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PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

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Blythe Corbett at SENSE Theatre

The SENSE Theatre program brings together children with autism and actor peers to put on stage productions. The goal is to help the children learn communication and social skills by making use of the spontaneity and flexibility required in theater. SENSE reflects the idea that role-playing and improvisation can be valuable tools for developmental disorders. See story on page 11.

Are Psychiatrists Prepared for Health Care Reform? Yes and No

Approximately a third of surveyed psychiatrists responded that they are participating in an integrated care network, and 14 percent indicated that they would be doing so in the coming year.

BY MARK MORAN

Many psychiatrists are prepared or are preparing to practice in service delivery models consistent with the Affordable Care Act (ACA)—including the collaborative care model—but a substantial number are not, and more outreach is necessary to engage psychiatrists in health care reform.

Those are the findings from a cross-sectional survey of U.S. psychiatrists appearing in the August 15 *Psychiatric Services in Advance*.

More than 60 percent of psychiatrists are assuming some kind of role consistent with health care reform, such as participation in a team service delivery model, but engagement in integrated care models is less common. The study also underscored the need to prepare psychiatrists for merit-based payment reforms.

"Although many psychiatrists are prepared to practice in models of care that are being implemented under the ACA, our findings highlight opportunities for further workforce development," said APA CEO and Medical Director Saul Levin, M.D., M.P.A., who is a coauthor of the *Psychiatric Services* study. The lead author of the study is Joyce West, Ph.D., of the American Psychiatric Association Foundation.

"APA has a wide range of resources to help prepare psychiatrists for performance-based payment reforms and to train psychiatrists for participating in the collaborative care model of integrated care," Levin said.

He especially emphasized the training APA is providing at annual meetings as part of the Transforming Clinical Practice Initiative (TCPI) of the Centers for Medicare and Medicaid Services. "As one of the Support and Alignment Networks (SANs) awarded under the TCPI grant, APA is committed to training 3,500 psychiatrists in the principles

see **Health Care Reform** on page 29

Everett Appointed Head of New SAMHSA Office

Anita Everett, M.D., and her staff will focus on expanding innovative, science-supported approaches to behavioral health.

BY VABREN WATTS

This month APA President-Elect Anita Everett, M.D., assumed a new position as the chief medical officer at the Substance Abuse and Mental Health Services Administration (SAMHSA).

Everett is now responsible for organizing and leading the newly created Office of the Chief Medical Officer, which is expected to provide valuable input into strategic initiatives, policy directions, and legislative issues to ensure that medically researched and clinically approved practices are incorporated in the development and implementation of SAMSHA programs and activities. Additionally, the office will play a key role in representing SAMHSA's clinical perspectives, particularly when collaborating with other Department of Health and Human Services entities and federal agencies.

"Having a psychiatrist as a member of the leadership team at SAMHSA will enable psychiatrists to join other mental health and public health professionals in guiding the federal component of our nation's behavioral health system," Everett told *Psychiatric News*. "I'm really excited about the new position."

One of Everett's first tasks will be to hire staff for the new office, including one policy analyst, one nurse practitioner, and a second physician. Everett also mentioned that she will begin the

see **Everett** on page 29

PERIODICALS: TIME SENSITIVE MATERIALS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Why 'Physician Heal Thyself' Does Not Work

BY MARIA A. OQUENDO, M.D.

August is a very quiet month in psychiatry, and that is true in academic centers as well. Much of the faculty is away. Residents have settled into their routine, the terror of those first weeks subsided. The August of 2014 had not been much different.

It was late on a Monday afternoon, and I was wrapping up the day, once again not accomplishing as much as I had hoped when the day started. My cell phone rang, and I heard the voice of the director for House Staff Mental Health at our hospital. Another referral, I thought to myself.

I was wrong.

I knew it was serious when she asked me to sit down. "One of the interns just died. We are not sure if it was an accident. He fell from a rooftop."

At that time, I did not know that this wonderful, brilliant young man was the roommate of one of my interns and a medical school classmate of another. The notion of how close this was to home was only exacerbated by my understanding that "there but for the grace of God …": my own interns, in that same crop of newly minted physicians; my own sons, one having just taken the MCATs. …

It had not been five days when news of yet another death at our hospital arrived, grimly delivered by the same director for House Staff Mental Health. Harrowing, devastating.

After that first Monday, those of us with expertise in suicide, physician mental health, or both deployed ourselves to meet with anyone who wanted to talk. Program directors, chief residents, chairs, resident groups.

My feelings all came flooding back when I received a call from a reporter with questions about physician suicide in the wake of an apparent suicide of a medical student in New York.

Such unnecessary losses are heartbreaking, but hardly surprising. Physicians have a higher suicide rate than that of the general population. In fact, the rate for male physicians is 70 percent higher than that of males of other professions. For female physicians, the rate is fourfold. Suicide is the second cause of death for physicians aged 24 to 35 years, just below accidents. In fact, every year, the equivalent of one medical school class dies by suicide (about 150 physicians per year).

But why? Why should those in the healing profession, usually with outstanding access to care, be at such heightened risk? We don't know the answer for sure, but there are some facts that might explain it, at least in part.

For one, stigma is alive and well among physicians. Some of it was institutionalized by state departments of health with applications for licensure that asked physicians whether they had ever had a psychiatric condition—mind you, not whether they had one currently or whether it affected their current functioning: *ever.* Fortunately, through advocacy and education, most of these types of questions have been eliminated. However, that is not the only cause of stigma. There is still much secrecy about mental health and concerns about its effects on career prospects. Do note that this occurs in a very worrisome context: physicians often do not have regular doctor's appointments, obviating opportunities for screening.

Yet, psychiatric conditions and suicidal ideation are far from rare in physicians. In surveys of students, house staff, and faculty, 10 to 12 percent reported suicidal ideation, but only 25 percent of those endorsing current suicidal thoughts were taking antidepressant medication, and only 16 percent were receiving psychotherapy. The treatment gap is staggering.

see ***From the President*** *on page 21*


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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.

Departments

PROFESSIONAL NEWS

Incoming NIMH Director Sees Shared Mission Between APA, Institute

Joshua Gordon, M.D., M.P.H., spoke with *Psychiatric News* about Research Domain Criteria, prevention, and APA's advocacy role.

BY MARK MORAN

Joshua A. Gordon, M.D., Ph.D., says his first priority as director of the National Institute of Mental Health (NIMH) is to listen and learn.

"I intend to spend the first six months to a year learning everything that is happening at the institute and how the research community and psychiatry can work together," he told *Psychiatric News*.

Gordon's appointment was announced by the National Institutes of Health on July 28, and he was expected to assume the new post by the time this issue went to press. He replaces Bruce Cuthbert, Ph.D., who served as acting director after the departure of Thomas Insel, M.D., who was director from 2002 to 2015.

"I am personally delighted with Dr. Gordon's appointment as director of NIMH," APA President Maria A. Oquendo, M.D., a professor of psychiatry and vice chair for education at Columbia University Medical Center, told *Psychiatric News*. "Having worked closely with him over the years, I can attest to the fact that in addition to being a scientist of the highest caliber, he has an open-mindedness, fairness, and thoughtfulness that are rare indeed. I look forward to seeing the wonderful things Dr. Gordon will do. For our part, APA will continue to pursue staunch advocacy for mental health research funding, the most effective path toward improving the lives of our patients."

Joshua Gordon, M.D., M.P.H.

As director of NIMH, Joshua Gordon, M.D., M.P.H., will be leading an organization that has an annual budget of $1.5 billion and supports more than 2,000 research grants and contracts at universities and other institutions across the country and overseas.

Gordon joins NIMH with an extensive research background that focuses on the analysis of neural activity in genetic mouse models that have genetic mutations of relevance to psychiatric diseases such as schizophrenia, anxiety disorders, and depression. His research involves an integrative neuroscience perspective and is performed across multiple levels of analysis, with the aim of understanding how a given disease mutation leads to a particular behavior.

His work has been recognized by several prestigious awards, including the Brain and Behavior Research Foundation–NARSAD Young Investigator Award, Rising Star Award from the International Mental Health Research Organization, A.E. Bennett Research Award from the Society of Biological Psychiatry, and the Daniel H. Efron Research Award from the American College of Neuropsychopharmacology.

In talking with *Psychiatric News*, Gordon emphasized the need to connect research to the real world of clinical practice and patients' lives. "I enjoy working with patients," he said. "I've had a clinical practice in addition to my research activities since residency because that's what keeps you connected to the people that research is supposed to serve."

Gordon's predecessor presided over a period of enormous change and advancement in brain and behavior research generally and at NIMH. Among the most important initiatives begun under Insel is the development of Research Domain Criteria (RDoC), designed to reconceptualize diagnosis of mental illness according to "domains" of brain function defined by genetics and neurobiology.

At the time of Insel's departure in 2015, the former NIMH director said he saw no conflict between *DSM* and RDoC. "RDoC is a guide to rethinking the way we do diagnosis and may inform *DSM-6* or *-7*, but for now clinicians should be using the *DSM* and ICD," Insel told *Psychiatric News*. "At this point, there is very little in genetics or neuroscience that can give us something better. RDoC is a pathway to get there, but it is not a product that can be used in the near term."

Gordon agreed. "I think RDoC is still in its childhood; it's still in the process of developing a framework for understanding the neurobiology of mental illness. It's not clear yet what it will produce and how it will complement *DSM*. Will the two in time be integrated? Or will RDoC reveal new diagnostic categories? I think we need to know more, and I look forward to helping develop the tools to evaluate just how helpful RDoC will be."

Gordon said he believes APA and NIMH share a common mission—to

see **NIMH** on page 26

Important Changes in *DSM-5* to Become Effective October 1

Each year on October 1, the International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10), is updated to reflect diagnostic changes in medicine. Since 2010, no major updates have been permitted so that physician practices, facilities, and payers in the United States could update their systems during the transition from ICD-9 to ICD-10, which went into effect on October 1, 2015.

APA has advocated that changes be made to ICD-10 to reflect the updated diagnoses in *DSM-5*. These include changes to align the terminology used in *DSM-5* with that used in the mental health chapter of ICD-10. In response, the Fiscal Year 2017 version of ICD-10, which takes effect October 1, will include most of *DSM-5*'s terminology.

In some cases, new codes have been added to ICD-10 to accommodate the new diagnoses that were added to *DSM-5*. The new codes will allow more accurate diagnostic recording,

see **DSM-5 *Changes*** on page 19

Alphabetical Listing of *DSM-5* Diagnoses and New ICD-10-CM-Codes

Disorder	Original Code *for use through Sept. 30, 2016*	New Code *for use beginning Oct. 1, 2016*
Avoidant/Restrictive Food Intake Disorder	F50.8	**F50.89**
Binge-Eating Disorder	F50.8	**F50.81**
Disruptive Mood Dysregulation Disorder	F34.8	**F34.81**
Excoriation (Skin-Picking) Disorder	L98.1	**F42.4**
Gender Dysphoria in Adolescents and Adults	F64.1	**F64.0**
Hoarding Disorder	F42	**F42.3**
Obsessive-Compulsive Disorder	F42	**F42.2**
Other Specified Depressive Disorder	F32.8	**F32.89**
Other Specified Feeding or Eating Disorder	F50.8	**F50.89**
Other Specified Obsessive-Compulsive and Related Disorder	F42	**F42.8**
Pica, in adults	F50.8	**F50.89**
Premenstrual Dysphoric Disorder	N94.3	**F32.81**
Social (Pragmatic) Communication Disorder	F80.89	**F80.82**
Unspecified Obsessive-Compulsive and Related Disorder	F42	**F42.9**

Dealing With Commercial Insurance Peer Reviews

If an insurer contacts you for a case review, following a few simple steps will help ensure that your patient gets the care he or she needs.

BY ELLEN JAFFE

FROM THE HELPLINE
(800) 343-4671
hsf@psych.org

Calls to APA's Practice Management HelpLine indicate there has been an increase in both concurrent and retrospective reviews by commercial insurers of the combined E/M and psychotherapy care provided by psychiatrists, regardless of whether the psychiatrists are members of the insurers' networks.

There are several important points to keep in mind if you are contacted for a review. First, be sure that you are given a written statement regarding the purpose of the review and issues to be covered. Second, since the focus of these reviews is invariably the medical necessity of the care, always ask to receive, and be prepared to understand, the precise guidelines the payer uses to determine the appropriateness of treatment. And, finally, remember to contact the HelpLine when you've been asked to do a review. APA has been tracking this kind of care management and is monitoring the reviews to determine whether they involve mental health parity issues and/or violations of the federal regulations governing claims denials.

Initially, you may be asked to participate in a phone call with one of the insurer's reviewers. This reviewer is almost never a psychiatrist but is typically a social worker or counselor who has some familiarity with providing behavioral health care. The focus of this initial contact is often on the length of time the patient has been receiving the combined E/M and psychotherapy services, with the suggestion that if the patient's condition has improved since treatment began and symptoms have abated, there may no longer be a necessity for continuing treatment.

The following vignette is an example of this type of call from an APA member:

During the initial phone call, the nonphysician reviewer referred to treatment guidelines and suggested the psychiatrist was not in sync with them. She noted that the psychiatrist had been seeing the patient for more than six months and that the patient was functioning better; she then explained that the company had patient education information available online that could provide the patient with the necessary ongoing support to cope with her depression and anxiety without the need for continued weekly treatment.

The psychiatrist did not agree with that conclusion and was then directed to schedule an appointment for a case review with one of the company's staff psychiatrists.

At the beginning of the subsequent phone call, the psychiatrist took the advice of APA's staff and asked to see the treatment guidelines referred to in the previous call so that she could better understand the basis for the insurer's concerns about continued treatment. She emphasized that she would not talk to the peer reviewer until after she had reviewed the guidelines. The peer reviewer sent the guidelines to the psychiatrist along with a statement that another phone review would be scheduled.

The reason that APA staff had suggested she ask to see the guidelines is that insurers are required by federal law to provide the specific information on which a denial of care is based. This is necessary to ensure that behavioral health care is not subject to limitations that are different from those applied to other types of medical care.

The second peer review call occurred a week later. The insurance company's treatment guidelines did not provide any definitive criteria about when therapy should be terminated. The psychiatrist maintained that, based on the patient's symptoms and functionality, there was continuing medical necessity for weekly treatment. The peer reviewer asked for specifics from the patient's life to support this, and the psychiatrist demurred, explaining that she could not provide that information because it was part of her psychotherapy notes (which are kept separate from patient medical records) and thus could not be released under HIPAA regulations. She instead cited the patient's medical comorbidities and asserted the necessity for continued care. The peer reviewer then asked how long the psychiatrist projected the need for care to continue. The psychiatrist responded that she thought treatment would be necessary for at least another six months. In response, the peer reviewer authorized four more months of weekly care.

Here are the take-home messages from this encounter:

- If you know your patient's care is medically necessary and stand your ground during a peer review, you will likely prevail.

- You need to document the psychotherapy you provide just as assiduously as you document E/M work if you want your treatment to stand up under a peer review or payment audit (see box below). PN

Ellen Jaffe is the manager of APA's Practice Management HelpLine.

How to Document Psychotherapy Sessions

By Ellen Jaffe

Although there are no official guidelines for documenting psychotherapy in patients' medical records, providing such documentation is as important as providing it for evaluation and management (E/M) services.

In May, a contractor for the Centers for Medicare and Medicaid Services (CMS) sent a document called a Comparative Billing Report (CBR) to more than 4,000 psychiatrists, comparing their billing practices for psychotherapy services with those of other psychiatrists in their state and across the United States. The CBRs cited previous reports on improper Medicare payments for psychiatry services and indicated that the reason the services were found improper was primarily due to insufficient documentation.

Although many of the errors found in earlier assessments were made by nonphysician psychotherapists, the CBRs defined what constitutes appropriate documentation that all psychiatrists who treat Medicare patients will find useful. It is similar to guidance that APA has long given its members.

- Date of service
- Diagnoses
- The time spent providing face-to-face psychotherapy with the patient and/or family members (For an encounter that also includes medical E/M services, the psychotherapy time should be differentiated from the E/M time.)
- The type of therapeutic intervention (for example, insight oriented, supportive, behavior modification)
- Target symptoms
- Progress toward achievement of treatment goals (This means, of course, that the patient record must include a treatment plan, although you do not need to refer to it in the documentation for each session.)
- For psychotherapy lasting more than 52 minutes (90837, 90838), the reason the session required this length of time

Previously, these seven items fulfilled the requirements for psychotherapy documentation, and when all were present, psychiatrists have not had problems when audited.

The CBRs refer to documentation requirements that are consistent with those of two Medicare administrative contractors (MACs). One of them—Cahaba Government Benefit Administrators, which is the MAC for Alabama, Georgia, and Tennessee—requires three extra pieces of information:

- The degree of patient interaction with the therapist
- The reaction of the patient to the therapy session
- Any changes in the patient's symptoms or behavior as a result of the therapy session (This item is questionable since it is unlikely that such changes can be determined at the time the session is documented. Perhaps the MAC meant to refer to the previous session.)

Keep in mind that notes about personal information that emerges during the psychotherapy session beyond the seven points listed above should not be included in a patient's medical record. Personal notes taken during the session to guide future treatment should also be kept separate from the medical record. Under HIPAA, the patient's insurer and the patient can legally access the medical record, but they cannot access your record.

COMMUNITY NEWS

New Facility to Be Capstone Of Indiana's Unified MH System

A new building will serve as the focal point for a major reorganization of mental health care delivery in Indiana.

BY AARON LEVIN

Indiana FSSA

The new Indiana Neuro-Institute and Advanced Treatment Center in Indianapolis will be connected to Community Hospital East to link psychiatric and other medical care.

Indiana health officials joined Lt. Gov. Eric Holcomb in August to break ground for the Indiana Neuro-Diagnostic Institute and Advanced Treatment Center (NDI). The new psychiatric hospital in Indianapolis is designed to evaluate and treat mental illness in a variety of patient populations before referring them to other state or community treatment settings for long-term follow-up.

The integrated system of care that will function within the building will be as contemporary as the facility, said geriatric psychiatrist John Wernert, M.D., M.H.A., secretary of the Indiana Family and Social Services Administration (FSSA), an APA distinguished fellow, former APA Board of Trustees member, and past chair of the APAPAC Board of Directors.

Wernert became head of the FSSA in June 2014, the first psychiatrist to hold this position. The agency portfolio includes Medicaid, mental health, aging, disability and rehab services, family resources, and early child care and pre-kindergarten. About 43 percent of the Indiana state budget passes through the administration, he said.

"This new institute is another part of our strong commitment to improving health care in Indiana and to caring for our most vulnerable fellow citizens," said Gov. Mike Pence (R) in a statement announcing the project last December.

The core of Indiana's public mental health care has been a constellation of six state psychiatric hospitals. Like most states, Indiana closed many state facilities over the past 40 years, going from over 6,000 state beds to 800 today. One of Wernert's first tasks was to get the six hospitals to function as a single system by developing uniform admission and discharge protocols, standard electronic medical records, drug formularies, and even dietary planning.

"We wanted to have the concept of one hospital with six campuses," he said. NDI will further consolidate that system by serving as the diagnostic center of excellence and the hub of the distributive model of care.

For a start, NDI will replace one aging state facility, the LaRue Carter Memorial Hospital in Indianapolis, built in 1931 as a veterans hospital. The state acquired the hospital in 1998 and has been carrying a census of 120 mentally ill children, adolescents, and adults in central Indiana's only state mental facility. However, the building's design and deteriorating physical condition have made it less and less appropriate for modern mental health care, according to a feasibility study.

The 159-bed, $120 million NDI facility will serve as a diagnostic and acute treatment center not only for mental illnesses, including substance use disorders, but also for traumatic brain injury, intellectual and developmental disabilities, and neurodegenerative diseases. Psychiatrist Jerry Sheward, M.D., has been named chief medical officer and is leading the design and transition phases now under way.

NDI will open in late 2018 and will integrate psychiatric and medical care, continuing one of Wernert's longstanding goals. Beginning in 2010, he worked with several federally qualified health centers and other rural practices in Indiana to move psychiatric care into primary medical settings and wanted to apply that principle to the state hospitals.

"Most state psychiatric facilities are located in rural areas, far from medical hospitals, which makes care challenging for our aging patient population," he said. "An elderly patient with schizophrenia, for instance, might also have diabetes, emphysema, and renal disease and need as much medical as psychiatric care."

To that end, NDI will be on the campus of Indianapolis Community East Hospital, a tertiary care hospital that is part of Community Health Network, the partner in NDI's management. The pairing of the two facilities may also reduce some duplication of technology and services. For instance, Community East also houses a cancer center, and NDI will be able to use its fMRI and PET scanners. Specialty medical services will be attached and readily available for the NDI patient population. The hospital's emergency room will also serve as a venue to manage intoxicated or acutely aggressive patients.

NDI expects to care for about 1,500 patients each year. For most, average length of stay is likely to be measured in weeks following evaluation and initial treatment. Beyond that point, patients will be referred to one of the five other state hospitals or to the 25 community mental health centers or to other community-based settings around the state.

The new building will be subdivided to serve a variety of patient populations. Twelve beds are allotted to children, including those with autism spectrum disorder or developmental disabilities. A 30-bed unit will serve adolescents, especially those with early-onset schizophrenia. Adults with severe mental illness will be housed in a 15-bed unit, while both qualifying children and adults may be placed in a 12-bed research unit.

A short-stay, 15-bed neuropsychiatric diagnostic unit will allow evaluation and treatment planning for difficult cases before they are sent for follow-up hospital or community care.

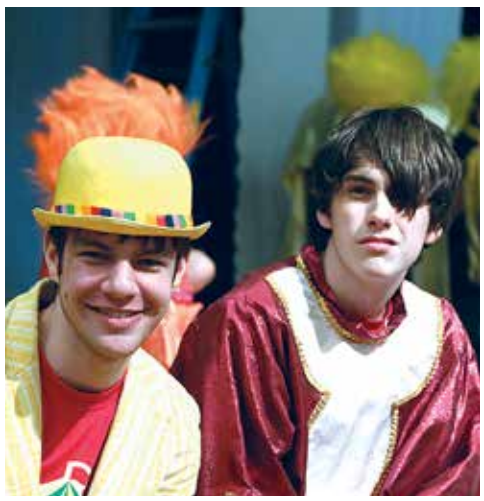
In addition, NDI will have a 24-bed forensic unit on the seventh floor with a separate drive-in entry at ground level and a secure elevator for access. The

*see **Facility** on page 27*

COMMUNITY NEWS

Acting May Help Break Down Barriers For Patients With Mental Illness

Using techniques related to acting or role-playing may help people with mental illness be more flexible, spontaneous, and social in their thoughts and behaviors.



BY NICK ZAGORSKI

Recent evidence suggests that techniques commonly used by actors may help engage patients in new ways.

"Acting requires being social, spontaneous, and flexible, which are exactly the behaviors that are often deficient in mental illness," Blythe Corbett, Ph.D., an associate professor of psychiatry and psychology at Vanderbilt University, told *Psychiatric News*.

Corbett, who also has a background in acting, thought these traits might be particularly helpful for engaging children with autism spectrum disorder (ASD), so several years ago she began recruiting middle- and high-school theater students to participate in a theater-based therapy program for similarly aged youth with ASD.

Photos: Blythe Corbett at SENSE Theatre

The program is known as the SENSE Theatre and is an outgrowth of Corbett's research group, the Social Emotional NeuroScience Endocrinology (SENSE) lab.

Over the course of two or 10 weeks (for winter and summer programs), children with ASD and their actor peers are tasked with putting on a short play in which all the children have parts. In addition to helping plan the production, the children engage in various theater games to learn about role-playing and improv during the course of the program.

"But while on the surface the children are put in a play and cast in a role, they also learn a lot about themselves, in a subtle way," Corbett said.

"And just seeing some amazing stage performances from children who began the program in a complete shell would be enough to consider SENSE Theatre a rousing success," she continued.

*see **Acting** on page 30*

PSYCHIATRY & PSYCHOTHERAPY

‘Medical Necessity’ in Psychiatry: Whose Definition Is It Anyway?

BY DANIEL KNOEPFLMACHER, M.D.

Want a surefire way to elicit groans among a group of psychiatrists? Ask them about the last time they tried obtaining a preauthorization for a patient. It becomes difficult to suppress feelings of rage and cynicism when, after a time-consuming phone conversation, one’s clinical decision is deemed “not medically necessary” (see related article on page 9).

This situation is especially common for psychiatrists trying to help patients obtain insurance reimbursement for psychotherapy. While psychotherapy is clinically accepted as a first-line treatment for multiple psychiatric diagnoses, insurance companies, citing their own views of “medical necessity,” routinely refuse to cover it altogether or at the prescribed frequencies.

Psychiatrists hoping to clarify medical necessity standards may be surprised to find no universally accepted definition of medical necessity. Without a federally mandated definition, it is no surprise that insurance companies interpret this concept on their own terms, often choosing cost savings over treatments widely accepted as standards of care in psychiatry.

In 2014, a class-action lawsuit filed against United Behavioral Health (UBH) directly challenged medical necessity criteria used to deny outpatient mental health care to several plaintiffs prescribed twice weekly sessions. The plaintiffs argued that UBH ignored its duties of loyalty and care when it implemented coverage guidelines inconsistent with generally accepted standards of care. Publicly available, UBH’s Level of Care Guidelines specify that medical necessity decisions “are for payment purposes only.”

Though the guidelines maintain that treatment decisions must be “in accordance with generally accepted standards of medical practice,” it is clear from UBH’s overemphasis of acute factors that the most salient determinant of coverage is “whether services are *cost-effective*.” The criteria create a prescriptive, one-size-fits-all approach that leaves little room for anything beyond brief, crisis-oriented treatment. Paradoxically, when payment structures unduly favor acute treatment of chronic, severe mental illness, both utilization and undertreatment costs inevitably accrue over the long term, rendering even the primary goal of “cost-effectiveness” illusory.

Though insurers clearly use “medical necessity” to mean “cost-effective” rather than “clinically effective,” their view is at odds with positions taken by nonprofit medical specialty associations. For example, the AMA defines “medically necessary” to mean “in accordance with generally accepted standards of medical practice,” while clearly advocating for coverage that is “not primarily for the economic benefit of the health plans.” Similarly, the Centers for Medicare and Medicaid Services, the American College of Medical Quality, and the American Association of Community Psychiatrists emphasize accepted stan-

Daniel Knoepflmacher, M.D., is an assistant professor of clinical psychiatry at Weill Cornell Medical College and an assistant attending psychiatrist at New York Presbyterian Hospital. He is also a member of the Group for the Advancement of Psychiatry Committee on Psychotherapy.

dards of medical practice over financial considerations in their definitions of medical necessity.

How did the term "medical necessity" evolve? It first arose in the 1940s, when private insurers emerged from the hospital industry. It was used to describe any medical service covered by insurance. Insurers set monetary limits but avoided judgments about the appropriateness of clinical decisions. Physician choices regarding treatment were autonomous.

By the 1960s, however, insurance companies began creating written guidelines defining medical necessity. The introduction of Medicaid led to state-specific definitions in which "cost-effectiveness" became part of the criteria.

In the 1970s, private insurers and Medicare began requiring physicians to justify the necessity of medical treatments. Consequently, economic rather than medical standards became the most common justification for denying treatment. By the 1980s, the pendulum shifted further when Congress set up peer-review organizations to evaluate Medicare benefits, and private insurance companies initiated prospective reviews and precertifications.

Efforts at health care reform in the 1990s brought attempts to define standards of medical necessity through federal legislation, introducing an alternate term, "medical appropriateness." According to the proposed criteria, if a medical treatment was "effective," "beneficial," and "judicious" (with all three of these terms having specific defini-

continued on next page

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tions), it would be deemed medically appropriate. However, this language was excised from the final health reform bill, which in the end failed to pass. In 2000, a Florida class-action suit against multiple insurers required their use of a standard definition of medical necessity with criteria similar to those for "medical appropriateness."

The Mental Health Parity and Addiction Equity Act of 2008 also lacks a federal definition of medical necessity, but it requires insurers to release their proprietary coverage guidelines. Some states have gone one step further by mandating the use of certain clinical guidelines developed by nonprofit, physician specialty groups, including the American Academy of Child and Adolescent Psychiatry and the American Society of Addiction Medicine.

Without universal medical necessity criteria for mental health care, clinicians and their patients are saddled with a concept highly susceptible to abuse by insurers. For now, multiple class-action suits are the main fronts in the battle against restrictive coverage criteria that limit access to appropriate psychiatric care. Hopefully, a combination of favorable court rulings, advocacy, education, and ultimately legislation will universalize a humane definition of medical necessity and create true parity. PN

References for this article are posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.9b14.

FROM THE EXPERTS

Assistance in Dying: Deepening Understanding of Novel Ethical Issues in Psychiatry

LAURA ROBERTS, M.D., M.A.

Assistance in dying for individuals who will soon succumb to a terminal illness is a topic that has been debated for decades in college classes, in medical school lecture halls, in ethics committee conference rooms, in state legislative sessions, and on the covers of popular magazines. Traditional arguments against

assisted-death practices have focused on the sanctity of life and the role of physician as healer. Arguments for assisted-death practices have highlighted the salience of compassion, autonomy, dignity, and, occasionally, the scarcity of health care resources. Until recently in psychiatry, assistance in death has been eschewed as essentially irrelevant: the illnesses our profession cares for are not "terminal," and our efforts are dedicated to prevention of early death—not the opposite.

And yet, assisted suicide and euthana-

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sia practices have entered the repertoire of physicians, including psychiatrists, in many countries in Europe. In this country, assisted suicide has been decriminalized in several states, and assisted-death legislation was adopted in Canada in June of this year. The conditions under which assistance in death are considered acceptable, or at least not criminal, in these varied places throughout the world are expanding. No longer is assistance in dying by physicians delimited to those near the very end of their lives due to a devastating physical illness. Assistance in dying definitions and guidelines have stretched to include conditions considered futile, including some neurocognitive, intellectual, and mental disorders, for example. A recent longitudinal report from Belgium indicates that out of 100 patients who requested euthanasia for psychological suffering associated with chronic, but not necessarily life-threatening, mental disorders, 35 had had their request carried out over the five-year period of the study.

Intentional hastening of death is absolutely unethical, according to the AMA and, following suit, APA. Empirical studies of physician attitudes toward assisted-death practices are not uniformly in support of this ethical stance. In a very early study I performed with colleagues, we found that consultation-liaison psychiatrists and psychosomatic medicine physicians were unwilling to perform assorted death procedures personally but were somewhat more accepting of other physicians' involvement.

In a second small study we conducted involving resident physicians, we found residents in internal medicine, emergency medicine, and psychiatry were not supportive of assisted-death activities, with psychiatric and internal medicine residents in greatest opposition. Larger empirical projects suggest that Oregon physicians do provide prescriptions of lethal medications that result in patient suicide.

While public opinion shows support for assistance in dying, studies of physically and mentally ill individuals have revealed more nuanced results. A number of studies of seriously ill individuals make clear that their hopes and requests pertain to relief of pain and optimal quality of life. Moreover, these studies have found no differences in unbearable suffering between patients who requested aid in dying and those who did not, although patients who also suffered from a depressive disorder were more likely to submit a request and more likely to change their minds within a few months. Polls of the general public indicate that even active euthanasia practices by physicians would be seen as acceptable by large numbers of adults in the United States.

Even within the House of Medicine, with its clear ethical stance, we are divided on the profound and fundamental issue of how we define the role of the physician. Do we help our patients bear their suffering—not turn away—and ease their burdens where we can? Do we stand with our patients as they live with illness and also as they eventually and often tragically confront their deaths?

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Do we protect our patients when they are at their most vulnerable and in great pain? Or do we act on their wishes, or the wishes of those to whom their lives have been entrusted?

In psychiatry, perhaps more than any other discipline in medicine, we should understand how good health and recovery may return, even after very serious episodes of illness. We should understand how vulnerability can be exploited. We should understand how wishes that are expressed may be transient or a reflection of compromised decisional capacity, despair, or distress that may lessen or reverse with treatment, emotional support, and the passage of time. We also should understand how disparities in the distribution of health resources greatly determine health care and health outcomes, with individuals with mental disorders often least able to advocate for themselves and protect their well-being and interests in society. The field of psychiatry for these reasons has an important perspective to offer to the world's discussion of the ethical acceptability of assisted-death practices by physicians, whether in relation to individuals with mental and other medical illnesses.

Deepening one's understanding of ethical issues, such as assistance in dying, and applying this understanding as an astute psychiatric practitioner are more than mere intuition, years of experience, or innate good judgment. A well-developed skillset is needed: the ability to recognize moral and values-laden aspects of an issue, the ability to seek additional information or counsel that will help resolve ethical tensions that exist, the ability to evaluate choices for their ethical intent or outcomes, and the ability to safeguard against actions that have irreversible and negative ethical consequences—these are all important clinical ethics skills. These skills are grounded in the rich multidisciplinary scholarship of biomedical ethics and its ever-growing base of empirical evidence. Clinical ethics skills are learned and taught intentionally. Moreover, wise practitioners appreciate that these capabilities require openness, self-observation, and practice to become integrated within one's therapeutic inventory to bring benefit to patients and to enhance the standard of care they receive.

Each new day brings encounters with people with serious illnesses whose care presents new ethical questions and challenges. Each new clinical practice approach, each new technological development, and each new social policy creates complex, seemingly unprecedented, and irresolvable dilemmas. Assisted-death practices, including assisted suicide and euthanasia, now being adopted widely throughout the world and increasingly affecting the lives, and deaths, of people with mental illness represent one such novel ethical dilemma.

Traditions, codes, and legal rulings may feel insufficient and, applied in rote fashion, will offer little support in such difficult situations. These situations represent an invitation for deepened understanding and for the development of greater and more sophisticated ethical skills—and, indeed, they define the real meaning of professionalism in the care of human suffering. PN

References for this article are posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.9b18.

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ADMSEP Scholars Program Develops Education Researchers

The Education Scholars Program was established to provide participants with the foundational knowledge and mentorship for pursuing scholarly activities in medical student education.

TEACHING PSYCHIATRY

BY MARK MORAN

The physician who is also a researcher is pursuing what some might say is a select career path. And the physician who is also an educator could be said to be following a road less traveled.

In that case, the physician-educator whose scholarly interest is medical education research must be a rare individual indeed.

And yet it's an increasingly necessary endeavor—research that seeks to answer the question: How can the education of aspiring physicians be improved?

"More and more we know it is important to take a scholarly approach to the work we do," said Susan Lehmann, M.D., the psychiatry clerkship director and associate professor in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins University School of Medicine. "No one is born knowing how to—say—evaluate a curriculum. But the way we improve is to evaluate our outcomes in a systematic way. We want to know, what are the best practices for teaching? How do we know the interventions we use are the best we can do?

"That kind of information is important now to medical schools that have to report to the stakeholders in medical education," Lehmann told *Psychiatric News*. "And for the medical educator, scholarly accomplishments are a metric for promotion."

Lehmann is co-administrator (along with Lisa Fore-Arcand, Ed.D.) of the Education Scholars Program—a program of the Association of Directors of Medical School Education in Psychiatry (ADMSEP). Fore-Arcand is an associate professor and education coordinator and assistant director of the psychiatry clerkship at the Eastern Virginia Medical School.

The ADMSEP Education Scholars Program was established to provide participants with the foundational knowledge and mentorship necessary for pursuing scholarly activities in medical student education. The first cohort of participants graduated in June 2014, and the second graduated this past June.

Scholars are expected to develop and complete a research project. Each scholar who completes the program is awarded a Certificate of Excellence in Educational Scholarship.

The Scholars Program is a two-year program of half-day structured workshops and didactics, specifically for Educational Scholar participants, at the beginning of each ADMSEP annual meeting. Additionally, scholars participate in conference call seminars three times a year; the conference calls are led by ADMSEP educators and focus on topics related to the implementation of each scholar's individual project. Scholars also work with a local mentor from their own institution whom they have identified, as well as with a senior ADMSEP mentor. At the third ADMSEP annual meeting after they have entered the program, scholars present their results from the preceding two years' work.

Brenda Roman, M.D., past president of ADMSEP, said the Scholars Program was begun in an effort to boost faculty development among members. "The scholars program is geared to early career academic psychiatrists interested in medical student education," she told *Psychiatric News.*

Roman and Lehmann said that a strength of the program is that it is a relatively inexpensive endeavor—the cost of the program is $500—and leans heavily on mentorship to help medical educators in psychiatry develop as research scholars.

"The structured didactic workshops at the two annual meetings provide scholars with foundational knowledge—how to come up with a good research question, how to develop an effective survey," Lehmann said. "The longitudinal elements of the program—the conference calls with ADMSEP experts—guide the scholar in the implementation of their project. The work with the local mentor and the senior ADMSEP mentor help with big-picture questions about research and medical education. These mentorships have resulted in terrific scholarly relationships."

Educators apply for the program by submitting a CV and their ideas for scholarship. Completed projects include research by scholar Matthew Goldenberg, M.D., M.Sc., the interim psychiatry clerkship director at Yale University, on factors that influence medical student choice of psychiatry as a career (*Psychiatric News,* September 2).

Susan Lehmann, M.D./Johns Hopkins University School of Medicine

Susan Lehmann, M.D., co-administrator of the ADMSEP Education Scholars Program, said educators need research to help improve teaching and educational outcomes.

The June 2015 issue of *Academic Psychiatry* included a study by former program scholar Carol Ping Tsao, M.D., titled "Medical Student Communication Skills and Specialty Choice." Ping Tsao and her colleagues Deborah Simpson, M.D., and Robert Treat, M.D., looked at whether communication skills differ between medical students entering person-oriented specialties (psychiatry, family medicine, pediatrics) and those entering technique- or procedure-oriented specialties.

They analyzed communication ratings by clerkship preceptors on institutionally required end-of-clerkship medical student performance evaluation forms from the 2011-2012 academic year (class of 2013).

Their results were surprising, perhaps even counterintuitive. There was no significant difference in mean communication scores for medical students who entered person-oriented versus technique-oriented specialties. But the study revealed something important: raters from technique-oriented clerkships offered higher communication score ratings than did raters from person-oriented clerkships, and significantly higher for those students entering technique-oriented specialties.

"[F]aculty from technique-oriented clerkships rated students entering technique-oriented specialties more favorably," the researchers stated. "Could there be unstated differences in the type and degree of communication expected for person versus technique-oriented specialties that can account for this finding?"

It's a striking example of the adage that you don't know what you don't know—and you won't know until you do some research.

"The authors did not find what they expected to find in terms of communication skill and specialty choice," Lehmann said. "The issue turned out to be more complicated than they had originally thought, and the study revealed something unexpected in that it suggested possible bias on the part of faculty rating the communication skills of students going into their type of specialty. The authors also reflected that the measurement tool they used to assess communication skills may have been lacking, too.

"The study suggested the need for further follow up," Lehmann continued. "It's a great example of how much is learned by a rigorous and systematic scholarly approach to a question. Sometimes the answer to your answer is not as straightforward as you thought, and you learn that to understand the problem better, you need to have better assessment tools and consider wider sources of bias. This is such an important lesson for all of us as medical educators. As in any field, systematic study of the work we do will lead to better understandings of the educational interventions we do with students and will help all of us become better educators." PN

More information about the ADMSEP Education Scholars Program is posted at http://www.admsep.org/resources.php?c=education-scholars.

DSM-5 Changes

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improved communication among clinicians, and better means for collecting prevalence data.

As of October 1, the codes for the following *DSM-5* disorders will no longer be valid. The new codes listed in the chart below must be used in their place.

A printable version of this list is available at http://APAPsy.ch/ICD-DSM and includes the diagnoses in both alphabetical order and the order in which they appear in the *DSM-5* classification. PN

Sleep Experts Issue Recommendations For Children and Adolescent Sleep

Children and adolescents need specific amounts of sleep to feel and function at their best, sleep experts say.

BY LYNNE LAMBERG

Children from infancy through age 18 need specific amounts of sleep to achieve optimal mental and physical health, according to a consensus panel convened by the American Academy of Sleep Medicine (AASM).

Regularly obtaining the recommended number of hours of sleep benefits youngsters' attention, behavior, learning, memory, emotional regulation, quality of life, and overall health, the AASM panel concluded.

Habitually sleeping fewer than the recommended number of hours is associated with problems in the same areas as well as an increased risk of accidents and injuries, the 13-member panel found.

Regularly getting less than or more than the optimal hours of sleep, the panel said, is also associated with other adverse outcomes, including hypertension, obesity, diabetes, and depression.

To reach its conclusions, the panel evaluated evidence from 864 scientific publications on sleep duration and health in pediatric populations, panel chair Shalini Paruthi, M.D., told *Psychiatric News*. Paruthi is an adjunct associate professor of internal medicine and pediatrics at St. Louis University School of Medicine and co-directs the sleep medicine and research center at St. Luke's Hospital in St. Louis.

Panelists reviewed more than 100 reports on sleep duration and mental health, as well as studies pertaining to general health, cardiovascular health, metabolic health, immunologic function, developmental health, and human performance.

Most studies were based on cohort or cross-sectional studies of community-based populations. They suggest associations, Paruthi noted, but do not establish causality. Information on children's sleep duration and other health measures generally came from parental or self-reports. Some studies confirmed total sleep time with a wrist-worn activity monitor, and a few used laboratory-based sleep monitoring.

In the mental health domain, longitudinal studies showed children who slept poorly and obtained less than average amounts of sleep in their first year or two of life had more difficulties with emotional, social, and behavioral functioning than their typically sleeping peers did several years later, according to parental reports on validated questionnaires.

Studies of children aged 6 to 13 years commonly focused on associations between total sleep duration and affect, emotional regulation, irritability, peer/family relations, and perceived health. These studies helped define hours of sleep associated with positive or negative outcomes in such areas.

"The most compelling data on associations between sleep duration and emotional health came from studies of adolescents," the panel's mental health co-chair, Kiran Maski, M.D., told *Psychiatric News*. Maski, an instructor in neurology at Harvard Medical School, directs the sleep/neurology clinics at Boston Children's Hospital.

In a survey of nearly 28,000 public school students in grades 8, 10, and 12 in Fairfax County, Virginia, in 2009, for example, high-school students reported averaging 6.5 hours sleep on school nights. About 20 percent of students said they typically slept less than five hours a night. Only 3 percent said they slept the optimal nine hours on average.

With every less hour of sleep that students got on average on a typical weekday, the odds rose significantly that the students reported that, in the past year, they had felt sad or hopeless for two weeks or more, seriously considered suicide, made a suicide attempt, and used alcohol, tobacco, marijuana or other illicit substances.

The small percentage of students who said they usually slept 10 hours or more also had higher odds of suicidal thoughts and behavior.

"This U-shaped curve, with emotional distress tied to both too little and too much sleep, deserves further attention," Maski said. Suicide is the third leading cause of death in adolescents.

Survey results helped convince the Fairfax County (Virginia) School Board to delay high school start times from 7:20 a.m. to between 8 a.m. and 8:10 a.m., starting in the 2015-2016 school year.

Concerns about adverse effects of insufficient sleep in adolescents have sparked a nationwide grass-roots advocacy movement to start schools later.

After their review, panel members discussed and voted on a range of evidence-based hours of sleep for each age group. They presented their recommendations at the joint annual meeting of the American Academy of Sleep Medicine and the Sleep Research Society in Denver this summer. The panel's report will be published in the *Journal of Clinical Sleep Medicine* later this year. The American Academy of Pediatrics has endorsed the AASM's recommendations.

Funding for the panel's work came from the National Healthy Sleep Awareness Project, a partnership between AASM, the Sleep Research Society, and the Centers for Disease Control and Prevention, to promote the nation's sleep health.

The pediatric guidelines serve as a companion to AASM's 2015 recommendation that adults aged 18 to 60 years obtain seven or more hours a night for optimum health (*Psychiatric News*, September 18; http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2015.9b12). PN

An abstract of "Recommended Amount of Sleep for Pediatric Populations: A Consensus Statement of the American Academy of Sleep Medicine" is posted at http://www.aasmnet.org/jcsm/ViewAbstract.aspx?pid=30652.

How Much Sleep Do You Need?

The American Academy of Sleep Medicine recommends the following hours of sleep at each stage of life for optimal health.

From the President

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Depression and alcohol misuse increase the risk for acting on suicidal thoughts, and data suggest that physicians are just as likely as the general population to meet criteria for depression. However, trainees may be at greater risk than their general counterparts. In a study of medical residents, the proportion of respondents meeting PHQ-9 criteria for depression increased from 4 percent before internship to just over 25 percent during internship, a six-fold jump.

As well, alcohol misuse is a common response to unmanageable stress, and a survey study showed that 20 percent of medical students, trainees, and faculty reported "drinking too much," which was associated with suicidal ideation, suicide attempts, and severe depression.

A critical question is why no one detects the suffering of these physicians. After all, they are surrounded by other health care professionals who should be able to see what is happening. However, most physicians have enormous personal strength, both emotional and intellectual "reserves." Accordingly, they often are able to compensate for the presence of psychiatric symptoms, which both makes it difficult to identify them so they can receive assistance and leads them to feel more isolated, since no one knows how they really feel.

The remedy then is self-identification. Many medical schools are now proactive in letting students know that they have access to care and encouraging them to seek help if they are feeling overwhelmed or distressed. That should promote a lifelong attitude of self-care. Other schools offer online wellness questionnaires that allow students who meet "caseness" criteria for depression or other conditions to be contacted by counselors to try to engage them in care.

But what about all of the physicians who are already out in the workforce? How can they be reached? One action that we plan to explore is to partner with the AMA or other medical organizations to remind physicians about the signs and symptoms of depression or alcohol misuse and reinforce the notion that treatments can and do work. PN

References for this article are posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.9b16.

CLINICAL & RESEARCH NEWS

Self-Management Interventions May Help Improve Mental, Physical Health

A recent meta-analysis explored the feasibility, acceptability, and effectiveness of programs that combine the management of psychiatric and other medical problems.

BY NICK ZAGORSKI

Stacey Kaltman, M.D., was developing a program to help Latino immigrants manage stress and depression when she realized there might be a way to offer even more support to patients dealing with comorbid conditions.

"Latinos, especially immigrants, are vulnerable to depression, but also diabetes," she told *Psychiatric News*. "But many of the patients I interviewed were being treated for their diabetes separately, which did not seem optimal, especially as many interventions, like exercise, are beneficial for both disorders."

Kaltman, an associate professor of psychiatry at Georgetown University Medical Center, decided she could adapt her depression intervention to target diabetes as well.

Her approach involved counseling patients using psychotherapy techniques such as behavioral activation to get them engaged and interested in making lifestyle changes, in a way that would work best for them.

"The counselor focuses on what patients want to do and has them come up with their own goals for how to improve," she explained.

She recently led a pilot study to test this intervention in 18 Latino patients and found that patients who participated in the program experienced drops in blood sugar levels and depressive symptoms.

Kaltman is one of a growing number of clinicians working to create patient-centered programs that co-manage psychiatric and general medical conditions, building on more established self-management interventions.

Stephen Bartels, M.D., a professor of psychiatry and community and family medicine at Dartmouth's Geisel School of Medicine, is working with colleagues at Dartmouth to develop a trio of integrated interventions for older adults with mental illness.

"People with serious mental illness are living longer, so we are seeing an increasing number of older adults coping with these disorders in their 50s and 60s, which is the same time that other big medical problems like diabetes, hypertension, and COPD begin to show up," he told *Psychiatric News*.

His programs include Integrated Illness Management and Recovery (I-IMR), which promotes individual goal development, healthy lifestyle practices, and improved awareness of comorbidities; Helping Older People Experience Success (HOPES), which emphasizes psychosocial skills training to better manage medical problems; and an automated telehealth intervention that aims to let people manage their conditions from home.

Each program offers something a little different, which Bartels said he believes is valuable given that the integrated self-management movement is still nascent and topics such as feasibility, scalability, and acceptability need to be addressed.

Bartels and his colleagues recently conducted a systematic review of inte-

CLINICAL & RESEARCH NEWS

grated self-management programs, which was published June 15 in *Psychiatric Services in Advance*.

The team identified 15 interventions in total (including HOPES, I-IMR, and automated telehealth). Most studies demonstrated feasibility, acceptability, and preliminary effectiveness, with patients experiencing improvements in self-management skills and clinical outcomes such as lower blood pressure and less use of acute health services. However, because the review included studies that were small in sample size or had other methodological limitations, it was difficult to determine which might offer the greatest benefits for patients. (Bartels noted that his group is part of a larger clinical study actively recruiting patients with comorbid mental and physical health problems from the Boston area to compare the effectiveness of the I-IMR approach with the automated telehealth option.)

"The other issue that current interventions haven't really addressed is how easy they can be rolled out to the greater population," Bartels said. He pointed out that many of the small trials that showed success employed intense, individualized therapy sessions, which would be difficult to implement at national levels.

"How much can we augment these interventions through technology, for example, or health workers who aren't specialists?" he continued. "Scalability will be a significant obstacle that researchers should factor in to study design."

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CLINICAL & RESEARCH NEWS

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Kaltman believes her intervention should be fairly easy to implement: although it involves individualized sessions, the program was designed to be run in clinics with few resources.

However, she has been thinking about potential strategies to help patients sustain their improvements, as her pilot study only monitored the patients for three months. "One idea was to have program graduates who did really well lead group sessions that patients could attend once they finished their individual therapy," she said.

First, however, Kaltman hopes to secure funding to carry out a randomized, controlled trial so she can determine just how much better this integrated approach is compared with standard care practices.

Bartels' meta-analysis was funded by the Health Promotion Research Center at Dartmouth, with additional support from the Centers for Disease Control and Prevention and National Institute of Mental Health. Kaltman's pilot study was supported by the National Institute of Mental Health. PN

An abstract of "Type 2 Diabetes and Depression: A Pilot Trial of an Integrated Self-Management Intervention for Latino Immigrants" is posted at http://tde.sagepub.com/content/42/1/87.abstract. An abstract of "Systematic Review of Integrated General Medical and Psychiatric Self-Management Interventions for Adults With Serious Mental Illness" is posted at http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201500521.

Will Patients With ADHD Benefit From Stimulant-Guanfacine Combo?

A comprehensive clinical study finds that combining guanfacine and methylphenidate decreased some ADHD symptoms, but a lack of cognitive improvements may suggest monotherapies will remain the preferred option.

BY NICK ZAGORSKI

While stimulants are still the primary pharmaceutical option for treating attention-deficit/hyperactivity disorder (ADHD), guanfacine—an α2A receptor agonist approved for ADHD in 2010—has emerged as an alternative option for patients who do not respond to first-line stimulant therapy. Could combining stimulants with the antihypertensive lead to greater improvements in patients with ADHD than either medication alone?

To explore this question, researchers at the University of California, Los Angeles (UCLA), enrolled youth aged 7 to 14 with ADHD in an eight-week, double-blind trial in which participants received immediate-release guanfacine (1 mg to 3 mg daily), extended-release d-methylphenidate (5 mg to 20 mg daily), or a combination of the two medications. The children's symptoms were assessed using the ADHD Rating Scale–Version IV (ADHD-RS-IV), and overall response rate was gauged using the Clinical Global Impression–Improvement (CGI-I) ratings.

While the effects were modest, there was a statistical improvement in symptoms among the patients taking the combination therapy compared with those taking monotherapies, the authors reported in the August *Journal of the American Academy of Child and Adolescent Psychiatry.* ADHD-RS-IV total score, for example, dropped by 18.3 points in the group that received the combination of the medications compared with 15.8 points for methylphenidate and 16.7 for guanfacine.

In addition, 75 percent of the patients taking both drugs achieved a treatment response by the study's end (measured as at least a 30 percent improvement in ADHD-RS-IV scores plus a rating of "much improved" or better on the CGI-I) compared with 62 percent for methylphenidate and 63 percent for guanfacine.

In contrast, the combination of guanfacine and methylphenidate had limited effects on cognitive performance, the authors noted in a separate report. The combination therapy was associated with improvements in working memory that were better than guanfacine alone but roughly the same as methylphenidate alone; cognitive performance was similar among the groups in all other measures evaluated.

While the safety and tolerability profiles of the combination therapy were about the same as those of the individual medications, Timothy Wilens, M.D., chief of child and adolescent psychiatry at Massachusetts General Hospital, told *Psychiatric News* that the limited cognitive effects of the combination therapy make it unlikely that clinicians will favor the combination therapy over monotherapy.

Because both medications are known to improve attention and hyperactivity

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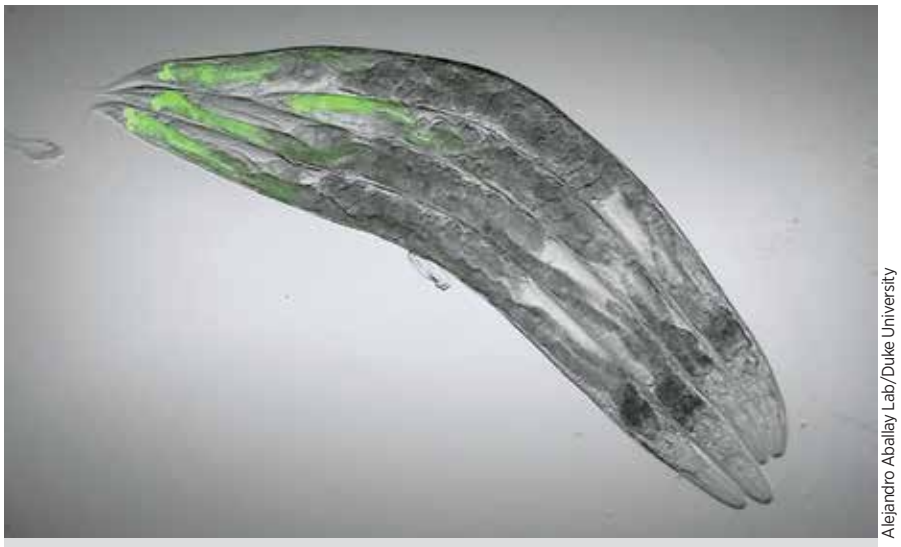
CLINICAL & RESEARCH NEWS

Researchers Identify Neural Circuit Between Brain and Gut in Animal Model

Researchers using a simplified animal model identifies a set of dopamine neurons that trigger immune responses to infection and the ability of chlorpromazine to induce bacterial resistance.

BY NICK ZAGORSKI



Alejandro Aballay Lab/Duke University

The guts of *C. elegans* are highlighted by a green fluorescent protein that is produced when the nervous system is targeted by genetic modifications or by drugs used in humans.

The human neural network may be infinitely complex, but researchers at Duke University have taken advantage of the much more simplified nervous system of the tiny worm *Caenorhabditis elegans* (300 neurons) to uncover a key neural circuit that controls the communication between the brain and the gut.

What's more, they found that this circuit is regulated by a dopamine receptor analogous to the human dopamine receptor D1, the main target of most antipsychotics.

These findings, which were published August 12 in *Current Biology*, provide some important new details about the cross-talk between the brain and immune system, which impacts a wide range of diseases including schizophrenia, Crohn's disease, Alzheimer's, and Parkinson's, to name but a few.

Lead author Alejandro Aballay, Ph.D., a professor of molecular genetics and microbiology at Duke School of Medicine, cautioned that the leap from *C. elegans* to humans is immense, but that someday drugs targeting the nervous system could be used to combat immune-related disorders.

Aballay and his graduate student Xiou Cao made the first connection in this gut-brain circuit after treating the worms with the dopamine blocker chlorpromazine and observing that the animals were more resistant to bacterial infection. Conversely, if the worms were given dopamine, they became slightly more susceptible to infection.

To gain a sense of how this resistance manifested, they used fluorescent bacteria, which enabled them to see that the digestive tracts of the worms given chlorpromazine had lower density of bacteria. This told the researchers that the drug didn't confer some passive resistance to the pathogens, but rather triggered some active microbial killing mechanisms.

They next made various mutant strains, each lacking a specific dopamine receptor, and saw that only the strains lacking the DOP-4 receptor (the DP-1 analog) maintained their infection resistance.

With the receptor identified, Aballay and Cao then began to piece together the circuit by selectively destroying DOP-4–containing neurons to see which ones affected their bacterial resistance, much like going through each bulb in a string of Christmas lights to find defective ones.

Aballay believes that this circuit relays important information about the state of intestinal flora to ensure the brain doesn't order any unnecessary inflammatory attacks.

"Humans have trillions of microorganisms in our guts, and we have to be careful when activating antimicrobial defenses so that we mainly target potentially harmful microbes without damaging our good bacteria—or even our own cells—in the process," he said in a press release.

Dopamine-targeting medications might therefore be used to fine-tune this cross-talk when needed, for example, lowering activity to turn off an autoimmune response. He thinks it might be interesting to see what effects that currently available drugs—like chlorpromazine—might have. Perhaps at lower doses, they may still provide some immune benefits without triggering their neuropsychiatric activity.

This research was supported by grants from the National Institute of Allergy and Infectious Diseases and National Institute of General Medical Sciences. PN

An abstract of "Neural Inhibition of Dopaminergic Signaling Enhances Immunity in a Cell-Non-autonomous Manner" is posted at http://www.cell.com/current-biology/abstract/S0960-9822(16)30675-3.

NIMH

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improve treatment of mental illness for all Americans. "Advocacy is the special role that APA has long played, and I know will continue to play," Gordon said.

He added that he hopes APA and its members will encourage patients to participate in NIMH-funded clinical research.

The theme at this year's IPS: The Mental Health Services Conference, and of Oquendo's presidential year, is "Implementing Prevention Across Psychiatric Practice."

Will prevention have a place in NIMH priorities?

"Absolutely," Gordon said. But he added that the promise of prevention is still to be realized. In schizophrenia, for instance, he noted that although research groups in the United States and other countries have been able to find cohorts of people at high risk for schizophrenia, it is still uncertain how many of those will in fact have true psychosis.

For now and the foreseeable future, Gordon said he's on the learning curve. "I hope APA members will be patient with me and that we can work together to further the priorities that APA shares with the institute and improve the treatment of people with mental illness." PN

Stimulant

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symptoms, researchers are now looking for ways to improve "meta" ADHD challenges, such as the ability to prioritize, organize, or plan effectively, Wilens, who was not a part of this trial, explained.

"And given that the symptom differences weren't even that huge among the groups, I think most people will still default to monotherapy when prescribing ADHD medication to children when they factor in the potential benefits versus issues like medication adherence and copays," he said.

Study coauthor Robert Bilder, Ph.D., the Michael E. Tennenbaum Family Professor of Psychiatry and Biobehavioral Sciences at UCLA, agreed that the methylphenidate-guanfacine combination is likely not the magic bullet that some clinicians had hoped for.

Bilder noted that one reason the patients taking methylphenidate and guanfacine experienced greater improvements in ADHD symptoms than cognition may be due to the sedative effects of guanfacine, which may interfere with the cognitive benefits of the medication. Another possibility, he said, is that the tests used to evaluate cognition in the study failed to fully capture cognitive improvements.

"But while we focused on the average group effects, there could be individual cases where using these medications in conjunction makes sense," he said. "Doctors should just have [tempered] expectations and not anticipate any dramatic effects."

UCLA

Robert Bilder, Ph.D., says that the sedative properties of guanfacine might explain why combining it with methylphenidate in children with ADHD did not lead to cognitive improvements.

The study was supported by a Research Center Grant from the National Institute of Mental Health. PN

LETTERS TO THE EDITOR

Addressing Mental Illness Biases Can Start Before Medical School

In the June 3 issue of *Psychiatric News*, Dr. Heidi Combs described several benefits of early exposure to mental health training in the course of medical education. Namely, she described the benefit of reducing stigma associated with mental illness. I agree, and I applaud Dr. Combs' work in this area. Stigma and misinformation about mental illness start early. News accounts and media portrayals of mental illness contribute to this.

At the University of Washington, undergraduate students interested in mental health topics can take an elective seminar in contemporary issues related to mental health. The course covers recent cases involving such topics as insanity, mass murder, police involvement with people with mental illness, and assisted suicide, among others. As part of the course, students view video clips and read media accounts of high-profile cases on these topics. Students are also provided supplemental academic literature related to each course topic.

Each week, students discuss in class the topics with an aim to remedy misinformation about mental illness and relevant laws and policies. The class also encourages students to think critically about these topics—including policy, legal, and ethical implications—and the bases for their opinions. The role of stigma toward people with mental illness is a running theme in the course. Here is one student comment:

"This class has really opened my eyes to the issues we have regarding mental health in this country. … I'll leave this class with a better ability to discuss these topics with families, friends, or strangers. The opportunity to discuss all these issues with my classmates, with their various opinions, created an educational experience with intellectually stimulating discussions. While we didn't 'find the answers' to the issues discussed, I definitely will leave this class with a better understanding regarding mental health and stigma in our country."

In the words of Dr. Combs: "[W]e should aim to reduce stigma toward mental illness, amplify empathy and understanding, and ultimately provide better care for persons with mental illness." This cannot begin too soon. PN

JENNIFER PIEL, M.D., J.D.
Seattle, Washington

Facility

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building will house its own courtroom to handle competency and other forensic cases without raising security risks or imposing potential staff shortages caused by transporting patients to regular courts elsewhere.

NDI also will have a dedicated research unit that will build on existing relationships with biotechnology partners and research universities such as Indiana University and Purdue University. The state will be able to partner with other hospital systems and BioCrossroads, a consortium of health systems, biotech companies, device manufacturers, and pharmaceutical companies, including locally based Eli Lilly and Co.

While no formal academic affiliation exists for the moment, the Community Health System began its own training program this year with four psychiatry residents and will build up that number to 16 over the next four years.

Like most new psychiatric hospitals, NDI will adopt a contemporary approach to architecture that eschews the ponderous asylums of yesteryear.

"It doesn't look like a prison or a state hospital," said Wernert. "There is a lot of glass and light and open interior space. The design honors patients and their families, and creates a modern environment for healing." PN

More information on the Indiana Neuro-Diagnostic Institute and Advanced Treatment Center is posted at https://secure.in.gov/fssa/dmha/files/Indiana_Neuro-Diagnostic_Institute_One-Sheet.pdf.

Health Care Reform

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and practice of collaborative care, a specific model of integrated care developed by the late Wayne Katon, M.D., Jürgen Unützer, M.D., M.P.H., and colleagues at the AIMS (Advancing Integrated Mental Health Solutions) Center at University of Washington," said Kristin Kroeger, who is spearheading the SAN grant.

Training was also offered at APA's 2016 Annual Meeting in Atlanta and will be again in October at IPS: The Mental Health Services Conference (see psychiatry.org/IPS for registration information).

The *Psychiatric Services* study used data collected from a large probability sample of U.S. psychiatrists who took part in the Study of Psychiatric Practice Under Health Care Reform, which was fielded in fall 2013. A total of 2,800 physicians in the United States who self-identified as psychiatrists and listed direct patient care as their type of practice were randomly selected from the September 2013 release of the AMA Physician Masterfile.

There were 1,188 respondents to the survey. Of these, 1,099 reported currently practicing psychiatry and treating psychiatric patients and provided the sample for this study. A four-page data collection instrument was mailed to the target sample with a $50 gift card to increase response. Three survey mailings were implemented at one-month intervals, followed by reminder postcards.

Most psychiatrists (64 percent) reported assuming at least one of the roles identified as being integral to the successful ACA implementation of health care reform; an additional 14 percent reported being likely or very likely to assume at least one of these roles beginning January 1, 2014.

Most commonly, psychiatrists reported practicing as a member of a team service delivery model (42 percent), providing ongoing mental health treatment for a caseload of patients with more severe mental illness, coordinating with a primary care clinician (41 percent), providing consultation to primary care and mental health clinicians caring for psychiatric patients with diagnostic or therapeutic challenges (39 percent), or providing leadership and supervision for team delivery of psychiatric and general medical care for psychiatric patients (33 percent).

Less commonly, psychiatrists reported that they oversee, track, and review care for psychiatric patients by working with practice leadership to ensure that services are available, appropriate, and well managed (21 percent) or that they currently provide general medical care to psychiatric patients (16 percent).

Here are some findings for specific reform-related categories:

- **Integrated Services Delivery Systems:** Nearly one-third of the psychiatrists (29 percent) reported they practice in at least one integrated treatment setting, and 13 percent reported they would be likely or very likely to do so beginning January 1, 2014. Eighteen percent of psychiatrists reported working in an integrated treatment setting with co-located and integrated specialty mental health and primary care services, and 15 percent reported working in a primary care treatment setting.

- **Payment Reforms:** A substantial proportion of psychiatrists (42 percent) reported receiving at least some reimbursement in the form of salary, and 4 percent reported that they would be likely or very likely to receive salary reimbursement beginning January 1, 2014. The other ACA physician payment reform mechanisms were rarely reported. Only 4 percent of the respondents reported fee-for-service reimbursement with a potential financial bonus for containing costs and meeting quality standards; 6 percent reported that they would be likely or very likely to participate in contracts with this type of payment beginning January 1, 2014.

- **Electronic Health Records (EHRs):** Approximately half the psychiatrists (53 percent) reported using any form of EHR for clinical functions not limited to billing or practice management. Eight percent reported that they planned to use an EHR within the next year, and 4 percent reported that they planned to use an EHR in more than one year. Twenty-one percent reported participating in the Medicare or Medicaid EHR Incentive Program, and 6 percent were planning to participate in the future.

The authors noted that engaging psychiatrists in integrated delivery systems and roles is especially challenging because traditional clinician CPT payment codes are not structured to reimburse for care coordination and for many functions integral to psychiatrists' participation in team-based services delivery. "The Centers for Medicare and Medicaid Services (CMS) is currently seeking to address this limitation," they stated.

(In fact, in July CMS released the proposed 2017 Medicare Physician Fee Schedule rule, which included coverage for "Psychiatric Collaborative Care Management Services." Such coverage would reimburse for consultative services provided to care managers within the primary care physician's office in the collaborative care model. The proposed rule was published in the *Federal Register* on July 15. CMS accepted comments on the proposed rule until September 6 and will issue its final rule later this year [*Psychiatric News*, July 28]).

The authors added, "The movement toward ACO's and CMS's aggressive goals of increasing use of global, capitated payments and 'merit-based' reimbursement rather than fee-for service payments may also help address this limitation. If successful, this paradigm shift may give health plans the flexibility and financial incentives to engage psychiatrists in salaried arrangements, helping to promote integrated treatment and offering the potential to contain or reduce health care costs, particularly for high-cost patients." PN

The *Psychiatric News* series "Changing Practice, Changing Payment" and a webinar on MACRA can be accessed at http://apapsy.ch/MACRA-Info. Information about the SAN grant and TCPI training is posted at http://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/transforming-clinical-practice-initiative/integrated-care-training-modules.

Everett

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process of seeking government funding opportunities to promote effective treatment and prevention of mental illness and substance use disorders.

Everett told *Psychiatric News* that her desire to contribute firsthand to healthy community, social justice, and public services is what led her to this position and has driven her professional career. "I have worked in virtually every aspect of the profession of psychiatry—including private, public, and academic institutions, as well as inpatient and outpatient services, and services for substance use disorders, geriatric, children, and persons with developmental disabilities."

Prior to taking on the role as SAMHSA's chief medical officer, Everett served as the division director of Johns Hopkins Community and General Psychiatry, Bayview Campus, in Baltimore, where her research focused on health behavior of individuals with long-term mental illnesses living in urban and underserved areas.

From 1999 to 2003, Everett served as inspector general to the Office of the Governor in the Department of Mental Health in Virginia, completing more than 80 inspections of institutions licensed to provide mental health services within the state. Everett has also been involved in multiple international projects such as working as a consultant with the Ministries of Health in the implementation of government-operated mental health services in Iraq and Afghanistan.

Anita Everett, M.D., says having a psychiatrist on SAMHSA's leadership team will help to advance the nation's behavioral health system.

Everett was elected president-elect of APA in February and will assume the office of president at the conclusion of the APA Annual Meeting in San Diego in May 2017. She has held numerous leadership roles within the organization, which include trustee-at-large on the APA Board of Trustees and chair of the APA Task Force on Healthcare Reform 2015.

"As practicing psychiatrists, we have the opportunity to be a catalyst for positive change in the lives of the patients we serve," Everett told *Psychiatric News*. "As active members of APA, we have the opportunities to be part of a catalyst for positive change on a larger scale."

Everett said that psychiatrists know more today than ever before about causes and treatments of behavioral health conditions and must continue to find ways to increase access to effective treatment and prevention.

"Our nation's behavioral health system is very complex," said Everett. "We cannot let that deter us from making a difference. As suggested as a tactic in the approach to complex tasks: 'A journey of a thousand miles begins with the first step,'" Everett concluded. PN

Acting

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"I don't know how many times a parent has come up to me after a performance and said, 'I could not believe my child could do that,'" echoed Catherine Coke, who directs high school theater at the University School of Nashville, which partners with Corbett's program. "I'll never forget the child who refused to accept a certificate of completion because the child did not want the program to end."

Recent trials by Corbett's group suggest the program may also have a lasting impact on the social abilities of the participants.

In a study published in the *Journal of Autism and Developmental Disorders*, Corbett and colleagues described how they randomly assigned 30 children with ASD aged 8 to 14 to participate in a 10-week, 40-hour theater-based program or be placed on a wait list.

After the program ended, the children who had enrolled showed significant improvements in social communication, group play, and face recollection compared with the controls. Participants who participated in the program also showed more group play with children outside the treatment setting, as well as improvements at home, which remained evident at a two-month follow-up.

Acting Exercises Build Trust in Group Therapy

Patients with autism are likely not the only ones who might benefit from acting. Miguel Alampay, M.D., J.D., has been exploring the use of improv for adults dealing with posttraumatic stress disorder as well as other mental issues.

"In the third year of my psychiatry training [at Walter Reed National Military Medical Center in Bethesda, Maryland], I was required to do a therapy group, and I got to thinking about barriers to care," he told *Psychiatric News*. "What prevents people from being forthcoming during a session, or from coming at all? And the answer was trust."

To break those trust barriers, Alampay developed a 12-week group therapy called Improv Life, which incorporates improvisation and role-playing games during the first half of each session prior to the formal discussion.

"What's nice about improv is that it's based on the principle of 'Yes, and?'" Alampay said. "In normal life, we are so used to hearing 'Yes, but. ...' However, the goal of improv is to take whatever is said to you and go with it, which keeps conversations going and helps someone open up."

He noted that the acting component of the program can be particularly therapeutic for participants who are active or retired military personnel. (Alamapy said he asks military personnel to remove any visible signs of their rank to encourage more participation.)

"In taking on a different role, they are able to adopt thoughts and emotions they could not display before," Alampay said.

Alampay said he has been very pleased with the results of his Improv Life groups (he's carried out two programs with 30 people total) and learned how to respond when negative behaviors emerge when participants practice role play, improvisation, and humor.

"It can be a fine line between a positive and negative coping mechanism," he said. "If patients are telling jokes to reinforce negative thoughts about themselves, you might be reinforcing their stigma if you go along with it. One has to be ready to anticipate these pitfalls and guide patients back to a positive frame of mind."

Patients Aren't Only Beneficiaries of Sessions

Integrating acting techniques into therapy does more than benefit the patients, Alampay and Corbett agreed. As Alampay prepares for the next phase of his career as an OSCAR (operational stress control and readiness) specialist in Japan, he said that he is grateful for all Improv Life has taught him.

"In my new role, I won't be conducting therapy, but rather I'll be out in the field with the Marines where I have to relate to them and get them to talk to me, to identify potential mental issues early on. And all the improv I did during my group sessions will be a huge boost."

Corbett likewise has seen how the SENSE Theatre has impacted the youth who help mentor their ASD peers.

"Not only do they all have a greater appreciation and empathy for the disorder, which is critical during the school-age years, but we've even had a few students who have become interested in mental health as a possible profession," she said. PN

An abstract of "Improvement in Social Competence Using a Randomized Trial of a Theatre Intervention for Children With Autism Spectrum Disorder" is posted at http://link.springer.com/article/10.1007%2Fs10803-015-2600-9.