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AMERICAN PSYCHIATRIC ASSOCIATION

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APA is holding its educational fall meeting—IPS: The Mental Health Services Conference—from October 6 to 9 in Washington, D.C. Enjoy the brilliant fall foliage while sharpening your skills and preparing for the changing health care environment. See page 17.

# AMA Calls for End of Ban on CDC Research on Gun Violence

**Two days after the massacre at a gay nightclub in Orlando, physicians in the House of the Delegates nearly unanimously voted in favor of passing an emergency resolution on gun violence.**

BY MARK MORAN

Congress should lift a ban that effectively prohibits research at the Centers for Disease Control (CDC) on gun violence as a public health hazard, declared the AMA House of Delegates at its meeting last month in Chicago.

The delegates, in an emergency resolution approved two days after the mass shooting at an Orlando, Fla., nightclub early on the morning of Sunday, June 12, adopted policy that calls gun violence "a public health crisis" requiring a comprehensive public health response and solution.

Importantly, the resolution, which was cosponsored by the AMA Section Council on Psychiatry, calls on the AMA to lobby Congress to overturn legislation that for 20 years has prohibited the CDC from researching gun violence. The language in that legislation—an amendment to the Labor-Health and Human Services-Education Appropriations bill passed in 1996—has remained in subsequent annual funding bills.

The resolution gathered support among AMA delegates almost immediately after the firearms massacre in

see **Gun Violence** on page 32

# Iowa Passes Psychologist Rx Law

**An extended process to determine training standards for prescribing psychologists is expected, say observers.**

BY AARON LEVIN

In May, Iowa became the fourth state to enact legislation permitting specially trained psychologists to prescribe psychotropic medications. However, implementation of the law will be delayed until specific education and training standards are determined by representatives from Iowa's boards of medicine and psychology.

APA, joined by other medical professional societies, opposes prescribing rights for psychologists, citing patient safety concerns.

New Mexico's prescribing law passed in 2002 and Louisiana's in 2004. Similar legislation passed in 2014 in Illinois, although details of the training requirements for psychologists there are still being working out. More than 30 states have considered such bills over the past two decades, but only four have become law.

"I was surprised at the outcome," said Jerome Greenfield, M.D., director of mental health services for the Iowa Department of Corrections and president of the Iowa Psychiatric Society (IPS), in an interview. "We presented good, organized, accurate information to legislators, but the issue became a pawn in a larger political chess game behind the scenes."

Iowa psychiatrists and other physicians can still influence implementation of the new law. The boards of medicine and psychology must agree on the precise wording for the psychopharmacological training of psychologists before they are permitted to prescribe.

"The IPS will work closely with this process to ensure that our concerns and suggestions are incorporated into the final rule," Joyce Vista-Wayne, M.D., of Mercy Medical Center in Des Moines and the immediate past president of the IPS, told *Psychiatric News*.

Pharmacological training isn't the only requirement psychologists will be asked to complete, according to language in the law. To receive a conditional prescription certificate, a psychologist must pass a certification examination, complete a postdoctoral master's degree in clinical psychopharmacology, and complete a "supervised and relevant clinical experience," including a practicum of unspecified length.

Holders of the conditional prescription certificate must practice under the supervision of a physician, who need not be a psychiatrist. They cannot treat persons under the age of 17 or older than 65, pregnant women, or people with "serious medical conditions." After two years, the

see **Iowa Law** on page 10

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

# Psychiatrists Have a Role to Play in Latest Gun Law Debates

BY MARIA A. OQUENDO, M.D.

The contrast between the brilliant morning light pouring through my kitchen window and one of the front-page headlines in the *New York Times* could not have been starker: "Bedlam Erupts in House Sit-In by Democrats" (June 23, 2016). As I pored over the paper, soaking in the details of the fracas over the lack of action on the latest gun control bill, I could barely believe it. There it was: the Republican leadership working to restore order by cutting off the microphones and the feed to C-SPAN; Democrats chanting, "No bill. No break." I could not help thinking: this is a watershed moment for psychiatry!

Why? Because guns kill people. Of course, that is an obvious statement. But guns kill people not only in the way that dominates public discourse and debates over policies on gun control: mass murder, homicide.

Guns kill people most often by suicide.

That is not to say that mass murder, so sadly common in this great country, or homicide, also dismally common, are unimportant. Our society most definitely needs to address these critical problems. But the sad truth is that most of the time, guns are used by people to kill themselves.

Do the math: in 2013, the rate of homicide by firearms in the United States was 3.5 per 100,000 people. In contrast, the suicide rate by firearms was 6.7 per 100,000 people. According to the Centers for Disease Control and Prevention (CDC), over 33,000 persons died from firearm injuries in 2013; suicides were close to double the number of homicides at 63.0 percent and 33.3 percent, respectively. That, for most of U.S. citizens, is a shocking fact.

To address these stunning statistics, we need to be active and we need to be practical. As psychiatrists, we have an active role to play in making these numbers a critical part of the conversation on gun safety and advocating for change.

One key first step in advocating for gun safety is to make sure that firearms are kept safe and secure, away from family or friends who may be suicidal. Interestingly, the New Hampshire Gun Safety Coalition has put together 11 "commandments" for gun safety and specifically recommends "temporary off-site storage if a family member may be suicidal." Although the availability of these guidelines is very helpful, adoption of even these modest steps has been difficult to secure. Even laws about gun safety, never mind gun control, have gone unpassed.

Worse, in Florida, physicians are forbidden to have general conversations counseling patients about gun ownership. This leaves a gaping hole in the assessment of availability of means to attempt suicide and for accidental deaths. According to the American Academy of Pediatrics, 10 additional states have introduced legislation that restricts doctors' ability to counsel patients about gun safety. Fortunately for our patients, there are no laws at either the federal or state level that prohibit doctors' questioning of patients about whether they own guns, if it is relevant to the patient's health or the health of others.

Now, at least there is a big fuss being made about the lack of progress on gun laws on Capitol Hill. For our patients, and for public health and safety, we need some action. And while I don't know if there will be action, that there is outrage on the Hill is huge progress. PN


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## IN THIS ISSUE



### Register Now for IPS

Registration for APA's 2016 IPS: The Mental Health Services Conference is now open. The theme of this year's meeting, which will be held in Washington, D.C., from **October 6 to 9**, is "Implementing Prevention Across Psychiatric Practice." Information on the program, registration, and housing can be accessed at psychiatry.org/IPS. Register now now to take advantage of the low registration rates. See page 17 for an overview of the meeting.

## Departments

PROFESSIONAL NEWS

# AMA Approves Motion Limiting Guns, Tasers in Medical Settings

**A brother with mental illness who was shot and Tasered in the hospital prompted orthopedic surgery resident Christian Pean, M.D., to bring the issue of firearm and stun-gun use in health care settings to the AMA for action.**

BY MARK MORAN

Christian Pean, M.D., an orthopedic surgery resident, initiated a resolution that was approved by the AMA House of Delegates last month to limit the use of firearms in health care settings.

A year ago in August, Alan Pean, a 26-year-old who has bipolar disorder, was shocked with a Taser and shot in a Houston hospital after driving himself there for treatment.

According to a report that appeared in the *New York Times* on February 12, Pean had sought care at the emergency department of St. Joseph Medical Center in Houston. He was admitted to the hospital and later became increasingly delusional while waiting overnight for treatment. At some point, nurses called security, and before the night was over, Alan was shocked with a Taser and shot in the chest by off-duty police officers.

Alan recovered, and today he is speaking out about what happened to him. He told the *Times*, "I thought of the hospital as a beacon, a safe haven. I can't quite believe that I ended up shot.' "

Christian Pean

Alan Pean, a patient with bipolar disorder who sought treatment at a Houston hospital, is seen with his mother, Lourdes Pean, and father, Harold J. Pean, M.D., two days after Alan was shocked with a Taser and shot last August.

Last month Alan's brother, Christian Pean, M.D., an orthopaedic surgery resident at NYU Hospital for Joint Diseases, brought the issue to the annual policymaking meeting of the AMA House of Delegates. That led to the delegates' approving a resolution—originally drafted by Pean and colleagues with the AMA Minority Affairs Section and supported by the AMA Section Council on Psychiatry—that advocates "that hospitals and other health care delivery settings limit guns and conducted electrical weapons [commonly known as Tasers] in units where patients suffering from mental illness are present."

"We brought this resolution to the AMA because it speaks to the different issues my brother's shooting raises about the safety of patients with mental illness in the hospital and other health care settings," Pean told *Psychiatric News*.

He said the use of firearms and Tasers on patients is becoming more common in American health care settings, one that disproportionately affects people with mental illness and, especially, racial and ethnic minority patients with mental illness.

According to the *Times*, "More and more American hospitals are arming guards with guns and Tasers, setting off a fierce debate among health care officials about whether such steps—along with greater reliance on law enforcement or military veterans—improve safety or endanger patients."

The *Times* added, "The same day Mr. Pean was shot, a patient with mental health problems was shot by an off-duty police officer working security at a hospital in Garfield Heights, Ohio. Last January, a hospital security officer shot a patient with bipolar illness in Lynchburg, Va. Two psychiatric patients died, one in Utah, another in Ohio, after guards repeatedly shocked them with Tasers."

In reference committee hearings prior to the meeting of the House of Delegates, the resolution was widely—and in some cases, passionately—supported. The resolution was also supported by the Section Council on Psychiatry.

"I applaud Dr. Pean for bringing this issue forward to the AMA. His action has both established new policy and helped increase awareness about the dangers associated with the presence of firearms and Tasers on inpatient psychiatric units," said David Fassler, M.D., alternate delegate to the AMA from the American Academy of Child and Adolescent Psychiatry. "Hopefully, the involvement of the AMA will lead to enhanced safety for both patients and staff."

Some physicians expressed that the safety of patients, physicians, and staff at hospitals sometimes depends on the use of force by security personnel; language in the original resolution that called for "restricting" firearms and Tasers was modified to "limited." Existing AMA policy was also reaffirmed in place of several other items in the resolution—those addressing advocacy for patients with mental illness, reporting of "sentinel events" in the hospital, and training of personnel in the "de-escalation" of potentially violent encounters.

"We are happy with the revised resolution and believe that its being adopted is an important step to address the issues it brought up," Pean told *Psychiatric News*.

*see* ***AMA on Guns*** *on page 22*

# AMA Updates Ethics, Addresses Zika, Juvenile Justice, Other Issues

The following are among the reports and resolutions approved by the AMA House of Delegates at last month's policymaking meeting in Chicago.

• **The Council on Ethical and Judicial Affairs (CEJA) Report on Modernization of Medical Ethics.** In 2008, CEJA began a project to comprehensively review and update the AMA's foundational document, the "Code of Medical Ethics," the first thorough review of the document in more than 50 years. The report finalizes the project after being debated by the House multiple times since 2008. An important change in the final report is that each opinion in the code is accompanied by the following language: "This opinion is offered as ethics guidance for physicians and is not intended to establish standards of clinical practice or rules of law."

• **Resolution on "Funding for Zika Control and Research"** urges Congress to enact legislation providing increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus without diverting resources from other essential health initiatives. It also encourages the Centers for Disease Control and Prevention to work with experts in all relevant disciplines to develop U.S. and global strategies to limit the spread of the virus.

• **The Council on Science and Public Health (CSPH) Report on "Juvenile Justice System Reform"** explains research findings on adolescent brain development and the harms of solitary confinement and addresses the importance of reentry and aftercare services to reduce recidivism in the juvenile justice system. "Our report focuses on the inappropriate use of solitary confinement for juveniles, for which there is policy but one that is not followed in all 50 states," said CSPH Chair Louis Kraus, M.D., a child psychiatrist. "The report also focuses on the need to address mental health and educational issues among juveniles in the justice system."

• **Resolution on "Policies on Intimacy and Sexual Behavior in Residential Aged-Care Facilities"** encourages long-term-care facilities to adopt policies that preserve residents' rights to pursue sexual relationships while protecting them from unsafe or abusive situations.

"The majority of long-term-care facilities have no formal policy on intimacy and sexuality," said geriatric psychiatrist Allan Anderson, M.D.,

*continued on next page*

# Slavitt Says CMS Is Determined to Listen to Physicians

**The acting administrator of CMS says that one of its priorities is to allow physician practices to drive how they participate in quality reporting programs and to focus on the needs of small group and rural practices.**

BY MARK MORAN

The federal government wants to start listening—really listening—to physician concerns, said Centers for Medicare and Medicaid Services (CMS) Administrator Andy Slavitt to the AMA House of Delegates last month.

In an address on the opening day of the House of Delegates meeting in Chicago, Slavitt sought to persuade physicians that the government is determined to reverse a pattern of top-down administration of rules and regulations for Medicare payment by listening to physician concerns and incorporating them into ongoing program improvement and refinement.

"I'm here to talk about reversing a pattern of regulations and frustration and ultimately unleashing a new wave of collaboration between the people who spend their lives taking care of us and those of us whose job it is to support that cause," he said.

Slavitt reviewed the passage of the Medicare Access and CHIP Reauthorization Act (MACRA), which crucially ended the sustainable growth rate component of the Medicare payment formula and created a new value-based payment system known as the Merit-Based Incentive Payment System (MIPS). MACRA also consolidated already existing quality improvement programs at CMS and reduced the number of quality reporting measures necessary.

On April 27 CMS released the highly anticipated proposed rule to establish key parameters for the new Quality Payment Program, a framework that includes the MIPS and Alternative Payment Models. APA has delivered comments to CMS in response to the proposed rule; a final rule is expected to be published in November.

Ted Grudzinski/AMA

CMS Administrator Andy Slavitt tells AMA delegates that the administration will focus on keeping "the patient at the center" of its programs and simplifying rules and regulations wherever possible.

Slavitt acknowledged that "with MACRA, we answered one question and opened up a set of others that are now ours to begin to address."

He said the key question to address is how to make the new quality payment system work so that physicians can focus on treating patients while also helping to keep the Medicare program solvent into the future.

"As the Medicare program moves into its golden years, so does the reality of the job it must do in caring for our nation's elderly and disabled," he said. "There are 10,000 new Medicare beneficiaries every day, a boom generation is turning 70, and the 85 and up generation is set to double over the next 10 years. With the growth of Medicare beneficiaries outpacing the growth of working Americans, we need to find ways, like we do in other sectors, to deliver better care at lower costs."

Slavitt emphasized three important, overarching changes to physician payment under MACRA. The first is that it sunsets three previous programs that had overlapping (and sometimes conflicting) requirements—the Physician Quality Reporting System, the Value Modifier, and the Meaningful Use Program—and replaces them with a single, aligned Quality Payment Program. Slavitt said the Quality Reporting System, which incorporates MIPS to pay physicians, will "reduce reporting requirements, eliminate duplication, and reduce the number of measures. For those who participate in Alternative Payment Models, those requirements are reduced further or eliminated."

Second, Slavitt said, MACRA reduces the combined possible downward adjustment of 9 percent that is occurring now from the three programs to a maximum of 4 percent in the first year of the Quality Payment Program. "The program is designed to build up over the course of several years, with more modest financial

*see* ***Slavitt*** *on page 35*

*continued from previous page*

a delegate to the Section Council on Psychiatry from the American Association for Geriatric Psychiatry. "This can cause significant stress and can result in legal proceedings such as a recent case where a husband was brought up on rape charges because his wife did not recognize him during a time when they purportedly had sexual activities."

Anderson said it is a complex problem involving whether individuals have the capacity to consent to participate in sexual activity.

- **Resolution on "Clarification of Medical Necessity for Treatment of Gender Dysphoria"** supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

"Gender dysphoria is widely recognized as exacerbated by lack of access to gender-affirming treatments," said Brian Hurley, M.D., the delegate from the Gay and Lesbian Medical Association to the Section Council on Psychiatry. "There are significant barriers faced by transgender people seeking gender-affirming care, so our AMA's promotion of gender-affirming care is critically important to meeting the needs of this vulnerable population."

Hurley also testified on a resolution, approved by the House, on "Sexual Orientation and Gender Identity Policies." "The report eliminates the term 'homosexual' as a noun and replaces it with the terms 'lesbian', 'gay,' and 'bisexual,' " Hurley said. "Further, where appropriate, we used the term 'transgender' to also discuss the health care needs of patients of all gender identities. This brings contemporary language into AMA policy and codifies the AMA's commitment to supporting people with diverse sexual orientations and gender identities."

- **The CSPH Report on "Increasing Awareness of Nootropic Use"** evaluates the use of nootropics—also known as "smart drugs"—which are prescription drugs, supplements, or other substances claimed to improve cognitive function, memory, learning, or intelligence. The CSPH recommends that the AMA oppose prescription of controlled substances for the purpose of cognitive enhancement in otherwise healthy individuals, discourage nonmedical use of prescription drugs for cognitive enhancement in schools and workplaces, and urge the Federal Trade Commission to examine advertisements for dietary supplements and herbal remedies that claim cognitive enhancement to ensure they are not misleading and are substantiated.

- **The Council on Medical Education Report on "Update on Maintenance of Certification and Osteopathic Continuous Certification."** The council asks the AMA to examine the activities that medical specialty organizations have undertaken for alternative pathways to board certification; asks the American Board of Medical Specialties (ABMS) to ensure that all ABMS member boards provide transparency related to costs of maintenance of certification and certifying exams; and encourages the ABMS to review policies regarding maintaining underlying primary or initial specialty board certification in addition to subspecialty certification.

- **Resolution on "Fixing the VA Physician Shortage With Physicians"** calls on the AMA to work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in Veterans Administration facilities. It also calls for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility. PN

The proceedings of the 2016 annual meeting of the House of Delegates can be accessed at http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/meeting-archives/2016-annual-meeting.page.

PROFESSIONAL NEWS

# Collaborative Care Model Prepares Psychiatrists for Value-Based Care

**Psychiatrists trained in collaborative care will be better prepared to meet the demands of the changing health care system.**

*This is the fifth in a series of articles on value-based payment.*


The movement toward "value-based payment" has greatly accelerated in recent years to address the high level of Medicare spending and is furthered by advances in technology—especially the proliferation of electronic health records (EHRs) and payer-incentive programs to encourage more EHR adoption. The goal of this evolution is summed up in the so-called Triple Aim: improved patient care, better population health, and lower per capita cost of health care.

In the fifth article in the series "Changing Practice/Changing Payment," *Psychiatric News* focuses on collaborative care, an established care model that seeks to meet the goals of the Triple Aim by integrating general medical and psychiatric care.

**Q** *Why collaborative care?*

**A** Mental illnesses such as depression, anxiety, and substance use disorders are responsible for 25 percent of all disabilities worldwide, with these disorders being a major driver of overall health care costs. There is growing acknowledgment by policymakers, payers, and providers that any solution to driving down the cost of health care must include treating mental health/substance use disorders with comorbid physical conditions.

As payers consider ways to curb the cost of health care, the integration of medical and behavioral health care is emerging as an effective solution. According to a study by Milliman, an estimated $10 billion to $15 billion could be saved each year for Medicare and Medicaid and $16 billion to $32 billion for the commercially insured through effective integration of mental health care with other types of medical care.

Psychiatrists are uniquely positioned to improve access to quality mental health care in integrated care settings. For decades, those in consultation/liaison psychiatry (also known as psychosomatic medicine) have been working in a variety of settings—primary care, hospitals, and outpatient specialty clinics such as those for diabetes care or women's clinics—to help patients with comorbid psychiatric and physical conditions. They may help treat elderly patients with unsuspected alcohol dependency who received coronary artery bypass surgery or coordinate care for someone diagnosed with cancer who is experiencing depression. More psychiatrists are involved with consult psychiatry through the use of the collaborative care model (CoCM), which improves the integration of physical and mental health care by applying the principles of effective chronic disease management to treating patients with mental illness.

CoCM is the most promising model for integrating physical and mental health care. Psychiatrists trained in collaborative care will be better prepared to meet the demands of the changing health care system, which seeks to improve patient satisfaction, improve population health, and lower the cost of health care.

**Q** *What is collaborative care and how does it work?*

**A** The CoCM uses a team-based, interdisciplinary approach to deliver evidence-based diagnoses, treatment, and follow-up care. The model differs from other attempts to integrate behavioral health services because of the replicated evidence supporting its outcomes, its steady reliance on consistent principles of chronic care delivery, and attention to accountability and quality improvement.

A collaborative care team is led by a primary care provider (PCP) treating patients with mental health/substance abuse conditions. They are supported by a behavioral health care manager and a psychiatric consultant. The team implements a measurement-guided care plan based on evidence-based practice guidelines and focuses particular attention on patients not meeting their clinical goals.

This model is flexible and can be implemented across varied geographic locations, practice sizes, and patient populations.

**Q** *What is the role of psychiatrists in the CoCM?*

**A** The psychiatrist provides population-based advice and individual treatment recommendations to the primary care team, including a clinic-based behavioral health provider. As a result, a scarce resource is leveraged to improve quality of care for an entire population of patients being treated in primary care—which is not feasible if the psychiatrist sees each patient directly, even for a one-time consultation.

**Q** *What evidence supports the CoCM?*

**A** More than 80 randomized, controlled trials (RCTs) have shown the CoCM to be more effective than care as usual. Meta-analyses, including a 2012 Cochrane Review, further substantiate these findings. As a result, the CoCM is recognized as an evidence-based best practice by a range of authorities, including the Centers for Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration, the surgeon general, the National Business Group on Health, and the Agency for Healthcare Research and Quality.

**Q** *How will CoCM prepare psychiatrists for changes in physician reimbursement?*

**A** As the health care system moves toward more team- and value-based care, psychiatrists trained in collaborative care are better positioned to work with multidisciplinary teams and participate in Alternative Payment Models, such as accountable care organizations, medical homes, and patient-centered health homes

APA is working with CMS and other physician groups to design reimbursement codes for the model. To date, CoCM services have typically been covered by grants and innovative state Medicaid programs.

**Q** *How do I learn more about implementing the collaborative care model?*

**A** Through the CMS Transforming Clinical Practice Initiative (TCPI), APA's Support and Alignment Network is training 3,500 psychiatrists in collaborative care and connecting them with Practice Transformation Networks across the country. Psychiatrists can sign up for free live or online training and receive CME credit and technical support for practicing in the CoCM.

To access more information about live trainings and links to the online courses, go to http://www.psychiatry.org/SAN. The course "Applying the Integrated Approach: Practical Skills for the Consulting Psychiatrist" will be offered at APA's IPS: The Mental Health Services Conference on Saturday, October 8. For more information, go to http://www.psychiatry.org/psychiatrists/meetings/ips-the-mental-health-services-conference/courses.

In addition, APA, in conjunction with the Academy of Psychosomatic Medicine, released the report "Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model." The report reviews the current evidence base for collaborative care, essential implementation elements with detailed examples, lessons learned by those who have implemented the model, and recommendations for how to advance its use to better meet the whole health needs of people with mental health conditions. PN

To read the report and learn more about TCPI and collaborative care, visit APA's integrated care webpage at http://APAPsy.ch/CollaborativeCare.

## Iowa Law

*continued from page 1*

holder of a conditional prescription certificate can apply for an unconditional prescription certificate.

The entire legislative process took place in a period of turmoil for Iowa's mental health payment system, said Greenfield. Two of the four mental health facilities in the state have closed, and recent changes in the mental health portion of the Medicaid program have led to further cuts in services. Psychologists claimed that prescribing rights would help to increase access to mental health services, especially in rural areas.

However, psychologists are predominantly concentrated around cities in Iowa, as they are in New Mexico and Louisiana, said Greenfield. "They may have added more prescribers but not more access."

To expand access to psychiatric services in the state, the IPS is seeking legislative support for parity payment for telepsychiatry and telemedicine services and is continuing a push to expand psychiatric training of primary care providers in rural and underserved areas, said Vista-Wayne.

In addition, Mercy Medical Center-Des Moines and Unity Point/Broadlawns Medical Center announced in March the start of two new psychiatry residency training programs in 2018, supplementing Iowa's sole existing program at the University of Iowa, she said.

Timing of work by the boards of medicine and psychology on the training rules is unclear at the moment, but proposed rules are unlikely to be drafted and open for public comment before December. PN

# ASSOCIATION NEWS

## Innovation Lab Winner Uses Speech Analysis To Diagnose Psychosis

**Engineer Jim Schwoebel has taken inspiration from his brother's experience with psychosis to design apps that can analyze verbal and written language for abnormalities.**

BY NICK ZAGORSKI

Cody Rall, M.D.

Innovation Lab winner Jim Schwoebel has developed language processing applications that might reliably, rapidly, and objectively identify psychosis in its earliest stages.

A simple, reliable, and objective tool to help identify patients experiencing prodromal psychotic symptoms would be invaluable not only to psychiatrists but also to primary care providers, and biomedical engineer Jim Schwoebel thinks he may have found that tool. He was the winner of the Innovation Laboratory at APA's 2016 Annual Meeting in Atlanta.

Schwoebel is developing a diagnostic speech test, which analyzes both the recorded speech and a transcript of that speech for details like maximum phrase length, word coherence, and use of determiner words (such as a, an, the, this). Combining these semantic and syntactic elements can reveal a risk score that identifies the likelihood that someone is experiencing a psychotic episode.

The seeds of this idea started a few years back after Schwoebel's brother was diagnosed with schizophrenia.

"I had been sensing that something was off about my brother's speech, so after he was officially diagnosed, I looked more closely at his text messages before his psychotic break and saw noticeable abnormalities," said Schwoebel.

He began developing some simple models but had a significant breakthrough when he read an intriguing study by researchers at Columbia University and Brazil on using automated speech processing to distinguish at-risk individuals who later did or did not transition to psychosis (*Psychiatric News,* November 6, 2015).

"As soon as I read it, I said, 'This model is so simple and elegant. A company needs to get this technology out there.' "

That's where the business side of Schwoebel kicked in—he's also a founder of NeuroLaunch, whose website describes the company's goal as "removing barriers for the most promising neuro-startups [to] sustain the world's most robust community of neuroscience innovators, investors, and thought leaders." Schwoebel has developed apps for multiple platforms, including iOS devices and the new Alexa device from Amazon, and he is raising seed money to spearhead some pilot studies.

In that regard, receiving the $2,500 prize for winning the Innovation Lab was a boost, though even without that, attending the APA meeting was a wonderful opportunity to get his idea out to potential investors and research collaborators, he said.

"It was also great to gain clinical insight on what the problems are in psychiatry, and other people at the meeting brought up cases where our apps could be used that I would not have thought of," he said. "While we were aiming for primary care, one great example brought up was emergency rooms, where our speech test might help distinguish if a psychotic episode was due to an illness or drug use."

Schwoebel also got details on places that would have databanks of oral and written speech that might help him test, refine, and expand the power of the processing software.

"I imagine doing this lab for the first time was challenging, but I applaud APA for getting involved in startups," Schwoebel told *Psychiatric News.* "To transform psychiatry, we need to adopt these new forms of technology." PN

## Residents Recognized at Annual Meeting for Outstanding Research Posters

**The next generation of psychiatrists is already showing great promise as researchers.**

BY AUSTIN DEMARCO

The Resident/Medical Student Poster Competition is an APA Annual Meeting tradition that allows residents and medical students to attend the meeting, present their research, and be recognized for quality work.

This year's winners were Monika Chaudhry, M.D., for "Renal Transplantation in a Patient With Schizoaffective Disorder, Bipolar Type"; Joy Lin, B.S., for "Effects of Childhood Adversity and Adulthood Trauma on C-Reactive Protein in the Health and Retirement Study"; Alexandra Rice, M.D., M.A., for "The Efficacy of Complementary and Alternative Therapies to Treat Depression During Pregnancy: A Meta-Analysis"; William Levitt, M.D., for "Program Development of a Buprenorphine/Naloxone (Bup/Nx) Outpatient Program in a Safety Net Hospital" and Jeremy Kidd, M.D., M.P.H., for "Special-'T' Training: Pre- , Post- , and 90-Day Outcomes From a Residency-Wide Professionalism Workshop on Transgender Health."

Leon Lewis

From left: Kristen Gialo, D.O., Jeremy Kidd, M.D., Stephanie Tung, M.D., Kimberly Parks, M.D., and Monika Chaudhry, M.D., were among the winners of this year's Resident/Medical Student Poster Competition at APA's 2016 Annual Meeting in Atlanta. Gialo was co-presenter with Rice (not pictured), and Tung and Parks were co-presenters with Chaudhry.

For each Annual Meeting, eligible residents and medical students are invited to submit abstracts for posters under five categories: Clinical Case Studies, Psychosocial and Biomedical Research Projects, Patient-Oriented Care and Epidemiology, Community Development and Service Projects, and Curriculum Development and Educational Projects.

Submitted abstracts are evaluated by a panel of judges; this year's judges were Ranna Perekh, M.D., Joan Anzia, M.D., Michelle Pato, M.D., and John Coverdale, M.D. All submitted posters were presented at the Annual Meeting, and winners received a medal and bragging rights for themselves and their institutions. PN

Austin DeMarco is the content coordinator in APA's Office of Scientific Programs.

# Ready for Psychiatry of the Future? IPS Will Help Get You There

**The institute has undergone major changes to prepare practitioners to work within the evolving health care environment and enhance their clinical skills.**

BY LORI RANEY, M.D.

This year's IPS: The Mental Health Conference, which is being held October 6 to 9 in Washington, D.C., is on track to be one of the best ever. With a theme chosen by APA President Maria Oquendo, M.D.—"Implementing Prevention Across Psychiatric Practice"—and a new approach of combining invited and accepted sessions to create a well-rounded program, it is designed to prepare practicing psychiatrists and others for the evolving health care environment.

This year's institute was built from the ground up, with new learning formats that are interactive and engaging. The Scientific Program Committee did an excellent job of reviewing recommendations from last year's meeting to provide what you want and need most and then looked forward to consider what you'll need to know in the next five or so years to continue to be successful. The areas of focus that were identified include psychopharmacology, integrated care, telemedicine, addictions, and policy issues.

Taking advantage of the meeting's D.C. location, we have scheduled major speakers from the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Council for Behavioral Health, to name a few, and maybe even a few politicians, given that the institute occurs just weeks before the presidential election. Stay tuned for further announcements about our keynote speaker.

As health care reform continues the steady march toward the Quadruple Aim of improving outcomes, reducing costs, and improving patient and provider experience of care, as well as toward value-based care and approaches designed to ensure these goals are met, we will benefit most from being proactive and prepared to competently participate and lead these efforts. The knowledge and skills obtained during this four-day scientific program, designed with the near future in mind, will help attendees gain confidence at this crucial time and return home more knowledgeable and prepared to embrace these changes.

Several key themes have the potential to address the psychiatrist workforce shortage, a key factor in assisting health care systems in addressing the impact of behavioral health conditions across delivery systems, by extending psychiatric expertise to larger populations in need through multiple approaches. The Integrated Care Track includes APA's free training in the collaborative care model. This four-hour course, which was very well attended at APA's Annual Meeting, will be offered twice. Designed to shift effective care of mild-to-moderate behavioral health conditions to primary care through indirect psychiatric consultation and education while saving precious specialty behavioral health resources for direct psychiatric care, the collaborative care model requires fewer psychiatrists for a defined population of patients and provides effective care to more people in need. New CPT codes under development for the collaborative care model will require certain psychiatric interventions that must occur for the team to be paid, and we will need to be prepared to perform these vital duties. Many presentations will cover "reverse" integration to address the mortality gap for persons with severe mental illness, and the ever-popular "Primary Care Skills for Psychiatrists" course is again in the line-up.

The Telemedicine Track also addresses the psychiatric workforce issue, particularly in remote areas, by offering topics ranging from the nitty-gritty details in setting up a program for direct care to a presentation on the use of Project ECHO to provide case-based learning about psychiatric medications in primary care settings. Finally, there will be a symposium on the emerging field of behavioral health "telehubs" to provide team-based services to small-to-medium or remote practices that lack the resources to provide varying levels of integrated care.

The Psychopharmacology Track will have a full-day course on adult medications and a half-day course on child medications (tailored for adult psychiatrists who also treat children), led by top specialists from Johns Hopkins, the University of Maryland, and other local institutions.

Following the highly successful "Forum for Medical Directors" convened by APA CEO and Medical Director Saul Levin, M.D., M.P.A., at last year's insti-

*see **IPS** on page 22*

Lori Raney, M.D., is chair of the Scientific Program Committee of the IPS: The Mental Health Services Conference and chair of the APA Work Group on Integrated Care.

# Prevention Will Be Central Theme Of This Year's IPS Conference

**APA President Maria A. Oquendo, M.D., hopes to use the IPS platform to educate members on the value of primary, secondary, and tertiary prevention strategies.**

BY NICK ZAGORSKI

As the APA community prepares to descend on the nation's capital this October 6 to 9 to attend the 2016 IPS: The Mental Health Services Conference, APA President Maria A. Oquendo, M.D., hopes the meeting can help ignite the conversation on a subject that has been fairly muted in psychiatry: prevention.

"There remains a certain resigned thinking among the public, and even among practitioners, that psychiatric conditions cannot be prevented," she said. "But in truth we have many avenues by which we can halt, or at least slow down, the trajectories of mental disorders."

The theme of the meeting, chosen by Oquendo, reflects her passion for this subject: "Implementing Prevention Across Psychiatric Practice."

As Oquendo elaborated to *Psychiatric News*, the mental health field has been engaged in preventative practices, but it has been heavily skewed toward preventing negative outcomes—such as suicide, other violence, or institutionalization—in individuals who have already been identified with a mental disorder. As these outcomes have serious consequences for those affected by illness, as well as their family, friends, and communities at large, these types of preventative efforts are essential and will be the subject of many of the sessions at this year's institute.

Sylvia Atdjian, M.D., for example, will chair a symposium on preventing violence and the need for restraints or seclusion in hospital settings, while Peter Chien, M.D., will lead a workshop on the clinician's role in preventing suicide in the health care setting.

But Oquendo stressed that such late-stage, or tertiary, prevention should be only one part of a comprehensive prevention strategy.

Psychiatry can benefit from more secondary prevention, which can entail either preventing the onset of secondary symptoms (for example, potential substance use or obesity) in someone newly diagnosed with a psychiatric disorder or treating patients showing subsyndromal levels of illness to delay or soften the impact of full-blown illness.

And though it may seem daunting, even primary mental health prevention—stopping at-risk people from developing a disorder—is possible, she believes, suggesting more support for childrearing practices aimed at mothers dealing with depression or other mental illness as one strategy.

Addressing social risk factors of disease is another area of opportunity, which will be the focus of the symposium "Inside Washington: National Perspectives and Cross-Sector Collaborations for Acting on the Social Determinants of Mental Health," chaired by Ruth Shim, M.D., M.P.H.

Oquendo noted that the use of the word "collaboration" is important as well. "Prevention is the direction medicine is going in general, and as we psychiatrists think about how we can make a difference in people's lives, we should think on how we work with other specialties to implement mental health prevention strategies across the board." PN

**Register Now and Save!**

IPS: The Mental Health Services Conference will be held **October 6 to 9** in Washington, D.C. Register now and save on fees. This year's meeting offers sessions in seven tracks: addiction psychiatry, information for medical directors and administrators, integrated and interdisciplinary care, psychopharmacology, prevention, quality and measurement, and technology in health care. To obtain information about the preliminary program and to register, go to psychiatry.org/IPS.

RESIDENTS' FORUM

# Insider's Guide to APA This Year

BY STELLA CAI, M.D.

Welcome to a new academic year! July is an exciting month for all of us. For our incoming residents, this marks the beginning of an incredible journey of becoming a psychiatrist. For the rest of us, we are proud that we have survived another year of sleepless nights on call and living on a resident's salary.

I know our lives can be so hectic and overwhelming, and becoming involved in an organization like APA may seem daunting at first. But don't fret—my goal as your resident-fellow member (RFM) trustee this year is to make APA more personable and readily accessible to you. To start, I want to share with you some tips on how to get involved. I hope you find amazing opportunities through APA that will enrich your training and career.

• **Attend IPS: The Mental Health Services Conference this year.** It focuses on the practice of psychiatry and health care delivery systems, which directly impact our future career. I wish I had known about the conference earlier in my residency since these fundamental skills are often not taught during our residency training. The conference is also smaller and more intimate than the Annual Meeting, making it easy for RFMs to network with the experts and leaders in our field. Best of all, RFMs can receive reimbursement for their registration by becoming a moderator for three sessions at the conference. This year, it will take place October 6 to 9 in Washington, D.C. (See page 17.)

• **Look into applying for APA fellowships early.** APA wants to attract a diverse pool of talented RFMs to become our future leaders. Every year, about 100 fellowships, ranging from public psychiatry to scholarly research to congressional leadership, are open for application. An APA fellowship experience is truly a privilege, but the application process can be highly competitive. My advice is to reach out to current or former APA fellows and APA administration for tips before applying. If your application was not accepted in the past, please continue to stay involved. We welcome returning applicants and will help you find a way to reach your academic pursuit.

• **Write and publish in the *American Journal of Psychiatry* (AJP) *Residents' Journal* and *Psychiatric News Residents' Forum*.** Don't worry, you don't need to be an excellent writer to

get published. APA has editors who are happy to help revise your draft, refine your ideas, and get it published. We are constantly looking for RFMs' unique perspective on emergent issues and interesting cases. Katherine Pier, M.D., is the editor-in-chief for the *AJP Residents' Journal,* and I am editor of the *Psychiatric News* Residents' Forum. Please keep your eyes peeled for article submission criteria, as they are different. We would love to hear from you!

• **Check out SET for Success online modules for free.** How many

Stella Cai, M.D., is APA's resident-fellow member trustee and a child psychiatry fellow at the Los Angeles County+University of Southern California Medical Center.

times do we tell ourselves to read a textbook on psychopharmacology when we get home? Many, many times. But sometimes, we just don't want to open a book after work. And that is completely OK! APA has launched the SET for Success online program at http://psychiatry.org/residents-medical-students/residents/set-for-success, and it should go a long way in helping to alleviate that internal conflict. Now you can watch short videos on various topics, such as the latest advances in psychiatry, psychopharmacology, and the business of medicine through APA's Learning Center. Furthermore, the program itself was built on ACGME core competencies and psychiatry milestones, and you can create a transcript of the video lectures you have watched. For residents in the 100% Club, your program director can log in to view them for free. Like most membership benefits, these lectures are also free for RFMs.

No matter which path you take to get involved with APA, know that you are a valued member of this organization. You have a voice as an RFM that can shape the organization and inspire others. As your RFM trustee this year, I hope to guide you through finding your passion and academic pursuit through our organization. PN

Have a question or concern? I'd like to hear from you. Contact me at stellacai85@gmail.com.

CLINICAL & RESEARCH NEWS

# Clinician Insight Can Help Meet MH Care Needs of LGBT People

**An awareness of the complexities of gender identity and sexual orientation can help practitioners caring for LGBT people.**

BY AARON LEVIN

Psychiatrists can help lesbian, gay, bisexual, or transgender individuals by ending their invisibility, said Harvey Makadon, M.D., at APA's 2016 Annual Meeting in Atlanta.

"Psychiatry has a long history of ignoring or demeaning homosexuality," said Makadon, a professor of medicine at Harvard Medical School and director of education and training programs at the Fenway Institute in Boston. He was joined by APA Leadership Fellow Jeremy Kidd, M.D., M.P.H., a PGY-3 at Columbia University.

Clinicians can begin reversing that history by first being aware of the complexities of gender identity and sexual orientation and then by educating themselves and their staffs on ways of creating a safer culture for their patients.

Gender identity is the internal sense

# CLINICAL & RESEARCH NEWS

of the person's gender—male? female? both? neither? Gender expression is how people "present themselves by means of behavior, mannerisms, speech patterns, dress, or hairstyles." Sexual orientation addresses the way a person identifies his or her physical and emotional attraction to others.

"You cannot assume someone's gender or sexual orientation by how the person looks or sounds," he said.

Transgender people—the T in LGBT—are those who perceive that their gender identity is not congruent with the sex they were assigned at birth.

All of these characteristics are not absolute but may lie along a spectrum, said Makadon. "Intersectionality," the individual's collection of various identities, can complicate things even more, he noted, citing the dilemma of black gay men who encounter homophobia in the black community and racism in the LGBT community.

Health care disparities affect LGBT patients as they do other minorities or marginalized groups, said Makadon. Disparities are caused by stigma and discrimination, and stigma can be interpersonal or structural.

David Hathcox

Be aware not only of patients' gender identity, but also of likely previous stigmatizing health care encounters, advises Harvey Makadon, M.D.

Structural stigma "includes the policies of government or private institutions that intentionally or unintentionally hinder the opportunities of certain groups."

Stigma can also be intrapersonal, when individuals internalize the discrimination they face in the world around them. That can lead to stress, anxiety, or depression. Effects also include greater risk of contracting HIV, delays in seeking both preventive and acute care, and poor adherence to treatment.

Disparities persist throughout the lifespan, said Makadon. LGBT individuals have two to three times the rate of suicide attempts of the general population, higher usage of tobacco and alcohol, greater victimization, and are less likely to be insured. Among their elderly peers, there is more isolation, less family support, and a lack of social and support services.

Caring for these patients involves a thoughtful approach with some awareness of their identities and self-perception as well as their health needs.

"You are almost certainly not the first health care staff person an LGBT person has encountered," he said. "So if the patient has experienced insensitivity, a lack of awareness, or discrimination, he or she may be on guard or ready for more of the same thing."

Defusing that anxiety and opening the door to therapeutic engagement can begin by using gender-neutral language and asking the patient about the name and pronouns by which they prefer to be called. Realize that the name on the insurance card may not match the apparent identity of the person in the exam room. As with any patient, it is important to take a history of sexual health. Train all staff members to be respectful.

"If necessary, apologizing when patients have uncomfortable reactions, even if what was said was well intentioned, can help defuse a difficult situation and reestablish a constructive dialogue about the need for care," he said. PN

# CLINICAL & RESEARCH NEWS

## Early Life Trauma May Predict Later Response to Antidepressants

**Children who experienced abuse between the ages of 4 and 7 were found to be about 1.6 times less likely to respond to medication, with sertraline being particularly ineffective.**

BY NICK ZAGORSKI

Exposure to abuse in childhood can have long-lasting effects, especially with regard to mental health. Research has shown that childhood abuse not only increases the risk of depression over the lifetime, but children who are abused often experience an earlier onset of depression that is more severe and often results in poorer outcomes.

New evidence now suggests that abuse can also greatly reduce response to antidepressants, with particularly poor outcomes for sertraline.

These findings, published in *Translational Psychiatry,* came from an analysis of over 1,000 adults who were randomly assigned to receive escitalopram, sertraline, or venlafaxine for eight weeks. Researchers used the Early-Life Stress Questionnaire (ELSQ) to assess participants' exposure to abuse or other trauma and the age at which such events first took place.

The researchers found that people with depression who experienced any childhood abuse (physical, emotional, or sexual) showed a lower rate of medication response and remission compared with depressed patients who had no trauma exposure or those who were exposed to nonabusive childhood trauma, such as parental divorce or serious injury.

Stanford School of Medicine

When treating depressed patients with a history of early childhood abuse, clinicians may want to consider alternative medications and adjunctive therapies that address the underlying trauma, according to Leanne Williams, Ph.D.

When the abuse occurrence was broken down by discrete age groups, the researchers found that abuse specifically from the ages of 4 to 7 was related to poor medication outcomes, with sertraline users showing the lowest rates of improvement. In contrast, there were no significant associations between poor medication outcomes and abuse that occurred between ages 8 to 12 or 13 to 17.

"These results do not imply that abuse occurring in later childhood has no ill effects," lead author Leanne Williams, Ph.D., a professor of psychiatry and behavioral sciences at Stanford University, told *Psychiatric News*. "They just indicate that abuse during this critical age range may have the most significant impact on future outcomes."

In fact, patients who experienced abuse between ages 4 and 7 represented only 18 percent of all iSPOT-D participants who responded to treatment after eight weeks and less than 16 percent of patients who achieved remission.

"I believe these odds make the chance of response too low to meaningfully consider these antidepressants as a first-line treatment for patients who experienced early abuse or neglect," Williams said. "Consideration should be given to alternative medications plus adjunctive therapies that address the trauma issues as well as the current experience of depression."

Trauma-focused behavioral therapies or interventions for posttrauma-related stress are two possible alternatives for depressed patients with a history of early child abuse, Williams noted. Once the experiences of trauma are addressed, antidepressants may prove to be more effective for this population, she said.

Before considering treatment, clinicians must first identify patients with a history of abuse, Williams added. A thorough patient evaluation is considered commonplace among psychiatric professionals, but many patients seeking depression care are being treated in nonspecialty settings that may not delve deeply into the past—despite the potential importance of these aspects of life history.

Williams suggested that memory and emotional development between ages 4 and 7 may offer one explanation as to why abuse during these early years appears to have the greatest effects on response to antidepressants later in life. "At these ages, [children] can begin consolidating memories of their experiences, but they do not yet have the capacity to reflect on and contextualize their experience of the trauma," she said.

Williams acknowledged the need for more longitudinal studies to explore how childhood trauma may alter circuits in the brain over time, possibly leading to an increased risk of depression and a decreased response to treatment.

Her research group is hoping to make use of such data as part of a "precision psychiatry and neuroscience" program they are developing, in which treatment choices can be tailored to the needs of patients based on their symptoms, brain circuitry, and trauma history.

This study was supported by Brain Resource Ltd. PN

An abstract of "Childhood Trauma Predicts Antidepressant Response in Adults With Major Depression: Data From the Randomized International Study to Predict Optimized Treatment for Depression" is posted at http://www.nature.com/tp/journal/v6/n5/full/tp201661a.html.

## AMA on Guns

*continued from page 8*

"The reaffirmation of policies that speak to some of the other concerns in the resolution is also positive, and we hope to build on this policy in the future."

Pean said he believes events such as what happened to his brother Alan "send a message of fear to patients and may be a serious deterrent to seeking mental health treatment if they think there is a possibility of being shot. It's important to remember that my brother willingly sought out health care services at the hospital."

Pean's involvement with the AMA began last year when he won an "Excellence in Medicine" award from the AMA Foundation. (Every year the AMA Foundation recognizes several physicians with this award, including residents and medical students who have demonstrated excellence in "advocacy, community service, public health, or education.") After that, he stayed in contact with other young physicians in the AMA. "I became involved with the Minority Affairs Section because the section is passionate about advocating for many of the same things I am passionate about," he said.

"After my brother's encounter, I started to talk to people about what kinds of effort could be made to reverse this trend," Pean said. "I decided that the AMA is the premier medical society and that it should address this problem."

Pean worked with psychiatrist Dionne Hart, M.D., to craft the language of the resolution and to gather support from psychiatrists and physicians in other specialties.

In the meantime, Alan Pean has been doing his own advocacy and has travelled to Yale University School of Medicine and Harvard Law School to talk about his experience.

"My brother felt it was imperative to speak about his mental illness and what happened to him," Pean told *Psychiatric News*. PN

The *Times* article on the shooting of Alan Pean is posted at http://www.nytimes.com/2016/02/14/us/hospital-guns-mental-health.html.

## IPS

*continued from page 17*

tute, a Medical Directors Track is being introduced to meet the needs of those working in or considering administrative roles. It will be offered in two three-hour blocks and include some didactics around common issues (finances, personnel issues, recruitment/retention, ancillary personnel, and more) and a theme-based networking opportunity that will be developed from a survey of participants at the beginning of the first block.

The Addiction Track includes a variety of sessions from the certification course for buprenorphine and information on successful interventions for nicotine and other addictions. We will explore what has happened in states such as Colorado that have legalized recreational marijuana and provide an update on K2 and other illicit substances.

The list of meeting highlights continues with sessions on assisted outpatient treatment, Certified Community Behavioral Health Centers, and many other topics to create a program that will bring you the latest information on clinical practice and service delivery to better position you for practice in the current environment as well as in the new infrastructure of health care delivery soon coming our way. PN

# Human Trafficking Should Be on Psychiatrists' Radar

**Sex trafficking entraps young people but inevitable encounters with the medical system can offer a chance for escape.**

BY AARON LEVIN

Sex trafficking of children and adolescents may be largely hidden from the eyes of the public, but when these young people seek medical care, it opens the door to intervention—provided the doctor becomes aware of their situation.

Psychiatrists should be especially alert to this population, said Rachel Robitz, M.D., a PGY-4 in psychiatry and family medicine at the University of California, San Diego, during a special session sponsored by APA's Division of Diversity and Health Equity at APA's Annual Meeting in Atlanta.

According to Robitz, only 13 percent of individuals in the United States who are recruited into sex trafficking are over the age of 25, and 83 percent are U.S. citizens. She noted that clinical samples show this population tends to have high levels of depression, anxiety, nightmares, substance abuse, overdoses, and suicide attempts.

"We also know that 88 percent of these young people saw a medical provider during the time they were being trafficked," said pediatrician Jordan Greenbaum, M.D., of Children's Healthcare of Atlanta.

"They are seen in the emergency room or as inpatients for many different reasons, but not for 'trafficking,'" said Mariam Garuba, M.D., an assistant clinical professor of psychiatry at the Columbia University Medical Center. "The question in your mind should be: 'Is this a survivor?'"

If children seem intimidated by the adults who brought them in or can't say where they came from or give their address, clinicians should have a heightened level of suspicion, said Greenbaum. Other risk factors suggesting that a person might be being exploited for sex include illicit drug use, abuse or neglect, self-harm, or running away from home. Nearly half of those being trafficked have an active case of sexually transmitted infections, and 30 percent have been pregnant.

To best respond to the needs of a patient who may be being trafficked, an evaluation should ideally occur with the accompanying adult eased out of the room, she said.

"Obtain a history to assess both the health and the safety needs of the child," said Greenbaum. "Diagnose and treat both acute and chronic conditions, since the latter may be a clue to long-term maltreatment. Document acute or remote head injuries, cigarette burns, or restraint injuries."

Tests for pregnancy and sexually transmitted diseases may be appropriate, too, she said.

A trauma-informed approach to treating these patients is essential, she said. Many of these children might seem "belligerent," but in fact they are traumatized, said Greenbaum.

Questions that address trafficking might include the following:

- "Has anyone ever asked you to have sex in exchange for something you wanted or needed—money, food, or shelter?"
- "Has anyone ever asked you to have sex with another person?"
- "Has anyone ever taken sexual pictures of you or posted such pictures on the Internet?"

While the role of the clinician is to assess the child's emotional and physical health and safety, provide information to the child, and offer referral and resources, providers must be aware of mandated reporting laws and should explain those to the victim—early in the conversation—to avoid a sense of betrayal. "Watch for cues of stress to avoid retraumatization," she said.

A program in Boston called "My Life, My Choice" seeks to prevent girls from

*see **Human Trafficking** on page 33*

# CLINICAL & RESEARCH NEWS

## Pharmacogenomics Can Better Inform Treatment

**Genomics is not a panacea but can guide new ways of thinking and open another door to thinking about diagnosis and treatment, the 2016 David A. Mrazek Memorial Award winner said during a lecture at APA's Annual Meeting.**

BY AARON LEVIN

"Pharmacogenomics can help create a new model of psychiatric practice that is genetically informed, neurobiologically empowered, and data oriented," Stephen Stahl, M.D., Ph.D., told a packed room at APA's Annual Meeting in Atlanta. Stahl, who is a professor of psychiatry at the University of California, San Diego, was the recipient of the 2016 David A. Mrazek Memorial Award, which honors the contributions of clinicians in the field of pharmacogenomics.

Genomics is not a panacea but can guide new ways of thinking about diagnosis and treatment, said Stahl.

"Genes don't code for psychiatric disorders or symptoms, just for proteins and epigenetic regulators," he said, noting that about 20 single-nucleotide polymorphisms have been studied in depression, but each has only a small effect. "We will have to look at a portfolio of genes, not just one, to better diagnose and treat patients."

Still, by studying genetic pathways, researchers can begin to uncover links between genes, circuits, and behavior, which may underlie variations in treatment responses.

For instance, increasing evidence suggests genetic tests that screen for pharmacokinetic metabolizing genes in the Cytochrome P450 system may help to better tailor antidepressant therapy to individual patients.

Medication doses used in clinical trials are normalized to white, male, extensive metabolizers, so a person who appears not to respond simply may be a different kind of patient, he said.

On one hand, patients with unexpectedly high serum drug levels or adverse effects may have poor P450 metabolism, while ultra-rapid metabolizers may have lower serum levels and worse efficacy and be labeled "treatment resistant" as a result.

"Patients with treatment-resistant depression who are fast metabolizers have low drug levels and exhibit poor therapeutic effects are probably not noncompliant but may require very high oral dosing or alternate routes of administration, such as intravenous or transdermal administration, to bypass metabolism in the liver," Stahl explained.

Conversely, slow metabolizers may need lower dosage levels to tolerate medication and reduce side effects, he said. "It's not what you take in your mouth, it's what gets into your brain."

Pharmacogenomic tests don't tell which drugs will work or which will be toxic, but testing adds to the evidence the psychiatrist must weigh in deciding a course of treatment, he said.

David Hathcox

Genetic testing has the potential to inform clinical decisions, especially for patients who don't respond to or tolerate drugs as expected, says Stephen Stahl, M.D., Ph.D., in delivering the David Mrazek Lecture.

"I look for equipoise, the balance of the evidence," he said. Tests add more or less evidence to a decision on whether a drug should or shouldn't be used.

When faced with a patient who is not responding to treatment and for whom there is no guidance from randomized, controlled clinical trials, Stahl suggested clinicians consider using a step-by-step approach, beginning with exhausting all existing evidence-based solutions.

"Then take a new history, including treatment responses, and find a new informant, if possible," he said. "Reconsider the original diagnosis. Perhaps treatment-resistant depression could be bipolar disorder with mixed features, for example."

After collecting new data, rebalance the evidence by combining the insights of neurobiology with genomics to come up with alternative treatment combinations, he suggested.

"Genetic testing is a clinical tool that is still in its infancy but has the potential right now to inform clinical decisions in some cases, especially for patients who don't respond to or tolerate drugs as expected," he concluded. "Psychiatry is the area of medicine that is the most exciting combination of art and science." PN

## PSYCHIATRY & PSYCHOTHERAPY

## Residents Want to Learn Psychotherapy: Thoughts on Supervision

BY KATHERINE G. KENNEDY, M.D.

A 2014 survey by J.G. Kovach, M.D., and colleagues published in *Academic Psychiatry* revealed surprising news: "Psychiatry residents want more psychotherapy education than they are receiving." Despite their hectic schedules, anticipated managed care roadblocks, and biologically focused research, psychiatry residents are hungry to learn psychotherapy.

What's more, the survey found that supervision supersedes coursework, readings, and their personal psychotherapy as psychiatry residents' favorite way to learn. Residents expressed interest in all types of psychotherapies, including psychodynamic, cognitive, behavioral, dialectical, supportive, family, and group. Given that residents highly value supervision, how can we optimize supervision and help busy residents?

Supervision requires a supportive environment in which residents can talk frankly and openly about their patients. In *A Resident's Guide to Surviving Psychiatric Training,* a 2015 APA publication, residents are encouraged to "think of your most difficult patients, the ones you really don't want to see" and "let your supervisor know everything, including your fantasies and fears, about this patient."

For residents to report honestly how they feel about patients—and share exactly the words they spoke rather than the words they imagine we wanted them to speak—supervisors must cultivate a space of safe reflection where we, as supervisors, are patient, thoughtful, empathic, and nonjudgmental. Maintaining this stance will require effort at times. Try to observe your own feelings about the relationship with the resident; that may provide clues about the resident's work with the patient. Supervisory moments may trigger memories of your own residency training. Keep in mind that what you say and how you behave may become the model a resident internalizes about how to engage with patients and colleagues.

In supervision, encourage your supervisees to consider every patient, especially their more complex ones, from a biopsychosocial perspective. Foster the idea that every patient encounter includes elements of therapy in terms of attention to the relationship between the patient and doctor; this concept is part of what psychiatry has to offer medicine in general. Too often, both supervisors and residents categorize patients as "medication management" or "psychotherapy" cases. Ask—and ask your supervisees to ask—more questions about patients. Encourage them to delve more deeply into their patients' backgrounds, behaviors, and beliefs. Teach your supervisees to develop a broad, biopsychosocial understanding of each patient. This will help residents discover and make more thoughtful, informed, and effective clinical interventions.

Your theoretical perspective—psychodynamic, cognitive, behavioral, dialectical, supportive, family, or group—will frame how the supervision unfolds. To illustrate, consider a psychodynamic perspective. In psychodynamically focused supervision, first encourage residents to make meaning out of words and actions. Later, introduce psychodynamic concepts, like transference, countertransference, and resistance to help expand residents' perceptions and open them up to new ways of listening. As residents begin to integrate a psychodynamic understanding of their patients into their work, often they will feel a sense of relief and increased self-efficacy. A "hopeless" case, where medication has been optimized but seri-

*continued on next page*

Katherine G. Kennedy, M.D., is in private practice in New Haven, Conn. She is also a member of the Group for the Advancement of Psychiatry Committee on Psychotherapy, member of the APA Council on Advocacy and Government Relations, trustee of the Austen Riggs Center in Stockbridge, Mass., and assistant clinical professor at the Yale University School of Medicine. This column is coordinated by the Group for the Advancement of Psychiatry Psychotherapy Committee.

# U.S. Experiences Uptick In Rates of Suicide

**While most age groups—particularly children and young adults—showed increases in suicide prevalence since 1999, rates for adults 75 and up have been declining.**

BY NICK ZAGORSKI

Aaron Levin

While Yeates Conwell, M.D., was encouraged by the drop in suicide rates among adults 75 and over since 1999, he cautioned that the incoming baby-boomer generation to this age bracket might bring rates back up.

This past April, the CDC's National Center for Health Statistics released updated data on suicide rates in the United States, which revealed an alarming trend.

After experiencing a period of nearly consistent decline in suicide rates from 1986 through 1999, the United States experienced a 24 percent increase in suicide between the years 1999 and 2014—rising from 10.5 to 13.0 per 100,000 people—with increases for both males and females in nearly every age bracket.

"This report reaffirms that psychiatrists and other providers need to identify individuals at risk for suicide, such as people with depression, anxiety, and substance use disorders, and treat them aggressively," said APA President Maria A. Oquendo, M.D., who has conducted extensive research into suicide prevention.

Such rigorous suicide prevention eincludes treating psychiatric illness, but also specifically targeting suicidal behavior through approaches like dialectical behavior therapy.

Safety planning is another critical tool at a therapist's disposal, she added. "Safety planning is a straightforward approach to help someone identify triggers for suicidal ideation and make a plan to manage them," she said. "It may involve listening to music or finding someone to talk to; they may seem like obvious items, but a suicidal patient would not think of them."

As to why rates have been rising these past two decades, David Fassler, M.D., a clinical professor of psychiatry at the University of Vermont College of Medicine, highlighted several potential contributing factors, including improved reporting, economic distress such as the 2007-2008 financial crisis, the increasing availability of opiates, and continuing challenges with timely access to effective care for people with psychiatric disorders.

The rise of social media may also be a contributing factor, especially for children exposed to cyberbullying and other online stressors. Indeed, the suicide rates for boys and girls 10 to 14 showed some of the greatest increases between 1999 and 2014; there was a 37 percent increase among boys 10 to 14 and a 200 percent increase among girls 10 to 14.

"The report, however, does not speculate on the causes for the observed increase in the suicide rates," Fassler stressed. "Clearly, further research is needed to fully understand the implications of the current findings."

While the increase in suicides, particularly among youth, garnered much of the media's attention after the release of the suicide data and reawakened speculation about the impact of the black-box warnings on antidepressant use and suicide risk in people under 25, there was one overlooked group for whom the trends were going in the right direction.

### Positive Data on Older Adults

Adults 75 and older of both sexes showed modest but clear decreases in suicide rates; males had an 8 percent decrease (from 42.4 to 38.8 per 100,000), and females had an 11 percent decline (from 4.5 to 4.0 per 100,000).

Yeates Conwell, M.D., professor and vice chair of psychiatry at the University of Rochester Medical Center and co-director of its Center for the Study and Prevention of Suicide, thinks that improvements to the health care system have helped drive these lower rates.

For one, advances in medicine are reducing disability and impairment among seniors, while laws such as the Mental Health Parity and Addiction Equity Act and the Medicare Improvements for Patients and Providers Act have made psychiatric care more accessible and eliminated the discriminatory copay for Medicare beneficiaries with mental illness.

In addition, while social media presents risks for some children, it can help seniors feel more connected to their friends and family.

"Over the past decade, we have been doing well at addressing three of the four D's that influence suicide in older adults: depression, debility, and disconnectedness," Conwell told *Psychiatric News*.

The fourth D—access to "deadly means," particularly firearms—remains a strong concern.

"That's why I have mixed feelings about these statistics," Conwell said. "It is great to see suicide rates diminishing among the elderly, but still too many older adults, particularly men, are taking their own lives."

A major concern is the looming demographic bubble of middle-aged adults that includes a large portion of the baby-boom generation. In the study period, adults aged 45 to 64 saw some of the largest increases in suicide risk (from 6.0 to 9.8 per 100,000 in women and from 20.8 to 29.7 per 100,000 in men) and also represented the most deaths by suicide in terms of raw numbers.

"Each generation has its own social and cultural traits," explained Conwell, suggesting that as this cohort ages, they may bring along an elevated suicide risk into the next age bracket. "I'm not sure whether we will keep seeing suicide rates among the elderly decrease," he said.

To try to keep the suicide rate from increasing among older adults, Conwell suggested that in addition to the efforts of health care professionals, families and communities can help by taking advantage of the skills and life experiences of these individuals, for example by encouraging more volunteerism among seniors.

"I believe that if older adults feel more assured that they have a role in later life, they will feel valued, and that will lead to positive mental health outcomes," he said. PN

The NCHS Data Brief "Increase in Suicide in the United States, 1999–2014" is posted at http://www.cdc.gov/nchs/products/databriefs/db241.htm.

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ous symptoms persist, can be transformed from frustrating to fascinating when psychodynamic understanding is present.

For example, after discussing her "psychotherapy" case, a supervisee mentioned struggling with her hostile feelings toward someone else she was treating—a chronically suicidal patient on a ketamine research unit. The resident understood her role on the unit as simply to monitor the patient's response to ketamine. For the resident, assuming a "bystander" role in the treatment and considering ketamine the "active agent" created feelings of helplessness and boredom. As the resident presented the patient's history and behavior on the unit, a vivid story of painful loss and familial turmoil emerged, rich with meaning. As her psychodynamic perspective of the patient deepened, the resident began to make informed interventions. When the patient's response validated her predictions, the resident felt increasingly hopeful, self-confident, and interested in the patient.

Another resident initially regarded his role in a Medicaid clinic for young adults as the performance of "med checks." With time, he began to bring a psychodynamic perspective to the clinical vignettes he presented in supervision and discovered that a psychodynamic framework "provided an additional lens through which difficult cases can be approached and understood."

Psychotherapy supervision challenges us to create an oasis of calm and compassion in which patients' lives can be thoughtfully examined. To paraphrase Donald Winnicott, M.D., "good enough" supervisors give their supervisees the freedom to securely explore the relationship with and psychology of each patient. Supporting residents with "good enough" supervision helps both residents and patients.

In a future article in *Psychiatric News,* the Group for the Advancement of Psychiatry Psychotherapy Committee will discuss challenges in meeting the needs for supervision in residency programs. PN

An abstract of "Psychotherapy Training: Residents' Perceptions and Experiences" is posted at http://www.ncbi.nlm.nih.gov/pubmed/25008313.

CLINICAL & RESEARCH NEWS

# Computer-Based Tool Can Offer Rapid Screening After TBI

**A combination of three tasks that test memory, attention, and processing speed can be completed in 10 minutes and is more sensitive than short clinical tests like the Montreal Cognitive Assessment.**

BY NICK ZAGORSKI

Many people who experience a traumatic brain injury (TBI) will develop some degree of cognitive impairment, but identifying these cases can be challenging. Triaging has become an important element of the process, and in this regard brief clinical questionnaires like the Mini-Mental State Exam (MMSE) or Montreal Cognitive Assessment (MoCA) have become valuable tools to screen for potential cognitive dysfunction.

However, these tests have several limitations, noted Anthony Feinstein, M.D., Ph.D., director of the neuropsychiatry program at Toronto's Sunnybrook Health Sciences Centre. One particular concern is that these assessments can misclassify many people because they do not do well in factoring in the age and education level of the patient.

As published June 3 in the *Journal of Neuropsychiatry and Clinical Neurosciences in Advance,* however, a simple computer-based tool developed by Feinstein's research group could offer better sensitivity while retaining the brevity.

The computer application combines three separate tasks: the Stroop Test, the Symbol Digit Modalities Test (SDMT), and the Paced Visual Serial Addition Test 2 (PVSAT-2). Together, these brief tests measure three cognitive domains frequently compromised following TBI: working memory, attention, and processing speed.

Feinstein and his team have been adapting these pencil-and-paper tests for the computer for many years now, having originally tested this screening tool for cognitive impairment in multiple sclerosis (MS).

"One of the key factors in creating these tests for MS patients was to include no motor components, so the patient does not have to manipulate a mouse or push anything," Feinstein told *Psychiatric News.* This same consideration applies to TBI patients, he said, as they often have upper body injuries as well.

"Other advantages are that the program is scripted simply, so it can be administered by a nurse or medical assistant, the providers who are usually the first port of call in the hospital setting," he added. "And two of the three tests are scored by the computer, so the results can be computed right away, and the patient does not have to wait or come back to the clinic."

In the current study, Feinstein and graduate student Jia Zhang enrolled 255 patients aged 14 to 62 years with various degrees of TBI—though predominantly mild TBI—and gave each participant a computerized assessment and a MoCA (both of which took around 10 minutes).

When using the standard cutoff of scoring lower than 26 (out of 30), 29 percent of the study participants failed the MoCA test; however, when factoring in the patient characteristics to reflect nor-

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mal scores for age and education level, the failure rate dropped to 1.6 percent (four out of 255).

"In these TBI cases, particularly the mild ones, the MoCA was not very helpful at all when considering age and education," Feinstein said.

The computer assessment, though, captured more impairment in this group. Among the 251 patients classified as cognitively normal, 55 percent failed at least one of the three tasks (29.5 percent failed the Stroop, 37.5 percent failed the SDMT, and 24.3 percent failed the PVSAT-2).

"We do not want to overreach with these findings, and even though this test is promising, it should not replace any detailed cognitive assessments," Feinstein said. "But I think it could be a valuable addition to a clinic, and many colleagues here in other departments have begun using it."

Feinstein also believes this computer test could be adapted for cognitive impairment arising from Alzheimer's or another dementia. It would require some tweaking, as dementias strongly affect working memory, so the assessment should include a greater proportion of working memory tasks. PN

An abstract of "Screening for Cognitive Impairments After Traumatic Brain Injury: A Comparison of a Brief Computerized Battery With the Montreal Cognitive Assessment" is posted at http://neuro.psychiatryonline.org/doi/abs/10.1176/appi.neuropsych.16010005.

CLINICAL & RESEARCH NEWS

# Cannabinoid Receptor Found to Help Suppress Habitual Behavior

**A mouse study finds that CB1 protein in orbitofrontal cortex neurons mediates the ability to switch between habitual and active-learning behaviors when needed.**

BY NICK ZAGORSKI

Everyone carries out daily habits and routines. As David Lovinger, Ph.D., chief of the Laboratory for Integrative Neuroscience at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), explained, "If your brain does not habitualize familiar tasks or places, it would be very difficult to focus because you're constantly processing all these sensory inputs."

Nonetheless, it's important that the brain can shift from habit mode to a more active, goal-directed mindset. While an

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occasional lapse is normal, a chronic inability to exit from habitual behavior is a critical element of both addiction and obsessive-compulsive disorders. A new study carried out by Lovinger and colleagues adds to the understanding of the brain circuits responsible for the habitual/goal-directed shift.

The results, published June 15 in *Neuron*, also point to a receptor called cannabinoid type 1 (CB1) as a key regulator of this circuitry.

The findings were made possible using a training strategy that enabled mice to push levers for food in both a habitual and goal-directed manner. The mice were placed in enclosures with differing visual decorations; the lever in the first dropped a food reward after it was pressed a certain number of times, while the lever in the second would drop a reward at a random time after the lever had been pressed once.

"In the first scenario, the mouse makes the connection quickly that pressing the lever 20 times, for example, gets it a reward," Lovinger told *Psychiatric News*. "In the second enclosure, that contiguity is disrupted. The mouse knows that pressing will eventually lead to reward, but it doesn't know how many, so it will just start pressing at a periodic rate."

On alternate testing days, the mice were allowed to eat their treats prior to the testing, and on these days—termed the devalued state because the desire for the reward is lessened—mice pressed the lever far less in the goal-directed enclo-

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sure, but still roughly the same amount in the random-time enclosure—much like a habit.

The researchers then tried these tests out on mice in which the neurons that travel between the orbitofrontal cortex (OFC) and dorsal striatum (DS, which links decision making and reward behaviors) were blocked and observed that the mice kept pressing a lot in both enclosures, suggesting an inability to switch out of habit mode.

"Normally, on devalued days the urge to default to the habit of pressing the lever repeatedly gets suppressed in some way because the brain is providing information that the food isn't as valuable," Lovinger said.

With the OFC-DS connection identified, the next question was what part of these neurons was responsible for suppressing habits? Some previous work by Lovinger's colleague and study coauthor Rui Costa, Ph.D., an investigator at the Champalimaud Institute for the Unknown in Lisbon, Portugal, pointed to CB1 as a potential candidate; the CB1 receptor interacts with endocannabinoids, natural messenger molecules in the body that are strikingly similar to THC, the active compound in marijuana.

When mice lacking the CB1 receptor in their OFC neurons were trained, they reduced their lever pressing in both enclosures on devalued days, reflective of a state in which the mice always used goal-directed behaviors because they could not form habits.

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Having found CB1 as the receptor that Helps suppress habits, Lovinger said the next step would be to find the agent in the OFC-DS neural circuit that strengthens habits—and that should provide major clues about how drugs of abuse like alcohol and marijuana disrupt the normal process of habituation.

While the NIAAA is more focused on the addiction side, Lovinger thinks the current knowledge gained on weakened habits could be valuable in neuropsychiatry as well.

"It may be a bit of a stretch, but ADHD could be mediated in part by reduced habit-forming potential," he said. "If someone is trying to pay attention to all potential outcomes in every decision, it could explain the lack of focus displayed by people with ADHD."

This study was supported by grants and awards from the NIAAA, Howard Hughes Medical Institute, European Research Council, and Brain & Behavior Research Foundation. PN

"Endocannabinoid Modulation of Orbitostriatal Circuits Gates Habit Formation" is posted at http://www.cell.com/neuron/fulltext/S0896-6273(16)30157-X.

EXCLUSIVE ONLINE CONTENT

**In Memoriam**

APA honors members whose deaths were reported from January 1 to April 30, 2016.
http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.6b50

## Gun Violence

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Orlando, the worst mass shooting in U.S. history. The shooting, which left 49 people dead and many others injured, took place early in the morning of the day that AMA delegates were gathering for reference committee hearings, where reports and resolutions are debated before going before the full House of Delegates.

By the time of the vote on Tuesday, June 14, more than 70 state and medical specialty societies had signed on as cosponsors to the resolution, including all of the member groups of the Section Council on Psychiatry.

APA CEO and Medical Director Saul Levin, M.D., M.P.A., said it was long past time to overturn the congressional ban on gun violence research at the CDC.

"The massacre in Orlando is just the latest and most egregious instance in an epidemic of gun violence that calls for a comprehensive public health solution," Levin said. "Last year, APA was one of seven physician organizations that called for policies to reduce firearm-related injuries and deaths. As physicians, we know that research is necessary to point us in the direction of common-sense solutions to this epidemic."

Levin's comments were echoed by AMA President Steven Sack, M.D. "With approximately 30,000 men, women, and children dying each year at the barrel of a gun in elementary schools, movie theaters, workplaces, houses of worship, and on live television, the United States faces a public health crisis of gun violence," Stack said in a statement. "Even as America faces a crisis unrivaled in any other developed country, the Congress prohibits the CDC from conducting the very research that would help us understand the problems associated with gun violence and determine how to reduce the high rate of firearm-related deaths and injuries. An epidemiological analysis of gun violence is vital so physicians and other health providers, law enforcement, and society at large may be able to prevent injury, death, and other harms to society resulting from firearms."

Psychiatrist Louis Kraus, M.D., chair of the AMA Council on Science and Public Health, told *Psychiatric News* that the resolution amounts to a demand for research that would provide important epidemiologic information about how to effectively intervene to reduce gun violence.

"We need good research, and for the past 20 years there has been a moratorium on research at the CDC," Kraus said. "We can't devise good interventions without good information."

Testimony on the floor of the House was passionate and urgent, and though not unanimously supportive, was very close to it. Addiction psychiatrist Michael Miller, M.D., said, "We are the shame of the world. Other countries look at us and wonder what is wrong in America."

Miller said the 20-year prohibition on research at the CDC has produced an environment of real avoidance among researchers, who fear that funding for their projects can be cut off if it runs afoul of the congressional language. "We need the AMA to take a stand on this," he told the House.

Specifically, the 1996 amendment states that "none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control." However, the practical effect of this language has been—as Miller stated on the House floor—to freeze virtually all research on firearms. Arthur Kellerman, M.D., M.P.H., stated in a December 2012 article in the *Journal of the American Medical Association,* "Precisely what was or was not permitted under the clause was unclear. But no federal employee was willing to risk his or her career or the agency's funding to find out. Extramural support for firearm injury prevention research quickly dried up."

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# JOURNAL DIGEST

BY VABREN WATTS AND NICK ZAGORSKI

iStock/Drazen Lovric

## U.S. Public Supports Raising Age To Purchase Tobacco

The majority of U.S. residents are in favor of raising the legal minimum age to purchase tobacco products, according to a study published last month in the *American Journal of Prevention Medicine*.

Researchers from the University of North Carolina analyzed data from a national telephone survey conducted from September 2014 to May 2015 that asked 4,880 adults 18 and older to indicate their support for policies that would increase the legal age for purchasing tobacco products from 18 to 19, 20, or 21.

While the level of support for raising the minimum age of sale for tobacco products varied slightly by geographical regions, the authors found overall 66 percent of the adults were in favor of the policy change. Odds of support for raising the minimum sales age to 21 trended higher than support for raising the age to 19 or 20 years.

"Both this work and previous research suggest that federal legislative action to raise the minimum age of tobacco sales would be well received by the public," the researchers wrote. "Policymakers should be aware that linking policy changes to trusted government agencies may facilitate adoption of policies that reduce tobacco use."

Lee J, Boynton M, Richardson A, et al. Raising the Legal Age of Tobacco Sales: Policy Support and Trust in Government, 2014-2015, U.S. *Am J Prev Med*. May 20, 2016. [Epub ahead of print] http://www.ajpmonline.org/article/S0749-3797(16)30116-7/abstract

iStock/KatarzynaBialasiewicz

## Over 2 Million College Students Use Alcohol or Marijuana Daily

Over 2 million college students in the United States use alcohol or smoke marijuana each day, according to a recent report by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The findings of the report were based on combined data from the 2011 to 2014 National Survey on Drug Use and Health (NSDUH). As part of the NSDUH, college students aged 18 to 22 were asked about their past year and past month use of alcohol and illicit drugs, which includes nine categories: marijuana, cocaine (including crack), heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives.

The results showed that on an average day in the past year, 1.2 million full-time college students drank alcohol, and 703,759 smoked marijuana. A total of 239,212 part-time college students engaged in alcohol use, and 195,020 smoked marijuana.

The report also found that on an average day in the past year, 2,179 full-time college students drank alcohol for the first time, and 1,299 used marijuana. As for part-time college students, 453 drank alcohol for the first time and 153 started using marijuana.

"Substance misuse at any age can jeopardize one's health and long-term well-being, but college students may be particularly at risk because of the pressures they face at this critical juncture of their lives," SAMHSA's Center for Substance Abuse Prevention Director Frances Harding said in press release. "College administration, faculty, and staff; students; parents; and the surrounding community must work to ensure that college students get the effective prevention programming and treatment services they need."

A Day in the Life of College Students Aged 18 to 22: Substance Use Facts. The CBHSQ Report. May 26, 2016. http://www.samhsa.gov/data/sites/default/fkiles/report_2361/ShortReport-2361.html

iStock/Christopher Futcher

## Exposure to Chemo Early in Life May Alter Executive Function

Higher exposure to the chemotherapy drug methotrexate appears to be associated with long-term executive dysfunction in survivors of childhood acute lymphoblastic leukemia, according to a study published in the *Journal of Clinical Oncology*.

Researchers at St. Jude Children's Research Hospital recruited over 200 pediatric patients, who were at least five years post-diagnosis and had been treated with chemotherapy, to perform a series of cognitive and neuroimaging tests. The researchers then compared pharmacokinetic assays collected during therapy with neurocognitive and brain imaging outcomes.

While overall intelligence of the survivors was within the normal range, measures of executive function, processing speed, and memory were lower in survivors than population means. Higher plasma methotrexate was also associated with neurological changes associated with executive function, such as thicker cortices in dorsolateral prefrontal brain regions.

"With five-year survival rates for pediatric ALL [acute lymphoblastic leukemia] approaching 95 percent, researchers are focused on better understanding and reducing the neurotoxicity patients still experience during and sometimes long after treatment," said lead study author Kevin Krull, Ph.D., in a statement. "It remains a relatively common problem even in the contemporary treatment era of chemotherapy only." PN

Krull K, Cheung Y, Liu W, et al. Chemotherapy Pharmacodynamics and Neuroimaging and Neurocognitive Outcomes in Long-Term Survivors of Childhood Acute Lymphoblastic Leukemia. *J Clin Oncol*. June 6, 2016. [Epub ahead of print] http://jco.ascopubs.org/content/early/2016/06/02/JCO.2015.65.4574.abstract

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(Kellerman was the author of a 1993 study in the *New England Journal of Medicine* titled "Gun Ownership as a Risk Factor for Homicide in the Home," which appears to have been the catalyst for the 1996 amendment. That study found that "keeping a gun in the home was strongly and independently associated with an increased risk of homicide. … Virtually all of this risk involved homicide by a family member or intimate acquaintance.")

Even after the 2013 Newtown massacre when President Obama issued an executive order to lift the ban, research on firearms remained stifled. A January 15, 2015 article in the *Washington Post* reported that "today the CDC still avoids gun research demonstrating what many see as the depth of its fear about returning to one of the country's most divisive debates."

The shooting in Orlando took place in a gay nightclub killing mostly Latino and black patrons. The incident sparked outrage among gay communities around the nation and among gay physicians at the AMA.

AMA Trustee Jesse Ehrenfeld, M.D., and neurologist Joshua Cohen, M.D., challenged delegates to honor the victims of the Orlando shooting by contributing to an AMA Foundation LGBT Honor Fund that provides up to $10,000 annually to initiatives of interest to the LGBT medical community.

Ehrenfeld and Cohen vowed to match contributions up to $15,000. Later in the meeting, they announced that delegates had committed more than $71,000. PN

The emergency resolution on gun violence and other items enacted by the AMA House of Delegates is posted at http://www.ama-assn.org/sub/meeting/index.html.

## Human Trafficking

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being trafficked in the first place.

"Pimps pick on vulnerable girls in recruitment," said Emily Rothman, Sc.D., an associate professor at the Boston University School of Public Health. Besides sexually seducing the girls, the pimps introduce them to a life that initially seems filled with money and glamour until they are entrapped.

The Boston program arranges group discussions with young women believed to be at risk of being trafficked, who are referred by schools and residential treatment centers. The program teaches about exploitation, unhealthy dating relationships, and the recruitment process in order to increase the girls' perception of the industry's dangers, not its purported glamorousness. They also hear firsthand from people who have been exploited.

Ultimately, young people who have been trafficked must decide for themselves that they want to get out of their situation, said Garuba. The trafficked life can be understood as a form of addiction, and relapse is likely.

"You need to plant the seed," she said. "Maybe the next therapist will help them take that next step." PN

More information about human trafficking can be found at https://healtrafficking.org/.

## Slavitt

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impacts in the first year when the vast majority of physicians are expected to be in the MIPS part of the program," he said.

Third, while the merit-based incentive portion of the law is designed to be budget neutral in general, there are new opportunities for additional bonuses. "In MIPS, in addition to the 4 percent positive payment adjustment, there is the potential for much higher payments through $500 million in funding over six years," Slavitt said. "Physicians earn a 5 percent lump-sum bonus for participating in an Advanced Alternative Payment Model."

Slavitt said that to make the new system work, the administration was determined to do something it hadn't done well in the past—listen to the needs and concerns of physicians and to their representatives in organized medicine such as AMA and APA.

"Our career staff and our regions have been tasked with connecting us closer and closer to where care actually happens," he said. "We began this by reaching out and meeting with over 6,300 stakeholders all across the country before we published the proposed rule in April. Our particular focus on meeting with practicing physicians in their offices, in workshops, in focus groups and in weekly sessions to listen to policy options and to dig into the details of how the concepts in MACRA translate into the realities of a busy practice. Since proposing the rule at the end of April, we've held over 135 events centered on physicians and clinicians affected by the Quality Payment Program."

Slavitt seemed to acknowledge that the government had earned physician distrust from a history of making rules and regulations that have tended to make being a physician more difficult.

"We don't win back hearts and minds with empty promises of quick fixes," Slavitt said. "We win them back by listening, by making progress even in small steps, and by calling attention to where the system remains dysfunctional. We don't have the option of running from these challenges because they at the very heart of the care we get, that our family gets, that our country gets."

Slavitt outlined four priorities to govern progress going forward:

- **Keeping the patient at the center care. "**In all my years, I have never met a physician who makes her decision on how to treat a patient based on how she gets paid," Slavitt said. "She does what she thinks is right for the patient and hopes that the system will support her. Physicians, and the patients they treat, deserve approaches that support them for doing the right thing, that encourage physicians to collaborate and reduce waste, and keep people at home and in comfortable settings so their lives continue as normally as possible."

- **Allowing practices to drive how they participate.** "We heard directly from many physicians, and specialists in particular, that a one-size-fits-all program won't work," he said. "That's why we are aiming to build a program that will be as flexible as possible so physicians can focus first, on what's right for their patients or makes sense in their local community and choose from a number of ways to participate in the Quality Payment Program. That means more options on choosing appropriate measures. Options on whether to participate in models like ACOs and Medical Homes and the flexibility to move between them without having to report multiple times. It also means using quality measures selected directly from work with specialty societies."

- **Focusing on policies based on the needs of small practices and those in rural or underserved areas.**

- **Simplifying whenever and wherever possible.**

He called on physicians to be patient and to work with the administration in refining the new system.

"I understand the temptation for this program to become a lightning rod for all that's wrong with the practice of medicine," he said. "But I ask you that you not make it the case that until every element is perfect, physicians remain cynical and on the sidelines. I promise you that this process and this program will be better with your input and participation, as you help make sure it connects as closely as possible to supporting the realities of patient care. It is essential that physicians not only participate in but have a leading voice in the change that is ahead." PN

For detailed information about MACRA and how it impacts psychiatrists, see the first installment of the *Psychiatric News* series "Changing Practice/Changing Payment" at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.5a3.