WWW.PSYCHNEWS.ORG | THE FIRST AND LAST WORD IN PSYCHIATRY | VOLUME 51, NUMBER 9, MAY 6, 2016

PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

ISSN 0033-2704

Hironori Asakawa/Kyodo News via AP

Tsutoshi Yoshida and his wife, Seiko, pray for their daughter who was killed by the tsunami in Namie, Fukushima, in 2011, on the tsunami's fifth anniversary. More than 18,000 people were killed, and the coastline along the country's northeast was devastated. While the psychiatric response to survivors has been strong, more care will continue to be needed. See story on page 21.

SSRI Exposure In Utero Linked to Higher Adolescent Depression

Researchers and reviewers both stress the importance of treating maternal depression. Future work will consider whether dosage, titration schedules, and timing of treatment may provide new guidance for treating pregnant women with depression.

BY MARK MORAN

Prenatal exposure to selective serotonin reuptake inhibitors (SSRIs) was associated with increased rates of depression diagnoses in early adolescence, according to a report published online on March 2 in the *Journal of the American Academy of Child and Adolescent Psychiatry.*

The study is the first to investigate the incidence of psychiatric diagnoses in offspring prenatally exposed to SSRIs as far out as adolescence. Researchers and those who reviewed the study alike emphasized that the findings are preliminary and should not be construed to change clinical practice. They underscored the vital importance of treating maternal depression, which can have significant adverse effects on offspring.

The leader of the project and second author of the paper, Alan S. Brown, M.D., M.P.H., told *Psychiatric News* that untreated maternal depression has been shown to increase risks of several perinatal outcomes including preterm birth, delivery by C-section, and bleeding during delivery.

see **Adolescent Depression** on page 30

APA Publishes New Practice Guideline On Antipsychotic Use for Dementia

Instead of focusing on an entire disorder, the guideline takes a more focused look at difficult decisions facing those who manage elderly patients with cognitive and behavioral problems.

BY NICK ZAGORSKI

On May 1, APA released its latest set of evidence-based recommendations with the publication of its Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia.

This new guideline represents a departure from the existing collection of APA practice guidelines that discuss treatment options for a disorder or class of disorders. The recommendations in the new guideline are tailored to a specific set of symptoms and a particular class of medication.

The topic may be narrow, but the implications are broad. There is an ever-growing population of patients who need to be treated for a variety of cognitive and behavioral difficulties and are frail and vulnerable due to their age and dementia.

Of the symptoms presented by these patients, agitation and psychosis are among the most debilitating; they are the leading risk factors for institutionalization and death in this population, according to the guideline. There is evidence that antipsychotics can alleviate these symptoms, but research suggests they provide only modest benefits and carry potential adverse health reactions.

"There are patients with dementia for whom the use of antipsychotics is warranted, but there is no easy way to determine those cases up front," said Laura Fochtmann, M.D., a professor of psychiatry at Stony Brook University School of Medicine and the medical editor of APA's practice guidelines.

With this new guideline, she continued, APA aims to provide rigorously reviewed, up-to-date evidence to help

see **Dementia** on page 34

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

PSYCHIATRIC NEWS

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

SUBSCRIPTIONS
U.S.: individual, $134. International: APA member, $182; nonmember, $201. Single issues: U.S., $24; international, $41. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or email institutions@psych.org.

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

My Final Column as President: Impact of APA

RENÉE BINDER, M.D.

As I reflect on the past year, I think about how much I have learned about how APA can have an impact on the mental health of our patients and our communities. I will specifically describe one recent event as well as other examples.

Meeting With Commandant of Marines

In February, I received an email from the counsel for the commandant of the U.S. Marine Corps. He asked for APA's help in dealing with the problem of suicide in the Marines. The scope of this problem was recently described in two *New York Times* articles about suicide in the 2nd Battalion, 7th Marine Regiment. That military unit returned from a dangerous tour in Afghanistan in 2008, where it had been deployed behind supply lines and had been under fire almost daily. During eight months of combat, the unit killed hundreds of enemy fighters and suffered more casualties than any other Marine battalion that year.

Since the end of deployment, 14 members of the unit have died by suicide, and many others have attempted suicide. The suicide rate for the 1,200 Marines who deployed with this unit is nearly four times as high as for young male veterans as a whole and 14 times as high as that for all Americans.

In March, Drs. Paul Summergrad and Maria Oquendo and I, together with APA's administrative leadership, met with the leadership of the U.S. Marine Corps. In attendance was Gen. Robert Neller, a four-star general who is the commandant of the Marine Corps and a member of the Joint Chiefs of Staff. In addition, the meeting was attended by another general, an admiral, and the heads of both the behavioral health and psychological health units for the Marines.

Gen. Neller started the meeting by saying that two active duty recruits had died by suicide in the previous week. He said that 60 percent of the Marines are under 25 and that he is motivated to prevent suicide in these brave young men. He specifically wanted APA's help with prevention, identifying tools for early recognition, and decreasing stigma so that the Marines would seek help. He spoke about the military culture and how it doesn't work to say to a Marine: "You did the best you could." He explained that Marines are trained to think that there is a "right way" and a "wrong way" and that there is always the "one best way" to do things.

APA plans on working with the leadership of the U.S. Marines with a multipronged approach to prevent suicide. This is an example of the ability of APA to try and improve the mental health of our country.

Other Examples of Outreach

In addition to the above example, I have participated in other experiences in which APA has been able to exert its influence to impact public policy. In the last seven months, I chaired three congressional briefings to educate members of Congress about mental health issues. The briefing in October addressed the decriminalization of people with mental illness. In December, the briefing included a panel of experts to address the importance of eliminating the Medicaid IMD (Institutions for Mental Diseases) exclusion as part of mental health reform to increase the number of available psychiatric beds. Another briefing in April dealt with the importance of collaborative care.

Other recent APA activities include the establishment of a mental health registry to help with quality measures and help our members meet the increasing regulatory requirements of Medicare and other payers. The registry will also have utility for research, improving care, and meeting ABPN MOC requirements. We are starting to look at potential revisions to *DSM-5,* which is probably our most influential APA document.

see ***From the President*** *on page 31*


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IN THIS ISSUE

Join 'Find a Psychiatrist'

If you haven't joined one of APA's newest member benefits—the Find a Psychiatrist national database—the Annual Meeting provides a good opportunity to do so. The database enables individuals to locate a psychiatrist living in their community. APA Members are invited to come to APA Central to have their portraits taken and uploaded to the database. Not attending this year's Annual Meeting? Join at http://psychiatry.org/fapoptin.

Departments

GOVERNMENT NEWS

Obama Proposes Raising Caps on Buprenorphine Prescribing

In laying out several new actions to fight the nation's opioid crisis, the president also announced the creation of a federal task force to advance access to mental health and substance use disorder treatment.

BY MARK MORAN

The White House in March announced a host of public and private sector initiatives addressing the nation's opioid epidemic, including a proposal to increase the current patient limit for qualified physicians who prescribe buprenorphine to treat opioid use disorders from 100 to 200 patients. Additionally, more than 60 medical schools announced that, beginning in fall 2016, they will require their students to take some form of prescriber education, in line with the newly released Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, in order to graduate (*Psychiatric News*, April 15).

President Obama, in an address at the National Rx Drug and Heroin Abuse Summit in Atlanta where he released the proposals, also announced the creation of an interagency task force to advance access to mental health and substance use disorder treatment, promote compliance with best practices for mental health and substance use disorder parity implementation, and develop additional agency guidance as needed.

The task force will work quickly across federal departments and with diverse stakeholders to identify and promote best practices for executive departments and agencies, as well as state agencies, to better ensure compliance with and implementation of requirements related to mental health and substance use disorder parity. The task force will also look to determine areas that would benefit from further guidance. They will present a report on their findings to the president by October 31.

APA President Renée Binder, M.D., called the task force "a very constructive step" and said gaps remain in enforcement of federal parity, especially around treatments for substance use disorder. "The establishment of the task force will increase visibility of this issue (federal law requires nondiscriminatory treatment of these patients by health plans) and highlight its significance," she said. "The particular emphasis on substance use disorder parity is warranted. This is an area where we have seen greater variability in plan policies regarding treatment options. This is important for persons with primary substance use disorder conditions, and also for our patients who have other psychiatric diagnoses with substance use disorder as a comorbidity."

Binder added, "APA is strongly encouraged that the timeline for this task force's work is focused. The report is due October 2016, and its charge stipulates that actions need to be implemented during its tenure and be completed by the end of its tenure."

The proposal to lift caps on buprenorphine prescribing met with preliminary approval from APA leaders. "These are very important steps to improve the accessibility of buprenorphine," Frances Levin, M.D., chair of the APA Council on Addiction Psychiatry, told *Psychiatric News*. "The problem, however, is getting physicians more comfortable prescribing [buprenorphine], since there are already many physicians who are certified but don't prescribe or underprescribe (*Psychiatric News*, March 18). "Training physicians while they are residents is a very good strategy," she said. "We need a grassroots approach."

Her comments were echoed by John Renner, M.D., vice chair of the council. "Our survey of addiction clinicians indicates that the majority are not comfortable treating numbers of patients in [the 150 to 200 patient] range," he told *Psychiatric News*. "It is possible that this change will create a number of large buprenorphine practices, but it will not generate the numbers needed to impact the current epidemic. We remain committed to our proposal to expand treatment services by also encouraging a larger number of small buprenorphine practices by expanding clinician training, permitting prescribing by physician assistants and nurse practitioners, and addressing clinicians' concerns about the system of DEA inspections."

Also speaking at the summit in Atlanta was psychiatrist Patrice Harris, M.D., M.A., who is chair of the AMA's Task Force to Reduce Opioid Abuse. As part of her remarks, she encouraged physicians to use state Prescription Drug Monitoring Programs.

"We urge physicians to register and use the state prescription drug monitoring program to check a patient's prescription history; educate yourself on managing pain and promoting safe, responsible opioid prescribing; support overdose prevention measures, such as increased access to naloxone; reduce the stigma of substance use disorders and enhance access to treatment; and ensure patients in pain aren't stigmatized and can receive comprehensive treatment." PN

HHS Proposes National Strategy for Pain Management

According to the American Academy of Pain Medicine, chronic pain affects more Americans than diabetes, heart disease, and cancer combined.

BY VABREN WATTS

Last month, the Office of the Assistant Secretary for Health at the Department of Health and Human Services (HHS) released the National Pain Strategy, the federal government's first coordinated plan for reducing the burden of chronic pain that affects millions of Americans.

Chronic pain, which in some cases can arise from injury, infection, or disease, is estimated to affect approximately 100 million U.S. adults at a cost of $560 billion to $635 billion.

"It has been acknowledged by most national medical organizations that pain is one of the more complicated and important conditions we face in medicine," said David Gitlin, M.D., chief of the Division of Medical Psychiatry at the Brigham and Women's Faulker Hospital and chair of the APA Council on Psychosomatic Medicine. "For many years pain was frequently missed or undertreated in many patients," he told *Psychiatric News*.

Over the past 20 years, Gitlin said the medical community has made marked improvements in the way it assesses and treats pain; however, he added, some of these changes may have contributed to "a significant increase in the use of opioid medications, which has contributed significantly to the current opioid crisis nationally."

The National Pain Strategy makes several recommendations for improving pain care in six key areas:

- **Population research:** Refine and employ standardized health care data methods to determine the extent to which people with common pain conditions receive various treatments and services, the costs of these services, and the extent of use of treatments; and develop a system of metrics for tracking changes in pain prevalence, impact, treatment, and costs over time.

- **Prevention and care:** Characterize the benefits and costs of current prevention and treatment approaches through benefit-to-cost analysis. Promote alternative pain treatments outside of opioid painkillers (for example, cognitive-behavioral therapy and acupuncture) and develop new interventions that will combine the biopsychosocial elements of patients, including self-management pain programs.

- **Disparities:** Improve the quality and availability of data to assess the costs of disparities in pain care. Work to understand the negative impact of biases on pain treatment and develop strategies to overcome such biases.

- **Service delivery and payment:** Tailor payment to promote and incentivize high-quality, coordinated pain care through an integrated biopsychosocial approach that is cost-effective, value-based, patient-centered, comprehensive, and improves outcomes for people with pain.

- **Professional education and training:** Develop, review, and regularly update core competencies for pain care education and licensure and certification at the undergraduate and graduate levels. Efforts to enhance health care provider knowledge and skills for safer prescribing practices and identify risks for opioid use disorder should be coordinated with ongoing activities across HHS.

- **Public education and communication:** Develop and implement

continued on next page

Masked Man Challenged Psychiatrists' Views on Homosexuality

A psychiatrist stigmatized because of his sexual orientation could protest only anonymously at APA's 1972 Annual Meeting.

BY AARON LEVIN

Kay Tobin/The New York Public Library

Gay advocates Barbara Gittings and Franklin Kameny, Ph.D., sit beside the masked "H. Anonymous, M.D.", who years later revealed himself as John Fryer, M.D. Maryland psychiatrist Kent Robinson, M.D., speaks at the podium.

50 YEARS

"Any attempt to formulate a succinct, comprehensive overview of what happened in Washington last month at APA's Annual Meeting is doomed," began *Psychiatric News'* June 2, 1971, coverage of what became one of APA's most significant turning points.

The report was brief: "Only a single disruption occurred ... when members of the Gay Liberation and the Radical Caucus seized the microphone. ..." during an otherwise uneventful business meeting.

Among those who grabbed the mic was Franklin Kameny, Ph.D., an astronomer who had been fired from a federal government job after his homosexuality became known. Kameny took the occasion to attack APA and psychiatry in general for its "oppression of homosexuals." At the time, homosexuality was defined as an illness in *DSM*, influenced both by psychoanalytic theory and general social prejudice.

This interruption was not well reported in the general press because at the same time some 7,500 anti-Vietnam War protesters were being arrested across town.

Kameny expanded his views on psychiatry's position on homosexuality in a long letter to the editor of *Psychiatric News* published in the July 7, 1971, issue.

"Basically, we object to the negative attitudes of psychiatry toward homosexuality," he wrote. "More specifically, we object to the sickness theory of homosexuality tenaciously held with utter disregard for the disastrous consequences of this theory to the homosexual, based as it is on poor science."

A more dramatic challenge to the status quo came a year later when the 1972 APA Annual Meeting in Dallas hosted a panel with gay advocates titled "Psychiatry: Friend or Foe of Homosexuals—A Dialogue." There, a man wearing a rubber Halloween mask and a bushy wig slipped into the room and was introduced as "H. Anonymous, M.D."

"I am a homosexual," he said. "I am a psychiatrist."

"The masked psychiatrist spoke of his difficulties in keeping his sexual orientation secret because of the bias and rejection he would encounter," reported *Psychiatric News*. "'My greatest loss,' he said, 'is my honest humanity. How incredible that we homosexual psychiatrists cannot be honest in a profession that calls itself compassionate and helping.'"

> "My greatest loss ... is my honest humanity. How incredible that we homosexual psychiatrists cannot be honest in a profession that calls itself compassionate and helping."

John Fryer, M.D., is honored by APA through presenting an annual award to an individual who has contributed to improving the mental health of sexual minorities.

Another panel member, APA Vice President (and later APA President) Judd Marmor, M.D., agreed with other speakers that psychiatry was biased against homosexuality.

"I must concede that psychiatry is prejudiced as has been charged," he said. "Psychiatric mores reflect the predominant social mores of the culture."

In a follow-up letter to the editor of *Psychiatric News*, Marmor argued by comparison that no one would suggest that strongly held religious convictions be considered to be mental illnesses.

"In a democratic society we recognize the rights of such individuals to have widely divergent religious preferences, as long as they do not attempt to force their beliefs on others who do not share them," he wrote. "Our attitudes toward divergent sexual preferences, however, are quite different, obviously because moral values—couched in 'medical' and 'scientific' rationalizations—are involved."

Even though APA removed homosexuality from its manual of psychiatric illnesses in 1973, "Dr. Anonymous" did not reveal himself until 22 years later. He was John Fryer, M.D. (1938-2003), who was forced to leave his psychiatry residency at the University of Pennsylvania when it was discovered that he was gay. He eventually became a professor of psychiatry at Temple University.

APA remembers the masked pioneer of gay rights in its annual John Fryer Award, which honors a person who has contributed to improving the mental health of sexual minorities. PN

For a contemporary discussion of homosexuality and its relation to psychiatry, see "A Symposium: Should Homosexuality Be in the APA Nomenclature?" from the November 1973 issue of the *American Journal of Psychiatry*, posted at http://ajp.psychiatryonline.org/doi/pdf/10.1176/ajp.130.11.1207.

continued from previous page

a national educational campaign about the impact and seriousness of chronic pain and promote safer use of all medications, especially opioids, among patients with pain.

"The [report's] emphasis on patient and provider education and use of alternative treatments are great issues to address," Gitlin told *Psychiatric News*.

He added, "Opioid medications will likely continue to be a critical component of treatment for some patients, and thus there will always be a subgroup of patients who will develop comorbid opioid use disorders, especially those who have demonstrated previous vulnerability. The goal of recognizing and responding effectively to the opiate use crisis needs to remain central to the overall strategy." PN

The National Pain Strategy is posted at http://iprcc.nih.gov/docs/HHSNational_Pain_Strategy.pdf.

PROFESSIONAL NEWS

Value-Based Payment Will Change Practice, Reimbursement

Psychiatric News is launching a series of articles examining the major federal initiatives that are driving the change to value-based payment and how these changes will affect psychiatrists.

CHANGING PRACTICE CHANGING PAYMENT

BY MARK MORAN

The notion that the American health care system should transition from paying for volume to paying for value has become nearly ubiquitous.

Writing in an online blog recently for the journal *Health Affairs,* four distinguished health economists noted that value-based payment is no longer a passing trend—it is where the health care system of the future is headed.

"There is a broad consensus that health care providers should be paid more if they deliver higher value care—that is, care that results in substantial health gains per dollar spent," wrote Nancy Beaulieu, Ph.D., a research associate at the Department of Health Care Policy at Harvard Medical School, and colleagues in the blog post "The Economics of Paying for Value" (March 15).

The movement toward value-based payment began more than 20 years ago, but in recent years it has gathered momentum with a proliferation of value-based payment programs in both the public and private sectors. These changes encompass dramatic reforms in the way physicians participating in Medicare and Medicaid will be paid and the emergence of a variety of new models of care by which physicians can organize themselves to deliver value-based care.

The movement has greatly accelerated since the passage of the Affordable Care Act (ACA) but has also been driven by technological change—especially the growth of electronic health records (EHRs) and payer incentive programs to encourage proliferation of EHRs. And some changes—especially the federal mental health parity law and provisions in the ACA requiring parity coverage of treatment for mental and substance use disorders—are especially relevant to psychiatrists.

The goal of this evolution is summed up in the so-called Triple Aim: better patient experience of care, lower per capita cost of health care, and improved population health. Altogether, this movement toward value-based payment represents a profound sea change in American medicine, requiring physicians to take specific actions and make substantive changes in the way they practice.

In the coming months, *Psychiatric News* will concisely but comprehensively cover all of the important components of this movement in a series of articles under the theme "Changing Practice/Changing Payment." Topics will include the following:

- **Medicare Access and CHIP Reauthorization Act (MACRA):** MACRA represents a major turning point in Medicare payment policy and quality programs. Over 23,000 psychiatrists provided services to Medicare patients in 2013. Several MACRA provisions

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also impact Medicaid, other federal programs, and potentially some private payers.

• **The Merit-Based Incentive Payment System (MIPS):** MIPS will replace current programs and penalties. Performance assessment under MIPS is designed to be more flexible than under current programs, with performance thresholds based on the average performance of one's peers.

• **Alternative payment models (APMs):** Under MACRA, physicians with sufficient revenue (or patients) tied to "eligible" APMs can earn bonuses and may not have to report under MIPS. *Psychiatric News* will examine MACRA requirements for APMs and how they may work for physicians and patients.

• **Electronic health records:** Quality reporting requirements are linked to the adoption of EHRs. *Psychiatric News* will outline the requirements and how they may affect reimbursement and practice.

• **Integrated care:** Models of integrated care have become central in the push toward value-based care and are ingrained in many of the federal initiatives that are changing how physicians are paid.

Importantly, the "Changing Practice/Changing Payment" series will outline specific actions that APA members will

*see **Value-Based Payment** on page 29*

PSYCHIATRY & INTEGRATED CARE

The Critical and Evolving Roles for Psychiatry in Health Reform

MICHELLE BLACKMORE, PH.D., SALLY RICKETTS, M.D., AND HENRY CHUNG, M.D.

As leaders of Montefiore Medical Center's Care Management Organization in New York City and its Bronx Behavioral Health Integration Project (Bronx-BHIP), this month's authors are a collective powerhouse in creating innovative integrated care models and reimbursement methodologies. They urge us to step up and help lead the way in health care reform.

—Jürgen Unützer, M.D., M.P.H.



Health care reform initiatives are rapidly transforming the U.S. health system. In particular, the accountable care Triple Aim to improve care quality and population

health while lowering health care costs has become ubiquitous across almost all aspects of primary and specialty care. Of particular interest to psychiatrists is the accelerating recognition that the success and sustainability of accountable care models are critically linked to timely behavioral health access and treatment.

Accountable care organizations (ACOs) often focus on creating integrated models centered on primary care practices. These practices provide preventive and chronic illness care, along with care coordination for patients with complex medical and psychosocial needs. Because evidence-based behavioral integration produces improved quality, lower costs, and seamless and holistic care, there is a strong desire to partner primary care and psychiatry; however, the dissemination of these models has been limited to settings where payment and information sharing are well aligned, such as in multispecialty patient-centered medical homes. Integration models such as collaborative care in primary care settings and provision of primary care for patients with serious mental illness within behavioral health settings are now seen as "must-haves" for ACOs and payers alike. With health reform, financial incentives to encourage integration are finally growing, and the need for psychiatrists to play the key clinical, supervisory, and administrative roles that will allow such models to scale and flourish has never been more pressing and urgent.

Emerging Policy Levers Support Integration

The traditional fee-for-service payment (FFS) mechanism as the sole mechanism for physician and hospital reimbursement is declining in favor of growing value-based payments (VBP) that reward the achievement of Triple Aim outcomes (quality, engagement and satisfaction, and costs). VBP models include some mix of FFS plus bonus incentives, episode-based payments, shared savings payments, and global capitation payments. Psychiatry, following the rest of medicine, will be pulled along this VBP continuum toward a more sustainable payment model that aligns incentives to provide timely patient access and engagement, coordinated care, evidence-based treatments, and outcome measurement.

Government and private payers are now actively providing support (through financial incentives and regulatory/policy changes) to health care providers to (1) integrate medical and behavioral health care at both the treatment and care-management levels, (2) increase the focus on achieving both medical and behavioral health outcomes on patients with comorbid conditions (for example, diabetic quality outcomes as well as depression outcomes), and (3) foster medical and behavioral health provider partnerships that improve information sharing, patient engagement, and shared accountability for health outcomes.

How Can Psychiatry Help Lead the Way?

Psychiatrists have the unique training and expertise to play the essential roles as providers, facilitators, and innovators to support the integration models that are critical to the success of accountable care models. At a population level, their expertise is critical to the implementation of workflows for identifying and monitoring behavioral health care

*see **Integrated Care** on page 21*

Michelle Blackmore, Ph.D., is a clinical psychologist and project director of the CMS-funded Bronx Behavioral Health Integration Project (B-BHIP) in Yonkers, N.Y. Sarah Ricketts, M.D., is medical director of behavioral health integration at the Montefiore Care Management Organization in Yonkers, N.Y. Henry Chung, M.D., is vice president and chief medical officer of the Montefiore Care Management Organization and executive project director of B-BHIP. Jürgen Unützer, M.D., M.P.H., is a professor and chair of psychiatry and behavioral sciences at the University of Washington, where he also directs the AIMS Center.

PROFESSIONAL NEWS

Laura Roberts, M.D., Lisa Dixon, M.D., Appointed as Editors

Laura Weiss Roberts, M.D., M.A., has been appointed editor-in-chief of books for APA's Publishing Division, and Lisa Dixon, M.D., M.P.H., has been appointed editor of the APA journal *Psychiatric Services.*

"We are delighted to have Drs. Dixon and Roberts, two very prominent and accomplished leaders in psychiatry, joining us in these leadership roles," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "They will each bring a tremendous depth of knowledge, experience, and innovation to our publications."

Roberts will assume her responsibilities on June 1, when Editor-in-Chief Robert E. Hales, M.D., M.B.A., steps down. Dixon will start her responsibilities as editor in January 2017, when the current editor, Howard Goldman, M.D., Ph.D., steps down.

Roberts is the chair and Katharine Dexter McCormick and Stanley McCormick Memorial Professor in the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine and chief of the psychiatry service for Stanford Hospital and Clinics. Since 2007, Roberts has served as the deputy editor of the books division for American Psychiatric Association Publishing (formerly American Psychiatric Publishing Inc.). She has also served as the editor-in-chief of the journal *Academic Psychiatry* since 2002.

Laura Weiss Roberts, M.D., M.A.

Lisa Dixon, M.D., M.P.H.

Roberts is a nationally recognized scholar and leader in ethics, psychiatry, medicine, and medical education. She is the author and editor of numerous books, including the *Clinical Guide to Psychiatric Ethics.* She received her medical degree at the University of Chicago Pritzker School of Medicine and completed her residency at the University of New Mexico School of Medicine.

Dixon is a professor of psychiatry at Columbia University Medical Center and the director of the Division of Behavioral Health Services and Policy Research in the Department of Psychiatry. She also directs the Center for Practice Innovations at the New York State Psychiatric Institute. In addition, she has served on the editorial board of *Psychiatric Services* and is currently the editor of a column in the journal dedicated to public-academic partnerships.

Her research has focused on improving the quality of care for individuals with serious mental disorders with a particular emphasis on addressing co-occurring addictions and medical problems and on services that include families. She has received numerous awards, including the National Alliance on Mental Illness (NAMI) Scientific Research Award in 2014. Dixon received her medical degree from Cornell University Medical College and her M.P.H. from Johns Hopkins University and completed her psychiatry residency at New York–Presbyterian Hospital/Weill Cornell Medical Center. PN

Sheppard Pratt Taps Trivedi for Top Post, Succeeding Sharfstein

Plenty of executive experience, coupled with his clinical background, drew Harsh Trivedi, M.D., and Sheppard Pratt together.

BY AARON LEVIN

Harsh Trivedi, M.D., M.B.A., currently the chief executive officer of Vanderbilt Psychiatric Hospital in Nashville, will become president and chief executive officer of the Sheppard Pratt Health System in Baltimore on July 1, succeeding former APA President Steven Sharfstein, M.D.

"Sheppard Pratt is one of the few positions I would consider leaving Vanderbilt for," Trivedi told *Psychiatric News.* "But to lead Sheppard Pratt and make meaningful improvements in the care of psychiatric patients across the country is not an opportunity to let go by."

In Sharfstein's nearly 25 years as president and CEO, Sheppard Pratt expanded to include two freestanding psychiatric hospitals, 12 special education residential and day schools, and a number of outpatient and telepsychiatry sites in Maryland.

Sharfstein will become president emeritus and will continue to treat patients (*Psychiatric News*, June 19, 2015).

"Harsh is respected in the field both for his work in behavioral health as a psychiatrist associated with Harvard, Brown, and Vanderbilt universities and as an administrator," said Sharfstein in a statement. "He is absolutely the right person for the job, and we're excited to see him bring new energy and vision to the health system."

Trivedi in turn praised Sharfstein's "visionary leadership" at Sheppard Pratt and his place at "the forefront of good psychiatric care."

Trivedi was a child and adolescent psychiatry fellow at Boston Children's Hospital and then director of adolescent services at Bradley Hospital in Providence before moving to Vanderbilt in 2010.

He has maintained a clinical practice throughout his career and will continue to do so at Sheppard Pratt. Success as a hospital CEO demands retaining a clinical perspective in the midst of administrative duties, he said.

Trivedi also sees a broader picture of his role at Sheppard Pratt.

"As health care reform evolves, we need a greater emphasis on the integration of psychiatric services with population health while better measuring outcomes," he said.

Sheppard Pratt

Harsh Trivedi, M.D., M.B.A., will take up the reins as head of the venerable Sheppard Pratt Health System on July 1.

One concern he hopes to address as the head of a specialized psychiatric system is the challenge of Medicaid's Institutions for Mental Diseases (IMD) exclusion, which affects Sheppard Pratt's accessibility for patients.

"We want to continue providing excellent clinical services across the community while considering how to provide compassionate, patient-centered, evidence-based care across all types of treatment settings," he said.

Trivedi earned his M.D. at the Icahn School of Medicine at Mount Sinai and his M.B.A. at the University of Tennessee. He is a consulting editor of *Child and Adolescent Psychiatric Clinics of North America* and chair of the APA Council on Healthcare Systems and Financing. He also serves on the American Hospital Association Governing Council for Psychiatric and Substance Abuse Services.

"Given the many things going on in the field, including the challenges of health care reform, this is a wonderful opportunity to think about what the future of our field is, as well as really guiding the path forward so we can provide better psychiatric services across the nation," he said. PN

Related information is posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2015.6a20.

COMMUNITY NEWS

Virginia County Builds Consensus To Keep Mentally Ill Out of Jail

"Slow but steady" is the watchword as one county tackles the problem of too many people with mental illness in jail.

BY AARON LEVIN

Arrestees with possible mental illness are screened at the Arlington County Detention Facility in northern Virgina.

Photos: Aaron Levin

Arlington County Police Capt. Brian Berke, M.S. (left), and Leslie Weisman, L.C.S.W., director of the county's Behavioral Healthcare Division, work closely together to divert people with mental illness from the criminal justice system.

The monthly meeting of the Arlington County (Va.) Mental Health Criminal Justice Review Committee illustrates just what it may take to reduce the number of people with mental illness in America's jails—patience, cooperation, time, persistence, commitment, and a lot of time showing up at monthly meetings.

What happens in Arlington is a snapshot of how counties around the country are learning to cope with the problem.

Every agency—and it's quite a list—concerned with the intersection of mental health and criminal justice in Arlington County regularly attends this meeting. For a start, members of the county's behavioral health care staff are there—the forensic team, the crisis intervention team coordinator, a therapist and social worker from the county jail, substance use staff, an emergency services therapist, a family representative, peer specialists, and senior management. Representatives from the sheriff's and police departments are there, too. So are those from the magistrate's office, the public defender, prosecutor, community corrections, and the district court judge's office. A psychology professor from a local university who helps train police officers sits in, too.

At the April meeting, the 20 or so attendees went down a list of recent accomplishments and wrestled with new problems:

A new mental health therapist started late last year, and recruitment had begun for another position for a bilingual candidate. The police department increased its weekly hours to provide security at the Crisis Intervention Center. Discussion of the creation of a mental health court or docket continued. The jail social worker said she wants to talk again with the jail's mental health contractor over the scheduling of psychotropic medication prescriptions for inmates.

The points raised may seem routine, but they reflect the philosophy upon which the county's program rests: Keep talking, keep listening, develop consensus among people and agencies with different priorities, and make incremental, but steady, progress over time.

In fact, Arlington County appears to be one of many jurisdictions developing systems to divert nonviolent, mentally ill arrestees as much as possible from simply cycling through the criminal justice system. Filling jails with such people does little good for public safety, for the person with mental illness, or for taxpayers (see box on page 29).

Cooperation in Arlington County goes back 25 years, said Leslie Weisman, L.C.S.W., chief of the Client Services Entry Bureau and director of Arlington's Crisis Intervention Center. Emergency therapists began building bridges by attending recruit training, riding on patrol with officers, and sitting in on roll calls. Eventually, a police captain was assigned as an intermediary between the two agencies.

More was needed, though, and so the seeds of the review committee were planted in 2003 with an assessment of the needs and gaps in the county's handling of people with serious mental illness involved in the justice system.

Weisman worked closely with police Capt. Brian Berke, M.S., a 30-year veteran of the force, for five years to develop a proposal for a round-the-clock crisis

*see **Jail** on page 29*

Program Hopes to 'Plant Seeds' for Long-Term Growth

"It was never my intention to work in a jail, but I've been here for 11 years," said Suzanne Somerville, L.C.S.W., mental health program manager at the County Detention Facility (or jail) in Arlington, Va.

Inmates taken to the jail are screened repeatedly for symptoms of mental illness, first by a sheriff's deputy at entry, later by the magistrate, and again as they go through a basic medical assessment.

Many inmates on a recent day know Somerville on sight and vice-versa. Some are "interdicted" under a Virginia law that makes it illegal for people convicted of misusing alcohol to buy, possess, or use alcohol.

"We live in a society that penalizes people with mental illness and substance abusers," said Somerville.

The mental health unit can hold 21 men and eight women. "There are fewer women, but they are very sick, and their needs are high."

Most of the sheriff's deputies on this floor have CIT training. Six therapists provide services, usually in small-group settings using cognitive-behavioral therapy, dialectical behavioral therapy, and some Gestalt therapy, said Somerville.

The jail operates an oversubscribed drug treatment program that includes daily treatment and AA-style meetings. A gym holds exercise equipment and a basketball half-court—"the biggest source of injuries, fights, and stress relief."

There is a room for group therapy, involving mostly psychoeducation, job and life skills training, and motivational interviewing, said Somerville. Classes are offered in parenting skills, anger management, and food service training.

"The best you can hope for is to plant a seed and facilitate growth," she said. "But I really feel that I do make a difference."

COMMUNITY NEWS

Devastation by Earth, Water, Fire Still Haunt Japan After Five Years

The effects of the Great East Japan Earthquake on the lives and mental health of many survivors will continue, says a Japanese psychiatrist.

BY AARON LEVIN

The earthquakes that hit the Japanese island of Kyushu in April were a bitter reprise of the magnitude 9.0 quake that struck March 11, 2011, initiating a tsunami that tore apart towns and leading to subsequent explosions at three nuclear power reactors at Fukushima. Five years later, social disruption and consequent psychological stresses remain realities for many survivors.

"People are resilient," said Jun Shigemura, M.D., Ph.D., of the Department of Psychiatry at the National Defense Medical College in Tokorozawa. However, that doesn't mean that many do not still need care, he added in an email interview with *Psychiatric News.*

"As the years have passed, the rates of distressed residents decreased, but the population became polarized," he said. "There are those who recovered and those who haven't, and this gap tends to get bigger and bigger."

Shigemura continued, "At the time of the earthquake, Japan did not have an official postdisaster dispatch system for mental health professionals. However, right after the disaster, prefectural mental health centers and three local medical schools took crucial roles in coordinating non-local psychiatrists and other mental health professionals offering to provide support in the affected area."

A year later, each of the three prefectures (the equivalent of a U.S. state) that suffered the brunt of the damage (Fukushima, Miyagi, and Iwate) established a multidisciplinary Center for Disaster Mental Health, staffed with psychiatrists, psychologists, social workers, and nurses. The medical schools set up departments of disaster psychiatry, and each prefecture organized teams to track long-term physical and mental health outcomes of survivors.

"A recent government report showed higher psychological distress rates for residents of Miyagi and Iwate prefectures, an increase of alcohol misuse in Iwate, and associations with lowered community bonding and adverse mental health compared with the general population," said Shigemura. Fukushima prefecture also showed decreasing, yet still high rates of psychological distress and vulnerabilities among women, he said.

The massive and continuing displacement of people from their homes also has created widespread distress. A total of 171,000 people from the affected areas still have not been able to return home, either because of damage to buildings or fear of radiation aftereffects.

"Any evacuation process is a community breakup process," said Shigemura. "Predisaster communities were dispersed to various temporary housing, and mental health workers have worked very hard to reconstruct those communities. However, it is now time for them to move to government-provided permanent housing, and this means yet another community breakup. Many evacuees choose not to move into permanent housing and seek to find their own homes instead."

The Great East Japan Earthquake alerted disaster response agencies to enhance mental health programs for their workers, said Jun Shigemura, M.D., Ph.D., of the Department of Psychiatry at the National Defense Medical College in Tokorozawa.

Japan's response to the earthquake, tsunami, and nuclear disaster of 2011 has helped many but must continue.

Radiation contamination around the Fukushima nuclear plant adds another layer of concern for residents evacuated from that area.

"Fukushima's radiation contamination level is way lower than that of Chernobyl, and no one died owing to acute radiation syndrome," said Shigemura. "Still, people's fear and health concerns were enormous. Risk communication mishaps led to public criticism and mistrust of the authorities, the electric company, and scientists. People became unsure of what to eat, where to take shelter, and who to believe. Some people tend to attribute ongoing physical symptoms to their radiation exposure regardless of their actual dose."

Fukushima power plant workers showed high levels of mental distress and social rejection, in part because the electric company was blamed for its mismanagement of the disaster.

Victims are stigmatized, as well, he said, "a reminder of what had happened to Hiroshima and Nagasaki survivors—they were called Hibakusha and were discriminated against."

The effects of the triple tragedy five years ago can be expected to linger indefinitely, he said.

"Japanese society will have to deal with postdisaster mental health issues as a public health topic for decades to come," said Shigemura. "Long-term, multidisciplinary approaches will be needed among psychiatrists to provide comprehensive solutions, and disaster preparedness and education will be crucial to enhance the level of mental health care in future disasters." PN

Early coverage of the effects of the earthquake, tsunami, and nuclear disaster in Japan is posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/pn.47.1.psychnews_47_1_15-a and http://psychnews.psychiatryonline.org/doi/full/10.1176/pn.46.11.psychnews_46_11_1_1.

Integrated Care

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needs for a defined patient population, as well as quality-improvement strategies for the attainment of both medical and behavioral health outcomes.

At the patient level, psychiatrist expertise in the biopsychosocial model of illness, chronic disease and medication management, and interdisciplinary team work are essential to helping patients achieve response and recovery. In late 2015, the Centers for Medicare and Medicaid Services announced that psychiatry will be included as a medical specialty to help align patients in Medicare ACOs. This auspicious development recognizes that after primary care, psychiatry has the same level of importance as cardiology, pulmonology, and a limited number of other specialties that can meaningfully impact the Triple Aim in partnership with primary care. It may also allow psychiatrists treating Medicare ACO patients to become involved in VBP arrangements (such as FFS plus incentive) as a way of rewarding the achievement of quality outcomes.

Psychiatrists in primary care settings must proactively define their role as behavioral health leaders within the health care team, providing training, supervision, consultation, and clinical review, in addition to providing direct patient care. For medically complex and acute patients, psychiatrists will also be asked to have a more direct treatment role in specialty clinics (for example, oncology, cardiology, pain management, and acute and subacute rehabilitation facilities) as these patients often have poorer health outcomes with high utilization.

The ability of psychiatrists to meet the changing demands of our health care system is not possible without embracing technology appropriate to patient choice and setting of care (for example, telemedicine/telepsychiatry, videoconferencing, evisits, online portals). A solid information technology infrastructure is required to maximize productive use of psychiatrist time, successfully manage and follow at-risk populations, guide evidence-based practice, and provide near and real-time data sharing across the continuum of care. Technology can help establish performance benchmarks, monitor care quality and cost savings, support nonbillable activities needed to improve engagement of psychiatric patients who often drop out of care, and promote model sustainability.

Psychiatry has a critical role to play in this time of change. The real question is whether there are enough psychiatrists who will step up and engage in these roles. We sincerely hope so. PN

Be Aware of Federal, State Guidelines When Prescribing

Best practices for prescribing can help to reduce the risk of patient misuse, abuse, or overdose of prescription medications, specifically controlled substances.

BY KRISTEN LAMBERT, J.D., M.S.W., L.I.C.S.W., AND MOIRA WERTHEIMER, J.D., R.N., C.P.H.R.M.

The Centers for Disease Control and Prevention (CDC) and numerous other regulatory agencies have declared the abuse of prescription drugs to be a national epidemic. The statistics are staggering: 15 million people (see http://www.samhsa.gov/prescription-drug-misuse-abuse) aged 12 and over have used prescription drugs non-medically and 44 people die each day (see http://www.cdc.gov/drugoverdose/epidemic/index.html) from an overdose of prescription pain medications.

As such, there is heightened scrutiny surrounding prescribing practices and national initiatives to improve prescribing practices in order to reduce instances of drug overdoses, death, and diversion. Whether or not you prescribe controlled substances on a regular basis, the increased regulatory scrutiny is likely to impact your practice at some point.

Psychiatrists have an important role in helping to ensure the safe and effective use of prescription medications and the avoidance of drug diversion. Utilizing prescribing best practices can help to reduce the risk of patient misuse, abuse, or overdose of prescription medications, specifically controlled substances.

It is critical to be aware of both federal and state guidelines when prescribing. Prescribing regulations vary among states; when federal laws are different from state laws, the more stringent rule applies.

It is important to be aware of what is available and what you may be required to do prior to prescribing. Forty-nine states and the District of Columbia have passed statutes establishing Prescription Drug Monitoring Programs (PDMPs), which are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients.

PDMPs can provide the prescriber

with information regarding a patient's controlled substance prescription history. This information helps prescribers identify high-risk patients.

There are several questions to consider about PDMPs before prescribing or issuing a refill:

- What are your state and federal regulations regarding reporting, accessing, and sharing prescription drug monitoring information?
- Are you first required to check your state PDMP database *before* you prescribe or issue a refill?
- What do your state regulations say about whether your office staff or a designated person can search the PDMP database on your behalf?
- Are you required to register with the PDMP?
- Are you required to check the PDMP and, if so, how often?
- Do you need to have an established physician-patient relationship before you can prescribe?
- Do you first need to examine the patient in person prior to prescribing?
- What are your state's telemedicine guidelines, and can you prescribe via telemedicine?
- Are you required to notify your patients that their information may be accessed via the PDMP?
- Are there circumstances in which you are immune from liability under your state PDMP (such as accessing, failing to access, or reporting data)?

There are many issues to consider

see ***Prescribing*** *on page 35*

Kristen Lambert, J.D., M.S.W., L.I.C.S.W., is vice president of the Psychiatric and Professional Liability Risk Management Group, and Moira Wertheimer, J.D., R.N., is assistant vice president of the Psychiatric Risk Management Group at AWAC Services Company, a member company of Allied World.

CLINICAL & RESEARCH NEWS

ECT Said to Be Valid Alternative For Elderly Patients With Depression

Age should be no barrier to receiving electroconvulsive therapy when indicated, clinical trials reveal.

BY AARON LEVIN

"We don't know exactly how electroconvulsive therapy works, but we do know a lot about what it does," said Georgios Petrides, M.D., of the Zucker Hillside Hospital in Glen Oaks, N.Y., and an associate professor of psychiatry at Hofstra Northwell School of Medicine.

"When I prescribe olanzapine to my patients, they never ask me, 'How does this work?' " said Petrides at the annual meeting of the American Association for Geriatric Psychiatry in Washington, D.C., in March.

"Part of the problem lies in inconclusive basic research on ECT combined with our limited knowledge of the underlying biology of mental illnesses," he pointed out during a session on the use of ECT for older patients. ECT's effects are also not very specific. It works across the spectrum of mental illnesses, including depression and mania, psychosis, Parkinson's disease, and catatonia. It also appears to be more efficacious in the most serious cases, rather than milder ones.

At least a dozen theories have been proposed as mechanisms of action for ECT but few, if any, have found much acceptance. Hypotheses began in the psychoanalytic era when it was suggested that ECT worked because of fear: the patient sought to avoid punishment, or was masochistic, or regressed under treatment to a pre-oedipal stage.

Others suggested that ECT caused a good kind of brain damage, a mysterious sort of psychosurgery. Amnesic theories argued that treatment made patients forget simply why they were depressed.

Neurotransmitter theories have suggested that ECT may increase dopamine release, decrease norepinephrine and serotonin, or cause changes in GABA or NMDA receptor activity.

More recently, researchers have put forth network theories, suggesting that ECT affects brain connectivity, while others have proposed that specific brain areas (especially the subgenual cingulate region) are affected by depression and by ECT treatment.

Perhaps no single theory will explain ECT or what it can treat.

"Depression is not a monofactorial illness," said Petrides. "And ECT, once deciphered, may be the royal road to the underlying biology of depression and to our understanding of treatments."

Until that day comes, ECT is still valuable for geriatric patients, said Adriana Hermida, M.D., an assistant professor of psychiatry and behavioral sciences at Emory University.

Dennis Skahill

Exactly how ECT works still awaits revelation, according to Georgios Petrides, M.D.

Pharmacotherapy is the first line of treatment for behavioral and psychiatric symptoms in dementia in elderly patients despite a lack of evidence, said Hermida. "However, clinicians should consider other treatments if the patient is resistant to medications."

Her review of the literature found a number of studies, often with small numbers of subjects, indicating that ECT can be used successfully in this population, she said. Her own research at Emory suggested that ECT was helpful in several ways: reducing agitation and the use of psychotropic agents and improving global functioning.

"ECT may be a treatment modality to consider for agitation and aggression in dementia especially when patients have been refractory to environmental modifications, behavioral interventions, and pharmacotherapy," she said.

Some patients did have transient confusion, while others had cognitive problems that largely resolved six months after the initial treatment, she said.

Certain concessions to age should be made, however. "Consider using right unilateral electrode placement with ultrabrief pulse width," she said. "Start with twice a week treatments rather than three and monitor the patient daily."

A third speaker, Charles Kellner, M.D., a professor of psychiatry at the Icahn School of Medicine at Mt. Sinai in New York, also recommends use of ultrabrief pulses, less than 0.5 milliseconds.

ECT is effective, said Kellner, but relapse rates are higher than they were 20 years ago, possibly because of less powerful forms of ECT.

Safety issues, defined as physical injury or death, are minimal, he said. Tolerability is better with modern techniques but could still be improved.

"There is less retrograde amnesia than in the past, with very recent memories the most vulnerable," he said. "Usually memory function returns to normal within a

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Dukakis to Speak in Atlanta

How ECT gave former Mass. First Lady Kitty Dukakis a second chance at life will be described by her in a special Annual Meeting session, "Re-Examining ECT: From Patient Perspectives on Stigma to Benefit for Veteran Mental Health." It will be held Monday, May 16, from 9 a.m. to noon in Room B407, Level 4, Georgia World Congress Center.

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Kundalini Yoga Found to Enhance Cognitive Functioning in Older Adults

Yoga can do more than reduce stress in older adults, says geriatric psychiatrist Helen Lavretsky, M.D.

BY VABREN WATTS

As life expectancy continues to increase, so does the need for more interventions to prevent or slow down the progression of cognitive impairment in aging populations. A pilot study presented at the 2016 Annual Meeting of the American Association for Geriatric Psychiatry suggests that a certain type of yoga may serve as a viable therapeutic option for middle-aged and older adults who are looking for ways to prevent or delay cognitive decline.

"There is a growing population of older adults who are worried about memory loss and other cognitive impairments such as Alzheimer's disease and other dementias," said Helen Lavretsky, M.D., a professor in residence in the Department of Psychiatry at the University of California, Los Angeles, in an interview with *Psychiatric News*. In fact, said Lavretsky, previous research has shown that subjective cognitive impairment occurs in an estimated average of 35 percent of community-dwelling older adults.

"We lack real interventions for people who are looking to prevent cognitive decline, so we wanted to show them that yoga could help them and offer an opportunity to improve their memory and cognition."

For the study, Lavretsky and colleagues recruited 81 participants aged 55 and older who had subjective memory complaints and met criteria for mild cognitive impairment, indicated by a total score of

*see **Yoga** on page 32*

CLINICAL & RESEARCH NEWS

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week. Some cognitive abnormalities can be distressing to patients, but they are usually transient and reversible."

Kellner and colleagues have completed a multicenter study on ECT. The first phase found that 62 percent of elderly patients in the PRIDE study achieved remission from depression. The second phase randomized remitters to receive venlafaxine and lithium or a combination of the two medications plus continuation ECT. Results have not yet been published, but the combined treatment appeared more effective in this cohort of elderly patients, said Kellner.

"This is a viable treatment technique for geriatric depression," he said "It acts rapidly, reduces suicidality very quickly, and is generally well tolerated, and the patients did well cognitively."

The results showed that the extra ECT proved significantly better in maintaining lower symptom levels versus the pharmacotherapy-only arm for up to six months.

"Practitioners should be liberal in prescribing additional ECT after the acute course—both tapering and maintenance—for selected patients to prevent syndromic relapse," he said. "We need to give patients as much ECT as they need and not stick to a rigid number of treatments." PN

An abstract of "The Role of Electroconvulsive and Neuromodulation Therapies in the Treatment of Geriatric Depression" is posted at http://www.psych.theclinics.com/article/S0193-953X(13)00089-0/abstract.

PSYCHIATRY & PSYCHOTHERAPY

Narcissistic Personality Disorder: The Treatment Challenge

BY FRANK YEOMANS ,M.D., PH.D., AND EVE CALIGOR, M.D.

This is part 2 of a two-part series.

There are different treatment approaches for narcissistic personality disorder (NPD). We will describe in this column the approach of transference-focused psychotherapy.

From a psychodynamic point of view, the particular challenge of NPD has to do with the psychological structure described in our last column (*Psychiatric News,* April 1). The "grandiose self" provides a facsimile of identity but one that is not based in reality and that covers over intense feelings of insecurity and/or aggressive affects directed toward others and toward the self. The particular mix

of these underlying states (insecurity/aggression) is related to the varied clinical presentations of NPD, which can be roughly divided into the "thick-skinned" type (overtly arrogant) and "thin-skinned" type (prone to bouts of insecurity). A particular diagnostic challenge is to identify the depressive-masochistic type of NPD that can underlie treatment-resistant depression (the patient feels his or her suffering is unique and exceeds that of others, with a conviction of moral superiority that does not allow the compromises that help "lesser" people get through life.)

The "grandiose self" is a narrative that shores up self-esteem but that does not correspond to objective reality. Take, for example, a young man, unemployed and supported by his father for four years since graduating from college, who, when asked what career plans he had, said that when it came time, he wanted to be the head of a major movie studio. This narrative fantasy covered over a life with no achievement in work or relationships. This type of fantasy is the "narcissistic bubble" that the person with NPD uses to avoid despair. The challenge for the therapist is to create a therapeutic alliance with the patient that will allow for the dismantling of the grandiose self without the person decompensating.

Creating an alliance with the NPD patient requires special skill because the main internal relationship pattern (dyad) embedded in the patient's mind is that of a superior person in relation to an inferior one—in more technical terms, the grandiose self and the devalued other. The narcissistic patient needs to devalue the other to fend off his or her underlying sense of worthlessness. The patient is always at risk of the devaluing attack turning against the self (a manifestation of the aggressive mental elements involved in NPD).

If the therapy frame is properly set up to allow the patient's "internal world" (internalized sense of self in relation to others) to unfold in the therapy, the patient will eventually devalue the therapist ("I can't believe you just said such a trite thing; don't you have an M.D.?" or "At

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Frank Yeomans, M.D., Ph.D., is a clinical associate professor of psychiatry and director of training at the Personality Disorders Institute of the Weill Medical College of Cornell University. Eve Caligor, M.D., is a clinical professor of psychiatry at Columbia University College of Physicians and Surgeons.

People With Psychiatric Illness Tend to Partner With Each Other

This mating pattern—which was not seen in patients with Crohn's disease, type 1 and type 2 diabetes, and rheumatoid arthritis—may hold important implications for how we understand the familial transmission of psychiatric conditions.

BY NICK ZAGORSKI

As technology advances and the genomes of more and more patients with psychiatric illness are acquired, researchers are uncovering new information about the genetics of psychiatric disorders.

More traditional approaches, such as an assessment of mating patterns, can also inform what researchers understand of how psychiatric illness is transmitted across generations. One case in point is a study published in the April issue of *JAMA Psychiatry* that looked at the nature and extent of nonrandom mating within and across psychiatric conditions.

Nonrandom mating occurs when mated pairs are more phenotypically similar than would be expected by chance; it's fairly common among humans who often find themselves attracted to people of a similar ethnic background, socioeconomic status, or personality.

By making use of extensive Swedish registry data, researchers from Karolinska Institutet in Sweden and the University of Carolina at Chapel Hill found that nonrandom mating also extends to a whole range of psychiatric disorders, including schizophrenia, bipolar disorder, major depressive disorder, autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder, anorexia nervosa, substance abuse, social phobia, agoraphobia, and generalized anxiety disorder.

For the purposes of comparison, cases of select nonpsychiatric conditions of similar incidence and age at onset were also identified, including Crohn's disease, type 1 and type 2 diabetes, multiple sclerosis, and rheumatoid arthritis. Mating relationships were identified through marriage records or records of individuals being the biological parent of a child in other registers.

On average, an individual with any of the psychiatric disorders was two to three times more likely to have a mate with a psychiatric disorder as well, with slightly higher odds that it would be the same disorder. This connection was not seen in the nonpsychiatric disorders, with the exception of people with multiple sclerosis, who were about two times more likely to have a mate who had multiple sclerosis.

Julia Grant, Ph.D., an associate professor of psychiatry at Washington University in St. Louis, who has carried out studies showing nonrandom mating in cigarette and alcohol dependence, said she is not surprised by the findings.

"It makes sense when you think that people with behavioral problems would find themselves in environments where they could meet someone who shares their dispositions, such as a bar, church, or a support group," she said.

When two people get married, the problems of one mate also run the risk of transferring to the other to some degree, Grant explained. For instance, if one person has alcohol dependence, the spouse may be more inclined to drink more and become dependent as well or might develop depression due to the stressed living environment, she said.

While the authors of the *JAMA Psychiatry* study acknowledged the findings could not rule out this possibility, they wrote, "In psychiatric samples, disorders exhibiting more marked spousal correlations and risk increases tended to be those that either emerge at an early age (for example, ADHD and ASD) or are associated with especially severe symptoms (for example, schizophrenia and substance abuse). Notably, some of these disorders (schizophrenia and ASD) are among those most likely to reduce overall reproductive success, suggesting that while these phenotypes may be under strong negative selection in the general population, they are being positively selected for within certain psychiatric populations."

The authors continued, "While this finding does not imply a determinant risk in a given child, at the population level, this tendency toward spousal concordance will result in a subpopulation of offspring who differ substantially from the genetic mean and are, as a whole, at heightened genetic risk for psychiatric disorders."

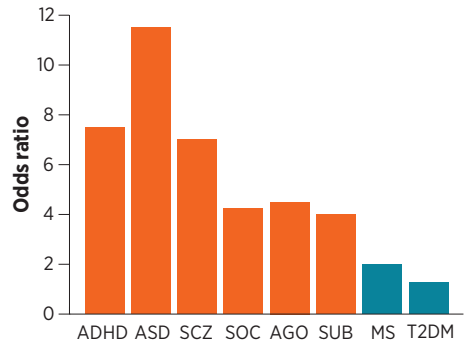
Andrew Heath, D.Phil., the Spencer T. Olin Professor of Psychology at Washington University, told *Psychiatric News* that while the risk to offspring is something that clinicians should monitor, he does not think clinicians should dissuade people with mental illness from finding opportunities to meet or become involved with peers. "I'm very much in favor of letting people decide their own lives."

Heath added that he believes future studies should consider the potential role technology might be playing in the high nonrandom mating seen for some of these severe conditions like schizophrenia. "In this age of expanding social media and online support groups, it would be valuable to see if the rates of spousal correlation have been increasing, and I don't think this has been touched on yet."

This study was supported by a grant from the Swedish Research Council. PN

Like Attracts Like?

A male with a psychiatric illness has much higher odds of pairing with someone with the same illness compared with those with other medical disorders. (X-axis shows respectively ADHD, autism, schizophrenia, social anxiety disorder, agoraphobia, substance use disorder, multiple sclerosis, and Type 2 diabetes.)



Source: Ashley Nordsletten, Ph.D., et al., *JAMA Psychiatry,* April 2016

Part one of this series, "Narcissistic Personality Disorder: Challenge of Understanding and Diagnosis," is posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.4a13. Reference is available by emailing cbrown@psych.org.

An abstract of "Patterns of Nonrandom Mating Within and Across 11 Major Psychiatric Disorders" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=2494707.

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first I thought you were good, but now I see you're as useless as my other therapists.")

The alliance at this point is based on the therapist's decision not to challenge the devaluing remarks: the therapist must avoid both the temptation to defend oneself or even retaliate and the urge to distance oneself mentally from the interaction. The alliance is built on the therapist's ability to tolerate and contain intense negative affects of being defective, inferior, worthless, and, in the most extreme cases, hateful (NPD often includes intense envy of others who are perceived as having/being more than the patient). This is very different from the therapeutic alliance with higher functioning patients, which feels from the start like a "helping alliance" with the two parties have mutually positive feelings.

The therapist's ability to be present in the face of the devaluing onslaught offers the patient a relationship based on authentic interest and curiosity about who the patient is. This relationship model is radically different from the patient's "superior/inferior" paradigm. The ongoing experience of this other relationship model will likely not be enough to help the patient explore and change his personality structure (the grandiose self). The therapist must also use the technical triad of clarification, confrontation of contradictions, and interpretation to help the patient see the obstacles that keep him from perceiving a relationship that is not based on devaluing the other. This generally entails working with a phase of "paranoid" transference. If the therapist does not defend himself against the patient's devaluation and continues with his authentic interest, the patient often becomes unsettled and puzzled. What is this new phenomenon? There is a phase of suspiciousness ("What are your motives? Are you trying to trick me?"). It is essential to explore these questions with the patient.

An additional crucial element to treating patients with NPD consists of interventions that focus on the patient's view of the therapist as defective and flawed. In these "therapist-centered interventions" the therapist explores the patient's critiques of him, accepting imperfections and shortcomings. This acknowledgement of imperfection, while at the same time being able to continue functioning without falling into a sense of worthlessness and despair, can open the eyes of NPD patients to a sense of internal richness complexity as an alternative to their rigid "perfect or worthless" view of self and others. Then they are more likely to choose the "grit" of real relations, including with oneself, over the retreat into a defensive grandiosity. PN

Jail

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intervention center and start crisis intervention team (CIT) training for officers. Later, the committee began addressing issues like the re-entry of prisoners to the community, postbooking diversion, trial competency, the role of forensic peer specialists, and safer transfer-of-custody procedures. The next step, a mental health court, awaits authorization by the state legislature.

The county's procedures are based on the sequential intercept model developed by psychiatrist Mark Munetz, M.D., Henry Steadman, Ph.D., of PRA Associates, and Patricia Griffin, Ph.D., of the National GAINS Center for People with Co-occurring Disorders in the Justice System.

"I believe the model has been helpful to communities and has been widely adopted as an approach to the problem," Munetz told *Psychiatric News*. "A number of states and many counties across the country have used it as a framework."

Aaron Levin

"We wait for six months after recruits complete the police academy to send them through CIT training so they get some field experience first," says Capt. Adrienne Quigley, M.P.A.

The model creates numerous points of intervention—"intercepts"—to "prevent individuals from entering or penetrating deeper into the criminal justice system," and to get them into treatment as soon as possible. The system provides alternatives beginning with the 911 dispatcher and continues through law enforcement contact, booking, courtroom, entry and discharge from jail, probation and parole, and community support and treatment.

When called to the scene of a disturbance or petty crime committed by a person with a probable mental illness, an officer can begin by asking the individual to voluntarily go for evaluation or treatment. If desperate family members call 911 for help, they can request a CIT-trained officer. The officer can consult by phone with an emergency services therapist who has access to prior reports of the person's mental health status.

If there are no apparent acute medical issues, the officer transports the individual to the County's Crisis Intervention Center (CIC), which is staffed by clinicians 24 hours a day, seven days a week. The CIC provides immediate assessment, office-based crisis stabilization, and referral to higher levels of care, including hospitalization, as required. The CIC also has several "calming rooms" where persons in crisis can remain for up to 23 hours, referred to as Office-Based Crisis Stabilization.

When required in more severe cases, a temporary detention order allows the officer to transport the individual for medical clearance. That is not unusual since many of those detained also have comorbid physical ailments. If needed, beds are found at the nearby Virginia Hospital Center. State law requires locating a bed within eight hours, and Virginia state hospitals serve as the reserve for that mandate. That option can tie up two officers for an entire shift to transport the patient.

"We have to make sure they land in a bed, not back on the street," said Weisman.

The system sees about 2,200 cases a year of whom between 280 and 350 are held on temporary psychiatric detention orders, generally at area hospitals. Data are collected on a number of parameters, such as the time it takes the police to transfer custody; recidivism; and the numbers of persons who go to community care, crisis stabilization, voluntary treatment, or involuntary detention.

The system may work well today but it took time to convince the police chief in the early years of the value of alternatives to arrest and to persuade supervisors to give officers 40 hours off from patrol duties for CIT training.

"Jail diversion is hard for officers to accept," said Berke. "They think their job is to arrest people."

If the old view was "lock 'em up," younger officers see CIT training and a more nuanced approach to mental illness as the norm today, said police Capt. Adrienne Quigley, M.P.A., the current liaison officer. "That also reflects a shift in the culture to de-escalation across the board to minimize the use of force as much as possible."

Lessening the resort to force also lessens the risk of injury to both individuals with mental illness and officers, which may account for at least some of the change in thinking about CIT.

There are limits, however. An assault on an officer is dealt with as a crime, no matter what, said Quigley. "Nothing can compromise officer safety. Just because someone has a mental illness does not give the individual carte blanche to commit crimes, so officers still have a lot of discretion."

"I'm impressed with the relationship between the clinical staff and the officers in the field," said psychiatrist John Palmieri, M.D., medical director for the county's Community Services Board. "It's a relationship built over time with mutual respect and trust to collaborate on improving the care that individuals get."

And taken together, Berke emphasized, CIT, the sequential intercept model, and the CIC are tools, not panaceas.

"In the past, we had only a hammer," said Berke. That was arrest. "Now we have lots of tools, and if people are taught to use them, they will use them and build better." PN

First APEX Awards Presented

David Hathcox

On April 18, APA presented its first American Psychiatric Excellence (APEX) Awards at a special fund-raising event held in conjunction with the national Stepping Up Summit. Above is Sen. Al Franken (D-Minn.), who was one of the award recipients and gave a keynote address; with him are APA CEO and Medical Director Saul Levin, M.D., M.P.A., and APA President Renée Binder, M.D. The three-day summit, of which the APA Foundation was a co-sponsor, brought together teams from 50 U.S. counties to advance the national movement to reduce the number of people with mental illness in America's jails. Complete coverage of the summit and the APEX awards event will appear in the next issue.

Value-Based Payment

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need to take to stay current with the movement toward value-based care. And it will also highlight the specific ways that APA's divisions of Policy, Programs, and Partnerships and Government Relations are working on behalf of members to advocate for their best interests as the health care system evolves and to help members meet the requirements of public and private payers.

"All of us today are practicing in a health care system undergoing dramatic transformation," said APA President Renée Binder, M.D. "While much about the traditional practice of medicine will endure, many other aspects of how we care for our patients and how we get paid for that care are changing. The goal of these changes is better, more comprehensive patient-centered care that contributes to a healthier population at lower cost. For our patients with psychiatric illness, new models of care could prove to be especially advantageous—particularly models of integrated and collaborative care that are better able to meet the general medical as well as psychiatric needs of individuals who often have multiple chronic conditions.

"Some of these changes are occurring very rapidly; others are more incremental," she said. "APA leadership and staff are closely monitoring these developments and working diligently with legislators and regulatory agencies to ensure that quality patient care, which depends on the doctor-patient relationship, is safeguarded.

"APA members can look forward to the *Psychiatric News* series 'Changing Practice/Changing Payment' as a source of useful information about all of these changes and how APA is helping to shape them to the benefit of members and their patients." PN

Animal Research Raises Troubling Questions About SSRIs

In 2004 psychiatrist Jay Gingrich, M.D., who trained as a molecular biologist, began working with mice on an experiment that would have troubling findings.

Those findings would lay the basis for an epidemiologic study appearing in the *Journal of the American Academy of Child and Adolescent Psychiatry* showing that there are higher rates of depression in adolescent offspring of mothers who used SSRIs during pregnancy.

Gingrich and colleagues at the New York State Psychiatric Institute engineered mice with a genetic knockout of the serotonin transporter, thereby mimicking the effect of lifelong exposure to SSRIs. "The behavior of the offspring mice pups as they matured was anything but what we would have expected," he told *Psychiatric News.* "They were clearly more anxious in new environments, less exploratory, and more depressed."

The same results were found when Gingrich and colleagues administered SSRIs to mice pups at early stages of life equivalent to the second and third trimester in humans. "These medications may have a very different effect on the fetal brain than on the adult brain, and the mice research appears to confirm that something very different may be happening in the fetal brain exposed to SSRIs that is setting them up for depression later."

Gingrich emphasized that like all preliminary research, the results require replication. And he stressed that treatment of maternal depression is vital to the health of offspring as well as the mother. "I know that for most people with whom I share this work, it is very paradoxical because the recommendation to treat maternal depression is intended to mitigate the risk to the child," he said.

Gingrich emphasized that the findings relate only to SSRIs, and other antidepressants do not appear to have the same risks found in the *JAACAP* study. He and epidemiologist Myrna Weissman, Ph.D., emphasized that dose, titration, and timing may also be crucial and can be manipulated to safely treat maternal depression.

"Ideally, what we will try to do in the next three years is gain enough new information so we can really help clinicians and their patients have some concrete data," he said. "We know dose and mechanism of action matter, and timing [during pregnancy] matters a lot. Hypothetically, for instance, we might be able to show that some drugs are safer and or that medication be tapered in the second trimester, eliminated in the third trimester, and begun again immediately after delivery. But that remains to be determined."

He added, "Nothing we are finding here is mitigating the need to aggressively treat depression postpartum."

Adolescent Depression

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"Untreated depression also has substantial adverse effects to the mother including relapse or worsening of depression, greater risk of suicide, and less adequate prenatal care," he said. "The association between maternal SSRI use and offspring depression also requires replication before these findings are considered as possible recommendations for clinical care. Hence, these findings must be viewed with considerable caution by clinicians and patients regarding the risks and benefits of use of SSRIs in pregnant women."

He is a professor of psychiatry and epidemiology at Columbia University.

The findings, which received widespread coverage in the national press, are striking. The study was based on previous animal studies by Jay Gingrich, M.D., Ph.D., of Columbia that suggested SSRIs have an adverse effect on the developing fetal brain. He told *Psychiatric News* that further research will try to pinpoint antidepressant medications, dosages, titration schedules, and periods during pregnancy when treatment might be more or less safe (see box).

Echoing the importance of treating maternal depression, epidemiologist Myrna Weissman, Ph.D., a lead author of the study, also emphasized the value of psychotherapy and other nonpharmaceutical interventions. She and Gingrich said follow-up research would include meta-analyses of evidence-based psychotherapies for perinatal treatment of depression.

(Other lead authors of the *JAACAP* study were Heli Malm, M.D., Ph.D., of Helsinki University, and Andre Sourander, M.D., Ph.D., of Columbia University and the New York State Psychiatric Institute.)

Brown and colleagues used Finnish national birth registry data to determine the cumulative incidence of depression, anxiety disorders, autism spectrum disorder, and attention-deficit/hyperactivity disorder in the offspring of four groups of mother-offspring dyads: mothers exposed to SSRIs during pregnancy (n=15,729), mothers exposed to psychiatric disorder but not to antidepressants (n=9,651), mothers who used SSRIs only before pregnancy (n=7,980), and children of mothers unexposed to either antidepressants or psychiatric disorders (n=31,394).

They found the cumulative incidence of depression among offspring exposed prenatally to SSRIs was 8.2 percent by age 14.9 years, compared with 1.9 percent in the psychiatric disorder/no medication group and 2.8 percent in the SSRI-discontinued group. In contrast, SSRI prenatal exposure was not associated with an increased risk of autism spectrum disorder, ADHD, or anxiety.

Psychiatrists who reviewed the report for *Psychiatric News* cautioned that—as with all epidemiological associations—correlation is not causation, and several raised severity of maternal depression as a factor that may have influenced rates of depression in adolescent offspring. Brown, Gingrich, Weissman, and colleagues did in fact seek to control for maternal severity using "proxies" such as history of previous hospitalization and use of multiple prescriptions.

Bonnie T. Zima, M.D., M.P.H., a member of the APA Council on Quality Care, said the study raises awareness about an important debate for women's health and their children.

She noted that among the mothers with any history of SSRI exposure or depressive disorder and no SSRI exposure during pregnancy, the proportion of mothers with other risk factors was generally higher than mothers who did not have a history of exposure to an SSRI during pregnancy or depressive disorder.

"Roughly 24 to 30 percent of the mothers in this group also had a history of smoking," she said. "Psychiatric comorbidity, including substance abuse, was also higher among these groups. Roughly 13 to 26 percent of the mothers had a history of other psychiatric diagnoses compared with only 2 percent in the unexposed group, and roughly 7 to 12 percent of mothers had a history of substance abuse compared with less than 1 percent in the unexposed group. Among mothers with exposure to an SSRI during pregnancy, almost 19 percent of mothers had a least one paid prescription for an anxiolytic or sedative medication.

"These data alone suggest that clinical awareness for other risk factors should be raised when providing prenatal care to mothers with a history of SSRI prescription, during or one year prior to pregnancy."

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At the same time, Zima acknowledged the power of the results. "Even when limiting the sample to mothers with exposure to only SSRI monotherapy, the risk of depression during early adolescence remained significantly higher than for offspring in the comparison groups."

What the study does not account for are effects of the postnatal environment. "The strength of this study is the capacity to include children aged 0 to 14.9 years, but the trade-off was that it also expanded the time window for child and youth exposure to other risk and protective factors that may have influenced their risk for developing early-onset depression," Zima said.

"By concluding with an ongoing debate, it powerfully reminds the clinical reader of the trade-offs we must make and share with our patients when considering medication treatment for affective disorders among women during their child-bearing years."

Past APA President Nada Stotland, M.D., emphasized the stigma surrounding depression, especially for expectant mothers who are concerned about the welfare of their offspring.

"It is impossible to ignore the likelihood that it was women with more severe and intractable depression who received medication," she said. "Therefore, it is likely that the adolescents exposed to SSRIs in utero had mothers who suffered from some degree of depression while the children were growing up, and that the children had a higher genetic loading for depression than the other subject groups. A great deal happens to a child between the uterus and adolescence.

"Despite repeated attempts to formulate an algorithm, there is no way to get beyond the need to make treatment decisions on a case-by-case basis, taking into account past history of depression and response to treatment, current severity of depression, access to quality psychotherapy, and the patient's concerns and preferences," Stotland said. "Somehow we hear far less, if anything, about medications needed during pregnancy to treat nonpsychiatric medical conditions. Women depressed during pregnancy are already anxious about causing harm to their babies.

"Most people hearing about the study will not get beyond the headline or will assume that there is a causal connection," Stotland said. PN

An abstract of "Gestational Exposure to Selective Serotonin Reuptake Inhibitors and Offspring Psychiatric Disorders: A National-Registry Study" is posted at http://www.jaacap.com/article/S0890-8567(16)30007-7/abstract.

From the President

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Also, as was exemplified in the incredibly successful APEX awards event, where we honored the cast of the "Orange Is the New Black" Netflix series, we also are beginning partnerships with Hollywood and other media outlets to get our message across about decreasing stigma and promoting mental health. Coverage of this event will appear in the next issue.

During my year as president, I have learned to appreciate the value of APA membership and APA's influence. I am immensely thankful to have had the opportunity to lead this great organization and to work with outstanding individuals in the administration, such as our CEO and medical director, Dr. Saul Levin; in the APA Assembly, especially the speaker, Dr. Glenn Martin; and with the outstanding members of the Board of Trustees, especially the immediate past president, Dr. Summergrad, and the president-elect, Dr. Oquendo.

It has been a privilege and an honor to represent our members and move our organization and our field forward for the benefit of our patients. PN

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Yoga

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0.5 on the Clinical Dementia Rating Scale.

In a 12-week randomized trial, 39 of the participants underwent one-hour weekly sessions of Kundalini Yoga, a nonstrenuous yoga that focuses on meditation and breathing techniques. They also carried out 20-minute daily homework assignments on Kundalini-inspired meditation and stretching. The remaining participants underwent Memory Enhancement Training (MET)—the "gold standard" technique for improving cognitive functioning, said Lavretsky. MET participants learned techniques for enhancing memory such as log tracking of activities and strategies for learning faces and names.

All participants were evaluated on various aspects of memory, executive functioning, and verbal fluency as well as mood and resilience during 12-week and 24-week follow-ups. The study was blinded; evaluators did not know the participants' treatment regimen.

The results showed that at 12 weeks, both the yoga and MET groups showed significant improvements in recall mem-

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ory and visual memory. Verbal fluency was significant only in the MET cohort, whereas improvement in executive functioning was significant only in the yoga cohort. While both the yoga and MET groups showed significant sustained improvement in memory up to the 24-week follow-up, only the yoga group showed significant improvement in verbal fluency and sustained significant improvements in executive functioning at week 24.

In addition, the yoga cohort showed significant improvement in depressive symptoms, apathy, and resilience from emotional stress. "Those taking yoga experienced a broader and more sustained effect," said Lavretsky, "not just on memory, but on other psychological domains."

Lavretsky attributed the improvement in memory, executive function, and mood to stress-reducing mind exercises associated with Kundalini Yoga that may elicit a "brain fitness effect."

She concluded that the findings should be addressed in longitudinal clinical trials that are directed at the prevention of cognitive decline and evaluate the response of biomarkers to treatment, thereby shedding light on the underlying mechanisms of the link between Kundalini Yoga and cognitive impairment. PN

An abstract of "Lifestyle Interventions In Late-Life Neuropsychiatric Disorders" is posted at http://asoft9256.accrisoft.com/aagp/clientuploads/2016_AnnualMeeting/AJGP_Supplement_PDF.pdf.

Dementia

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clinicians and caregivers make decisions that are as informed and thoughtful as possible.

The guideline covers a range of topics within the umbrella of antipsychotic usage in this population, including parameters for assessing patient symptoms and the risk/benefit ratio of medication, followed by several recommendations related to the dosing, duration, and monitoring of antipsychotic therapy.

In line with health concerns of antipsychotic use among senior patients, the practice guideline stresses the importance of clinicians' being judicious about these medications. As a case in point, the recommendations note that antipsychotics should be tapered within four weeks if no clinically meaningful response is observed; while in patients who do respond, antipsychotics should be tapered within four months of initiation.

In addition, one of the key recommendations is that a long-acting injectable antipsychotic should not be used unless it is needed for a co-occurring chronic psychotic disorder.

While the focus of this guideline is antipsychotic therapy, it emphasizes that any such medication given to dementia patients should be just one part of a comprehensive treatment plan that is person-centered and includes appropriate pharmacological and nonpharmacological interventions.

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"One should not make any decision concerning the initiation or discontinuation of an antipsychotic in a vacuum," Fochtmann said.

As with last year's release of the updated Practice Guidelines for the Psychiatric Evaluation of Adults (*Psychiatric News,* August 7, 2015), this publication follows the standards set forth in a 2011 Institute of Medicine (IOM) report titled "Clinical Practice Guidelines We can Trust."

Developed in response to perceptions that practice guidelines across health disciplines were somewhat inconsistent and occasionally affected by potential conflicts of interest, the IOM set a process that adhered to high standards in regard to composition of the guideline writing groups, management of potential conflicts, transparency of the review process, and synthesis of the available evidence.

> "There are patients with dementia for whom the use of antipsychotics is warranted, but there is no easy way to determine those cases up front."

In addition, the new guideline includes an Expert Consensus Survey to supplement the expertise of the Guideline Working Group. It was developed by Joel Yager, M.D., a professor of psychiatry at the University of Colorado School of Medicine. The Expert Consensus Survey—also known as a "snowball survey"—was sent to psychiatrists regarded as experts on the treatment of agitation or psychosis in people with dementia. They were asked to provide input on therapeutic strategies as well as nominate other experts they knew.

The members of the working group include Victor Reus, M.D. (chair), Laura Fochtmann, M.D., A. Evan Eyler, M.D., M.P.H., Donald Hilty, M.D., Marcela Horvitz-Lennon, M.D., M.P.H., Michael Jibson, M.D., Ph.D., Oscar Lopez, M.D., Jane Mahoney, Ph.D., R.N., Jagoda Pasic, M.D., Ph.D., Zaldy S. Tan, M.D., M.P.H., Cheryl Wills, M.D., Richard Rhoads, M.D., and Joel Yager, M.D. PN

APA's Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia is posted at http://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426807. The IOM report "Clinical Practice Guidelines We Can Trust" is posted at http://iom.nationalacademies.org/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx.

Prescribing

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regarding PDMPs, and advances in the ability to electronically track patients' prescription medications are likely to continue to evolve in the years to come.

Online resources are available to prescribers concerning PDMPs. In addition, should you have any questions, consult with an attorney or risk management professional. PN

MED CHECK

BY VABREN WATTS

FDA Committee Votes in Favor Of Nuplazid for Psychosis in PD

An Food and Drug Administration (FDA) advisory committee voted 12-2 in March in favor of approving the antipsychotic ***Nuplazid*** (***pimavanserin***) for Parkinson's disease-associated psychosis (PDP). If approved, the medication would be the first to specifically treat this condition.

The advisory panel vote came after the committee reviewed the results of a phase 3 trial involving 199 patients who were randomly assigned to take pimavanserin or placebo in addition to their standard antiparkinsonian medications for six weeks. The primary outcome was antipsychotic benefit as assessed by the Parkinson's disease–adapted scale for assessment of positive symptoms (SAPS-PD) in all patients who received at least one dose of a study medication and had a SAPS assessment at baseline and at least one follow-up.

Ninety recipients of placebo and 95 recipients of pimavanserin were included in the primary analysis, which found pimavanserin was associated with a –5.79 decrease in SAPS-PD scores compared with –2.73 for placebo.

Although several reviewers on the FDA advisory committee questioned whether the benefits of pimavanserin in treating PDP symptoms were "clinically meaningful," the group concluded that even the modest benefit of pimavanserin offered an advantage for PD patients, who have few options for treating symptoms of PDP.

Can Citalopram, Methylphenidate Combination Reduce Symptoms Of Severe Mood Dysregulation?

The National Institute of Mental Health (NIMH) is conducting a clinical trial to evaluate the effectiveness of ***citalopram*** plus ***methylphenidate*** versus methylphenidate plus placebo for decreasing irritability in children with severe mood dysregulation (SMD). SMD is characterized by chronic sadness or irritability, as well hyperarousal (such as insomnia, distractibility, and hyperactivity) and extreme responses to frustration (such as frequent temper tantrums). There are no approved pharmacological treatments for SMD.

For the 12- to 15-week trial, children aged 7 to 17 with SMD will be gradually withdrawn from all current psychotropic medications, followed by a one-week period during which they will take no psychotropic medications. All participants will then be treated once daily with methylphenidate (dose ranging from 5 mg to 80 mg) for two weeks. In the final phase of the trial, participants will be randomly assigned to continue methylphenidate treatment along with daily adjunctive treatment with citalopram (dose ranging from 5 mg to 40 mg) or placebo for eight weeks.

FDA Rejects Cognitive Claim For Brintellix

Takeda Pharmaceutical Company Limited and H. Lundbeck A/S, manufacturers of ***Brintellix*** (***vortioxetine***), announced last month that the FDA has declined their request to expand the antidepressant's approval to treat cognitive dysfunction in adults with major depressive disorder (MDD). This rejection was somewhat unexpected after the FDA's Psychopharmacologic Drugs Advisory Committee voted 8-2 to expand Brintellix's label after clinical trials suggested the medication demonstrated a statistically significant improvement in cognitive performance over placebo and the antidepressant ***duloxetine.***

FDA Issues New Safety Warnings For Opioids

The FDA announced in March that it has issued classwide safety labeling changes—including boxed warnings—for immediate-release (IR) opioid pain medications in an ongoing effort to educate prescribers and patients about the potential risks associated with opioid use. IR opioids are intended to treat pain every four to six hours.

As part of the boxed warning on IR opioids, the FDA will now require a precaution that chronic maternal use of opioids during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated properly.

In addition, the FDA is requiring updated labeling for all opioids—both IR and extended-release and long-acting (ER/LA) products—to include safety information about potentially harmful drug interactions with other medications that can result in serotonin syndrome.

Modified labeling for all opioids will also include information about opioid effects on the endocrine system, including adrenal insufficiency and androgen deficiency. The labeling changes will make it clear that these negative outcomes can occur whether a patient is taking an opioid to treat pain or if the product is being used for medication-assisted treatment for opioid use disorder.

The FDA is currently reviewing available scientific information about potentially serious outcomes related to interactions between benzodiazepines and opioids. Once this review is completed, the FDA will take necessary actions to ensure prescribers and the public are informed of the risks involved with the use of these medications. PN