WWW.PSYCHNEWS.ORG | THE FIRST AND LAST WORD IN PSYCHIATRY | VOLUME 51, NUMBER 19, OCTOBER 7, 2016

PSYCHIATRIC NEWS

AMERICAN PSYCHIATRIC ASSOCIATION

ISSN 0033-2704

AP Photo/David Goldman

Now that the U.S. presidential race is in the homestretch, Democratic candidate Hillary Clinton and Republican candidate Donald Trump have released information on their health and mental health platforms. See article at right.

Candidates Reveal Positions on Mental Health

Clinton says she'll push for integrated care and parity; Trump wants to repeal "Obamacare" and supports "free market" health reform.

BY AARON LEVIN

Proposals for mental health care by the candidates for the U.S. presidency are as divergent as the candidates themselves.

Democrat Hillary Clinton's campaign devotes a detailed, 10-page document to the subject, while Republican nominee Donald Trump embeds his mental health plans within two broader areas: health care reform and ways to reform the Department of Veterans Affairs.

Trump's core proposal rests on long-standing Republican opposition to the Affordable Care Act (ACA).

"On day one of the Trump Administration, we will ask Congress to immediately deliver a full repeal of Obamacare," says the candidate's website.

With that out of the way, he favors "free market" approaches to health care, like selling health insurance across state lines, allowing a tax deduction for health insurance premium payments, making Medicaid a block grant program, and promoting the use of health savings accounts.

Trump's position on mental health states in full:

"Finally, we need to reform our mental health programs and institutions in this country. Families, without the ability to get the information needed to help those who are ailing, are too often not given the tools to help their loved ones. There are promising reforms being developed

see **Candidates** on page 28

APA Hails Collaborative Care Codes, Urges CMS to Reconsider Payment Plan

Levin said the new codes will support a model in which patients benefit from a collaborative, team-based approach that applies well-established principles of population-based behavioral health care and employs specific behavioral health expertise.

BY MARK MORAN

APA has strongly commended the Centers for Medicare and Medicaid Services (CMS) for proposing coverage for collaborative care services beginning in January 2017, calling the government's recognition of collaborative care—and the role of psychiatrists in that model—"a huge advancement in health policy."

"For patients with common behavioral disorders who are treated in primary care, the collaborative care model (CoCM) maximizes the effectiveness of current behavioral health treatments by ensuring that patients are identified, treated, and monitored proactively, with clinical guidance provided by a qualified psychiatric consultant," wrote APA CEO and Medical Director Saul Levin, M.D., M.P.A., in a letter last month to CMS Administrator Andrew Slavitt, M.B.A. "In this model, primary care providers receive extensive support from a team that includes a trained behavioral health care manager and a psychiatric consultant. Patients benefit from the heightened benefits of a collaborative, team-based approach that applies well-established principles of population-based behavioral health care and employs specific behavioral health expertise."

The letter was in response to the proposed Medicare Physician Fee Schedule issued in July (*Psychiatric News,* August 5) and includes extensive recommendations for refining or revising the proposed rule. The comments include detailed recommendations for a host of proposals in the rule, but focus especially on the new codes for coverage of collaborative care services that can be submitted by primary care physicians (GPPP1, GPPP2, GPPP3). The final rule is expected to be issued around November 1.

(G codes are temporary codes, and they had to be used for the 2017 collab-

see **Codes** on page 40

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

15 

Two state programs show collaborative care benefits for youth, clinicians.

21 

Education on infant MH should be integral part of child psychiatry training.

31 YouTube

YouTube presents 'distorted picture' of schizophrenia, report finds.

PSYCHIATRIC NEWS

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

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

EDITORIAL OFFICES
Telephone: (703) 907-7860
Email: cbrown@psych.org
Web site: psychnews.org

ADVERTISING SALES
Frank Cox, Kathleen Harrison, Tim Wolfinger, Eamon Wood, Pharmaceutical Media Inc., 30 East 33rd Street, New York, N.Y. 10016; (212) 904-0379; fax: (212) 685-6126; twolfinger@pminy.com. Nonpharmaceutical and Classified advertising: ewood@pminy.com; (212) 904-0363.

CHANGES OF ADDRESS
Call the APA Answer Center at (888) 35-PSYCH in the U.S. and Canada; in other countries, call (703) 907-7300.

FROM THE PRESIDENT

So What's NIMH's New Director Really Like?

BY MARIA A. OQUENDO, M.D.

The rumor mill was just churning. Everywhere I turned, people wanted to know. "Who will it be?" "I heard it will be a woman!" "Is it true that it is going to be a Ph.D.?"

The National Institute of Mental Health (NIMH) directorship had been recently vacated by Dr. Thomas Insel, who spent over a decade at the helm when he left to join Google in the Bay Area. The keen interest came from all areas—yes, researchers, but it came from other academics, too, as well as advocacy groups and professional organizations.

I was attending APA's IPS: The Mental Health Services Conference in New York in October 2015 when the email from Dr. Francis Collins' office came in: "The National Institutes of Health (NIH) director wanted to talk to me on the phone. Might I be available?" I could not imagine what this was about. But the director wanted to ask me to serve on the search committee to identify the next NIMH director. As I absorbed the question, I realized that as president-elect of APA and a member of the NIMH Advisory Council, it made sense that he was reaching out, seeking input from the Association that represents psychiatry in this fine country.

The process was rigorous and thoughtful. The committee, ably chaired by Drs. Nora Volkow and Walter Koroshetz, was charged with reviewing the robust set of applications, selecting a subgroup for interview, and sending a few names to the NIH director for consideration. The process would take the better part of nine months.

I was thrilled when Dr. Collins

Joshua A. Gordon, M.D., Ph.D.

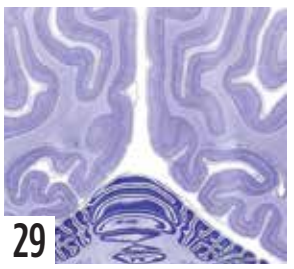
announced that Joshua A. Gordon, M.D., Ph.D., of Columbia University would be the next NIMH director (*Psychiatric News,* September 16). There were many reasons for my enthusiasm. Of course, he is a brilliant and creative scientist. Goes without saying. But Josh has many other talents. He and I had gotten to know each other well when we worked closely to write a grant application for a research track for the residency at Columbia. After it was awarded, we worked shoulder to shoulder to get it off the ground and turned it into an exemplary program, often lauded by Dr. Insel for the quality of the recruited residents and the solid foundation they were provided, much of this due to Josh's leadership.

Josh is collaborative to a fault, determined, hard working, and a wonderful, superorganized administrator. This last attribute became abundantly apparent to me when the time to prepare the competitive renewal for our grant came around. Josh had just been tenured and was planning to bicycle across the United States to celebrate. But, we had a grant to resubmit that supported our research-oriented residents. This was really important. I had some trepidation about how we were going to pull this off with him on the road, mostly incommunicado. Then I received his email with a work plan that knocked my socks off. I had been submitting grants for nearly two decades without the benefit

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


5


13


29

IN THIS ISSUE

5 | **Psychiatrist Is First to Serve on Women's Preventive Services Panel**
As a member of the task force that recommends preventive health care services for women, Maureen Van Niel, M.D., hopes to bring attention to the importance of including mental health in preventive medicine.

11 | **Should You Disclose Confidential Information to Your Patient's Family?**
Psychiatric News readers discuss points to consider when family involvement may be needed to deal with a patient in crisis. An ethics expert responds.

13 | **Psychiatrist Discovers His Guide Dogs Do More Than Offer Him Support**
After an illness left him weak, Edward Kantor, M.D., began using guide dogs. He soon learned that his canine companions benefitted his patients as well.

29 | **Scientists Map Gene Expression Across Development in Rhesus Monkeys**
The molecular atlas may help researchers better understand normal brain development and identify neurodevelopmental processes involved in psychiatric disorders.

APA Petition Candidates: Please Note

The deadline to submit a petition to run for APA office in the 2017 election is November 15. More information is available by sending an email to election@psych.org.

APA 2017 ELECTION

Departments

4 | FROM THE PRESIDENT
14 | ETHICS CORNER
15 | PSYCHIATRY & INTEGRATED CARE
22 | FROM THE EXPERTS
29 | RESIDENTS' FORUM
32 | JOURNAL DIGEST
33 | MED CHECK

PROFESSIONAL NEWS

First Psychiatrist Joins Federal Panel On Women's Preventive Health Services

Involvement of a psychiatrist will help ensure that preventive mental health services are an integral part of primary and specialty health care for women of all ages.

BY AARON LEVIN

The Women's Preventive Services Initiative (WPSI) is in the midst of updating its guidelines for women's health, for the first time with the participation of a psychiatrist.

Recommendations accepted under the WPSI umbrella are covered without copayments under the Affordable Care Act (ACA) and thus determine how much a woman pays for her health care.

Representing APA on the panel is the president of APA's Women's Caucus, Maureen Van Niel, M.D., a private practitioner in Cambridge, Massachusetts. She is the first mental health practitioner of any kind to be appointed to the panel.

WPSI's origins lie in provisions of the ACA that increased the focus on preventive care. A report in 2011 from the Institute of Medicine (now the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine) noted: "Women stand to benefit from this shift given their longer life expectancies, reproductive and gender-specific conditions, and historically greater burden of chronic disease and disability."

That report also recommended eight preventive health care services for women:

- Screening for gestational diabetes
- High-risk human papillomavirus DNA testing
- Annual counseling on sexually transmitted infections for sexually active women
- HIV counseling and screening

The mental health aspects of a medical condition are just as important as the physical ones in preventive medicine, says Maureen Van Niel, M.D., the first psychiatrist appointed to the Women's Preventive Services Initiative Task Force.

- Contraception counseling
- Lactation support and counseling
- Screening and counseling for interpersonal violence and domestic violence
- At least one well-woman preventive care visit annually for adult women to obtain the recommended preventive services

The IOM also called for reviewing and updating these guidelines every five years, so in March the Health Resources and Services Administration (HRSA) under the Department of Health and Human Services awarded a five-year contract to the American College of Obstetricians and Gynecologists (ACOG) to manage a collaborative review process. ACOG then invited representatives of 21 other health professional organizations and advocacy groups to serve on the WPSI's multidisciplinary steering committee.

Prior close cooperation between APA and ACOG leaders led to a request for a psychiatrist to join the panel, so CEO and Medical Director Saul Levin, M.D., M.P.A., appointed Van Niel to fill the post.

The Pacific Northwest Evidence-Based Practice Center at the Oregon Health and Science University reviewed the published research for each topic.

*see **WPSI** on page 34*

Surgeon General Calls on Physicians To Help End Opioid Abuse

A loose approach to prescribing drugs to treat chronic pain needs to be corrected, says U.S. Surgeon General Vivek Murthy, M.D., M.B.A.

BY AARON LEVIN

Overdose deaths—primarily due to prescription pain relievers and heroin—have quadrupled in the United States since 2000, reaching 28,467 deaths in 2014, according to the Centers for Disease Control and Prevention (CDC).

The causes of this upsurge are complex, but today's epidemic can be said to have begun in the 1990s, when physicians were encouraged to pay greater attention to pain and to treat it more aggressively, according to U.S. Surgeon General Vivek Murthy, M.D., M.B.A.

At the same time, pharmaceutical companies increased marketing efforts directed at physicians for opioids.

Once touted as the answer to chronic pain, opioids have become a major drug of abuse, and physicians must become more circumspect in prescribing them, says U.S. Surgeon General Vivek Murthy, M.D., M.B.A.

"The results have been devastating," wrote Murthy in a letter that was sent to all U.S. physicians in late August. The letter—which Murthy noted marks the first sent from his office to health professionals to address a public health crisis—is part of the Surgeon General's Turn-TheTide Campaign, a national effort to raise awareness about those affected by opioid use disorder, successful treatment programs, and the challenges that remain in communities hardest hit by the epidemic.

He urged physicians to take the pledge posted on his website to help stem the nation's opioid epidemic by learning how to treat pain safely, screening patients for opioid use disorder, and educating the public about addiction.

"Years from now, I want us to look back and know that in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way," wrote Murthy. He suggested that clinicians follow guidelines from the CDC in assessing pain and function.

"If physicians within the house of medicine work together, we can implement better, safer treatments for pain and get patients who currently have an opioid use disorder into treatment programs that can help," said APA CEO and Medical Director Saul Levin, M.D., M.P.A.

"Opioids can provide short-term benefits for moderate to severe pain," the CDC reminds prescribers. "Scientific evidence is lacking for the benefits to treat chronic pain."

With that in mind, clinicians should discuss with patients the benefits and risks of treatment alternatives. Murthy asked doctors to consider nonopioid therapies for chronic pain, like NSAIDS or physical therapy, before prescribing opioids, when possible.

If opioids are indicated, the CDC advises starting with a low-dose, immediate-release formulation. Reassessment should come one to four weeks after the initial prescription.

Screening can identify patients who meet criteria for opioid use disorder,

*see **Surgeon General** on page 30*

Readers Describe Complex Factors In Approaching Confidentiality

Patient status and history and family dynamics are among the factors that help determine to what extent family should be involved in an adult patient's treatment for psychiatric illness.

In the September 2 issue, *Psychiatric News* asked readers to respond to the question, "What Would You Do?" in the following scenario: "You are treating a patient with bipolar disorder and a past history of suicide attempt. He appears to be stable, but he tells you that recently he has stopped taking his medication. His parents are anxious to know of his progress, but the patient is 25 years old and has not authorized release of information about his treatment to family members. Would you disclose to the parents that the patient has ceased taking medication?"

Here is a sample of responses:

The dilemma for clinicians—can and should they disclose relapse-relevant information to the immediate family if the family appropriately asks about clinical status?—is one that is ideally anticipated well in advance of its occurrence. That typically means having a frank discussion with patients when they are well, along the lines of a psychiatric advanced directive. For example: "In a clear-cut life-and-death emergency, I will need to speak with your emergency contacts, the same as if you were having a heart attack or a stroke and couldn't communicate and advocate for your own best interests. But, what should we do if the hazards aren't so obvious? Do you really want your immediate family to be in the dark?"

Knowing that family communication styles are themselves highly relevant to the outcome of bipolar disorder, it makes sense to identify the role of the family up front as one component of the overall treatment plan; if the patient decides to withhold permission for relevant dialogue with the family, it's then the treater's job to point out how they are setting themselves up for trouble.

Perhaps the most effective intervention is for the clinician to underscore his or her overwhelming concern for the patient's welfare. The clinician can offer to be a moderator of communication between patient and family by proposing a joint meeting where all stakeholders and the patient are present, to air concerns and minimize surprises by making everyone's fears explicit, and, consequently, shared.

Inasmuch as the therapeutic alliance often stands as the core of any good treatment, it becomes critical to tackle head-on the pitfalls of "privacy and confidentiality" conflicts when the patient and treater share the mutual goal of averting preventable harm to the patient.

JOSEPH F. GOLDBERG, M.D.
Clinical Professor of Psychiatry
Icahn School of Medicine
New York, New York

Your discussion of information sharing seems to omit one key consideration: many families of mentally ill individuals are not capable advocates for the patient. They may have played a role in the development of the disorder. They may not have the resources to provide the sort of support you're assuming. The family might not trust psychiatrists (or other mental health professionals). I see countless stories of patients (mostly with bipolar disorder) whose families don't buy into the prevailing paradigm of mental illness. They shame the patient. They discourage various aspects of treatment. Hearing that a medication is potentially addictive, they discourage the patient from taking it. They simply "don't believe in mental illness." Even the well intentioned may minimize the seriousness of the illness.

CANDY CLOUSTON, M.S., M.B.A.
Chicago, Illinois
Ms. Clouston is a patient reviewer of psychiatric papers that appear in the British Medical Journal.

Unfortunately, much of life is too ambiguous to be reduced to algorithms and checkboxes. I personally look for common sense to guide me. Here are the factors I would consider:

- Why has the patient stopped taking the meds? This is a common occurrence for many young people with a mental health diagnosis. They feel better, consider themselves "cured," and stop the meds. For them, the diagnosis and meds feel like an assault on their worth and potential "attractiveness" to peers. But there are other reasons to explore—side effects, paranoia about the actual medications, etc.

- Treatment context (private patient, community mental health center, etc.) determines both the time and resources available to address this issue. The task is to evaluate who is or has been a resource for this person, whether he takes medication or not. That way, regardless of what the patient decides, there are people in his life who can "watch out" for him.

- What do I expect to happen if the patient stops taking meds? Of course, I would talk with the patient about continuing the medication and educate him in detail about what he can expect if he stops. That way, if he relapses, he can catch it early. The downside of pressuring someone is that you alienate him. Usually better to work with patients to titrate down slowly and have them return for appointments. That way you can work together as a team to discover the minimum dose.

PEGGY FINSTON, M.D.
Private Practice
Toms River, New Jersey

An extensive and consistent body of research has provided evidence that the inclusion of families in the care of adults with a variety of mental disorders is associated with better outcomes for everyone. Yet, such inclusion is the exception rather than the rule.

One simple and person-centered strategy that has been tested and found to be effective is called REORDER—**RE**covery **OR**iented **DE**cision-making for **R**elatives' support. This approach can easily be embedded in routine care and starts with the basic premise that family involvement does not have to be all or nothing. Clinicians talk with patients about who is in their family, help them define their treatment goals, and inquire about how families can help them meet their treatment goals (or not!). Patients are asked to weigh the pros and cons of family involvement and are included in the discussion of whether to involve their families and, if so, how. A randomized trial of REORDER produced a fivefold increase in family contact with care in a manner that was respectful of both patient and family needs and preferences.

REORDER does not address every situation in which family contact and information may be desirable. But it creates an easily implemented structure and process for meeting the needs and optimizing outcomes of both patients and families. PN

LISA DIXON, M.D., M.P.H.
Director, Division of Behavioral Health Services and Policy Research and the Center for Practice Innovations
New York State Psychiatric Institute
New York, New York

The *Psychiatric News* article "Confidentiality: When Does It Give Way to Other Ethical Imperatives?" is posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.9a12.

Ethics Expert Responds

Response by Paul Appelbaum, M.D., the Dollard Professor of Psychiatry, Medicine, and Law; director of the Division of Law, Ethics, and Psychiatry; and director of the Center for Research on Ethical, Legal, and Social Implications of Psychiatric, Neurologic, and Behavioral Genetics in the Department of Psychiatry at Columbia University College of Physicians and Surgeons:

The responses above point to a number of key issues in dealing with confidentiality vis-à-vis family members. Drs. Goldberg and Dixon both underscore the importance of planning ahead. For many patients with serious mental disorders, situations in which familial involvement may be helpful are all too common: discontinuation of medication, development of suicidal ideation, relapse of substance abuse. Helping patients think through these issues in advance and identify when the involvement of family members may be helpful relieves clinicians and patients alike of the burden of having to deal with these questions at times of crisis.

A second take-home message is that no single approach is right for all patients. As Ms. Clouston notes, not all families are helpful in facilitating treatment. Indeed, some family members, sometimes because of their own psychopathology, can undercut psychiatrists' efforts to treat their relatives effectively. Thoughtful involvement of families means assessing whether their engagement in the treatment process is likely to be useful. Dr. Finston seconds the need for approaching each situation on its own terms, pointing to the probable consequences of patients' noncompliance as important determinants of clinicians' responses.

All of this is possible within the constraints of HIPAA and other statutes governing psychiatrist-patient confidentiality. Although there will undoubtedly be cases like the one in the vignette where, lacking patients' consent to contact family members and fearing relapse as a result of nonadherence to medication, psychiatrists find themselves in a bind, the number of such instances can be minimized by thoughtful advance planning jointly with patients.

Furry Friend Assists Psychiatrist Up Steps and Through Life

A companion and helper came from unexpected quarters when Edward Kantor, M.D., was recovering from illness.

BY AARON LEVIN

Psychiatrist Edward Kantor, M.D., was having a tough time getting through the day at work.

Kantor had fallen ill in March 2009 with a severe lung infection that progressed to pneumonia, then acute respiratory distress syndrome, followed by numerous secondary complications. By the time he was discharged from the hospital in early July, he had to cope with motor, balance, and lung problems, some of which still have not fully resolved.

He got back to working about half time by December of 2009. Kantor, an associate professor of psychiatry and residency training director at the Medical University of South Carolina in Charleston, is a consultation/liaison psychiatrist, and his job demands a lot of walking around the hospital and the emergency department. He is also an expert on disaster psychiatry and has worked on aspects of emergency planning and response for over 30 years, including the Virginia Tech and Charleston church shootings.

A devastating illness left one psychiatrist in need of help, which arrived on four legs and was named Hunter.

As time went on, his condition improved slowly, but the functions of daily living did not come back easily.

Until he met Hunter.

Visiting his brother in New York, he spent some time playing with one of the family dogs, a moment that led his sister-in-law to observe that a dog—the right kind of dog—perhaps could help Kantor.

Another sister-in-law had a volunteer connection with The Seeing Eye, which raises and trains guide dogs for blind people. She led him to Hunter, a very intelligent animal who could no longer work as a guide dog after he developed seizures.

"Many of the dogs that don't make the cut as a Seeing Eye guide dog can be amazing at other things like police K-9 work, bomb sniffing, or search and rescue," said Kantor. "Dogs with medical problems can be hard to place, though."

Hunter needed love and a home that could manage his medical issues, and Kantor was willing to deal with the dog's potential frailties. Hunter also needed a purpose, and he loved to work.

"He adapted to me, and I adapted to him."

Mere walking was a chore for Kantor, who was still on oxygen. Hunter kept him balanced on uneven ground. He pulled him up steps and kept him from falling. He countered any instability and made up for general lack of strength.

"It's really uncanny how he'd pull if I was shifting the other way—when he was doing his job right," he said. "Occasionally he was a little bit single-minded at first. Seeing Eye guide dogs are trained in 'intelligent disobedience,' and so display independent thinking at times, but we worked well as a team, and it only got better with time."

As Kantor recovered and spent more time at work, new questions arose.

In theory, service dogs can usually move throughout the hospital, but Kantor didn't want to disrupt the psychiatric work environment or disturb patients. No conflicts arose at first because he took Hunter only to his office in the resident education center, where no patients were seen. Going to the clinic was another matter.

"It occurred to me that you can't have a dog in a psychiatry appointment without the dog somehow becoming part of the discussion," he said. Soon, a different discussion emerged, one involving liability insurance and hospital lawyers.

The lawyers, though, came up with a solution—write a new job description with an animal-assisted therapy protocol that did not intrude into patient care but did allow Kantor some discretion to bring the dog into some settings at the right time—like the geriatric psychiatry unit where he rounded some weekends.

Hunter behaved well in the hospital, even with agitated, psychotic, and angry patients. "Somehow, the dog had an ability to shift the focus and make encounters less hostile," said Kantor. "It gives you something to talk about that doesn't threaten the patient. So he's been a big help."

"There have been a few cases where people with almost no memory appear to re-engage in the presence of the dog," he said. "One day, a woman who couldn't form complete sentences said, 'Looking at him, you would think you should be afraid, but he's such a gentle soul.'"

Staff on the ward were astonished.

"I'd say 90 out of a 100 people wanted the dog in the room, probably more than they wanted me in the room," said Kantor. "Even the ones who couldn't remember my name remembered the doctor with the dog, and that's typically who they asked the nurses for."

But illness eventually caught up with Hunter.

"He was with me for almost two years, and one night he had a bad seizure and stopped breathing and didn't recover," said Kantor. "It was pretty traumatic, actually, because we were with each other 24/7."

Photos: Edward Kantor, M.D.

Kantor's new best friend, Eaton.

Hunter died in January 2015, and even six months later, Kantor thought he wasn't ready to bring a new dog into his life. But things changed when he got another call from The Seeing Eye's adoption coordinator. By chance, another dog was available that seemed like a good fit for Kantor. He returned to The Seeing Eye and met Eaton, a younger, healthy dog who had done so well in his early training that he was assigned to breed new guide dogs. He had retired from that job by the time he and Kantor met and was available for adoption.

Hunter and Eaton helped Kantor in quite different ways.

"Among other things, Hunter was fully trained and had worked as a guide dog for a blind person, so he was very used to one person and was very single-minded and focused," said Kantor. "With me, he had to adjust to a sighted person, but he was incredibly intuitive and over time adapted well."

Eaton, in contrast, had undergone general training but not the blind-specific schooling, so their developing relationship focused more on learning to work together rather than adjusting to a new task.

Eaton soon fit in well with Kantor and his work at MUSC. "He's quite loving and social with other dogs, babies, kids, and geriatric patients, but he still manages to maintain his focus on helping me."

Of course, some people, with or without mental illness, are just not dog people.

"We had one patient on our geriatric unit say, 'Get that mangy animal out of my room!'" recalled Kantor. "And we said, 'OK, I'm sorry you feel that way. We don't mean to intrude.' Three days later, after he saw Eaton interacting with everybody else on the unit, he said, 'Is it OK if I change my mind?' We had a nice little sit-down, he stroked Eaton, and he talked about his own pets when he was a kid. I think Eaton makes a difference for many patients—certainly he makes a difference for me. The dogs changed my life."

If at first Kantor was afraid that Hunter and Eaton would disrupt his practice, thinking about their therapeutic role and his own recovery from debilitating illness clarified the dogs' place in his world. Their presence on the wards became intentional rather than accidental and disjunctive.

"Recovery is a process, and sometimes we need help," said Kantor. "I was fortunately able to adapt, and I think the dogs actually made me a better psychiatrist. Sometimes the nonverbal communication you get from a patient involving an animal is even more effective than struggling to find the language to talk about something directly." PN

PROFESSIONAL NEWS

Group Unveils Strategy for Reducing Suicide Rate 20 Percent by 2025

Educating the firearms community and health care professionals about suicide prevention could help drive down the nation's suicide rate, says the American Foundation for Suicide Prevention.

BY AARON LEVIN

Every year, an estimated 42,000 people in the United States die by suicide. The American Foundation for Suicide Prevention (AFSP) believes that investing in three critical areas could reduce the U.S. suicide rate by 20 percent by 2025.

"Our modeling shows we could save thousands of lives each year if we focus on the best strategies and interventions, and apply them widely," said AFSP CEO Robert Gebbia in an August teleconference. The current age-adjusted rate for suicide is 12.93 per 100,000, according to the AFSP website. A 20 percent reduction would cut that rate to 10.34 per 100,000, amounting to about 8,600 lives saved per year by 2025.

The approach planned for "Project 2025" will be dynamic and flexible, subject to modification as results appear, Gebbia said.

Half of all people who die by suicide use firearms, according to Gebbia, so AFSP will ally with the National Shooting Sports Foundation, a firearms trade group, to work with gun retailers, shooting ranges, and gun owners. The partnership will develop educational programs and materials to inform the firearms community about suicide prevention. Screening this population may help identify those who are "suffering in silence" before they harm themselves, Gebbia said.

"If 50 percent of gun buyers are exposed to educational messages about prevention and there is a 20 percent effect, we could save 9,500 lives by 2025," he added.

AFSP

The American Foundation for Suicide Prevention wants to take the most promising interventions, strategies, and programs and apply them widely to save the most lives, said AFSP CEO Robert Gebbia.

A second preventive strategy aims to identify people at risk of suicide who visit large health care systems but remain undetected.

"We know that 50 percent of people who die by suicide have been seen recently in primary care settings, although usually not for psychiatric reasons," Kelly Posner, Ph.D., an AFSP board member and an associate professor of psychiatry at Columbia University, told *Psychiatric News*. "So we know we need to screen and assess these people and get them into the right care."

AFSP will provide training and information to health care systems to help health care workers detect patients at risk of suicide, provide short-term interventions, and connect at-risk patients with better long-term follow-up care. Such procedures would likely save another 9,200 lives, said Gebbia.

A third target of Project 2025's agenda is emergency departments.

"About 39 percent of people who die by suicide have been seen previously in an emergency department but presented with nonpsychiatric, nonsuicidal symptoms," he said. "We could do a much better job of screening and short-term inter-

see **Suicide** on page 16

ETHICS CORNER

An Ethical Approach to Email and Text in Patient Care

BY CLAIRE ZILBER, M.D.

This is the third in a series of articles in this column designed to facilitate adaptation to modern digital media by helping psychiatrists maintain professionalism and boundaries while employing new technology. Specifically, this article addresses ethical concerns when using email and text messaging to communicate with patients.

Although some institutions, such as the Armed Forces and Massachusetts Institute of Technology, have had access to electronic message sharing systems since the 1960s, email became accessible to the masses in the 1990s. Psychiatrists who are mid-career or older probably began using email for work at medical schools, hospitals, or clinics and only later created a personal email account. For many physicians, email is cognitively congruent with professional work, so it may feel natural to use email to communicate with patients.

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

Nokia was the first mobile phone capable of sending a text message, in 1993, but text messaging didn't take off until the start of the 21st century. In the United States, texting surpassed calling on phones in 2007. Especially for those under 40, many people prefer the speed and convenience of text instead of voice messaging. Indeed, many corporations are eliminating voice mail in favor of text and other instant messaging applications.

Both email and text have the advantage of convenience, and many patients would prefer to use these modalities to communicate with their health care professionals, especially for less sensitive information like scheduling an appointment. The ethical psychiatrist must weigh the advantages of convenience and patient preference against concerns about confidentiality and boundaries.

Because of its association with workplace communication, it may feel very natural to email with colleagues and patients about clinical matters. This communication can be printed for inclusion in a paper chart or digitally saved into an electronic medical record (EMR). For physicians in some health care settings, email communication with patients via a password-protected website is an explicit expectation. Those providers don't need to worry as much about confidentiality, but they should notify the patient that those communications may be read by anyone with access to the EMR, so while the communication is considered confidential, it is not entirely private.

Email communication outside of a password-protected patient portal is more vulnerable to being hacked. Additional hazards to confidentiality are the possibility of inadvertent forwarding of an email chain containing information not intended to be shared with a third party. For example, a patient might email a psychiatrist about two problems, a fight with a family member and a potential medication interaction. The psychiatrist might forward the email to the patient's primary care provider (PCP) to confer about the medication interaction, inadvertently disclosing the family fight. Emails are also susceptible to being read by patients' family members without permission and by employers if patients are using their work email account.

Text messaging is even more convenient than email and is especially efficient for scheduling appointments, receiving notice from patients that they are running five minutes late to their appointment, or other nonclinical tasks. It may be a more reliable way to communicate with adolescents and young adults who don't listen to their voice messages. Most people read and respond to text messages much faster than they do to emails or voice mails.

What's the downside of all this convenience?

Text messaging suffers from similar confidentiality concerns as email. Cell phones can be hacked, and the text history read. Incoming text messages can be briefly displayed on a phone's screen for anyone to see. Unlike email, one can't easily print a record of a text conversation, so it cannot be included in the medical record, as all communication between doctor and patient should be. Furthermore, text messaging is too brief of a format for clinical communication, yet that temptation will arise. A patient could send a text asking to change the dose of a medication, for example, and the psy-

see **Ethics Corner** on page 24

PSYCHIATRY & INTEGRATED CARE

Collaborative Care for Youth: Statewide Success Stories

BY ROBERT J. HILT, M.D.

The need for consultative services like the ones described by this month's author, Bob Hilt, M.D., reflects the very real workforce shortages in our field; in some communities the wait to see a child psychiatrist can be as long as nine to 12 months, if one is available at all. This often leaves primary care providers as the sole mental health prescriber for a child and the need for those of us in the mental health field to help them with that task. Dr. Hilt and his colleagues have stepped up in spades by completing more than 10,000 provider-to-provider consultations since 2008, helping community providers deliver limited intervention services and using "teachable moments" to help shape care not just for one child, but for subsequent children a provider might see.

—Jürgen Unützer, M.D., M.P.H.

There is a need to improve access to high-quality child psychiatric services, as highlighted by the following statistics: (1) half of all lifetime cases of mental illness begin by age 14, (2) there is a severe shortage of child psychiatrists—fewer than eight child psychiatrists per 100,000 U.S. children, and (3) about 80 percent of children with mental illness fail to receive specialty mental health treatment. Unaddressed child mental illness unfortunately translates into more long-term mental health disability for adults.

Collaborative care offers a way to leverage child psychiatric expertise to impact the lives of whole populations of children, though how best to do this for kids is still being explored. Collaborative care could include referral support, mental health screening and tracking, training for nonspecialists, specialist telephone consultations, direct patient consultations, co-located therapists, oversight care reviews, EMR integration, and/or fully integrated mental/behavioral health services within a primary care practice.

The following is how two state Medicaid divisions have approached this challenge. Washington State Medicaid has for nearly a decade operated statewide child mental health consult service programs. The first of its initiatives was mandatory second-opinion medication reviews for state-defined "outlier" child psychotropic prescribing, such as child doses over twice the adult FDA maximum. While the initial goal was obtaining second-opinion authorization/denial recommendations, over time the consulting child psychiatrists learned to use oversight reviews to offer more clinically useful collaborative care support for a provider's most challenging cases. This approach made a huge difference in provider-reported value of the program. For instance, last year's mandatory second-opinion review feedback from prescribers rated a mean of 6.0 on a 7-point scale regarding the statement, "The consultant offered appropriate and helpful treatment suggestions for my patient."

The second collaborative care initiative was to give all primary care providers access to elective, hotline-like, telephone-based consultations with a child psychiatrist about any patient they see. This Partnership Access Line (PAL) has been staffed such that primary care providers can expect to nearly always get directly connected to a child psychiatrist when they call. They also receive access to a social worker helping with referrals, access to televideo patient consultations, locally hosted free CME education events, and a treatment guide designed for primary care mental health. Provider feedback for this service has consistently been

*see **Integrated Care** on page 38*

Robert J. Hilt, M.D., is an associate professor of psychiatry at the University of Washington and the associate medical director of Behavioral Health Consultative and Community-Based Programs at Seattle Children's Hospital. Jürgen Unützer, M.D., M.P.H., is a professor and chair of psychiatry and behavioral sciences at the University of Washington, where he also directs the AIMS Center, dedicated to "advancing integrated mental health solutions."

LEGAL NEWS

Remember to Keep Psychotherapy Notes Separate From Patient's Medical Record

Psychotherapy notes receive special protection under the HIPAA Privacy Rule, but adherence to certain guidelines is required.

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

The Privacy Rule under the Health Insurance Privacy and Portability Act (HIPAA) generally treats all protected health information uniformly with the exception of "psychotherapy notes." These notes receive greater protections against disclosure if they meet the strict definition set out in HIPAA and are kept separate from the remaining medical record.

HIPAA explicitly defines "psychotherapy notes" as the following: "Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. "

Psychotherapy notes do not include information contained elsewhere in the medical record or information regarding:

- Medication prescription and monitoring
- Counseling session start and stop times
- Modalities and frequencies of treatment furnished
- Results of clinical tests
- Any summary of the following items:
  - Diagnosis
  - Functional status
  - Treatment plan
  - Symptoms
  - Prognosis
  - Progress to date

Psychotherapy notes are treated differently from other protected health information because they contain the psychiatrist's personal notes and often include sensitive information of the type that is not normally needed for the patient's "treatment, payment, or health care operations" as defined by HIPAA.

The heightened protection against disclosure afforded to psychotherapy notes means that with the exception of disclosures that are required by law, that is, duty to warn or report abuse or neglect, a patient must specifically authorize the disclosure of psychotherapy notes to a third party. This heightened protection also extends beyond the patient's death. Additionally, in 1996 the United States Supreme Court ruled in *Jaffee v. Redmond* that psychotherapy notes were not discoverable even pursuant to a court order.

Moreover, the HIPAA Privacy Rule now requires that covered entities (CEs) that maintain psychotherapy notes include a statement in their Notice of Privacy Practices indicating most uses and disclosures of psychotherapy notes. This requirement does not necessitate that CEs include a description of their record-keeping practices pertaining to psychotherapy notes.

To sum up, psychiatrists are not required to maintain "psychotherapy notes." If, however, psychotherapy notes are maintained, the psychiatrist should understand how they are defined and protected under HIPAA and should ensure that the notes are kept separate from the patient's medical record. In addition to understanding HIPAA's requirements, psychiatrists also need to be aware of any applicable state statutes pertaining to patient privacy protections.

For more information, see APA's *HIPAA Privacy Manual Update, A Guide for Your Psychiatric Practice* at http://www.psychiatry.org/psychiatrists/practice/practice-management/hipaa, and consult with your local attorney or risk management professional if you have any questions or concerns.

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

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

Suicide

continued from page 14

ventions, as well as better transition and follow-up care."

Such programs could save another 1,100 lives, he believes. AFSP sees itself as a catalyst and will work with other collaborators like professional associations, accrediting bodies, and others.

The organization has already made grants to researchers at the University of Pennsylvania, Columbia University, and the University of Massachusetts to study a safety planning intervention that covers "warning sign identification, limiting access to lethal means, and personalized strategies to deescalate a suicide crisis," according to AFSP.

Setting a goal to reduce suicide rates by 20 percent within 10 years may seem like an overly ambitious goal, but it may be what is required to attack this significant public health crisis, said Posner.

"Everything we've done so far has been based on individual risk factors," she said. "Now we need more powerful ways to identify patterns by being aggressive in our thinking and combining modern analytic tools and the scientific data we have collected." PN

More about the American Foundation for Suicide Prevention's Project 2025 is posted at https://afsp.org/american-foundation-suicide-prevention-launches-project-2025/.

Educator Argues for Integrating Infant MH in Child Psychiatry Training

Making infant mental health education an integral part of child and adolescent psychiatry training requires a "champion," someone in the department who is committed to making it happen.

TEACHING PSYCHIATRY

BY MARK MORAN

For many American child psychiatrists, the study of infant mental health and development, although a thriving field of research and clinical endeavor going back to the late 1970s, is a sidelight to their core training—an elective and still slightly exotic area of interest.

But in a commentary posted August 25 in *Academic Psychiatry*, Joy Osofsky, Ph.D., argues that child psychiatry fellowship programs should integrate infant mental health into the regular training curriculum. As a model, she offered the comprehensive training program in the Department of Psychiatry Harris Center for Infant Mental Health at the Louisiana State University Health Sciences Center (LSUHSC).

Osofsky, director of the Harris Center, argues that with an increasing focus throughout American health care on prevention and integration of behavioral health and general medicine—including pediatrics and obstetrics/gynecology—incorporation of infant mental health into the regular training curriculum of child psychiatrists is vital.

"As there is greater recognition of the importance of prevention, which is aided by addressing problems early in young children, child psychiatry needs to respond with an enhanced focus on ages 0–3 with more comprehensive training," Osofsky wrote. "Through the increased understanding and application of key concepts provided in infant mental health training, child psychiatry fellows will become competent in a repertoire of skills that can be used to assess, comprehend, and treat a varied patient population in a more thoughtful and helpful manner."

Her coauthors were Martin J. Drell, M.D., Howard J. Osofsky, M.D., Ph.D., Tonya Cross Hansel, Ph.D., M.S.W., and Andrew Williams, M.D.

In the article, she noted that neither requirements of the Accreditation Council for Graduate Medical Education nor the Milestones Project for residency programs make specific reference to infant mental health. Osofsky told *Psychiatric News* that though there are notable exceptions, including some training programs that have been pioneers in the field, most child psychiatrists receive only occasional instruction in infant emotional and behavioral development.

"It's not really on the radar of training programs," she said. "You might have a lecture here or there or a course offered as an elective, but the idea of incorporating it into a program so that it is regular part of the training of every child psychiatrist has not generally been accepted."

There's support for the idea among academic child psychiatrists. In a statement about infant psychiatry on the website of the American Academy of Child and Adolescent Psychiatry, Charles Zeanah, M.D., vice chair for child and adolescent psychiatry at Tulane University School of Medicine, wrote this:

"Prevention is the great uncharted territory in child psychiatry. If the idea of using relationships to effect powerful changes in the brain that have lasting impacts on children appeals to you, then you should consider infant mental health as an area of focus. I have been privileged to watch it grow from an exciting but obscure area to one that has grabbed the attention of the Surgeon General, the Institute of Medicine, and the authors of Healthy People 2010, the nation's blueprint for public health in the first decade of this century. What we need now is to grab the attention of you, the future leaders of child and adolescent psychiatry."

The Harris Center for Infant Mental Health, established in 2006, offers multidisciplinary training to child psychiatry fellows, psychologists, and social workers. Since then, the child psychiatry rotation has evolved into a mandatory 12-month course that begins in the second year of training. During the rotation, child psychiatry fellows learn methods for conducting infant mental health assessments, evaluations, and treatment for young children and their parents or caregivers using evidence-based practices. The training program includes four components: weekly didactics, infant observation, clinical experience, and reflective supervision.

"We meet once a week for a year," Osofsky told *Psychiatric News*. "We have a two-hour didactic class where a lot of information is shared. We also meet for an hour and a half of group supervision in which trainees present cases."

Joy Osofsky, Ph.D.

Joy Osofsky, Ph.D., believes that as American health care moves toward prevention and integrated care, the training of child psychiatrists needs to incorporate infant mental health.

The group supervision is intended to help residents gain an understanding of the emotions and feelings that may emerge when providing treatment for very young children and their caregivers who may be at high psychosocial risk.

During the course of their rotation, trainees assess and provide treatment for at least two young children, aged 0 to 3 years, with their parents or caregivers. Videotaping is encouraged and is used by trainees when they present their cases for group supervision.

Faculty and trainees have sometimes been known to bring their own infants in for observation. "It's important to have the perspective of normal development," Osofsky said.

What has been the response of trainees and faculty? "They think it's excellent," she said. "At first there was some skepticism, but our child psychiatry fellows really enjoy it. They like the didactics because they are learning new material that isn't covered in any other course. There's also a focus on normal as well as abnormal development that trainees like.

"I have found that adult psychiatrists are becoming more interested in early life development because of what they see in their patients," she added. "We have both child and adult psychiatrists who are very positive about our program."

Osofsky tells other institutions that the key to integrating infant mental health into their training curriculum is having a champion to push that goal. At LSUHSC, Osofsky credits Martin Drell, M.D., director of Infant, Child, and Adolescent Psychiatry, as that champion.

"You need someone who says not only 'I think it should be done,' but who says, 'I will do it,'" she said. PN

"Infant Mental Health Training for Child and Adolescent Psychiatry" is posted at http://link.springer.com/article/10.1007/s40596-016-0609-9.

From the President

continued from page 4

of Josh's work plan! We planned to complete the work in advance, assigning different pieces to ourselves and checking off the boxes as we progressed.

Of course, there are other key attributes. Importantly, he is positive and caring and has a terrific sense of humor, so critical for jobs in which frustration can be a daily (hourly?) event. He is interested in all sorts of research, not only wet-lab work, and supported trainees interested in areas ranging from bioethics to global mental health to computational neuroscience.

And that, I think, is the best thing about Josh. He is open-minded. As a basic science researcher, he is deeply curious about talk therapy and co-taught a course for residents with a psychoanalyst. How many wet-lab researchers would do that? The course was about how talk therapy might bring about changes in the brain, a critical acknowledgement that, yes, the brain is the substrate for talk therapies, and we need to understand how they work.

Josh is open-minded in other ways too. He is interested in new ideas and hearing the arguments for them. Should NIMH fund more services research? Does NIMH need to fund more clinical trials to bring new therapeutics to our patients? Should global mental health have more funding? Now, this does not mean he won't ask pointed questions. He absolutely will. But pointed in a warm, avuncular way.

We are extremely lucky to have Josh at the helm of NIMH, and I can't wait to see the great things he is going to do. Go, Josh! PN

CLINICAL & RESEARCH NEWS

New Compound May Offer Power Of Morphine With Less Risk

Preliminary studies in mice suggest an experimental drug called PZM21 is associated with less respiratory distress, constipation, and addictive properties than morphine while showing comparable analgesic potency.

BY NICK ZAGORSKI

Sifting through a haystack of over 3 million chemical compounds, a multidisciplinary team of investigators may have found a truly golden needle—a painkilling drug that offers the strength of morphine, but not the addictive properties or other serious health effects.

In preliminary mouse studies, this newly minted agent, known as PZM21, was found to be comparable in analgesic power to both morphine and TRV130, an experimental drug in phase 3 clinical studies; however, PZM21 provided relief for a longer time (up to three hours per dose, compared with two hours for morphine and one and a half hours for TRV130).

Unlike existing painkillers, this compound was associated with moderate constipation and did not cause any significant respiratory distress, which is the main cause of death due to an opioid overdose.

If these results hold up, then the risk of overdoses from PZM21 may be low, as mice given PZM21 also showed no preference for rooms containing this drug when given options to choose, tests known as conditioned place preference.

Brian Shoichet, Ph.D., a professor of pharmaceutical sciences at the University of California, San Francisco, and one of the lead investigators in this work, did caution that these preference studies haven't yet ruled out an addictive potential for PZM21.

"We've only shown so far that this drug doesn't activate any reinforcing behaviors, but further animal studies are needed that more directly test addiction," he told *Psychiatric News*. Additional testing is also needed to ensure that long-term use does not lead to any toxicity.

"So PZM21 still has a long way to go before any clinical application, and there could be a potential dead end any step along the way," he continued. "But we are cautiously optimistic at this point, and there haven't been any hints of a showstopper yet."

The discovery of PZM21 was first made possible in 2012 when researchers at Stanford University led by Nobel laureate Brian Kobilka, Ph.D., identified the three-dimensional architecture of the mu opioid receptor, the target of morphine and related drugs.

Kobilka then passed the baton to Shoichet, a frequent collaborator with an expertise in molecular docking—the discipline of finding just the right molecule to fit the pocket of a target receptor.

Shoichet and his lab first ran their collection of 3 million potential drugs through a computer-based screening program that modeled over 1 million possible docking configurations for each compound (a scale that would not have been possible 10 or 15 years ago). They then chose the top 2,500 molecules that had some docking potential and winnowed this list down to 23 promising candidates, which were tested in laboratory assays.

Seven of these bound to the receptor strongly enough to be considered viable, and some chemical tweaking of the structures and further lab tests carried out by colleagues at the University of North Carolina and Florida Atlantic University eventually produced the final product and potential boon for the growing opioid epidemic.

"I think it's important to point out that we managed to translate a basic molecular discovery into an experimental drug in just a few years," Soichet said. "These exciting results arose from fundamental research."

The results of this collaborative effort were published August 17 in *Nature*. The study was supported by grants from the National Institutes of Health and German Research Foundation, as well as the Michael Hooker Distinguished Professorship. PN

An abstract of "Structure-Based Discovery of Opioid Analgesics With Reduced Side Effects" is posted at http://www.nature.com/nature/journal/vaop/ncurrent/full/nature19112.html.

Prescription Opioid Misuse Gateway to Heroin Among Veterans

While the discovery of PZM21 provides some encouragement in the struggle against opioid addiction, another study published August 23 in *Addiction* highlights the severity of this public health problem. A 10-year assessment of nearly 3,400 military veterans—none of whom had taken an opioid drug at the study's start—found that prescription opioid misuse led to a 5-fold increased risk of heroin use. Of the 500 participants who initiated heroin use between 2002 and 2012, 77 percent reported prior or concurrent nonmedical prescription painkiller use.

Other risk factors for heroin use identified in the analysis included being male (2.6-fold risk), African American (2-fold risk), or abusing stimulant drugs (2.1-fold risk). Receiving a prescription for an opioid painkiller was not a significant risk factor for heroin use, though; short-term prescriptions incurred a 1.7-fold risk, while longer-term prescriptions had no statistically significant risk. This suggests most opioids were acquired nonmedically, and the study authors recommended that health care professionals who serve veterans should watch closely for signs of nonmedical use of opioid painkillers.

An abstract of "Nonmedical Use of Prescription Opioids Is Associated With Heroin Initiation Among U.S. Veterans: A Prospective Cohort Study" is posted at http://onlinelibrary.wiley.com/doi/10.1111/add.13491/full.

FROM THE EXPERTS

Which Antidepressant Is Best for Patients With Coronary Artery Disease, Depression?

BY PETER SHAPIRO, M.D.

Coronary artery disease is the leading cause of death in the United States and leads the list of contributors to the global burden of disease.

About 20 percent of coronary disease patients also experience depression—a factor associated with an increased risk of recurrent myocardial infarction and death.

Current guidelines urge cardiologists to screen for depression and then to treat or refer for treatment as needed. As such, interest has grown in defining optimal depression treatments for this patient population. Which antidepressant is best?

Peter Shapiro, M.D., is a professor of psychiatry, director of the fellowship training program in psychosomatic medicine, and associate director of the Consultation-Liaison Psychiatry Service at Columbia University Medical Center. He has written over 60 original peer-reviewed publications in cardiovascular disease psychiatry and psychophysiology.

Evidence Base for SSRIs Grows

Multiple randomized, placebo-controlled trials have demonstrated the efficacy of SSRIs (including sertraline, citalopram, and fluoxetine) for depression treatment in coronary disease patients.

Most recently, the EsDePACS trial in Korea randomized patients two to 14 weeks after a confirmed acute coronary syndrome event who were experiencing symptoms of depression to placebo or escitalopram (flexible dosing from 5 to 20 mg/day, for 24 weeks).

The researchers found escitalopram was superior to placebo with respect to the primary outcome, change in the Hamilton Rating Scale for Depression (between groups difference, 2.3 points; P=.018, effect size=0.38), and also for secondary outcomes including the Montgomery-Asberg Depression Rating Scale, Beck Depression Inventory, and Clinical Global Impression-Severity of Illness scale.

There were no differences between escitalopram and placebo with respect to cardiovascular safety measures or adverse events except for complaints of dizziness, which was more frequent in subjects taking escitalopram.

Escitalopram can now be added to the list of SSRIs with evidence of efficacy for treatment of depression in coronary disease patients and a low adverse effect burden over the acute treatment period. There is no comparable evidence base for other antidepressants, except for tricyclic agents, which have fallen out of favor due to orthostatic hypotension, effects on cardiac conduction, and anticholinergic effects.

continued on next page

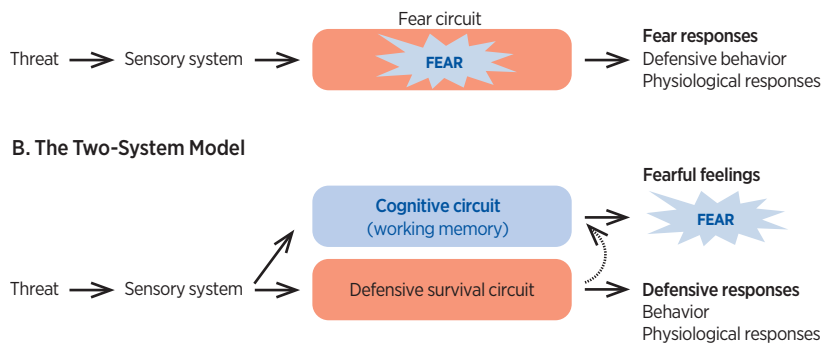
Neuroscientists Propose New Model For Understanding Fear, Anxiety

Animal models for testing treatments of anxiety may successfully replicate the physiological responses to a threatening situation, but may not adequately capture the subjective experience of fear and anxiety in humans.

BY MARK MORAN

Model Proposes 'Two-System' Theory of Fear and Anxiety

The traditional fear circuit model assumed a single, subcortical circuit with the amygdala at its hub. The two-system model proposes that higher-order cortical circuits involved in memory and attention govern subjective feelings of fear and anxiety.



Source: Joseph LeDoux, Ph.D., and Daniel Pine, M.D., *AJP in Advance,* September 9, 2016.

The neuroanatomical understanding of fear has long relied on a so-called "fear circuit" with the amygdala as its hub. This circuit has often been said to be the key to understanding maladaptive fear and anxiety in people with anxiety disorders.

Embedded in the fear circuit theory is an assumption that the subjective experience of fear and the behavioral and physiological reactions to fear (such as the fight-or-flight phenomenon) are products of the same circuit.

Now two leading neuroscientists have proposed, in a landmark review paper in the September 9 *AJP in Advance*, a conceptual framework that replaces the unitary fear circuit model with a "two system" model—one neurocircuit that governs physiological responses to imminent threats (freezing, racing heart, sweating palms) and another, separate but related circuit that governs the subjective feelings of fear or anxiety that typically compel patients to seek treatment.

In the paper, Joseph LeDoux, Ph.D., director of the Emotional Brain Institute of New York University and the Nathan S. Kline Institute for Psychiatric Research, and Daniel Pine, M.D., director of the Section on Development and Affective Neuroscience in the National Institute of Mental Health Intramural Research Program, propose that the physiological and behavioral responses to an imminent threat that comprise the fight-or-flight phenomenon are regulated by subcortical neural networks centered on the amygdala and operate nonconsciously.

However, they propose that the subjective experience of fear is regulated by higher order cortical networks responsible for cognitive processes such as attention and working memory. They make the same distinction for anxiety and other emotions—different circuits underlie the conscious feelings of these emotions and nonconsciously controlled behavioral and physiological responses that also occur in tandem.

That's a crucial distinction, if LeDoux and Pine are correct, because animal models used to test medications for treating anxiety disorders—founded on the more traditional unitary fear circuit theory—may successfully replicate the physiological responses to a threatening situation, but not adequately capture the subjective experience of fear and anxiety as felt by humans.

"The traditional approach has assumed that emotions like fear are products of innate brain circuits inherited from animals," LeDoux told *Psychiatric News*. "These circuits are further assumed to give rise to both the subjective feeling of fear

see ***Fear*** *on page 36*

continued from previous page

It is important to note that while the acute safety of SSRIs has been examined in this patient population, the safety of long-term SSRI use and possible beneficial effects on cardiovascular outcomes have not yet been proven.

The use of SSRIs, or any antidepressant, requires attention to interactions with other medications the patient is prescribed. For example, strong inhibitors of cytochrome 2D6, such as fluoxetine and paroxetine, may increase blood levels of beta-blockers (which are a mainstay of coronary disease treatment), causing bradycardia. SSRIs can also interact with antiplatelet agents and anticoagulants to raise the risk of bleeding. Concerns about dose-related QT interval prolongation with citalopram have stirred controversy, but may be overstated.

Patients May Prefer Psychotherapy

One underappreciated aspect of psychopharmacological treatment of depression in coronary patients is that most patients identified through screening don't want to take more medicines.

A study by Karina Davidson, Ph.D., and colleagues found that when coronary disease patients with high depression symptoms on screening were offered a first-line choice of brief psychotherapy, medication, neither, or both, most chose neither or psychotherapy. Although some patients ended up using medication as well, this patient-preference-driven, stepped approach led to high patient satisfaction with treatment and a large treatment effect.

Bottom line: The best therapy for a patient with coronary artery disease and depression symptoms may be to hold off on antidepressants, at least at first, especially if stepped care with psychotherapy and careful followup is available. There is a good case to be made for escitalopram and sertraline as the default drugs of choice. PN

References for this article are posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.pp9a1.

CBT for Ultra-High-Risk Patients Lowers Incidence of Psychosis

In the group receiving CBT, the number of patients who remitted from ultra-high-risk status was significantly higher, and among those individuals who did convert to psychosis, the time to conversion was longer.

BY MARK MORAN

The use of cognitive-behavioral therapy (CBT) in patients identified as being at ultra-high risk (UHR) for psychosis appears to effectively lower the incidence of conversion to psychosis after four years, according to a report in the August *Schizophrenia Bulletin*.

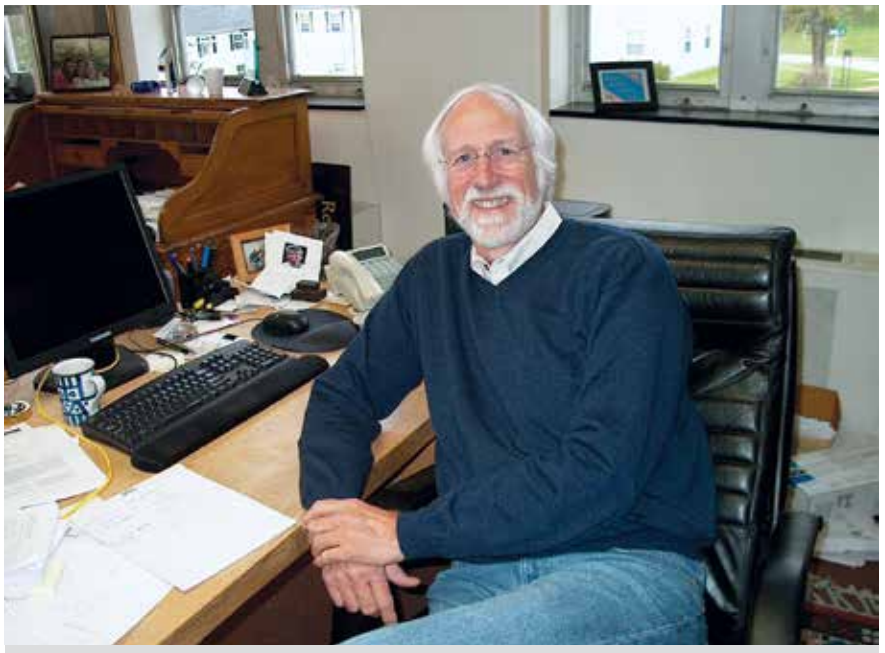
Moreover, significantly more patients receiving CBT remitted from their UHR status compared with patients receiving treatment as usual, suggesting that CBT may prevent psychosis and improve long-term trajectory.

The report looks at four-year outcomes comparing CBT specifically adapted for patients at ultra-high risk of psychosis and treatment as usual in patients enrolled in the Dutch Early Detection Intervention and Evaluation (EDIE). In a previous publication, researchers at the Parnassia Psychiatric Institute in the Hague, the Netherlands, demonstrated that CBT halved the incidence of psychosis over an 18-month period.

The longer follow-up results in the new study, including the higher rates of remission, add to a body of literature from programs serving UHR patients on the effectiveness of CBT.

"Delay of the onset of a first psychotic episode might prove to be more than postponement of transition to psychosis alone and might be regarded as real prevention, since very few participants made the transition from UHR to psychosis after the first 12 (and 18) months," the researchers stated.

"Ultra-high risk" has come to define a group of patients with either a family history of psychosis and/or significant impairments in cognition and social and occupational functioning that do not yet rise to the level of clinical psychosis. In the Dutch study, criteria for inclusion included a family history of psychosis or scores on the Comprehensive Assessment of At-Risk Mental States (CAARMS) in the range of the "at-risk mental state," and a score on the Social and Occupational Functioning Assessment Scale (SOFAS) of 54 or less and/or a reduction of 30 percent on the SOFAS for the duration of at least one month in the past year.



William Carpenter, M.D.

William Carpenter, M.D., editor of *Schizophrenia Bulletin*, says CBT has consistently been shown to be effective in trials of patients at high risk for psychosis even though "treatment as usual" in such trials is likely to be quite good.

The Dutch EDIE study was a randomized, controlled trial with 196 patients at ultra-high risk of psychosis in secondary mental health care at six sites in the Netherlands. Patients in both conditions received treatment as usual (TAU)—that is, routine care provided for the nonpsychotic disorders (mainly depressive and anxiety disorders) for which the patients initially sought treatment. The experimental group received TAU plus CBT, with a maximum of 26 sessions in the first six months after inclusion.

In the four-year follow-up, 56 patients in the CBT group and 57 patients in the TAU group were evaluated.

The number of participants converting to psychosis in the CBT group increased from 10 at 18 months to 12 at four-year follow-up. In the TAU group, the number of participants who transitioned to psychosis at four-year follow-up remained at 22, the same number that had transitioned at 18 months.

The researchers noted that this rate of conversion continues to represent a significantly better outcome for the CBT group over four years. Moreover, the number of days to transition to psychosis was significantly higher in the CBT group (1,322.45 days) compared with the TAU group (1,188.91).

Especially important is the fact that remission from subthreshold psychotic symptoms was significantly higher in the CBT group—with 76.3 percent of the participants who received CBT and 58.7 percent of the participants receiving TAU having remitted from UHR status by four years. Remission from UHR status is clinically relevant, as most transitions from UHR to psychosis occur within the first 12 months after clinical presentation, the authors noted.

"This trial shows that CBT for patients at ultra-high risk of psychosis was successful in reducing the risk of a first psychosis by 50 percent and that these favorable effects were sustained over four years," the researchers stated. "In addition, the CBT intervention achieved higher remission rates in UHR symptomatology."

The researchers noted, however, that social functioning is still affected in most participants (even in participants who remitted from UHR status), and many still suffer from positive, negative, and cognitive symptoms; behavioral change symptoms; and anxiety.

"Much is gained by preventing a first psychotic episode, since patients who made a transition showed more severe psychopathology and worse social functioning compared with those who did not transition," they stated. "The prognosis of the UHR status is much more favorable than the prognosis after a transition to a first psychotic episode."

William Carpenter, M.D., editor of *Schizophrenia Bulletin*, told *Psychiatric News* that the advantage of CBT has been consistently shown in trials of patients at clinical high risk of psychosis, despite the fact that treatment as usual in studies like the Dutch EDIE is likely to be very good.

"This suggests to me that the effect of treatment versus no treatment is very robust both for secondary prevention of full psychosis and for symptoms and probably function. Our field should make early detection/therapeutic intervention a major priority because it is our best opportunity to improve the life course in persons vulnerable to psychotic disorders. The current emphasis on first psychotic episode intervention attempts to shorten the duration of untreated psychosis. Targeting high-risk patients seems certain to reduce the duration of untreated psychopathology and the duration of untreated psychosis."

Carpenter also said he believes the diagnosis of attenuated psychosis syndrome in Section 3 of *DSM-5* should be moved to the main text to help clinicians, including primary care physicians, translate evidence-based care developed in expert centers to sites where patients routinely seek care.

He added, "Integrated care is essential and needs to include CBT. This is a severe challenge in the U.S. medical system with an inadequate workforce of trained therapists and inadequate support of integration across disciplines." PN

"Four-Year Follow-up of Cognitive Behavioral Therapy in Persons at Ultra-High Risk for Developing Psychosis: The Dutch Early Detection Intervention Evaluation (EDIE-NL) Trial" is posted at http://schizophreniabulletin.oxfordjournals.org/content/42/5/1243.abstract.

Ethics Corner

continued from page 14

chiatrist might reflexively respond by text rather than calling the patient to inquire about symptoms, side effects, and context, all of which are required to make an appropriate medical decision.

The confidentiality and clinical concerns surrounding text and email can be mitigated by setting clear limits with patients about whether and how you communicate within these media, and then being consistent in upholding these standards. Patient reports that contain identifying information should not be sent by standard email but can safely be sent within password-protected systems, such as an EMR portal or secure platforms like ShareFile. Even if a patient indicates willingness to forgo confidentiality by transmitting sensitive clinical information by email or text, it is the psychiatrist's duty to uphold the usual standards of privacy expected of us. PN

CLINICAL & RESEARCH NEWS

Joint Commission Releases New Standards for Eating Disorder Programs

The number of eating disorder programs in the United States operated by for-profit behavioral health organizations increased from 22 in 2006 to 75 in 2016.

BY VABREN WATTS

In July, the Joint Commission—an agency that accredits and certifies nearly 21,000 health care organizations and programs in the United States—implemented new requirements for behavioral health care organizations that provide care for people with eating disorders.

Joint Commission accreditation and certification are recognized nationwide as symbols of quality that reflect an organization's commitment to meeting certain performance standards.

continued on next page

CLINICAL & RESEARCH NEWS

continued from previous page

The standards—which are based in part on the APA Practice Guideline for the Treatment of Patients With Eating Disorders, Third Edition—were developed in response to concerns that some organizations purporting to offer eating disorders programs may not be providing adequate behavioral and physical health care services to patients.

"A lot of things are changing in the field of eating disorders," said Angela Guarda, M.D., director of the Johns Hopkins Eating Disorders Program, one of the few remaining academic programs that offers inpatient, partial hospital, and outpatient treatment for eating disorders.

When managed care in the United States dramatically shortened hospital stays for eating disorders in the 1990s, more patients began seeking care at private residential programs, Guarda told *Psychiatric News*. In fact, according to an analysis by Guarda and colleagues that appeared June 1 in *Psychiatric Services,* the number for such residential programs in the United States jumped from 22 facilities in 2002 to 75 facilities in March.

"Although facility standards are being established for residential treatment, there is still no industry consensus about either the care components required to accomplish treatment goals or benchmarks for assessing quality of care," Guarda and colleagues wrote. "Most programs provide some evidence-based treatments, such as cognitive-behavioral therapy, but many also offer treatments

CLINICAL & RESEARCH NEWS

that lack empirical support but are attractive to patients, such as equine therapy, dance, or drama."

Additionally, peer-reviewed evaluation of the effectiveness of these residential programs is scant, which has some experts in eating disorders, including Guarda, concerned.

"[E]ating disorders have the highest mortality rate of any behavioral health disorder," David Baker, M.D., M.P.H., executive vice president of the Division of Health Care Quality Evaluation at the Joint Commission, said in a press release. "This makes it very important that these programs provide the safest, highest quality care possible. With the new standards … we aim to provide Joint Commission–accredited organizations with the tools they need to improve care and treatment for these individuals."

The new eating disorder standards for behavioral health care address 11 critical aspects of care, which are summarized in four categories.

*see **Joint Commission** on page 34*

> "A lot of things are changing in the field of eating disorders."
>
> —Angela Guarda, M.D.

Candidates

continued from page 1

in Congress that should receive bipartisan support."

The latter presumably refers to HR 2646, the Helping Families in Mental Health Crisis Act, advanced by Rep. Tim Murphy (R-Pa.) and Eddie Bernice Johnson (D-Texas), and S 2680, the Mental Health Reform Act of 2016, led by Sens. Bill Cassidy (R-La.) and Chris Murphy (D-Conn.). The House passed HR 2646 nearly unanimously in July. APA supports both reform bills.

For veterans, Trump proposes to increase funding to expand and improve care for posttraumatic stress disorder, traumatic brain injury, and suicide prevention services.

"More funding will also support research on best practices and state of the art treatments to keep our veterans alive, healthy, and whole."

He also suggested placing satellite clinics, staffed by VA health personnel, within rural hospitals or other health care sites, to ease access to care in underserved areas.

Trump would also permit veterans to get care not only at VA clinics and hospitals but also at any doctor's office or medical facility that accepts Medicare. However, proposals to turn veterans' health care into a health insurance system have been met in the past with skepticism, if not outright opposition, by veterans' service organizations.

For her part, Clinton points to her record on health care as senator from New York, which included co-sponsorship of legislation backing mental health support for college students and veterans, along with mental health parity laws.

"The next generation must grow up knowing that mental health is a key component of overall health, and there is no shame, stigma, or barriers to seeking out care," said Clinton's statement. "Hillary will convene a White House Conference on Mental Health within her first year in office—to highlight the issue, promote successful interventions, and identify barriers and solutions."

(The Clinton campaign generally refers to the candidate by her first name.)

Clinton's list of proposals has several major themes, including integration of mental and physical care systems, promoting early diagnosis and intervention, and enforcing mental health parity. Many of these themes align with APA's core priorities.

Clinton would expand reimbursement procedures for collaborative care under Medicare and Medicaid and do away with the prohibition against payment for primary care and mental health care services on the same day. Early diagnosis and care would range from action to address maternal depression and trauma and stress in the lives of young children, as well as college mental health services. Programs to identify problems among school children—like APA's Typical or Troubled program—are included.

Clinton notes that provisions of the ACA and the Mental Health Parity and Addiction Equity Act of 2008 "are too often ignored or not enforced." She would crack down on parity violations by randomly auditing insurers, improving transparency of nonquantitative treatment limitations, and strengthening compliance with network adequacy requirements. She also would increase federal support for suicide prevention and research, and expansion of police officers' training for crisis intervention with people with mental illness.

Additionally, a Clinton administration would encourage independent living for people with mental illness and other disabilities by expanding community-based supported housing and employment. PN

Hillary Clinton's "Comprehensive Agenda on Mental Health" is posted at http://apa-psy.ch/Hillary. Donald Trump's "Healthcare Reform to Make America Great Again" is posted at https://www.donaldjtrump.com/positions/healthcare-reform.

CLINICAL & RESEARCH NEWS

Primate Brain Atlas Reveals Details of Gene Expression Across Early Lifespan

Researchers have developed a primate brain atlas providing genomic and anatomic data across 10 different points in mammalian development from gestation to young adulthood.

BY NICK ZAGORSKI

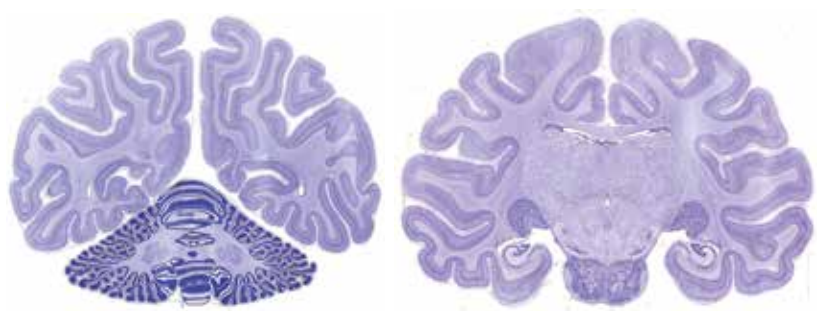
In an ambitious effort that combines advanced genomics with classical imaging and staining techniques, researchers have composed a time-lapsed portrait of global brain development in the rhesus macaque from early gestation to adulthood.

Other studies in recent years have revealed some details about how genes are expressed in different parts of the brain over time, but this project—published July 13 in *Nature*—has resulted in the most comprehensive spatial and temporal map of mammalian development to date, noted lead investigator Ed Lein, Ph.D., of the Allen Institute for Brain Science in Seattle.

As part of their analysis, Lein and his team of nearly 100 scientists from multiple institutes compared the trajectory of gene expression in their samples to existing data for rats and humans. They found that 9 percent of genes had differing activity over time in humans compared with macaques, while 22 percent of genes differed between humans and rats. So while this new map was built from a nonhuman model, Lein believes it still should provide meaningful insights into the human brain.

Genomics and Imaging Merge to Build Brain Atlas

By combining gene expression data with detailed anatomical data from rhesus macaques (such as the stained sections of adult neocortex, cerebellum [left], and hippocampus [right] seen below) across 10 distinct time periods, the Nonhuman Primate Brain Atlas is providing a comprehensive spatiotemporal picture of mammalian brain development.



Source: Allen Institute

Some insight has already been gained as it relates to the developmental trajectories of schizophrenia and autism spectrum disorder (ASD), psychiatric disorders with strong genetic links.

These disorders share many clinical characteristics—including social and emotional withdrawal, communication deficits, and poor eye contact. What Lein and his colleagues found was that risk genes associated with ASD and schizophrenia were highly active in the same brain region—the neocortex, which is involved in many higher brain functions like language.

The activity was also clustered in the same types of cells, namely postmitotic cells (progenitor cells that have finished their cycles of proliferating and are in the process of maturing and forming connections with other neurons). In comparison, genes associated with microencephaly were active in premitotic brain cells, which would lead to less proliferation and smaller brains.

The only major difference between schizophrenia and ASD was timing, according to the findings. Autism-

see ***Primate Brain*** *on page 30*

RESIDENTS' FORUM

Spirituality Is Not a Four-Letter Word

BY HANNAH ROGGENKAMP, M.D.

In our climate of strong religious convictions and polarizing public fights over doctrine, breaching the topic of religion and spirituality as a young physician can seem like the shakiest of shaky ground. For the inexperienced psychiatrist, the struggle is real. We are scared of offending people with any of the intimate questions we ask, and religion feels no less private than sexual history. Religion and spirituality, when approached correctly, can provide a beautiful window into the psyche of our patients. It's also unavoidable—religious topics are an ACGME-required part of our psychiatric training.

My father was a Lutheran pastor, and my mother was raised a born-again Christian; I grew up in a progressive but religious household. My father loved ministering to sick people in hospitals, and he handled parishioners' deaths with fearless compassion. I believe I mirror some of my dedication to patient care based on his example. In times of severe illness, however, even the strongest faith can be questioned. When my mother was diagnosed with ALS, she spoke of wondering what she had done, spiritually, to deserve her fate. I think she struggled with the issue until her life ended.

Despite knowing this, I don't always ask my patients about spirituality. Why not? Too often, as trainees, we feel the need to narrow our exam to what is necessary for an assessment; we give a treatment recommendation and then move on. But religion and spirituality are at the core of most patients' lives: a 2014 Gallup poll revealed that 86 percent of the general population is religious or spiritual. And our colleagues are, too: 76 percent of psychiatrists, according to one survey. More science: high intrinsic religiousness can predict more rapid remission of depression, especially in patients with poor physical functioning. Religious and spiritual involvement appears to buffer patients from stress, and offering therapies augmented with a spiritual component to religiously or spiritually oriented patients is associated with increased efficacy of treatment. Nonetheless, the potentially negative effects of religion should not be overlooked; we've all encountered the gay or lesbian patient who feels deep shame due to a prohibitive religious upbringing.

So how do we incorporate religion into our training and our care? A fan of checklists, I have used the following four questions (which were developed by a consensus panel of the American College of Physicians) as a basic approach to the spiritual history:

- Is faith (religion, spirituality) important to you?
- Has faith been important to you at other times in your life?
- Do you have someone to talk to about religious matters?
- Would you like to explore religious or spiritual matters with someone?

Here are some additional tips gleaned during residency:

- Engage hospital chaplains in your inpatient psychiatric and consult-liaison work, utilizing them for patient interviews and family meetings, when appropriate.
- With permission, collaborate with your patient's pastor or spiritual guide for context and coordination. When doing cognitive-behavioral therapy for psychosis, for example, a patient with religious delusions may be able to question the delusional content more safely with his or her pastor.
- If a patient asks you about your religious beliefs or spirituality, deal with it like any other personal question, responding with, for example: "I'm wondering why this question came up. What do you imagine?" Once the motivation has been explored, it becomes a judgment call. Less experienced practitioners may want to avoid disclosure as a rule; however, in the right setting, it could deepen the therapeutic alliance. For example, a patient struggling with feeling internal religious judgment could have a corrective emotional experience when the therapist reports that he or she does not share that same religious judgment of the patient. In the end, every psychiatrists needs to be prepared to tackle this issue, so careful self-reflection is highly suggested.
- Listen to spiritual or religious concerns carefully, but avoid giving an opinion. (I have found that aligning

see ***Residents' Forum*** *on page 39*

Hannah Roggenkamp, M.D., is an advanced research fellow in the Mental Illness Research, Education, and Clinical Centers (MIRECC) at the Puget Sound VA Healthcare System in Seattle.

CLINICAL & RESEARCH NEWS

Standardized Scoring System Developed For Premenstrual Dysphoric Disorder

Termed C-PASS, the new program hopes to offer a standardized and simplified approach to diagnosing PMDD.

BY NICK ZAGORSKI

To diagnose a patient with premenstrual dysphoric disorder (PMDD), which is characterized by significant premenstrual changes in mood and behavior that resolve with the onset of menses, it is recommended that clinicians track the frequency, severity, duration, and cycling of a woman's daily symptoms over a two-month period.

Because obtaining such detailed daily symptom records from patients can be difficult, many clinicians rely on retrospective self-reports from patients; a 2014 survey of 87 practicing physicians found that only 11.5 percent routinely used 60-day monitoring for making a PMDD diagnosis.

"Retrospective reports do seem fine for many conditions, but for some reason we don't yet understand, we can't rely on this kind of analysis for PMDD," said Tory Eisenlohr-Moul, Ph.D., a postdoctoral fellow in reproductive mood disorders at the University of North Carolina (UNC). Additionally, because there are no concrete rules for what constitutes a significant change in mood before and after menstruation, or even what defines a cycle, interpreting the data can be difficult.

Eisenlohr-Moul and colleagues recently developed a PMDD scoring system that they believe offers a standardized and simplified approach to diagnosing PMDD. They described this system, known as the Carolina Premenstrual Assessment Scoring System (C-PASS), in the August 13 *AJP in Advance.*

Instead of requiring a clinician to interpret two months of daily symptom data across four diagnostic dimensions (symptoms, severity, cyclicity, and chronicity), clinicians enter the daily symptom ratings provided by the patient over two months, and the program computes whether the patient meets the criteria for a PMDD diagnosis. The program can also be used to determine whether a patient has menstrually related mood disorder (MRMD)—which applies to women who experience distress and impairment sufficient to warrant treatment, but do not meet the full *DSM-5* criteria for PMDD.

To field test C-PASS, the team entered two months of daily symptom scores provided by 200 women who had participated in a PMDD study at UNC. They then compared the diagnoses computed by C-PASS with the diagnosis made for these women by David Rubinow, M.D., the Meymandi Professor and Chair of Psychiatry at the UNC School of Medicine, a leading authority on PMDD who helped champion its inclusion in *DSM-5*.

The C-PASS program identified 38 women with PMDD, 46 with MRMD, and 116 with no diagnosis, which was in agreement with Rubinow's assessment for 189 of the 200 cases. Among the 11 disagreements, the authors believe that C-PASS was correct in seven of the disagreeing cases going by clinical definitions, while the program made an inaccurate diagnosis in the other four disagreements because it did not adequately measure postmenstrual symptom improvements.

"Overall [the program] performed very well and offers a good starting point toward achieving a consistent diagnosis across clinics and research labs," Eisenlohr-Moul said. She added that further validation is needed by testing C-PASS in additional patient groups, and her group continues to fine-tune the program based on clinician feedback.

Further down the road, she envisions linking C-PASS with public facing digital tools where women concerned about the possibly having this condition could input their daily symptoms into apps that automatically calculate and send updates on symptoms to their practitioner. Such information could be used to evaluate the condition on a weekly basis, determine whether a diagnosis can be made, or evaluate the effectiveness of treatments.

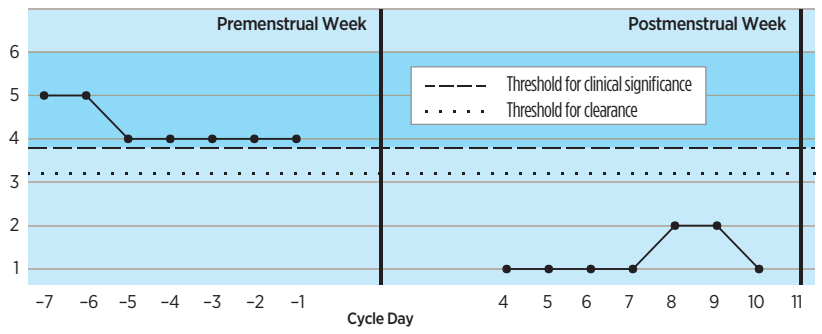
"There will still be a time lag required for making a proper PMDD diagnosis," Eisenlohr-Moul said. "But we can streamline the time management portion at least and ease the decision-making process."

This study was supported by grants from the National Institute of Mental Health. PN

"Toward the Reliable Diagnosis of *DSM-5* Premenstrual Dysphoric Disorder: The Carolina Premenstrual Assessment Scoring System (C-PASS)" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2016.15121510. C-PASS worksheets can be found in a variety of formats at https://www.med.unc.edu/psych/wmd/resources/clinicians-researchers/C-PASS.

C-PASS Provides Quick and Reliable Readout of PMDD Symptoms

The Carolina Premenstrual Assessment Scoring System (C-PASS) looks to simplify the process of interpreting two months of daily symptom ratings required to diagnose Premenstrual Dysphoric Disorder (PMDD) by offering an easily visualized readout and standardized diagnostic criteria.



Source: Tory A. Eisenlohr-Moul, Ph.D., et al. *AJP in Advance*, August 13, 2016

Primate Brain

continued from page 29

related gene activity was highest during the prenatal period (though many genes were also somewhat active after birth), while schizophrenia risk genes didn't turn on until around three months after birth, which would be consistent with the later onset of this disorder.

This concurrence in space but variance in timing also suggests that while clinical symptoms of these illnesses may appear similar, there likely are differences in the underlying causes. Autism risk genes, for example, impact early processes like the ability of a neuron to form appropriate connections, while schizophrenia risk genes may alter the ability of neurons to change or refine existing connections.

This intriguing observation may be only the first of many, as all of the information gathered by this team has been placed in the National Institutes of Health (NIH) Blueprint Non-Human Primate Brain Atlas, which contains a wealth of imaging, anatomical, and informatics data.

"This tremendous resource is freely available to the research community and will guide important research into the causes of many neurodevelopmental disorders for years to come," said Michelle Freund, Ph.D., a program officer at the National Institute of Mental Health (NIMH) Office of Technology Development and Coordination, in a statement.

This project was funded by a contract from NIMH as part of the NIH Blueprint for Neuroscience Research. PN

An abstract of "A Comprehensive Transcriptional Map of Primate Brain Development" is posted at http://www.nature.com/nature/journal/v535/n7612/full/nature18637.html. The NIH Blueprint Non-Human Primate Atlas is accessible at blueprintnhpatlas.org.

Surgeon General

continued from page 5

enabling the provision or a referral for treatment, particularly that assisted by medications like methadone, buprenorphine, or naltrexone.

Finally, Murthy urged his fellow physicians to make clear to other Americans that addiction is a chronic illness and must be approached that way.

"There is no single solution to the opioid abuse epidemic," wrote Jerome Adams, M.D., M.P.H., of the State of Indiana Department of Health in Indianapolis, and two colleagues in the June *American Journal of Public Health*. "We must educate the public and prescribers about the dangers of opioids, teach prescribers about opioid alternatives for pain management, optimize prescription drug monitoring programs, and increase the availability of substance-use disorder management." PN

To read more and pledge your support of the Surgeon General's campaign to end the opioid epidemic and access APA training and other resources on opioid use disorder, visit http://psychiatry.org/psychiatrists/end-the-opioid-epidemic.

Most YouTube Videos Don't Depict Schizophrenia Accurately, Study Finds

Of 4,200 YouTube videos purporting to show symptoms of schizophrenia, only 12 were accurate, researchers find.

BY VABREN WATTS

A study published August 15 in *Psychiatric Services in Advance* is a reminder that just because something is on the Internet, it doesn't mean it is accurate. The study found that YouTube is not a very reliable source of information on the signs and symptoms of schizophrenia. In fact, the study concluded that the global video-sharing site "offer[s] a distorted picture of the condition."

"Residents and psychiatrists now have a study that has examined the content online on YouTube as it relates to mental illness," John Luo, M.D., a psychiatrist and senior physician informaticist at the University of California Los Angeles Health, told *Psychiatric News*. "This study has done the groundwork to raise awareness that the majority of the videos on YouTube do not present an accurate portrayal of the symptoms of acute schizophrenia."

iStock/Anatolii Babii

The study was led by a team of researchers from the United Kingdom who performed a search for all YouTube videos purporting to show footage of individuals exhibiting the signs and symptoms of acute schizophrenia. Eligible videos were independently rated by two consultant psychiatrists on two occasions for probable psychiatric diagnosis and psychopathological symptoms; the raters were also asked to answer the question "Considering the quality and content of this video, would you consider using it in a medical student teaching session as an illustration of the signs and symptoms of acute psychosis in schizophrenia?" Videos receiving a "yes" response by both independent raters were considered to have good educational utility.

Of the 4,200 videos assessed, 35 videos met the authors' eligibility and adequacy criteria. Of these 35 videos, only 12 were considered to present accurate depictions of acute schizophrenia.

"Our main findings were that eligible videos were largely inaccurate, containing psychopathological features not specific to schizophrenia," the researchers wrote. "Mental health professionals and medical schools should be aware of this source of inaccurate information when advising students and patients about sources of health information."

The authors pointed out that their study did not examine the extent to which YouTube videos affected viewers' attitudes and understanding of schizophrenia, but noted that other studies have provided evidence that similar videos can change attitudes about schizophrenia.

"The relationship between misrepresentations of mental illness on the Internet and public understanding of these conditions will be an important focus for future work," they concluded. PN

"Schizophrenia on YouTube" is posted at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500541.

JOURNAL DIGEST

BY NICK ZAGORSKI AND VABREN WATTS

iStock/sfrank600

Use of Opioid Substitute Kratom Higher Than Ever Before

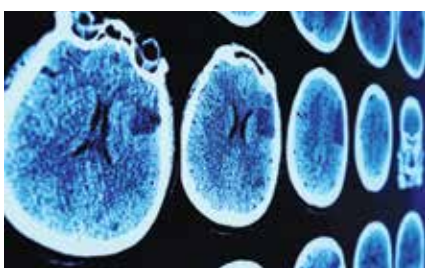
According to a report by the Centers for Disease Control and Prevention (CDC), exposure to kratom (*Mitragyna specicosa*)—a plant known for its stimulant and opioid effects that is typically consumed as tea, chewed, smoked, or found in capsules—is on the rise.

According to the CDC's *Morbidity and Mortality Weekly Report*, the number of calls made to U.S. poison centers for kratom exposures jumped from 26 calls in 2010 to 256 calls in 2015. Of the 660 calls made from 2010 to 2015, 41.7 percent required some form of treatment by health care professionals. One death was reported among the calls.

Alcohol, benzodiazepines, narcotics, and acetaminophen were the most commonly reported substances used in combination with kratom.

The CDC stated that the public and all health care professionals should be aware of kratom and its threat as an emerging public health problem.

Anwar M, Law R, Schier J. Kratom (*Mitragyna speciosa*) Exposures Reported to Poison Centers–United States, 2010–2015. *Morbidity and Mortality Weekly Report*. 65(39);748–749. http://www.cdc.gov/mmwr/volumes/65/wr/mm6529a4.htm?s_cid=mm6529a4_w



iStock/sudok1

Cancer-Derived Antibodies May Not Contribute to Psychosis

Despite evidence to suggest that antibodies targeting onconeural antigens may contribute to some psychotic disorders, a *Journal of Neuropsychiatry and Clinical Neurosciences* study published online August 31 concluded that serum onconeural antibody positivity is rare among patients acutely admitted for inpatient psychiatric care.

To study the prevalence of onconeural antibodies in patients admitted for psychiatric inpatient care, the authors tested the serum of 585 psychiatric inpatients for the presence of antibodies against 15 different neuronal antigens. Serum from only one patient was found to be weakly positive to antirecoverin—an antibody associated with tumor-associated retinopathy.

"To our knowledge, this is the first study addressing the prevalence of a large number of well-characterized onconeural intracellular autoantibodies in patients admitted to acute psychiatric inpatient care," the authors wrote. "We conclude that serum onconeural antibody positivity is rare among patients acutely admitted for inpatient psychiatric care, and routine screening is not likely to be clinically informative in most cases."

They concluded, "Additional studies are needed to determine the frequency of onconeural antibody positivity using CSF studies in this population and to clarify both the clinical indicators and risk-benefit ratio of CSF onconeural antibody screening among acutely admitted psychiatric inpatients."

Sæther S, Schou M, Stoecker W, et al. Onconeural Antibodies in Acute Psychiatric Inpatient Care. *J Neuropsychiatry Clin Neurosci.* August 31, 2016. [Epub ahead of print] http://neuro.psychiatryonline.org/doi/full/10.1176/appi.neuropsych.16050110

iStock/&#169 Ned White

Supportive Behavioral Therapy May Reduce Pain, Alcohol Use

A low-cost intervention that combines principles of cognitive-behavioral therapy with an approach that encourages patients to identify ways to function in the face of pain can reduce pain and alcohol use and improve pain-related functioning over the long term, according to a study published in *Addiction*.

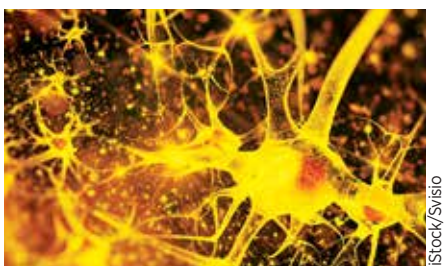
To determine how ImPAT (Improving Pain during Addiction Treatment) compares with other common approaches to patients with substance use disorder and pain, researchers from the VA Ann Arbor Healthcare System's Center for Clinical Management Research and University of Michigan Medical School's Addiction Center randomly assigned 129 VA patients (who were all receiving outpatient addiction treatment) to receive ImPAT or a general educational support.

Veterans who received ImPAT reported significantly lower levels of pain intensity, improved pain-related functioning, and lower levels of alcohol consumption 12 months after beginning therapy compared with those receiving educational support. The groups reported similar frequency of drug use over the follow-up period, however.

"These results highlight the need for addiction treatment programs to offer a multifaceted approach that doesn't only address substance use but also the other factors that might be driving substance use, including pain," lead author Mark Ilgen, Ph.D., stated in a press release.

The study authors have already launched a follow-up study in a larger group of 480 nonveterans in a residential addiction treatment program.

Ilgen M, Bohnert A, Chermack S, et al. A Randomized Trial of a Pain Management Intervention for Adults Receiving Substance Use Disorder Treatment. *Addiction*. August 2016; 111(8):1385-1393. http://onlinelibrary.wiley.com/doi/10.1111/add.13349/abstract



iStock/Svisio

Stem Cells Reveal New Clues About Children With Williams Syndrome

Researchers have successfully cultured a neuronal network from children with Williams syndrome—a rare inherited disorder that is sometimes characterized as "reverse autism" because of the extremely social nature of children with the disorder.

To examine how neural progenitor cells in patients with Williams syndrome compared with those of patients without the disorder the researchers from the University of California, San Diego; the Salk Institute for Biological Studies; and elsewhere acquired stem cells from the dental pulp of baby teeth donated by young children with Williams syndrome.

Neural progenitor cells in Williams syndrome failed to proliferate as well as typically developing neural progenitor cells. The cells that reached maturity were characterized by "longer total dendrites, increased spines and synapses, aberrant calcium oscillation, and altered network connectivity," the authors reported.

The neuronal morphology was confirmed with an analysis of postmortem brain tissue, suggesting that these changes occur early in development and are maintained after birth.

"This model of human-induced pluripotent stem cells fills the current knowledge gap in the cellular biology of Williams syndrome and could lead to further insights into the molecular mechanism underlying the disorder and the human social brain," the authors stated.

This study was published in *Nature*.

Chailangkarn T, Trujillo C, Freitas B, et al. A Human Neurodevelopmental Model for Williams Syndrome. *Nature*. August 10, 2016. [Epub ahead of print] http://www.nature.com/nature/journal/vaop/ncurrent/full/nature19067.html

iStock/michaelquirk

Cost-Effectiveness of Second-Line Antidepressants Found to Be Similar

While previous studies have found bupropion, sertraline, and venlafaxine to be equally effective in treating major depressive disorder in patients who first fail to respond to citalopram, few studies have compared the cost-effectiveness of the treatments. A study from the STAR*D (Sequenced Treatment Alternatives to Relieve Depression) trial suggests there is no significant difference in the cost-effectiveness of switching to bupropion, sertraline, or venlafaxine after an unsuccessful treatment with citalopram.

The findings were published August 15 in *Psychiatric Services in Advance*.

A total of 727 patients with major depressive disorder who inadequately responded to citalopram were randomly switched to treatment with bupropion (average daily dose, 223 mg), sertraline (94 mg), or venlafaxine (122 mg) for depression treatment. The calculated costs associated with treatment were based on three components: antidepressant medications, other medications (medications commonly required to manage the side effects of antide-

continued on next page

MED CHECK

BY VABREN WATTS

FDA Gives Nod to Investigational Therapies for Alzheimer's

Two investigational therapies for Alzheimer's disease (AD) were recently granted the Food and Drug Administration (FDA) Fast Track Designation—a classification that facilitates the development and expedites the review of medications.

One of these therapies is ***AZD3293***, an oral beta secretase cleaving enzyme (BACE) inhibitor co-developed by Eli Lilly and AstraZeneca. Studies suggest that inhibiting BACE can prevent the formation and build-up of beta-amyloid, a hallmark of AD.

The companies are currently carrying out several trials of the BACE inhibitor, including a phase 2 placebo-controlled trial and two phase 3 trials of patients with early-stage AD. Final results for both trials, the companies predict, should be available by 2019.

Biogen Inc. was also granted FDA Fast Track status for its monoclonal antibody ***aducanumab***.

A recent phase 1b placebo-controlled trial of 165 patients with prodromal and mild AD found that use of aducanumab was associated with a dose-dependent reduction in beta-amyloid in the brain. Exploratory data also suggested dose- and time-dependent slowing of clinical decline as measured by the Clinical Dementia Rating-Sum of Boxes and the Mini-Mental State Examination scores.

Biogen is currently testing the antibody in individuals with early AD in a phase 3 trial that aims to enroll approximately 1,350 patients, according to information on Clinicaltrials.gov. The studies are expected to be completed in early 2022.

Also this summer, Biogen together with Eisai Co. Ltd. announced that they had received approval from the FDA to begin a phase 3 trial of the BACE inhibitor ***E2609***.

The FDA's decision was partly based on data from placebo-controlled phase 2 clinical studies that showed that patients with early to moderate AD responded favorably to doses of E2609 at 5 mg, 15 mg, and 50 mg daily. Beta-amyloid levels in the plasma and cerebral spinal fluid were reduced in a dose-dependent manner in patients taking E2609.

Upcoming phase 3 trials will include patients with early Alzheimer's who will receive daily 50 mg doses of E2609 or placebo daily. The primary outcome measure will be dementia severity at study endpoint which will be assessed at 24 months.

Postpartum Depression Therapy Receives FDA Breakthrough Designation

Sage Therapeutics in August announced that its investigational drug for postpartum depression, ***SAGE-547***, a GABAA modulator delivered intravenously, has been granted Breakthrough Therapy Designation by the FDA—a classification that expedites the development and review of a drug.

The FDA's decision was based primarily on the findings of a phase 2 trial of 21 patients who experienced severe postpartum depression within four weeks of delivery. Women taking the medication intravenously were found to have a significant reduction in their Hamilton Rating Scale for Depression scores compared with women administered placebo.

The effect of SAGE-547 was maintained through a 30-day follow-up period, and the medication was generally well tolerated.

FDA Warns About Combined Use Of Opioids, Benzodiazepines

The FDA announced in August that it will require class-wide changes to the labels of all prescription opioid medications and benzodiazepines in an effort to inform health care providers and patients of the serious risks associated with the combined use of the medications.

The agency will now require boxed warnings—the FDA's strongest warning—and patient-focused Medication Guides for nearly 400 products, including prescription opioid analgesics, opioid-containing cough products, and benzodiazepines. The warnings will describe the serious risks associated with using these medications at the same time.

The requirement came after a review by the agency found the number of patients receiving overlapping benzodiazepine and opioid analgesic prescriptions increased by 41 percent between 2002 and 2014—an increase of more than 2.5 million opioid analgesic patients receiving benzodiazepines. The review also revealed that from 2004 to 2011, the rate of emergency department visits involving nonmedical use of both drug classes increased significantly, with overdose deaths involving both drug classes nearly tripling during this period.

The agency said that it is currently examining available evidence regarding the risks of the combined use of benzodiazepines and opioids in patients who are undergoing medication-assisted treatment to treat opioid dependence.

Abuse-Deterrent Claim Retracted For Investigational Opioid Drug

In August, Endo Pharmaceuticals announced that the company had decided to withdraw its supplemental New Drug Application relating to abuse-deterrent labeling for its opioid pain medication ***Opana ER***.

While the company initially suggested that a new version of the medication, which was released in 2012, had a special coating making it more difficult to snort, the FDA found it may have made the medication easier to prepare for injection.

"We anticipate the generation of additional data and we will seek collaboration with FDA to appropriately advance Opana ER," Sue Hall, Ph.D., global head of R&D at Endo said in a press statement. PN

continued from previous page

pressants), and health care facility use (including outpatient visits, emergency room visits, and hospitalization).

Results showed that although the total costs among the three groups were significantly different, none of the pairwise differences in overall costs for the three drugs attained statistical significance—a finding the authors attributed to "the large variability in costs."

"This study reemphasizes that overall treatment costs need to be considered rather than drug costs alone in order to estimate the costs incurred or cost-effectiveness within a clinical trial," the study authors wrote.

Singh A, Brooks M, Voorhees R, et al. Cost-Effective Drug Switch Options After Unsuccessful Treatment With an SSRI for Depression. *Psychiatr Serv*. August 15, 2016. [Epub ahead of print] http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500448

iStock/MJFelt

Patients With Mental Illness May Face Longer Waits at ER, Only to Be Transferred

People who visit emergency rooms (ER) for mental health care may wait almost two hours longer compared with nonpsychiatric care seekers, and get transferred to another facility six times as much, according to study appearing in the September issue of *Health Affairs*.

"Previous research shows that patients in the ER often experience lengthy wait times, but our new study shows that psychiatric patients wait disproportionately longer than other patients—sometimes for several hours—only to ultimately be discharged or transferred elsewhere," lead author Jane M. Zhu, M.D., M.P.P., of the Perelman School of Medicine at the University of Pennsylvania said in a press statement. "Overall, the study highlights the degree to which emergency departments struggle to meet the needs of mental health patients."

The study examined data for more than 200,000 ER visits from 2002 to 2011 that were collected as part of the Center for Disease Control and Prevention's National Hospital Ambulatory Medical Care Survey.

The analysis showed that psychiatric patients experienced average length-of-stays that were significantly longer than non-psychiatric patients for multiple outcomes: 355 versus 279 minutes (5.9 hours versus 4.7 hours) for patients admitted for observation, 312 versus 195 minutes (5.2 hours versus 2.4 hours) for patients who were transferred, and 189 versus 144 minutes (3.5 hours versus 2.4 hours) for patients who were discharged.

Only in the case of patients admitted for observation did this length-of-stay gap appear to close between 2002 and 2011.

"There has been progress made recently as the number of hospital-based psychiatric ER units has increased, along with regional psychiatric emergency care facilities that can quickly take in patients who visit local ERs," Zhu said. "However, these improvements have yet to offset the overall shortage of psychiatric inpatient resources." PN

Zhu J, Singhal A, Hsia R. Emergency Department Length-Of-Stay For Psychiatric Visits Was Significantly Longer Than For Non-psychiatric Visits, 2002-11. *Health Aff*. September 1, 2016; 35(9):1698-1706. http://content.healthaffairs.org/content/35/9/1698.long

WPSI

continued from page 5

"Everything we do is evidenced-based," said Van Niel in an interview. "We're really responding to the best science, the best studies—not to anyone's personal impressions."

Part of Van Niel's role has been to introduce consideration of the emotional impact of alternatives under discussion into the current round of recommendations. That might include whether some screening or its outcome might engender anxiety in patients, as may happen following a diagnosis or a false positive.

Other members of the panel have been very open to discussing the mental health aspects of each category of services, said Van Niel.

"I think for a long time people thought that the 'medical' problems deserved the most attention," said Van Niel. "Only now can we see that mental health problems are also medical problems. They're part of systems within the body and just as measuring blood sugar in a patient is important, so is assessing their mood."

The updated draft recommendations were published September 1 for comments. They contained a number of clarifications and suggestions for implementation, including the addition of follow-up care to be provided without cost-sharing. Final recommendations will be submitted December 1 to be considered for adoption by HRSA and insurance coverage under the ACA.

For instance, gestational diabetes coverage would go beyond screening to include care throughout pregnancy, as well as supplies, counseling, and education. Coverage for interpersonal and domestic violence screening would expand to include a "broad range of services that may be needed to help adolescents and women in these circumstances."

There is one entirely new recommendation, covering breast cancer screening for average-risk women. It calls for screening mammography every one or two years for women at average risk, coupled with an informed decision-making process covering the benefits and harms of different screening intervals, with consideration of "patient values and preferences."

Van Niel intends to expand her role—and psychiatry's—within WPSI as time goes by.

"In future years, I hope to specifically suggest including coverage of primary mental health problems that occur only in women, such as perinatal mood or anxiety disorders or conditions arising during menarche, pregnancy, or menopause," she said. PN

The Women's Preventive Services Initiative website is http://www.womenspreventivehealth.org/.

Joint Commission

continued from page 27

- **Assessment:** Collect and analyze necessary data, as determined by the organization, from patient at admission and discharge to effectively treat the patient and as a measure of the organization's effectiveness in treating eating disorders.
- **Treatment:** Cover specific core care, treatment, or service components that are provided by the organization to individuals with eating disorders, including psychosocial, medical, nutritional, and psychiatric components, and maintain a line of communication with other medical facilities that may be providing care to a patient while he or she is in rehabilitation for an eating disorder.
- **Family Involvement**: Engage family members of patients who have not acknowledged the organization's efforts to involve them in the individual's care, treatment, or services, in accordance with the needs and preferences of the individual served.
- **Organizational Practices and Policies**: Supply patients and their families

with information regarding insurance and financial assistance and ensure that residential facilities have specific policies regarding the individual's ability to leave the facility, have visitors, and access the Internet.

Guarda told *Psychiatric News* that while she believes the new standards will serve to help patients with eating disorders, she would like to have seen more details relating to assessing treatment outcomes.

"It's unclear whether measurements of certain outcomes are necessary for Joint Commission accreditation," said Guarda. "The standards are giving the organizations power to decide what critical data should be collected. For example, successful treatment of anorexia requires both assessment of eating behaviors and weight gain in patients," she explained. "Improvements in eating behaviors are not enough; there has to be a weight gain associated with the measure of success." PN

The *Comprehensive Accreditation Manual for Behavioral Health Care (BHC) Organizations* is posted at http://www.jcrinc.com/2016-comprehensive-accreditation-manual-for-behavioral-health-care-cambhc-/. Explanations and supporting evidence for the critical aspects of care are posted at https://www.jointcommission.org/standards_information/r3_report.aspx. An abstract of "Marketing Residential Treatment Programs for Eating Disorders: A Call for Transparency" is posted at http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201500338.

Fear

continued from page 23

and to behavioral and physiological symptoms that also occur. As a result, so the logic goes, it should be possible to develop new treatments that make people feel less anxious by testing whether behavioral or physiological symptoms are reduced in animals. Medications that make animals less timid behaviorally are expected to make people less fearful or anxious."

That hasn't worked, he said. "We propose that the reason for this is that the brain circuits that underlie conscious feelings are different from those that underlie behavioral and physiological responses and may require different treatments," LeDoux explained. "Behavioral and physiological symptoms may be treatable with either medications and/or certain psychotherapies, such as cognitive-behavioral therapy, while conscious feelings may have to be addressed with psychotherapeutic treatments that focus on the feelings themselves."

Experts in anxiety research who reviewed the paper for *Psychiatric News* said it could be a game changer. "What they are saying that is crucial is that a rodent model of anxiety is probably not going to be able to capture what happens in people," said Barbara Milrod, M.D., a professor of psychiatry at Weill Cornell Medical College and an expert on psychotherapeutic treatment of anxiety.

"This is a really important paper," Murray Stein, M.D., vice chair for clinical research in the Department of Psychiatry at University of California, San Diego,

told *Psychiatric News*. "It's going to be controversial, in a good way, because it is deliberately meant to shake things up and get those of us who work in this area to think differently about the nature of fear and anxiety. LeDoux and Pine suggest we have been going down the wrong path by looking at animal behavioral models for what we call fear and anxiety, because what we are modeling in animals isn't what we are measuring, assessing, and trying to treat in humans."

LeDoux said that doesn't mean animal research has been useless. "Both sets of symptoms, the subjective conscious and behavioral/physiological, must be understood and treated. And different treatments may be required. Behavioral and physiological symptoms may be treatable with medications or certain psychotherapies, such as cognitive-behavioral therapy, while conscious feelings may have to be addressed with psychotherapeutic treatments. Animal research is important and useful, especially if we know how to use it."

He added, "Our ability to understand the brain is only as good is our understanding of the psychological processes involved. If we have misunderstood what fear and anxiety are, it is not surprising that efforts to use research based on this misunderstanding to treat problems with fear and anxiety would have produced disappointing results." PN

"Using Neuroscience to Help Understand Fear and Anxiety: A Two-System Framework" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2016.16030353.

Integrated Care

continued from page 15

positive. This collaborative care support service was made available by both Washington and Wyoming Medicaid divisions. More details of the PAL elective primary care consultation service are posted at www.seattlechildrens.org/PAL.

Combining elective PAL consultation and mandatory second-opinion review consultation programs into a single service allows greater staffing flexibility (it's difficult to always have a child psychiatrist "available") and helps to ensure the fidelity of message regardless of the door of entry for collaboration assistance. The consultants work as a team, discuss challenging scenarios together to reach a best consensus approach, and formally audit the consultations for consistency of best practice messaging. Overall system outcomes have been notable; for instance, in just the first three years of combined PAL/Second Opinion consult services, Washington's preexisting rapid increase in child antipsychotic use reversed course, and then decreased by 17 percent.

Collaborative care systems need to be explicitly tailored to local needs. In working with Wyoming Medicaid, we learned that children in their foster care system had additional challenges with getting timely access to child psychiatric assessments, and this lack of access negatively impacted overall treatment planning. So we created a path for rapid-access but in-depth system collaboration televideo patient consultations for the foster care system. An analysis of the whole package

of Wyoming's collaborative care (PAL, Second Opinion, and foster care consults) found desirable outcomes beyond positive provider feedback. There were 42 percent fewer kids under 5 receiving psychotropic medications and 52 percent fewer kids receiving more than 150 percent of the adult FDA maximum-dose psychotropics. Also, by reducing clinically unnecessary residential care placements, the collaborative care system saved money with a 1.8-to-1 return on investment.

Based on all of these experiences, I encourage others to consider working with one of the many types of developing collaborative care systems in their own areas, as it can be highly rewarding work. PN

Robert J. Hilt can be contacted at Robert.hilt@seattlechildrens.org.

Residents' Forum

continued from page 29

myself religiously has the potential to disrupt the therapeutic alliance.)

As residents, we are so intently focused on keeping patients alive and learning psychiatry that we sometimes miss the intangible parts of our work. Regardless of our religious beliefs, or lack thereof, patient care can be a way to serve a higher power and receive spiritual nourishment. Evidence-based treatment and spiritually informed care are compatible. As we help patients share their spiritual beliefs with us, our work becomes deeper and more meaningful and can lead us to the core of the human experience. PN

Codes

continued from page 1

orative care codes because they will not be finalized in time to be incorporated into the 2017 CPT manual.)

In the proposed rule, published in the *Federal Register* on July 15, CMS proposed to support payment of psychiatrists for consultative services they provide to primary care physicians in the CoCM, citing models of collaborative care described or reviewed in publications from the University of Washington, the Institute for Clinical and Economic Review, and the Cochrane Collaboration. The codes themselves are submitted by the primary care physician.

While hailing the three new codes for these services, APA also urged CMS to reconsider the proposed payment amount. APA noted that the proposed work values for the codes underestimate the work involved and are not sufficient to sustain the model.

"We believe that the proposed valuation of the psychiatric consultant is not representative of the actual work being performed," Levin wrote. "CMS's proposal to crosswalk the work of the psychiatric consultant [in the three codes] to CPT code 90836, *Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service*, for a work RVU of 0.42, is not appropriate. … While psychotherapy is an important management option, it is not the work being performed. The psychiatric consultant's work is inherently medical and is more equivalent to the medical decision making of an evaluation and management (E/M) service."

Levin noted that patients enrolled in the CoCM are typically those who have not responded to standard care and need additional specialty evaluation and involvement to enable the development of an appropriate and effective treatment plan. The psychiatrist is evaluating the patient's condition based upon the data provided by the primary care provider and the behavioral health care manager including medical history, prior treatment history, and other pertinent biopsychosocial information.

"In sum, the proposed crosswalk is based upon a misunderstanding of the work of the psychiatric consultant and would result in values insufficient to sustain the model, which would also impede adoption of the CoCM," Levin wrote. "The work of the psychiatric consultant in all three codes should be valued no less than that of the primary care physician."

In the proposed rule, CMS also supported payment for another new code—GPPPX—to pay for "care management services for behavioral health conditions" in primary care settings. In its letter, APA generally supported adoption of the new code but sought clarification from the administration.

"We commend CMS's effort to expand Medicare coverage and payment to additional services involving care for patients with behavioral health conditions based on the recognition that significant time and resources are expended on patients with behavioral health conditions that are not currently compensated," Levin wrote.

"However, it is not clear from the proposed rule precisely which services, practitioners, patients, and circumstances would qualify for the billing of the GPPPX code. We recommend that CMS provide further clarification regarding the precise services contemplated for g-code GPPPX."

APA's letter also includes detailed responses to the CMS proposal to provide payment for "prolonged services codes" for time spent providing non-face-to-face services following an E/M visit and coverage for assessment and care for cognitive impairment. PN

The text of APA's letter is posted at http://psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/medicare/medicare-fee-schedule.