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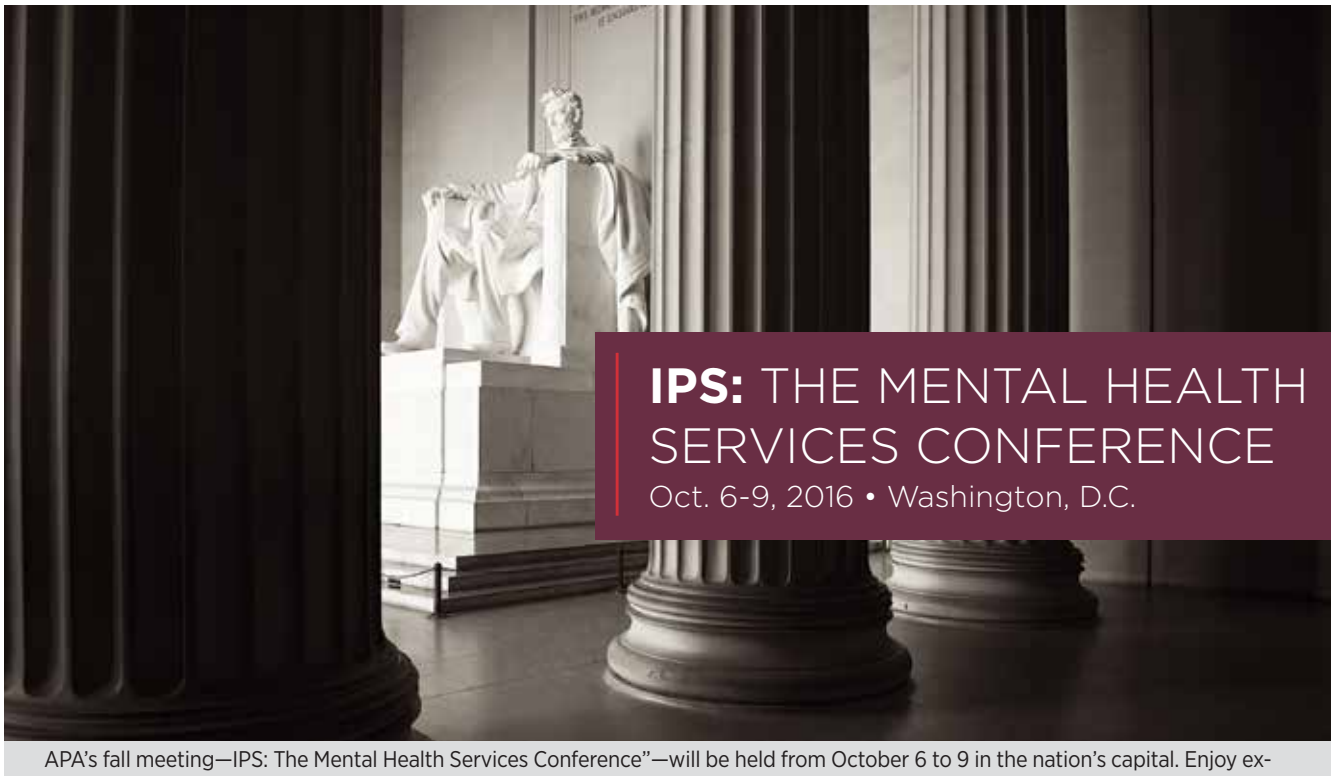

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APA's fall meeting—IPS: The Mental Health Services Conference"—will be held from October 6 to 9 in the nation's capital. Enjoy exploring new sites as well as longtime favorites while sharpening your skills and preparing for psychiatry's future. See pages 4 and 17.

HHS Takes Actions To Expand Treatment, Research In Opioid Crisis

The federal government hopes to expand access to addiction treatment, improve prescribing practices, and reduce administrative burdens.

BY AARON LEVIN

The Department of Health and Human Services (HHS) in July took steps to combat the opioid epidemic by issuing a rule expanding access to buprenorphine treatment and proposing elimination of a possible financial incentive to overprescribe opioids.

In other actions, HHS will require Indian Health Service practitioners to check state Prescription Drug Monitoring Program (PDMP) databases before prescribing opioids. The agency also announced the start of more than a dozen new research studies on pain treatment and opioid misuse.

The department's new rule on buprenorphine treatment increases from 100 to 275 the number of patients a specially trained physician can treat. Addiction specialists and those who practice in a qualified health setting will be eligible for the higher patient limit after they have held a Drug Enforcement Administration waiver for the 100-patient limit for at least a year.

"These are reasonable steps forward, but the real question is how to get more trained prescribers to take more patients," said Frances Levin, M.D., chair of APA's Council on Addiction Psychiatry and a

see **Opioid Crisis** on page 3

CMS Proposes Rule to Reimburse For Psychiatric Collaborative Care

The proposal should help to expand the collaborative care model by removing a principal barrier—lack of a structure for reimbursement.

BY MARK MORAN

Medicare plans to begin reimbursement next year for collaborative care services, according to an announcement last month by the Centers for Medicare and Medicaid Services (CMS).

In the proposed Medicare Physician Fee Schedule rule, CMS has included coverage for "Psychiatric Collaborative Care Management Services." The decision will support payments to psychiatrists for consultative services they provide to primary care physicians in the collaborative care model (CoCM). The model was developed by the late Wayne Katon, M.D., and Jürgen Unützer, M.D., M.P.H., at the AIMS Center of the University of Washington. It is the only evidence-based model of its kind and has been proven effective in more than 80 randomized, controlled trials.

The proposed rule was published in the *Federal Register* on July 15. CMS will accept comments on the proposed rule until September 6 and will issue its final rule later this year.

The new codes open the door to greater adoption of the CoCM model by removing a principal barrier—the lack of a structure for reimbursement of consulting physicians who participate in the model. Development of codes and payment for them has been a major APA priority.

"This is a huge win for APA, psychiatrists, as well as patients with mental health and substance use disorders," said APA CEO and Medical Director Saul Levin, M.D., M.P.A.

In the CoCM, the primary health care provider employs a behavioral health care manager to provide ongoing care management for a caseload of patients with diagnosed mental health or substance use disorders. The psychiatrist

see **CMS** on page 32

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

Opioid Crisis

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professor and chief of the Division of Substance Abuse at Columbia University and the New York State Psychiatric Institute.

Increasing the waiver limit is not enough, she said in an interview. Many physicians, possibly a majority, now holding waivers do not treat the maximum number of patients allowed, and some do not treat any.

Even when trained, many are not comfortable using buprenorphine or working with patients with drug use disorders, she said. Other problems like insurance barriers, the lack of staff resources, or the inability to provide or refer to psychotherapy hamper broader use of buprenorphine.

Drug monitoring programs, which require physicians to check a database to see what other drugs a patient may be taking, have been a state responsibility and have proven generally useful, said Levin.

"I find it extremely helpful not just for monitoring use of opioids but also for seeing what drugs have been prescribed by other doctors that the patient hasn't told me about," she said.

Improving access to addiction treatment will require more prescribers to treat more patients, says Frances Levin, M.D., chair of APA's Council on Addiction Psychiatry.

In 2014, the most recent year for which complete statistics are available, 47,055 people died of drug overdoses in the United States, of which 28,647 (61 percent) involved opioids. HHS announced its opioid initiative in March. The program focused on improving prescribing practice, expanding use and access to medication-assisted treatment, and increasing the use of naloxone to reverse overdoses (*Psychiatric News*, May 6).

President Obama has requested $1.1 billion over the next two fiscal years to finance those goals.

The agency also set forth steps to continue its research plan to study more about the epidemiology of opioid use, advance knowledge of pain and addiction, and find new treatments.

HHS will also eliminate use of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey questions on pain as a criterion for Medicare payment. To keep patient pain management satisfaction scores high, some clinicians have felt pressure to overprescribe opioids. Now, hospitals will still ask patients about pain management, but the answers will not affect payments.

APA played an important role in shaping the final rule on limits for patients treated with buprenorphine by one physician.

"We welcome the final rule raising the cap on buprenorphine patients because it balances the needs for access to quality care and safety," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "APA had provided feedback to SAMHSA, and we are encouraged that the agency followed the spirit of our recommendations."

The American Academy of Addiction Medicine and the American Osteopathic Academy of Addiction Medicine joined with APA in offering comments to HHS about the buprenorphine limit. PN

More information on the Department of Health and Human Services' opioid initiative is posted at https://aspe.hhs.gov/sites/default/files/pdf/107956/ib_OpioidInitiative.pdf.

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FROM THE PRESIDENT

This Year's IPS to Emphasize Prevention, Preparing for Psychiatry's Future

BY MARIA A. OQUENDO, M.D.

It was so exciting to hear that that the Centers for Medicare and Medicaid Services (CMS) made a landmark decision to provide coverage for psychiatric care delivered in the context of collaborative care models (see page 1). The approval, effective in 2017, is the perfect backdrop for this fall's IPS: The Mental Health Services Conference. This year's theme, "Implementing Prevention Across Psychiatric Practice," sets the tone for the meeting, which will focus on a burgeoning type of excellence in psychiatric care: prevention.

The theme dovetails perfectly with the recent U.S. Preventive Services Task Force report, which underscores the importance of screening for depression. The task force proposes that depression screening should be no different from obtaining patients' vital signs and that it is pertinent in the care of children, adolescents, pregnant women, adults, and seniors.

And why not? Surely, screening for depression and other psychiatric symptoms is as important as screening for diabetes, obesity, or high blood pressure. In fact, estimates suggest that by 2030, depression will be the number one cause of disability worldwide. Importantly, depression screening is preventive especially when cases among mothers can be identified and treated because such treatment can prevent untoward outcomes in their children.

Over the last years, the IPS conference has become the "Must Attend" APA meeting especially for providers working in public and government mental health agencies that deliver desperately needed care for the challenging psychiatric and behavioral health problems afflicting our communities. This is because the conference gets better every year as we work to learn from our participants about what works and what doesn't and about topics they would like to see covered. In fact, because of feedback received from members and attendees, this year we will include an exciting new array of topics and tracks. For example, the innovative Medical Director and Administrators Track will provide sessions dealing with the interface of administration, psychiatric practice, legal issues, and delivery of care. Another novel track will cover child and adolescent psychopharmacology and related behavioral health interventions, which practicing community psychiatrists face daily in their clinical activities.

Additional foci for the conference will include quality measures and improvement, the role of technology in delivering mental health services, evidence-based psychotherapies, and, of course, prevention. All this in addition to our well-attended courses in psychopharmacology and integrated primary care for psychiatrists.

We could not have a better venue for this year's conference: Washington, D.C. This wonderful city provides the perfect setting to bring together experts in the field of community psychiatry, primary care, behavioral health sciences, and public health administration and policymakers. Indeed, participants will not only benefit from the multiple workshops, symposia, and poster presentations offered at the meeting, but they also will have the opportunity to interact with key mental health policymakers. There will be sessions about the Herculean efforts that have resulted in several recent pieces of important legislation on Capitol Hill, and attendees will have the opportunity to discuss the future of public mental health services. Having this meeting in the nation's capital, where so many of the debates about mental health and prevention take place, will certainly make this year's IPS one of, if not *the* best confer-

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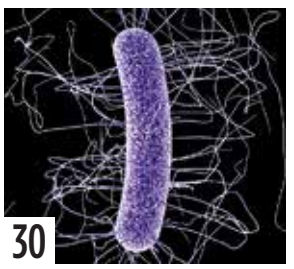
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Register Now for IPS

IPS: The Mental Health Services Conference will be held in Washington, D.C., from **October 6 to 9**. Information on the program, registration, and housing can be accessed at psychiatry.org/IPS. For information on the meetings highlights and special integrated care training, see the above article and the articles on page 17.

Departments

House Approves Comprehensive Mental Health Reform Bill

Among the important reforms is the addition of an assistant secretary for mental health and substance use disorders in the Department of Health and Human Services. A major responsibility would be promotion of science-driven and evidence-based approaches to care.

BY MARK MORAN

Last month the House of Representatives approved the first comprehensive mental health system reform legislation in years, raising the possibility that the Senate will act on similar legislation before the year is over.

The Helping Families in Mental Health Crisis (HR 2646) Act was passed by the House on July 6 by a vote of 422-2. The bill, introduced by Reps. Tim Murphy (R-Pa.) and Eddie Bernice Johnson (D-Texas), has 197 cosponsors, including 141 Republicans and 56 Democrats. It unanimously passed in the House Energy and Commerce Committee in June.

A companion bill in the Senate, the Mental Health System Reform Act of 2016 (S 2680), has been introduced in the Senate by Sens. Chris Murphy (D-Conn.) and Bill Cassidy, M.D. (R-La.). At press time, it was considered highly unlikely the Senate would act before the August Congressional recess, but Health, Education, Labor, and Pensions Committee Chair Lamar Alexander (R-Tenn.) has indicated a desire for the Senate to consider S 2680 early in September, keeping alive the prospect of a mental health bill that could be signed into law during this session of Congress.

APA has been a staunch supporter of the Murphy-Johnson bill and is also urging the Senate to act quickly. Should the Senate act in September, a conference committee would then deliberate a compromise between the two bills.

"Comprehensive mental health reform is urgently needed in our country, and this bipartisan legislation helps address this critical need," said APA President Maria A. Oquendo, M.D. "We now strongly urge the Senate to take up mental health reform legislation that will make care more available to those who need it, especially patients and families living with serious mental illness. We look forward to working with members of both parties to pass mental health reform this year."

APA CEO and Medical Director Saul Levin, M.D., M.P.A., expressed gratitude to Reps. Murphy and Johnson for their leadership in introducing the House bill and moving it forward. "It is their dedication to improving the lives of people with mental illness and their years of persistence in advocating for change that has brought us close to achieving much-needed comprehensive mental health reform," he said.

The Murphy-Johnson legislation approved by the House last month includes a number of sweeping reforms, supported by APA. Among them:

- Coordination of fragmented mental health resources across federal departments and agencies through the establishment of an assistant secretary for mental health and substance use disorders within the Department of Health and Human Services. The individual must be a highly qualified mental health clinician whose duties and priorities would emphasize promotion of science-driven and evidence-based approaches to care.

- Establishes a "Nationwide Strategy" to increase the psychiatric workforce and recruit medical professionals for the treatment of individuals with serious mental illness and substance use disorders. Moreover, the legislation would fix barriers to participation of child and adolescent psychiatrists in the National Health Service Corp and explicitly authorizes the Minority Fellowship Program.

- Improved enforcement of the Mental Health Parity and Addiction Equity Act by requiring annual reports to Congress on parity compliance investigations from federal departments, tasking the proposed assistant secretary with coordinating all programs and activities related to parity in health insurance benefits, and requiring the Government Accountability Office to investigate compliance of the parity law.

- Increased funding for the National Institute of Mental Health in support of important research on brain disorders, innovative treatments and technologies, and the determinants of violence directed at oneself and others.

- Support of funding for innovative models of care that have the power to reduce long-term disability for individuals with severe mental illness including the Recovery After an Initial Schizophrenia Episode (RAISE) program, which helps individuals with schizophrenia to lead productive, independent lives while aiming to reduce the financial impact on public systems.

In a statement on his website following the House vote, Murphy said the bill promises an end to "the era of stigma."

"This historic vote closes a tragic chapter in our nation's treatment of serious mental illness and welcomes a new dawn of help and hope," he wrote. "Mental illness is no longer a joke, considered a moral defect and a reason to throw people in jail. No longer will we discharge the mentally ill out of the emergency room to the family and say 'Good luck, take care of your loved one, we've done all the law will allow.' Today the House voted to deliver treatment before tragedy." PN

APA's Division of Government Relations is urging members to contact their senators in support of S 2680. In coming weeks, APA will provide a venue on the APA website and resources for communicating with the Senate. Members should look to *Psychiatric News* and other communications from APA for details.

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ence for the professional growth of psychiatrists, psychologists, social workers, primary care providers, administrators, and other behavioral health professionals.

I am especially delighted that this year's IPS will have the participation of medical students, residents, and our public psychiatry fellows (see page 17). It is critical to engage these emerging leaders who are the future of our profession and who will shape public psychiatry and behavioral health in the years to come.

Looking forward to seeing you in Washington, D.C.! PN

I wish to thank Alvaro Camacho, M.D., a member of the IPS Scientific Program Committee, for his assistance in preparing this article.

LEGAL NEWS

You Receive Notice to Appear For Deposition: Now What?

Alerting your risk management professional and taking the time for thorough preparation will help ensure your protection.

BY KRISTEN LAMBERT, J.D., M.S.W., L.I.C.S.W.

Some of you may have had an opportunity to attend the session "Mock Trial: Lessons From the Bar and Risk Management" at APA's 2016 Annual Meeting in May. One part of the presentation was a mock deposition of a psychiatrist defendant who was sued after a patient died by suicide. Even if you were unable to attend the session, some of the principles discussed are important to keep in mind in case you are ever faced with being deposed as a treating psychiatrist, an expert witness, or a defendant in a lawsuit.

We receive many calls on our risk management hotline regarding depositions. Some psychiatrists may have already appeared at a deposition, unrepresented by counsel; the caller may not have been a defendant at the time of the deposition, oftentimes stating he or she had done "nothing wrong," was "honest about the care," and "had nothing to hide."

A deposition is one of the most important and critical aspects of a lawsuit. How a witness presents at the deposition can significantly impact a case, and if information is uncovered during the deposition and the witness is not a defendant at the time, he or she may be added as a defendant or, without realizing it at the time, could later be designated an expert witness against the defendant.

What is a deposition? A deposition is a chance for an attorney to ask questions of a witness, party, or expert under oath; gather information and develop facts about a lawsuit; and/or find out what information the witness will have to say at trial. The deposition testimony is transcribed and can be obtained by other attorneys years later.

You may receive a deposition notice in a variety of ways: a notice of deposition either communicated by phone or letter by an attorney, a subpoena that compels you to appear, or a court order by which the court orders you to appear.

You should contact your insurer as soon as you receive notice that an attorney wants to take your deposition. Also, always have counsel represent you at your deposition, no matter the situation. Further, depending upon the manner served or other factors, you may or may not have to appear. Your deposition testimony can impact the case you are being called on, can result in your being added as a defendant even if you are not at the time of the deposition, and can impact you in the event you ever testify in the future on any matter.

Although not an exhaustive list, here are a few points to keep in mind regarding depositions:

- Deposition preparation is critical.

- Anticipate that it will take time away from your job to adequately prepare.

- It is important to review pertinent records (that is, of care you were involved in). However, prior to doing so, discuss with your attorney.

- It is crucial to meet with your counsel before the deposition.

- The testimony given will follow you through the entire course of litigation and beyond.

- Deposition testimony will likely be used at trial to potentially call your credibility into question.

- The plaintiff's attorney will be looking for you to be inconsistent at your deposition versus your testimony at trial.

If you become aware that an attorney wants to take your deposition, contact your risk management professional at your insurance company before responding, even if the situation appears innocuous. It is critical to prepare for the deposition and ensure that you have counsel represent you as the testimony provided could impact you for years to come.

For other risk management topics, see the online risk management courses available on APA's Learning Center Risk Management page at http://www.psychiatry.org/psychiatrists/practice/risk-management. PN

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

RESIDENTS' FORUM

Residents Can Help to Curb the Current Opioid Epidemic

BY RACHEL KATZ, M.D.

On February 2, 2016, the White House released an update to the President's annual budget, proposing $1.1 billion in additional funding to address the growing epidemic of prescription opiate and heroin abuse in the United States. This revision of the 2010 National Drug Control Strategy and 2011 Prescription Drug Abuse Prevention Plan pledged improved access to medication-assisted treatment, addiction research, prescriber training, and expanded prevention efforts for an illness to which the Centers for Disease Control and Prevention attributes greater annual mortality than motor vehicle accidents.

Even as top government agencies fight to stem the tide of opiate abuse, overdoses, and deaths, the stigma of addiction persists—among the general population, those who represent us in government, and even our colleagues in medicine—resulting in inadequate access to what is now the standard of care for opiate use disorders: detoxification then multimodal treatment programs that include long-term opiate replacement medication.

Reluctance to accept opiate replacement and harm-reduction practices as the new standard perpetuates inadequate care practices, despite compelling data that detoxification-only and abstinence-only approaches result in high rates of relapse and overdose. Despite legislative measures increasing prescriber oversight and limiting opioid availability, the numbers of opioid users, overdoses, and deaths continue to escalate, with an alarming transition rate to heroin (now often laced with fentanyl at unpredictable potencies).

As psychiatrists, we have a unique role to play in this public health crisis. Residents, in particular, can take actions now to curb the current opioid epidemic:

Advocate within your training program

- Request training in naloxone-kit prescribing and counseling, and prescribe naloxone kits to appropriate patients and their families.

- Obtain a Drug Enforcement Agency "X" license to prescribe buprenorphine/naloxone and be familiar with the practice.

- Seek to care for patients with comorbid substance and psychiatric disorders to better appreciate their accompanying diagnostic challenges and complex care needs.

- Request education on the ever-evolving legislative changes regarding opiates and other substances of abuse.

- Stay up to date with the literature linking substance use and chronic psychiatric illness.

Advocate within your community

- Encourage local governments to approve over-the-counter access to naloxone emergency kits.

- Be a proponent of the harm-reduction model; abstinence-only programs are often inadequate and can perpetuate stigma.

- Emphasize the need to treat rather than incarcerate.

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Rachel Katz, M.D., is a PGY-4 and chief resident in psychiatry at Yale University. Katz is the senior deputy editor of the *American Journal of Psychiatry Residents' Journal*.

Telepsychiatry: What You Should Know Before You Go Live

Telepsychiatry has the potential to expand the reach of psychiatry in rural and underserved areas, but there are important issues of which clinicians should be aware surrounding licensure, practice, and payment.

BY NATHAN TATRO

Video and digital technology is expanding the reach of physicians to remote and rural areas of the country. For psychiatrists in short supply in many areas of the country, telepsychiatry has the potential to improve access to mental health treatment.

Here are some "nuts and bolts" about a rapidly emerging technology.

Q *What is telemedicine?*

A Telemedicine, as defined by the American Telemedicine Association (ATA), is "the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status." Over the past several decades, the use of telemedicine as an alternative to patient-doctor, face-to-face care has increased and includes multiple therapeutic modalities, including two-way video communication, email, smartphone applications, and more. The early years of telemedicine focused on delivering care to patients in rural and remote areas. Now, telemedicine is used widely in hospitals, home health agencies, and private practices, among other settings.

Q *How do psychiatrists fit in?*

A Telemedicine in psychiatry, known as telepsychiatry, has also seen substantial growth over the past decade. With increased access to high-speed broadband internet access in conjunction with widespread use of high-quality video cameras built into computers, smartphones, and tablets, psychiatrists are increasingly turning to telepsychiatry as a means of expanding or augmenting their practice.

Recently, APA updated its position statement on telepsychiatry as follows:

"Telemedicine in psychiatry, using video conferencing, is a validated and effective practice of medicine that increases access to care. APA supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is in the best interest of the patient and is in compliance with the APA policies on medical ethics and confidentiality."

Q *What are some important considerations when practicing telepsychiatry?*

A Many studies have compared the clinical effectiveness of telepsychiatry with in-person treatment. The general consensus is that, while additional research is needed, practicing telepsychiatry appears to be feasible across multiple care settings and that patient outcomes are, in general, similarly positive.

However, there remain several practical issues related to telepsychiatry of which clinicians should be mindful when considering adding telepsychiatry to their therapeutic repertoire:

- **Videoconferencing and security:** There are a number of live videoconferencing options on the market—many of which are available for free. However, the degree to which some videoconferencing applications (or "apps") adhere to various federal security regulations, including the Health Insurance Portability and Accountability Act (HIPAA), remain nebulous. Some apps purport to be HIPAA compliant, whereas some meet the HIPAA standard only after the user agrees to a business associate agreement (BAA) with the vendor. When evaluating software or third-party vendors that host videoconferencing (many of which cater specifically to health care/telemedicine), it is important to ask whether the software meets certain HIPAA requirements, such as data encryption and security standards.

- **Licensure issues:** Presently, the degree to which a clinician may practice telemedicine varies by state. Most states require that a clinician be licensed in the state in which the patient resides and in which the clinician practices. Some states allow out-of-state physicians to practice telemedicine without an in-state license as long as the standard of care is met. Before integrating telemedicine into your practice, it is a good idea to contact your malpractice carrier to determine your state's (and any state in which you wish to practice) regulations on telemedicine.

- **Reimbursement issues:** Reimbursement for telepsychiatry services is—like licensure issues—highly variable state to state. Parity between reimbursement for in-person and telemedicine encounters is not yet a reality in all states, especially for third-party payers. If you accept private insurance, it is a good idea to find additional information as to whether the insurance that you accept also reimburses for telepsychiatry. Additional information can also be found on the American Telemedicine Association's website under its "State Legislation Matrix" at www.americantelemed.org.

- **Clinical Practice Issues:** While there are many similarities between practicing psychiatry face to face with a patient versus using videoconferencing, there are some differences with which clinicians should be familiar before engaging in telepsychiatry. A good starting point is to become familiar with current practice guidelines for this form of therapy. In 2013, the ATA's Telemental Health Work Group, composed of a diverse group of mental health professionals, released "Practice Guidelines for Video-Based Online Mental Health Services." That resource can be found at http://bit.ly/1EAs6Yd.

Q *How can APA help you make use of telepsychiatry?*

A APA continuously monitors federal and state regulations and legislation related to telemedicine and telepsychiatry, especially on issues pertaining to reimbursement and licensure. Additionally, APA's Committee on Telepsychiatry is exploring many practical, clinical, and policy issues related to telepsychiatry and welcomes input from the broader APA membership.

Finally, APA recently launched its Telepsychiatry Toolkit, an evolving resource for members who want to learn more about telepsychiatry. The toolkit includes videos, links to clinical and policy documents, and other pertinent educational resources. It can be accessed at http://www.psychiatry.org/telepsychiatry. PN

More information on telepsychiatry and risk management is posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.2a13.

Nathan Tatro is APA's health information technology specialist.

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- Support the enforcement of prescription monitoring programs and mandated reviews by prescribers.

- Volunteer to speak publicly to provide evidence-based information and combat stereotypes.

Advocate within your medical system

- Assess whether your hospital is equipped to host a needle-exchange program or will accept unused medications.

- Seek out opportunities to collaborate with medical and surgical training programs to provide education about the treatment of patients with comorbid substance use disorders.

- Emphasize the importance of frequent reviews of prescription monitoring programs and the dangers of haphazard prescribing practices.

During the last opiate epidemic, of the 1880s, largely considered iatrogenic, physicians played a considerable role in limiting access to opiates, advocating for more appropriate prescribing practices, increased police involvement, and eventually the passage of the Harrison Act of 1915, which mandated monitoring and documentation of prescriptions from medical sources.

We must prepare ourselves for the influx of patients who will need our care. We must provide care that is supported by the literature rather than public or political opinion. We can help curb this epidemic, like our predecessors before us. PN

This column originally appeared in the June issue of the *American Journal of Psychiatry-Residents' Journal*, an e-publication that serves as a forum for medical students, resident physicians, and fellows to share ideas and experiences in training, clinical practice, research, and careers. To submit a manuscript, please visit http://mc.manuscriptcentral.com/appi-ajp.

VIEWPOINTS

The Slippery Slope to Euthanizing Psychiatric Patients

BY RONALD PIES, M.D.

Imagine that your adolescent son or daughter suffers from a serious and intractable depressive illness. Every treatment short of electroconvulsive therapy has been tried, but nothing has really worked. After years of misery, your teenage child tells you, "That's enough. I'm done! I'm gonna end this, one way or another." How would you feel if your child's doctor now offered to help your child commit suicide by prescribing a lethal drug?

If you think this scenario is the stuff of Orwellian fiction, think again. So-called "physician-assisted dying"—even for people with nonterminal illnesses, like major depression—is now accepted practice in parts of Europe. Extending this "right" to youth with intractable mental illness could eventually become legal in Canada. And if current trends favoring "physician-assisted suicide" (PAS) in the United States accelerate, we could find ourselves in a similar position.

Let's be clear: I am not talking about a terminally ill, mentally competent adult's right to refuse useless treatment as death approaches—a right clearly recognized by U.S. courts. Nor am I talking about physicians prescribing a lethal drug to a mentally competent adult who wishes to end his life, in the context of a terminal illness like pancreatic cancer. Indeed, five U.S. states already permit PAS in this context. I am talking about vulnerable young people with potentially treatable psychiatric disorders who have decided that "enough is enough"—even though their competence to make such decisions is highly questionable.

I am writing about this in the face of several recent developments. First, Canada is now considering assisted suicide for "mature minors" with psychiatric illnesses causing "intolerable suffering." The basis for this proposal is a recent report to Canadian lawmakers from the Special Joint Committee on Physician-Assisted Dying. This clear expansion into the realm of adolescent mental illness seems to validate the "slippery slope" argument that many medical ethicists have raised with regard to physician-assisted suicide.

The proposal regarding PAS for mature minors with mental illness has not yet been enacted into Canadian law. However, Canada's Parliament recently passed Bill C-14, which provides for "one or more independent reviews relating to requests by mature minors for medical assistance in dying"— potentially including "requests where mental illness is the sole underlying medical condition." If, after review, the mental illness clause is enacted into law, this could mean that young people with potentially reversible conditions like major depression would be able to receive a physician's "assistance" in committing suicide.

It is far from clear how "maturity" will be determined in such cases or what that

term means in the context of the normal adolescent's stormy emotions and incompletely developed brain. Furthermore, while psychiatric illness does not preclude competence to make medical decisions, it is

Ronald Pies, M.D., is a professor of psychiatry and bioethicist affiliated with SUNY Upstate Medical University and Tufts University and the author of *Psychiatry on the Edge.*

often extremely difficult to establish competence in the presence of serious psychiatric illness. Thus, the adolescent with severe major depression who hasn't responded to several antidepressants may wrongly conclude, "There's no hope for me. I'm finished. My only option is suicide!" even though there are still many potentially effective remedies available.

The expanding notion of PAS for persons with mental illness is not confined to Canada. In Belgium and the Netherlands, PAS is legally permitted for cases of "unbearable suffering" due to "untreatable" mental illness—despite controversy over how these terms are defined and how patients are selected.

Fortunately, in the United States, the slippery slope toward euthanizing psychiatric patients may have been roughened. Recently, APA's Ethics Committee unanimously supported the following resolution: "The American Psychiatric Association holds that a psychiatrist should not deliberately prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death."

It is one thing to argue that mentally competent adults with demonstrably terminal illnesses ought to be at liberty to end their own lives. It is another to argue that physicians ought to be willing participants in that process. And it is truly a bridge too far to argue that physicians ought to "assist" vulnerable, mentally unstable youth in taking their own lives. PN

ETHICS CORNER

Is it Ethical to Skype With Patients?

BY CLAIRE ZILBER, M.D.

This article is the second in a series designed to facilitate our adaptation to modern digital media by helping us maintain our professionalism and boundaries as we venture into these new social territories. Specifically, this article addresses ethical concerns when using Skype, FaceTime, and similar video technology applications to communicate with patients.

Telepsychiatry uses a closed network established between two health facilities, such as an academic medical center and a rural clinic or correctional facility. It has enormous advantages for increasing access to expert care and includes built-in protections to safeguard confidentiality and uphold the standard of care. Skype and similar technology may be appealing as a way to expand telemedicine to private practices and patients' homes. It offers more conve-

Claire Zilber, M.D., is chair of the Ethics Committee of the Colorado Psychiatric Society, a former member of the APA Ethics Committee, and a private practitioner in Denver.

nient access to care for patients who live in remote locations or have limited mobility, using technology that many people already possess in their desktops, laptops, tablets, or smartphones. Increasing access to care promotes the ethical principle of justice, in line with Section 9 of APA's *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry,* which states, "A physician shall support access to medical care for all people."

Before deciding to practice psychiatry via Skype, you must weigh the potential risks associated with this technology. Four major areas of concern are confidentiality, maintenance of the standard of care, safety, and regulatory compliance.

The confidentiality of a Skype call can be compromised in several ways. Skype calls are encrypted, so they are not easily hacked, but it is theoretically possible for a hacker to gain access to a device's video camera. Of more concern is the ability of either party on a Skype call to record the conversation without the other person's knowledge or consent. This is illegal, but it could still occur. An additional concern is the potential loss of confidentiality if a third party enters the room during a Skype conversation between a psychiatrist and a patient. If you do choose to Skype with patients, the potential loss of confidentiality should be a part of your informed consent discussion.

While Skype enhances access to care, it risks compromising the standard

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of care. Admittedly, most of the psychiatric exam and treatment is a visual and verbal interaction. Nevertheless, there are elements of the exam, such as taking vital signs and checking for cogwheeling or rigidity, that are impossible to do over Skype. In addition, some elements of an assessment, such as examination of intention or resting tremors, may be difficult to do using video technology because of the graininess of the image. These portions of the exam may be performed by a health care provider at the patient's location in formal telemedicine settings, but there is typically no health care provider in the patient's home during a Skype session. This drawback could be mitigated if the patient came to your office for an in-person exam once a quarter.

Another concern is patient safety. If a patient in your office reveals acute suicidal or homicidal intent, you can call 911 and directly monitor the patient until authorities arrive to transport the patient to an emergency room. With Skype, the patient can hang up and leave or self-harm before help arrives. This risk has always existed with phone calls between providers and patients, but phone calls are typically a form of communication used between office visits and not the primary mode of clinical encounter. Before embarking on Skype-based treatment, you should assess your comfort with these safety risks.

Regulatory considerations for Skype-based treatment include reim-

bursement and licensing. If you are billing insurance for a Skype encounter, it is essential that you comply with CMS eligibility criteria. These are detailed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf. The patient must be located at an eligible site, which is any one of several defined health care facilities, but not the patient's home. If the patient is not using insurance to pay for treatment, these restrictions do not apply.

An additional regulatory hurdle is the requirement that health care providers be licensed in the state in which medical treatment occurs, defined as the state where the patient is located. If the patient is in a state other than the one(s) in which you are licensed, it is crucial that you check with the medical licensing agency in the state(s) in which you are licensed as well as in the state in which the patient is located to ensure that you are not practicing medicine without a license.

In summary, expanding access to care by using Skype and similar video communication technology upholds the ethical principle of justice and the moral virtue of providing care to all. Fulfilling this ethics principle must be weighed against potential compromises to confidentiality, standard of care, patient safety, and regulatory compliance. Establishing policies and procedures for Skype-based treatment in your practice is one way to mitigate the risks and maximize the benefits. PN

COMMUNITY

Mental Health in Workplace Integral to Business Success, CEOs Say

Leaders discuss the ways that businesses can support employees and manage mental health issues.

BY AARON LEVIN

Corporate leaders met in New York in June to discuss the importance of mental health in the workplace and why there was a business case for ensuring that it is positive.

The event may reflect a growing awareness among leaders of American business that businesses and organizations that support the mental well-being of employees function better.

The fact that corporate presidents and CEOs were represented around the table was an indication that concern for workers' health has moved beyond the level of human relations or benefits managers, said Clare Miller, director of the Partnership for Workplace Mental Health at the American Psychiatric Association Foundation, which helped facilitate the meeting.

The event was held at Deutsche Bank's New York headquarters in Manhattan, co-hosted by the Foundation, the National Alliance on Mental Illness of New York, and the Northeast Business Group on Health.

"This meeting was a perfect illustration of the reality that mental health and substance use disorders affect every part of our society, including the workplace," said Herbert Kleber, M.D., a professor of psychiatry and founder/director emeritus of Columbia University's Division on Substance Abuse. "It was gratifying to be able to represent the APA at an event with CEOs to advance our mutual interest in health and productivity."

Peter Hancock, president and CEO of insurance giant AIG, led the discussion, joined by Kathy Wylde, president for the Partnership for New York City, and New York City First Lady Chirlane McCray.

Mental health should be considered an important workplace issue, noted Wylde. "Mental illness accounts for 30 percent of disability costs and up to $100 billion a year in lost worker productivity."

Company leaders can understand those financial costs, but their concerns about mental health should also go beyond health care dollars.

"CEOs want to establish workplace cultures the support mental health," APA CEO and Medical Director Saul Levin, M.D., M.P.A., told *Psychiatric News*. "Important steps in that direction include reducing stigma by talking about mental health and mental illness and providing employees with true access to quality care."

"As a CEO, I understand that the success of my company depends on the performance of employees, and work performance is inextricably linked to mental and physical health," said Byron Boston, president, CEO, and co-CIO of Dynex Capital Inc. "This is about being a good leader, and it's also why we invest in our employees and their mental health." PN

More information about the Partnership for Workplace Mental Health is posted at www.workplacementalhealth.org. APA's guide for business leaders, *Working Well: Leading a Mentally Healthy Business Toolkit,* is posted at http://psychiatry.org/File%20Library/PWMH/working-well-toolkit.pdf.

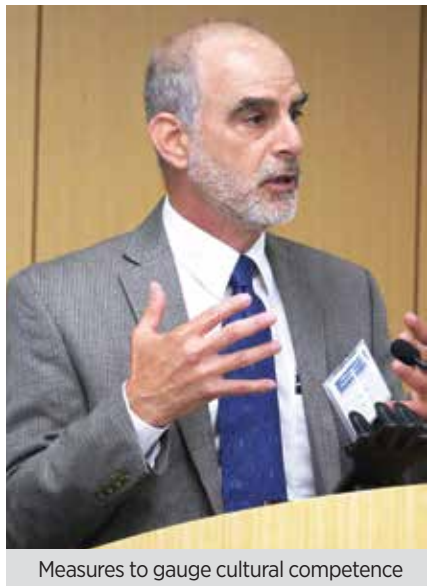
COMMUNITY

Implementing Cultural Competence Means Inclusion Plus Measurement

Making diversity really work takes special efforts throughout an organization.

BY AARON LEVIN

Changes in policies, values, structures, and standards will help build real cultural competence, said Terry Cross, M.S.W.



Measures to gauge cultural competence should apply across all the health professions, said Joshua Schwarz, Ph.D.

Sonja Harris-Haywood, M.D., M.S., measured and validated knowledge and implementation of cultural competence.

Photos: Aaron Levin

Cultural competence—whether in health care, academia, or business—should mean more than encouraging more people of different racial or cultural backgrounds to be part of an organization, according to speakers at a conference in Washington, D.C., in June.

The goal is not simply the achievement of diversity but inclusion, said opening speaker Terry Cross, M.S.W., of the National Indian Child Welfare Association.

"Cultural competence means being able to function in the context of cultural differences," said Cross. "Inclusion is not just having people show up at the door but about their being able to be who they are."

The conference was cosponsored by APA, Ohio State University, and General Motors.

Yet how can an organization know where it stands and how well it has progressed toward achieving cultural competence and inclusion?

"You can't manage what you can't measure," said Joshua Schwarz, Ph.D., a retired professor of management at Miami University, Ohio, recalling an adage in the field.

Most attempts to measure cultural competence have been ad hoc, limited to specific occupational categories, poorly validated, or not freely available, said Schwarz.

In response, he and his colleagues developed the Healthcare Provider Cultural Competence Instrument, which incorporates both a general awareness/sensitivity dimension and a more conventional multicultural approach to measurement. It also has cross-occupation validity, a better approach than developing individual training programs for smaller professional populations, he said.

"Have patience," added Sonja Harris-Haywood, M.D., M.S., senior associate dean in the College of Medicine at the Northeast Ohio Medical University in Cleveland. "Cultural competence assessment and measurement is a journey."

Harris-Haywood helped develop a set of 67 questions to measure knowledge of cultural competence and its implementation, as well as community engagement.

In medicine, said Schwarz, "the most important aspect of cultural competence is the attitude of practitioners toward patients, particularly patients from different cultures."

At a minimum, clinicians must be aware of how their own biases influence patients' experience of the health care encounter, he said. Clinicians must learn the skills needed to draw from patients their own perspectives on illness so they can take part in informed decision making.

Inclusion is difficult today less because of major, blatant forms of discrimination than of less obvious exclusion, said Ranna Parekh, M.D., M.P.H., director of APA's Division of Diversity and Health Equity.

Parekh noted that Harvard psychiatrist Chester Pierce, M.D., coined the term "microagressions" in 1970 to describe not the major indignities of traditional racism but the "subtle, stunning, often automatic, and nonverbal exchanges" that implicitly degrade members of minority groups and provide advantage to members of the dominant culture. The tension and stress induced by microaggressions can affect physical and mental health as well as job prospects, said Parekh.

Measuring the subtleties of inclusion is more difficult than simply counting heads, noted several speakers.

"Metrics are indispensable to transforming organizations into learning organizations," said Douglas Haynes, Ph.D., a professor of history and vice provost for academic equity, diversity, and inclusion at the University of California, Irvine (UCI).

"For too long, we didn't measure diversity and inclusion," he said. "We have to recognize the uneven landscape of opportunity."

Universities typically focus on getting new students or faculty from diverse cultural backgrounds into their institutions and helping them adjust. To go beyond that, UCI more recently has required all applicants for faculty positions to provide a diversity statement—but doesn't specify what is to be included and so permits an open-ended response.

Surveys of faculty attitudes at UCI find high stated support for diversity, inclusion, and equity but also significant levels of microaggressions and bias in personal interactions, said Haynes. "We need to come up with some type of training tool associated with assessment so we can feed that back to equip the faculty to be more self-aware."

The result would enable people at UCI to "maximize their potential for growth and achievement and increase the capacity of the university to be responsive to the grand challenges of society and the world."

Within the medical professions, one way of achieving greater goals is by breaking down professional silos, said Robert Like, M.D., M.S., a professor and director of the Center for Healthy Families and Cultural Diversity at the Rutgers Robert Wood Johnson Medical School in New Brunswick, New Jersey.

"We need more co-teaching and more co-learning to understand both our own and others' perspectives," he said. "How do we teach what is universal as well as what is individual?"

Hot-button issues that bring out people's emotions may create problems in the open, but Like warned that "cold-button" issues may cause people to shut down and not communicate, thus blocking resolution of conflicts.

Attitudinal change is slower than behavioral change, said Parekh. However, consciousness of microaggressions can lead to "microaffirmations"—subtle, small acknowledgments of a person's value and accomplishments—that can affect both personal interactions and institutional behavior.

Finally, said Bruce Steward, former acting director of the Office of Diversity and Inclusion in the U.S. Office of Personnel Management, it may be time for a "New IQ"—an "inclusion quotient."

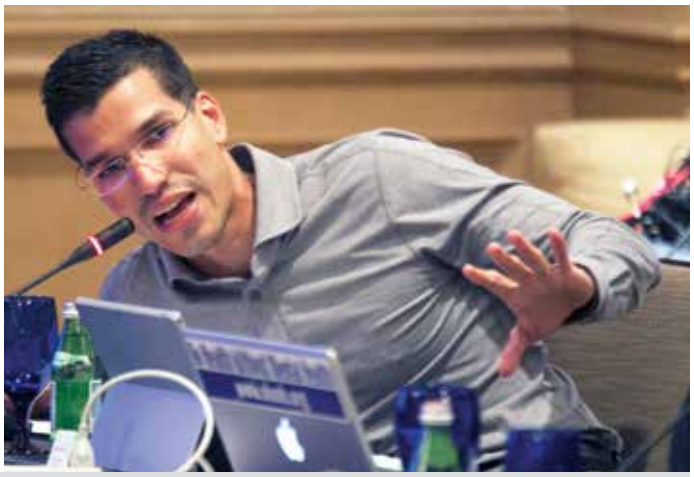
"The old IQ was about how smart you are as an individual," said Steward. "The new IQ is about how smart you make your team. We know that the more diversity you have on your team, if managed in an inclusive way, it makes for a smarter team."

Maintaining that diversity means developing practices that become habitual, said Steward, who identified five habits that reinforce inclusion. Fairness is the biggest challenge, he said. However, openness, cooperation, support (especially for work-life balance and for diversity and inclusion), and empowerment all contribute to upholding diversity. PN

More information about APA and diversity issues can be found in the article "Diversity Mental Health Month: Cultural Competency Key to Better Outcomes" at http://www.psychiatry.org/news-room/apa-blogs/apa-blog/2016/07/diversity-mental-health-month-cultural-competency-key-to-better-outcomes.

ASSOCIATION NEWS



Photos: David Hathcox

Clockwise from top left: Stella Cai, M.D., APA's resident-fellow member trustee, comments on the proposal to use the PGY-4 year for subspecialty training. Maria A. Oquendo, M.D., presides over her first Board meeting as APA president. Hector Colon-Rivera, M.D., attends his first Board meeting as the APA/SAMHSA/Diversity Leadership fellow. Daniel Gillison, who became executive director of the APA Foundation in June, comments on the link between his work at the National Association of Counties and APA's work to reduce the criminalization of people with mental illness.

Trustees Take Action on Range of Issues

The APA Board of Trustees acts on issues important to the future of psychiatry.

BY MARK MORAN

Further plans for the development of an APA-owned mental health registry and deliberations about the future of residency training in psychiatry were among the issues on which the Board of Trustees took action last month in Arlington, Virginia.

Board members took another step toward creation of a mental health registry when they voted to have APA's Finance and Budget Committee explore ways to create cost savings or identify revenue opportunities to build the registry. The motion approved by the Board also called for the committee to report back to Trustees with its evaluation of options at the Board's October meeting

Additionally, Trustees considered a proposal from the American Board of Psychiatry and Neurology (ABPN) to provide an unrestricted $1 million grant to APA to help develop the registry to ensure that their diplomates can participate.

Development of a mental health registry is expected to help APA members comply with Physician Quality Reporting System (PQRS) and Merit-Based Incentive Payment System (MIPS) requirements and avoid established penalties, which began in 2016 (2 percent) and will increase to 9 percent in 2022. A registry would also allow psychiatrists to submit performance and practice data from the registry for Maintenance of Certification Part 4 credit.

Additionally, a registry will provide a national research database with aggregate de-identified data to help improve patient outcomes, develop new diagnostics and therapeutics, develop practice guidelines, identify gaps in care, inform APA educational programs, help with *DSM-5* updates, and support advocacy initiatives. It will also allow APA to develop new psychiatric quality measures (with funding from the Centers for Medicare and Medicaid Services until 2019).

In other business, Trustees—responding to a request for input from ABPN—voted not to support the option of allowing psychiatry residents to use their PGY-4 year of training to begin ACGME-accredited subspecialty fellowship training. (Currently, only residents who enter child and adolescent training are able to use their fourth year of generalist training for subspecialization.)

"Training psychiatrists of the future is something everyone in our field cares deeply about, and there is a diversity of perspectives on whether to create new shorter pathways to complete fellowship training," Board member Richard Summers, M.D., who is past chair of the Council on Medical Education and Lifelong Learning, told *Psychiatric News* in comments after the meeting. "I am pleased that the Board upheld a commitment to generalist training and recognized the importance of emphasizing training in addictions, geriatric psychiatry, and psychosomatic medicine in a four-year adult residency."

Trustees also reaffirmed a decision by the Joint Reference Committee that approval and implementation of an Assembly action paper on APA's referendum voting procedure is not feasible. The action paper concerns the process for allowing members to vote in a referendum on changes to APA policy; currently, referendum items are included on the ballot for national elections. The Assembly paper, citing low voter turnout, called for referendum items to be voted on when members are sent their dues notices.

Additionally, Trustees voted to approve the recommendation of the Membership Committee to expand the definition of medical student members in the Operations Manual to allow international students to be eligible for membership by adding the following statement after the first sentence in the chapter on medical student members: "Individuals in medical schools outside the U.S. or Canada are also eligible for medical student membership if the school is listed in the World Directory of Medical Schools and the applicant provides proof of enrollment."

Trustees also approved the nomination of H. Steven Moffic, M.D., to receive the 2016 Administrative Psychiatry Award, and of writer and activist Chirlane McCray, the first lady of New York City, to receive the 2016 Award for Patient Advocacy. PN

APA members can access archived summaries of Board actions at http://psychiatry.org/about-apa/meet-our-organization/governance-meetings/governance-meeting-archives.

Nominations Sought for APA's 2017 Election

APA 2017 ELECTION

All APA members are invited to submit nominations for APA's 2017 election for the offices of president-elect and secretary. APA members in Areas 2 and 5 are invited to submit nominations for trustees in their respective Areas. Resident-fellow members are invited to submit nominations for resident-fellow member trustee-elect. Nominations should include the full name of the APA member and the corresponding office(s) for which the individual is being nominated and be sent by **October 1** to election@psych.org. APA is also accepting nominations for the Minority/Underrepresented (M/UR) Trustee. Nominees must be a member of one of the seven Assembly M/UR caucuses (American Indian/Alaska Native/Native Hawaiian; Asian American; Black; Hispanic; Lesbian/Gay/Bisexual; International Medical Graduate; and Women). Nominations for M/UR Trustee must be sent to election@psych.org no later than **August 15** and nominees must have been a member of their M/UR caucus as of **June 15**. More information about APA's 2017 election is posted at http://apapsy.ch/APAelection.

ASSOCIATION NEWS

Integrated Care Track at IPS Looks at Expanding Model to New Settings

IPS: The Mental Health Services Conference will offer free training in integrated care through the CMS Transforming Clinical Practice Initiative. The training will be offered twice on Saturday, October 8.

BY MARK MORAN

This year's integrated care track at IPS: The Mental Health Services Conference will include some of the tested favorite courses and workshops that members have come to expect of the track, along with some new learning experiences on how the collaborative care model can be adapted to diverse settings.

"We will be offering many of the same themes seen in previous years including sessions on behavioral health homes and early mortality in the SMI population, but we will also be looking at new ways to offer integrated care," said Scientific Program Chair Lori Raney, M.D., who is also chair of the APA Work Group on Integrated Care. "We know the collaborative care model works, but not everyone has the resources or the staffing necessary to fit the standard model of collaborative care. So we hope at the IPS to go another layer deeper and look at how we can use technology, task sharing, blended models, and other adaptations to bring the model to diverse settings."

Importantly, IPS will be the site of two training sessions in integrated care offered through the Centers for Medicare and Medicaid Services' (CMS) Transforming Clinical Practice Initiative (TCPI). (Three training courses were offered at the 2016 Annual Meeting in Atlanta.)

Register Now and Save!

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

Through the TCPI, APA is receiving a $2.9 million, four-year federal grant from CMS. APA is one of just 39 organizations that was chosen to participate in the TCPI; as one of the Support and Alignment Networks (SANs) awarded under the grant, APA is committed to training 3,500 psychiatrists in the principles and practice of collaborative care, a specific model of integrated care developed by the late Wayne Katon, M.D., Jürgen Unützer, M.D., M.P.H., and colleagues at the AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington.

The course being offered at the IPS is "Integrating Behavioral Health and Primary Care: Practical Skills for the Consulting Psychiatrist." The training will be offered twice on Saturday, October 8: from 8 a.m. to noon and again from 1 p.m. to 5 p.m. Participants will be seated on a first-come, first-served basis.

The course is designed to make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; dis-

see ***IPS*** *on page 24*

Why Should Residents Attend IPS? Two Residents Give Their Reasons

IPS: The Mental Health Services Conference has long had the reputation of being APA's "resident-friendly" meeting. But why is that? Two psychiatry residents share their perspective.

BY PETER URESTE, M.D.

Last year was the first time I attended IPS: The Mental Health Services Conference. I attended as an awardee of the APA's Public Psychiatry Fellowship. I had not yet attended IPS so I had no idea what to expect. As I approached the registration table, my first impression was extremely positive—everyone was warm, smiling, and welcoming. I also came across a few colleagues whom I knew from prior social advocacy experiences. This led me to realize that many people who attend this conference are like-minded and share an interest in social justice and commitment to caring for underserved communities.

I was impressed by how approachable the other attendees were. Many of them gave me their business cards and made themselves available for mentoring. The list of workshops was also impressive! I attended a workshop on the Black Lives Matter Movement, and every seat was taken. In fact, conference staff had to bring in more chairs to accommodate those who had had no choice but to sit on the floor.

I also attended a workshop on sexual trafficking of black women and acquired greater knowledge about this issue, particularly signs to look for during clinical visits that may suggest a patient is a survivor of sex trafficking. After the session, I met one of the presenters. Later we met for coffee and discussed the problems affecting both of our inpatient psychiatric units. She was training in New Orleans, and I was in Los Angeles. Both of our county inpatient units cared for marginalized patients, many who were the sickest of the sick in our cities and turned to public hospitals as their safety net. We also shared the initiatives in our hospitals that were addressing barriers to care.

Another special aspect of the IPS is that attendees include not just psychiatrists but also nurses, social workers, physician assistants, pharmacists, psychologists, students, and lawyers. This multidisciplinary group of attendees is a unique aspect of the conference that allows for richer conversations about patient care and the overall health care system.

I strongly recommend that residents—and members in general—attend IPS to find out for themselves what makes this conference so intimate and special.

BY AMY GAJARIA, M.D.

Like Peter, last year was my first year attending IPS: The Mental Health Services Conference. Before last year, I thought that the Annual Meeting was APA's only educational conference. I'm so glad that I got to discover IPS as part of my Public Psychiatry Fellowship with APA! IPS is one of the friendliest conferences I've ever attended. Some academic conferences can feel intimidating, particularly because I'm a resident, but at IPS everyone was approachable and really wanted to meet each other and share ideas.

At last year's conference, I was lucky enough to attend a great session on an innovative program on integrating legal and mental health services for families experiencing domestic violence and a session discussing how APA could function as a nongovernmental organization at the United Nations. I liked that there was a mix of sessions with different perspectives, but all were clinically relevant and focused on improving care for underserved populations within the mental health system.

I also appreciated meeting psychiatrists from throughout the United States and Canada as well as a number of other countries who shared my interests. Sometimes I feel somewhat isolated at my institution with regard to my interests, so a real draw of attending the IPS is the chance to meet and learn from like-minded colleagues.

I did miss out on one evening session I wanted to attend, though. I had heard of this musical called "Hamilton" and thought I'd try to get some tickets by waiting in line for the lottery. I figured there might be only 10 or 15 other people there, so it was worth a shot. While that endeavor was unsuccessful, I was successful at visiting some great innovative programs for people with mental illness in New York City that were sources of inspiration for me coming home to Toronto (and I did buy a copy of the "Hamilton" cast album—which is basically the same as seeing it on Broadway, right?). PN

Peter Ureste, M.D., is a geriatric psychiatry fellow at the University of California, San Francisco. Amy Gajaria, M.D., is a PGY-4 psychiatry resident at the University of Toronto.

How Much Should Psychiatrists Weigh Costs When Prescribing?

Researchers find that the long-acting injectable (LAI) haloperidol decanoate is more cost-effective than a second-generation LAI. This raises questions about choice when one intervention is marginally more effective but significantly more costly than another.

iStock/Sezeryadigar

BY MARK MORAN

To what extent should clinicians consider "cost-effectiveness" in the choice of treatment?

It's a question *Psychiatric News* put to several experts in light of a new report in *Psychiatric Services in Advance* that found the long-acting injectable (LAI) paliperidone palmitate (PP), a second-generation antipsychotic, is not as cost-effective as the first-generation LAI haliperidone decanoate (HD), despite having a slight advantage in terms of clinical effectiveness.

Robert Rosenheck, M.D., a professor of psychiatry and public health at Yale Medical School, and colleagues conducted a double-blind, randomized 18-month clinical trial at 22 clinical research sites in the United States to compare the cost-effectiveness of HD and PP. A total of 311 adults with schizophrenia or schizoaffective disorder who had been clinically determined to be likely to benefit from an LAI antipsychotic were randomly assigned to monthly intramuscular injections of HD (25 mg to 200 mg) or PP (39 mg to 234 mg) for up to 24 months.

Results showed that PP was associated with a small but statistically significant health advantage over HD, as measured by "quality-adjusted life years" (QALY), drawing on scores on the Positive and Negative Symptom Scale (PANSS). The cost of PP ran on average $2,100 more per quarter for inpatient and outpatient services and medication compared with HD. Statistical analysis that divides incremental costs by incremental benefits generated an incremental cost-estimate ratio of $508,241 per QALY for PP compared with HD—well above the $100,000 per QALY benchmark often used by policymakers to determine if something is cost-effective (see box).

"The results of this study should encourage consideration of older, less expensive drugs, such as HD," Rosenheck and colleagues wrote. "Used at moderate dosages in this study, HD's overall effectiveness and tolerability were only slightly worse, as reported here, than those of PP, and it had clear advantages in cost-effectiveness. … A rational policy for treatment of chronic schizophrenia might limit use of the more expensive LAIs to patients who do not benefit from or cannot tolerate HD."

In an interview with *Psychiatric News*, Rosenheck said the results should be useful to payers and policymakers. However, he emphasized that individual clinicians also have a responsibility to pay attention to cost-effectiveness.

"It's true that research on effectiveness and cost-effectiveness tells us about averages, not about individuals, and this kind of study does not tell the individual practitioner how to prescribe individualized therapy for every patient," he said. "On the other hand, I think psychiatrists tend to be more sensitive to pharmacologic risks than to economic risks. Many patients with serious mental illness are poor and insurance coverage is uneven. A study like ours allows clinicians to say, 'I can prescribe you an effective medicine that fits your budget.'"

He added, "If psychiatrists don't play a role in developing a scientific basis for cost-effectiveness, then the only people who are setting the agenda are those whose main interest is profit. Cost-effectiveness becomes especially important when there is a treatment that is marginally more effective but significantly more costly. Then we have to face the question of the monetary value of health benefits. That is extremely painful and extremely hard to do scientifically."

William Carpenter, M.D., a professor of psychiatry at the University of Maryland and editor of *Schizophrenia Bulletin*, has been critical of pharmaceutical companies that market "me-too" drugs—medications that have virtually the same mode of action as other drugs in the same class and generally differ only in side-effect profile, but are often significantly more expensive than older drugs that are as effective.

"It's very good to have this type of head-on comparison to provide perspective and guidance for decision makers on mental health services," he said. Carpenter suggested that clinicians have an ethical duty to pay attention to cost-effectiveness.

Others who reviewed the report for *Psychiatric News* agreed it offers valuable information for payers and policymakers, but questioned the degree to which individual clinicians should apply cost-effectiveness in the treatment of individual patients.

"This is likely to be useful information for payers and policymakers since it provides a rational basis for determining that populations of patients should first be treated with HD before they receive treatment with PP," said Stephen Marder, M.D., a professor of psychiatry and behavioral health and the director of the section on psychosis in the Department of Psychiatry at the University of California, Los Angeles.

"My concern is that this information may not translate well for a prescriber and a patient who need to deal with other considerations," Marder said. "If the patient is concerned about weight gain, HD was shown to have an advantage. If an individual is vulnerable to developing discomforting akathisia or if there is a worry about tardive dyskinesia, the calculation of a QALY loses its meaning and interferes with a decision that is in the best interests of an individual."

Eric Slade, Ph.D., an associate professor of psychiatry at the University of Maryland, agreed. "I'm not sure that clinicians should consider cost," he said. "Their job is to identify the best course of treatment for each patient. The cost of antipsychotic treatment, particularly injectables, is generally borne by Medicaid and other public payers. Cost-effectiveness findings

continued on next page

What Is a Quality-Adjusted Life Year?

Cost-effectiveness research is a highly technical and somewhat rarified area of health services research that looks at the relative costs of a "quality-adjusted life year" (QALY).

Eric Slade, Ph.D., an associate professor of psychiatry at the University of Maryland and an economist who specializes in mental health services research, explained that the QALY is a metric of health and morbidity developed by medical "decision scientists" and economists. "The concept is that all states of morbidity can be valued on a 0 to 1 scale, where 0 represents death and 1 represents 'perfect health,'" he said. "One quality-adjusted life year is interpreted as one year of perfect health."

Slade explained that QALY ratings are usually based on a "preference-weighted" quality-of-life scale, of which there are several. Preference weighting means that a sample of individuals is asked a series of questions about the relative values they would place on different health limitations—for instance, vision impairment compared with mobility impairment. The answers to these questions are then used in an analysis to value different states of health.

In the Rosenheck study (see above), the authors used a special version of the standard methodology to capture the value of changes in psychotic symptoms, translating scores on the Positive and Negative Symptom Scale (PANSS) scores into QALYs.

Rosenheck and colleagues found that compared with haloperidol decanoate, peripalidone palmitate was associated with .0297 greater QALYs over 18 months, or approximately .02 QALYs over 12 months—an improvement of 2 percent of one year of perfect health or approximately one week of perfect health during a full year.

That's a relatively small benefit. And the cost of that small benefit for paliperidone is very high. The added cost of producing one additional year of perfect health using paliperidone versus haloperidol was over $500,000, Slade said.

According to Slade, $100,000 per QALY is often used by policymakers as a benchmark. "If something costs more than $100,000 per QALY, it is not considered cost-effective," he said. "If something costs less than $100,000, it is considered cost-effective. This threshold is somewhat arbitrary and is frequently debated. However, many prevalent health care services have been shown to cost less than $100,000 per QALY. Interventions like vaccinations are among the most cost-effective in health care, costing generally less than $100 per QALY."

PSYCHIATRY & INTEGRATED CARE

25 Years of Integrating Care at Safety-Net Health Care System

BY ROBERT C. JOSEPH, M.D., M.S.

This month's column features Dr. Robert Joseph, who has spent 25 years perfecting the role of a consultation-liaison psychiatrist at Cambridge Health Alliance (CHA), one of our nation's premier safety-net health care systems. Even in Cambridge, Massachusetts, an urban area that has one of the highest concentrations of psychiatrists in the nation, it can be exceedingly difficult to get mental health care, and Robert's work to integrate behavioral health services into primary care has made a big difference in improving access to care. His journey toward a fully integrated behavioral health care system at CHA is an inspiration to many of us.

—Jürgen Unützer, M.D., M.P.H.

Late in medical school, I found myself torn between doing a residency in internal medicine or psychiatry. I loved medicine but found myself frustrated during an ambulatory medical clerkship by the sense that I was trying to practice psychiatry with my hands tied behind my back. Many of the patients I met seemed anxious, depressed, or overwhelmed, and many of those without overt emotional symptoms were engaged in self-destructive behavior or poor self-care. I felt at a loss to understand their behavior or how to help them.

This experience was among the factors that led me to pursue a career in psychiatry, where I was drawn to the opportunity to better understand the nature of patients' distress and behavior. Following residency, an interest in medical education led me to the practice of consultation-liaison psychiatry at Cambridge Health Alliance, an academic medical center affiliated with Harvard and Tufts Medical School.

Cambridge Health Alliance is a safety-net primary care network with two community hospitals and a strong history of commitment to community medicine and psychiatry. Initially, I worked within a fairly traditional model of consultation psychiatry, providing psychiatric opinions upon request to my medical and surgical colleagues within a general hospital while supervising adult psychiatry residents and eventually fellows in psychosomatic medicine.

As a consult psychiatrist, I quickly became aware of the burden of mental illness in medical settings and how little conventional psychiatry seemed to offer many of these patients (despite the fact that Cambridge has one of the highest per capita rates of psychiatrists in the country). This was in part due to the limited resources and less-than-friendly access policies available to safety-net patients, but also due to the fact that most patients did not tend to define their symptoms or maladaptive behavior in terms of emotional distress and therefore would rarely seek or accept a referral for psychiatric care.

Concurrently, I observed how much psychological distress (as well as overt mental illness) was seen exclusively by my medical colleagues despite the minimal training they received in this area. Mental illness was, of course, sometimes overlooked and sometimes poorly managed, but I was equally struck by the persistent efforts of many of my primary care colleagues to address these problems in the context of difficult-to-access specialty care.

These observations gradually led me to develop an ambulatory integrated care practice beginning in 1990. The service began by providing consultations at one internal medicine training site while precepting medical residents. Over the subsequent decade, the clinical service gradually grew to include all 15 affiliated primary care sites.

As a consult service, our mission

*see **Integrated Care** on page 30*

Robert C. Joseph, M.D., M.S., is an assistant professor at Harvard Medical School, director of the Consultation-Liaison and Primary Care Mental Health Service at Cambridge Health Alliance, and program director of the Fellowship in Psychosomatic Medicine.

continued from previous page

are aimed at mental health system planners, typically state mental health administrations or their equivalent at the local, state, or federal levels."

Slade added, "The cost-effectiveness findings from the Rosenheck study imply that from a cost-effectiveness perspective, it may be worth having Medicaid provide some regulatory guidance regarding patient access to PP. Although PP results in slightly greater quality of life, the cost of achieving that improvement is greater than the conventional threshold of acceptable cost."

Jim Sabin, M.D., is the director of the ethics program at Harvard Pilgrim Health Care and has written extensively about the ethics of resource allocation within systems of care. He hailed the Rosenheck study as "remarkably and admirably explicit about cost issues and unembarrassed about it."

He continued, "We have been so reluctant to entertain these questions in the United States, as if health and money can't be thought of together. But a symptom of this reluctance is what has happened to our health care costs."

Sabin, who is also a professor in the departments of Population Medicine and Psychiatry at Harvard, acknowledged a "serious conundrum" translating cost-effectiveness—which serves as a useful guide to policymakers concerned with population health—into clinical decision-making for the individual patient. But he emphasized that such decisions can be made ethically and rationally within a system of care (as opposed to ad hoc decision-making by individual prescribers) that accommodates the imperatives of population health and the individual.

"A well-functioning system serves both perspectives," he told *Psychiatric News*. "Balancing population health and individual considerations can open up very thorny and challenging questions that are ideally addressed within systems in a thoughtful way, with no pre-existing rules about how powerfully an individual preference should drive the allocation of resources."

An organized, systemic approach to resource allocation can also avoid singling out particular groups for cost-cutting, he said. "My concern is that a stigmatized group, such as people with severe schizophrenia, could become the focus for resource allocation applying cost-effectiveness approaches in ways that aren't applied to less stigmatized but equally or more costly areas. That's a real social risk." PN

"Cost-Effectiveness of Long-Acting Injectable Paliperidone Palmitate Versus Haloperidol Decanoate in Maintenance Treatment of Schizophrenia" is posted at http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201500447.

FROM THE EXPERTS

Be Sure to Check the PDMP Before Prescribing Controlled Medications

BY ANNA LEMBKE, M.D.

On a Tuesday clinic not long ago, I was delighted to see Mrs. M on my schedule. I walked into the exam room where the psychiatry resident, an understated and able young woman, was jotting down notes on her clipboard.

Mrs. M and I locked eyes and smiled at each other. It was good to see her again. (As one of my wisest supervisors taught me years ago, we get paid to see our patients, but the relationship is real, based on trust, shared intimacies, and mutual affection.)

"Mrs. M is doing well," said the resident. "No new medications or medical problems. She continues to take Lexapro and finds it helpful for anxiety. She'd like to continue and is also requesting a small dose of Ativan, for the occasional breakthrough anxiety."

In all the time I'd been treating Mrs. M—nearly a decade by my count—she had never needed to see me more than once or twice a year and had never needed much more than a refill of her stable medications. Having her on the schedule was like an oasis amid a sea of chronically and severely mentally ill patients. Her visits were reliably quick, straightforward, and mutually reassuring. Furthermore, I saw Mrs. M as a role model of sorts—someone I hoped I could emulate as I aged.

In her 60s, Mrs. M was still happily married with well-adjusted grown children, healthy grandchildren, and family reunions where people actually got along. Youthful, trim, and sprightly, she could have graced the cover of *Outside Magazine*.

"How are your kids?" I asked her. "And your grandkids?" She updated me on the goings-on in her extended family, and the happy tidings were balm to my soul—a reminder that not all families are rife with dysfunction and multigenerational trauma.

"So about that Ativan," said the resident, breaking into my reverie. "I was just about to check the PDMP when you came in."

The PDMP (prescription drug monitoring program) is a statewide database listing all the controlled drugs (Schedules 2 through 5) dispensed by a pharmacy to a given patient in a given time period within that state. The purpose of checking the PDMP is to optimize safe prescribing. The PDMP can help clinicians avoid prescribing medications that may have dangerous interactions with other medications and mitigate the risk of prescription drug misuse, overuse, and addiction.

A substantial part of my job as an academic psychiatrist at a large teaching hospital is to supervise medical students and residents in the practice of medicine. In 2011, the same year the Centers for Disease Control and Prevention declared a nationwide prescription drug epidemic, I began to require my students to check the PDMP before initiating or renewing a prescription for any controlled drug.

I teach my residents to check the PDMP right there in the room with the

Anna Lembke, M.D., is an assistant professor of psychiatry and behavioral sciences and the chief of addiction medicine at Stanford University School of Medicine. She is author of the forthcoming book *Drug Dealer, MD: How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop*, available for preorder at http://apapsy.ch/Hooked.

patient. I even have the patients look at the computer screen, so they can see for themselves what kind of data the PDMP includes: prescriber's name, name and location of the dispensing pharmacy, and the drug (strength and quantity), all neatly linked to the patient's name, date of birth, and home address. Checking the PDMP during the visit contributes to full transparency in the therapeutic relationship.

There are several pieces of information contained in a patient's controlled substance prescription history that should serve as a red flag to the clinician:

- Benzodiazepines co-prescribed with opioid painkillers, a combination that increases the risk of accidental overdose
- Multiple prescriptions for the same or similar drug from different doctors ("doctor shopping"), a sign or harbinger of addiction
- Prescriptions for tramadol, an opioid with serotonergic properties that, when combined with selective serotonin reuptake inhibitors, increases the risk of serotonin syndrome
- The combination of a benzodiazepine, a stimulant, and an opioid—a drug trifecta that represents dangerous polypharmacy, with drugs working at cross-purposes and posing a risk for addiction

"No need to check the PDMP," I said to my resident, as she was turning to the computer to access the database. She didn't say anything. In retrospect, I imagine her eyebrows rose. "Mrs. M and I go way back, and there's never been a problem with her Ativan." Just for good measure, I turned to Mrs. M and added, "Now don't take these every day, or you'll build up tolerance and they won't work."

"Not to worry," Mrs. M assured me. "I use them only when I'm getting on an airplane to visit my kids."

I said goodbye to Mrs. M and moved on to my next patient. I didn't think about Mrs. M again until my resident later said she'd like to discuss her at our noon interdisciplinary meeting. She had checked the PDMP after all and discovered something unexpected.

Drug-seeking patients use a variety of techniques to get the drugs they want. They engage in these techniques on a somewhat unconscious level, driven by the physiologic imperative that defines the addictive process. One of the most reliable techniques is to flatter the doctor—to tell her how much better she is than other doctors; how much more knowledgeable, able, and compassionate. When I looked back, I realized Mrs. M had frequently regaled me with how incompetent her other psychiatrists had been.

All doctors, even very experienced ones, have blind spots when it comes to drug-seeking patients. One patient type that is especially challenging for me is one I call "The Twin." The Twin is the patient who is your mirror double—someone who is from the same race or socioeconomic class, went to the same schools, has the same interests and hobbies, or, most challenging of all, is a health care professional. When we see ourselves in our patients, we often assume their motives and intentions are the same as ours.

"Mrs. M has been getting Xanax from another prescriber," said my resident. She showed me a printed copy of the PDMP.

Mrs. M was back in our office a week later and admitted she had lied to us about her benzodiazepine use. She described a slow and insidious process of dependence on benzodiazepines over the past year, getting them from us and her primary care doctor. Thanks to my diligent resident, Mrs. M's troubles were caught before her problem grew into a more serious and protracted addiction.

In the weeks that followed, Mrs. M endured a painful taper off of benzodiaz-

see **From the Experts** on page 22

AMA Recommends Schools Start Later To Improve Teen Sleep

Sleep-deprived teens may have an elevated risk of injuries, says the CDC.

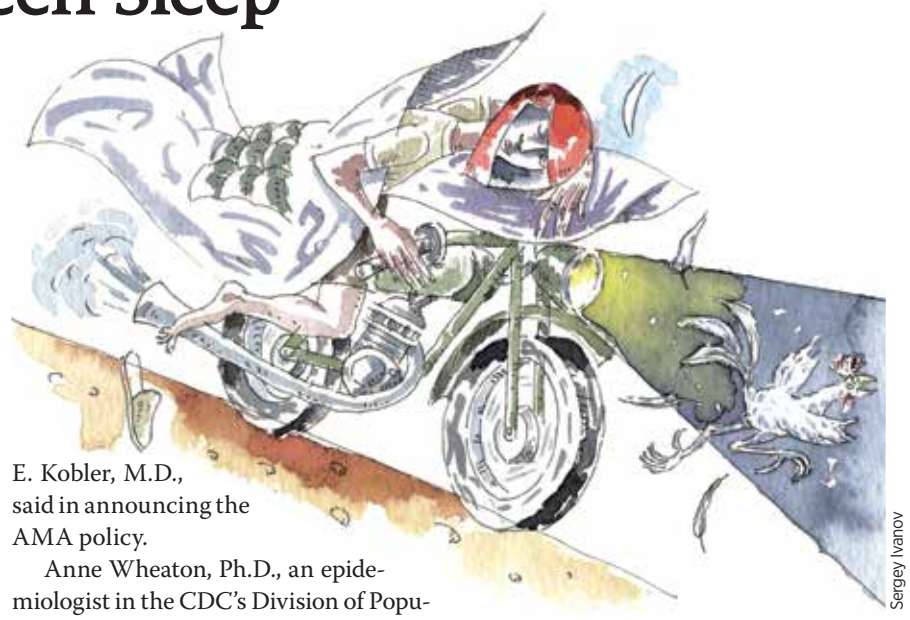
BY LYNNE LAMBERG

In a policy adopted at its annual meeting in June, the AMA called on the nation's school districts to start middle and high school classes at 8:30 a.m. or later to optimize students' sleep, mood, health, safety, and learning opportunities.

The AMA policy affirms the American Academy of Pediatrics' landmark 2014 school start time recommendation, endorsed by the Centers for Disease Control and Prevention (CDC) and other medical organizations.

The proposed start time, roughly 30 to 60 minutes later than most schools start now, acknowledges a pubertal delay in the biological clock that thwarts teens' attempts to fall asleep before 11 p.m. Most teenagers need 8.5 to 9.5 hours of sleep each night to achieve optimal alertness, which may be hard to achieve with early school start times.

"We believe delaying school start times will help ensure that middle and high school students get enough sleep and that it will improve the overall mental and physical health of our nation's young people," AMA board member William E. Kobler, M.D., said in announcing the AMA policy.



Sergey Ivanov

Anne Wheaton, Ph.D., an epidemiologist in the CDC's Division of Population Health, and colleagues recently reviewed 38 reports examining the association between school start times, sleep, and other health measures in adolescents.

Later school start times allow teenagers to sleep longer on week nights, mainly by delaying morning rise times, the researchers reported in the *Journal of School Health* in May.

Most studies showed that when school started later, attendance improved, tardiness fell, fewer students fell asleep in class, grades rose, motor vehicle crashes declined, and self-reported symptoms of depression dropped.

Wheaton and other CDC colleagues also reported recently that too little or too much sleep may put teenagers at increased risk of injuries while driving, riding in cars with others, and biking.

Injuries from motor vehicle crashes are the leading cause of death in U.S. adolescents. In 2013, 2,163 U.S. teens aged 16 to 19 years died in motor vehicle crashes, and 243,243 received treatment in emergency departments for motor vehicle crash injuries, according to the CDC.

Wheaton's group analyzed data provided by 50,370 teenagers, a nationally representative sample of U.S. high school students in grades 9 to 12. The students had participated in the CDC's national Youth Risk Behavior Surveys in 2007, 2009, 2011, or 2013, completing an anonymous self-administered questionnaire in a single class period.

Teenagers who usually sleep less than seven—or more than 10—hours on school nights are more likely than peers who sleep nine hours to drink and drive, text while driving, and engage in other behaviors that boost risks of motor vehicle and other traffic injuries, the researchers wrote in the April 8 *Morbidity and Mortality Weekly Report.*

More than two-thirds of the students reported sleeping seven hours or less on school nights, while about 2 percent said they usually slept 10 hours or longer. Only 6 percent reported averaging nine hours of sleep.

Nine percent of the students said they had driven a car or other vehicle when they had been drinking alcohol, and 30 percent said they had texted or emailed while driving at least once in the past month.

Nine percent reported infrequently wearing a seatbelt when riding in a car driven by someone else. Twenty-six percent reported riding in a car or other vehicle with a driver who had been drinking alcohol at least once in the previous 30 days. Among students who reported riding a bicycle in the previous year, 86 percent said they rarely wore a bicycle helmet.

Prevalence of all five injury-related risk behaviors varied by sleep duration, the researchers found. Students who slept seven hours or less on average on school nights were more apt to report all five behaviors than those who slept nine hours.

Students who slept 10 hours or longer were more apt than those who averaged nine hours to report infrequent seatbelt use, riding with a drinking driver, and drinking and driving.

"Adolescents' brains aren't geared to thinking through consequences of their actions," Wheaton told *Psychiatric News.* Not getting enough sleep may make teenagers more likely to take risks, she said, and less likely to reflect on possible outcomes before they act. Overlong sleep, she said, a common symptom of depression, also may alter judgment.

One limitation to the data used in this study, Wheaton cautioned, is that the data are cross-sectional. While the researchers found shorter sleep associated with a higher prevalence of risk behaviors, they could not determine causality. PN

An abstract of "School Start Times, Sleep, Behavioral, Health, and Academic Outcomes: A Review of the Literature" is posted at http://www.ncbi.nlm.nih.gov/pubmed/27040474. "Sleep Duration and Injury-Related Risk Behaviors Among High School Students—United States, 2007–2013" is posted at http://www.cdc.gov/mmwr/volumes/65/wr/mm6513a1.htm.

Efforts Converge to Boost Awareness of Teen Sleep Needs

Hundreds of schools in the United States have delayed start times in recent years to foster adolescent sleep, Terra Ziporyn Snider, Ph.D., co-founder and executive director of Start School Later (SSL), told *Psychiatric News*.

A nationwide coalition of parents, educators, sleep specialists, and others, SSL serves as a school start time information clearinghouse and support network.

The United States has 15,000 school districts, and 39,700 public schools, Snider noted. In communities that have adopted later start times specifically to benefit teen sleep, she said, research to assess outcomes is underway.

As with any public health issue, Snider observed, improving awareness of adolescent sleep needs and adopting strategies to ensure teenagers get adequate sleep require grass-roots advocacy and education of students, parents, teachers, physicians, and the larger community.

Changing attitudes and practices requires local, state, and national efforts, she said, along with legislation, and possibly even litigation.

In May, the state of Maryland passed the nation's first legislation endorsing the 8:30 a.m. or later school start times for middle and high schools recommended by the American Academy of Pediatricians and other medical groups. The Orange Ribbon for Healthy School Hours bill provides certification, beginning in the 2017–2018 school year, of middle or high schools that start classes at 8:30 a.m. or later and do not require students to board a school bus before 7:30 a.m.

The bill also specifies the need to educate the community about healthy sleep, provide an opportunity to air concerns about changing school start times, and allow time to prepare for those changes.

SSL and other sleep groups are organizing a national meeting on adolescent sleep and school start times to be held in April 2017.

More information about Start School Later is posted at http://startschoollater.net/.

From the Experts

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epines. Withdrawal is marked by mood lability, extreme emotional fragility, and debilitating anxiety and depression. Between visits there were tearful and angry phone calls from Mrs. M as well as her husband. Mrs. M made it through, and she is now benzodiazepine-free.

We all learned lessons from the experience. Mrs. M learned how addictive benzodiazepines can be, even in the absence of a personal history of addiction. I learned a lesson in humility, again. (Will I ever get this right?) My resident learned how fallible attendings are. (Perhaps she already knew.) She also learned what I myself had forgotten in the face of my own narcissism and wishful thinking—check the PDMP before prescribing a controlled drug, no matter how much you like the patient or feel convinced the patient can't possibly be misusing the drug you are prescribing. Sometimes an oasis turns out to be just a mirage. PN

Citalopram May Offer Limited Benefit For Patients With Complicated Grief

Only recently has complicated grief been recognized as a distinct syndrome that causes considerable distress and impairment.

BY VABREN WATTS

Use of citalopram alone or in combination with psychotherapy for complicated grief may do little to help patients experiencing the persistent maladaptive thoughts, dysfunctional behaviors, and poorly regulated emotionality that characterize this chronic condition, according to findings published last month in *JAMA Psychiatry*. However, a combination of citalopram and complicated grief therapy (CGT) may lead to improvements in patients with complicated grief and co-occurring depression.

"Clinicians often attribute complicated grief symptoms to MDD and treat accordingly," Katherine Shear, M.D., a professor of psychiatry at the Columbia University College of Physicians and Surgeons, told *Psychiatric News*. "But complicated grief, which was added to *DSM-5* under the name of Persistent Complex Bereavement Disorder, is a distinct syndrome that causes considerable distress and impairment and needs targeted treatment."

Shear told *Psychiatric News* that although it is common for patients with complicated grief to experience co-occurring depressive symptoms, the primary symptoms of complicated grief and response to treatment differ from that of major depressive disorder.

Shear and colleagues randomly assigned 395 bereaved adults who met criteria for complicated grief (defined as 30 points or higher on the Inventory of Complicated Grief) to one of four groups: citalopram only (CIT, median dose 40 mg for 12 weeks), placebo only, combined CGT and citalopram treatment, or CGT and placebo treatment.

> "In contrast, response to targeted psychotherapy for complicated grief was substantial."
> —Katherine Shear, M.D.

Follow-up assessments took place 4, 8, 12, 16, and 20 weeks after the first treatment visit and six months after study treatment termination.

The authors found that patients who received CGT with placebo showed greater improvements than those who received placebo alone (82.5 percent versus 54.8 percent). However, the addition of citalopram was not found to significantly improve CGT outcome (CGT with CIT versus CGT with placebo: 83.7 percent versus 82.5 percent). In contrast, depressive symptoms decreased significantly more when CIT was added to treatment (CGT with CIT versus CGT with placebo: Quick Inventory of Depressive Symptoms mean difference, -2.06).

"We were surprised that we did not see more of an effect with the antidepressant," said Shear. "In contrast, response to targeted psychotherapy for complicated grief was substantial."

Although most psychiatrists are aware of the immense impact that losing a loved one can have on a patient, Shear said greater efforts are needed to train clinicians on how to recognize and treat the symptoms of complicated grief.

This research was funded by the National Institute of Mental Health. PN

An abstract of "Optimizing Treatment of Complicated Grief" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=2526240.

Lithium May Reduce Self-Harm, Injury In Patients With Bipolar Disorder

Lithium performed better than valproate, quetiapine, and olanzapine among patients on one maintenance medication, while the other three showed comparable rates.

BY NICK ZAGORSKI

Patients with bipolar disorder have increased risks of self-harm and suicide, but determining the medications that might best mitigate this risk has been difficult, due to the fact most trials exclude those with a history of suicidal behavior. A study published this month in *JAMA Psychiatry* now suggests lithium may help to lower rates of self-harm and unintentional injury in patients with bipolar disorder compared with those prescribed other common maintenance treatments for the disorder.

A team of researchers at University College London (UCL) and the University of Oxford analyzed electronic health record (EHR) data from 6,671 patients with bipolar disorder who were prescribed either lithium, the anticonvulsant valproate, or the antipsychotics olanzapine or quetiapine—the four most common medications given for bipolar maintenance therapy in the United Kingdom. They then compared the rates of suicide, self-harm, and unintentional harm (for example, falls or car accidents) among this population.

Olimpik/Shutterstock

Lead author Joseph Hayes, M.B.Ch.B., a clinical research fellow in the Division of Psychiatry at UCL, told *Psychiatric News* that it was important to examine unintentional harm because it is a common yet understudied outcome of bipolar disorder; studies have shown that deaths from accidental injury are around six times higher in people with bipolar disorder.

"In addition, unintentional injuries are believed to arise from manic as opposed to depressive symptoms," Hayes said. "So the best medication to treat deliberate harm may not be the best at reducing unintentional harm."

The results of the analysis by Hayes and colleagues suggest that lithium may, in fact, be most appropriate for both.

The authors found that self-harm rates in patients prescribed lithium were about 205 incidents per 10,000 person-years at risk (PYAR) compared with 392 for valproate, 409 for olanzapine, and 582 for quetiapine. Lithium also resulted in fewer cases of unintentional harm (583 per 10,000 PYAR) than valproate (669) or quetiapine (705), but was similar to olanzapine (569 per 10,000 PYAR). The number of suicides was too low to uncover differences among these four medications.

The observed superiority of lithium in reducing self-harm and unintentional injury suggests that the medication may reduce impulsive behaviors in addition to stabilizing mood, suggested Hayes. While he noted it is possible that clinician monitoring of lithium (due to the medication's potential toxicity) may improve adherence, the analysis found that lithium patients had the same amount of physician contact as patients taking other medications.

While Hayes and colleagues attempted to adjust the results for all possible factors that might also affect patient outcomes, such as demographics or clinical history, subtle but important elements of clinician decision-making could not be analyzed, Michael Ostacher, M.D., M.P.H., an associate professor of psychiatry at Stanford University School of Medicine, told *Psychiatric News*.

"You can account for a lot of confounding variables, but you can't adjust for a clinician's gut feeling," Ostacher, who was not involved with this study, said. For instance, because lithium has a narrow dosage window between being therapeutic and toxic, a clinician may be less likely to prescribe the medication to those at greatest risk of self-harm, he said. As a result, "the population that received lithium might be less prone to commit harm to begin with," he explained.

"Still, I believe lithium is an effective but underutilized medication and am not opposed to any data that suggests we should use lithium more," he continued. (Ostacher is part of a multi-center prospective study examining the effects of add-on lithium in veterans with major depression or bipolar disorder and suicidal behaviors.)

Hayes acknowledged that while his study could not take every possible variable into account, he believes the findings of the trial are an important step forward.

"There is growing evidence that lithium works better than other drugs for mood stabilization, and little evidence that these other drugs have a positive impact on self-harm," he said. "So I believe the case for use of lithium as a first-line therapy is getting stronger. Of course, we always need to be mindful of the potential side effects of all bipolar drugs and work to mitigate or minimize these, and I think further research on how to do this is necessary."

This work was supported by a Medical Research Council Population Health Scientist Fellowship. PN

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cuss principles of integrated behavioral health care; describe the roles for a primary care consulting psychiatrist in an integrated care team; and apply a primary care–oriented approach to psychiatric consultation for common behavioral health presentations.

The course will also educate psychiatrists on how to engage in TCPI and connect with primary care networks in their regions that are recruiting psychiatrists with integrated care training.

Speakers include Raney; Erik Vanderlip, M.D., M.P.H., a physician dually trained in family medicine and psychiatry and coauthor of a recent APA resource document on integrated care; and Anna Ratzliff, M.D., Ph.D., and Lydia Chwastiak, M.D., of the AIMS Center. They will present didactic material, facilitate group exercises, and include time for questions and discussion.

Apart from the TCPI training, APA will offer multiple workshops, lectures, and alternative learning experiences throughout the conference. Raney drew special attention to sessions that focus on using technology, including telepsychiatry, to expand the scope of integrated care

On Thursday morning, October 6, Ratzliff and colleagues from the University of Washington will discuss residency training in integrated care during the session "Building an Integrated Care Training Program."

Later that day, physicians from the American Association of Community Psychiatrists will present the session "Integrated Care and the Role of the Community Psychiatry Fellowship." And Vanderlip, Ratzliff, and Chwastiak will lead the innovative "Collaborative Care Simulation Lab," in which participants will use case vignettes to role play the care of patients in a collaborative care system.

On Friday, October 7, experiences in integrated care in diverse parts of the country will be addressed in the session "Community Clinics on the Continuum of Integrated Care: Lessons Learned in Cleveland, Miami, and New York City." Alternative models of integrated care will be investigated in the sessions "Collaborative Care: One Size Doesn't Fit All" and "Care Coordination for Behavioral Health Problems in Primary Care Settings: How Far Can We Stretch This Approach?"

Also on Friday, Vanderlip will lead the perennially popular course on primary care skills for psychiatrists.

Saturday, October 8, is reserved for the TCPI training, and on Sunday, October 9, integrated care goes international when Unützer and colleagues lead the symposium "Challenges and Opportunities in Implementing Collaborative Mental Health Care in Low- and Middle-Income Countries."

Also on Sunday, Benjamin Druss, M.D., and colleagues will look at emerging models of integrated care and the role psychiatrists can play in addressing the 20- to 30-year mortality gap among those with serious mental illness.

"We are offering the standards in integrated care, but we hope to provide conference participants this year other options for expansion and implementation," Raney said. "How far can we push this model of collaborative care by really thinking outside of the box?" PN

The preliminary program for IPS: The Mental Health Services Conference is posted at https://www.psychiatry.org/psychiatrists/meetings.

CLINICAL & RESEARCH NEWS

Metabolites Offer New Clues About Medication Response

The nascent field of pharmacometabolomics is hoping to use the thousands of chemicals circulating in the body as objective biomarkers that can help identify which patients will respond best to psychiatric medications.

BY NICK ZAGORSKI

Over the past decade or so, mental health researchers have become increasingly aware of how pharmacology and genomics can inform their efforts to improve the response of patients to prescribed medications.

While there have been some promising breakthroughs—recent studies of note have uncovered genetic variants that could be linked with response to acamprosate (for alcoholism) and clozapine (for psychosis)—more often than not efforts to mine the genome for biomarkers have come up empty.

This is especially true of efforts to identify biomarkers for depression.

According to Richard Weinshilboum, M.D., a professor of pharmacology at the Mayo Clinic, there are a couple of factors that may explain the disappointing returns.

"Phenotypic heterogeneity [in depression] is a major problem" when trying to identify biomarkers for depression, he told *Psychiatric News*. For example, while anhedonia (loss of feeling pleasure) is considered a common symptom of depression, not everyone with depression reports anhedonia, nor does everyone with anhedonia suffer from depression.

A second factor that complicates the ability of researchers to uncover biomarkers for depression involves how patient response to treatment is measured. While sobriety and symptoms of psychosis are relatively objective clinical states, measuring mood can be more subjective.

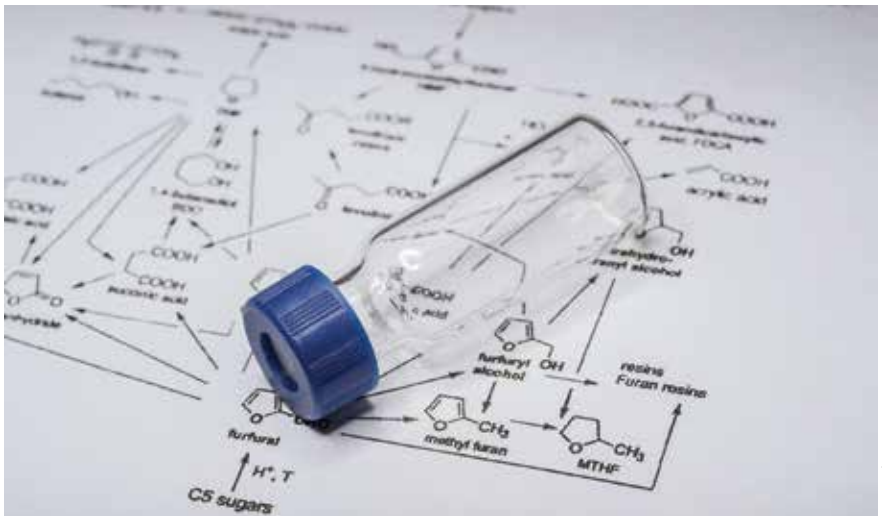
"What we need is to move closer to a biological phenotype for depression," he said.

In that regard, another field of "omics" might provide help—metabolomics.

"Genes can only tell you what might happen, but metabolites are a reflection of what is happening once you introduce something like medication into a body," Oliver Fiehn, Ph.D., a professor of molecular and cellular biology at the University of California, Davis told *Psychiatric News*.

Metabolomics relies on deep phenotyping, acquiring metabolite samples of patients (typically from blood or urine) before and after they take medications to identify metabolic parameters that correlate with drug response. These metabolic profiles are then used to inform genomic searches.

In 2011 Fiehn and colleagues analyzed about 100 common metabolites in 20 depression patients who achieved remission using citalopram along with a comparable set of non-remitters. Their analysis revealed that remitters had much lower levels of the amino acid glycine in their blood.



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These results led them to compare several genes related to glycine metabolism in two different sets of patients enrolled in depression studies. They discovered a variant in the gene for glycine dehydrogenase (which breaks down excess glycine in the body) that was associated with a better outcome after taking selective serotonin reuptake inhibitors (SSRIs), such as citalopram.

While glycine might seem an unusual marker for SSRIs, Fiehn noted that it is a neurotransmitter (particularly abundant in the spinal cord) in addition to an amino acid, so there may be some biological interactions that are worth pursuing.

Earlier this year, Weinshilboum led another study that looked at metabolic changes in response to citalopram (and the related escitalopram) therapy. The group analyzed a set of 31 metabolites that were all ringed molecules such as serotonin, tryptophan, or vitamin A.

see ***Metabolites*** *on page 30*

Determining Onset Timing of Postpartum Depression May Lead to Improvements in Treatment

An assessment of over 700 new mothers identified five symptoms that substantially differed between women whose depression emerged before, during, or after pregnancy.

BY NICK ZAGORSKI

It is well known that postpartum depression is a common disorder that can adversely affect the health of both the mother and child. What is less talked about, experts say, is how important identifying when a mother's depression originates might be to guiding treatment decisions.

"The onset time of depression diagnosed in a postpartum woman has implications for the potential severity of the disease and how it should be treated," Sheehan Fisher, Ph.D., an instructor of psychiatry and behavioral sciences at Northwestern University Feinberg School of Medicine, told *Psychiatric News*. However, the natural fluctuations in a woman's hormones and mood during and after pregnancy can make it difficult to pinpoint just when symptoms of depression first emerge.

In an effort to identify characteristics that might distinguish the time of onset and type of depression identified during the postpartum period, Fisher and colleagues from Northwestern and the University of Pittsburgh assessed 727 mothers who had received a diagnosis of postpartum depression four to six weeks after giving birth.

The study participants were given a comprehensive clinical assessment to categorize all their symptoms and identify the depression onset date. The assessment revealed that 25 percent of the women developed depression before pregnancy, 37 percent during pregnancy, and 38 percent after the birth of their child; 75 percent of the women were diagnosed with unipolar depression and 25 percent had bipolar depression.

The women were screened using the Structured Clinical Interview for *DSM-IV* (SCID) for Axis I Disorders and the Structured Interview Guide for the Hamilton Depression Rating Scale-Atypical Depression Symptoms (SIGH-ADS), a comprehensive assessment that looks at 21 typical and eight atypical depressive symptoms. Of these 29 symptoms, four (difficulty falling asleep, hypersomnia, paranoia, and obsessive-compulsive traits) were substantially different between the groups.

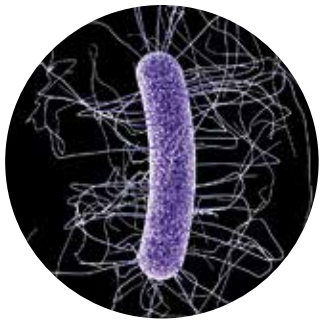
> "Clinicians cannot just look at total [SIGH-ADS] scores when trying to diagnose the onset of depression in a postpartum woman."
>
> —Sheehan Fisher, Ph.D.

Women who had depression before they became pregnant were more likely to have experienced paranoia, insomnia, or hypersomnia during the course of illness, whereas obsessive-compulsive symptoms were most pronounced in women who developed depression in the postpartum

see ***Postpartum*** *on page 31*

Experts at BIO Convention Discuss Link Between Infection, Psychiatric Disorders

Infections can trigger some neuropsychiatric disorders through inflammation and autoimmune reactions. A group of clinicians and researchers discussed how clinicians from different medical specialties might work together to improve the diagnosis and treatment of these conditions.



BY JUN YAN, PHARM.D.

There is mounting evidence to suggest underlying connections linking infection, inflammation, and autoimmunity to a surprising number of neuropsychiatric disorders. At the 2016 BIO International Convention in June, a group of clinicians and researchers discussed the apparently rising incidence of these disorders and what can be done to better diagnose and treat them.

"We're seeing a rapid increase in bipolar-like syndromes in pediatric patients," Kiki Chang, M.D., a professor of psychiatry and behavioral sciences at Stanford University Medical Center, said during the panel discussion. Chang is a child psychiatrist at a specialty clinic in Stanford's Pediatrics Department, which treats children with pediatric acute-onset neuropsychiatric syndrome (PANS).

Children with PANS have a combination of neuropsychiatric symptoms, including obsessive-compulsive behaviors, tics, irritability, anxiety, emotional lability, and aggression. The syndrome has a sudden onset, often overnight, and occurs primarily in boys, according to Chang.

One of the known causes of PANS is streptococcal infection. Some children develop antibodies that cross-react with neural proteins, which leads to inflammation in the basal ganglia and causes pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections (PANDAS), a subset of PANS. Most children with strep throat do not develop PANS or PANDAS, which has led some researchers to believe that those who do develop the syndrome may have genetic variations related to the immune system that render them more vulnerable, Chang said. If researchers are able to pinpoint these genetic variations, they may also uncover new clues about the mechanisms of certain neuropsychiatric and developmental disorders.

The panelists also discussed the role of immunological factors in neuropsychiatric disorders, including mood disorders, dementia, and autism.

"There is a surprising amount of information to support the association between inflammatory symptoms and, for example, autism, but it remains unclear whether the association is cause or effect," said Dennis Wall, Ph.D., an associate professor of pediatrics at Stanford University School of Medicine.

Wall's laboratory is sequencing the genomes of thousands of family members of children with autism and using bioinformatics tools to map a clearer picture of the genotypes and phenotypes of the disorder.

Among suspected environmental contributors to autism, the bacterial flora in the human gut, also known as microbiome, is garnering more attention of researchers, Wall noted. Scientists are only beginning to genotype the DNA of gut bacteria to understand the differences among individuals and the possible effects of abnormal gut microbiome on health. (Wall's laboratory is sequencing the microbiome DNA of patients with autism in collaboration with the American Gut Project with the hope of identifying disease signatures.)

Panelist Jonas Korlach, Ph.D., the chief scientific officer of Pacific Biosciences, a company specialized in genomic sequencing, described a growing body of published cases of abnormal (e.g., lack of bacteria diversity and abundance) gut bacterial ecology in patients with autism. For example, he noted one study found using antibiotics to suppress Clostridium difficile infection in the gut was associated with behavioral improvements. Korlach, whose son has autism, recounted his search of tests for measuring metabolic and microbiome imbalances that may be the causes or contributors of his son's autism. He believes that treating these imbalances may help to reduce autistic symptoms.

As a child psychiatrist, Chang has seen an uptick in not only the number but also the complexity of neuropsychiatric disorders in the clinic, he said. "They have ceased to fit into … nice little psychiatric [diagnostic] boxes anymore." He pointed out that inflammation has only recently been recognized as a possible mechanism leading to neuropsychiatric disorders, but the concurrent and dramatic rise in the incidences of neurodevelopmental disorders and autoimmune diseases, particularly food allergies, should prompt more investigation. He also noted the high incidence of psychiatric comorbidities in patients with inflammatory and autoimmune diseases.

The panel all agreed that medical specialties need to break out of silos and diagnose and treat neuropsychiatric diseases from a whole-body perspective.

"I work directly with a rheumatologist … and infection disease [specialists]," said Chang. He pointed to personal experience in successfully treating children with neuropsychiatric disorders with anti-inflammatory, immunosuppressive, and antibiotic agents. "This is the next frontier." PN

Integrated Care

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from the outset was to help the primary care providers manage the mental health needs of their patients. We provided formal and informal consultations and brief treatment and triaged those patients who needed (or wanted) ongoing or intensive care to a general psychiatry clinic.

Over time and influenced by the work of Ed Wagner, Wayne Katon, and Jürgen Unützer (among others), the service has gradually adopted a population-based, proactive style of integration utilizing screening and a collaborative care model with consulting psychiatrists, embedded therapists, and care managers.

As the service grew, training of residents and workforce development followed. It soon became apparent that the pace of the work (high volumes of new patients and quicker turnover compared with general psychiatry) was a challenge for staff and trainees. Beyond the labor involved with the sheer number of discrete patients seen, some staff missed the satisfaction of longer-term relationships with patients. This was most difficult for staff who transitioned from a traditional delivery model. Conversely, traditionally trained consult psychiatrists sometimes struggled with the ongoing responsibilities for patients inherent in ambulatory work and with the fact that some patients seen in primary care have no comorbid medical illness.

Despite these challenges, there seems little doubt about the value of integrated care in a safety-net population, including communities relatively well endowed with mental health providers. Even in Cambridge, the mismatch between the prevalence of psychiatric morbidity and access to conventional psychiatric care is acute. Our integrated program has dramatically improved access, and our providers feel well supported by the initiative. One primary care colleague recently commented that the integration service has elevated the quality of psychiatric care he is able to provide and went on to speculate about how this could be a valuable model for other specialists as well.

Finally, as noted in previous articles in this column, promoting workforce development and the training of psychiatrists along with emphasizing the rewarding nature of the consultant's work is crucial to sustaining this transformational effort. In addition to providing direct patient care, the psychiatric consultant is essential to the functioning of the treatment team. To be effective, the consultant must develop close working relationships with the members of a multifaceted treatment team while providing essential clinical expertise.

Most importantly, the consultant, in conjunction with the treatment team, can take satisfaction in helping many patients who otherwise would receive no care. PN

Metabolites

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Similar to the glycine studies, the researchers saw that a greater drop in plasma serotonin concentration following SSRI treatment correlated with a strong medication response; a subsequent genome-wide analysis using this metabolic profile uncovered two genetic variants linked to positive outcome.

"These are two genes that no one probably would have thought about as associated with an SSRI—in fact [one of them] didn't even have a name when we initially made the connection," Weinshilboum said, highlighting the potential of metabolomics to uncover unexpected connections.

While such results are encouraging, Fiehn cautioned that there are multiple obstacles to overcome as the

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LETTERS TO THE EDITOR

Reducing Prescription Drug Abuse

We as psychiatrists are well aware that prescription drug abuse is a serious health problem of epidemic proportions in this country. Patients are often unable or unwilling to disclose their use of controlled substances, leaving prescribers and pharmacies unaware of the potential for harmful drug interactions and risk of overdose. De Marco and coworkers found that psychiatric patients are especially vulnerable to controlled substance misuse.

We need to be proactive in identifying and helping patients who are abusing prescription medications. Patients whom I have treated for such abuse report that they feel more relief than they expected. They are also more receptive to healthy lifestyle changes such as sleep hygiene, regular gentle exercise, and healthy eating. Being in treatment for substance abuse can provide a window of opportunity for compliance with psychotherapy.

To protect vulnerable patients, I believe that psychiatric outpatient clinics and acute care wards should establish prescribing standards for medications that are frequently abused. At intake and follow-up appointments these standards for safe prescribing should be shared with patients so that patients are aware that there is organizational support for prescribers who want to be careful about the amount, frequency, and duration of prescribed controlled substances. Also, before prescribing a controlled substance, we need to take the time to review the state prescription drug monitoring program database.

Moreover, we need to be sensitive to the warning signs that patients may be abusing controlled substances, such as multiple doctor switching, multiple doctors prescribing at the same time, frequent reports of lost or stolen scripts, refusing to get police reports to document these claims, phone calls from multiple states demanding refills to be called in to a pharmacy outside the state, and verbal abuse of prescribers who want to check that the medication is being used properly.

Access to treatment continues to be a problem, and I urge more psychiatrists to get training to prescribe buprenorphine, Suboxone, and other medication-assisted treatments. Health care organizations should have policies to identify dual-diagnosis patients so that doctor switching and other unhealthy ways of coping with addictions are addressed within short-term and long-term goals outlined in the patients' initial treatment plan.

GERALDINE IDONIBOYE, M.D.
Johnstown, PA.

Parting Words

Twenty-five years ago, in these pages, I proposed a nationwide—eventually, a worldwide—computerized patient-information system listing, in chronological order and updated periodically, individual patients' diagnoses, characteristic symptoms, and treatment. Such a system could help reduce the incidence of misdiagnosed, factitious, and malingered cases.

As I now prepare to retire from psychiatric practice, no such unitary system exists. Instead, there has been a proliferation of mutually incompatible systems that do not intercommunicate. The perverse argument that such chaos affords additional protection for patients' confidentiality was tellingly answered some years ago by a *Newsweek* article titled "Confidentiality Can Kill."

If a unitary medical information system existed, imagine falling ill while traveling far from home. A local physician enters your secure identifiers into the system and immediately receives the complete case history needed to help plan your treatment. Such a system could be lifesaving.

Approaching retirement, I would like to make another proposal.

Soon after I began residency training, I consulted the program director about a patient who was diagnosed with schizophrenia.

"Viral schizophrenia?" riposted the director.

He was using gentle sarcasm to remind me that *DSM-III* required specific names for particular "types" of schizophrenia. I had consciously omitted stating one, as it seemed to me immaterial to the patient's treatment. Now the current *DSM-5*, published in 2013, does without the old schizophrenia typology (though ICD-10 retains it).

About the time that I was completing my residency, our profession's program of rationalizing psychiatric terminology had replaced the Greek diagnostic term "paranoia" with the more intuitive "delusional disorder," and it seemed to me that it might be time to do something about the last weird Greek term, "schizophrenia"—which a psychiatrically naïve public has tended to interpret as "split personality" and which pretentious commentators use in describing "schizophrenic" (paradoxical or dilemmatic) life situations. Switching to a more transparent term would seem especially appropriate as we do not know the cause of what the term's author, Eugen Bleuler, pointedly referred to in the plural as "the schizophrenias."

In a February 2 editorial in the *BMJ* titled " 'Schizophrenia' Does Not Exist," Dutch psychiatry professor Jim van Os has proposed renaming "schizophrenia" to "psychosis spectrum disorder." He argues that the term "schizophrenia" only reifies an apparently heterogeneous diagnostic construct, obfuscates the nature of the syndromes in question, and creates an unhelpful sense of hopelessness about their prognoses.

Replacing the term "schizophrenia" with something more intuitive might take "schizophrenic situations" out of public discourse and remove some of the recondite aura that still surrounds psychiatry. PN

CHRISTOPHER KASPAREK, M.D.
Salinas, Calif.

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field of pharmacometabolomics moves forward.

"Metabolites come in more than 50 shades of gray," he said. "There are thousands and thousands of different chemicals in our bodies, and unlike DNA or proteins that are built from discrete building blocks there is no common denominator for metabolites."

Because current technology allows only for a limited number of related metabolites to be analyzed together, Fiehn noted it will take a while to accumulate and validate a comprehensive library of metabolic profiles that might be predictive of drug response.

Another challenge for the field moving forward is whether the activity of metabolites in the blood accurately reflects what goes on in the brain.

Biological tests on any genetic variants identified through a metabolite-guided process—usually in cultured lab cells or animal models—can offer insight as to the role metabolites might play in the brain.

Despite these and other hurdles, Fiehn is optimistic about the future of metabolomics: "These studies are bringing us to a more thorough understanding how these medications operate which helps with choosing both current treatments and designing the next generation," he said. PN

"Glycine and a Glycine Dehydrogenase (GLDC) SNP as Citalopram/Escitalopram Response Biomarkers in Depression: Pharmacometabolomics-Informed Pharmacogenomics" is posted at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3034442/. "TSPAN5, ERICH3 and Selective Serotonin Reuptake Inhibitors in Major Depressive Disorder: Pharmacometabolomics-Informed Pharmacogenomics" is posted at http://www.nature.com/mp/journal/vaop/ncurrent/full/mp20166a.html.

Postpartum

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period and least pronounced in those with an onset during pregnancy.

Fisher said that these symptomatic differences are not surprising, as postpartum depression is often tied to concerns over the health and safety of the newborn child.

The authors also examined whether any symptoms could differentiate unipolar and bipolar depression, and found that agitation was significantly higher in women who received a bipolar diagnosis, regardless of onset time.

When looking at composite scores on clinical assessments, the differences between the groups were limited. While women with pre-pregnancy depression had a marginally significant increase in total SIGH-ADS score compared with the other two groups, there was almost no difference when factoring in the score for only the 21 typical symptoms.

The findings suggest that "clinicians cannot just look at total scores when trying to diagnose the onset of depression in a postpartum woman," Fisher told *Psychiatric News*.

"The differentiation of chronic, semi-acute, and acute depression reveals the vulnerability and resiliency of the depression identified in the postpartum," Fisher and colleagues wrote. "A comprehensive assessment of onset timing, typical and atypical symptoms, and unipolar versus bipolar disorder is recommended to improve the effectiveness of postpartum treatment."

This study was published May 28 in the *Journal of Affective Disorders* and was supported by a grant from the National Institute of Mental Health. PN

An abstract of "Factors Associated With Onset Timing, Symptoms, and Severity of Depression Identified in the Postpartum Period" is posted at http://www.jad-journal.com/article/S0165-0327(16)30608-5/abstract.

CMS

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provides the primary care practice with expert advice and consultation through regular case review and recommendations for treatment and medication adjustments. In especially difficult cases, the psychiatrist may also provide direct treatment.

APA is in the process of analyzing the proposed values for the codes to determine whether they are sufficient to support the CoCM model. APA leadership and staff will have more than one avenue through which to properly value the codes—through comments submitted to CMS and through APA's participation in the Relative Value Update Committee (RUC) valuation process.

The RUC, created by the AMA in 1991, advises CMS about changes in the "relative value units" used in the formula for determining physician payment under Medicare. The 29-member committee—with representatives from the AMA, APA, and other specialties—offers recommendations about the relative value units that result in payment for every reimbursable code in the *Current Procedural Terminology Manual* and helps to derive values for newly introduced procedures that receive codes.

"The APA administration is continuing to review the rule for specifics and will work with CMS to ensure that there is adequate compensation to support the work of psychiatrists in collaborative care networks," Levin said.

Medicare coverage for collaborative care services and adoption of the related codes is an important step in the evolution of integrated care. It is part of a larger strategy that CMS says is designed to pay physicians for value of care provided (as opposed to paying for the volume of services) and to reward physicians to spend more time with patients. In the proposed rule, for instance, CMS is also proposing that Medicare pay for cognitive and functional assessment and care planning for patients with cognitive impairment, including patients with Alzheimer's.

"Today's proposals are intended to give a significant lift to the practice of primary care and to boost the time physicians can spend with their patients listening, advising, and coordinating their care—both for physical and mental health," CMS Acting Administrator Andrew Slavitt said in a statement on the CMS website. "If this rule is finalized, it will put our nation's money where its mouth is by continuing to recognize the importance of prevention, wellness, and mental health and chronic disease management."

These Psychiatric Collaborative Care Management Services may be billed on a monthly basis by the primary care provider who employs a behavioral health care manager and has a separate financial arrangement to reimburse the psychiatrist. These are the temporary "G" codes for 2017 that have been included in the proposed rule:

- **GPPP1:** Initial psychiatric collaborative care management, with 70 minutes of behavioral health care manager time.

- **GPPP2:** Subsequent psychiatric collaborative care management, with 60 minutes of behavioral health care manager time.

- **GPPP3:** Additional 30 minutes of behavioral health care manager activities.

These are similar to the Psychiatric Collaborative Care Management codes that the CPT Editorial Panel approved for use starting in 2018.

The CPT coding proposal was brought by APA, with the assistance and participation of several other medical specialty societies, including the American Academy of Child and Adolescent Psychiatry, the American Academy of Family Physicians, and the American College of Physicians.

Importantly, APA received a grant from CMS through its Transforming Clinical Practice Initiative to train psychiatrists and primary care physicians in the CoCM and to encourage systems to implement the model. Training will be provided online and at APA meetings, including the upcoming IPS: The Mental Health Services Conference in Washington, D.C., in October (see page 17). PN

Information about the Transforming Clinical Practice Initiative and APA's free training for psychiatrists is posted at http://www.psychiatry.org/SAN. More information about the proposed rule is posted at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-07-07.html.