements of child health care, and changes under way in the American health care system may present opportunities for major improvements in care and cost, said Gregory Fritz, M.D., a professor and director of the Division of Child and Adolescent Psychiatry at Brown University's Warren Alpert School of Medicine in Providence, R.I.

"Adults like to romanticize childhood and don't understand the profundity of childhood mental illness," said Fritz.

The keys to caring for children, he continued, lie in early recognition and treatment of their symptoms and integrating their care with care provided by pediatricians.

"Primary care is where the patients with mental disorders are," said Fritz, president of the American Academy of Child and Adolescent Psychiatry. "There is a high level of trust, providers know the family better, and there is less stigma attached to a primary care visit."

Unfortunately, the barriers to better care for children still amount to a "perfect negative system," he said.

"Situational problems, developmental questions, and behavioral problems also can be important but are not diagnosable, and their treatment is thus not reimbursed," he said. The traditional model of paying only for face-to-face care has impeded the adoption of integrated or collaborative care models in which psychiatrists serve in a consultative role.

He outlined other barriers as well. Mental health and primary care practitioners may be on different insurance panels and use different electronic health record systems. *DSM* and ICD diagnostic categories do not reflect lower levels of severity that require attention if early diagnosis and intervention are to be effective.

The time has come, said Fritz, to bring together federal and state agencies, insurers, and professional organizations to provide the big solutions to improving child mental health care: end fee-for-service payments, end mental health carveouts, enforce the 2008 parity law in combination with the Affordable Care Act, and better educate both primary care and mental health clinicians about new models of practice.

In the clinic, managing mental illness in young people requires subtle but significant shifts in thinking, said Karen Dineen Wagner, M.D., Ph.D., a professor and chair of psychiatry and behavioral sciences at the University of Texas Medical Branch, Galveston. For instance, depression in children and adolescents presents differently from depression in adults and requires different approaches to evaluation and treatment, she said.

"Compared with adults, children with depression usually present more often with irritability than with sadness," she said. Frequently, depression is comorbid with other problems common to young people, such as anxiety, ADHD, conduct disorder, substance use, or anorexia.

David Hathcox

Because children's brains are still malleable, modest investments in their present mental health pays off in the long run, according to Gregory Fritz, M.D.

David Hathcox

Parents' information about their children may be more useful when evaluating an adolescent patient for depression, says Karen Dineen Wagner, M.D., Ph.D.

Screening can be done with the Mood Disorder Questionnaire–Adolescent, a modification of the PHQ-9. After some trial and error, Wagner and colleagues found that parents' responses to the questionnaire were more useful than either the adolescents' answers or an "attributional" form that asked teens what they thought their friends or teachers might be saying about them.

As for treatment, only two drugs are approved for use in youth by the Food and Drug Administration (FDA): fluoxetine for ages 8 to 17 and escitalopram for ages 12 to 17, said Wagner. "The youngest age in the clinical trials determines the lower end of the approved age range. So what do you do if an 11-year-old doesn't respond to fluoxetine?"

One looks at other trials, she said, even if the FDA has not approved the drugs for pediatric use. For instance, one clinical trial found positive results for citalopram in ages 7 to 17, while two pooled trials of sertraline did so for ages 6 to 17.

Another issue with pediatric clinical trials is that 61 percent of youth respond to the drugs, but 50 percent respond

see ***Child Psychiatrists*** *on page 37*

CLINICAL & RESEARCH NEWS

Baseline Somatization May Predict Sports-Related Concussion Recovery

A large, prospective study finds higher baseline scores on the Brief Symptom Inventory-18 somatization subscale were independently associated with longer recovery from postconsussion symptoms.

BY AARON LEVIN

As the risk of concussion has risen higher in the consciousness of sports fans, players, and parents, so has the interest in finding better ways to diagnose and treat such injuries.

Now, a prospective study of more than 2,000 athletes published in the May 17 issue of the journal *Neurology* suggests that preinjury somatic symptom reporting may predict postconcussive symptom recovery.

For the study, Lindsay Nelson, Ph.D., an assistant professor of neurosurgery and neurology at the Medical College of Wisconsin in Milwaukee, and colleagues recruited 2,055 physically and psychologically healthy high school and college athletes (80 percent male), who underwent a 90-minute preseason baseline examination. Out of this group, 127 sustained concussions involving a direct blow to the head. About 63 percent of the athletes with concussions played football and 24 percent soccer. The injured athletes received 60-minute postconcussion examinations four times: within 24 hours of injury and eight, 15, and 45 days later.

Most recovered fairly quickly, with 64 percent of the athletes recovering within one week and 95 percent within one month.

As has been previously reported in athletes who present with symptoms of concussions in outpatient specialty clinics, the authors found that symptom severity was the strongest predictor of longer recovery time.

In addition, higher baseline scores on the Brief Symptom Inventory-18 somatization subscale were independently associated with longer recovery from symptoms. Somatization appeared to increase either the athletes' perception of their symptoms or their willingness to report them.

"The results don't surprise me, but it's important to firm up impressions with data," sports psychiatrist Antonia Baum, M.D., a private practitioner in Chevy Chase, Md., and an assistant clinical professor of psychiatry and behavioral sciences at George Washington University School of Medicine, told *Psychiatric News*. "Concussion symptoms are largely subjective, so it's important to look at the patient's background, not only for diagnosis but to guide treatment, as well," added Baum, who was not involved with this study.

Neither depression nor anxiety was strongly associated with postinjury symptoms or recovery time.

"This finding rules out the possibility that acquiescence or general distress inflate symptom ratings broadly and instead points to a specific influence of somatization on postconcussive symptoms and subsequent recovery," Nelson and colleagues wrote.

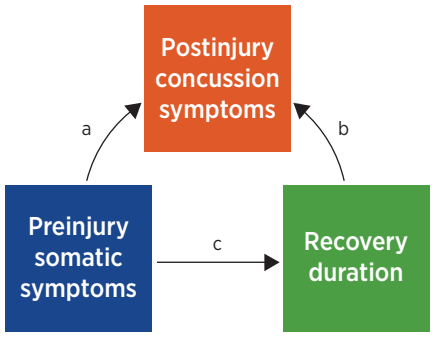
They further hypothesized that preinjury somatization affects the time for postconcussion recovery both directly and indirectly, by influencing the athletes' reports of acute symptoms following injury. Ongoing subjective symptoms may lengthen impairment and increase service use.

"Of particular interest is that preinjury somatization's role in predicting postinjury symptom recovery was related to its effect on postinjury symptom reporting rather than an effect of prolonging postconcussive symptoms," wrote David Loring, Ph.D., a professor of neurology and pediatrics at Emory University School of Medicine in Atlanta, and Michael Makdissi, M.B.B.S., Ph.D., of the Olympic Park Sports Medicine Centre in Melbourne, Australia, in an accompanying editorial. "These data also highlight that concussion assessment requires consideration of preinjury psychological function in addition to the postinjury clinical presentation."

"[C]linicians should assess psychological health factors in the management of athletes recovering from sports-related concussions," concluded Nelson and colleagues. "Future work clarifying the psychological, cognitive, and neurobiological underpinnings of somatization is needed to understand the mechanisms by which this construct contributes to enhanced experience or reporting of postconcussive symptoms and subsequent recovery time." PN

Symptoms, Before and After Concussion

Reported preinjury somatic symptoms appear to affect later postconcussion recovery duration indirectly (a, b), by influence reporting of postinjury concussion symptoms.



Source: Lindsay Nelson, Ph.D., et al., *Neurology*, May 17, 2016

An abstract of "Preinjury Somatization Symptoms Contribute to Clinical Recovery After Sport-Related Concussion" is posted at http://apapsy.ch/sports. An excerpt of "Baseline Somatization Influences Sport-Related Concussion Recovery" is posted at http://apapsy.ch/sports2.

FROM THE EXPERTS

Neuromodulation May Benefit Patients With Varying Psychiatric Illnesses

BY ANDREW LEUCHTER, M.D.

While many are accustomed to thinking of communication in the brain as being driven by neurotransmitters, the brain networks that regulate mood, thought, and circadian rhythms are bound together by both electrical and chemical neurotransmission.

The brain utilizes more energy per ounce than any other organ in the body, and most of this energy is devoted to creating and sustaining the electrical charge of neurons. Electrical firing of neurons creates functional networks in the brain and facilitates the release of serotonin, norepinephrine, and other neurotransmitters. Interestingly, extracellular levels of these neurotransmitters also regulate the rate and pattern of electrical firing of neurons and the frequency of rhythmic brain oscillations. Electrical and chemical neurotransmission are in essence two sides of the same coin, creating and sustaining functional brain networks.

Thus it is not surprising that neuromodulation—technologies that apply magnetic or electrical energy to the brain to alter neurotransmission—have been found to produce therapeutic effects similar to those of medication.

Repetitive transcranial magnetic stimulation (rTMS), one of the newest treatments for major depressive disorder (MDD), is one such technique. It utilizes electromagnetic induction to create small currents in key mood-regulating areas of the prefrontal cortex.

The most common rTMS treatment target is the left dorsolateral prefrontal cortex (DLPFC). Patients treated with at least 30 sessions of high-frequency (10 Hz) rTMS in this region have been reported to have response and remission rates of up to 58 percent and 37.1 percent, respectively, when combined with antidepressant medication.

The benefits of rTMS treatment for MDD can be sustained for a year in up to 70 percent of patients and are similar to those seen in patients taking medication alone.

rTMS is not electroconvulsive therapy (ECT)—one of the first neuromodulation techniques introduced nearly 80 years ago, which involves broad delivery of depolarizing current substantial enough to induce a seizure. rTMS uses magnetic induction to depolarize neurons and cause firing but only in a focal area under the stimulating magnet. Other neuromodulation techniques include trigeminal nerve stimulation (TNS), which introduces a subthreshold current into the brain through a superficial branch of the trigeminal nerve,

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Andrew Leuchter, M.D., is a professor of psychiatry and biobehavioral sciences and the director of the Neuromodulation Division at the Semel Institute for Neuroscience and Human Behavior at the David Geffen School of Medicine at the University of California, Los Angeles.

CLINICAL & RESEARCH NEWS

continued from previous page

and deep brain stimulation (DBS), which introduces very small currents directly into mood-regulating areas deep in the brain such as the anterior cingulate cortex.

Despite the notable differences in these techniques, all have been reported to have antidepressant efficacy.

What's Behind Neuromodulation's Antidepressant Effects?

We are accustomed to thinking of pharmacologic treatments that penetrate the brain broadly as antidepressant treatments. How can the application of energy at such disparate levels and diverse manners have similar antidepressant efficacy?

The action of neuromodulation treatments can best be understood from the standpoint of network-based treatments of depression. These treatments are applied to brain regions that constitute "hubs" of mood-regulating networks of the brain. For example, rTMS stimulation of any one of these hubs does not remain local, but increases cortical excitation that spreads over the surface of the brain within milliseconds. At the same time, rTMS administered to the left DLPFC rapidly induces blood flow changes throughout the limbic system in the thalamus, caudate, and other subcortical and cortical areas with connections to the site of stimulation. Similarly, TNS changes blood flow in the anterior cingulate cortex, the inferior frontal gyrus, and medial and middle frontal gyri including the DLPFC.

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CLINICAL & RESEARCH NEWS

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There are many levels at which antidepressant treatments may work: within an individual cell, at the level of cell-to-cell communication (that is, chemical or electrical synapses), or at the level of communication among larger functional groupings of cells (that is, brain circuits or networks).

Antidepressant medications can be conceptualized as working "bottom-up" from the level of the synapse, changing transmission between individual neurons that then feeds up to the level of circuits, networks, and the brain as a whole. Conversely, neuromodulation treatments work in a "top-down" manner, altering the transmission of information at the level of brain networks that then feeds down to the level of the individual synapse.

While medications and neuromodulation treatments work at different levels of biological complexity, they presumably both feed down to affect neuronal processes such as cell metabolism and gene transcription. Neuromodulation and medication treatments of MDD may in fact be synergistic, interacting across different levels of biological complexity to enhance the efficacy of the treatments. Such synergy could explain why patients who do not appear to respond during a course of rTMS treatment may experience a reduction in depressive symptoms during later courses of medication treatment.

The Future of Neuromodulation

There is a great deal that remains unknown regarding the efficacy of neuromodulation treatments for MDD.

There are a number of possible treatment targets for rTMS, including left DLPFC, right DLPFC, as well as the dorsomedial prefrontal cortex. There are also a number of different frequencies and patterns of stimulation ("pulse sequences") that appear to be effective ranging from 1 Hz to 10 Hz and even higher (so-called "theta burst" stimulation). The parameter space for adjusting these factors—one or more site(s) of simulation, and frequency and pattern of stimulation—is huge. Methods such as electroencephalographic (EEG) recording during stimulation to determine how stimulation alters brain network function may offer insights into how best to direct TMS treatment for each individual.

Finally, there are multiple neuromodulation technologies that may be effective for MDD that have not been fully explored and/or approved by the Food and Drug Administration. Such technologies include repetitive transcranial direct current stimulation (tDCS) or transcranial alternating current stimulation (tACS), which utilize small batteries and electrodes attached to the scalp, and synchronized transcranial magnetic stimulation (sTMS), which utilizes rotating neodymium magnets to impart low intensity sinusoidal waveform stimulation. Some of these technologies have been determined to pose no significant risk to the patient and, once efficacy is more clearly established, may even be available for patients to use at home.

Neuromodulation treatments also appear to have efficacy beyond the treatment of MDD; for example, studies suggest that rTMS can also be used for treatment of obsessive-compulsive disorder, posttraumatic stress disorder, fibromyalgia and other chronic pain conditions, auditory hallucinations, and other neuropsychiatric illnesses.

As the evidence base for neuromodulation treatments continues to grow, diagnostic tests will increasingly be used by clinicians to guide the selection of the most effective neuromodulation procedure or to adjust treatment settings for each patient. In addition to prescribing medications, psychiatrists may one day find themselves performing office-based brain stimulation procedures and prescribing devices to be used at home. PN

CLINICAL & RESEARCH NEWS

Hospitalizations Among Veterans Rise After FDA Issues Citalopram Warning

Rapidly reducing dosages from greater than 60 mg/day to 40 mg/day or less may have precipitated worsening symptoms of depression, PTSD, and other mental health disorders, according to study authors.

BY AARON LEVIN


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The Food and Drug Administration's 2011 warning against prescribing doses of citalopram above 40 mg/day was back in the news last month after a report published in *AJP in Advance* concluded that all-cause hospitalizations and deaths among veterans rose significantly following reductions in prescribed doses of the medication.

The FDA's 2011 warning came after a growing body of evidence suggested that doses of citalopram exceeding 40 mg/day were associated with QT prolongation.

The move was intended to reduce the incidence of fatalities and health problems due to QT interval prolongation, but study authors David Rector, Ph.D., Pharm.D., of the University of Minnesota, and colleagues observed an uptick in suicidal ideation and hospitalization for worsening depression after citalopram doses were reduced.

Rector and colleagues analyzed data contained in the VA's national electronic medical records database to determine if unintended increases in suicide and hospitalization due to worsening depression were offsetting the intended benefits of limiting citalopram.

They identified 265,795 veterans who filled at least one outpatient citalopram prescription in the three months before August 2011. At the time the warning was issued, 35,848 veterans had active citalopram prescriptions for 64 mg/day, on average. By 180 days after the safety communication was issued, 60 percent had filled prescriptions for 40 mg/day or less.

The researchers used statistical analysis to compare hospitalizations and mortality after citalopram doses were or were not reduced to 40 mg/day or less. They found the unadjusted incidence of all-cause hospitalizations or deaths was more than 2.5 times higher after citalopram dosages were reduced to 40 mg/day or less. Hospitalizations for depression, diagnoses of self-injury, or death were also higher after citalopram dosages were reduced. At the same time, there was no noticeable reduction in hospitalizations for cardiac arrhythmias, according to the researchers.

"In the present study, deaths that were directly or possibly indirectly related to worsening mental health may have offset deaths from cardiac arrhythmias incurred by a continuance of higher prescription dosages," the researchers wrote. "The safety warning may have prompted electrocardiograms that led to dosage reductions that prevented some hospitalizations for cardiac arrhythmias and deaths. However, the net effect of the large number of citalopram dosage reductions that occurred shortly after the safety communications were issued appeared to manifest as an increase in hospitalizations for mental health disorders."

The FDA stood by its recommendation to limit dosage of citalopram to 40 mg/day after a commentary was published on a similar study in the *American Journal of Psychiatry* in January 2014.

In response to a request for comment on the paper by Rector and colleagues, an FDA spokesperson told *Psychiatric News*, "The FDA does not typically comment on specific studies, but evaluates them as part of the body of evidence to further our understanding about a particular issue and assist in our mission to protect public health."

The study was funded by a VA Health Services Research and Development grant. PN

"Outcomes of Citalopram Dosage Risk Mitigation in a Veteran Population" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2016.15111444. "Cardiac Safety Concerns Remain for Citalopram at Dosages Above 40 mg/Day," the 2014 commentary by FDA leaders in response to questions over citalopram recommendations, is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2013.13070905#.

Psychiatric Comorbidities May Emerge Before Cancer Diagnosis

An analysis of Swedish health registers finds that risk for a range of mental health problems begins about 10 months prior to diagnosis and peaks one week after.

BY NICK ZAGORSKI

Being diagnosed and living with cancer can cause significant psychological stress. As a result, patients with cancer may be at a heightened risk of psychiatric comorbidities, such as depression, anxiety, and substance use disorder. A 2011 meta-analysis estimated that up to 40 percent of cancer patients in hospital settings are believed to have some type of mood disorder.

While numerous studies have examined the short- and long-term impact of a cancer diagnosis on mental health, less is known of the impact of diagnostic testing leading to the diagnosis. A study in the April 28 *JAMA Oncology* suggests that the risk of a psychiatric comorbidity can become heightened nearly a year before an official cancer diagnosis.

These findings arose from a nationwide analysis of over 300,000 cancer patients in Sweden and more than 3 million cancer-free individuals selected as controls. The researchers, led by a group at Sweden's Karolinska Institutet, compared the rates of five disorders between these groups: depression, anxiety, substance use, somatic/conversion disorder, and stress/adjustment disorder.

The relative rate for all of the examined mental disorders started to become elevated about 10 months before the diagnosis. While these risks were low at first—the average risk increase was only 1.1 times greater—it continued to rise as time progressed, eventually peaking at 6.7 times increased risk one week after the cancer diagnosis. Although the rate increase dropped rapidly after this point, it remained elevated for up to 10 years following the diagnosis.

Study author Fang Fang, M.D., Ph.D., an assistant professor of medical epidemiology and biostatistics at Karolinska, noted that the workup period after a patient is referred to a cancer specialist ranges from a couple of weeks to a couple of months, so the first risks of a psychiatric issue may coincide with the initial onset of cancer-related symptoms.

Fang and her colleagues also examined eight of the most common individual cancer types and found that the pre- and postdiagnosis risks of a mental disorder were greater for cancers that have a poorer prognosis, such as colorectal cancer, than those that are viewed as more benign.

When looking at specific mental disorders, the authors found that the risk for each one was roughly similar prior to a diagnosis, but immediately after diagnosis the highest risk was for stress/adjustment disorder, followed by depression, anxiety, somatic/conversion disorder, and substance use disorder.

Groups such as the Institute of Medicine and the National Comprehensive Cancer Network have previously issued recommendations that psychological and social care be integrated into cancer care. As Fang and colleagues noted, the findings of the *JAMA Oncology* paper support these guidelines "and call for extended vigilance for multiple mental disorders starting from the time of cancer diagnostic workup."

Jesse Fann, M.D., M.P.H., a professor of psychiatry and behavioral sciences at the University of Washington and the director of psychiatry and psychology services at the Seattle Cancer Care Alliance, said that collaborative care either in the primary care or oncology setting may be the best fit for providing cancer patients behavioral health services.

Specifically, Fann noted the potential value of models that use a stepped approach, in which the degree of behavioral care is matched to the complexity of the condition.

"Because some patients will improve spontaneously while others will progress to more chronic mental health conditions, the priority following identification of new distress should be close follow-up and intensifying treatment if symptoms do not improve," he told *Psychiatric News*.

This study was supported by grants from the Swedish Cancer Society and the Swedish Research Council for Health, Working Life, and Welfare. PN

"Clinical Diagnosis of Mental Disorders Immediately Before and After Cancer Diagnosis: A Nationwide Matched Cohort Study in Sweden" is posted at http://oncology.jamanetwork.com/article.aspx?articleid=2517400.

CLINICAL & RESEARCH NEWS

‘Curbside’ Consults With Primary Care Involve Quick Response, Education

Psychiatrists working in collaborative care networks must be readily available to primary care physicians who are seeking guidance on a patient’s treatment.

BY MARK MORAN

You’re the consulting psychiatrist in a collaborative care network when you receive the following telephone call from the network’s behavioral health professional: “The primary care provider wanted me to call you. We have this girl who has done well on Strattera 40 mg per day, but now her insurance company won’t pay for it so we need to try something else. She had trouble in the past with Adderall and methylphenidate. What should we do? Try Adderall again?”

As the consulting psychiatrist, what other information do you want to know? Are there any measurement tools you would suggest? What recommendations would you offer, and what kind of education would you offer to the behavioral health provider?

That’s one exercise in “curbside” consultation that psychiatrists attending the session “Effective Curbside Consultation” practiced at APA’s 2016 Annual Meeting in Atlanta. Lori Raney, M.D., chair of the APA Work Group on Integrated Care, and John Kern, M.D., director of the Regional Community Mental Health Center in Merrillville, Ind., described the essentials of curbside consultation, modeled several consultations, and then asked attending psychiatrists to practice with each other using hypothetical scenarios like the one described above.

Every consultation with primary care is an opportunity for education, they emphasized.

Curbside consultation with primary care—either directly or through a behavioral health professional who works in the primary care clinic—is an essential skill for psychiatrists participating in collaborative care networks.

David Hathcox

“Curbside” consultations with primary care physicians require the psychiatrist to be available within two hours of the initial request, says Lori Raney, M.D. At left is John Kern, M.D.

Psychiatrists need to be readily available to consult—within two hours of the initial request—and should be welcoming to primary care physicians who may be anxious and worried about a case.

“ ‘I’m here to help you. How can I help you?’ should be your mantra,” Raney said.

Not infrequently, primary care physicians are concerned that they are doing something wrong in a patient’s treatment. “You want to convey that you understand they are calling about something really important,” Raney said. At the same time, the curbside consultation is typically brief—3 to 6 minutes.

“It’s not a lecture. Curbside consultation boils down to how much information we can translate to the primary care physician in a short period,” Raney said. “But it’s more than merely giving someone information. It’s about educating primary care doctors about behavioral and mental health.”

Raney and Kern said the top reasons that primary care physicians call psychiatrists for consults are medication choice, diagnosis clarification, information about behavioral interventions, and general education. The top disorders that primary care physicians call about are anxiety disorders, major depression, substance use, and “difficult” patients.

Raney and Kern also emphasized that psychiatrists should be prepared to consult about all manner of behavioral issues, regardless of specialty training. “Just because you are a general psychiatrist, you can’t say, ‘I don’t do child psychiatry,’ ” Kern said. PN

Payment Models

continued from page 9

A New payment models are evolving to address behavioral health. Most Medicare models target primary care, physical conditions, or procedures. But Medicaid and private insurers are leading the way in developing new models that focus on behavioral health. A prime example is the collaborative care model developed by the AIMS Center at the University of Washington in which primary care practices have a behavioral health care manager who manages care for their patients with behavioral health conditions, and a psychiatrist consults with the practice to review patient progress and make recommendations for adjusting treatment. The state of Minnesota developed the first Medicaid ACO, which has emphasized improving behavioral health care.

Q *Are psychiatrists currently involved in new models of care?*

A The collaborative care model was developed by psychiatrists. Many psychiatrists—particularly those who work with integrated health systems or large, multispecialty practices—are seeing patients who are part of ACOs and other APMs. Some ACOs have a psychiatrist as their medical director or in a similar leadership position.

Q *What is APA doing to help psychiatrists participate in new models of care?*

A One of the most important activities that APA is doing is participating in the CMS Transforming Clinical Practice Initiative (TCPI). The TCPI aims to improve patient outcomes, reduce costs, and transition 75 percent of clinician practices to APMs. As a TCPI Support and Alignment Network, APA offers psychiatrists the opportunity to receive free integrated care training. APA can also connect psychiatrists with Practice Transformation Networks that can provide quality improvement, workflow redesign, data collection, and optimization of electronic health records to assist in the transition to new models of care. For more information about TCPI, go to www.psych.org/SAN.

APA is also working for its members in other ways:

- APA is coauthor, with the Academy of Psychosomatic Medicine, of the recent report “Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model.” The report includes a working set of principles defining evidence-based integrated care implementation and highlights the importance of primary care integration through the collaborative care model.

- The MACRA pathway for new models of care should support the development of models for behavioral health and reward psychiatrists for participating in those models. APA’s MACRA comments will point out that it will be very difficult for new APMs that focus on behavioral health to meet the proposed “advanced” APM criteria. APA will also urge CMS to give psychiatrists the credit they deserve for caring for patients who are part of ACOs and other “advanced” APMs.

- APA will be working with APA member experts to explore new opportunities for psychiatrists to develop and participate in “advanced” APMs, including possible approval for the collaborative care model. More information will be provided to APA members as these efforts evolve. PN

Members with questions about Alternative Payment Models should contact Eileen Carlson, APA’s director of reimbursement policy, at ecarlson@psych.org.

Can Meditation Alter Neural Circuitry?

Renowned neuroscientist Richard Davidson, Ph.D., discusses the evidence to suggest that meditation may alter the way the brain processes emotional stimuli.

BY NICK ZAGORSKI

Lisa Helfert 2016

An inspirational meeting with the Dalai Lama propelled Richard Davidson, Ph.D., to study the neuroscience of meditation, he tells attendees as he presented the 2016 Stephen Straus Distinguished Lecture of the National Institutes of Health.

Meditation has been defined as a practice than can help transform the mind. Typically this transformation is viewed as spiritual, but can meditation also bring about biological transformations?

Richard Davidson, Ph.D., a professor of psychology and psychiatry and founder of the Center for Healthy Minds at the University of Wisconsin-Madison, is one of many researchers who believe the answer to this question is yes. He addressed this topic last month at the 2016 Stephen E. Straus Distinguished Lecture in the Science of Complementary Therapies at the National Institutes of Health campus in Bethesda, Md.

While acknowledging that interpreting clinical studies and other scientific data related to meditative practices presents several methodological and conceptual challenges, Davidson described several findings that point to neural changes associated with various forms of meditation.

Decades ago, the primary focus of Davidson's research was on how individuals respond to adversity. As he explained during the lecture, this focus expanded shortly after his own transformative experience upon meeting the Dalai Lama in 1992.

"I had given him a tour of our lab and he asked me, 'Why don't you use some of your research tools to study kindness and compassion instead of adversity and fear?'" Thus began his long career of research on Buddhist monks and other long-term practitioners of meditation to identify how the practice may affect neural circuitry.

His work has reinforced the idea that meditation is a skill that can elicit a range of brain changes. For example, when people are presented with emotional stimuli, the amygdala (a key region for processing emotions) shows heightened reactivity. Davidson's group found that when people with a long history of meditation (several thousand hours or more) are presented with an emotional challenge (for example, seeing a hostile image), the amygdala more quickly returns to baseline levels compared with people who do not meditate.

Davidson said that he believes that the ability of those practicing meditation to recover from an emotionally charged state faster than those who do not regularly meditate may reflect the expert practitioners' greater sense of self-acceptance that enables them to become more resilient to stress.

*see **Meditation** on page 36*

VIEWPOINTS

Expanded Psychiatric Care Can Transform Federally Qualified Health Centers

BY KRISTOPHER KALIEBE, M.D.

Federally Qualified Health Centers (FQHCs), which provide affordable comprehensive services in underserved communities, are a critical part of the American health care system. The expansion of psychiatric care in the FQHC system can make FQHCs even more transformative.

I have two distinct experiences as a psychiatrist at FQHCs in Louisiana. Since 2011, I have worked as a consultant to primary care teams in rural health care clinics (primarily FQHCs) across Louisiana. (Efforts to expand and integrate behavioral health services through a collaborative care system arose in part from the Deepwater Horizon Medical Benefits Class Action Settlement: Gulf Region Health Outreach Program.) This model helps to ensure the efficient use of resources and increase coordination, communication, and access to behavioral health care. I work both on site and via telepsychiatry and find both approaches to be effective.

In addition, for over a decade, I have run a weekly psychiatric clinic (fee-for-service, not based on a collaborative model) at an FQHC outside of New Orleans. In this setting, I regularly see a dozen or more patients a day and manage the tension between obligations to current patients and the community's need for new referrals—a tension common throughout the country, where many have limited access to psychiatric services. In Louisiana, FQHCs are one of the few settings that receive adequate reimbursement for Medicaid patients; thus, FQHCs are one of the only settings where most children in Louisiana can access psychiatric services.

Through my work in various FQHCs and different care delivery systems, I can see that growing both standard clinics and adopting team-based collaborative care at FQHCs will take pressure off schools, social service agencies, law enforcement, and courts. These agencies frequently interact with individuals who do not have access, but could benefit from community-based outpatient behavioral health care.

Community mental health centers, substance abuse treatment programs, emergency rooms, and inpatient psychiatric units struggle to fulfill their specialized missions, as the current system of care is siloed and fragmented. A comprehensive medical home for patients at FQHCs would enable most behavioral health care to be delivered in a primary care setting and, as needed, patients can be matched with the correct type of specialized care, including higher levels of service for the acutely ill.

In addition to increasing the availability of behavioral health services, more must be done to change how behavioral health care is approached. Rather than prescribing costly medications with limited clinical benefit, more must be done to emphasize the value of psychotherapy and mind-body techniques such as breathing exercises, mindfulness meditation, and expressive therapies. Self-help is also underutilized: quality psychoeducation and self-help are inexpensive, easy to access, and surprisingly effective.

Poor nutrition, a sedentary lifestyle, and sensory overload are the enemies of both physical and mental health, and FQHCs are a perfect setting for offering comprehensive interventions aimed at both physical and mental health care. FQHCs also offer the opportunity to expand supports for entire families, including increasing parent training and family therapies.

To be truly transformative, FQHCs will require additional social workers, care managers, and/or embedded behavioral health specialists. Psychiatrists must be supported in their various roles, including both as treatment providers and as collaborators supporting primary care teams. PN

Kristopher Kaliebe, M.D., is an assistant professor in the Department of Psychiatry at Louisiana State University, New Orleans.

JOURNAL DIGEST

BY VABREN WATTS AND NICHOLAS ZAGORSKI

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Mindfulness-Based Cognitive Therapy May Reduce Relapse in MDD Patients

A meta-analysis published in *JAMA Psychiatry* suggests that mindfulness-based cognitive therapy (MBCT) may be just as or more effective in preventing or delaying relapse in patients with recurrent major depressive disorder (MDD) than other types of depression therapies, especially in individuals with pronounced residual symptoms.

MBCT combines the concepts of cognitive therapy with meditative practices and attitudes based on the cultivation of mindfulness.

For the study, an international team of researchers performed a systematic review of randomized trials published from November 2010 to November 2014. To meet inclusion, studies were required to have compared the effectiveness of MBCT with at least one non-MBCT treatment, such as antidepressant treatment and cognitive psychological education, to prevent symptom relapse in adults with recurrent MDD who were in full or partial remission.

The effectiveness of MBCT treatment was measured by the absence of relapse to depression within 60 weeks of follow-up, measured by the Structured Clinical Diagnostic Interview. The researchers also examined the impact of sociodemographic factors and psychiatric variables on MBCT effectiveness.

Nine trials met inclusion in the meta-analysis, with a total of 1,258 participants. Of the participants who received MBCT, 38 percent had a depressive relapse within the 60-week follow-up compared with 49 percent among those who did not receive MBCT. Results also showed MBCT to be more effective in people presenting greater depressive symptoms at baseline compared with those who did not. There was no statistical correlation between MBCT and age, sex, education, or relationship status.

In an accompanying editorial, Richard Davidson, Ph.D., founder of the Center for Healthy Minds at the University of Wisconsin-Madison, wrote that "the opportunity now is to examine in more detail which types of patients benefit most from MBCT, the mechanisms by which MBCT is producing its beneficial change, and how we can better measure the mediators of therapeutic change."

Kuyken W, Warren F, Taylor R, et al. Efficacy of Mindfulness-Based Cognitive Therapy in Prevention of Depressive Relapse. *JAMA Psychiatry.* 2016;73(6): 565-74. http://archpsyc.jamanetwork.com/article.aspx?articleid=2517515

iStock/cosmin4000

Experimental Cancer Drug Shows Promise for Fragile X

An experimental drug called nutlin-3, currently being tested as a retinoblastoma treatment, may improve learning and memory associated with fragile X syndrome, according to an animal study published in *Science Translational Medicine*.

Fragile X syndrome, caused by mutations in the FMR1 gene, is the most common inherited cause of autism spectrum disorder.

In studying a mouse model of fragile X, researchers found that the mutations in FMR1 led to more activity of a protein called MDM2, which in turn led to greater proliferation of neural stem cells, but less differentiation into mature neurons. Instead, these mice produced more astrocytes, a type of cell that carries out several supporting functions in the brain.

Low doses of nutlin-3, which is an MDM2 inhibitor, helped correct this imbalance between astrocytes and neurons, and restored spatial memory and object recognition in the deficient mice.

The authors also found that nutlin-3 seemed to have no visible effects on already mature neurons.

Li Y, Stockton M, Bhuiyan I, et al. MDM2 Inhibition Rescues Neurogenic and Cognitive Deficits in a Mouse Model of Fragile X Syndrome. *Sci Transl Med.* April 27, 2016. http://stm.sciencemag.org/content/8/336/336ra61

People Withdrawing From Opioid Addiction May Abuse Imodium

People attempting to self-treat symptoms of opioid withdrawal may be at risk of abusing the over-the-counter antidiarrheal medication loperamide (marketed as Imodium), according to a case report in the *Annals of the Emergency Medicine.*

Loperamide, a μ-opioid agonist, has not been observed to have effects on the central nervous system similar to those of prescription painkillers or heroin when used at the recommended dose. However, the antidiarrheal drug may manifest these effects at doses that are at least 10 times higher than daily recommendations.

One patient had ingested a loperamide concentration of 77 ng/mL and another 144 ng/mL (the therapeutic range is 0.24 ng/mL to 3.1 ng/mL). Both cases resulted in overdose of loperamide, interaction with emergency medical services due to cardiovascular events, and ultimately death. (Although high doses of loperamide may increase risk of cardiovascular events, it was not confirmed that the patients died from loperamide-associated adverse cardiovascular events.)

From 2011 through 2014, national poison centers reported a 71 percent increase in calls related to intentional exposure to loperamide.

"Health care providers must be aware of increasing loperamide abuse and its underrecognized cardiac toxicity," lead author William Eggleston, Pharm.D., of the Upstate New York Poison Center, said in a press release. "This is another reminder that all drugs, including those sold without a prescription, can be dangerous when not used as directed."

Eggleston W, Clark K, and Marraffa J. Loperamide Abuse Associated With Cardiac Dysrhythmia and Death. *Ann Emerg Med.* April 26, 2016. [Epub ahead of print] http://www.annemergmed.com/article/S0196-0644(16)30052-X/fulltext

see ***Journal Digest*** *on page 32*

Journal Digest

continued from page 31

iStock/BraunS

Marijuana Use By Teens May Increase Risk Of Paranoia, Hallucinations

Adolescents who regularly use marijuana may be more likely to experience subclinical paranoia and hallucinations, even after sustained abstinence from the drug, according to a study in *AJP in Advance*.

Researchers from the University of Pittsburgh Medical Center and Arizona State University, Phoenix, analyzed data from a sample of 1,009 adolescent boys from Pittsburgh who self-reported annually on the number of days they used marijuana in the past year and experiences of subclinical psychotic symptoms (for example, feelings of paranoia, hallucinations, or bizarre thinking) from age 13 to 18. The teens also annually reported on the number of days they used alcohol, tobacco, and other illicit drugs.

As expected, substance use increased from age 13 to 18. By the last assessment, 270 participants reported having used marijuana weekly, 325 had used alcohol weekly, 377 had used tobacco daily, and 134 had used other illicit drugs at least once. For each year the participants engaged in weekly marijuana use, their expected level of subsequent subclinical psychotic symptoms rose by 21 percent, and their expected odds of experiencing subsequent subclinical paranoia or hallucinations rose by 133 percent and 92 percent, respectively.

Additional analysis revealed that even when adolescents stopped using marijuana for one year, the effect of prior weekly marijuana use on total subclinical psychotic symptoms, paranoia, and hallucinations persisted. For each additional year adolescents engaged in weekly marijuana use, their expected number of total subclinical psychotic symptoms rose by 29 percent during subsequent periods of yearlong abstinence, and their expected odds of experiencing paranoia and hallucinations rose by 112 percent and 158 percent, respectively.

"[T]he most concerning finding is that the effect of prior weekly marijuana use persists even after adolescents have stopped using for one year," the researchers wrote. PN

Bechtold J, Hipwell A, Lewis D, et al. Concurrent and Sustained Cumulative Effects of Adolescent Marijuana Use on Subclinical Psychotic Symptoms. *Am J Psychiatry.* May 3, 2016. [Epub ahead of print] http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2016.15070878

Fort Hood

continued from page 15

Army Medical Center. He was counseled about preaching to his patients and was cited for a "lack of professionalism and work ethic," but responded to counseling by correcting his behavior.

He was allowed to graduate from residency in 2007, despite continuing questions about his professionalism and work ethic. He spent the next two years in a disaster and preventive psychiatry training fellowship at USUHS before being assigned to Fort Hood as a staff psychiatrist.

There, an evaluation completed just two days before the killings declared Hasan to be "an outstanding physician who has the potential to excel. ... He should be selected for positions of

increasing responsibility. Promote now."

Hasan told the board that he had begun contemplating doing something violent but had informed no one. In fact, said Joshi, Hasan had no unusual risk factors or history of violence before the attack at Fort Hood. There was no evidence of abuse, bad behavior, or special education during his childhood. An indifferent high school student, he served as an enlisted man in the Army in 1988-90 before going to college.

Hasan for a time corresponded with Anwar Al-Awlaki, an imam and an American citizen who became a leader of Al Qaeda in Yemen. Awlaki was killed in a U.S. drone strike in 2011. Their communication was noted by the FBI, but its inquiry ended when it was learned that Awlaki had earlier presided at Hasan's mother's funeral outside Washington, D.C.

In the end, the sanity board concluded that, at the time of the crime, Hasan was not suffering from a mental illness and he was not "unable to appreciate the nature and quality and wrongfulness of his conduct." Nor did he have any clinical diagnosis when evaluated. Finally, he understood the charges against him and was competent to stand trial, said the board.

Hasan told the board that he wanted to become a martyr, either by being killed at Fort Hood at the time of the shootings or by the death penalty, said Joshi. "He denied having remorse for his actions." PN

A summary of the sanity board's report is posted at https://assets.documentcloud.org/documents/750594/hasan-document.pdf.

Bupropion

continued from page 21

treatment on average lost 7.1 pounds compared with nonsmokers taking fluoxetine. Changes in weight associated with all other antidepressant medications were not significantly different from those associated with fluoxetine, except for sertraline users, who gained an average of 5.9 pounds.

(The only antidepressant for which the weight gain was found to be as pronounced as that of antipsychotics is mirtazapine; those using the drug gained on average 11.6 pounds compared to fluoxetine users, but because of the small number of patients receiving that medication in the study, the finding was not statistically significant.)

"[I]t is suspected that the dopaminergic and noradrenergic effects of bupropion play important roles in the regulation of appetite, satiety, craving, and feeding behavior," the authors wrote.

The weight loss effect for bupropion was not seen in smokers, many of whom were likely being prescribed the drug specifically for smoking cessation. "People who are trying to quit smoking are commonly known to gain weight on average," Arterburn explained. "So, the effect of quitting smoking on weight gain was big enough to reverse the protective effect of bupropion on weight."

Simon told *Psychiatric News* that the relationship between depression and weight gain—and the possible compounding influence of antidepressants—is complex.

"We know from lots of previous research that people who are depressed

are more likely to be obese," he said. "Is that because depression increases the risk for weight gain, or because overweight people are more likely to be depressed? On top of that, if people are taking an antidepressant, how do you know if this is related to the medicine?

"In clinical practice it's a challenge, because weight gain is a gradual thing, unlike other side effects. All people on average gain weight as they age, so if someone is taking medication and gradually gaining weight, it's difficult to know the cause."

Simon said the study suggests that all antidepressants have some effect on weight, and that only bupropion actually lowered weight at two years.

"Previous research has confirmed that treatment effects on depressive symptoms are roughly equal across all antidepressants, so clinicians largely make prescribing decisions on the basis of side effects and cost," Simon added. "For patients for whom obesity is a serious problem, the findings from the study are an important piece of information to consider."

Arterburn and Simon said future research at the GHRI will focus on genetic factors that may indicate which patients being prescribed antipsychotics or antidepressants are most likely to experience weight gain.

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

"Long-Term Weight Change After Initiating Second-Generation Antidepressants" is posted at http://www.mdpi.com/2077-0383/5/4/48/htm.

Meditation

continued from page 29

This resilience even goes beyond the brain, as some of Davidson's latest research found that expert practitioners showed a lower inflammatory reaction when a topical capsaicin cream was applied to their skin.

Not everyone can devote thousands of hours to meditation, but Davidson also highlighted research from his team that showed even short-term practice can be beneficial. He discussed one study that found that just two weeks of compassion-based meditation (that is, training to feel more empathy for oneself and others) led to more altruistic behaviors among study participants who took part in a monetary redistribution game.

But while such observations are promising, Davidson noted the need to develop a viable placebo to use in mindfulness research.

"The power of positive thinking can skew research results, and I think this is especially strong in mindfulness studies," he said. "We need a reliable, active comparator if we want to assign specificity to any of the changes we see in people who meditate."

Davidson described a technique developed by his group that may one day offer a viable control for mindfulness studies. The program, called the Health Enhancement Program (HEP), mimics several aspects of mindfulness practice, including music therapy or yoga, but deemphasizes the importance of self-awareness during the practice.

The Stephen E. Straus Distinguished Lecture in the Science of Complementary Therapies is presented by the NIH's National Center for Complementary and Integrative Health and honors its founding director. PN

More information on the Stephen E. Straus Distinguished Lecture series is posted at https://nccih.nih.gov/news/events/lectures.

Child Psychiatrists

continued from page 23

to placebo, compared with 30 percent among adults, making it hard to separate effects.

When parents express anxiety about using SSRIs and ask for psychotherapy, Wagner explains that cognitive-behavioral therapy (CBT) takes time to work and that a faster response can be obtained by combining an antidepressant with CBT. CBT can teach social skills and problem-solving techniques as well. Wagner counsels patience once an SSRI is prescribed.

A 36-week trial of a drug is too brief, she said. "The clock starts when the child is well, usually around six months. Go for one year and then taper off to observe the effect."

Wagner suggested using an algorithm to plot treatment, beginning with an SSRI, then trying an alternative SSRI if that doesn't work, then switching to a different class of antidepressants, and finally trying newer drugs.

"We need to become much more systematic in treating depression," she concluded. PN

Reform

continued from page 1

"The act is the first attempt in the House and the Senate to take a holistic look at a broken system," said Murphy. "We assessed the problem as being threefold: a lack of resources, a lack of coordination, and a lack of focus on continuing stigma."

Spending in Medicare, Medicaid, and private insurance is highly concentrated, and all citizens pay for it, directly or indirectly, said Ashish Jha, M.D., M.P.H., director of the Harvard Global Health Institute and a professor of medicine at Harvard Medical School and the Harvard T. H. Chan School of Public Health.

"About 21 percent of the Medicare population had a mental health diagnosis, but 49 percent of the high-cost patients had such a diagnosis, primarily depression, anxiety, or schizophrenia," said Jha. "However, we can't point to any one mental health diagnosis as the problem."

Five critical components were needed for meaningful mental health reform, said Oquendo.

First, all federal mental health initiatives must be overseen by physicians with expertise in psychiatric conditions, she said. "Because psychiatric and substance use disorders are fundamentally brain disorders, leadership with the appropriate biological training is key."

She also called for more research support at the National Institute of Mental Health, National Institute on Drug Abuse, and National Institute on Alcohol Abuse and Alcoholism, as well as more resources for training psychiatrists and other mental health clinicians. Greater emphasis on preventing mental illness is also essential, she said, along with stronger federal enforcement of the Mental Health Parity and Addiction Equity Act.

In thanking the senators for their efforts, Oquendo said, "APA is very encouraged that the components of meaningful mental health reform are addressed in the bill."

Child and adolescent psychiatrists face additional problems as they seek to help solve the problems addressed by the bill, said Gregory Fritz, M.D., a professor of psychiatry at Brown University School of Medicine and president of the American Academy of Child and Adolescent Psychiatry.

Medical school loan repayment plans don't include child and adolescent psychiatrists, an oversight rendering them ineligible for such programs, said Fritz. Also, National Health Service Corps loan relief is available only within two years of completion of a "primary residency," again leaving out child psychiatrists, who must complete a two-year fellowship. Amendments covering changes to eliminate these restrictions have been proposed, he noted.

"Let's not leave the children out," said Fritz. "We need to get the details right."

"Ignoring mental health is hugely costly to our health system, our treasury, and our own pockets," said Jha. "If we get it right, we will be fiscally more prudent and provide better care for our patients."

Cassidy and Murphy emphasized the importance of grassroots support of mental health reform in the months ahead.

"Even in this election year, we can still pass the Mental Health Reform Act and get it signed by the president," said Cassidy. PN

In a blog post on APA's website, Oquendo urged her fellow psychiatrists to contact their representatives in Congress and ask them to support comprehensive mental health reform. The blog can be accessed at https://www.psychiatry.org/news-room/apa-blogs/apa-blog/2016/05/comprehensive-mental-health-reform-essential-to-the-future-of-psychiatry?_ga=1.49902063.853835964.1456864781.