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PSYCHIATRIC NEWS

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AP Photo/Henry Burroughs

Republican presidential candidate Barry Goldwater greets supporters in 1964 in Rock Island, Illinois. Comments by psychiatrists questioning Goldwater's psychological fitness for office at that time led to the creation of APA's "Goldwater Rule" in 1973. Discussion of the rule has surfaced again as the nation gets swept up in media speculation about the mental status of another Republican presidential candidate.

History of Goldwater Rule Recalled As Media Try to Diagnose Trump

APA's Goldwater Rule retains its relevance today, as the 2016 presidential campaign reveals.

BY AARON LEVIN

What began as one of the strangest presidential campaigns in living memory became even stranger in August when columnists and op-ed writers decided en masse to diagnose one of the candidates with mental illness.

On the same day in the *Washington Post,* Robert Kagan referred to the Republican nominee as "a man with a disordered personality," and Eugene Robinson said, "I am convinced that he's just plain crazy."

Keith Olbermann, writing in *Vanity Fair,* hauled a bit of science into the arena, using the Hare Psychopathology Checklist to rate Donald Trump. He awarded the candidate 32 out of a possible 40 points, clearly above the 30-point cutoff for certifiable psychopathy. (Olbermann did not complete a checklist for Trump's Democratic opponent, or anyone else, as a control.)

Charles Krauthammer, who at least trained as a psychiatrist, referred to Donald Trump's "hypersensitivity and unedited, untampered Pavlovian responses" and concluded: "This is beyond narcissism."

Maureen Dowd of the *New York Times* went so far as to fantasize the Republican candidate waking up on Inauguration Day 2017, marveling at his new surroundings until, in the last paragraph, she reveals him as being not in the White House, but being escorted down the hall by two white-coated orderlies for his "impulse-control/delusion-reduction therapy."

Not to be outdone by mere pundits, Trump himself called Hillary Clinton "unbalanced" and "a totally unhinged person."

"Honestly, I don't think she's all there," he said.

With all these amateur (or semi-professional) mental health experts weighing in, why shouldn't practicing psychiatrists add their finely tuned wisdom to the discussion?

Because it's unethical, at least for APA

see ***Vote*** *on page 31*

When Should Psychiatrists Manage Medical Conditions?

The decision algorithm developed by leaders in integrated care can give psychiatrists some guidance on when it is appropriate to treat patients with common conditions.

BY MARK MORAN

Psychiatrists may increasingly be counted on to provide basic primary care—screening for and treating common conditions—to those with serious mental illness and/or substance use disorders.

But when and under what circumstances is that appropriate or necessary?

A "decision algorithm" comprising five domains—the nature and severity of the problem, the patient's access to existing primary care services, the general medical training and comfort of the psychiatrist, the capacity of the provider's environment for management and follow-up, and patient preference—can help psychiatrists determine when their primary care skills are necessary and appropriate.

The decision algorithm was developed by Erik Vanderlip, M.D., M.P.H., the George Kaiser Family Foundation Chair in Psychiatry and an assistant professor in the departments of Psychiatry and Medical Informatics at the University of Oklahoma and a member of APA's Council on Psychosomatic Medicine; Lori Raney, M.D., principal of Health Management Associates in Denver, Colorado, and chair of the APA Work Group on Integrated Care; and Benjamin Druss,

see ***Manage*** *on page 39*

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

PSYCHIATRIC NEWS

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FROM THE PRESIDENT

The FDA Is Listening

BY MARIA A. OQUENDO, M.D.

I must admit I always feel a little wary when giving a radio interview and questions are being called in by the public. I wait, wondering what's next and hoping I can be helpful. In fact, calls are usually from individuals with questions about how to best help themselves or their loved ones. Not that these calls are easy to handle on the air, like the one a few years ago from a mother of a suicidal adolescent who clearly needed an emergency department evaluation.

But then it happened. "Hello, my name is Joe, and I'm calling from Oregon." After the warm greeting, his tone changed, as he sharply questioned how psychiatrists could support a barbaric treatment such as ECT. I did my best to counter with information about the evidence for its safety and life-saving effects, explaining that this excellent treatment was often vilified unjustly. I do not believe Joe was convinced.

Not one week later, I was pleasantly surprised to receive an invitation from Robert M. Califf, M.D., commissioner of the Food and Drug Administration (FDA). The invitation was to participate in the FDA's stakeholder listening session as this issue of *Psychiatric News* went to press. The goal is to provide APA and other thought leaders with the opportunity to bring burning issues to the attention of the FDA.

I should note that there were several sources of surprise to me with regard to this invitation—perhaps the most salient one was the notion that a major federal agency would use some of the same strategies that we use in global mental health (GMH) research. Community-based participatory research in GMH settings employs focus groups and other community-engagement approaches to ensure that the research design ultimately is informed by the viewpoints of key stakeholders. The idea is that the research design does not come from "on high" but rather is a product of a close collaboration with the community and local agencies and universities. This strategy promotes not only "buy in," but optimally "want in." Similarly, the FDA is clearly seeking to engage those of us most affected by its decisions—patients and their families, physicians, and health care delivery services—to maximize the likelihood that its policies will take into account the nuances of the "real world" and ultimately be better received.

Given Joe's call, it will not shock you that the APA administration and I selected support for the FDA's proposed rule change to reclassify ECT devices from Class III (high risk) to Class II (low risk) as a key item to discuss. We will talk with the FDA about the utility and safety of ECT and the need to enhance its availability, injecting robust data into the debate. But ECT is only one of the topics that we will raise with the FDA. We will also encourage a review of prescription practices in view of the opioid epidemic and underscore the need for ensuring diversity in clinical-trial samples to generate data applicable to the diverse U.S. population.

Now, I don't know if Joe will be at the FDA hearing, and even if he were, I am not sure he would be convinced. But what I do know is that we need to be persistent in adhering to the dissemination of the best data available about treatments that work, treatments that save lives. PN


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IN THIS ISSUE

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, special tracks, and housing can be accessed at psychiatry.org/IPS. For additional information on the meeting, see page 22.

Departments

Confidentiality: When Does It Give Way To Other Ethical Imperatives?

One expert describes a tension between the enduring psychiatric ethical principle of confidentiality and that of "paternalism," the ethical imperative to do what psychiatrists think is best for patients.

BY MARK MORAN

When 21-year-old Susanna Gabay left a Eugene, Oregon, hospital in early April 2010 after being treated for a psychotic episode—apparently successfully—she returned to her apartment in town with an appointment to see a community psychiatrist a month later, on May 5.

But Susanna never made it to the follow-up appointment, and on May 6 she took her own life. Her parents, Jerry and Susan Gabay, told *Psychiatric News* that though Susanna had signed an authorization allowing release of information to her family, they were in fact given scant information about the nature of her condition and, crucially, were not told of her risk for suicide.

The tragedy of Susanna's death may have stemmed from the shortened hospital stays and failure to coordinate follow-up care that have been endemic in a fragmented mental health care system. But Jerry and Susan also believe the lack of communication from the hospital and clinicians who treated her—despite Susanna's authorization—left them blind to the seriousness of her condition. They say her death is attributable in part to a "culture of silence" among clinicians about sharing information with family members and caregivers.

The Gabays believe clinicians are too inclined, by training and long tradition, to err on the side of caution about sharing information—a tendency abetted by what they also believe is an overly-restrictive interpretation of the Privacy Rule within the Health Insurance Portability and Accountability Act (HIPAA).

Since their daughter's death, the Gabays have championed the rights of family members and caregivers to have access to information about loved ones being treated for serious mental illness. They were instrumental in the passage of a law last year by the Oregon legislature that clarifies conditions under which protected health information may be disclosed by a health care provider, consistent with HIPAA, without obtaining an authorization from the individual and without incurring liability.

"At minimum, providers must be encouraged to seek authorizations to communicate with appropriate supporters of the patient and then actually communicate," Jerry, a board member of the Oregon National Alliance on Mental Illness, told lawmakers during testimony on the bill.

The Gabays also helped to develop, with the support of the Oregon Council on Child and Adolescent Psychiatry and the Oregon Psychiatric Physicians Association, resource materials to guide both clinicians and family members about the circumstances under which information—and what kind of information—can and should be divulged. In an interview with *Psychiatric News*, Susan Gabay said, "The responsibility to protect the safety of the patient trumps confidentiality."

Navigating Between Confidentiality and "Paternalism"

Confidentiality is a bedrock ethical principle of psychiatry: the nature of mental illness and the suffering that brings patients to a psychiatrist render what transpires between therapist and patient especially sacrosanct—and in some people's opinion, inviolable.

But this longstanding ethical principle can come into conflict with a recovery movement that has empowered family members and caregivers to expect that clinicians will share information vital to their loved one's recovery. The tension between these two conflicting precepts has been heightened as well by publicity about acts of violence committed by individuals treated for mental illness.

In the wake of the 2012 shooting at Sandy Hook Elementary School in Newtown, Connecticut, and subsequent Congressional hearings during which clinicians expressed confusion about what the HIPAA Privacy Rule allows or does not allow, the Office of Civil Rights in the Department of Health and Human Services issued a clarification, underscoring that clinicians could indeed disclose information about a patient's treatment under certain conditions (*Psychiatric News*, March 21, 2014).

Additionally, among the provisions in the Helping Families in Mental Health Crisis Act, sponsored by Rep. Tim Murphy (R.-Pa.), is one that calls on the secretary of Health and Human Services to promulgate final regulations clarifying circumstances under which a clinician may disclose the protected health information of a patient with mental illness to family. The bill was approved by the House 422-2 on July 6.

In an interview with *Psychiatric News*, Steven Kenny Hoge, M.D., chair of APA's Council on Psychiatry and Law, described the dilemma for clinicians as a tension between the demands of confidentiality and the competing ethical principle of "paternalism"—a term of art in medical ethics denoting the duty to do what is best for the patient.

"Imagine a patient who is a young man with schizophrenia. He is intermittently psychotic but denies that he

see ***Confidentiality*** *on page 39*

What Would You Do?

You are treating a patient with bipolar disorder and a past history of suicide attempt. He appears to be stable and doing well, but he tells you that recently he has stopped taking his medication. His parents are anxious to know of his progress, but the patient is 25 years old and has not authorized release of information about his treatment to family members. Would you disclose to the parents that the patient has ceased taking medication? What factors would you weigh in making your decision?

Write to *Psychiatric News* and tell us how you would deal with this clinical dilemma. We will publish a selection of responses, with commentary from experts. Send your responses to mmoran@psych.org.

Communicating With Family Members and Caregivers

The Oregon Council on Child and Adolescent Psychiatry, assisted by Jerry and Susan Gabay, issued "Suicide Prevention in Youth and Young Adults: Communicating With Families Saves Lives—A Checklist for Health Providers and Mental Health Practitioners." The checklist includes these steps:

- Complete a comprehensive risk assessment including patient interview, record review, and solicitation of information from family/parents. If you do not feel qualified to complete a comprehensive risk assessment, refer the patient for urgent evaluation and verify completion.
- If the patient is 18 or older, or if you believe confidentiality is required by law or common medical practice, seek an authorization to release information for the family/parents or document a compelling reason not to do so. Be assertive and persuasive in obtaining this authorization.
- Interview the family to obtain additional history about the patient and to determine what the family/parents already know about the illness/need for treatment. An authorization is not necessary to do this.
- Obtain authorizations to obtain information from all previous treatment providers and promptly request treatment records, including psychotherapy notes, psychiatric treatment, and relevant medical records.
- Review the medical records carefully to gain a comprehensive knowledge of risk factors for the patient.
- Following the initial evaluation, communicate with the patient and the family/parents regarding diagnoses, treatment recommendations, and safety issues. Do not assume they know anything about the nature of mental illness, treatment, risk factors, or community resources.
- Explicitly inform the family in the presence of the patient of all safety issues, including risk factors for suicide and what steps to take if danger exists, such as ridding the home of firearms/other means of self-harm and creating a plan to monitor and support the patient.
- Discuss available community resources to help the family and patient, including resources for case management, support groups, improving mental health at home, and other relevant factors.
- Coordinate provision of care when a patient transitions from one level of care to another, or from one provider to another.
- Involve the patient and family in the planning process, including discussion of interim safety plan.
- Assure follow-up is in place with a specific timely appointment.
- Assure that the follow-up provider has full knowledge of history and risk issues/records.
- Confirm that the patient has attended the follow-up appointment.

The checklist and other resources are posed at http://www.aacap.org/AACAP/Regional_Organizations/OCCAP/Suicide_Prevention_Communication_Checklist.aspx.

PROFESSIONAL NEWS

Generic, Class Substitution of Meds: Does it Harm Patients?

Clinicians discuss the benefits and risks of substituting generic for brand-name drugs, including a controversial proposal for "therapeutic substitution" of lower-cost drugs in the same therapeutic class.

BY MARK MORAN

Should generic medications be substituted at the pharmacy for prescribed brand-name formulations?

In light of widespread public concern about spiraling pharmaceutical drug prices, it's a question that is receiving some attention.

Psychiatric News spoke with clinicians about "generic substitution"—the practice of substituting a generic formulation of a brand-name drug—and the more controversial cost-control practice known as "therapeutic substitution." The latter, which is the substitution of a different, lower cost molecule for another prescribed medication in the same "therapeutic class," was the focus of a recent report in *JAMA Internal Medicine* that highlighted the potential cost-saving implications of therapeutic substitution.

While generic substitution is widely legal and commonly practiced, clinicians who spoke with *Psychiatric News* cautioned that how patients respond to generics can differ from how they respond to brand-name drugs.

"I think [generic substitution] is generally safe," said Philip Muskin, M.D., a professor of psychiatry at Columbia University Medical Center, chief of the Consultation-Liaison Psychiatry Service, and editor of *Psychiatric News PsychoPharm.* "There is little evidence to support the idea that generics are less effective. However, that doesn't necessarily mean they are the same. The chemical may be the same, but the preparation may be very different, and that can be important."

Pill coatings and inert ingredients that go into preparing the generic formulation may produce different, or worse, side effects in patients than those they experience with a brand. This may be particularly true for extended-release pills when a generic preparation may be absorbed at a very different rate than the brand. "The challenge for the patient and physician is to keep in mind that there may be side effects they have not seen before with a brand-name formulation," Muskin said.

Child psychiatrist Adelaid Robb, M.D., said she believes the safety of generic substitution depends not only on the patient, but also on the drug being prescribed. Robb noted that when the patent for Prozac ended and patients who had been receiving higher doses of the drug for obsessive-compulsive disorder (OCD) were switched to a generic formulation, some patients experienced the return of some symptoms.

University of Michigan School of Medicine

Gregory Dalack, M.D., a member of APA's Council on Quality Care, says a much better option than therapeutic substitution would be an alert in electronic health records that provides information about the options for therapeutic substitutions, including cost differentials.

"When they switched to the generic, they lost efficacy because the highest dose on the generic wasn't as high as

*see **Generic** on page 34*

Assembly Responds to Arkansas Law on 'Therapeutic Substitution'

iStock/alvarez

The 2013 Arkansas law appears to be the first in the nation explicitly authorizing substitution by a pharmacist of lower cost drugs for higher priced, brand-name medications in the same therapeutic class.

BY MARK MORAN

The APA Assembly has requested that the Association revisit its existing position statement on medication substitution, which addresses the substitution of lower cost generic medications for prescribed brand-name drugs by pharmacists.

An action paper approved at the Assembly meeting in May seeks to address concerns raised by a 2013 Arkansas law that authorizes a pharmacist to dispense a lower cost drug in the same "therapeutic class" as the prescribed drug. According to the state law, the pharmacist must have authorization from the prescriber for every prescription in order to make the substitution and must notify the prescriber within 24 hours after the substitution has been dispensed; however, the law does not require the pharmacist to consult with the prescriber before making the specific substitution.

The Arkansas law appears to be the only one of its kind authorizing "therapeutic exchange"—which is distinct from the much more common and widely legal "generic substitution." The latter is the substitution of a brand-name drug with its generic equivalent; therapeutic substitution is the substitution of a different molecule in the same "therapeutic class" as the prescribed brand-name drug.

According to the Assembly action paper, "This Act enables prescribers in Arkansas to authorize pharmacists to substitute medications with similar mechanisms of action, with dosages determined by the pharmacist, and with notification to (and not necessarily in consultation with) the prescriber after the drug has already been dispensed."

APA's current position on medication substitution, first approved by the Board of Trustees in 1995 and reaffirmed in 2009, states that APA "opposes the practice of therapeutic interchange of psychoactive medication, including the interchangeability of generic and brand medications, without the express consent of the prescribing psychiatrist."

APA's Joint Reference Committee (JRC) referred the Assembly action paper to the Council on Quality Care, Council on Healthcare Systems and Financing, and the Council on Advocacy and Government Relations and asked for a report on the issue for review at the JRC's October meeting.

Eugene Lee, M.D., Assembly representative from the Arkansas Psychiatric Society (APS), said, "My concern is that this practice might not be safe for our patients if prescribers, including psychiatrists, are delegating the authorization for such substitution to the pharmacist." Lee told *Psychiatric News,* "It's a patient safety issue and is not consistent with the doctrine of informed consent."

Lee added that he believes it is possible the language in the law allowing substitution of "lower cost" drugs could enable pharmaceutical companies to use vouchers and other tools to lower the cost to the patient, while still reaping reimbursement from insurance companies for the market cost of the drug.

In 2015, the APS, with the support of APA, supported state legislation exempting psychiatric medications from therapeutic exchange at the pharmacy.

"[T]hese regulations de facto grant pharmacists, albeit with 'physician consent,' inappropriately broad prescribing authority without a full patient medical

continued on next page

PSYCHIATRY & INTEGRATED CARE

Payment for Important Work Gets Approved

BY JÜRGEN UNÜTZER, M.D., M.P.H.

More than two decades ago, in April 1995, Wayne Katon, M.D., and colleagues at the University of Washington and Group Health Cooperative of Puget Sound published the results from the first randomized, controlled trial (RCT) of collaborative care in the *JAMA*. Their work showed that this new model of care in which psychiatric consultants work closely with primary care providers to treat depression nearly doubled the likelihood that patients would improve compared with usual primary care.

By 2008, dozens of RCTs had replicated this original finding in different settings, with different patient populations, and with different psychiatric disorders. A meta-analysis concluded we no longer needed additional studies—it was time to move the model into practice.

But practice is slow to change. With the exception of a few pioneering, capitated health care organizations such as Kaiser Permanente, Intermountain Health Care, the U.S. military, and the Veterans Administration, the lack of a reimbursement mechanism under traditional fee-for-service payment systems has been a major barrier to the widespread adoption of collaborative care. Psychiatrists have attended presentations and courses about collaborative care and returned to their practices wondering how they could get paid for doing this important work.

All this is about to change. Earlier this year, the AMA approved a set of Current Procedural Terminology (CPT) codes that allow primary care practices to bill for collaborative care. These codes cover the work of mental health care managers in primary care clinics and the important contributions of consulting psychiatrists to such collaborative care teams.

In addition, the Centers for Medicare and Medicaid Services (CMS) recently announced that Medicare plans to begin coverage and reimbursement for "specific behavioral health services furnished using the Collaborative Care Model, which has demonstrated benefits in a variety of settings" as part of its Medicare Physician Fee Schedule rule starting in 2017. These monumental steps should increase access to evidence-based mental health care that has been proven to increase patient and provider satisfaction, improve health outcomes, and reduce overall health care costs, achieving the "Triple Aim" of health care reform.

But CMS is going well beyond simply paying for mental health care. It is shifting the focus from traditional fee-for-service payment to "value-based purchasing," creating financial incentives for providers to improve both the quality and the outcomes of care (see the "Changing Practice/Changing Payment" series in *Psychiatric News,* accessible at http://apapsy.ch/MACRA-Info). Earlier this year, Sylvia Burwell, the secretary of Health and Human Services, announced that within a few years, more than half of health care paid for by CMS will be in "alternative payment mechanisms" that focus on quality, outcomes, and overall value.

In psychiatry and in mental health more broadly, we have lagged behind our medical colleagues in our capacity to measure the quality and outcomes of our work. A recent issue brief from the Kennedy Forum ("A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services") summarized the tremendous potential to advance mental health care by using simple patient-reported outcome measures to track the care we provide. A number of mental health quality and outcome measures have been proposed and implemented by a wide range of health care organizations and payers. As an example, the National Committee for Quality Assurance (NCQA) recently adopted new depression measures in their 2016 Healthcare Effectiveness Data Set (HEDIS) for the accreditation of Health Plans, including two measures of depression treatment response and remission that are becoming widely used in accountable care contracts and other value-based purchasing arrangements.

With new CPT codes and CMS payments for collaborative care and a national movement toward measurement-based practice, this is an excellent time for psychiatrists to learn the skills needed to support a successful collaborative care practice. Over the past year, APA has made a substantial commitment to helping its members learn these skills. With help from a $3 million Transforming Clinical Practice Initiative grant from CMS, APA is offering free training in evidence-based collaborative care to psychiatrists through online training modules (accessible at http://apapsy.ch/CCare) and in-person training at APA's IPS: The Mental Health Services Conference, Annual Meeting, and district branch meetings.

I am deeply appreciative of our colleagues around the country and leaders in such organizations as CMS and the NCQA for taking important steps to make effective collaborative care available to more Americans. I only wish that Dr. Katon, who led the early research establishing the effectiveness of collaborative care and who mentored many young psychiatrists along the way, was with us to celebrate these achievements. A visionary who was well ahead of his time, he saw more than two decades ago that an effective partnership with our colleagues in primary care was a powerful way, perhaps the only way, for us psychiatrists to reach all those in need of effective mental health care. PN

"A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services" is posted at https://www.thekennedyforum.org/news/measurement-based-care-issue-brief.

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history or medical training," APA CEO and Medical Director Saul Levin, M.D., M.P.A., and then APS President Erick L. Messias, M.D., wrote in a letter to the Public Health, Welfare, and Labor Committee of the Arkansas House of Representatives outlining objections to the 2013 law authorizing therapeutic substitution. "[I]ndividual drugs within the therapeutic classes used to treat individuals with psychiatric disorders have very different clinical indications, mechanisms of action, and side-effect profiles. Drug prescribing is therefore complicated given the nature of medications in the classes for the treatment of psychiatric disorders. In short, these drugs are not clinically interchangeable. Pharmacists simply will not have the requisite medical history of the patient and therefore are not equipped to make a clinically appropriate decision."

The legislation supporting the exemption of psychiatric medications from therapeutic exchange was not approved. PN

APA's position statement on therapeutic substitution is posted at http://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2015-Medication-Substitutions.pdf.

Jürgen Unützer, M.D., M.P.H., is a professor and chair of psychiatry and behavioral sciences at the University of Washington, where he also directs the AIMS Center, dedicated to "advancing integrated mental health solutions."

LEGAL NEWS

What to Do If You Get a Subpoena or Court Order

If the subpoena or court order involves releasing patient records, your professional liability insurer can give you specific guidance on how to proceed.

BY MOIRA WERTHEIMER, ESQ., R.N., C.P.H.R.M.

At some point in your career, you will likely receive a subpoena or a court order pertaining to litigation brought by or involving a patient. A *subpoena* is a written order commanding someone to produce documents or materials (including treatment records) and/or provide live testimony at a deposition, trial, or hearing. Depending on the laws of your state, subpoenas may not need to be signed by a judge to be valid.

A *court order*, in contrast, is an official decree signed by a judge that requires the recipient to do something specific. Unless there is a compelling reason why you cannot appear on the date set or before the deadline set by the court, you need to appear.

Although the Health Insurance Portability and Accountability Act (HIPAA) permits a "covered entity" (that is, health plans, health care clearinghouses, and health care providers to which HIPAA rules apply) to disclose protected health information pursuant to a subpoena and/or a court order, it is important to understand the type of request received. The standards for HIPAA compliance differ depending on whether the request is pursuant to a subpoena versus a court order. Additionally, it is important to understand your particular state's patient confidentiality protections, as there are often additional protections and requirements under state law. Failing to respond or responding inappropriately to a subpoena or a court order may subject you to court sanctions or a breach of confidentiality claim.

Thus, upon receiving a subpoena or a court order, you should first contact your professional liability insurer. Many policies provide coverage for attorney representation for these matters, even if you are not a party to the litigation and the legal action is not considered a claim under your professional liability policy. When responding to subpoenas and court orders, it is often advisable to have attorney representation as your response will depend on the specific circumstances involved as well as the rules for your particular state.

If the subpoena or court order involves releasing medical records, absent certain circumstances, medical records cannot be disclosed without patient consent. Moreover, even if the subpoena/court order is accompanied by a signed release, there may be clinical or legal reasons for not releasing the records in response to the subpoena/court order.

In addition, numerous states have heightened protections against disclosing behavioral health/psychiatric records due to the sensitive information contained within, even in the presence of a subpoena. Having attorney assistance can help you determine whether and what records must be produced, whether any of the records need redacting, and whether your state law permits you to charge fees to cover the administrative costs associated with the records production. Legal counsel can also assist you in navigating federal and state privacy laws when complying with the request.

If the subpoena or court order involves providing testimony regarding the treatment you provided to a patient, it is advisable to have attorney representation—even in situations where you are not a party to litigation. Your attorney can help you prepare for the questions expected to be asked by the other attorneys involved in the lawsuit, and this preparation can help minimize the risk of inadvertently providing an opportunity for another party to bring litigation against you.

To sum up, if you receive a subpoena or a court order, promptly notify your liability insurer to determine whether your professional liability policy provides coverage for legal representation, even if you are not a party to the litigation. An attorney will help you navigate the numerous federal and state laws to ensure that you avoid a breach of confidentiality claim and/or court sanctions.

For other risk management topics, please 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

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Moira Wertheimer, Esq., R.N., C.P.H.R.M., is assistant vice president of the Healthcare and Psychiatric Risk Management Group of AWAC Services Co., a member company of Allied World.

RESIDENTS' FORUM

American Journal of Psychiatry Residents' Journal Calls For Submissions

BY KATHERINE S. PIER, M.D.

Ten years ago, Robert Freedman, M.D., and Susan Schultz, M.D., editor-in-chief and deputy editor, respectively, of the *American Journal of Psychiatry (AJP)* conceived the *Residents' Journal* to facilitate ongoing collaboration between medical students, residents, and psychiatry fellows. In its infancy, it included instruction to trainees from the *AJP* editors on how to navigate the "green book" that arrives in our mailboxes each month. For trainees, they realized, it can be difficult to know where to start.

Over the past decade, the *Residents' Journal* has come to embody a truism of academic medical training: the best learning takes place by doing. And so the *Residents' Journal* has evolved into its present form: a publication written and edited by and for psychiatry trainees.

When I submitted a manuscript during my second year of residency, I didn't envision how integral the *Residents' Journal* would become in my life and to my training. I don't think there is any way to articulate how publishing enhances clinical experiences and how much our clinical and life experience gives way to wonderful prose.

From recording a podcast, becoming the editor of a theme issue, or writing one of the following article types, the *Residents' Journal* is a symbol of what we can accomplish during our training through collaboration. I invite every medical student, psychiatry resident, and fellow to submit a manuscript this year, record a podcast episode, and be part of our collective voice and journey through psychiatric training.

Theme Issues

It should be noted that while there will be several theme issues this year, there will also be issues without a theme. Therefore, most topics can easily find a home in the *Residents' Journal.*

These are the themes scheduled to date:

- **Suicide risk and prevention.** If you would like to write on this topic, please contact me at Katherine.Pier@mssm.edu.
- **Medical conditions and child psychopathology.** If you would like to write on this topic, please contact our guest section editor, David Saunders, M.D., at david.saunders@yale.edu.
- If you have written for the *Residents' Journal* and want to edit a section, contact me at the email above.

Article Types

- **Commentaries** are opinion pieces on a topic of the writer's choice.
- **Letters to the Editor** are shorter reflections on a subject touched upon in a prior issue of the *Residents' Journal.*
- **History of Psychiatry** pieces allow us to learn about and reflect on our field in a historical context.
- **Reviews** of the academic literature on a topic of the writer's choice are powerful opportunities to learn and teach.
- **Case reports** gives us an opportu-

see ***Residents' Forum*** *on page 19*

Katherine S. Pier is editor-in-chief of the *American Journal of Psychiatry Residents' Journal* and a PGY-4 resident at the Icahn School of Medicine at Mount Sinai. She would like to thank the members of the 2016-2017 *Residents' Journal* Editorial Board.

ADMSEP Leaders Adapt Milestones To Medical Student Education

The learning goals and milestones are structured similarly to the residency Milestones developed by ACGME and align with the Core Entrustable Professional Activities outlined by the Association of American Medical Colleges.

TEACHING PSYCHIATRY

BY MARK MORAN

The Milestones Project has come to medical school education.

Educators with the Association of Directors of Medical School Education in Psychiatry (ADMSEP) have developed a set of learning goals and milestones in psychiatry for medical students. They are aligned with the core competencies developed for residency programs by the Accreditation Council for Graduate Medical Education (ACGME) and structured, like the residency Milestones, in successive stages of advancing knowledge as students move through medical school.

Brenda Roman, M.D., chair of the ADMSEP Task Force that developed the initiative for medical school education, told *Psychiatric News* that the "Key Diagnoses, Learning Goals, and Milestones for Psychiatry in Undergraduate Medical Education"—its formal name—constitutes a set of competencies associated with caring for patients with psychiatric illness that all students should be able to demonstrate before graduating, regardless of the field of medicine in which they choose to specialize.

Unlike the residency Milestones, however, meeting the ADMSEP learning goals and milestones is voluntary, and they are designed to be flexible enough for adaptation to the culture of individual medical schools.

"They are meant to be broad enough so that individual schools can choose to include more specific objectives and readily incorporate them in the framework," she said. "Directors of psychiatric education for medical students can use this document as a guideline, realizing that each school has unique circumstances, patient populations, and missions that need to be taken into consideration in determining what is best for an institution and its students."

Roman is past president of ADMSEP and assistant dean of medical education at Wright State University Boonshoft School of Medicine in Dayton, Ohio.

The six competencies are medical knowledge, patient care (clinical skills), systems-based practice, interpersonal skills and communication, caring-valuing (professionalism), and practice-based learning.

For instance, under the "medical knowledge" competency, the ADMSEP learning objectives cover four specific skills: describe the normal psychological development across the lifespan, describe the psychobiological-behavioral theories for psychiatric disorders and substance use disorders, describe the psychopharmacological treatments and psychotherapies for psychiatric disorders, and demonstrate knowledge of psychiatric concepts, components of the psychiatric mental status exam, and cognitive screening.

Each of those skills is further broken down into more granular learning objectives for the preclinical and clinical stages of medical school.

"The learning goals and milestones should be regarded as a precursor to residency—what all general medical students should know about a topic in psychiatry so they are prepared to tackle residency Milestones," said task force co-chair Dawnelle Schatte, M.D., in an interview with *Psychiatric News*. "It's a consensus document of experts, not a requirement dictated from the top down." She is director of undergraduate medical education at the University of Texas Medical Branch at Galveston.

Schatte also said the learning goals and milestones align with the Core Entrustable Professional Activities developed by the Association of American Medical Colleges. The latter are a formal outline of the activities and requisite competencies and behaviors that every graduating medical student should be able to perform without supervision at the start of residency (*Psychiatric News*, July 25, 2014).

APA Director of Education Tristan Gorrindo, M.D., told *Psychiatric News* that the ADMSEP initiative is in line with a larger trend in medicine toward collaborative care.

"Only a small number of medical students will choose a career as a psychiatrist, but increasingly it is important that every medical student have foundational knowledge in treating patients with mental illness," he said. "As the availability of models like collaborative care continues to grow, internists, pediatricians, and family practice physicians need basic competencies in mental health. These milestones help promote the development of baseline education at the medical school level to give students a solid foundation for additional training they may receive in residency. This project serves all of medicine, not just psychiatry."

Brenda Roman, M.D.

Brenda Roman, M.D., chair of an ADMSEP task force that helped to develop the guidance "Key Diagnoses, Learning Goals, and Milestones for Psychiatry in Undergraduate Medical Education," said the resource is designed to be adaptable to the culture of individual medical schools.

Additionally, Roman and colleagues have outlined a set of "key diagnoses." These are the major psychiatric diagnoses that medical students should know by the time they graduate from medical school. Ideally, all students would have had clinical exposure or other intensive exposure through a learning experience to at least one of the diagnoses under each diagnostic category. Roman said they were selected because they are common or critical in the care of patients regardless of their age.

The diagnoses are grouped into 11 broad groups: neurodevelopmental disorders, schizophrenia spectrum and psychotic disorders, bipolar and related disorders, anxiety disorders, trauma and stressor-related disorders, eating and feeding disorders, somatic symptom and related disorders, substance-related and addictive disorders, cognitive disorders, personality disorders, and medication-induced movement disorders and other adverse effects of medication.

Roman said the "Key Diagnoses, Learning Goals, and Milestones" were built upon a similar document developed by ADMSEP educators more than a decade ago focused on clinical learning objectives. When the Milestones Project for residency was initiated, educators in pediatrics became the first specialty group to include the period of medical school. It was natural for psychiatric educators to do the same, drawing on the original learning objectives.

An 11-member task force, including Roman and Schatte, met for two years in person and via conference call. "Our collective expertise created a first draft that was further refined and edited by the members of the executive council of ADMSEP, then distributed to the membership for comments for a period of three months," Roman said. Based on member comments, the task force refined it again and presented it to the Executive Council for approval a year ago.

Roman said she knows from the recent ADMSEP meeting that many medical school leaders are using the new resource as they undertake curriculum reform. More generally, schools can use the resource as a guide for complying with licensing requirements of the Liaison Committee on Medical Education.

"ADMSEP wanted to be the leaders in developing milestones for medical student education," Roman said. "Many of us in medical education see this as the future." PN

"Key Diagnoses, Learning Goals, and Milestones for Psychiatry in Undergraduate Medical Education" can be accessed at http://www.admsep.org/milestones.php?c=taskforce.

Residents' Forum

continued from page 14

nity to share what we've observed and learned during our residency.

- **Book and movie reviews** create important dialogues about what we encounter in the media.

- Our **Perspectives on Global Health** column is a vehicle for sharing insights from scholarly projects abroad.

- Our **Arts & Culture** column is a forum for creative nonfiction. Please contact our Culture Editor, Aparna Atluru at Apatluru@gmail.com for more information.

For a list of manuscript types and guidelines for submission, please see http://ajp.psychiatryonline.org/residents_journal/rj_ifora.

Podcasts offer another entry point for trainees to interact with the journal. Podcasts are an invaluable educational tool for readers to learn from and teach one another.

On behalf of the editorial board, we hope you will find time this year to submit a manuscript to the *American Journal of Psychiatry Residents' Journal*. PN

EDUCATION & TRAINING

Research Reveals Profile of Students Inclined Toward Choosing Psychiatry

Most people who choose psychiatry make that decision sometime during medical school. Among those students, the quality of the clerkship experience is paramount.

BY MARK MORAN

Fifty percent of students who enter medical school determined to be a psychiatrist stick with that choice through graduation and enter training in psychiatry.

That's a rate of stability of preference over time that is higher than exists for any other field of medicine, and it tells educators something interesting about the characteristics of new physicians drawn to psychiatry.

At the same time, people who end up in psychiatry are highly likely to have chosen the profession during medical school after initially preferring a different specialty. For those students, the most important factor in their decision to be a psychiatrist is the quality of the psychiatry clerkship rotation.

Other factors associated with choosing psychiatry are valuing work-life balance in their career and majoring in psychology as an undergraduate.

Psychiatric medical education researchers Matt Goldenberg, M.D., and John Spollen, M.D., say these and other factors that emerged from studying the background and specialty preferences of students in medical school offer clues about how to increase the number of new physicians entering the profession.

They say there is a uniqueness to the field of psychiatry—the reason that people who are drawn to it from the beginning is probably because of aspects that are exclusive to psychiatry, so they stick with their choice.

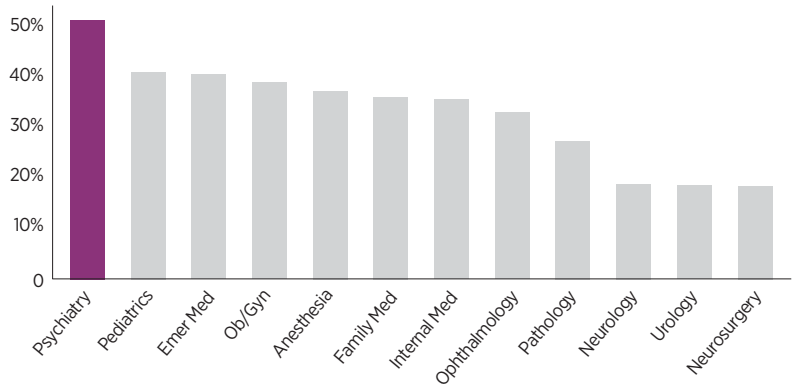
"Psychiatry is unique enough that people who come into medical school focused on psychiatry are unlikely to find anything else that is as good a fit," Spollen told *Psychiatric News*. "One type of surgery isn't a great deal different from another type of surgery, but there's nothing quite like psychiatry if that's what you want to do."

Goldenberg said one intervention to increase psychiatry's numbers is to influence admissions committees to recruit undergraduate students who indicate an interest in psychiatry. Additionally, the field could take steps to introduce psychiatry—what it is and how it is different from other fields of medicine—into undergraduate curricula.

Nonetheless, most people who choose to enter the field do so during medical school, so the quality of the medical school experience in psychiatry is vital. In fact, of all medical specialties, psychiatry is second only to urology in the percentage of students who switch their specialty preference from matriculation to graduation from medical school.

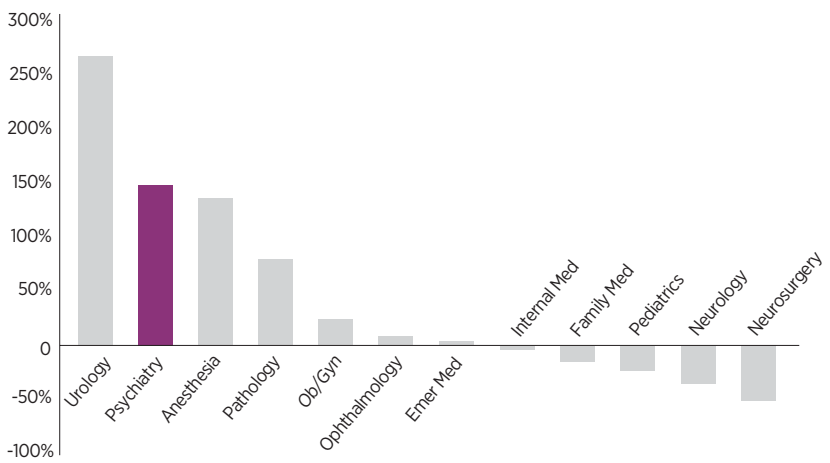
Students Who Prefer Psychiatry at Matriculation Tend to Stick With It

A little more than 50 percent of medical students who say they want to enter psychiatry when they begin medical school will actually do so upon graduation.



Most Psychiatrists Switched Specialty Preference During Medical School

The number choosing psychiatry upon graduation is approximately 150 percent greater than the number that indicated it as a preference when entering medical school.



Source: Matthew Goldenberg, M.D., M.Sc., John Spollen, M.D., and D. Keith Williams, Ph.D.

Key Points

Research by Matt Goldenberg, M.D., and colleagues reveals a useful profile of medical students who choose to enter psychiatry.

- Students entering medical school who want to be psychiatrists are likely to stick with that choice throughout. These students may benefit from early identification of their interest with mentoring and tailored clinical experiences to nurture their interest.
- Attracting college graduates who have an initial interest in psychiatry seems likely to increase recruitment rates.
- Most students who become psychiatrists make that decision during medical school. These students may benefit from targeted psychiatry interest groups or other recruitment efforts that highlight work-life balance and non-science aspects of the profession.
- The student's rating of the clerkship is the most significant factor in choosing psychiatry as a specialty upon graduation.

Bottom Line: Applying the information learned through this study can help educators recruit more medical students into psychiatry.

Goldenberg said among the factors that influence the decision to choose psychiatry among those who are undecided or prefer something else when they enter medical school, the most important is whether they report having an excellent clerkship experience.

"I think it speaks to the importance overall of the medical school experience in recruiting doctors into psychiatry," he said in an interview. "We know that four out of five medical school students make their decision to enter psychiatry sometime during medical school, and we know that the clerkship is crucial. If we want to increase our numbers, we need to value the educational experience in medical school and do our best to make the clerkship an excellent experience."

Goldenberg's research on factors related to medical student choice of specialty was done as a scholar in the Association of Directors of Medical School Education in Psychiatry's (ADMSEP) Education Scholars Program. Spollen, who served as a mentor on the project, received support from the APA Division of Education.

Goldenberg, Spollen, and colleagues have presented their work as posters at ADMSEP meetings and during workshops at APA's Annual Meeting.

"We are very aware that there continues to be a shortage of psychiatrists," said Brenda Roman, M.D., past president of ADMSEP. "Matt's research showing that early interest in psychiatry is a strong predictive factor means it's important for educators to be involved in admissions committees so they can select students interested in our field.

"For me as a psychiatric educator, this research challenges us to think in new ways about the clerkship experience during medical school and expanding on the traditional concept of the rotation through an inpatient unit," Roman said. "Mentoring is so important in medical school, and strong role models in medical school can go a long way in combatting some of the stigma associated with being a psychiatrist."

Goldenberg and colleagues used data from the Association of American Medical Colleges surveys of 29,714 students who graduated medical school in 2013 and 2014. They analyzed 29 variables hypothesized to be associated with psychiatry specialty choice. Statistical analysis identified subgroups of students based on the highly associated variables who were more or less likely to choose psychiatry.

They found that a student's rating of the psychiatry clerkship as excellent was the factor most associated with psychiatry specialty choice. Other highly associated factors include undergraduate psychology major, reporting work-life balance as a strong influence on specialty choice, and reporting educational debt as having no influence on specialty choice. PN

Lone Psychiatrist Carries Burden Of Caring for South Sudan's MH

The development of the nascent country's mental health system rests on one woman's shoulders.

BY AARON LEVIN

Atong Akol, M.D.

Atong Ayel Longar Akol, M.D., is the only practicing psychiatrist in the newly created country of South Sudan.

Atong Ayel Longar Akol, M.D., is the director for mental health in South Sudan's Ministry of Health. She also lectures at the University of Juba, where she is organizing its psychiatric curriculum, and serves as the mental health manager for GEMS Development Foundation, a nonprofit focused on ending hunger in South Sudan.

And, yes, she does clinical work, too.

Akol juggles all those hats because she is the only working psychiatrist in her country, which achieved independence in 2011. (One other South Sudanese psychiatrist no longer practices in the field, she said.)

Akol was interviewed in Atlanta, where she attended APA's 2016 Annual Meeting and presented a talk titled "A Project for Mentally Ill Survivors in South Sudan: Transforming the Present, Shaping the Future."

In South Sudan, a country of 12 million people, mental health resources are minimal, she said. There are just two psychiatric nurses in the country. Only 29 psychologists live there, but they are mainly academics, not clinicians. Akol is now training some of them to do clinical work. In addition, there is no regular funding for mental health services or medications.

Furthermore, South Sudan has no psychiatric hospital. One ward in the Juba teaching hospital holds only 12 psychiatric beds. Akol works there each day until 2 p.m. and then goes to her office at the Ministry of Health. In two other teaching hospitals, psychiatry is integrated into general medicine departments.

The main prison has an 80-bed ward for violent patients, where she visits them to diagnose their disorders and prescribe medications. "That treatment can shorten their stay in prison," she said.

Originally, GEMS—the acronym stands for "Goats, Education, Medicine, Sustainability"—donated goats to families in rural areas to help end hunger and alleviate poverty. Now, Akol is expanding that mandate by developing a mental health program in Juba and supplying small quantities of medication to patients.

In the short term, said Akol, she seeks to expand the existing psychiatric ward at Juba Hospital, set up a 20-bed day care treatment center, develop a regular supply of medications, and encourage vocational and recreational therapies for patients.

She began a community outreach program in the cities of Juba and Wau and the state of Warrap that provide treatment to patients with severe mental illnesses or epilepsy. Many of these people were homeless or had been chained up by their families for want of better care, said Akol. The program served 300 patients in its first quarter (March to May 2015) and has expanded to care for 760 patients from December 2015, to February 2016.

Over the longer term, she hopes to develop national treatment guidelines, establish two or three psychiatric hospitals, expand training for mental health providers, and begin research on the efficacy of treatment programs.

She would like to add newer psychotropics to the national formulary, but there is a serious roadblock to their importation, she said: pharmaceutical companies won't enter a market unless there are sufficient psychiatrists in the country to write prescriptions.

Given that, access to psychiatric medications is difficult, she said. Often, pharmacists buy medications from neighboring countries and resell them locally at high prices.

Cultural barriers to care exist as well. Akol is fighting a slow battle against the belief that mental illness is a curse or punishment and not a disease. As in other developing countries, one path to better understanding mental illnesses leads to the doors of practitioners of traditional medicine.

"People trust the traditional healers, so I want to start a community mental health clinic and try to train health workers there to work with traditional healers," she said. "They would provide social support, but if a patient needs

see **South Sudan** on page 24

Nominations Sought For APA's 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. More information about APA's 2017 election is posted at http://apapsy.ch/APAelection.

ASSOCIATION NEWS

Psychiatry Innovation Lab Comes to IPS

Following a successful debut at the Annual Meeting, the Innovation Lab once again will challenge and reward creative thinkers looking at new ways to improve mental health care.

BY NICK ZAGORSKI

APA's 2016 Annual Meeting in May featured the debut of the Psychiatry Innovation Lab, a new educational component designed to foster creative solutions for improving the delivery of quality mental health care, while also providing a venue for innovators to connect with peers, collaborators, and investors. Because of the wide enthusiasm with which it was met at that meeting, it is now being introduced at APA's fall meeting, IPS: The Mental Health Services Conference, being held this year in Washington, D.C. "Psychiatry Innovation Lab: Pitch an Idea. Build a Team. Design a Venture. Measure your Impact" will take place on Saturday, October 8, from 1 p.m. to 5 p.m.

There are multiple ways to get involved:

- Have an innovative idea? Individuals or groups can submit their pitches using the application form on http://apapsy.ch/InnovationLab. Submissions are due by September 21. The seven most promising pitches will be selected as finalists for the competition, and 10 others will be designated as "wildcards" with an opportunity to be selected as a finalist by the session audience.

- Have unique expertise that can help an innovator? Nonmembers with business, administrative, or other skills are invited to apply as "innovation leaders" who will be teamed with a finalist to help evaluate and improve the finalist's idea.

- Have some time while at the IPS? All APA members are invited to attend the Innovation Lab, where they can join a finalist of their choice and the finalist's innovation leaders.

Nina Taylor

Nina Vasan, M.D., is the creator and chair of the Innovation Lab series. With her at APA's 2016 Annual Meeting in May are APA CEO and Medical Director Saul Levin, M.D., M.P.A., and Education Director Tristan Gorrindo, M.D.

All those interested in participating in the lab should submit their application by the September 21 deadline.

The format will be similar to the event held at the Annual Meeting, in which the seven finalists will first pitch their ideas to expert judges, followed by an interactive breakout session in which the participants and attendees partner into teams to brainstorm the questions posed by the judges during the pitch session and work together to improve their innovations.

"There has been a call to action by the federal government to accelerate innovation in mental health," said Nina Vasan, M.D., a psychiatry resident at Stanford University and founder and chair of the Innovation Lab series. "The Psychiatry Innovation Lab is APA's response to the challenge, and it provides a platform to turn good ideas into impactful ventures."

"We want a range of ideas from diverse perspectives," Vasan told *Psychiatric News*. "People naturally associate innovation with technology, but I want to encourage people to think more broadly and inclusively about innovation. It can mean novel partnerships, new models of care delivery, or a better distribution of evidence-based medicine."

The proposals need not be limited to clinical care, as there are numerous problems related to parity, education, research, and prevention that need to be addressed.

"Prevention is especially pertinent for this meeting, as [APA President] Dr. Maria Oquendo made 'Prevention in Practice' the central theme of IPS," Vasan said. "I think it is a brilliant theme, and I hope many applicants will celebrate that theme as part of their proposals."

Since this year's meeting happens to be in the nation's capital and during the presidential campaigning season, Vasan believes ideas that address the role of the government in mental health care delivery—for example, launching effective public health campaigns or improving mental health for Medicare and Medicaid beneficiaries—would fit in thematically as well. PN

More information on the Innovation Lab and application forms are posted at the Innovation Lab website at http://apapsy.ch/InnovationLab.

'APA On Tour' to Examine Link Between Climate Change and Mental Health

Threats to mental health due to climate change include cognitive damage, psychological trauma, and increased violence, according to some experts in environmental psychiatry.

BY VABREN WATTS

The Division of Diversity and Health Equity will sponsor an APA on Tour event at this year's IPS: The Mental Health Services Conference, highlighting the impact of climate change on mental health.

"Climate change is no longer a theory," said event chair Robert Ursano, M.D. "Changes in climate are expected to create more variability on the weather and more potential weather-related disasters, which can result in alterations of levels of distress, changes in health-risk behaviors such as smoking and medication adherence, and worsening of psychiatric illnesses such as posttraumatic stress disorder and depression."

iStock/satori13

Ursano is chair of the Department of Psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, and chair of APA's Committee on Psychiatric Dimensions of Disasters.

Because of such consequences, Ursano said that understanding disaster psychiatry—the prevention and treatment of disaster-related psychiatric illness and distress—is of utmost importance.

The event, to be held Friday, October 7, will feature a panel of speakers who will give various perspectives on the ramifications of atmospheric changes on mental health in addition to providing preventive measures and interventions that may potentially thwart negative outcomes.

Panelists will include Joshua Morganstein, M.D., assistant chair of psychiatry and a commander at the U.S. Public Health Service, who will give a keynote address on evidence-based impacts of climate change on mental health, and Elizabeth Haase, M.D., an associate professor of psychiatry at the University of Nevada, who will lead a discussion on mental health risks linked to adverse environmental changes such as rising levels of carbon dioxide in the atmosphere and air pollution that can lead

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Psychiatric News Shines Light on College Mental Health 50 Years Ago

Whether colleges should ask applicants about their psychiatric history was a topic for extended consideration in *Psychiatric News* half a century ago.

BY AARON LEVIN

Darren McCollester/Getty Images

A 1967 Harvard study found that students with previously treated psychiatric problems performed as well at the university as a control group.

Surveys of college admissions officers 50 years ago revealed that many application forms often inquired about a high school student's emotional problems or psychiatric treatment, according to two articles in the February and March 1967 issues of *Psychiatric News*. Some went so far as to ask about a history of mental illness in the applicant's family.

The issue arose because in 1966, Max Siegel, Ph.D., a psychologist and associate dean of students at Brooklyn College, had argued in the *New York Times* that colleges were discriminating against former mental patients.

Intrigued by the question, *Psychiatric News* assistant editor Gail Dearing then asked 100 college psychiatrists for their opinions; 61 responded.

"[M]ore than two-thirds reported that in their experience, usually extensive, with college admission committees, they have not observed out-and-out prejudice against individuals who have been, or are being, treated for emotional problems," wrote Dearing.

Sometimes, she reported, colleges were likely to ask for more information from parents or therapists or request an evaluation from their own student health service psychiatrists to "determine whether the student promises to be able to function adequately and withstand the pressures of college. When asked how they use this information in reaching a decision, one college said, 'We make inspired guesses.' "

Other university health personnel went even further in discounting the value of such information.

"People with obvious signs of emotional conflict may at times do very well in college," Dearing quoted Dana Farnsworth, M.D., a psychiatrist and director of Harvard University Health Services from 1954 to 1971. "If we exclude all who have potential emotional disorders, we would keep out practically all applicants."

Indeed, a Harvard study then under way in 1967 indicated that students with previously treated psychiatric problems did just as well at the university as a control group.

In October 1966, the APA Assembly approved a measure deploring inquiries about an applicant's psychiatric history.

Of course, both colleges and psychiatry have changed since then. For example, such questions would not appear on today's admissions applications, said Michelle Mott, a spokesperson for the American Association of Collegiate Registrars and Admissions Officers in Washington, D.C.

"It seems that doing so could be equated with asking a student to disclose health information, and that might not be permissible," Mott told *Psychiatric News*. "While there seems to be an increase in students identifying their mental health issues on campuses, and those students are likely bringing those issues with them, it is not common practice to gather that information through the admissions process."

"It's a very different world today," agreed Jerald Kay, M.D., a professor emeritus of psychiatry in the Boonshoft School of Medicine at Wright State University in Dayton, Ohio, and co-editor with Victor Schwartz, M.D., of *Mental Health Care in the College Community* (Wiley, 2010). For one thing, there is much more openness at colleges (and society in general) about mental illness.

More is known today about the epidemiology of mental illness in young people, said Kay in an interview.

"We have many more students matriculating with some sort of disorder, but we also have a better understanding of psychopharmacology and psychotherapy," he said. "Our challenge now is to see that all the people who need help get it."

To that end, campus mental health services have shifted away from a counseling model, said Kay. Now they are more like community mental health centers, providing not only counseling but ready to offer crisis intervention, group therapy, or even hospitalization when necessary.

At the same time, there are also new problems to cope with.

"We have a better handle on substance abuse now, although everyone is struggling with what to do about alcohol," he said. "Binge drinking is a big problem on campuses."

Dearing reported on ways to clear a path to college for students with a history of psychiatric or emotional problems.

"Paramount among the solutions suggested is the need to educate college admissions officials," wrote Dearing. "They need to know what mental illness is and the complex forms it may take, and to be convinced that many people do recover from episodes which led them to consult a psychiatrist, particularly adolescents experiencing 'health' situational adjustment reactions." PN

An abstract of "College Mental Health: A System in Transition" by Victor Schwartz, M.D., and Jerald Kay, M.D., is posted at http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(14)70334-7/abstract.

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to increased rates for cognitive damage among an exposed population.

Haase will also discuss strategic plans to help prevent and remedy damage to the environment—and its subsequent outcomes—through environmental leadership among youth, environmental engagement though performance arts, faith-based environmental action movements, and research-based communication skills that will help Americans best understand and adapt to new value systems.

"I hope that people will be awed by the many programs already under way to build emotional and social resilience to the psychological impact of environmental and climate change," Haase told *Psychiatric News*.

Robin Cooper, M.D., an assistant professor of psychiatry at the University of California, San Francisco, will talk about climate change and the mental health of disenfranchised communities, focusing on the aftermath of Hurricane Katrina and Superstorm Sandy.

"Climate change will likely reinforce and amplify current socioeconomic disparities, leaving low-income, minority, and politically marginalized groups with fewer economic opportunities and more environmental and health burdens," Cooper told *Psychiatric News*. She explained that disenfranchised communities have the least resources to buffer themselves from climate-related repercussions and are least able to recover once affected. "Issues of equity must be a major concern and focus of the impact of climate change."

Cooper told *Psychiatric News* that she hopes that all attendees will come to understand the significant association between climate change and mental health. She added that psychiatrists must use professional organizations to advocate for education, research, and effective public policy.

"To continue to remain silent on this issue is to avoid one of the most significant issues of our time and to fail to protect our vulnerable patients," Cooper concluded. PN

MEMBERS IN THE NEWS

Renato Alarcón: Long-Time Advocate For Cultural Awareness in Psychiatry

Witchcraft? Chemical imbalance? Culture shapes how patients experience and describe symptoms, this expert says.

BY LYNNE LAMBERG

As a young Peruvian-born and educated physician, Renato Alarcón, M.D., bumped into cultural challenges both personally and professionally when he came to the United States in 1967 for a fellowship in psychosomatic medicine at the Johns Hopkins University School of Medicine.

"On hearing my accent, patients may have wondered how much I knew or could understand about their concerns," he recalled.

"I noticed that clinical presentations placed little emphasis on patients' race, ethnicity, religious beliefs, or other cultural factors," Alarcón said. "As an international medical graduate, encountering cultural differences myself, I thought those variables needed more attention."

Culture affects how patients experience, explain, and report disturbed thoughts, feelings, and behaviors, he said. Some people attribute depression, anxiety, or other symptoms to witchcraft. Some somaticize, converting mental distress into pain and other bodily symptoms. Others say they have a chemical imbalance. In each instance, Alarcón said, patients have interpreted their symptoms through the prism of their culture.

Alarcón stayed at Hopkins until 1972, completing his residency in psychiatry and a fellowship in clinical psychopharmacology and earning his M.P.H. there.

He went on to a distinguished career in academic psychiatry, first in Peru, and then after he returned to the United States in 1980, seeking to enlarge understanding of the impact of culture on psychiatric diagnosis and treatment and improve global mental health. Now emeritus professor of psychiatry and psychology at the Mayo Clinic College of Medicine, Alarcón talked recently with *Psychiatric News* about what cultural psychiatry is—and is not.

Taking culture into consideration enables psychiatrists to depathologize behaviors they might otherwise view as symptomatic, Alarcón said, and to obtain a fuller picture of what patients are experiencing. Knowing patients' traditions and beliefs may allow psychiatrists to employ culture in a psychotherapeutic role, by building rapport and collaboration, he suggested.

Cultural knowledge also may benefit treatment and prevention, he said. Encouraging some patients to participate in religious or other social rituals, for example, may help ease their distress and prevent relapse.

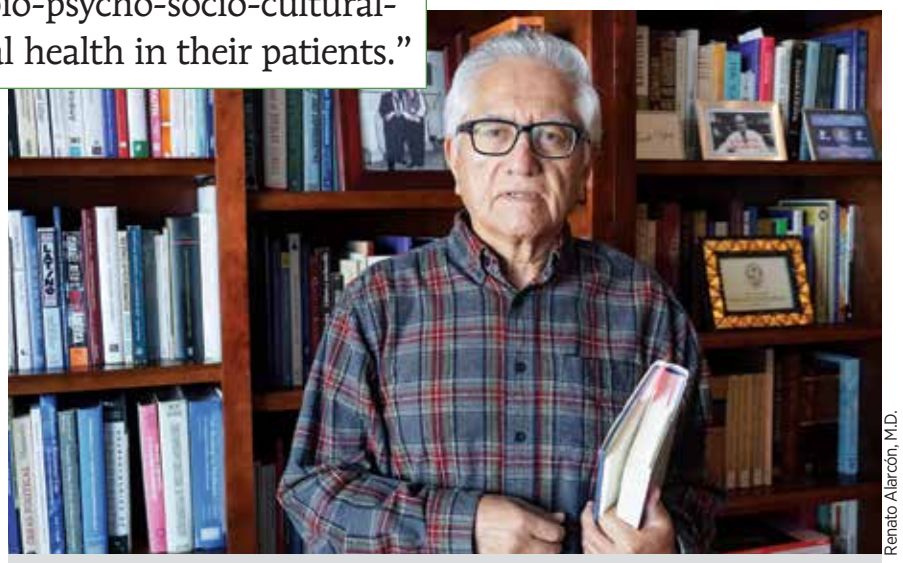
Cultural psychiatry is not a subspecialty, Alarcón asserted. Cultural understanding should be an integral part of the education and practice of every psychiatrist, he said. It is relevant to all patients, not only those who are immigrants or members of minority populations. The cultural identity of a person reared in Manhattan, for instance, likely differs considerably from that of a person reared in the Mississippi delta.

> "All psychiatrists should strive to foster bio-psycho-socio-cultural-spiritual health in their patients."

Cultural psychiatry is not anti-biological, he noted. Cultural understanding adds to that derived from knowing the neurobiological substrates of an illness. "All psychiatrists," he said, "should strive to foster bio-psycho-socio-cultural-spiritual health in their patients."

As a member of the *DSM-5* study group on gender and cross-cultural issues, Alarcón helped develop the Cultural Formulation Interview, a set of 16 brief culture-focused questions to aid in mental health assessment. He also helped amend the now-outdated concept of culture-bound syndromes and refine information on the handful of disorders included in the *DSM-5*'s Glossary of Cultural Concepts of Distress.

"One often hears physicians say all patients should be treated the same way. But reality is not like that," he noted. "Racism, sexism, and other forms of discrimination still exist, and stigma is a universal phenomenon."



Renato Alarcón, M.D.

Renato Alarcón, M.D., is a co-developer of the *DSM-5* Cultural Formulation Interview, which helps clinicians account for the influence of culture in their clinical work, improve patient-clinician communications, and ultimately improve outcomes.

Even psychiatrists may hold stereotypes based on a patient's country of origin, color, gender, socioeconomic status, or other characteristics, he noted, and may assume a person's cultural load is unchangeable.

"The important thing," he asserted, "is to understand the human entity, the patient's background, why he or she comes to see you now but didn't come earlier, and how he or she explains their symptoms and causes of those symptoms."

The individualistic approach, a strong aspect of American life and of Western culture in general, he said, stresses that people need to take responsibility for their own behavior. It often neglects, however, a cultural background that encourages reliance on family and friends. If psychiatrists fail to ask about cultural issues, he said, their work is incomplete.

Growing up in Arequipa, Peru, Alarcón credits his parents, both teachers, with spurring his interest in interpersonal relationships and medicine. On Alarcón's 11th birthday, his father gave him a book on psychology by Honorio Delgado, M.D., also a native of Arequipa, and a leader of Latin American psychiatry. Delgado, who died in 1969, later became one of Alarcón's mentors.

Alarcón now holds the Honorio Delgado Chair at the Universidad Perúana Cayetano Heredia School of Medicine in Lima, Peru, from which he graduated in 1965.

Alarcón received APA's Simón Bolivar Award and George Tarjan Award. He also is an APA distinguished life fellow.

The author or coauthor of over 250 articles, 15 books, and 70 book chapters, Alarcón is the senior editor of *Psiquiatría (Psychiatry)*, the most widely used psychiatric textbook in Latin America. This 1,000-page textbook includes chapters from nearly 300 contributors from Latin and Central America, Brazil, Spain, and the United States. The fourth edition of the book, sponsored by the Pan American Health Organization, is scheduled for publication in 2017. PN

South Sudan

continued from page 21

higher levels of care, they could refer them to the clinic," she said.

Yet another hurdle is psychiatry's stigmatized place within the medical profession in South Sudan, although Akol is working to change that. The medical school only recently introduced psychiatry into its curriculum, but there is still no residency program in the country. Akol did her residency in Khartoum, the capital of Sudan, the larger country from which South Sudan was carved in 2011.

"I believe better days are coming," she said. "I am grateful for being a part of this year's APA meeting."

Already, members of APA's Council on International Psychiatry have offered resources to help Akol plan her next steps for training, curriculum development, and new ideas for expanding the profession of psychiatry in her country.

"I say, don't invest in South Sudan," she said. "Invest in the South Sudanese people."

However, her work has been at least temporarily interrupted by yet another flare-up of violence in fighting in South Sudan between the government and forces loyal to the country's former vice president.

"We faced lots of challenges a few days ago, and most people have been displaced," Akol told *Psychiatric News* in an email in mid-July. "The hospital is working although we have challenges with the manpower. I had to suspend my projects for two weeks as I help my family settle in Nairobi [in neighboring Kenya]." PN

The GEMS website is http://goatsfortheoldgoat.com/.

CLINICAL & RESEARCH NEWS

Odor Test May Predict Early-Stage Dementia

Damage in the olfactory bulb and neurons extending from the olfactory to the brain is a hallmark of early dementia.

BY VABREN WATTS

At the 2016 Alzheimer's Association International Conference (AAIC) in July, researchers presented evidence to suggest that a low-cost smell identification test may be able to predict cognitive decline and the early onset of dementia in older adults.

"Neurofibrillary tangles, a feature of Alzheimer's neuropathology, occur in the olfactory bulb early in the course of Alzheimer's disease," Devangere Devanand, M.D., a professor of clinical psychiatry at Columbia University Medical Center and co-director of the Memory Disorders Center at the New York State Psychiatric Institute, told *Psychiatric News*. "This [abnormality] results in damage to the neurons that project from the olfactory bulb to brain

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CLINICAL & RESEARCH NEWS

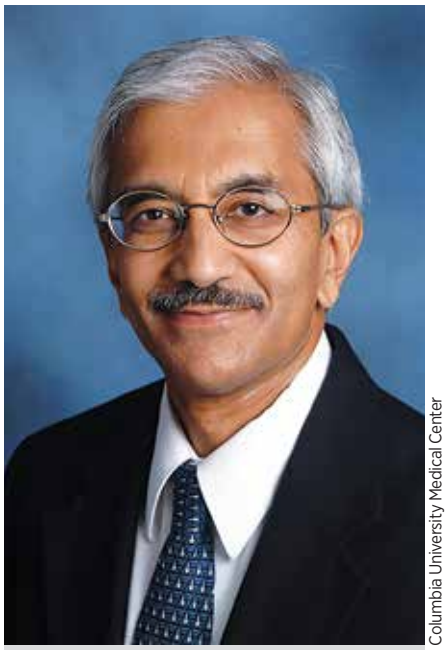
continued from previous page

areas that are involved in odor memory and odor naming."

The ability to assess early impairment in odor identification may help identify patients with dementia earlier, he explained.

At AAIC, Devanand and colleagues described the results of a study evaluating whether the University of Pennsylvania Smell Identification Test (UPSIT) could be used to predict patients who are most likely to develop dementia or cognitive decline. (The UPSIT is a scratch and sniff test that evaluates the ability of users to recognize 40 odors.)

The researchers administered UPSIT to 397 older adults (average age of 80 years) from a multiethnic population in Manhattan, New York, who did not have dementia at the start of the study and were followed for four years. All participants had an MRI scan to measure the thickness of the entorhinal cortex, one of the first regions of the brain known to be affected by Alzheimer's disease. Composite cognitive domain scores were derived from memory, language, and visual-spatial tests.



Columbia University Medical Center

Devangere Devenand, M.D., says that mental health professionals need to become aware of alternative and less expensive options for improving the diagnosis of dementia and Alzheimer's disease.

At the four-year follow-up, 12.6 percent of the participants had developed dementia, and 19.8 percent had signs of cognitive decline. Low UPSIT scores—indicative of a decreased ability to identify odors—and entorhinal cortical thinning were significantly associated with the transition to dementia after adjusting for age, education, gender, language of UPSIT administration (English or Spanish), functional status, and intracranial volume. Low UPSIT scores also predicted cognitive decline; entorhinal cortical thinning was not associated with cognitive decline.

"Our research showed that odor identification impairment, and to a lesser degree entorhinal cortical thickness, were predictors of the transition to dementia," study presenter Seonjoo Lee, Ph.D., an assistant professor of clinical biostatistics in psychiatry at Columbia, said during a press conference at AAIC. The findings also suggest that impairments in odor identification may precede thinning in the entorhinal cortex in the early clinical stage of dementia, she added.

"These findings show that olfactory identification can be an inexpensive and useful option to improve diagnosis of cognitive impairment and predict outcomes in patients with cognitive decline," Devanand said.

The work was supported by the National Institute on Aging. PN

More information is posted at http://www.multivu.com/players/English/7865353-aaic-2016-smell-eye-tests/docs/press-release-1431686133.pdf.

Older Patients With Depression May Benefit From ECT, Medication Combo

Patients who received ultrabrief ECT and pharmacotherapy displayed more rapid and sustained improvements in depressive symptoms than with pharmacotherapy alone—and few adverse effects on cognition.

BY NICK ZAGORSKI

Electroconvulsive therapy (ECT) is known to be an effective option for treating acute depression in elderly people who often do not respond to or who cannot tolerate standard antidepressants. The effectiveness of longer-term ECT in preventing relapse is more ambiguous; studies have shown it is about as effective as medication, but concerns over adverse cognitive effects associated with the technology have led to limited use.

The results of a two-part study of using ultrabrief ECT (where brain stimulation is delivered using shorter electrical pulses) now suggest that treating geriatric patients with ECT and pharmacotherapy may lead to more rapid and sustained improvements in depressive symptoms than pharmacotherapy alone, with few adverse effects on cognition.

The findings of the two-phase, multicenter study known as PRIDE (Prolonging Remission in Depressed Elderly) were published July 15 in *AJP in Advance*.

For the first part of the study, 240 seniors with depression (aged 60 and over) received three sessions of right unilateral ultrabrief ECT per week. (Compared with conventional ECT, this technique delivers shorter electrical pulses [less than 0.5 milliseconds each] to only one side of the brain.) The participants also received open-label venlafaxine daily (target dose of 225 mg/day).

There was no set timeframe for this first phase, and patients were treated until they achieved remission in their depression (requiring a Hamilton Rating Scale for Depression [HAM-D] score of less than 10 on two consecutive visits) or were classified as a nonremitter (indicating they plateaued in their improvements after a minimum of 12 ECT sessions).

Nearly 62 percent of patients achieved remission, 10 percent were classified as nonremitters, and 28 percent discontinued before they could be classified. The average number of sessions required for remission was 7.3—about 2.5 weeks, which is faster than antidepressants on average, noted lead author Charles Kellner, M.D., a professor of psychiatry at the Icahn School of Medicine at Mount Sinai in New York.

Additional analysis revealed that ECT was more effective in older patients than in younger patients (remission rates were 70 percent in patients aged 70 and older compared with 55 percent in patients aged 60 to 69). The authors noted that previous studies suggest that ECT appears to be more effective in older adults, but they said it is unclear why this might be.

The authors found no statistical differences in cognition scores between the start and end of this treatment phase (using the mini-mental state exam), though Kellner noted that a more thorough analysis of neurocognitive data will be published in a forthcoming paper. Other adverse effects were also rare and occurred in only 5 percent pf participants.

For the second phase of the PRIDE trial, 120 of the remitters were randomly assigned to continue receiving ECT sessions along with medication (venlafaxine plus lithium) or medication alone for 24 weeks.

"During this maintenance phase, we did not require a fixed schedule for the ECT sessions after the first month, but rather developed a protocol that would evaluate each patient and treat them as needed," Kellner told *Psychiatric News*.

This flexible regimen, known as Symptom-Titrated, Algorithm-Based Longitudinal ECT, took into account patients' current and previous HAM-D scores to classify them as low, moderate, or high relapse potential; based on this classification, the patients either went without ECT (low relapse potential group) or received one (moderate) or two (high) ECT sessions weekly.

After 24 weeks, the group receiving continuation ECT had an average HAM-D score of 5.5 and a 13 percent relapse rate, compared with a HAM-D score of 9.4 and 20 percent relapse rate for patients receiving medication only.

As was found during the first phase, cognition scores were the same between the ECT and medication groups. "Ultrabrief ECT is a newer form of this technology that is gaining evidence, but it is well-tolerated so doctors should not be afraid to use it in older patients," Kellner said.

Georgios Petrides, M.D., a co-investigator on this study, agreed that the findings provide a good blueprint for keeping depression at bay. Petrides is an associate professor of psychiatry at Hofstra Northwell School of Medicine and the director of the ECT Division at the Zucker Hillside Hospital.

"The highest risk of relapse occurs in the first seven to eight weeks after the acute treatment, and the tailored approach we described in our study enables us to be vigilant and treat promptly, without giving unnecessary ECT treatments," he said.

PRIDE was supported by multiple grants from the National Institute of Mental Health. PN

An abstract of "Right Unilateral Ultrabrief Pulse ECT in Geriatric Depression: Phase 1 of the PRIDE Study" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2016.15081101. An abstract of "A Novel Strategy for Continuation ECT in Geriatric Depression: Phase 2 of the PRIDE Study" is posted at http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2016.16010118.

FROM THE EXPERTS

ECT Found to Help Patients With Medication-Resistant Schizophrenia

BY GEORGIOS PETRIDES, M.D.

Electroconvulsive therapy (ECT) is the oldest biological treatment in modern psychiatry. It is now more than 80 years old, and its efficacy in treating severe mental illness is unsurpassed.

Convulsive therapy was first introduced in 1934 by Ladislaus von Meduna in Hungary as a treatment for "dementia praecox," the term for schizophrenia at the time. The first patient to receive the therapy had been diagnosed with dementia praecox and was catatonic and bedridden for years. The patient recovered completely after eight sessions of convulsive therapy in which seizures were induced with camphor oil.

The first treatment using electricity to induce a seizure was performed in 1938 in Rome by Ugo Cerletti and Lucio Bini on a patient exhibiting agitation, disorganization, neologisms, and delusions of thought control and broadcasting. He also recovered completely and, the new method of treating schizophrenia spread very quickly. ECT was introduced in the United States in 1939 by Lothar Kalinowski, a student of Cerletti and Bini, and was first offered as a clinical treatment in 1941 at Hillside Hospital in New York.

It soon became clear that ECT was extremely helpful not only for treating psychosis, but also conditions such as depression, mania, catatonia, delirium, epilepsy, and parkinsonian symptoms.

With the introduction of antipsychotics and antidepressants in the 1950s, the use of ECT declined. The antipsychiatry movements of the 1960s and 1970s in the Western world further decreased the use of ECT.

Over the past 30 years, however, the use of ECT has undergone an unprecedented revival due to its superior efficacy and safety in treating severe mental illnesses refractory to medications. While ECT in the United States today is a common treatment option for patients with treatment-resistant depression, it is often overlooked as a treatment option for patients with schizophrenia. In fact, patients with schizophrenia in the United States are less likely to receive ECT compared with patients in other parts of the world, even when medications do not work for them.

There are several factors contributing to the underutilization of ECT including stigma, limited availability of ECT in state and county hospitals, poor reimbursement, and limited knowledge of its effectiveness among medical and mental health professionals.

APA's Task Force for ECT recommends the use of ECT for patients with schizophrenia who are catatonic and/or experiencing affective symptoms, considered to be suicidal, or failing to respond to medications.

Several studies over the last few

see ***From the Experts*** *on page 38*

Georgios Petrides, M.D., is an associate professor of psychiatry at Hofstra Northwell School of Medicine and the director of the ECT Division at the Zucker Hillside Hospital.

CLINICAL & RESEARCH NEWS

Targeted CBT May Be Best for Treating Cognitive Problems in Cancer Survivors

Many cancer survivors find themselves dealing with deficits in concentration and working memory even years after their chemotherapy has concluded.

BY NICK ZAGORSKI

Thanks to advances in cancer therapy, cancer survivors are leading longer, fuller lives. As the population of cancer survivors has grown, however, it has become increasingly clear that some will experience long-term cognitive effects of cancer therapy—a condition commonly known as "chemobrain."

"Most patients will report cognitive issues during the chemotherapy process, but as these are potent agents, feeling weak, confused, or disoriented is not surprising," said Tim Ahles, Ph.D., a behavioral psychologist at Memorial Sloan-Kettering Cancer Center who has dedicated himself to understanding the cancer-cognition connection. Ahles noted that evidence also indicates hormonal therapies and radiation for cancer may also compromise cognition.

"If these problems were limited to the short term, it might not be a big issue," he continued. "However, cancer survivors are still showing signs of cognitive impairment years after their last treatment."

Although older patients with cancer might be expected to show some degree of age-related cognitive decline (such as loss of episodic memory), Ahles noted that chemotherapy-induced problems most often affect attention, working memory, and processing speed. In addition, these deficits typically do not get progressively worse as would be expected with an age-related disorder.

A recent study from St. Jude Children's Research Hospital also found higher exposure to a chemotherapy drug was associated with long-term executive dysfunction in survivors of pediatric cancer (*Psychiatric News*, July 1).

Ahles thinks that chemotherapy agents may compromise the brain's ability to distinguish relevant information from irrelevant information, which might explain why cancer survivors experience symptoms that resemble attention-deficit/hyperactivity disorder (ADHD). Because most chemotherapy drugs cannot cross the blood-brain barrier, however, the exact mechanism by which they exert their effects is unknown (with brain tumors being an exception).

Treating cognitive issues with cancer patients and survivors can be challenging. While many cancer patients and survivors experiencing chemotherapy-induced cognitive problems are given stimulants such as methylphenidate or modafinil, it remains unclear whether this is the best approach for all patients, who may be in a weakened state due to ongoing chemotherapy. Cognitive therapies can also be used to treat chemotherapy-induced cognitive dysfunction, but this approach also presents challenges.

As Robert Ferguson, Ph.D., an assistant professor of medicine at the University of Pittsburgh Cancer Institute Biobehavioral Oncology Program told *Psychiatric News*, an important component of cognitive-behavioral therapy (CBT) is to educate patients about their disorder, so they can be more aware of their behaviors and actively work to change them.

"But we don't really have that luxury when discussing cancer-related cognition problems, because our understanding of what these chemotherapies are doing is still quite limited," he said.

He noted that while many cancer survivors are older adults, the distinct manifestation of chemotherapy-induced problems means that applying existing CBT programs for dementia may not be appropriate. At the same time, ADHD-tailored cognitive therapies, which often require intensive training to get patients to improve their attention and working memory skills, may not be a good fit either.

Such cognitive training is time consuming, Ferguson said, "and cancer survivors have already given up a lot of their time. They want to get back to their regular lives as quickly as possible."

To assist cancer survivors with cognitive dysfunction, Ferguson and colleagues at the University of Maine (where he was prior to joining Pittsburgh) have been working on a CBT therapy known as Memory and Attention Adaptation Training (MAAT).

MAAT, which was designed to be administered over the course of just one

see ***CBT*** *on page 33*

Experts Debate Effectiveness of Antidepressants in Youth

Of the 14 medications included in a recent meta-analysis, only fluoxetine was found to be statistically more effective than placebo at relieving symptoms of depression in youth aged 9 to 18.

BY NICK ZAGORSKI

A comprehensive meta-analysis published this past summer in the *Lancet* concluded that most antidepressants offer few benefits for the acute treatment of depression in children and adolescents.

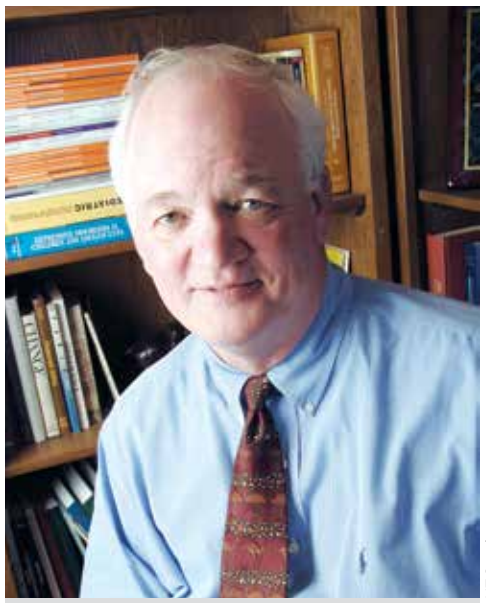
Of the 14 medications included in the analysis (amitriptyline, citalopram, clomipramine, desipramine, duloxetine, escitalopram, fluoxetine, imipramine, mirtazapine, nefazodone, nortriptyline, paroxetine, sertraline, and venlafaxine), only fluoxetine was found to be statistically more effective than placebo at relieving symptoms of depression in youth aged 9 to 18 while also demonstrating favorable tolerability ratings.

In contrast, nortriptyline was shown to be significantly less effective than placebo and several other medications, while imipramine was significantly less well tolerated than placebo, venlafaxine, and duloxetine.

The findings attracted widespread media coverage, including renewed questions about the use of antidepressants in youth.

"Every decision about whether and what to prescribe needs a complex and partly intuitive calculation of the balance between harms and benefits according to the patient's circumstances," Jon Jureidini, M.B.B.S., Ph.D., a child psychiatrist at the Women's and Children's Hospital in Adelaide, Australia, wrote in a related editorial. The finding of the meta-analysis "has disturbing implications for clinical practice, concluding as it does that the risk-benefit profile of antidepressants in the acute treatment of depression does 'not seem to offer a clear advantage for children and adolescents.'"

Graham Emslie, M.D., the Charles E. and Sarah M. Seay Chair in Child Psychiatry at the University of Texas Southwestern Medical Center, told *Psychiatric News* that while he does not question the accuracy of the findings, he cautions against drawing the conclusion that the findings suggest antidepressants cannot benefit some youth with depression.



UT Southwestern

Graham Emslie, M.D., noted that while the recent meta-analysis found no superiority for most antidepressants over placebo in acute symptom improvements, it did not address long-term benefits such as length of remission.

"The results of this review are not much different from what we've known from other research, but none of these studies have proved the negative [that antidepressants are doing more harm than good]; they have just failed to show the positive," said Emslie, who was not involved with this study.

There are multiple reasons that a drug may fail to work significantly better than a placebo, Emslie explained. One reason that most of the antidepressants in this study appeared to be no more effective at treating depression in youth than placebo may be that the response rates seen for the placebo groups showed dramatic differences (whereas the drug rates were fairly consistent). A higher than average placebo response runs the risk of masking a successful therapy, he said.

In addition to the varying placebo response rates in the trials, Andrea Cipriani, M.D., Ph.D., an associate professor of psychiatry at the University of Oxford and lead author on the *Lancet* paper, noted that most of the 34 clinical trials had at least a moderate risk of

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Experts Warn Against At-Home Electrical Stimulation Therapy

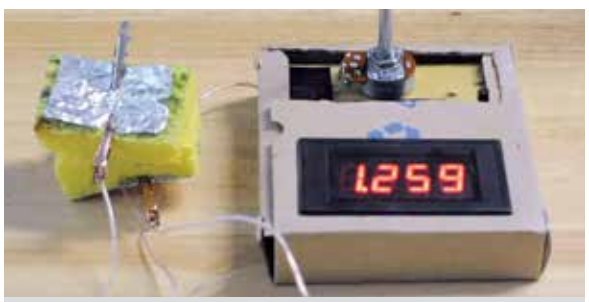
Experts hope to raise awareness and instill caution about the underappreciated practice of do-it-yourself noninvasive stimulation to improve mood or enhance functioning.

TECH TIME

BY NICK ZAGORSKI

Noninvasive brain stimulation is a promising therapy for a wide range of psychiatric and neurological issues, but it's attracted the attention of a group that has some researchers worried: people who are willing to self-administer brain stimulation to boost brain function.

"As clinicians and scientists who study noninvasive brain stimulation, we share a common interest with DIY [do-it-yourself] users … to improve brain function," wrote Michael Fox, M.D., Ph.D., associate director of the Berenson-Allen Center for Noninvasive Brain Stimulation at Beth Israel Deaconess Medical Center in Boston and colleagues in a recent open letter in the *Annals of Neurology*. "However … there is much about noninvasive brain stimulation in general, and tDCS [transcranial direct current stimulation] in particular, that remains unknown."



Whether commercially bought or homemade, do-it-yourself electrical stimulation is gaining popularity. Given the risks and uncertainties, however, neuromodulation experts urged caution in a recent open letter.

Transcranial direct current stimulation (tDCS) involves passing a constant, low-intensity current between two electrodes on the scalp. Several clinical studies have suggested that use of tDCS leads to functional improvements in patients with neurological problems.

"Whereas some risks, such as burns to the skin and complications resulting from electrical equipment failures are well recognized, other problematic issues may not be immediately apparent," the letter continued.

Fox, who is also an assistant professor of neurology at Harvard Medical School and studies the effectiveness of noninvasive brain stimulation, told *Psychiatric News* that his motivation in penning the letter stemmed from his belief that it was important to raise awareness of the potential risks associated with DIY stimulation.

The letter detailed a range of issues and uncertainties surrounding noninvasive stimulation, with an emphasis on tDCS, which is one of the more well-studied noninvasive techniques, and also one that can be readily built or readily bought.

"You do not need complicated equipment to make tDCS devices, so it lends itself to low-cost and high-market penetration," said Mark George, M.D., the Layton McCurdy Endowed Chair of Psychiatry and Behavioral Sciences at the Medical University of South Carolina and one of the 39 experts who signed their support of the open letter.

"But we know that anything that has the power to heal or shape the brain also has the power to harm it, so this is an area of great concern for psychiatrists," he added.

"I get questions about these [consumer stimulation devices] all day long, and if anyone seems curious I say no," he said. "I know my advice may only go so far for a patient who may be desperate, but I tell them to wait until the evidence for noninvasive stimulation is there."

One of the major issues with DIY applications, George said, is the variability of the electrical stimulation across individuals; this not only applies to the fact every person will respond to tDCS to a different degree, but also that the intensity needed to produce an effect varies in each person.

"It's not a one-size-fits-all strategy; a critical first step to treating someone with any type of stimulation, like electricity or magnetism, is to establish his or her threshold," he said. According to George, determining this threshold is the equivalent of reaching the proper dose of medication.

For established techniques, like transcranial magnetic stimulation (TMS) or electroconvulsive therapy, clinicians understand how to reach these levels; in TMS, for example, the magnetic energy needed for clinical effectiveness is believed to be the amount required to make a person involuntarily move a thumb.

"But for noninvasive electrical applications like tDCS, we haven't been able to individually dose yet," he said. As a result, people using homemade or purchased devices are more often than not applying too much or too little current.

Even if DIY tDCS users achieve some kind of response, there could be subtle consequences of which they aren't aware, said Fox. "Brain networks are interconnected, so improving the activity of one region may lead to a negative outcome somewhere else," he explained. In the letter, he used an example that tDCS might help someone learn new material at the expense of losing previously learned knowledge.

"How common are these trade-offs? We don't know."

Unfortunately, despite these risks, not much can be done about DIY devices, George told *Psychiatric News*, as commercial stimulators are not regulated by the Food and Drug Administration. "The companies that make them have also been careful not to use medical terms when they describe their devices," he said. "Rather, they say they can help you get energized or relaxed."

Such marketing by the makers of commercial stimulators likely attracts people who do not have a mental disorder, George said, noting that these devices have become popular among video gamers, athletes, and college kids.

What is recommended as a therapeutic option for patients with mental illness may be different from what would be recommended for people without a mental illness, Fox said.

"The goal of tDCS research is to treat brain disease, and if there is a reasonable chance to improve a patient, we can also accept some risks of adverse changes. But we would not accept those risks if we were just trying to enhance function in a healthy brain." PN

"An Open Letter Concerning Do-It-Yourself Users of Transcranial Direct Current Stimulation" is posted at http://onlinelibrary.wiley.com/doi/10.1002/ana.24689/full.

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bias, many had incomplete reporting of results, and several were unpublished.

The authors also noted that the analysis may not have been a thorough reflection of clinical practice, as trials recruiting participants with treatment-resistant depression, patients with subsyndromal depression, or treatment durations of less than four weeks were excluded.

While the meta-analysis compared short-term response to the antidepressants with placebo (the studies included ranged from 6 to 12 weeks in length), it did not compare remission, which considers the length of time that a patient feels better before relapsing as opposed to the degree of their improvement.

Still, Cipriani and colleagues concluded that the findings support the use of psychotherapy as a first-line intervention for depression regardless of severity, while fluoxetine can be a consideration in patients with moderate-to-severe depression who do not have access to psychotherapy. Emslie, however, questioned whether there is enough evidence to say one approach is superior to another.

"We should be arguing about how we leverage all our options to provide the most effective treatments, rather than pitting them against each other," he said.

David Fassler, M.D., a clinical professor of psychiatry at the University of Vermont College of Medicine who was not involved with this study, agreed.

"Medication can be helpful for some children and adolescents with depression, but medication alone is rarely the best intervention for these kids. We also know that many of these young people can be treated successfully without medication," Fassler said. "Medication should be used only as part of a comprehensive plan, individualized to the needs of the child and family."

The challenge, he continued, is to make sure that children and adolescents with depression and other psychiatric disorders have access to the most appropriate and effective treatment possible.

The *Lancet* meta-analysis was supported by a grant from the National Basic Research Program of China. PN

An abstract of "Comparative Efficacy and Tolerability of Antidepressants for Major Depressive Disorder in Children and Adolescents: A Network Meta-Analysis" is posted at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30385-3/abstract. The editorial "Antidepressants Fail, But No Cause for Therapeutic Gloom" is posted at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30585-2/abstract.

MED CHECK

BY VABREN WATTS

FDA Advisory Panel Recommends Approval of Morphine Tablet With Abuse-Deterrent Properties

A Food and Drug Administration (FDA) advisory panel in August voted 18-1 to recommend the approval of ***Arymo ER, an extended-release morphine tablet*** indicated for management of pain severe enough to require daily, around-the-clock treatment. Most members of the panel also voted favorably that if approved, Amyro ER be labeled as an abused-deterrent product by oral, nasal, and intravenous routes.

The recommendations were based on data presented from five phase 1 pharmacokinetic studies as well as two phase 3 human abuse liability studies. The abuse liability trials revealed that "drug liking" was significantly reduced when Arymo ER was manipulated compared with that of crushed ***MS Contin***, an approved extended-release morphine formulation.

The FDA is not bound by the recommendations of its advisory panels, but will consider the guidance during the review of the new drug application for Arymo ER. The company said it expects to hear a decision from the FDA on this product by October 14.

Zydus, Sun Pharmaceuticals Issue Antidepressant Recall

Zydus Pharmaceuticals and Sun Pharmaceuticals Industries in July announced voluntary recalls of several lots of antidepressants in the U.S. market.

Zydus recalled 35 lots of its antidepressant ***venlafaxine HCl ER*** 75 mg and 150 mg capsules—a generic version of ***Effexor XR***. The recall includes all 30- , 90- , and 1,000- count bottles with expiration dates from September 2017 to December 2017. (The company recommends that anyone with the affected lots discontinue the use, dispensing, and distribution of the product immediately.)

The recall was issued after tests revealed the medication has marginally higher dissolution rates than normal at different time points, which Zydus said poses a minimal risk to patients.

Failed dissolution specifications were said to also be behind Sun Pharmaceuticals Industries' decision to recall of over 16,085 bottles of its antidepressant ***bupropion hydrochloride extended release*** 150 mg tablets (60-count bottles). Exposure to the recalled products is not expected to cause adverse health consequences.

Tau Aggregation Inhibitor Fails As Add-On Therapy, But Shows Promise as Monotherapy

TauRx Pharmaceuticals Ltd. in July announced that its tau protein aggregation inhibitor ***LMTX***—intended to treat mild to moderate forms of Alzheimer's disease—failed to meet primary endpoints in a phase 3 clinical trial involving 891 participants with mild to moderate Alzheimer's disease (many took the medication in combination with their standard Alzheimer's treatment regimen).

The company reported that patients who took LMTX as a monotherapy, however, experienced a statistically significant benefit on the cognitive and functional outcomes, and brain atrophy measured.

"These results support the targeting of the tau tangle pathology in Alzheimer's disease as being a very promising drug development pathway," Claude Wischik, Ph.D., co-founder of TauRx Pharmaceuticals, said in a press release. "However, the reason for the observed loss of efficacy of LMTX when taken in combination with currently available treatments for Alzheimer's disease is not as yet understood."

Participants were randomized to receive daily oral LMTM of 150 mg or 250 mg; to remain blinding, the control group received 8 mg of LMTX daily. Participants were stratified by disease severity, global region, and whether they were taking an Alzheimer's medication.

Primary efficacy outcomes were change from baseline on standard measures of cognition and function, including the Alzheimer's Disease Assessment Scale cognitive subscale and Alzheimer's Disease Cooperative Study–Activities of Daily Living scale. These assessments were performed at baseline and every 13 weeks during the study. Study participants also received magnetic resonance imaging every three months. PN

Goldwater Rule's Origins Based on Long-Ago Controversy

Restraint of psychiatrists' comments on political candidates is grounded in APA's response to an attempt to question Barry Goldwater's mental health during the 1964 campaign for president.

BY AARON LEVIN

"Do you believe Barry Goldwater is psychologically fit to serve as President of the United States?" the editors of Fact magazine asked 12,356 psychiatrists during the 1964 presidential campaign between Goldwater and Lyndon Johnson.

The responses set off a wave of reaction that resonated again most recently after media speculation about the mental status of the current Republican presidential candidate.

Fact published numerous comments questioning Sen. Barry Goldwater's psychological capacity for office, which ultimately led to the creation of APA's "Goldwater Rule" in 1973.

A look at the original episode reveals as much about psychiatry's changes over the last half century as it does about politics then or now.

The harshly negative responses by people who had never even met Goldwater seem astonishing by today's standards, as a sampling suggests:

"I believe Goldwater to be suffering from a chronic psychosis," wrote one.

"A megalomaniacal, grandiose omnipotence appears to pervade Mr. Goldwater's personality giving further evidence of his denial and lack of recognition of his own feelings of insecurity and ineffectiveness," wrote another.

"From his published statements I get the impression that Goldwater is basically a paranoid schizophrenic who decompensates from time to time. … He resembles Mao Tse-tung," said a third.

Not wanting to exclude other relevant 20th-century tyrants, another claimed, "I believe Goldwater has the same pathological makeup as Hitler, Castro, Stalin, and other known schizophrenic leaders."

Others pushed back. In reality, Goldwater had worked in his family's business, then served as a transport pilot in World War II, and retained a commission in the Air Force Reserve for many years. He was twice elected senator before the 1964 presidential race and would be again in 1968, 1974, and 1980.

It was difficult, said one psychiatrist quoted in *Fact*, to believe that a man who was "psychotic" or "schizophrenic" would have managed all that.

"I served as a flight surgeon in the USAF," wrote Wilbert Lyons, M.D., of Sellersville, Pa. "I speak with authority when I say that Sen. Goldwater could not be a jet pilot if he were emotionally unstable."

Goldwater certainly held very conservative political views and expressed them forcefully. Many of the respondents who declared him "unfit" were likely expressing their own political biases in psychiatric terms. Tellingly, many of them asked that their names be withheld from publication, perhaps hinting at some guilt feelings over their cavalier, remote diagnoses of the candidate.

Nevertheless, many other respondents understood immediately the greater implications of the question for psychiatry's purported role in the electoral process.

"Your inquiry for a professional opinion regarding Sen. Barry Goldwater's general mental stability is an insult to me," wrote Thomas Stach, M.D., in 1964. "An inquiry of this type regarding any individual can only be based on ignorance of the field of psychiatry."

Stach demanded an apology from the editors to all the psychiatrists who had received the survey.

"It was astounding to me when the survey first came out," Stach, now retired in Willowbrook, Ill., told *Psychiatric News*. "It was impossible for a psychiatrist to come to a conclusion like that without a personal examination. The psychiatrists who were baited into giving responses were imprudent."

Some offered a nuanced statement of their own positions.

"Politically, I heartily disapprove of Goldwater," wrote Joseph Schachter, M.D., Ph.D., in 1964. "In fact, I find him somewhat frightening. Yet I do not feel I can honestly say he is psychologically unfit to serve as president."

"I still think that's a plausible view of the Goldwater situation," said Schachter, now retired and living in New York City, in a recent interview. "Psychiatrists and psychoanalysts have the right as citizens to comment on elections and candidates and are free to do that, but without selecting a psychiatric diagnosis."

"Vetting a candidate should be based on his or her position on the issues," agreed Stach. "The survey betrayed the ignorance of the questioner."

APA's initial reaction to the *Fact* magazine article came swiftly.

"[S]hould you decide to publish the results of a purported 'survey' of psychiatric opinion on the question you have posed, the Association will take all possible measures to disavow its validity," wrote APA Medical Director Walter Barton, M.D., in a letter to the magazine's editors on October 1, 1964.

APA President Daniel Blain, M.D., denounced the compilation as "a hodgepodge of the personal political opinions of selected psychiatrists speaking as individuals. … [T]he replies to the question have no scientific or medical validity whatsoever."

Tying political partisanship to the psychiatric profession, continued Blain, "has, in effect, administered a low blow to all who would work to advance the treatment and care of the mentally ill of America."

APA's formal response came in 1973 with the adoption of Section 7.3 in the *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, which became known as the Goldwater Rule.

The rule applies to public figures and states: "[I]t is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement" (see box below).

Text of APA's Ethics Annotation Known as 'Goldwater Rule'

7. 3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.

—*APA's Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (http://apapsy.ch/Annotations)

The episode and the subsequent adoption of Section 7.3 appear to have dampened the enthusiasm of most APA members for a repeat performance, leaving psychiatric diagnosis to the media (see page 1). PN

"Goldwater v. Ginzburg" by John Martin-Joy, M.D., is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.14111410.

Vote

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members, with reasoning going back half a century, when Sen. Barry Goldwater (R-Ariz.) was the Republican nominee for president in the 1964 election.

Back then, *Fact* magazine asked 12,000 U.S. psychiatrists if they thought Goldwater was "psychologically fit" to be president.

Only 2,417 responded, with half saying "no," mostly employing the dominant psychoanalytic language of the day. The rest thought Goldwater was as qualified as anyone, and many objected to the poll itself. Goldwater later sued the magazine and won.

"This large, very public ethical misstep by a significant number of psychiatrists violated the spirit of the ethical code that we live by as physicians and could very well have eroded public confidence in psychiatry," said current APA President Maria A. Oquendo, M.D., in a recent blog post on APA's website.

Despite that misstep and the reaction to it, accusations of mental disability are never far from political campaigns, said former APA President Paul Appelbaum, M.D., the Dollard Professor of Psychiatry, Medicine, and Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University.

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"If you look back over the last 50 years since the Goldwater incident, it seems that there has been some public discussion of the mental health of candidates in almost every election," said Appelbaum. "At the moment, that discussion may be more intense, but its recurrence shouldn't surprise anyone."

In 1973, APA responded with the creation of Section 7.3 in the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry,* informally known as the Goldwater Rule (see box on page 31).

"Simply put, breaking the Goldwater Rule is irresponsible, potentially stigmatizing, and definitely unethical," wrote Oquendo.

The Goldwater Rule remains relevant, said Appelbaum. A diagnosis made at a distance is likely to be inaccurate and simply reflect the commenting psychiatrist's political views, he said. As a result, the candidate may be unfairly hurt in the eyes of the public. Goldwater felt personally aggrieved by the *Fact* episode.

"It's important to be circumspect and be sure that people understand what you're claiming and what you're not claiming," added Ezra Griffith, M.D., a professor emeritus and senior research scientist in psychiatry at Yale University School of Medicine and chair of APA's Ethics Committee. "It's difficult to make claims about someone you've never examined and about whose background you have limited knowledge, or if you haven't interviewed any collateral witnesses. The scandal following the Goldwater incident occurred because psychiatrists were making statements without being mindful of an ethics-based practice that guides a professional's behavior."

Accusations of mental deficiencies exploit the heightened stigma attached to mental illness. Much has been written about the current candidates' hair, for example, said Griffith, but no one has asked dermatologists for their professional opinions.

Appelbaum also worries that people who could benefit from psychiatric treatment would look at psychiatrists who assessed candidates based on television reports as being incapable of rendering a scientifically sound diagnosis.

However, other psychiatrists believe that perhaps APA's rule should not be so rigid. In a recent article in the *Journal of the American Academy of Psychiatry and the Law* (which Griffith edits), Jerome Kroll, M.D., and Claire Pouncey, M.D., Ph.D., challenge elements of the Goldwater Rule, which, they wrote, "denies an individual psychiatrist's responsibility to speak up about political leaders' behaviors that strongly suggest psychopathology. … The Goldwater Rule cannot distinguish between thoughtful and well-researched psychiatric commentary on public figures and the flippant sound bites about celebrities and politicians [that] make each day's headlines."

This view may be at odds with APA's official position, but Griffith believes such arguments are legitimate in ethics discussions. "It's important not to close debate," he said. "When encountering ethics dilemmas, disagreeing parties in the debate are motivated by different interests, different points of view, and different approaches."

Ultimately, each voter's own assessment of the candidates is what counts.

"Sometimes people are not crazy; sometimes people are just acting badly," said Appelbaum. "How they act and what they say tell us more about their likely future behavior than any psychiatric speculation." PN

The discussion of the Goldwater Rule by APA President Maria A. Oquendo, M.D., is posted at https://www.psychiatry.org/news-room/apa-blogs/apa-blog/2016/08/the-goldwater-rule.

CBT

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month, focuses on teaching patients compensatory skills to manage cognitive issues; such strategies include encouraging patients to make schedules or softly talk through tasks as they are being performed.

A few years back Ferguson carried out a small clinical study in 40 breast cancer survivors and found that MAAT did provide modest benefits for some elements of cognitive function, as well as anxiety related to their cognitive problems. In a more recent study, Ferguson found cancer survivors also reported cognitive improvements following MAAT by videoconference. (Patients could participate in the program at home, which Ferguson noted was another important consideration for cancer survivors.)

While Ferguson noted that more research is needed to determine the long-term effects of MAAT on larger populations of cancer survivors, he said he believes MAAT may serve as a simple way to offer them a strategy for coping with cognitive challenges. PN

An abstract of "A Randomized Trial of Videoconference-Delivered Cognitive Behavioral Therapy for Survivors of Breast Cancer With Self-Reported Cognitive Dysfunction" is posted at http://onlinelibrary.wiley.com/wol1/doi/10.1002/cncr.29891/abstract. "Development of CBT for Chemotherapy-Related Cognitive Change: Results of a Waitlist Control Trial" is posted at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3955296/.

Generic

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on the brand," she said. "It was almost a quarter dose lower, and some patients experienced breakthrough symptoms."

Gregory Dalack, M.D., chair of the Department of Psychiatry at the University of Michigan and a member of APA's Council on Quality Care, said his own experience treating patients switched from brand name to generics has been generally favorable. "I favor use of generic forms of medications whenever possible," he said. "I have had a very small number of patients—perhaps five—over the course of my career whom I felt did do better on a brand drug versus the generic, but we have generally come to this after the switch from brand to a newly available generic does not go well and we try some alternative dosing first."

In light of what is widely regarded as an alarming increase in drug prices, some believe there is an ethical case for the use of generics. "When public or private insurance is paying for the drug, substituting an FDA-approved generic medication for a branded drug serves general welfare by saving money," Jim Sabin, M.D., director of ethics at the Harvard Pilgrim Healthcare Plan, told *Psychiatric News.*

But he added, "When an individual is self-paying for a medication, the person should have the right to purchase the branded product. In principle, allowing an individual to have access to the branded product by paying the price

difference between the generic and the branded drug is a good policy. It gives the individual choice, but it does not require others to pay for his preferences.

"There should be an easy-to-use appeal mechanism, so that if there is a reason other than preference on the part of the physician or the patient, the branded product can be dispensed," he said. "Having had a previous allergic reaction to the generic is an example of a justifiable appeal."

"Overuse" of Branded Drugs?

Therapeutic substitution appears to be a step further—and perhaps a step too far—to address rising drug prices.

A study appearing in the June issue of *JAMA Internal Medicine* looked at the price differential associated with hypothetically substituting generic medications that were different from prescribed brand-name drugs but were in the same therapeutic class.

That study found that from 2010 to 2012, an estimated $73.0 billion in total excess expenditure and $24.6 billion in out-of-pocket excess expenditure was attributable to what the authors called branded drug "overuse." The drug classes with the highest excess expenditure included statins ($10.9 billion), atypical antipsychotics ($9.99 billion), proton pump inhibitors ($6.12 billion), selective serotonin reuptake inhibitors ($6.08 billion), and angiotensin receptor blockers ($5.53 billion).

The study authors acknowledged widespread opposition to therapeutic

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substitution. "There is legitimate concern that therapeutic substitutions could lead to worse clinical outcomes, but this would likely be concentrated in high-risk drug classes," they stated. "If therapeutic substitution were to become commonplace, more efficient systems that allow for seamless communication among prescribers, pharmacies, and insurance companies should be in place."

In response to a query from *Psychiatric News*, lead author Michael Johansen, M.D., of the Department of Family Medicine at Ohio State University, emphasized that he does not favor substitution by a pharmacist without consultation with the prescribing clinician.

"Automatic therapeutic substitution would have the potential to be detrimental to patients' health," he said. "There are certainly occasions when use of more expensive branded products is warranted based on a clinical scenario. Within this study, we attempted to mitigate this by decreasing the number of hypothetical substitutions of psychiatric medications. That being said, some of the drug classes with the highest excess expenditure were psychiatric medications. For instance, escitalopram had billions expended on it when there were five other SSRIs available. It is rare that the use of this drug was clinically necessary.

"The take-home message from the study is that prescribing in the United States is inefficient," Johansen said. "Too many branded drugs are used when generics will work equally effectively at

dramatically lower prices.This does not mean we shouldn't prescribe branded drugs, but this should be restricted to times when it is absolutely necessary."

Therapeutic Substitution Opposed

All of the clinicians who spoke with *Psychiatric News* were unanimous that therapeutic substitution was at least unwise, and possibly dangerous.

Glenn Martin, M.D., immediate past speaker of the APA Assembly, told *Psychiatric News* that he believes the policy is "problematic and potentially dangerous." He said, "We know that even within relatively well-defined classes, not all drugs are the same, especially when it comes to side effects, drug interactions, and patient tolerance."

Martin added, "Psychiatrists understand and value the important role of pharmacists and are happy to collaborate with them. But class substitution without prior specific approval by the physician is not in the patient's best interest and should definitely not be allowed to be mandated as a cost-saving tactic."

At APA's 2016 Annual Meeting, the Assembly approved an action paper requesting the Association to revisit its position on the issue of medication substitution without the express consent of the prescribing psychiatrist. The action paper was in response to a 2013 Arkansas law that appears to be the first in the nation allowing the practice of therapeutic substitution (see article on page 12).

Instead of allowing the decision to be made by pharmacists, Dalack said,

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a more favorable option might be the inclusion of alerts in a patient's electronic health record that indicate information about the options for therapeutic substitutions, including cost differentials. "That way I could consider and discuss with my patient."

Child psychiatrist Robb echoed that comment. "The appropriate time to be thinking about cost is during the initial discussion with a patient, not after he or she has been stabilized on a brand-name drug." PN

"Estimation of Potential Savings Through Therapeutic Substitution" is posted at http://archinte.jamanetwork.com/article.aspx?articleid=2520679.

From the Experts

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years have sought to examine and document the efficacy of ECT alone or in combination with antipsychotic medications in people with schizophrenia. Most of the literature consists of observational studies and case series; however, there are several well-controlled studies that have been published on this issue. Among them, Worrawat Chanpattana and colleagues reported that 56 of 104 (54 percent) of patients with medication-resistant schizophrenia responded to a six-week course of ECT plus flupenthixol.

Our group at the Zucker Hillside Hospital recently published the results of a randomized, controlled, single-blinded trial, where we examined the efficacy of ECT as an augmentation strategy for patients who failed to respond to clozapine. In our sample, 10 of 20 patients (50 percent) responded after receiving ECT and clozapine for eight weeks (response was defined as 40 percent reduction in the psychotic items of the Brief Psychiatric Rating Scale [BPRS]). In contrast, none of the patients in the comparison group responded to clozapine monotherapy. An additional 47 percent (9 of 19) of patients responded to the ECT-clozapine combination in the crossover phase of the study, for a total of 49 percent (19/39) response rate to the ECT-clozapine combination. These findings suggest that patients who are resistant to clozapine—the only medication approved for medication-resistant schizophrenia—may benefit from ECT.

Wenzheng Wang and colleagues also recently published a meta-analysis of five randomized, single-blind, controlled trials comparing ECT alone with antipsychotic medications in patients with schizophrenia. They reported that as early as one to two weeks into therapy, ECT (n=153) outperformed antipsychotic monotherapy with a large effect size (-0.84 to -1.26) in psychopathology reduction as measured by the BPRS or the Positive and Negative Syndrome Scale (PANSS). The findings support the combined use of antipsychotics and ECT.

The majority of ECT studies in schizophrenia report substantial benefits while there are no reports of worsening of psychopathology with ECT. Positive symptoms seem to respond better to ECT than negative symptoms, and the combination of ECT with antipsychotic medications seems to be superior to either modality alone, and there is no need for antipsychotic medication adjustment during ECT. The most common side effect reported is transient memory disturbance, which is similar to that observed in depression studies.

ECT is a powerful tool in our armamentarium for the treatment of schizophrenia and should be considered as the next step when results with medications are suboptimal. PN

References for this article are posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.pp7a4.

Manage

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M.D., M.P.H., a professor and the Rosalynn Carter Chair in Mental Health at the Rollins School of Public Health at Emory University. The algorithm is described in the July *American Journal of Psychiatry.*

In interviews with *Psychiatric News,* all three authors—leaders in the movement to integrate mental health and general medical care—said the algorithm provides a framework by which a psychiatrist considering physical health management could do so in a reasoned, practical, efficacious, and person-centered manner.

"There is no one one-size-fits-all approach for when a psychiatrist should do this," said Druss. "It depends on how urgent the need is, whether there is somewhere more appropriate that the patient should be getting primary care, the psychiatrist's familiarity and comfort level, the support the clinician has on site, and the patient's preference," Druss said. "Put those together, and this algorithm begins to provide a way to think about these problems."

Druss said psychiatrists working in the public sector have increasingly been seeking to diminish the mortality gap between the general population and those with serious mental illness (SMI) by providing better care of common medical conditions—especially cardiovascular and metabolic illnesses. In recent years, APA has offered training in primary skills at the Annual Meeting and IPS: The Mental Health Services Conference. Also, last year the APA Board of Trustees approved a position statement declaring that screening and sometimes treating common medical conditions is an essential component of psychiatric practice (*Psychiatric News,* September 15, 2015).

"We know there is a need, and a lot of psychiatrists are getting the training, and now we have a statement from our professional organization saying that doing this is within the standard of care," Raney said. "Now the question is, when is this appropriate? We decided that if we had something published, it might help clinicians be less anxious about practicing outside of our traditional scope. The graph can help a psychiatrist walk through when he or she can and should be providing primary care and when the patient should be referred."

Vanderlip said the psychiatrist is sometimes the only person who knows what kinds of conditions are impacting the patient's health. "But that psychiatrist may often be unclear about where to draw the line and actually intervene," he said. "What we tried to do is establish a framework that a general psychiatrist could use to decide whether or not they should manage general medical conditions."

Each of the five domains is broken down into two or three descriptors, which then lead variously to a decision to treat, refer to primary care, or refer to emergency care. For instance, the domain of "system capacity for management and follow-up" is broken down into two possibilities—adequate systems in place or limited system capacity—which (depending on other domains) leads to a decision to treat or refer (see chart). System capacity refers to the availability of staff to take vital signs or blood draws, for instance, and other factors in the clinician's practice environment that can support provision of primary care.

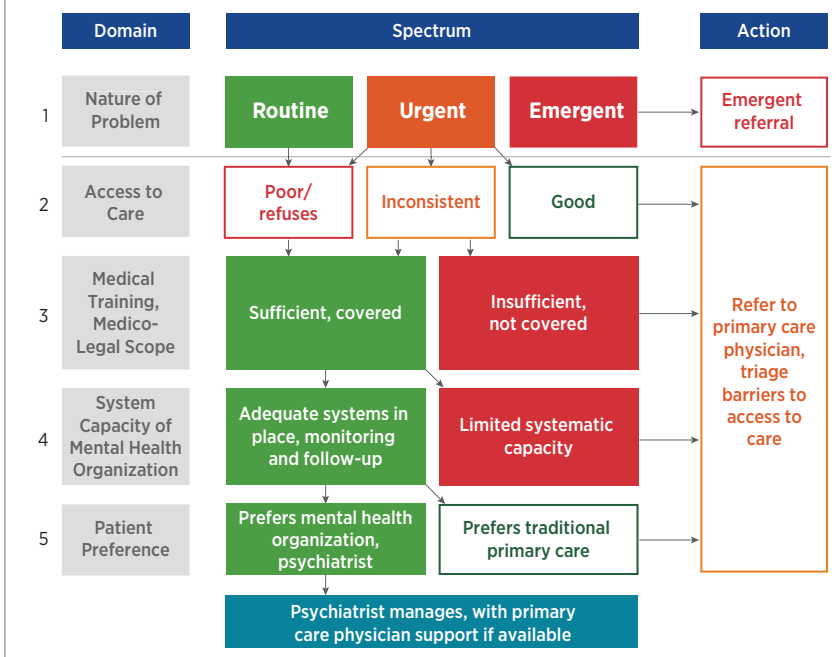
The presence of routine or possibly urgent conditions in a patient with poor or no access to primary care coupled with sufficient clinician training, legal coverage, system support, and the patient's approval for receiving care in a mental health setting leads to the decision that the psychiatrist can manage the patient.

Raney added, "The take-away message is that we are having trouble moving the dial on the mortality gap in the SMI population. There are so many patients who simply won't engage with primary care. What this decision algorithm does is give psychiatrists some guidance on when it is appropriate to treat common conditions." PN

"A Framework for Extending Psychiatrists' Roles in Treating General Health Conditions" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.15070950#.

Deciding When to Treat and When to Refer

A "decision algorithm" comprising five domains can help psychiatrists determine when to intervene in the general medical care of a patient.



Source: Erik R. Vanderlip, M.D., M.P.H., et al., *American Journal of Psychiatry*, July 1, 2016

Confidentiality

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is mentally ill and tells the clinician 'My parents want to view me as ill because that's better for them. I don't want you telling my parents anything.' "

"In fact," Hoge said, "the parents or caregivers may be providing a great deal of support and structure with regard to appointments, taking medications, and otherwise helping the patient adhere to treatment. Historically, pre-HIPAA many psychiatrists would take a more paternalistic approach that, at least in some cases, would cause the clinician not to follow the patient's explicit directive.

"That's become complicated by what appears to be a relatively rigid regulatory scheme in HIPAA that suggests to many clinicians that it is not only unethical but illegal to take this more paternalistic approach. In the span of my career, medicine has gone down a path that has de-emphasized paternalism. But I continue to believe that our primary duty as physicians is to do what is best for the patient and that we should have both professional ethics and laws that support physicians in doing what is best for their patients."

Past APA President Paul Appelbaum, M.D., said there are other instances where the boundary separating confidentiality and the imperative to act in the patient's interest may not at all be a bright line, such as when a patient is doing or not doing something that undermines treatment—not taking medication regularly or abusing substances—about which family members might be usefully informed.

"In the current regulatory structure, that's hard to do without consent," he told *Psychiatric News*. "The first option for any clinician is to try to get consent. The regulations do allow disclosure of information to people assisting in the care of the patient if the patient is aware of it and doesn't object. You don't actually need affirmative written consent."

Appelbaum is the Elizabeth K. Dollard Professor of Psychiatry, Medicine, and Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University.

Ultimately, he said, clinicians must choose between confidentiality or paternalism on a case-by-case basis. "Family members play an important role in recovery, which is made more difficult when they have an adult family member about whom they are unable to obtain any information because the patient has told the clinician not to talk to family members. All of us have a strong impulse to act on the patient's best interest when they lack some degree of insight or capacity to make a truly informed choice.

"But there is something to be said on the other side as well—that to single out psychiatry patients for a lesser degree of protection than other general medical patients are afforded seems inherently discriminatory," Appelbaum added. "That's something we ought to consider seriously when thinking about changes to the law."

Since their daughter's death, Jerry and Susan Gabay have made prevention of suicide, and the empowerment of families and caregivers, a mission. They say they respect the importance of confidentiality—certainly regarding the actual content of psychotherapy—but they argue that the clinician's ability to navigate the boundaries between confidentiality and communication with family is in the nature of the title of "professional."

"There is, of course, a tension between confidentiality and the value of sharing information," Jerry Gabay said. "But there is also a reason clinicians are called professionals and not functionaries—because they can make those determinations responsibly." PN

APA has extensive resources for members about HIPAA and the Privacy Rule at http://www.psychiatry.org/psychiatrists/practice/practice-management/hipaa. The text of the legislation approved in Oregon is posted at https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2948.