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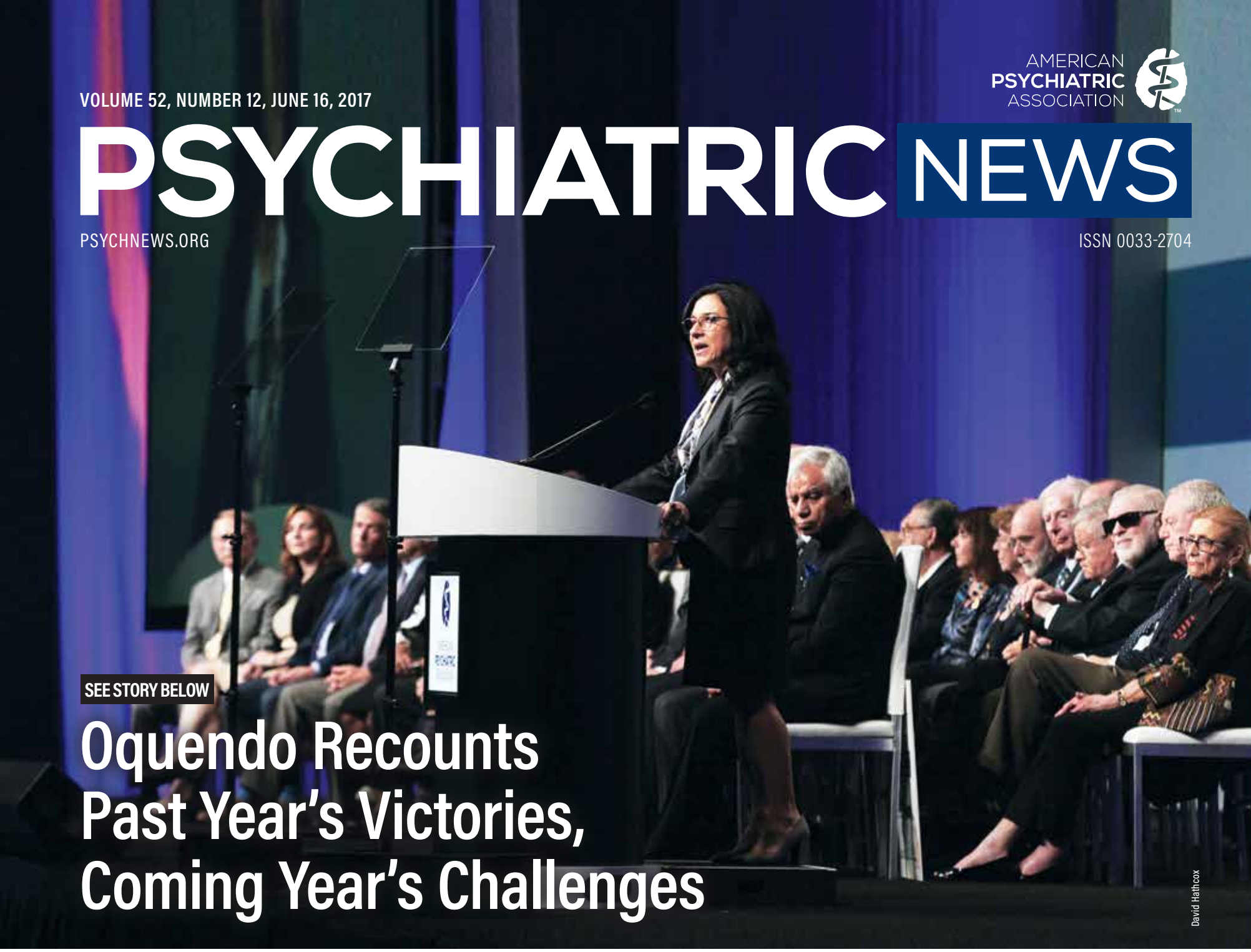

David Hathcox

SEE STORY BELOW

Oquendo Recounts Past Year's Victories, Coming Year's Challenges

BY MARK MORAN

"We are at the threshold of a wonderful era for psychiatry," said APA President Maria A. Oquendo, M.D., Ph.D., recapping an eventful presidential year highlighted by her presence at the White House for the signing of the 21st Century Cures Act last December.

In her presidential address last month at the Opening Session of APA's 2017 Annual Meeting, Oquendo recalled her participation in hearings on Capitol Hill on mental health reform and the opioid epidemic and looked ahead to new challenges for an APA growing in membership and moving to a new headquarters building. But it was Oquendo's opportunity to witness the signing of the 21st Century Cures Act that she said would be the lasting memory of her presidential year.

"I was honored and grateful to have the opportunity to represent our great Association at this landmark event," she said. "When President Obama and Vice President Biden came onto the stage, there was loud, protracted applause. What followed was one of the most moving ceremonies I have witnessed. … They spoke about how this was the last bill that President Obama would sign into law."

Among the specific provisions of the bill that she outlined were these:

- Funds for medical research through the National Institutes of Health, including $1.5 billion for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative.

- Teeth for enforcing mental health care parity.

- Strategies to improve the recruitment, training, and retention of a mental health/substance use disorder workforce.

- Coordination of fragmented mental health resources across federal agencies through the establishment of an Assistant Secretary for Mental Health and Substance Use in the Department of Health and Human Services (psychiatrist Elinore McCance-Katz, M.D., has been nominated for this position).

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PSYCHIATRIC NEWS

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Majority of Americans Say Mental Health Care Should Be Covered by Insurance

Among other findings, the APA-sponsored poll suggested that few Americans believe mental health is a high priority for policymakers or that the country is headed in the right direction with regard to addressing the opioid crisis. ***BY MARK MORAN***

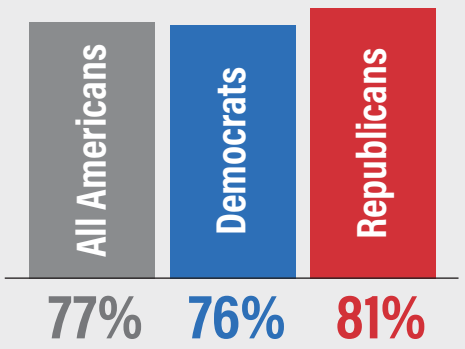
Mental health is important to Americans, and they think it should be important to their elected representatives as well, according to the results of a national poll released last month by APA.

The poll found that a majority of Americans believe mental health care should be covered by insurance, including public insurance plans, but a strong majority also believe that mental health is not a priority to elected representatives. At the same time, accessing mental health care is challenging for many who report they do not know how to access it if needed. The poll also found high percentages of Americans who are anxious about their health, safety, finances, relationships, and politics (see box on facing page).

A striking finding from the poll was the extent to which the opioid addiction crisis has touched the lives of many Americans.

Political Affiliation Doesn't Matter

The majority of Americans believe that mental health care should be provided through private health insurance or a union.



"This poll gives us some insight into Americans' understanding of the importance of mental health and the strong bipartisan support for mental health coverage," said APA President Maria A. Oquendo, M.D., Ph.D. "However, the number of people who don't know how to access mental health care and don't know about their coverage raises concerns."

Seventy-seven percent of Americans said private health insurance offered through an employer or union should cover mental health, including 76 percent of Democrats and 81 percent of Republicans. Fifty-one percent said that mental health care should be covered by all types of insurance, including individually purchased health insurance; insurance purchased through the health insurance exchanges or marketplace; and Medicaid, Medicare, and other government-provided sources (such as veterans benefits). This includes 55 percent of Democrats and 51 percent of Republicans. Baby boomers are more likely than millennials to support mental health coverage. At the same time, more than two-thirds (69 percent) think

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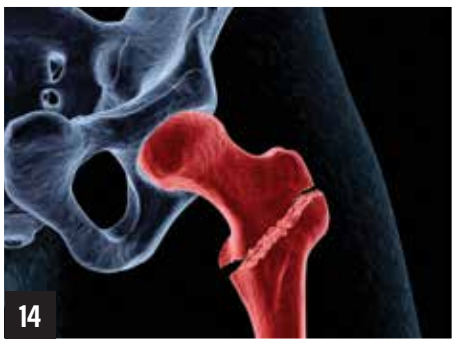
IN THIS ISSUE



DEPARTMENTS

Interested in Expanding Your Practice?

Collaborative care continues to be an exciting area of growth and opportunity for psychiatrists. APA is offering free training under the Transforming Clinical Practice Initiative (TCPI) supported by a $2.9 million, four-year federal grant. More information about the training is posted at www.psychiatry.org/TCPI.

continued from facing page

that mental health is a low priority or not a priority among Washington, D.C., policymakers.

"We've made progress in recent years with improving and expanding mental health coverage, but the American Health Care Act [AHCA] passed by the House will reverse much of that progress," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "The AHCA will remove insurance coverage from millions of Americans and roll back Medicaid expansion that occurred under the Affordable Care Act, potentially reducing access to care for the 1.3 million Americans with serious mental illness and the 2.8 million Americans with substance use disorders."

Importantly, the poll suggests that the opioid addiction crisis has made itself widely felt. More than a quarter of Americans and more than a third of millennials reported knowing someone who has been addicted to opioids or prescription painkillers. More than two-thirds of Americans said they "understand how someone accidentally gets addicted to opioids." Most Americans believe people can recover from opioid addiction, but most do not believe the country is moving in the right direction to address the problem. Regardless of gender, age, or income, only 20 percent of Americans believe that the country is headed in the right direction with regard to addressing the opioid crisis.

"Our poll findings show that Americans are aware of the problem of opioid addiction, believe people can recover, and want to see an emphasis on making treatment available," said Levin. "APA has long been involved in educating psychiatrists about addiction treatment, including medication-assisted treatment, and providing opportunities for medical students and residents for learning about addiction psychiatry. The number of young people—1 in 5—who believe it's OK to share prescriptions is troubling."

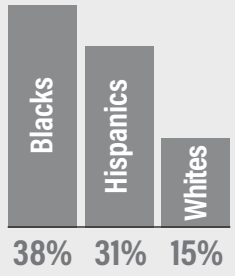
These findings are from an APA-sponsored poll conducted online using ORC International's CARAVAN® Omnibus Survey. A nationally representative sample of 1,019 adults were surveyed from April 20 to 23. The margin of error is +/-3.1 percentage points. The findings were extrapolated to the U.S. population. **PN**

Americans Report Anxiety in Five Domains

Americans have a lot to be anxious about today, according to the results of a national poll released by APA last month. Nearly two-thirds of Americans are extremely or somewhat anxious about health and safety for themselves and their families, and more than a third are more anxious overall than last year, the poll found.

Respondents were asked to rate their anxiety in five areas: health, safety, finances, relationships, and politics. The results include the following:

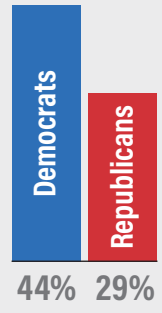
- Blacks and Hispanics reported higher levels of anxiety than whites. More than twice as many blacks and Hispanics (38 percent and 31 percent, respectively) reported being extremely anxious about their health compared with whites (15 percent).



- People on Medicaid reported being more anxious than those with private health care.
- More than one-third of respondents said they are more anxious than last year. Millennials are more likely than baby boomers to have more anxiety this year than last (41 percent and 32 percent, respectively).

- More than half of respondents reported being somewhat or extremely anxious about paying their bills and about the impact of politics on their daily life.

Democrats, Republicans, and Independents reported similar levels of anxiety overall. However, more Democrats (44 percent) than Republicans (29 percent) reported that their stress has increased in the past year. By generation, millennials were the most anxious, and baby boomers were the least.



CBO Says Millions of People Could Lose Coverage Under AHCA

The House of Representatives rushed through passage of the American Health Care Act before the extent of its impact was known. **BY HARRIET EDLESON**

If the replacement bill for the Affordable Care Act (ACA) that narrowly passed the U.S. House of Representatives last month becomes law, it will leave some 14 million more people uninsured next year than under current law and 23 million more in 2026.

These were among the findings of the Congressional Budget Office (CBO), the nonpartisan federal agency that analyzes pending legislation for economic and other impacts.

The House passed the American Health Care Act (AHCA) May 4 by a vote of 217-213, before that version of the bill had been scored by the CBO. The bill now moves on to the Senate, where it is expected to undergo significant changes before it comes up for a vote.

"The CBO analysis may cause senators to be more careful in how they draft their version of the bill," said Ariel Gonzalez, J.D., APA's chief of government affairs. "It's our hope the Senate throws away the House-passed AHCA and starts over with a bill that protects access to mental health and substance use treatment services. If the Senate drafts a bill that is materially different from the House version, it could be difficult to pass in any sort of conference between the two houses. Such a result could be considered a political win."

APA has been urging senators to draft a bipartisan bill of their own. Among the issues of concern to APA are how the House version of the AHCA would impact people with mental illness and substance use disorders. An estimated 1.3 million Americans with serious mental illness and 2.8 million Americans with substance use disorders gained coverage with the expansion of Medicaid under the Affordable Care Act.

According to the CBO report, in 2026, "an estimated 51 million people under age 65 would be uninsured, compared with 28 million who would lack insurance that year under current law. Under the legislation, a few million of those people would use tax credits to purchase policies that would not cover major medical risks."

Among the issues most important to APA are that essential health benefits—which include mental health/substance use treatment—continue to be covered and that patients with pre-existing conditions are able to afford health care coverage.

"Congress made much progress over the past three years, culminating in the passage last year of the bipartisan, bicameral 21st Century Cures Act," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "This current bill reverses those gains. We stand ready to work with both parties to ensure adequate health care for all Americans."

APA has offered the following recommendations to lawmakers:

- Maintain the current level of coverage for mental health and substance use disorders in health insurance plans.
- Maintain safeguards in private insurance by specifically prohibiting denial of coverage based on pre-existing conditions, eliminating lifetime and annual dollar limits on essential health benefits, and discrimination based on health status, including a history of mental illness or substance abuse.
- Ensure sufficient funding under Medicaid for mental health and

see **CBO** *on page 20*

Urge Your Senators to Start Over on AHCA

APA members are urged to contact their senators to express opposition to the AHCA and instruct the Senate to set aside the House bill and start over on new legislation that does not put at risk health care for people with mental health/substance use disorders. To make such communication quick and easy, visit the APA Advocacy Center at http://cqrcengage.com/psychorg/home.

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David Hathcox

APA President Maria A. Oquendo, M.D., Ph.D., greets Sen. Dean Heller (R-Nev.) in a meeting last month on Capitol Hill.

APA President Visits Senators To Speak Out Against AHCA

Oquendo and five other medical society leaders met with senators and staff members to point out the severe shortcomings of the American Health Care Act. **BY HARRIET EDLESON**

APA President Maria A. Oquendo, M.D., Ph.D., joined physicians from the Front Line Physicians Coalition to meet with seven senators and their staff members May 11, urging them to create a health care bill that would protect millions of currently insured individuals from losing coverage.

The physicians discussed their grave concerns about the American Health Care Act (AHCA), a bill passed by the House of Representatives last month.

Meetings took place in the offices of Sens. Roy Blunt (R-Mo.), Bob Corker (R-Tenn.), Jeff Flake (R-Ariz.), Cory Gardner (R-Colo.), Dean Heller (R-Nev.), Lisa Murkowski (R-Alaska), and Rob Portman (R-Ohio).

Coalition members spoke of the "devastating impact" the bill would have on access to insurance, specific benefits, and patient protections for millions of Americans. They also noted that they would evaluate any health care legislation based on how it "supports or conflicts with our shared principles."

In addition to APA, the other members of the coalition are the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Congress of Obstetricians and Gynecologists, and American Osteopathic Association. They represent more than 560,000 physicians, trainees, and medical students. This same coalition had expressed its strong opposition to the AHCA in late April.

Coalition members urged the Senate staffers to write a bill that would accomplish the following:

- Protect Medicaid eligibility, benefits, and coverage.

- Establish affordable premiums and deductibles for older, sicker, and poorer patients.

- Prevent insurers from charging higher and unaffordable premiums to those with pre-existing conditions.

- Prevent loss of coverage for essential health benefits.

see **AHCA** *on page 10*

Trump Budget Proposal Cuts MH, Substance Use Services

APA is calling on Congress to reject the proposed budget in favor of a bipartisan solution that ensures Americans get the health care they need. **BY HARRIET EDLESON**

The White House budget proposed in late May for Fiscal 2018 signals potential harm to mental health and substance use care and the future of medical research. It would cut the National Institutes of Health budget by $5.8 billion as well as the budgets of the Substance Abuse and Mental Health Services Administration, Medicaid, the Centers for Disease Control and Prevention, and the Food and Drug Administration.

These and other proposed reductions are meant to offset a $54 billion increase in defense spending that President Donald Trump is planning for Fiscal 2018.

These are among the targeted cuts that impact mental health care and medical research:

- A more than $252 million cut to the budget of the Substance Abuse and Mental Health Services Administration. Programs that could be affected include the Community Mental Health Services Block Grant, the Primary and Behavioral Healthcare Integration Program, and the Behavioral Health Workforce Education and Training program.

- Approximately $627 billion in cuts to Medicaid over 10 years.

- A $1.2 billion cut from the Centers for Disease Control and Prevention, targeting HIV/AIDS programs and chronic disease prevention among other programs.

- An almost $1 billion cut from the Food and Drug Administration.

"The proposed budget cuts will roll back much of the recent advances the nation has made in terms of health care," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "We need more funding for medical research and prevention programs, not less. We call upon members of both parties to work together to fund these vital programs and initiatives."

Trump's budget proposal is far from a done deal, however. "It is being greeted by both sides of the aisle as not viable," said Ariel Gonzalez, J.D., APA's chief of government affairs. "It's not something that's going to be passed in its current form. It's a political document, a statement by the president as to what his priorities are."

Gonzalez used the Fiscal 2017 budget as an example. In a rejection of the White House proposal for 2017 to cut $1.2 billion from the budget of the National Institutes of Health, Congress pushed through a bipartisan deal that increased its funding by $2 billion (*Psychiatric News,* June 2). **PN**

NIAAA Strategic Plan Targets Areas Where Immediate Impact Is Possible

NIAAA's five-year plan will emphasize areas where most progress can be made in the coming years and includes developing new tools and paradigms for diagnosing alcohol-related disorders. **BY NICK ZAGORSKI**

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has released a five-year strategic plan that focuses on areas in which the institute hopes to advance the diagnosis, treatment, and prevention of alcohol-related problems.

The plan encompasses five broad goals for biomedical research: identifying the mechanisms underlying alcohol's effects, improving diagnosis of alcohol disorders and their consequences, developing and improving prevention strategies, advancing treatment options, and increasing public awareness.

"Rather than just create a list of generic strategies within each goal, NIAAA focused on key areas where we are poised to make the most progress in the coming years," said NIAAA Acting Deputy Director Patricia Powell, Ph.D.

Powell added that this new vision will not dramatically shift funding allocated to NIAAA's various research portfolios. Rather, each specific portfolio will prioritize certain objectives.

For example, under the diagnosis goal, NIAAA is investing in three-dimensional image analysis to improve the diagnosis of fetal alcohol spectrum disorder (FASD). These scanners create heat maps of facial topography that can be quickly analyzed to determine whether an FASD is present. The institute also hopes to identify prenatal biomarkers, whether metabolic, genetic, or image based, to diagnose FASD in utero and allow for early intervention efforts.

Pharmacology is another important area. There are only three FDA-approved medications for alcohol use disorder (AUD), and each has some drawbacks. Powell said that recent early-stage clinical work in this area has shown some promise (for example, a vasopressin receptor antagonist, ABT-436, has had encouraging phase 2b clinical results), but agreed that many obstacles remain that slow the drug-development process and contribute to high failure rates of initially promising drugs.

As part of the strategic plan, NIAAA is seeking to improve both animal models of alcohol disorders and human laboratory paradigms. "We must appreciate that alcohol disorders are heterogenous and build clinical studies around specific aspects of the disorder," she said. For example, if a medication being studied is targeted at anxiety pathways, the research needs to include participants with high anxiety levels and employ validated tests that assess anxiety-induced cravings.

Powell said that NIAAA will also continue to develop better technology for measuring alcohol exposure. Current tools for alcohol monitoring work well but can be cumbersome and do not offer true real-time monitoring. The institute recently held a monitoring-device competition that resulted in a prototype wristband that continuously measures alcohol levels via sweat readings. Such a device is useful for not only research purposes but also commercial applications so that, for example, individuals can unobtrusively monitor their level of intoxication, said Powell.

Perhaps one of the most significant items noted in the NIAAA strategic plan is the proposed development of a new diagnostic model of AUD, the Addictions Neuroclinical Assessment (ANA). The ANA is envisioned as a wide-ranging battery of tests, including genetic, neuroimaging, and behavioral assessments, that can identify clinical subtypes of AUD, which in turn can guide the development of personalized treatments.

see **NIAAA** *on page 20*

NIAAA Acting Deputy Director Patricia Powell, Ph.D., says that a key theme of the new strategic plan is to support clinical studies and other research that recognize the heterogeneity of alcohol use disorder.

Overview of the NIAAA 2017-2021 Strategic Plan

Goal 1: Identify Mechanisms of Alcohol Action, Alcohol-Related Pathology, and Recovery.

- *Objective 1a:* Identify mechanisms underlying alcohol use disorder and co-occurring mental health conditions.
- *Objective 1b:* Identify genomic and nongenomic factors associated with resilience and vulnerability to alcohol misuse, alcohol use disorder, and co-occurring mental health conditions.
- *Objective 1c:* Identify mechanisms through which alcohol affects health and disease across the lifespan.

Goal 2: Improve Diagnosis and Tracking of Alcohol Misuse, Alcohol Use Disorder, and Alcohol-Related Consequences.

- *Objective 2a:* Improve the diagnosis of alcohol use disorder.
- *Objective 2b:* Develop new approaches for diagnosing fetal alcohol spectrum disorders, enabling early interventions.
- *Objective 2c:* Develop and evaluate measures to improve the diagnosis of alcohol-related organ damage, especially alcoholic liver disease, and assess its progression.
- *Objective 2d:* Track the prevalence, patterns, and trends of alcohol use, misuse, and alcohol use disorder; co-occurring conditions; and alcohol-related consequences across the lifespan.

Goal 3: Develop and Improve Strategies to Prevent Alcohol Misuse, Alcohol Use Disorder, and Alcohol-Related Consequences

- *Objective 3a:* Promote universal screening and brief intervention for alcohol and other substance use.
- *Objective 3b:* Develop, evaluate, and promote effective strategies for preventing alcohol misuse, alcohol use disorder, and related consequences for individuals at all stages of life.

Goal 4: Develop and Improve Treatments for Alcohol Misuse, Alcohol Use Disorder, Co-Occurring Conditions, and Alcohol-Related Consequences.

- *Objective 4a:* Improve existing behavioral treatments for alcohol use disorder and co-occurring conditions, and develop new behavioral treatments based on advances in neuroscience and basic behavioral research.
- *Objective 4b:* Develop novel medications for treating alcohol use disorder and co-occurring conditions.
- *Objective 4c:* Identify factors that facilitate or inhibit sustained recovery from alcohol use disorder.
- *Objective 4d:* Advance precision medicine by evaluating which treatments for alcohol use disorder and related conditions work best for which individuals.
- *Objective 4e:* Develop and evaluate interventions to treat fetal alcohol spectrum disorders, alcoholic liver disease, and other negative health outcomes caused by alcohol misuse.
- *Objective 4f:* Evaluate the effectiveness, accessibility, affordability, and appeal of alcohol use disorder treatments and recovery models, and test strategies to increase their adoption in real-world settings.

Goal 5: Enhance the Public Health Impact of NIAAA-Supported Research.

- *Objective 5a:* Improve public awareness of the effects of alcohol on health and well-being and of the options for preventing and treating alcohol misuse, alcohol use disorder, and alcohol-related problems for individuals at all stages of life.
- *Objective 5b:* Develop and promote tools and resources to assist health care providers, researchers, and policymakers in addressing alcohol misuse, alcohol use disorder, and other alcohol-related health consequences.
- *Objective 5c:* Strengthen partnerships to extend the reach of the alcohol-related health information developed and distributed by NIAAA, and facilitate the implementation of evidence-based preventive and treatment interventions.

A Medical Examiner Wants Information. What's Next?

BY MOIRA WERTHEIMER, J.D., R.N., C.P.H.R.M.

Moira Wertheimer, J.D., 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.

A young man is found deceased in a car in a nearby park, and there does not appear to be any foul play involved. A search of the victim's car reveals some drug paraphernalia and an empty prescription bottle containing medicine that you prescribed. The medical examiner contacts you and requests the records of your last three visits with the patient and a list of all medications you prescribed. You are not sure if you are permitted to release the requested mental health information.

Unfortunately, there may come a time in your psychiatry practice when one of your patients becomes a medical examiner (ME) case. When this happens, you may receive a request for information from the ME regarding your recent treatment and/or any medications you may have prescribed. The request may or may not come in the form of a subpoena, and often it may come via an email or telephone call. In addition, in some jurisdictions the request may come from a coroner as opposed to an ME.

"Coroner" and "ME" are discrete titles (often used interchangeably) referring to individuals who complete somewhat similar roles, but they may have very different training and qualifications. Some jurisdictions may use a coroner system to investigate and determine a cause of death. The federal privacy laws discussed below do not distinguish between ME requests or coroner requests for information. For the purposes of this discussion, I am using the term ME.

Under most state laws, the ME, typically a physician, is charged with impartially investigating and subsequently certifying the cause or manner and circumstances of the patient's death, that is, homicide, suicide, accident, natural, or undetermined. As such, the ME may seek information from treating physicians to prepare a record of facts surrounding the patient's cause of death. Keep in mind that an inquiry from the ME does not necessarily mean he or she is evaluating the treatment provided.

As you know, federal and state privacy laws govern when and how protected health information (PHI) may be released absent specific patient consent, including PHI of a deceased patient. The Health Insurance Portability and Accountability Act (HIPAA) does not treat psychiatric information differently from other health information (except for heightened protection against disclosure of psychotherapy notes). As such, under HIPAA, a psychiatrist may disclose PHI to the ME to assist with identifying the deceased, determining the cause of death, and carrying out "other duties as authorized by law." Similarly, 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, permits disclosure of PHI when requested by the ME.

In addition to the federal HIPAA and Part 2 regulations, you must also determine whether your state's privacy laws permit you to release the requested information. Many states' privacy laws afford greater protection against disclosure than HIPAA or Part 2 protections. When there is a difference between federal and state confidentiality protections, deference should be given to the law affording greater protection against disclosure without patient consent. Please consult with your local attorney or risk management professional to determine whether you may release PHI in response to the ME's request. **PN**

FROM THE EXPERTS

Care of Depressed Older Patients: Research vs. Real World

BY BENOIT H. MULSANT, M.D., M.S.

Benoit H. Mulsant, M.D., M.S., is a professor and chair of the Department of Psychiatry at the University of Toronto and a senior scientist at the Centre for Addiction and Mental Health, Toronto. His research focuses largely on how best to treat older patients with psychiatric illness. Over the past five years, Mulsant has received research support from Brain Canada, the Canadian Institutes of Health Research, the National Institutes of Health (NIH), the U.S. Patient-Centered Outcomes Research Institute, Bristol-Myers Squibb (medications for a NIH-funded clinical trial), Eli Lilly (medications for a NIH-funded clinical trial), and Pfizer (medications for a NIH-funded clinical trial).

Over the past 25 years, the rate of antidepressant use in the United States has climbed steadily. Despite more than 14 percent of Americans 60 and older being prescribed antidepressants, many older patients continue to experience significant depressive symptoms.

Why do some older patients continue to experience symptoms of depression while on antidepressants?

Meta-analyses of placebo-controlled trials consistently demonstrate the efficacy of antidepressants in both the short- and long-term treatment of late-life depression.

Some clinicians have suggested that antidepressants are effective in older patients who participate in randomized clinical trials but not in "real-world patients" seen in clinical settings. Typically, patients seen in clinical settings are more difficult to treat than those who enroll in clinical trials. However, this explanation is unlikely to account for the gap between the efficacy of antidepressants in clinical trials and their much poorer effectiveness when they are prescribed under usual care conditions.

Several studies point to the role that the delivery of care may play in how older patients respond to antidepressants. Two large randomized studies have shown that older patients treated following measurement-based algorithms are more likely to respond to antidepressants than those treated under usual care conditions.

Why might this be? Patients who participate in clinical trials are treated according to a well-defined treatment protocol that predetermines the antidepressant they should receive and its titration. This is based on depression and side-effect scores obtained with validated instruments. In contrast, under usual care conditions antidepressants are selected idiosyncratically to "match" patients' specific factors and titrated based on clinical impression. These differences in process of care contributed to the finding that antidepressants prescribed under usual care conditions in these two large studies were half as effective as a placebo used in research clinics.

Other studies show that the number and frequency of visits can predict the efficacy of both antidepressants and placebo in the treatment of depression. In the absence of a structured process of care including regular visits to monitor symptoms and side effects, older, depressed patients who are dissatisfied with their antidepressants are likely to stop taking them.

Another likely explanation for the antidepressant efficacy-effectiveness gap is a partial mismatch between older patients who receive antidepressants and those who could benefit from them. The number of American adults who are prescribed an antidepressant is at least double the number who meet the criteria for a depressive or anxiety disorder and are most likely to benefit from antidepressant pharmacotherapy. At the same time, other studies show that at least half of older patients with a major depressive disorder do not get treated. Depressed patients who are older, male, poor, Hispanic, or African American are among those least likely to be diagnosed as having depression and be treated for the disorder.

Clinicians in general and psychiatrists in particular can improve the outcomes of older, depressed patients by following a few key principles:

- **Be careful when selecting the patients to whom you prescribe antidepressants.** Some older patients who are asking for an antidepressant probably do not need one, and some patients who are reluctant to take an antidepressant may need it.

- **Use a measurement-based algorithm.** Instead of trying to match specific patients with specific antidepressants, use only a small number of preselected antidepressants in your practice. Start older patients on a low dose and titrate systematically based on the scores of a depression scale.

see **Experts** *on page 20*

David Hathcox

APA President-elect Anita Everett, M.D., addresses attendees at the Opening Session of APA's 2017 Annual Meeting in San Diego last month.

Everett to Center Presidency On Innovative Solutions To Expanding Care

Innovative systems are needed to extend psychiatric expertise to patients who are currently unable to access care. **BY MARK MORAN**

"Keep the engagement going, and don't drop the connections you make at the Annual Meeting," urged APA President-elect Anita Everett, M.D., in her speech last month at the Opening Session of APA's 2017 Annual Meeting. She also exhorted meeting attendees to step up their involvement with an APA that is growing in numbers and influence.

"I encourage each of you to take just one more step to deepen your involvement with APA," Everett said. "It could be as simple as following APA's accounts on social media or taking one of the free member courses available each month. You could get more involved with your district branch or sign up to join the next phase of the PsychPRO registry. And if you aren't already a member of APA, your next step could be stopping in the Exhibit Hall this week to learn about the benefits of membership."

Everett told her colleagues that APA exists to help them meet their aspirations. She outlined her own aspirations and goals for her upcoming presidential year, emphasizing three items in particular—the development of innovative systems for improving access to care, team-based care for first-episode psychosis, and initiatives regarding physician wellness and burnout.

Referencing the serious shortage of general psychiatrists and child and adolescent psychiatrists, Everett said it will require innovative systems and technologies—such as integrated care models and telepsychiatry—to extend psychiatric expertise to patients who won't otherwise receive care. To organize and advise APA's Board of Trustees on innovations and aspirations, she has appointed the Work Group on Access to Treatment Through Innovation.

A community psychiatrist deeply committed to the needs of patients in public systems, Everett hailed the work of APA's public psychiatrists. "I have appointed many leaders in community and public psychiatry to positions throughout our APA," she said. "Good community psychiatrists are systems thinkers and gravitate toward working in team-based settings to address the circumstances, treatment, and recovery support of our most seriously ill. All of these advances give me great hope that we can improve access to mental health care and provide more effective care to the people who come to see us."

First-episode psychosis is an area that has garnered attention as a sentinel event where timely intervention can be critical. Right now, she said, the gap between a first episode and the start of treatment is an average of eight years. "That's far too long, and we can and must do better," she said. "Team-based models that provide treatment early to young adults will help us shorten the time between symptom onset and treatment. The promise here is the opportunity to keep kids on or near the life trajectory they would have had. In my year as president, I plan to work with our Council on Children, Adolescents, and Their Families to identify gaps for psychiatry that our organization can address so that adult and child psychiatrists are equipped to provide the best evidence-based care to patients at this critical juncture."

Everett also promised to make physician wellness and physician burnout a priority. "More than half of physicians in the United States report feeling at least one symptom of burnout, with emotional exhaustion topping the list," she said. "Most of us right here in this room have felt, at the very least, some degree of compassion fatigue and, at most, have experienced deep and pervasive episodes of burnout in our careers as psychiatrists. … We need to assure that employed physicians, and especially those in community mental health centers, have jobs that are generative, meaningful, and valued."

Richard Summers, M.D., psychiatry training director at the University of Pennsylvania, chairs a work group on physician burnout appointed by Everett. "By the end of the year, we hope to have tools and resources to share with all of you on this important issue," she said.

Everett closed by urging psychiatrists at the meeting to dream big. "Become what you aspired to be. You can make a difference, and I hope that in my term as president I can initiate a few things that enhance your professional lives, too. This is an exciting time for psychiatry, and I can't wait to see what we can accomplish together." **PN**

Rep. Tim Murphy Wins Javits Award

Rep. Tim Murphy (R-Pa.), who spearheaded the effort for mental health reform in Congress, was chosen to receive APA's 2017 Jacob K. Javits Award for Public Service. The award was presented by APA President Maria A. Oquendo, M.D., Ph.D., at the Opening Session.

Murphy, a clinical psychologist, was the author of the 2014 Helping Families in Mental Health Crisis Act. After two years of debate and compromise, the legislation was included in the bipartisan 21st Century Cures Act, signed into law by President Barack Obama last December. APA President Maria A. Oquendo, M.D., Ph.D., attended the signing.

The bill represents the first major mental health reform in decades. "It was a bruising battle," Murphy told the audience. "We didn't get everything we needed, but we need everything we got. This is our joint accomplishment. We know what mental illness does to an individual, a family, a community, and a nation. This is our time to make sure our nation addresses its most serious public health problems."

A commander in the Navy Reserve, Murphy is assigned to Walter Reed National Military Medical Center in Bethesda, Md., where he continues to practice psychology in the Traumatic Brain Injury/PTSD Inpatient Unit.

David Hathcox

Community, Spirituality Important in Recovery, Says Vargas

The tables were turned during APA's Annual Meeting when award-winning television journalist Elizabeth Vargas, who has interviewed world leaders, was interviewed about her anxiety and alcoholism by Nora Volkow, M.D., director of the National Institute on Drug Abuse and internationally renowned expert on addiction.

The conversation took place after Vargas delivered the 2017 William C. Menninger Memorial Lecture, in which she recounted her story of anxiety, addiction, and recovery (see below). "It's so important for us as clinicians and researchers to hear your story," Volkow said. "We know that alcoholism is a disease of the brain, but every story of addiction is different."

Volkow remarked on how prominent was the theme of stigma and shame in her story. "It's true," Vargas said. "I am sure if I had cancer, I would feel terribly upset about those missed parts of my children's lives, but I wouldn't feel that I had done something wrong. To know that addiction is a disease of the brain is one thing, but to really embrace it is something else."

When Volkow asked what psychiatrists should know about addiction and recovery, the journalist urged clinicians to pay attention to the value of community and spirituality in recovery. "It's so encouraging to simply know there is a place to go where people understand your addiction," she said. "As physicians, you know all about the brain and the body, but I think the role of community is so important too."

David Hathcox

From Depths of Addiction to Triumph of Recovery

ABC news anchor Elizabeth Vargas described the evolution of her alcoholism after a lifelong battle with anxiety during the William C. Menninger Memorial Award Lecture at APA's Annual Meeting. ***BY MARK MORAN***

Elizabeth Vargas, who delivered the 2017 William C. Menninger Memorial Award Lecture at APA's Annual Meeting last month, has traveled the world covering breaking news stories, reporting on in-depth investigations, and conducting interviews with high-profile newsmakers. She's been credited by *The New York Times* for reinvigorating the newsmagazine format with her "intellectually brave" reporting.

"But in the past two years, I have become known for something else," Vargas said. "I made headlines because I was forced to admit publicly that I am an alcoholic."

David Hathcox

Elizabeth Vargas says that the stigma associated with mental illness added to the burden of the shame that she carried.

The award-winning co-anchor of ABC's "20/20" with David Muir delivered a candid address, describing the evolution of her alcoholism and its roots in a gripping anxiety she has experienced since childhood. In September 2016, Vargas published the memoir *Between Breaths: A Memoir of Panic and Addiction*. The book details her struggles with anxiety and alcohol abuse and tells a powerful story of recovery and coping.

"My earliest memories are infused with anxiety," Vargas said. "I'm an Army brat, and my father was a lifetime Army officer. When I was 6, we were stationed in Japan when my dad went to Vietnam. That's when my anxiety moved in and took over my life.

"I began to have these panic attacks when I would cling to my mother's skirts shrieking for her not to leave me. My mother didn't know how to care for my anxiety, and I don't judge her for that. We weren't even paying attention then to soldiers returning from the war with PTSD, and we certainly weren't paying attention to their children."

She also learned how to hide her distress. Vargas recalled a neighbor being recruited to look after her when her pregnant mother was in the hospital. When Vargas had a panic attack, the neighbor asked her incredulously, "What in the world is the matter with you?"

"That's when I learned my panic and anxiety were shameful and were something I must hide," Vargas said. "I literally white-knuckled my way through childhood and adolescence. Through it all I kept my anxiety a secret. I didn't have a name for it. All I knew was that I seemed to be suffering in a way no one else was. I was singular in my struggle. That meant something must be wrong with me."

It was years later, on her first job as a local television anchor, that Vargas said she learned of the "powerful seduction" of a glass of wine.

"It had a profound effect on my anxiety," she said. "Suddenly the world seemed gentler. Those nightly glasses of wine became a routine for me. Over the decades I needed that wine to relax. By the time I made it to network, I was drinking wine every night. I needed that wine to ease my stress, and I failed to recognize its power."

Over time the drinking escalated—"the nightly glass of wine morphed into a bottle of wine," she said—and a familiar story ensued of alcoholic disintegration. "What I regret most about my disease was the life I missed out on, so many precious moments with my children," she said. "I loved my children more than the universe, but I couldn't stop drinking for them. When you are in the grip of this disease, you don't see it."

> "If my story can help reduce the stigma around addiction in even a small way, I will feel that I have contributed something."

In time she bottomed out and sought help. Recovery wasn't immediate—she would relapse and return to rehab—but today it has been years since she last had a drink.

Her presence at the rehab was leaked to the press, and Vargas's plight was made public. Though that publicity was unsought, Vargas said that the 2012 memoir was a coming-clean.

"The response to my story has been extraordinary," she said. "People have stopped me on the street to tell me I saved their life. I don't know if that is true—it sounds rather grandiose to me. But the relief that I felt in writing this book and coming clean was enormous. I do know that if I convinced one other person to get help who needs it, or to reach out and share their experience with someone, and if my story can help reduce the stigma around addiction in even a small way, I will feel that I have contributed something." **PN**

David Hathcox

Author Susannah Cahalan tells Annual Meeting attendees that her illness began with eccentric thoughts, such as an obsession with bedbugs, and progressed to erratic behavior.

Medicine Embodying Art and Science Credited For Author's Recovery

Asking the right questions eventually led doctors to the realization that Susannah Cahalan had anti-NMDA receptor encephalitis, a rare autoimmune condition that mimics the symptoms of psychosis and other mental disorders. **BY MARK MORAN**

"I know what it is like to lose your grip," author Susannah Cahalan said. "I have come back intact, and I hope I can share with you the perspective of a patient. I want to offer you a view from the inside of psychosis, hallucinations, and delusions."

The author of *Brain on Fire* spoke at the Opening Session of APA's 2017 Annual Meeting last month, in which she described her experience with anti-NMDA receptor encephalitis, a rare autoimmune condition that mimics the symptoms of psychosis and other mental disorders.

"At the most basic level," Cahalan said, "I hope I can make you aware of this diagnosis since the vast majority of patients with this disorder will see a psychiatrist before they see another physician."

Her story is harrowing. In 2009, Cahalan was living the life of an on-the-go young reporter for the *New York Post* when she fell—actually, "nosedived" might be a better word—into an illness that physicians could not readily identify, though it mimicked in some ways the symptoms of psychosis. After a month in the hospital and a dizzying array of tests that turned up nothing, neurologist Souhel Najjar, M.D. (who is chair of the Department of Neurology at Hofstra University), made the right diagnosis—anti-NMDA receptor encephalitis.

The disorder had been identified only in 2007. A December 7, 2008, report in *Lancet Neurology* by Josep Dalmau, M.D., and colleagues reported a case series of 100 patients with the disorder. They described it as "a severe form of encephalitis associated with antibodies against NR1–NR2 heteromers of NMDA." Patients who were treated rapidly with immunotherapy survived.

Cahalan told her story with a writer's flair and the verve of someone who had come back from a dark place that few have visited. Using videos of herself in the hospital and audio transcripts of conversations with her boyfriend (now husband) who witnessed her disintegration, Cahalan illustrated her descent into florid psychosis.

It began insidiously with odd, eccentric thoughts—an obsession with bedbugs—that progressed into more ominous delusions and erratic behavior (rifling through her boyfriend's possessions) and finally devolving while in the hospital to a state that mirrored catatonic psychosis.

A review in the *New York Times* of Cahalan's 2012 book said, *Brain on Fire* is at its most captivating when describing the torturous process of how doctors arrived at that diagnosis." When neurologist Najjar, who was familiar with the 2008 *Lancet Neurology* article, came to assess Cahalan, he asked her to draw a clock, she said. The image she drew—which she reproduced for the audience—showed a circle with all 12 numbers crowded into one quadrant. That and other clues suggested to the neurologist that she might have the rare autoimmune disorder described by Dalmau.

Najjar would provide the title to Cahalan's book when he told the author's anxious family, "Her brain is on fire. Her brain is under attack from her own body." After rapid treatment with immunotherapy, Cahalan recovered.

Though her baffling condition was bound to be uncovered by a neurologist, Cahalan said her story testifies to the value of clinical skills familiar to psychiatrists. "I believe my story is a triumph of clinical care," Cahalan said. "It highlights the science but also the art—the art of listening to patients and asking the right questions. Those are the tenets of any great physician." **PN**

AHCA

continued from page 4

- Prevent insurers from imposing annual and lifetime limits on coverage including for those who receive medical coverage from their employers.

Coalition members also said that any new health care bill should include the following provisions:

- Ensure currently insured individuals do not lose their coverage due to policymakers' action or inaction.

- Ensure uninterrupted coverage and benefits for the more than 20 million individuals and families covered in states that have expanded Medicaid or purchased qualified health plans from the exchanges. Also, ensure adequate federal funding to support Medicaid as currently available.

- Ensure that current subsidies are not eroded and that premium and cost-sharing subsidies are sufficient to make coverage affordable and accessible.

- Ensure children, adolescents, and adults with pre-existing conditions cannot be denied coverage, charged higher premiums, or subject to cancellation.

- Prohibit insurers from establishing annual and lifetime caps on benefits for children, adolescents, and adults and from charging higher premiums based on gender.

- Continue to ensure that all health plans provide evidence-based, essential benefits including coverage for physician and hospital services and prescriptions; mental health/substance use disorder treatment; primary care services; preventive services at no out-of-pocket cost to insured individuals, children, and families including contraception and other women's preventive services; and maternity care.

- Ensure that parity between medical/surgical benefits and mental health/substance use disorder benefits is maintained.

"It was a great opportunity for the leaders of the six medical associations to really let Republican senators in Medicaid expansion states understand the profound impact of the AHCA on their constituents," said Ariel Gonzalez, J.D., APA's chief of government affairs. "The potential loss of essential health benefits is very real." **PN**

APA members are urged to write their senators and ask them not to support the House version of the AHCA and instead craft a new bill. See box on page 3.

Kenneth Fung, M.D., Brings Culturally Sensitive Psychiatry To Toronto's Asian Community

Understanding the ways in which culture impacts the willingness to seek treatment supports prevention efforts and breaks down barriers to getting help. **BY MARK MORAN**

"Culture is everywhere," says psychiatrist Kenneth Fung, M.D.

For Fung, who is president-elect of the Society for the Study of Culture and Psychiatry, culture is key to a more thorough understanding of health and illness, of how people respond to being "sick" and of how clinicians approach recovery. He has brought a passion for the practice of cultural psychiatry to community activism, teaching, and clinical work.

In particular, Fung has sought to understand and challenge stigma about mental illness and treatment among the Asian communities of his hometown Toronto. He is a co-founder of the Asian Initiative in Mental Health Program (AIM) at the Toronto Western Hospital, which serves the local, underserved Cantonese- and Mandarin-speaking communities and is a training ground for medical students and residents interested in cross-cultural psychiatry.

Among other programs, AIM sponsors the Early Intervention in Psychosis Program, which is focused on members of the Chinese immigrant community in Toronto who experience a first episode of psychosis. In addition to his efforts to increase culturally competent mental health care through AIM, Fung provides psychiatric consultation and training for mental health care organizations for minorities.

> "When you are surrounded by your own culture, you don't see it—which means you can't see your own blind spots."

For his work with AIM, Fung was one of three winners of the 2016 APA Foundation Awards for Advancing Minority Mental Health announced at the annual benefit of the American Psychiatric Association Foundation at APA's 2016 Annual Meeting in Atlanta.

"Culture is all important in how people experience mental illness, and understanding the cultural barriers to seeking care among our immigrant populations is critical to addressing the inequities in access to care that exist in many North American communities," said Ranna Parekh, M.D., director of APA's Division of Diversity and Health Equity. "Kenneth Fung's work in the Asian communities of Toronto is exemplary of the kind of good work that can be done when psychiatry is culturally informed and culturally sensitive."

Cultural Perceptions Affect Care Seeking

As a Chinese Canadian who immigrated to Toronto at the age of 13, Fung has brought his personal experience to the understanding of culture, mental illness, and psychiatry.

"While I certainly experienced much less hardship than many immigrants, I did encounter personal experiences of racism, bullying, and difficulty with languages in school, and my parents struggled through acculturative challenges," he told *Psychiatric News*. "When I sometimes 'forgot' that I was a minority when focused on fitting in, there were intermittent jarring reminders in the way of insults and bullying—from taunts about my accent or my last name to 'Why don't you go back home?' "

Early in training, Fung became aware of how cross-cultural illiteracy could blind even the most exemplary physicians. "I became keenly aware that many otherwise excellent psychiatrists are oblivious to the importance of cultural differences," he said.

In 2000, he embarked on a fellowship in cultural psychiatry looking at alexithymia—the inability to express feelings—among Chinese Canadians.

"Sitting in a family doctor's office in Chinatown, I had the opportunity to chat with patients while they were filling in my research inventory," he recalled. "An elderly woman tearfully related to me her personal difficulties and depressive symptoms, while vowing to me that she would never burden her wonderful family doctor with these unimportant and irrelevant issues."

University of Toronto

Kenneth Fung, M.D., says that the stigma associated with mental illness causes many Asian individuals to avoid seeking care until they are very ill.

Fung said that such barriers to care arising from alternative cultural ideas, lack of mental health understanding, and stigma are very real in the Chinese community. Maria Chiu, Ph.D., and colleagues reported in the August 2, 2016, *Journal of Clinical Psychiatry* that after adjusting for sociodemographic characteristics, immigration, and discharge status, Chinese patients had greater odds of being involuntarily hospitalized and exhibiting severe aggressive behaviors than the general population.

"It is likely that cultural perceptions of mental illness among these different ethnic communities and the commensurate delay in seeking help resulted in greater illness severity at time of hospitalization," the researchers concluded.

Fung said, "We have known now for many years that among the immigrant Asian population, people are much less likely to get help in a timely way when they need it. They have vastly underutilized the mental health system in terms of their ratio to the overall population—not because they don't experience the same problems, but because they wait until the situation is an emergency."

Fung has devoted himself to a range of community activities aimed at decreasing stigma and improving access to care in immigrant communities. As clinical director at AIM, Fung oversees all clinical services and provides direct psychiatric consultations and treatment including outpatient psychotherapy and group therapy. He is also a psychiatric consultant to two other clinics serving Asian communities in Toronto.

As coordinator for the core curriculum for cultural psychiatry in the residency program at the University of Toronto, Fung aims to increase the level of cultural competence among the next generation of psychiatrists. And he has worked with local media to promote mental health awareness in the broader public; he helped create and co-chair "Mindfest," an annual academic-community collaboration and festival celebrating mental health and illness awareness, to be held for the fifth consecutive year this October.

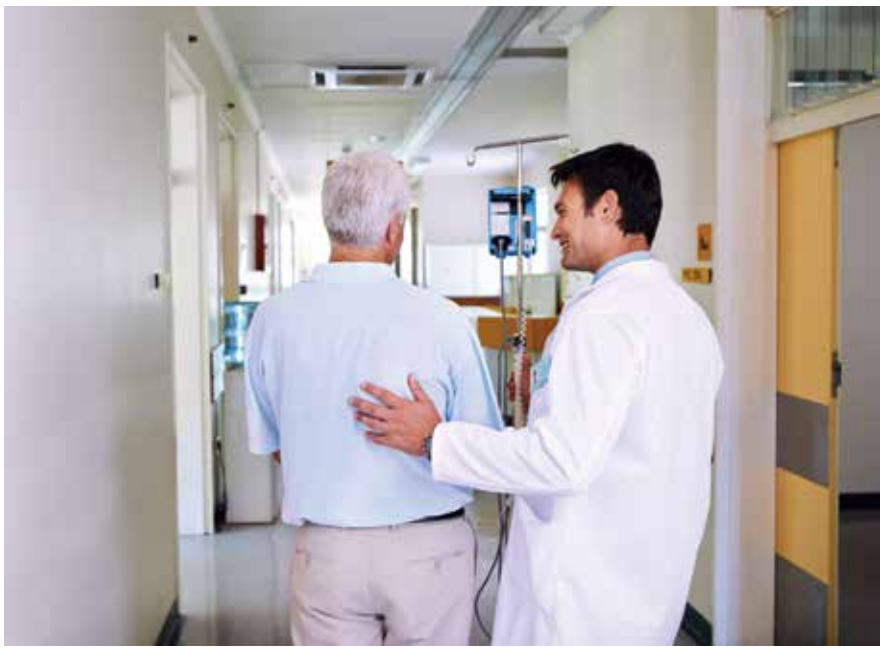
Fung is co-principal investigator for the Toronto site of "Strength in Unity: Men Speaking Out Against Stigma," an anti-stigma intervention project among Asian communities in Canada. The aim of the project, funded by the Movember Foundation, is to mobilize youth and men from Asian communities in Toronto, Calgary, and Vancouver to become community mental health ambassadors and to address the stigma of mental illness in their communities.

Strength in Unity grew out of a previous project, "CHAMP: Community Champions HIV/AIDS Advocates Mobilization Project," for which Fung was a co-principal investigator. The study engaged 66 ethno-racial leaders from the faith, media, and social justice sectors and people living with HIV in two stigma-reduction training programs: Acceptance Commitment Therapy Training and Social Justice Capacity Building. Participants were followed for a year, and data on changes in their attitudes and behaviors as well as their actual engagement in HIV prevention, support, and stigma reduction activities were collected.

CHAMP results showed that the interventions were effective in reducing HIV stigma and increasing participants' readiness to take action toward positive social change.

Culture, Fung knows, is the air we breathe—for good and for ill—and often just as invisible. "When you are surrounded by your own culture, you don't see it—which means you can't see your own blind spots," he said. "If we as psychiatrists don't pay attention to culture and its impact on our patients, we won't see our own blind spots when it comes to treating them." **PN**

"Ethnic Differences in Mental Illness Severity: A Population Study of Chinese and South Asian Patients in Ontario, Canada" is posted at http://www.psychiatrist.com/JCP/article/Pages/2016/v77n09/v77n0904.aspx.



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Opioid Epidemic Extends to Post-Surgical Patients

Experts estimate that as many as 2 million patients will transition to persistent opioid use following elective, outpatient surgery this year in the United States. **BY JOANN BLAKE**

Opioid use that persists past normal surgical healing time has become so prevalent in the United States that a study published April 12 in *JAMA Surgery* called this overuse "one of the most common complications of elective surgery."

The study, "New Persistent Opioid Use after Minor and Major Surgical Procedures in U.S. Adults," found higher-than-expected rates of opioid consumption that could translate into millions of new, long-term opioid users, among a large group of privately insured patients following minor and major surgical procedures.

Perioperative prescribing for acute care has received little attention until now, said lead author Chad M. Brummett, M.D., an associate professor at the University of Michigan School of Medicine and director of clinical research in the Department of Anesthesiology. "The data in this study are among the first to quantify the serious scope of this problem," he said.

Chad M. Brummett, M.D., says that patients likely continued using opioids for reasons other than for treating the intensity of surgical pain.

Brummett and colleagues used a nationwide insurance claims dataset from 2013 to 2014 to identify U.S. adults aged 18 to 64 with no history of opiate use in the 11 months prior to surgery. For patients filling a perioperative opioid prescription, researchers calculated the incidence of persistent opioid use for more than 90 days among "opioid-naïve" patients after minor surgical procedures (for example, varicose vein removal, carpal tunnel surgery, and laparoscopic appendectomy) and major surgical procedures (examples: bariatric surgery, hysterectomy, and ventral incisional hernia repair).

"Persistent use" is defined as filling an opioid prescription, such as hydrocodone or oxycodone, between 90 and 180 days after surgery. This definition represents the time a normal surgical recovery would be expected from the procedures selected and is more conservative than the three-month definition of long-term postsurgical pain by the International Association for the Study of Pain, according to the study.

The final study group consisted of 36,177 patients, with 29,068 (80 percent) receiving minor surgical procedures and 7,109 receiving major procedures. The study group had a mean age of 44.6 years and was predominately female (29,913, or 66 percent) and white (26,091, or 72 percent).

The rates of new persistent opioid use were similar between the two surgery groups, ranging from 5.9 percent to 6.5 percent. The incidence in the nonoperative control group was only 0.4 percent. Risk factors associated with new persistent opioid use included preoperative tobacco use, alcohol and substance use disorders, anxiety, depression, and preoperative pain disorders.

"This study has important implications for psychiatrists because most of the risk factors [for opioid overuse] are psychiatric disorders," said Andrew J. Saxon, M.D., a professor and director of the Addiction Psychiatry Residency Program at the University of Washington and director for the Center of Excellence in Substance Abuse and Treatment at the Veterans Administration Puget Sound Health Care System.

"Psychiatrists should be attentive to the risk history of their patients undergoing surgery," he advised. Some patients are at a higher risk of addiction and introducing them to opioids can be like "setting a match to a powder keg," he said.

Although the added sedation from opioids generally does not cause adverse interactions with psychiatric medications, physicians should be extra vigilant regarding patients taking benzodiazepines because of the risk of respiratory depression and other complications when combined with opioids, he said.

Saxon suggested that physicians follow the basic advisory on acute use of opioids contained in the "CDC Guidelines for Prescribing Opioids for Chronic Pain—United States, 2016," issued March 18: "Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed."

A surprising finding in the study involved patients who received an opioid prescription from their doctors in the 30 days before surgery. The odds for these patients of persistent opioid use after surgery were almost twice as high, even after adjusting for variables.

Given that more than 50 million ambulatory surgical procedures are performed in the United States annually, the findings of the study suggest that more than 2 million people may transition to persistent opioid use following elective, outpatient surgery each year, said Brummett. Patients on Medicaid and the uninsured, groups that have shown high rates of opioid use, were not included in this research, but will be studied by this research group in the future, he said.

The multilevel, multivariate logistic regression model with data from U.S. Census Bureau geographic regions examined differences in persistent opioid use between surgical types while controlling for patient characteristics including age, sex, race and ethnicity, education, history of tobacco use, mental health disorders, and pain disorders. Regional variation was found, with higher rates of new persistent opioid use in the East South Central and West South Central United States.

Prolonged opioid use following surgery may not be a consequence of poorly controlled pain, according to researchers. The pain experienced after major procedures would be expected to be greater than for minor procedures, which could more likely result in continued opioid use for long periods. However, that was not the case. The study found that new persistent opioid use did not differ much between major and minor procedures.

Patients likely continued using opioids for reasons other than for treating the intensity of surgical pain, the study concluded. While overestimating the safety of this prescribed medication, patients may use an opioid medication for other purposes such as back and neck pain, headache, osteoarthritis, and insomnia or may use the drug to treat emotional pain and distress.

The study was funded by the Michigan Department of Health and Human Services and the Agency for Health Care Research and Quality. **PN**

An abstract of "New Persistent Opioid Use after Minor and Major Surgical Procedures in U.S. Adults" is posted at http://jamanetwork.com/journals/jamasurgery/fullarticle/2618383.

Catherine P. Bradshaw, Ph.D., M.Ed., says the findings suggest that "strategies, policies, and increased awareness can make an impact. We need to keep our efforts going and not take our foot off the gas."

10-Year Study Suggests Progress on Bullying

The number of students in Maryland schools reporting bullying in the past month fell more than 15 percent between 2005 and 2014. **BY JOANN BLAKE**

Bullying in U.S. schools appears to be trending downward, according to a report in the June issue of *Pediatrics*. The study, which analyzed reports of bullying in Maryland schools over a 10-year period, showed a striking drop in the numbers of students who reported experiencing bullying in the past month, from a high of 28.5 percent in 2005 to 13.4 percent in 2014.

The authors noted that very few other studies have followed bullying over multiple years, and virtually none of the large, population-based research has included longitudinal data across 13 indicators of bullying behaviors.

The research team was led by Tracy Evian Waasdorp, Ph.D., M.Ed., a research scientist at the Children's Hospital of Philadelphia and the Johns Hopkins Bloomberg School of Public Health. The group gathered reports about bullying from anonymous online surveys of 246,306 students in grades 4 through 12 from 109 Maryland schools within a large public school district. Survey questions included whether the students had experienced bullying in the past month, and if so, the type of bullying experienced; whether they had seen others bullied; and how safe they felt at school. Bullying indicators included such behaviors as physical pushing and hitting to verbal threats and rumors; the survey also asked about perpetrating bullying, witnessing bullying, and retaliating aggressively.

Using longitudinal linear modeling to analyze changes over time, the researchers found that while bullying remains prevalent in schools, 10 of the 13 bullying-related indicators measured suggested positive improvements. Physical, verbal, and relational (having rumors spread) bullying experiences decreased 2 percent each year to below 10 percent in 2014.

The study also found that the number of students who believe adults "do enough to stop" bullying is growing (38.8 percent expressed this opinion in 2005 compared with 71.3 in 2014). More students also reported they feel safe at school (78.6 percent in 2005 compared with 88.5 percent in 2014).

"Rather than being in a crisis mode, the set of indicators is moving in a positive direction," said study co-author Catherine P. Bradshaw, Ph.D., M.Ed., a professor and associate dean for Research and Faculty Development at the University of Virginia. The findings suggest that "strategies, policies, and increased awareness can make an impact. We need to keep our efforts going and not take our foot off the gas."

Bullying Prevalence Rates Vary

Tackling bullying remains a top priority for mental health professionals to improve child well-being. There is still a large bullying problem, "and the complexity and impact of bullying may be hard to judge from only examining prevalence rates," Stephen S. Leff, Ph.D., and Chris Feudtner, M.D., Ph.D., M.P.H., of the Children's Hospital of Philadelphia wrote in a related editorial.

Estimates of bullying and cyberbullying prevalence reported by national surveys tend to vary. According to the latest report by the National Center for Education Statistics, bullying fell to 22 percent in 2013, down from 28 percent in 2011. Moreover, the bullying rate had hovered close to 30 percent in 2005 and rose to 32 percent in 2007.

The lack of a uniform definition of bullying has hindered the ability to understand the true magnitude, scope, and impact of bullying and track trends over time, according to the Centers for Medicare and Medicaid Services. Unlike several other studies on bullying, Waasdorp and colleagues used the World Health Organization and CDC's definition of bullying as follows: "A person is bullied when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more persons. Bullying often occurs in situations where this is a power or status difference. Bullying includes actions such as making threats, spreading rumors, attacking someone physically and verbally, and excluding someone from a group on purpose."

Waasdorp and colleagues were surprised to find that cyberbullying (via email and blogs) fell from 6 percent in 2005 to 3.6 percent in 2014. However, the authors noted that because social media platforms have changed so much since 2005, broader definitions of cyberbullying are needed.

The variation in study results also may be attributed to different definitions and measurements, said Bradshaw. She noted that in this study, students were asked if they had been bullied or been the perpetrator within the past 30 days (not if they had ever been bullied) and were asked to report on a large number of indicators (13). The study did not separate out and calculate rates for vulnerable youth groups such as lesbian, gay, bisexual, and transgender, she said.

Schools Have More Work to Do

Stuart W. Twemlow, M.D., a psychiatrist and former professor of psychiatry and behavioral sciences in the Menninger Department of Psychiatry at Baylor University College of Medicine, expressed skepticism that the results of the *Pediatrics* study suggest any significant shifts in bullying, except for parental awareness. "Adults now know more about the serious effects of bullying, and they've become protective of their children," said Twemlow, who co-wrote with John Sacco, Ph.D., *Why School Antibullying Programs Don't Work* and *Preventing Bullying and School Violence*.

Twemlow said he believes the prevalence of bullying has remained at about 30 percent in most elementary schools, while there may be a decrease in more "refined" forms of bullying in high school that occur during activities such as sports and debate.

Educational programs don't work unless the whole school becomes involved, he said. Bullying that has just occurred must be handled in an appropriate way, which is to "go to the source"—those involved in the incidents including the bully, the victim, and the audience, said Twemlow. School authorities should refrain from picking out the bully and victimizing him or her publicly, which could worsen the situation, he said. There is emerging research that some widely used approaches such as "zero tolerance" policies are not effective against bullying and should be discontinued, according to a 2016 report on bullying from the National Academies of Science, Policy, and Practice.

The current political climate may also influence bullying behavior among children and teens in years to come, Twemlow said.

Bradshaw agreed. "It's a moving target. Who knows how today's events will affect bullying? Maybe we will see a change. But right now, this is a positive story."

The research was supported in part by grants from the U.S. Department of Education, the William T. Grant Foundation, and the National Institute of Justice. **PN**

"10-Year Trends in Bullying and Related Attitudes Among 4th- to 12th-Graders" is posted at http://pediatrics.aappublications.org/content/early/2017/04/27/peds.2016-2615. The editorial "Tackling Bullying: Grounds for Encouragement and Sustained Focus" is posted at http://pediatrics.aappublications.org/content/early/2017/04/27/peds.2017-0504.

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Patients Taking Psychotropic Medications Found to Be At Elevated Risk of Fractures

A population-based study finds that a widely used fracture assessment tool may dramatically underestimate risk in people who take SSRIs, antipsychotics, and benzodiazepines. ***BY NICK ZAGORSKI***

Clinicians typically avoid prescribing psychiatric medications that increase risk of dizziness or disorientation to people at high risk of bone fractures. A study published April 19 in *JAMA Psychiatry* suggests the risks of fractures among adults taking psychotropic medications may be broader and more significant than was previously appreciated.

The researchers analyzed data on more than 65,000 adults in Manitoba, Canada, who had received a bone mineral density (BMD) scan. They found that the risk of a major osteoporotic fracture (MOF) was 1.43-fold higher in people taking selective serotonin reuptake inhibitors (SSRIs), 1.43-fold higher among people taking antipsychotics, and 1.15-fold higher among people taking benzodiazepines compared with people not taking these medications. Included MOFs were hip fractures, arm fractures, and vertebrae fractures.

When looking only at hip fractures, one of the most common causes of debility among seniors, the risks were higher still: 1.48-fold higher for SSRIs, 2.14-fold higher for antipsychotics, and 1.24-fold higher for benzodiazepines.

Lead study author James Bolton, M.D., an assistant professor of psychiatry at the University of Manitoba, told *Psychiatric News* that these results have clinical implications for both primary care and mental health providers.

"First, for general practitioners and other primary physicians, it's important to recognize that these medications are associated with a significant risk of fracture, one that is not considered in the standard FRAX assessment," he said. FRAX is a widely implemented evaluation tool that combines BMD scan data with other clinical assessments to measure a patient's 10-year probability of having a bone fracture.

In fact, Bolton and colleagues quantified the degree that FRAX underestimated risk in people taking psychotropic medication by comparing the actual MOF outcomes in their study sample with the expected number based on average FRAX scores. They found that FRAX underestimated fracture risk by 36 percent among SSRI users, 60 percent among antipsychotic users, and 13 percent among benzodiazepine users.

"As for psychiatrists like myself, the data do suggest that a more refined approach to prescribing may be worthwhile for older adults, especially patients who have an elevated osteoporosis risk such as women," Bolton said. (About 90 percent of the people in the FRAX study were women.)

When treating depression in older adults, for example, Bolton noted that tricyclic antidepressants did not increase fracture risk in adults, while other antidepressant classes increased overall MOF risks, but not the risk of hip fracture. Likewise, lithium was not associated with any fracture risk, while other mood stabilizers increased MOF risk, but not hip fracture risk.

Because of the way the study was designed, however, Bolton could not consider the mechanisms that underlie this increased fracture risk, which he said he believes is the next important question to ask. One plausible explanation is that these elevated risks reflect an increased rate of falls due to the side effects of psychotropic medication. However, some of the study findings seem to point to other explanations such as a direct effect of psychotropic medications on bone strength and density. For example, there was no association between fracture risk and age for any of the medications, and older age is associated with an increased risk for falls.

This study made use of the Manitoba Bone Density Program database and included adults aged 40 and older who received a bone scan between January 1, 1996, and March 28, 2013. The study cohort included 62,275 women and 6,455 men; of this group, 12,982 had a diagnosis of a mental disorder, 11,938 were using psychotropic medication, and 2,468 were taking multiple psychotropics.

The Manitoba Centre for Health Policy at the University of Manitoba supported this study. **PN**

An abstract of "Association of Mental Disorders and Related Medication Use With Risk for Major Osteoporotic Fractures" is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2618262.

PSYCHIATRY & INTEGRATED CARE

New York State's Path to Behavioral Health Integration

BY JAY CARRUTHERS, M.D., AND LLOYD SEDERER, M.D.

Under the leadership of Drs. Lloyd Sederer and Jay Carruthers, New York state has created a robust, large-scale implementation of evidence-based integrated care. In this month's column, they identify factors that were critical for the program's success and challenges they anticipate in the future.

—Jürgen Unützer, M.D., M.P.H.

Jay Carruthers, M.D., is a psychiatrist working for the New York State Office of Mental Health, where he leads behavioral health integration and the Suicide Prevention Office. He is also an assistant professor of psychiatry at Albany Medical College. Lloyd I. Sederer, M.D., is chief medical officer of the New York State Office of Mental Health, an adjunct professor at the Columbia University Mailman School of Public Health, the medical editor for mental health at *The Huffington Post*, and a contributing writer to *U.S. News and World Report*. 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."

There is saying in Spanish that roughly translates to "the path is made by walking it." This certainly holds true for New York state's effort to implement behavioral health integration (BHI) into primary care—specifically the Collaborative Care Model (CoCM).

Despite compelling evidence (more than 80 randomized, controlled trials showing CoCM to be significantly more effective than treatment as usual), despite the widely acknowledged gaps in access to behavioral health services, and despite the fact that most patients prefer to receive services in a primary care setting rather than a behavioral health specialty setting, very few primary care sites were practicing CoCM in New York state (NYS) as recently as five years ago.

That changed when the NYS Office of Mental Health, in partnership with the NYS Department of Health, began the largest state-based program in the nation to fully integrate behavioral health detection and treatment into primary care settings.

The New York State Experience

The NYS BHI "walk" has had two phases. Phase I began as part of the Centers for Medicare and Medicaid Services (CMS) Hospital Medical Home Demonstration Project grant. Funded with graduate medical education monies, the portion of the grant led by the NYS Office of Mental Health was a 2.5-year implementation of CoCM for depression in 19 academic medical centers, with 32 participating primary care training sites. Our success demonstrating feasibility and clinical outcomes resulted in

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Six-Question Screen for ADHD Developed for Adults

This rapid assessment tool builds on the previously developed World Health Organization Adult ADHD Self-Report Scale and reflects DSM-5 diagnostic criteria. **BY NICK ZAGORSKI**

Making use of an advanced machine-learning algorithm, a team of physicians and researchers has developed a *DSM-5*-based tool to screen adults for attention-deficit/hyperactivity disorder (ADHD).

The screen consists of just six questions, each with a numbered scale of severity (see box). It is intended to offer health care providers a rapid, easily scored, and accurate diagnostic screen that can be used to refer someone for a more thorough evaluation.

"We hope that this tool will do for ADHD screening what the PHQ [Patient Health Questionnaire] has done for depression screening of adults in primary care settings," said study co-investigator Lenard Adler, M.D., a professor of psychiatry and child and adolescent psychiatry at NYU Langone Medical Center.

Adler and his colleagues used the *DSM-IV*-based World Health Organization Adult ADHD Self-Report Scale (ASRS) as the template. The ASRS includes structured questions pertaining to each of the inattention and hyperactivity-impulsivity symptoms plus 11 questions related to problems in executive function that are associated with adult ADHD.

Ronald Kessler, Ph.D., the McNeil Family Professor of Health Care Policy at Harvard Medical School, told *Psychiatric News* that updating the ASRS to comply with *DSM-5* was not difficult; ADHD's core symptoms were not changed in *DSM-5*, just the number needed to qualify for a diagnosis (down to five from six) and the age of onset (now 12 years of age instead of 7).

The team analyzed data from hundreds of people who had taken the ASRS and then underwent a clinical interview to confirm an ADHD diagnosis.

The samples used included two distinct groups: one consisting of 327 participants from the general community (in which ADHD prevalence is low) and one consisting of 300 people who attended NYU Langone's ADHD program (in which prevalence is much higher).

Adler said that including the Langone sample was important since it represents people whom primary care providers are most likely to encounter—adults who think they might have ADHD.

As for including a general population sample, Kessler said that the screen could also be used in workplace settings as part of a wellness program. Doing so might provide data demonstrating how undiagnosed ADHD affects productivity, which might encourage employers to invest in mental health services.

The screen has four questions that pertain to core ADHD symptoms and two that relate to deficits in executive function. The scale ranges from 0-24 points, with 14 or higher considered the most accurate cutoff for possible ADHD.

The *DSM-5* ASRS performed well in both general and clinical populations, identifying more than 91 percent of true ADHD positives in each group. However, in the clinical sample, the test had a higher false positive rate than in the general sample—26 percent versus 4 percent. This was expected since the Langone group had more people with subclinical inattentive and/or hyperactive traits.

Timothy Bilkey, M.D., an Ontario psychiatrist who specializes in diagnosing and managing adults with ADHD, thinks that this screen will be valuable in identifying people for a fuller clinical evaluation.

"These are much like the questions I would ask in the first few minutes of a clinical interview to distinguish ADHD from symptoms that are related to a mood disorder or a substance use problem," he told *Psychiatric News*.

One item not captured, though, was memory issues. "I call it PDF—procrastination, distractibility, and forgetfulness. These are three problems that need to be established in both adulthood and childhood" for a diagnosis of ADHD.

"Another concern is that this scale will most likely capture people already aware that they might have a problem," Bilkey added. "But many adults have managed to get by with ADHD for years or decades and can be somewhat oblivious." That's why Bilkey encourages clinicians to take a collateral history of a patient with family or friends to confirm the severity of problems.

The *DSM-5* ASRS Screening Scale was developed with support from Shire Pharmaceuticals. The details were published in the May 1 *JAMA Psychiatry*. **PN**

"The World Health Organization Adult Attention-Deficit/Hyperactivity Disorder Self-Report Screening Scale for *DSM-5*" is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2616166. The accompanying editorial, "Good News for Screening for Adult Attention-Deficit/Hyperactivity Disorder," is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2616165.

DSM-5 Adult ADHD Self-Report Scale

- How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly? (*DSM-5* A1c, scored 0-5)
- How often do you leave your seat in meetings or other situations in which you are expected to remain seated? (*DSM-5* A2b, scored 0-5)
- How often do you have difficulty unwinding and relaxing when you have time to yourself? (*DSM-5* A2d, scored 0-5)
- When you're in a conversation, how often do you find yourself finishing the sentences of people you are talking to before they finish them themselves? (*DSM-5* A2g, scored 0-2)
- How often do you put things off until the last minute? (Non-*DSM*, scored 0-4)
- How often do you depend on others to keep your life in order and attend to details? (Non-*DSM*, scored 0-3)

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legislative funding for Phase II of the initiative, a Medicaid supplemental monthly payment for CoCM to further scale up the work heretofore done.

We see our success as a product of two forces: (1) unrelenting attention to performance measurement and (2) achieving sustainable financing beyond the grant.

In Phase I, we demonstrated that 84 percent of participating clinics could achieve fidelity to six significant measures of clinical performance. Moreover, depression improvement scores for approximately 6,000 participating patients improved from 14 percent to 46 percent of those diagnosed and delivered integrated primary care treatment.

When the grant expired in December 2014, the Office of Mental Health began Phase II, which we call the NYS Medicaid Collaborative Care Program. Securing what is a unique, state-funded monthly Medicaid case rate for CoCM was essential. The program now has 74 participating sites, including many Phase I grant participants, and extends beyond academic medical center sites to cover Federally Qualified Health Centers and Independent Provider Association sites. Signs of additional payer support from Medicare and commercial plans seem to be adding momentum.

Meaningful Outcomes

Attention to performance measurement has been a mainstay of the NYS BHI initiative, seeking the right balance between structure, process, and outcome measures. For Phase I, early emphasis was on structural and process measures, like behavioral health care manager training, a patient registry, and screening yield rates. Sites were held to strict reporting requirements. When they demonstrated greater implementation proficiency, our emphasis shifted to patient engagement and outcomes: *Are patients getting better? If not, are their cases being reviewed, with associated changes in the treatment plan?*

In Phase II, first-year data sustain the proof of the gains we had made. The Average Clinical Improvement Rate (defined as the percent of patients receiving depression care whose PHQ-9 score was reduced by 50 percent or dropped below 10 after enrollment for 12 weeks) now exceeds 50 percent, consistent with CoCM clinical trials demonstrating efficacy over usual community care. Among patients not improving, we have seen critical increases in engagement (as measured by a greater number of changes in treatment plans and case reviews by a psychiatrist, a hallmark of an effective CoCM program).

Looking Ahead

Our path ahead for BHI and the CoCM in NYS will continue to challenge practices, payers, and regulators. Because over 40 percent of all NYS practices have five primary care doctors or fewer, and hiring a FTE behavioral health specialist and finding a consulting psychiatrist is generally out of reach, we see this as a major barrier to statewide implementation. Innovative models that share care manager resources and leverage technology, like telephonic outreach and telepsychiatry, will be essential. Finally, in the rush to value-based purchasing in health care, we will have to ensure incentivizing rigorous forms of BHI, such as CoCM, which work and in which measurement-based care is the norm. **PN**

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Medicated ADHD Patients Have Reduced Risk of Motor Vehicle Crashes

Researchers estimate that 1 in 5 of vehicle accidents involving people with ADHD could have been avoided if they had been on the proper medication. **BY HARRIET EDLESON**

Medication for attention-deficit/hyperactivity disorder (ADHD) may help to lower the risk of motor vehicle crashes among patients with ADHD, a study published May 10 in *JAMA Psychiatry* suggests.

In a national sample of 2.3 million patients with ADHD in the United States, those who took ADHD medication were significantly less likely to be involved in crashes.

Motor vehicle crashes are a major public health problem, and research has shown that individuals with ADHD are more likely than others to experience these accidents. The purpose of the study was to explore the association between ADHD medication use and the risk of motor vehicle crashes in a large cohort of patients with the disorder.

Zheng Chang, Ph.D., and colleagues in the Department of Medical Epidemiology and Biostatistics at Karolinska Institutet in Stockholm, Sweden, used data from the Truven Health Analytics MarketScan Commercial Claims and Encounters database to identify people aged 18 and older who had an ADHD diagnosis or had received ADHD medication between January 2005 and the end of December 2014. Patients were tracked from first inpatient or outpatient diagnosis or filled prescription until first disenrollment (zero days of medical or drug coverage in a month) or December 31, 2014, whichever came first. The number of emergency department visits for motor vehicle crashes for these patients was compared with that of non-ADHD controls.

The study cohort consisted of 2,319,450 patients diagnosed with ADHD; the mean age was 32.5 years, and 51.7 percent were female.

During follow-up, 1,946,198 patients (83.9 percent) received at least one prescription for an ADHD medication. A total of 11,224 patients (0.5 percent) had at least one emergency department visit for a motor vehicle crash. Patients with ADHD had a significantly higher risk of a motor vehicle crash than matched controls (odds ratio [OR]=1.49 for men and OR=1.44 for women). Untreated patients with ADHD had the highest risk of a motor vehicle crash compared with medicated patients with ADHD and controls.

Chang and colleagues also compared the risk of motor vehicle crashes in individual patients during months when they were medicated and not medicated. Male patients had a 38 percent lower risk of crashes when taking ADHD mediation compared with months not receiving the medication, while female patients had a 42 percent lower risk. Similar decreases existed in all age groups.

ADHD medication use was associated with a 34 percent lower risk of accidents two years later in male patients with ADHD and a 27 percent lower risk in female patients with ADHD.

The findings suggested that up to 22.1 percent of the crashes involving ADHD patients could have been prevented if they had been taking medication.

"These findings call attention to a prevalent and preventable cause of mortality and morbidity among patients with ADHD," wrote the researchers. "If replicated, our results should be considered along with other potential benefits and harms associated with ADHD medication use."

The study is the first to "demonstrate a long-term association between receiving ADHD medication and decreased motor vehicle crashes," the authors wrote. "If this result indeed reflects a protective effect, it is possible that sustained ADHD medication use might lead to lower risk of comorbid problems ... or contribute to long-term improvements in life functioning."

"Clinicians should not presume that all ADHD medications at any dosage will be effective for every patient," Vishal Madaan, M.D., and Daniel J. Cox, Ph.D., wrote in an accompanying commentary. They are in the Department of Psychiatry and Neurobehavioral Sciences in the University of Virginia Health System. "Health care professionals should ensure that both the medication and dosage are optimal for a particular patient-driver, that the medication coverage is adequate for the particular patient's driving routine, and that the medication prescribed is not responsible for worse driving as its effects wear off (rebound effect)."

In addition to asking patients about school and work performance, clinicians should ask about symptoms "suggestive of distracted driving" such as repeated speeding tickets, missing traffic signs, swerving and switching lanes haphazardly, road rage, and consistently fiddling with the radio, Madaan told *Psychiatric News*.

He also advised that if a patient is taking an ADHD medication that works well, clinicians should ensure that it lasts long enough to cover times when the patient may be driving. **PN**

"Association Between Medication Use for Attention-Deficit/Hyperactivity Disorder and Risk of Motor Vehicle Crashes" is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2626505. "Distracted Driving With Attention-Deficit/Hyperactivity Disorder" is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2626500.

First Genetic Variant Identified For Anorexia Nervosa

A genomewide analysis of thousands of samples also identifies several links between anorexia and metabolic traits such as obesity, cholesterol levels, and insulin resistance. **BY NICK ZAGORSKI**

An international research consortium has uncovered the first genetic variant associated with anorexia nervosa, a serious and potentially lethal eating disorder that affects around 1 percent of the population. The identified variant, known as rs4622308, is found on chromosome 12 and has been previously linked with both type 1 diabetes and rheumatoid arthritis.

This groundbreaking study was published May 12 in *AJP in Advance*.

Study co-author Cynthia Bulik, Ph.D., Distinguished Professor of Eating Disorders at the University of North Carolina School of Medicine, told *Psychiatric News* that the findings of this genomewide analysis go beyond one single variant.

"Our foot is on the accelerator now," she said. "Once we find one genetic locus, it puts us on a trajectory to find many more."

Bulik explained that methodologically, the researchers have a handle on how big a sample size they need to uncover similar variants. This study analyzed genomes of 3,495 anorexia nervosa cases and 10,982 controls, and 13,000 additional anorexia samples are queued up for the next round.

In addition, with some potential genes identified, the researchers can also do more targeted studies. This rs4622308 variant overlapped six genes, and six other genes were close enough to potentially be affected by the variant.

What really intrigued the team, however, was the genetic correlations they uncovered between anorexia and other medical and psychosocial traits. They found a strong association among anorexia, neuroticism, and schizophrenia, which reinforces many clinical and epidemiological observations showing these traits co-occurring.

Also, there were several genetic correlations with metabolic parameters; people with anorexia tended to have more favorable variants associated with cholesterol levels, while far fewer variants associated with obesity or insulin resistance.

"For the longest time, anorexia has been seen as a purely psychiatric illness," Bulik said. "These findings should make us reconsider."

Bulik noted that she has frequently

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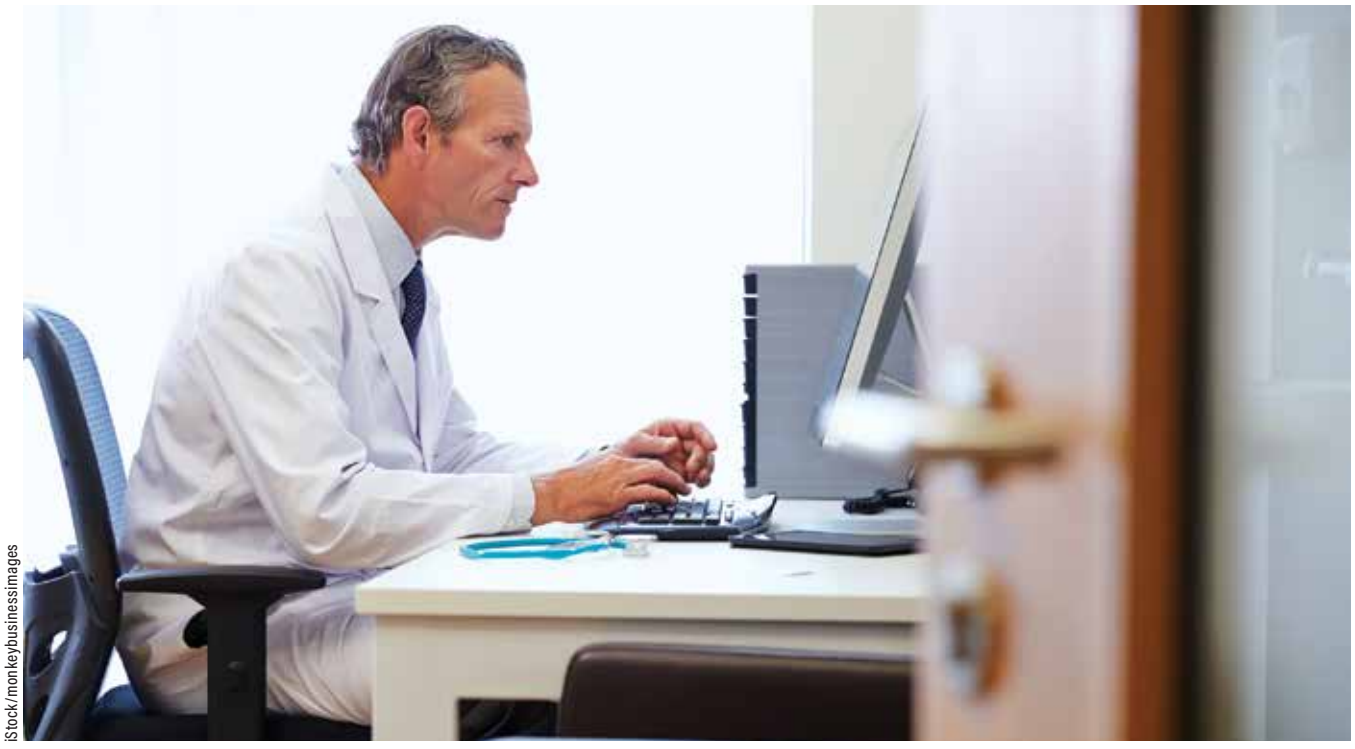

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Restrictions on Pharma Detailing Said To Impact Prescribing Patterns

Within a couple of years of policies going into effect, prescribing for drugs that were heavily marketed by detailing declined by 8.7 percent, while prescribing for nondetailed drugs increased by 5.6 percent. **BY JUN YAN, PHARM.D.**

During the past decade, more medical schools and academic medical centers have adopted policies to restrict the traditional marketing tactics employed by the pharmaceutical industry. Such practices—known as "pharmaceutical detailing"—include visits by sales representatives, who hand out gifts to doctors, buy lunch for medical students, and talk about a company's new FDA-approved drug.

When academic medical centers establish policies to ban or limit detailing to physicians, the heavily marketed drugs are prescribed less, a large study published May 2 in *JAMA* shows.

This study, led by Ian Larkin, Ph.D., at the University of California, Los Angeles, looked at the prescribing patterns between 2006 and 2012 of over 2,000 physicians at 19 academic medical centers in five states (California, Illinois, Massachusetts, Pennsylvania, and New York) before and after each center implemented conflict-of-interest policies. These policies included prohibiting or putting caps on meals and gifts to physicians and restricting salespersons' access to patient-care facilities.

To isolate the effect of the conflict-of-interest policies from many other forces that can influence prescribing behaviors, the researchers compared the physicians at the academic medical centers with more than 24,000 physicians in the same geographic area who had similar prescribing habits and were of the same age and specialty, but did not work in an environment with such restrictions.

In the one- to three-year period after the implementation of the academic medical center policies, prescribing for drugs that were heavily marketed by detailing declined by 8.7 percent, while prescribing for nondetailed drugs increased by 5.6 percent. Generic drugs accounted for over 95 percent of the nondetailed drugs.

Eleven of the 19 centers not only restricted gifts to physicians and salesperson access, but also set up mechanisms to penalize physicians and salespersons that violate their policies. At these centers, the change in prescribing patterns was more profound than centers that did not have enforcement mechanisms, the study showed.

The largest decrease of brand name drugs being marketed after the policies occurred in several types of new drugs: sleep aid drugs, drugs for gastroesophageal reflux disease, drugs for attention-deficit/hyperactivity disorder, antidepressants, antihypertensives, and lipid-lowering drugs.

The results of the study complement those of other similar studies, reported the authors. "Future research should examine the relationship between the content of academic medical center detailing policies and the prescribing patterns of physicians, especially because such policies are increasingly being adopted by private medical practices," they concluded.

"The study by Larkin et al. suggests that the policies physicians and clinical organizations adopt may influence prescribing, which may reduce patients' out-of-pocket costs," Colette DeJong, B.A., and R. Adams Dudley, M.D., M.B.A., wrote in a related editorial. "However, restricting interaction between physicians and the pharmaceutical industry without replacing the education about novel drugs that it offers also has possible risks."

DeJong and Dudley outlined the potential benefits of pharmaceutical detailing before proposing several strategies for addressing conflicts of interest (COIs) related to industry marketing, including the development of an alternative method of drug education.

"There are feasible alternatives to industry detailing for keeping physicians informed about drugs, but those approaches are largely untested in the United States. It has never been more important for physicians to come together to consider these alternatives, generate evidence about their effectiveness, and move the health care system toward solutions that lower costs for patients and minimize COIs," they concluded.

Since 2007, the American Medical Student Association (AMSA) has been collecting information on conflict-of-interest policies at U.S. medical schools and publishing their evaluation of these policies in a scorecard (http://amsascorecard.org/). The rating system considers many potential conflicts of interest, such as gifts, meals, promotional activities, and financial disclosure requirements.

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

"Association Between Academic Medical Center Pharmaceutical Detailing Policies and Physician Prescribing" is posted at http://jamanetwork.com/journals/jama/fullarticle/2623607. The related editorial "Reconsidering Physician-Pharmaceutical Industry Relationships" is posted at http://jamanetwork.com/journals/jama/fullarticle/2623589.

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been asked whether anorexia is the opposite of obesity, and her answer until now had been no. "I had always believed constitutional fitness, the ability to eat and not gain weight, was the comparable bookend to obesity. But I think I might be wrong, especially given the strong genetic correlation between anorexia and BMI."

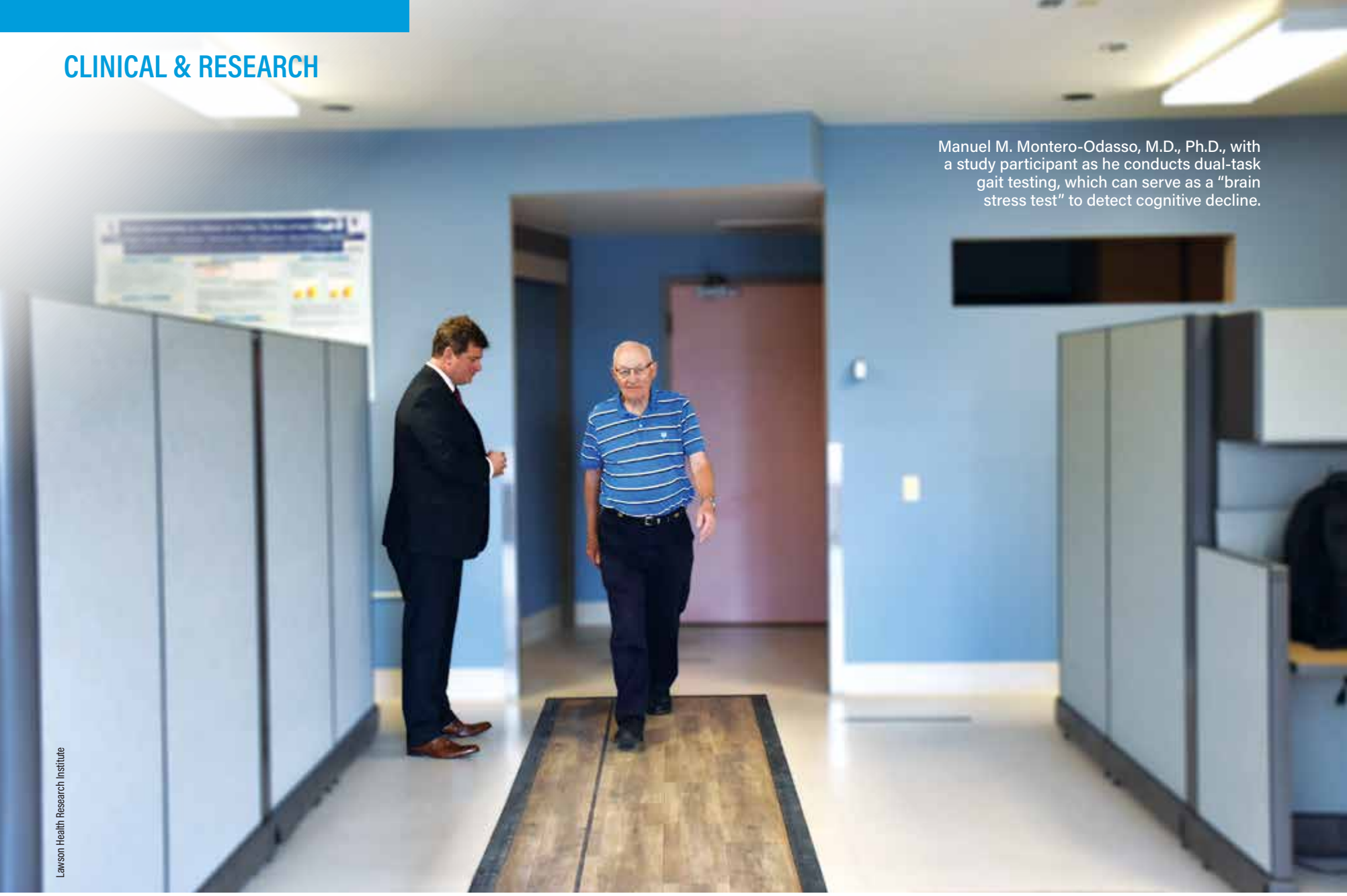
As highlighted in the article, Bulik thinks that these correlations might explain the similarities seen in people with morbid obesity or anorexia undergoing treatment. While controlled dietary interventions can bring people back to normal weights, patients quickly revert to their high or low weights once the programs end.

More research is needed to make the connections between these disorders stronger, but Bulik thinks it might be time to change how disorders of appetite dysregulation are conceptualized and instead think of both anorexia and obesity as having psychiatric and metabolic components (currently obesity or food addiction are not classified as mental disorders).

In addition to the next batch of anorexia samples, Bulik and her colleagues are launching another genomewide study to identify variants associated with bulimia, and in the future, they hope to test how the microbiome may work along with genetic profiles to influence eating disorders.

This international study was supported by multiple sources, including grants from the National Institutes of Health, Australia's National Health and Medical Research Council, German Research Foundation, and more. A complete list can be accessed at the link below. **PN**

"Significant Locus and Metabolic Genetic Correlations Revealed in Genome-Wide Association Study of Anorexia Nervosa" is posted at http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2017.16121402.



Manuel M. Montero-Odasso, M.D., Ph.D., with a study participant as he conducts dual-task gait testing, which can serve as a "brain stress test" to detect cognitive decline.

Lawson Health Research Institute

Dual-Task Gait Testing Identifies MCI Patients Likely to Develop Dementia

Easy to administer, noninvasive, and low-cost, dual-task gait testing may capture some subtleties missed by global cognitive methods. **BY JOANN BLAKE**

Gait disturbances may predict dementia progression in older adults with mild cognitive impairment (MCI). Single-task and dual-task gait testing (walking and performing a challenging cognitive task simultaneously) were used in a recent study to identify participants with MCI at greater risk to develop dementia.

The study, published May 15 in *JAMA Neurology,* found that low performance in dual-gait testing was significantly linked to a two- to threefold increase risk of dementia, independent of age, sex, education, comorbidities, and baseline cognition.

The research team, led by Manuel M. Montero-Odasso, M.D., Ph.D., director of the Gait and Brain Lab at the Schulich School of Medicine, University of Western Ontario, Canada, used a neuropsychological test battery to assess cognition and recorded gait velocity under single-task and three dual-task conditions. Dual-gait cost was defined as the percentage change between single- and dual-task gait velocities, using an electronic walkway that provided data to assess both spatial and temporal gait parameters. For the dual tests, participants moved at their usual pace on the walkway, while doing the following cognitive tasks aloud: (1) counting backward from 100 by ones, (2) subtracting serial sevens from 100, and (3) naming animals.

The 112 participants who took part in this ongoing prospective cohort study were community-living older adults (mean age 76 years; 55 women) with MCI, a pre-dementia state that carries a 10-fold increased risk of dementia. Data were collected from July 2007 to March 2016, and participants were followed up to six years with biannual visits.

Of the 112 participants in the study, 27 (24 percent) progressed to dementia. Of those 27 participants, 23 progressed to Alzheimer's disease (85 percent), two to Lewy body dementia (7 percent), one to frontotemporal dementia (4 percent), and one to vascular dementia (4 percent).

The researchers found that those participants who progressed to dementia had a significantly lower dual-task gait velocity result and a higher dual-task gait cost in the three test conditions. High dual-task cost in gait velocity while counting backward and naming animals was associated with dementia progression (incidence rate, 155 per 1,000 person years). Slow single-task gait velocity (less than 0.8 m/second) failed to predict progression to dementia.

"Although we expected that dual-task gait could predict incident dementia, we were surprised by the magnitude of the predictive ability, as it seems higher than cognitive testing," Montero-Odasso wrote in an email to *Psychiatric News*. "This may suggest dual-task gait as a test is capturing some subtleties that global cognitive tests may not grasp."

> "We were surprised by the magnitude of the predictive ability, as it seems higher than cognitive testing."

Generally, about one-third of individuals with MCI remain clinically stable after the initial diagnosis or even revert to normal cognitive functioning making it difficult to

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JOURNAL DIGEST

BY NICK ZAGORSKI

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Buprenorphine Outperforms Morphine for Neonatal Abstinence Syndrome

Buprenorphine is a more effective treatment for neonatal abstinence syndrome (NAS) than the current standard of morphine, reports a study published in the *New England Journal of Medicine*.

The study involved 63 full-term infants who had been exposed to opioids in utero and had signs of NAS, including irritability, tremor, and poor feeding. The infants were randomized to receive either sublingual buprenorphine (0.075 mg/ml every 8 hours) or oral morphine (0.4 mg/ml every 4 hours) until they stopped showing symptoms of NAS. Infants with symptoms that were not controlled by the assigned opioid were treated with adjunctive phenobarbital.

Compared with morphine, the group receiving buprenorphine had on average shorter treatment durations (15 days versus 28 days) and shorter hospital stays (21 days versus 33 days). There was no significant difference between the number of infants in both groups that required adjunctive phenobarbital (five in the buprenorphine group versus seven in the morphine group).

Rates of adverse effects were also similar between the two groups. However, the study authors noted that buprenorphine did not lower the respiratory rate as much as morphine did. "This potential advantage, along with a longer interval between doses, may allow for investigation of buprenorphine in outpatient settings," the authors wrote.

Kraft W, Adeniyi-Jones S, Chervoneva I, et al. Buprenorphine for the Treatment of the Neonatal Abstinence Syndrome. *N Engl J Med*. May 4, 2017. [Epub ahead of print] http://www.nejm.org/doi/full/10.1056/NEJMoa1614835

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accurately predict progression to dementia, including Alzheimer's disease.

Simple motor tests such as gait velocity and dual-task gait can serve as a screening test for psychiatrists to select which patients may need more invasive or expensive testing, including biological and imaging biomarkers to predict their dementia risk, according to Montero-Odasso.

"Due to the simplicity of the testing, we believe it could be easily incorporated in specialist clinics as part of the comprehensive assessments of older adults with cognitive complaints," he wrote. Furthermore, the testing is easy to administer, noninvasive, and low cost. Dual task gait velocity can be simply measured using a stopwatch, and dual-task gait cost is easily calculated.

Dual-task gait testing may serve as a kind of "brain stress test" to detect impending cognitive decline in patients with subclinical damage, Montero-Odasso and colleagues wrote. They noted that brain circuits shared by both cognition and motor-gait performance can be impacted by neurogenerative aging.

"Episodic memory, a cognitive domain that was affected in all of our participants who progressed to dementia, relies on frontal-hippocampal circuits that are also central for gait control. In addition, gait control also relies on the prefrontal-striatal networks that are involved in executive function, which was similarly impaired in all of our participants who progressed to dementia," they wrote.

The Gait and Brain Study is a longitudinal, clinic-based cohort study that started in 2007 to identify motor biomarkers that could predict cognitive decline in older adults. The program continues to enroll participants, currently at 250 older adults, with a goal to recruit a total of 400. The study will continue at least until 2022, based on current funding, according to Montero-Odasso.

The Gait and Brain Study is funded by grants from the Canadian Institutes of Health and Research, the Ontario Ministry of Research and Innovation, the Ontario Neurogenerative Diseases Research Initiative, the Canadian Consortium on Neurodegeneration in Aging, and by the Department of Medicine Program of Experimental Medicine Research Award, University of Western Ontario. **PN**

An abstract of "Association of Dual-Task Gait With Incident Dementia in Mild Cognitive Impairment: Results From the Gait and Brain Study" is posted at http://jamanetwork.com/journals/jamaneurology/fullarticle/2625135.

Utrecht University

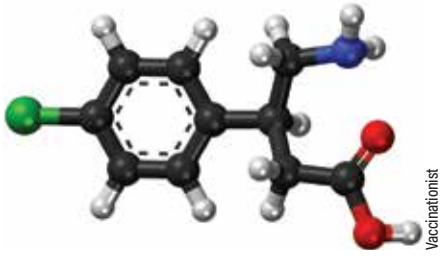
Mobile Version of CBT-I Found to Be Effective

Cognitive-behavioral therapy for insomnia (CBT-I) has shown effectiveness in both face-to-face and online formats. A study in the *Journal of Medical Internet Research* now reports the first randomized trial of a mobile phone version of CBT-I.

A total of 151 adults with a history of mild insomnia were assigned to receive either the mobile CBT-I application for six to seven weeks or be placed on a wait list. The app, known as Sleepcare, packages together a sleep diary, relaxation exercises, and educational materials about sleep and sleep hygiene.

At the conclusion of the study, the investigators found that the group receiving the app showed significant improvements in both insomnia severity and sleep efficiency, and these improvements were retained at a three-month follow-up visit. In general, the size of the improvements was about the same as observed for other web-based CBT-I approaches.

Horsch C, Lancee J, Griffioen-Both F, et al. Mobile Phone-Delivered Cognitive Behavioral Therapy for Insomnia: A Randomized Waitlist Controlled Trial. *J Med Internet Res*. Apr 11, 2017; 19(4): e70. http://www.jmir.org/2017/4/e70/



Vaccinationist

Baclofen Incites Earlier Reaction to Alcohol

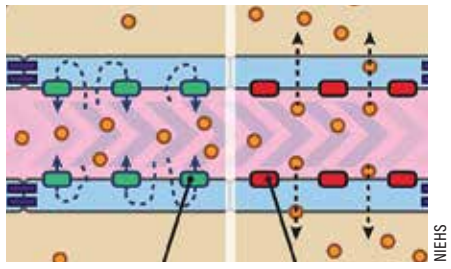
Baclofen—a GABA receptor agonist—has been studied as a potential medication for alcohol use disorder. A small study in *Translational Psychiatry* found that while patients administered the medication did not drink less, they did report a greater response to alcohol.

The study enrolled 34 anxious, alcohol-dependent individuals and randomized them to receive either 30 mg baclofen or placebo for at least eight days. Each participant then took part in a monitored alcohol self-administration test to assess desire to drink.

There were no differences in average alcohol consumed between baclofen and placebo, with both groups drinking around 43 to 45 grams. However, the baclofen group reported higher intoxication feelings after taking their initial "priming" drink, and they also reported greater ratings of feeling high or intoxicated during the test. In addition, heart rate was greatly reduced in the baclofen group.

"Hypothetically, amplification of subjective responses to alcohol after an initial drink may reduce the amount of subsequent alcohol drinking as the desired effects have already been achieved," the authors wrote.

Farokhnia M, Schwandt M, Lee M, et al. Biobehavioral Effects of Baclofen in Anxious Alcohol-Dependent Individuals: A Randomized, Double-Blind, Placebo-Controlled, Laboratory Study. *Transl Psychiatry*. Apr 25, 2017; 7(4):e1108. https://www.nature.com/tp/journal/v7/n4/full/tp201771a.html



NIEHS

Amitriptyline May Improve Blood-Brain Barrier Permeability

The tricyclic antidepressant amitriptyline may make it easier for drugs to pass through the blood-brain barrier, according to a study in the *Journal of Cerebral Blood Flow and Metabolism*.

For the study, researchers at the National Institute of Environmental Health Sciences started by treating isolated capillaries from rats with lysophosphatidic acid (LPA). LPA reduced the activity of P-glycoprotein, a cellular protein found on the brain's border that actively pumps drugs and other chemicals back into the bloodstream.

They next administered amitriptyline (this drug also interacts with LPA-related signaling pathways) to the capillaries and found that it could also rapidly turn off P-glycoprotein activity. This inhibition was reversible, as P-glycoprotein pump activity returned to normal once the amitrip-

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Oquendo

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- Grants to support integrated care models for primary care and behavioral health care services.

- Funding of $1 billion over two years to combat the opioid epidemic.

The outgoing president also emphasized the centrality of the opioid epidemic in the past year and APA's efforts to educate policymakers about the issue.

"In the most recent briefing on the opioid epidemic, APA lined up speakers that were simply spectacular," Oquendo said. "National leaders talked about what was needed to stem the increasing toll of prescription opioid misuse and its biological basis. … The discussion ranged from the importance of research to find new methods for identifying vulnerable individuals to the need to delineate the neurobiological changes that lead to the inexorable addiction that haunts some of those exposed to prescription opioids. Discussion about how stigma is actually codified in the way that some insurance companies go about approving detox or inpatient treatment, increasing risk for relapse and even death, was heart rending."

Two weeks before the Annual Meeting, Oquendo joined other physicians from the Front Line Physicians Coalition to visit seven Republican senators with concerns about the American Health Care Act. (The coalition comprises, in addition to APA, five other major medical associations representing pediatricians, family physicians, internists, osteopaths, and obstetrician/gynecologists. See page 4.)

"Strikingly, mental and substance use disorders were very much on the minds of all the members of the coalition. Whether it was the OB/GYNs' president talking about babies in opioid withdrawal ending up in the Neonatal Intensive Care Unit, or the internists' president talking about depressed diabetics who could not adhere to treatment, or the pediatricians' president talking about suicidal behavior in adolescents—everyone was committed to making sure that psychiatry was right there, front and center, at every last one of the seven conversations."

Oquendo added, "Before the Affordable Care Act, people with mental health issues struggled to obtain insurance coverage to help them access care. While not perfect, the ACA changed that by requiring companies to cover those with pre-existing conditions—including mental health—and by mandating coverage of treatment for mental and substance use disorders. This law strengthened parity protections first outlined in federal law in 2008.

"As physicians, none of us wants to see these advances rolled back," she said. "We want to ensure patients continue to have access to care and that their mental and substance use disorders are treated just like any other ailments." That was the message that the coalition brought to Capitol Hill.

Finally, Oquendo touched on APA's growing membership and its move later this year to a new headquarters closer to the U.S. Capitol in Washington, D.C.

"I am pleased to be leaving APA in strong standing," she said. "Our membership is more than 37,000 people strong—the highest numbers we have seen in 14 years. We have particularly seen growth in the number of women, African American, Asian, and Latino psychiatrists who are members of APA, as well as the number of international members joining our ranks."

Oquendo said the future is bright for psychiatrists and their patients. "We know more about the brain than ever, and new treatments are being developed that range from pharmacology to behavioral interventions and from brain stimulation to psychological treatments," she said. "As exciting, we have joined our sister disciplines in medicine to develop preventive strategies and influence health policy. These will form the centerpiece of 21st-century medicine and 21st-century psychiatry." **PN**

Journal Digest

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tyline infusions stopped.

These experiments were successfully conducted in blood vessels from both normal rats and a rat model of amyotrophic lateral sclerosis (ALS).

"Activating an endogenous phospholipid-induced signaling cascade at the capillary endothelium with nanomolar concentrations of a therapeutic already present in the clinic may provide a safe and effective means to target P-glycoprotein while avoiding side effects associated with dosing and specificity," the authors wrote.

Banks D, Chan G, Evans R, et al. Lysophosphatidic Acid and Amitriptyline Signal Through LPA1R to Reduce P-glycoprotein Transport at the Blood-Brain Barrier. *J Cereb Blood Flow Metab*. April 27, 2017. [Epub ahead of print] http://journals.sagepub.com/doi/full/10.1177/0271678X17705786

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People With Mental Illness May Seek More Acute Care Following Bariatric Surgery

An assessment of health records from 8,192 patients who had undergone bariatric surgery found that preoperative mental illness was not associated with less postoperative weight loss.

However, patients with severe depression or anxiety disorder, bipolar disorder, or schizophrenia did have more follow-up emergency department (ED) visits and longer hospital stays compared with patients with no mental illness.

One year after surgery, for example, patients with severe depression or anxiety (n=500) were about 30 percent less likely to have zero ED visits and 60 percent less likely to have zero hospital stays compared with surgery patients with no preoperative mental illness.

Patients with bipolar disorder, schizophrenia, or psychosis (n=508) were 40 percent less likely to have zero ED visits and 50 percent less likely to have zero hospital stays. These risks persisted two years after the surgery.

"This finding underscores the need to explore tailored, supportive postoperative outreach to minimize the risk of adverse health outcomes among patients with known mental illness," the study authors wrote.

The records were from bariatric patients across seven health care systems in the United States that are part of the Patient Outcomes Research to Advance Learning (PORTAL) network. This analysis was published in the journal *Obesity*. **PN**

Fisher D, Coleman K, Arterburn D, et al. Mental Illness in Bariatric Surgery: A Cohort Study From the PORTAL Network. *Obesity*. May 2017; 25(5): 850-856. http://onlinelibrary.wiley.com/doi/10.1002/oby.21814/abstract

CBO

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substance use issues and not shift the cost to states in a way that forces them to tighten eligibility requirements, provider reimbursement, or benefits.

- Ensure full implementation and enforcement of the bipartisan Mental Health Parity and Addiction Equity Act.

"As the Senate debates reforms to the health system, services for people with mental health and substance use disorders—and their families—must be maintained. APA urges the Senate to reject the American Health Care Act in favor of bipartisan legislation," said APA in a statement released after the CBO score was announced. **PN**

NIAAA

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In some ways, this initiative resembles the National Institute of Mental Health's (NIMH) initiative to reclassify mental disorders by integrating clinical symptoms with neurobiological measures.

"Our approach is not as sweeping as NIMH's, since we are only looking at one psychiatric disorder, but it goes back to the fact that AUD is heterogenous," Powell said. "One person may drink too much because alcohol is wonderful and intoxicating, while another does so because that person can't leave the house and face the world. Right now, both would be considered as having the same disease."

Even though the approach may not be that sweeping, Powell said this is still a dramatic change, and NIAAA will pilot the adoption of ANA within the institute's intramural research division. **PN**

The NIAAA Strategic Plan 2017-2021: Charting a Course for the Next Five Years of Alcohol Research is posted at https://www.niaaa.nih.gov/about-niaaa/strategic-plan-2017-2021.

Experts

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- **See older patients more frequently.** Plan on frequent follow-ups with your older patients, during which you can offer consistent education and support. Typically, older patients should be seen four to six times during the first 12 weeks of treatment (including a visit within the first two weeks after initiating a new antidepressant). Titrate antidepressants that are tolerated but do not seem to work initially; discontinue antidepressants that are not tolerated or do not seem to work after six to 12 weeks (including at least four weeks at the maximum recommended and tolerated dosage). If the patient does not seem to respond to an antidepressant after 12 weeks, consider switching to a different antidepressant rather than combining several medications. **PN**

References for this article are posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2017.pp1b3.