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David Hathcox

Richard Summers, M.D., chair of APA's Work Group on Psychiatrist Well-Being and Burnout, updated the Board of Trustees about five areas on which the work group is focusing, and said burnout and wellness are hot topics throughout medicine. Everyone is talking about these subjects, he said. See story on page 3.

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Connecting with other physicians is key to addressing burnout.

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Want to be a better advocate for psychiatry? Check out these tools.

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IPS lineup demonstrates the many ways to enhance patient care.

Latest Republican Effort to Repeal ACA Fails in Dramatic Early Morning Vote

After two months of Republican efforts to do away with the signature achievement of the Obama presidency, APA is hoping legislators will take up bipartisan efforts to stabilize insurance markets to ensure coverage for millions. ***BY MARK MORAN***

In the wake of the failure of a Senate bill last month that would have repealed select portions of the Affordable Care Act (ACA)—the so-called "skinny" ACA repeal package—APA is calling for a renewal of bipartisan efforts to improve the ACA for the benefit of all Americans.

"With today's vote, psychiatrists and other health providers can thank the Senate that our patients will not lose access to health care," said APA CEO and Medical Director Saul Levin, M.D., M.P.A., in a statement on July 28, hours after the Senate's reform effort failed. "The American Psychiatric Association has repeatedly reached out to members of Congress to express our concerns that proposed bills in the House and Senate would take away treatment for mental health and substance use disorders, as well as reduce the number of people with health insurance.

"There are challenges with our current health care system that Congress can and must address to improve the system overall," Levin continued. "We need to stabilize health insurance markets and make sure all Americans have options to purchase comprehensive insurance at affordable rates, as well as continued access to mental health and substance use disorder services."

The "skinny" or partial ACA repeal package—known as the Health Care Freedom Act—was defeated by a vote of 49 to 51 with Republican Sens.

see **ACA** on page 19

PERIODICALS: TIME SENSITIVE MATERIALS

Medicare Fee Schedule Has Good News For Psychiatry

The Trump administration proposes to increase practice expense values for some 50 codes commonly used by mental health professionals. This should translate into substantial increases in overall payment to clinicians.
BY MARK MORAN

Psychiatry appears to benefit in some significant ways in the 2018 proposed Medicare Physician Fee Schedule, released last month by the Centers for Medicare and Medicaid Services.

Highlights of the fee schedule include a proposal that, if approved, would substantially increase payments for conditions commonly

see **Medicare** on page 19

PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Rebirth of APAF's Center for Workplace Mental Health

BY ANITA EVERETT, M.D.

APA and the APA Foundation offer many excellent programs, resources, and benefits to our members. One of the priorities of my year as APA president is to raise awareness of these initiatives and benefits among the broader membership.

One initiative that is making a difference in spreading the word about the importance of investing in mental health care is the Center for Workplace Mental Health, which is under the purview of the APA Foundation. The mission of the center is to help workers with mental illness by inspiring companies to increase awareness of mental health issues and provide better support for employees.

The Center for Workplace Mental Health, originally known as the Partnership for Workplace Mental Health, grew out of the idea that APA should be partnering with employers to work on issues related to mental health. I had

the opportunity to witness this initiative from its inception while I served on the Council for Healthcare Systems and Financing. In the beginning, many of the conversations we had centered around why employers should even consider offering coverage for mental illness and substance use disorders.

This may seem strange today at a time when parity for mental health and substance use disorders is the law, and when many employers have established employee assistance programs (EAPs), but when this initiative started 15 years ago, the conversation surrounding mental health was, unfortunately, much different. The widespread stigma of mental illness made it difficult to engage with employers on this subject, even when APA wanted to highlight their efforts as success stories.

Today, thankfully, the situation has progressed to the point that not only are many employers willing to talk about mental health, but they also actively seek help from the Center for Workplace Mental Health. This new reality is reflected in the partial name change of the initiative from a "Partnership" to a "Center." It has evolved into a robust program whose staff and resources help employers work through issues, such as adaptation to and compliance with mental health parity laws, and develop new and better ways to support their employees and give them access to care.

Two ways in which the center facilitates this is through the ICU (Identify, Connect, Understand) and Right Direction programs. ICU is an awareness campaign tailored for the workplace and designed to reduce the stigma associated with mental illness. The idea is to foster a workplace culture where mental health can be discussed openly and where emotional health is valued. ICU, sometimes referred to as "I See You," was initially developed by DuPont's Employee Assistance Program. DuPont has since donated the program to the

see **From the President** *on page 20*

IN THIS ISSUE

DEPARTMENTS

Register Now for IPS: The Mental Health Services Conference

If you prefer learning at a smaller CME meeting where you can connect with the experts, APA's fall meeting was designed with you in mind. This year's theme is "Enhancing Access & Effective Care." Learn more and register at psychiatry.org/IPS. See article on page 11.

David Hathcox

Board Opposes Use of MOC Status To Penalize Physicians

A work group on physician wellness and burnout is working to develop resources that will help physicians deal with professional stress and to connect with other members in order to diminish professional isolation. ***BY MARK MORAN***

Decisions regarding physician licensure, hospital privileges, credentialing, or participation in insurance panels shall not in any way be contingent on completion of or participation in Maintenance of Certification (MOC).

That's the policy approved by APA's Board of Trustees at its meeting in Washington, D.C., last month. During the meeting, the Board also addressed physician burnout and wellness and updating of *DSM-5*, and approved policy opposing restrictions on international medical graduates (IMGs) entering U.S. graduate medical training and legislative attempts to permit pharmacists to alter prescriptions, among other issues.

The position statement on MOC was approved in response to an action paper by the Assembly in May and to widespread concern about MOC, especially the Part IV Performance in Practice component (also known as Improvement in Medical Practice). "Performance in Practice" refers to a requirement that physicians build into their routine practice the capacity to assess their performance continually against guidelines for best practices and make improvements to meet those guidelines.

"APA is strongly supportive of life-long learning for all physicians," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "However, many members have expressed their frustration with the current structure of MOC, many of whose requirements are unnecessarily burdensome and often irrelevant to clinical practice. We are committed to working with the American Board of Psychiatry and Neurology to improve MOC. In the meantime, however, we strongly oppose any attempt to penalize physicians for licensure or credentialing purposes for failure to participate in or complete MOC."

David Hathcox

Rustin Carter, M.D., the APA/American Psychiatric Foundation/SAMHSA Diversity Fellow, reminded trustees that physician burnout encompasses a spectrum that at the far end includes major depression and suicide. To his left is Chandan Khandai, M.D., M.S., the APA/APAF Leadership Fellow, and James Batterson, M.D., speaker-elect of the Assembly.

APA President Anita Everett, M.D., echoed those comments. "This is an issue of professional satisfaction and physician well-being," she said. "Physicians are alre ady burdened with administrative and other requirements unrelated to taking care of patients. Maintenance of Certification is a major concern for physicians of all disciplines, contributing significantly to professional dissatisfaction and burnout. It is unacceptable for licensing or other bodies to use MOC as a criterion for licensing, hospital privileges, or insurance empanelment."

Everett has made addressing physician burnout and wellness a major priority of her presidential year. Connected to that initiative, the Board heard a report from Richard Summers, M.D., who is chair of the Work Group on Psychiatrist Well-Being and Burnout appointed by Everett. (See related story on page 8.)

Summers said the work group planned to do the following in five areas:

- **Data:** Recommend a process to assess members' wellness, professional satisfaction, and experience with burnout based on available data.

- **Resource Document:** Work with APA administration to create a resource document that will include a review and summary of relevant research and tools on psychiatrist well-being and burnout. Update the APA position statements on well-being and burnout.

- **Education:** Recommend specific educational activities about physician wellness, including work-life balance, desirable practice parameters, and self-care for APA

see **Board** *on page 20*

Board Approves Process for Mediating Election Violations

APA's Board of Trustees approved the following four recommendations proposed by the Ad Hoc Work Group on Election Violation Issues to resolve allegations of violations of APA's election guidelines.

- When there is an allegation of a violation of the election guidelines, the Elections Committee will decide whether a violation did in fact occur and its severity.

- If the violation does not immediately disqualify a candidate from the election, the Election Committee will call for a timely telephonic mediation between the opposing candidates with the chair of the Elections Committee serving as a mediator. Each candidate will have the right to ask a fellow APA member to be on the call for moral support and advice.

- If the parties agree upon a remedy, then the Elections Committee will follow that path. If they do not agree upon a remedy, the Elections Committee will determine a remedy giving due consideration to the remedies proposed by the candidates.

- APA should discourage the concept of "leveling the playing field" by suspending the rule or allowing the opposing candidate to also violate the rules.

APA's election guidelines are posted in a PDF accessible at http://apapsy.ch/election_guidelines.

You Suspect Your Patient's Parent Is Using His Medication

Protect yourself in this situation by following a few risk management tips. **BY ANNE HUBEN-KEARNEY, R.N., B.S.N., M.P.A.**

You have an adolescent patient with attention-deficit/hyperactivity disorder and prescribe Adderall for him. You become aware that one of your patient's parents is demonstrating increasingly strong mood swings, is more anxious and irritable, reports an inability to fall asleep and stay asleep, and has had quick weight loss. You also become aware that this parent frequently calls for medication renewals for her child because she says she spilled the medications into the sink when she opened the container, the pharmacy dispensed fewer pills than ordered, or the family will be out of town on vacation when the renewal is due.

You are also concerned that the patient's symptoms are not controlled well in the school setting, and he also reports that his mother does not give him his medication every day.

You suspect that your patient's mother may be taking his Adderall. Now what can you do?

First, address your concerns with your patient's mother. Be calm, understanding, and open. Expect a range of responses from her, from adamant denial and anger at being accused of stealing the medications to her revealing that she has been taking the medication in her desire to be the "perfect mother" because the Adderall gives her the "energy to get everything done."

If she admits to taking the Adderall, the next step is to ask why and attempt to understand her motives so that you can decide whether further actions are needed. Here are some risk management points to consider:

- When you first suspect there may be an issue, consult with your risk management professional or attorney to best determine whether there are any child abuse/neglect reporting obligations or whether any other steps should be taken.

- Consider referring the mother for treatment/counseling.

- Order laboratory testing for the patient to determine if the patient has been taking the medication.

Anne Huben-Kearney, R.N., B.S.N., M.P.A., is assistant vice president of the Psychiatric and Healthcare Risk Management Group of AWAC Services Company, a member company of Allied World.

- If you are in a state that has a Prescription Drug Monitoring Program (PDMP), check to see whether this patient has had this medication, or another, filled by different providers. Where applicable, state PDMPs collect designated data on substances dispensed in the state as a tool to address prescription drug abuse, addiction, and diversion. Refer to the National Alliance for Model State Drug Laws (www.namsdl.org/prescription-monitoring-programs.cfm) for the link to your state's statutes and regulations regarding PDMPs.

- Consider developing a contract with the mother and adhere to the prescription renewal process without exception regardless of the reasons provided for early renewal.

- Determine whether you are safely able to continue to treat the patient with medication or whether termination should be a consideration.

- Document that you had a discussion with the mother about the risks of taking controlled substances prescribed to another person.

- To reduce the potential for parental use of medications prescribed for their child, ensure that the informed consent with the prescription includes the following:

- Education on the medication and its effects.

- Requiring parental signature on the consent that

- the medication should be used for the child only in the prescribed dosage.

continued on facing page

ETHICS CORNER

Self-Justification About Conflicts of Interest

BY CLAIRE ZILBER, M.D.

Some amount of self-interest is inevitable; we all need to make a living. At the same time, the high cost of health care makes society question the altruism of physicians. We know that psychiatrists receive a tiny slice of the health care budget pie, and we may have some degree of envy for those in more lucrative specialties. Of the 27 medical specialties surveyed in the 2017 Medscape Physician Compensation Survey, psychiatry is in the bottom quartile of earners, just above pediatrics, family medicine, endocrinology, internal medicine, and infectious disease, and equal to rheumatology. Meanwhile, orthopedics, plastic surgery, urology, and cardiology make about twice what we do. Add to the mix the burden of paying off student loans and funding our children's education, and the altruism that inspired us to choose psychiatry may be overshadowed by other motivations.

Although we want to think of ourselves as patient-centered and compassionate, it is easy to stray from that noble path. The soprano inner voices of discernment and virtue are drowned out by the bass voices of self-interest and greed. In the last six months, I have heard from patients and colleagues about three ways in which psychiatrists may increase their revenue by justifying the need for additional clinical services.

The first of these I learned from an elderly patient transferring her care from another psychiatrist because she didn't like the office requirement that she provide a urine sample for a toxicology screen at every visit. This patient had no history of substance abuse. She could understand why the doctor might want to test his patients at all initial visits, but repeated testing seemed clinically unnecessary to her. She felt that either he didn't know her as an individual with a specific history or he didn't trust her. In turn, she didn't trust him. Perhaps, like me, she suspected that this in-office testing was an additional revenue stream for the psychiatrist.

Another transferring patient specifically asked me about my policy for late arrivals to appointments. His previous psychiatrist would not see people who showed up 10 minutes late for appointments and would charge them for the missed session.

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

This policy is understandable in the context of a busy mental health center or hospital-based clinic, where providers have 15 minutes to see a patient and write a note; one late patient can throw off the entire day's schedule. It's more difficult to understand in a private-practice setting. My patients know that they have reserved a specific interval of time with me, they are paying for it, and they are entitled to as much as their late arrival allows. If they are 15 minutes late for a 20-minute medication monitoring appointment, they understand that we will be rushed and may have to schedule a second appointment if a significant medication change is indicated.

On two separate occasions with colleagues, in the setting of case conferences, they declared that they strongly encouraged all of their patients to see them twice a week for psychotherapy. If there was an abundance of psychiatrists so that patients would feel free to move to another provider if they don't want twice weekly therapy, the policy would select for patients who want intensive psychotherapy. However, in Colorado and throughout most of the country, there is a shortage of psychiatrists, and few who are accepting new patients. Patients who are desperate for help and have sufficient resources may feel somewhat coerced to comply with the psychiatrist's recommendation, even if it's not really what they want or need.

While ordering routine in-office labs, creating strict policies about late arrivals, and scheduling frequent visits may all seem like justifiable actions when seen from a business perspective, they have the potential to harm the patient-psychiatrist relationship. When a psychiatrists' actions are based on what is expedient for the practice, they may inadvertently be a betrayal of the patient. Our foremost duty is to our patients. Considering the many rewards we glean in our profession, it behooves us to guard against the appearance of ingratitude or greed, and redouble our commitment to putting patients first. **PN**

Michelle Massi/iStock/mathisworks

Steven Chan, M.D., M.B.A., is a clinical informatics and digital health fellow at the University of California, San Francisco; John Torous, M.D., is co-director of the Digital Psychiatry Program at Harvard-affiliated Beth Israel Deaconess Medical Center in Boston; and John Luo, M.D., is a health science clinical professor in psychiatry and director of the psychiatry residency program at the UC Riverside School of Medicine.

How to Keep Therapeutic Alliance Alive in the Age of EHRs

TECH TIME

BY STEVEN CHAN, M.D., JOHN TOROUS, M.D., AND JOHN LUO, M.D.

This is the conclusion of a two-part series on the effective and efficient use of EHRs.

In our last article in *Psychiatric News*, you learned tactics for optimal use of the electronic health record, or EHR. Many EHRs have features—like order sets and text-expansion shortcuts—that can help you finish the work day on time. But what about managing the therapeutic alliance, when you've introduced the EHR as the third entity in the room? Or the transference toward the EHR?

For starters, the physical placement of your computer can make the difference between effective and poor nonverbal communication.

A study involving nonverbal communication found that the least effective spaces are ones where the clinician's back is to the patient. An observational study of 50 videotaped sessions in the VA Health System found that an open setup—in which a computer and patient are positioned within the same field of view as the physician—helped the physicians view both the EHR and patient simultaneously, verify data, and even share information on the monitor for patient education. Sustained eye contact, a close distance to the physician, and direct body orientation contributed to a feeling of positive affect, social readiness, emotional support, and availability for communication.

In contrast, closed setups prevented the physicians from making eye contact. In closed setups, the patient's chair and the computer were placed 180 degrees from the physician. The physician had to turn his or her back to the patient while using the computer.

Aside from computer and furniture placement, there are many other strategies for improving nonverbal communication. Remember to be mindful of body language, even while typing. And think of the computer as an opportunity to use visual aids.

Be POISED During Clinical Encounter

In a commentary on EHRs in the January 2016 *JAMA Internal Medicine,* Richard Frankel, Ph.D., proposed POISED as a mnemonic for physicians to remember to use good computer habits while in a patient-doctor encounter. We've adapted these six steps for mental health clinicians here:

- **Prepare:** To improve the patient experience and trust, know about the patient ahead of time instead of logging in, fiddling with, and becoming frustrated with the computer in the first few minutes of the patient encounter.

- **Orient:** Frankel advised that the best practice is to spend 1 to 2 minutes conversing with the patient without using the computer at all. He recommended following up with a bridging statement, such as, "I'm going to be using the computer from time to time to help me keep track of things."

- **Information Gathering:** Patients nowadays expect clinicians to use the computer when gathering information. They may question whether the clinician is taking them seriously if they are not entering information into the computer. At the same time, if patients are discussing something very emotional, not using the computer is important to demonstrate sensitivity and connection.

- **Share:** Clinicians can point out items on the computer display as a way to discuss and double-check parts of the patient history, assessment, and treatment plan. This can have a positive effect on the therapeutic alliance.

- **Educate:** Clinicians can use the computer screen as a visual aid and teaching aid. For instance, clinicians could show a patient's medication history, a graph of changes in mood over time, or a diagram of the human brain.

- **Debrief:** Computers should be used to capture instructions. Entering information while verbally instructing patients—for outpatient discharge print-outs or after-visit summaries (AVS)—can reinforce the importance of the instructions.

POISED is a framework that works with all patient-clinician encounters—not just for physicians, but for all behavioral and physical health. We anticipate that this framework will be needed more as patients bring in technology that records their symptoms, such as smartphone mood-tracking apps, journaling apps, and activity tracking devices.

Keep the Good in Mind

Despite the hassles of EHRs, keep their benefits in mind. EHRs offer numerous benefits over paper records, such as streamlining communication with colleagues and other providers, teaching moments with patients, and being more reliable records. And, as noted in the last issue of *Psychiatric News,* there are many shortcuts that can make your documentation process faster.

Knowing these tactics and clinical practices will help you be part of the discussion about the role of information technology in psychiatry so you can help shape their use in our profession. **PN**

"Computers in the Examination Room" is posted at http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2473626.

continued from facing page

- the parents will give the child the medications as ordered.

- the medications will be secured.

- the parents will comply with the renewal process.

As with all prescribed medications, you have the responsibility to educate the patient and parents on the purpose, side effects, and appropriate monitoring to ensure that the patient is getting the medications and treatment recommended. You also have the responsibility to monitor the patient's use of the prescribed medications and the renewal process to promote safe patient care. **PN**

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New Report Highlights Need For Integrative Adolescent Care

Understanding which physical health conditions are associated with depression is important to aid in prevention efforts and timely identification of at-risk populations. **BY MIRIAM TUCKER**

A report from the Substance Abuse and Mental Health Services Administration (SAMHSA) sheds new light on the complex interaction between mental and physical illness among adolescents.

Authors Sarra L. Hedden, Ph.D., and colleagues from SAMHSA's Center for Behavioral Health Statistics and Quality analyzed 2005-2014 data from the National Survey on Drug Use and Health regarding the association between major depressive episode (MDE) and several chronic and acute medical illnesses.

Among many findings, the data showed that asthma, diabetes, bronchitis, pneumonia, and obesity (in females) were significantly associated with MDE in the past year. Adolescents with past year MDE were also much more likely than those without to report fair or poor overall health versus good or excellent overall health. The findings were mostly consistent across age, gender, socioeconomic, and racial/ethnic groups.

The data were cross-sectional and therefore do not indicate directionality or prove causation, but the point is to highlight the associations and the need for integrative approaches to management, according to study co-author Rachel Lipari, Ph.D.

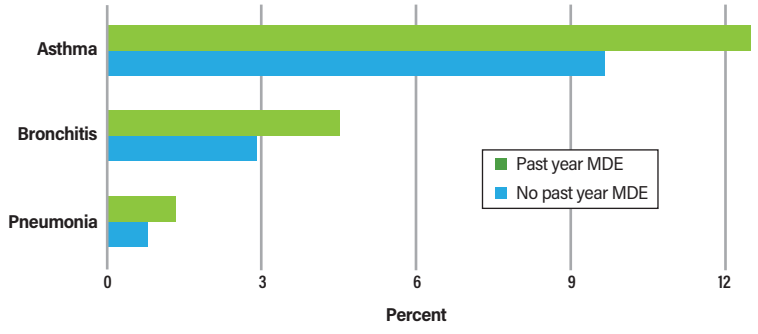
"It's just a single point in time, but it is a very large, nationally representative survey. We're looking at associations between physical and behavioral health that we see in clinical settings, but we're now able to replicate these relationships on a national level."

Added co-author Lisa Rubenstein, M.S., "We're focusing on the importance of integration between primary care, specialty care, and behavioral health. The way we see the important usage of these data is to have tailored messages. If you're taking care of people with depression, you might have better behavioral health outcomes if you partner with the primary care providers."

Advertisement

Youth Depression, Physical Illnesses Appear to Be Linked

Among other illnesses, asthma, bronchitis, and pneumonia were more likely to be reported among youth aged 12 to 17 with a major depressive episode (MDE) in the past year compared with those without past year MDE, according to 2005-2014 data from the National Survey on Drug Use and Health.



Source: Sarra L. Hedden, Ph.D., et al. *CBHSQ Data Review*, May 2017

And for primary care providers, Rubenstein said, the goal is to promote depression screening among patients with asthma or diabetes, or obese females. "Until we can do full integration, this really needs to be addressed," she noted.

Washington, D.C., child psychiatrist Adair Parr, M.D., called the report's cross-sectional nature "a limitation," but she also sees it as an important reminder for psychiatrists to be mindful of any diagnosed physical illnesses and to be on the alert for incident medical conditions in existing patients with depression or other major mental illnesses.

For children with a chronic condition, she said, questions to consider asking them and their families include "How are they managing that in addition to their emotional problems? What are their coping strategies? What is the family support like?"

Lipari and her colleagues plan to delve further into the data using advanced statistical techniques to tease out more information about the identified relationships.

Report Part of Larger Effort

The report is part of a multipronged SAMHSA initiative to promote optimal integrative care models. The agency's annual National Children's Mental Health Awareness Day in May focused on the importance of integrating behavioral health and primary care for children, youth, and young adults with mental and/or substance use disorders (*Psychiatric News,* June 2).

The main event was held in Washington, D.C., while related events and activities were held in other cities nationwide. Several panels examined models for fully integrated health care and how best to facilitate communication among providers.

Parr was among the panelists at the D.C. event (*Psychiatric News,* August 4). She described her recent work in setting up a collaborative care psychiatry program within a large private pediatric practice. She reviews patients' electronic medical records and makes recommendations to the pediatricians via chart notes. For patients who need greater assessment and intervention, Parr sees them in person.

"It's kind of a hybrid of co-location and the collaborative care model," she explained, adding that the setup overcomes both the geographic and financial barriers in usual-care models. "Everyone is challenged by communication, ... and often you're not getting paid for that time."

To aid in promoting such endeavors, SAMHSA has begun partnering with professional societies and organizations that specialize in the medical conditions cited in the report, including APA, the American Academy of Pediatrics, the American Academy of Family Physicians, the American Diabetes Association, and other federal agencies, to work on an integration campaign.

A meeting is now being planned to examine the various evidence-based integrative models, including co-location, full integration, and telehealth for remote areas that lack mental health professionals. "That hasn't been done before," Rubenstein said. "It's the application of the data that's new and exciting." **PN**

"Comparison of Physical Health Conditions Among Adolescents Aged 12 to 17 With and Without Major Depressive Episode" is posted at http://bit.ly/2qPH7V5.

Psychoanalytic Association Clarifies Position on Goldwater Rule Equivalent

APA issues a reminder that it stands firmly behind its Goldwater Rule after a media report on the American Psychoanalytic Association's position on commenting on public figure makes headlines. **BY AARON LEVIN**

Maybe it was all just a misunderstanding, but the American Psychoanalytic Association (APsaA) recently found itself in a public tangle over whether it did or did not give its members a green light to comment on the mental health of public figures.

Interest in such professionally informed commentary has risen over the last year. For psychiatrists who are members of APA, offering a professional opinion about a public figure's mental health without an examination and without consent violates Section 7.3 of APA's *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, known informally as the Goldwater Rule. Other organizations and other professions may set their own standards for such discourse.

News coverage of the issue was spurred by a July 6 email sent to APsaA members from its Executive Council reaffirming that the "organization will speak to issues only, and not about specific political figures."

The Executive Council was responding to calls from some members to take a stand on President Donald Trump, explained APsaA President Harriet Wolfe, M.D., a clinical professor of psychiatry at the University of California, San Francisco, and a training and supervisory analyst at the San Francisco Center for Psychoanalysis.

The policy of focusing on issues was an accurate reflection of APsaA's existing position, formalized most recently in 2012, which states the following: "Never make a definitive statement about the personal psychodynamics or diagnosis of a public figure."

However, the email also said, "[I]t is important to note that members of APsaA are free to comment about political figures as individuals."

That sentence caught the attention of the online magazine *STAT*, interpreting it as a move to unbar the doors. *STAT* posted an article on July 25, headlined "Psychiatry Group Tells Members They Can Ignore 'Goldwater Rule' and Comment on Trump's Mental Health." Other news outlets picked up the story as well.

The headline stumbled in several ways. APsaA says that its members "include psychiatrists, psychoanalysts, psychologists, psychotherapists, and social workers." In addition, the Goldwater Rule only applies to members of APA and not to other organizations, and President Donald Trump was not mentioned at all in the email.

Rebecca Brendel, M.D., J.D., a consultant to APA's Ethics Committee, said the APA's Goldwater Rule represents sound professional ethics, but it does not apply to non-members or to other groups.

APsaA does have an ethical code but it only addresses clinical practice, not public commentary, said Wolfe in an interview.

"It speaks about competence, truthfulness, scientific responsibility, and personal integrity," she said. "If a member speaks publicly about a public figure and appears to be making a psychodynamic or diagnostic statement, it would be unprofessional and alarming but not an ethical violation."

For its part, APA immediately reaffirmed its own stance in a July 27 statement.

"The American Psychiatric Association stands firmly behind the Goldwater Rule," said Rebecca Weintraub Brendel, M.D., J.D., a consultant to APA's Ethics Committee and an assistant professor of psychiatry at Harvard Medical School. "Our position has not changed. The Goldwater Rule applies to the 37,000 physician members of the American Psychiatric Association, not other groups, non-members, or non-physicians. The rule represents sound psychiatric ethics, preserves the integrity of the profession, and respects the patients that our members serve."

see **Goldwater Rule** *on page 17*

New Jersey DB Board Recognized for 100% APAPAC Participation

All of the members of the New Jersey Psychiatric Association (NJPA) Board of Trustees have indicated their appreciation of their partnership with APA on government matters by making donations to APAPAC, APA's political action committee.

"The NJPA Board's dedication to APA's advocacy efforts through APAPAC is an example to all DB/SA and APA leaders of how they can lead by example," said Charles Price, M.D., chair of APAPAC's Board of Directors. "The NJPA board understands that APAPAC is working every day to fight for psychiatry and our patients on Capitol Hill, and we hope that other state and district associations will join their efforts in getting APAPAC's message out to their membership and commit to getting 100% board support for APAPAC."

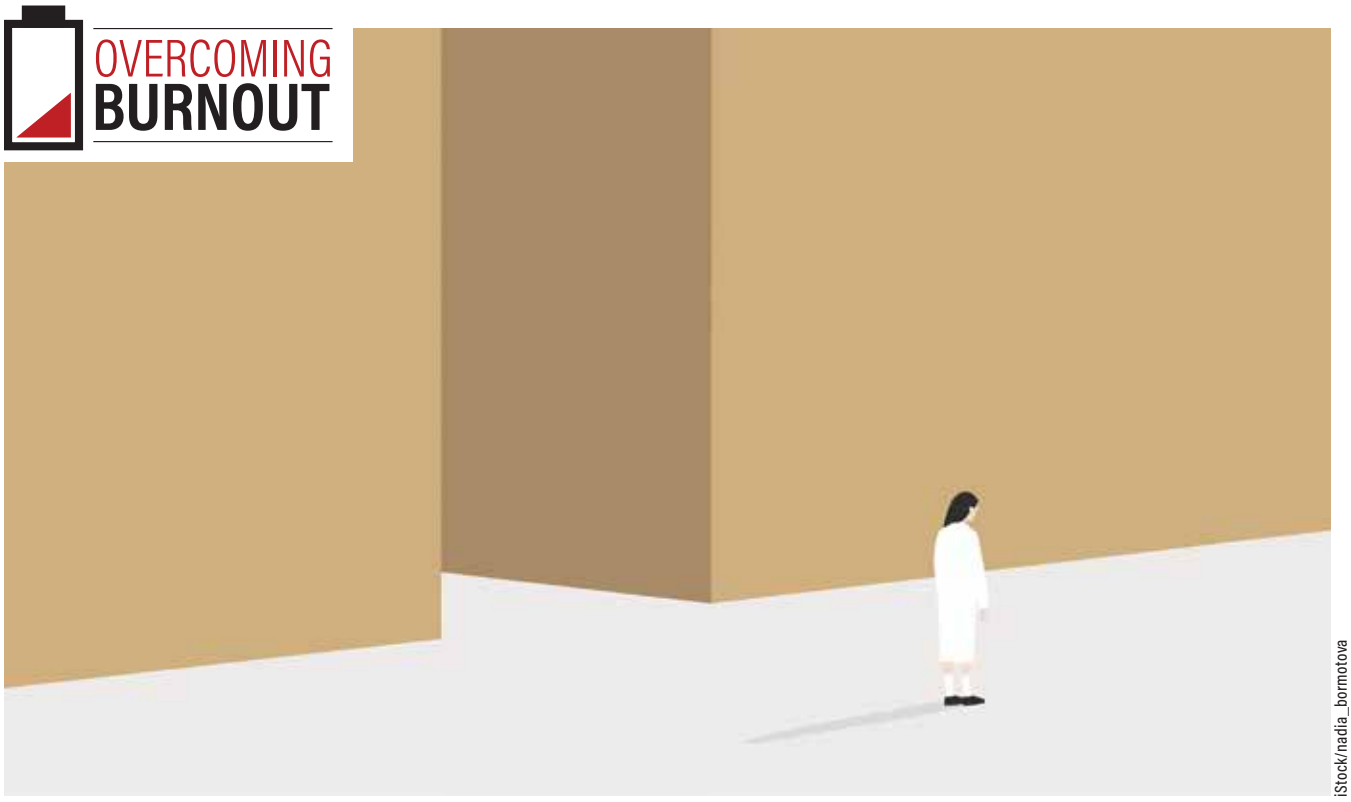
Debra Koss, M.D., co-chair of NJPA's Council on Advocacy, noted that APA's Department of Government Relations has been available to support the NJPA by providing resource materials, offering a national perspective, and connecting NJPA to other district branches and state associations working on similar issues.

"Everyone in NJPA's leadership recognizes the impact of our advocacy work on psychiatrists' ability to deliver quality patient care," she said.

NJPA President Randall Gurak, M.D., added, "NJPA's significant involvement in state legislative matters led to an understanding of how critical it is to have access to lawmakers and educate them on the science behind what we do every day in practice. We need to do this on both the state and national levels. The members of the NJPA Board of Trustees are proud to have offered their support to APAPAC to accomplish this goal."

APAPAC Board Chair Charles Price, M.D., is photographed with members of the 2016-2017 NJPA Board: (from left) Vice President Jessica Abellard, M.D., Trustee-at-Large William Hankin, M.D., APA Assembly Area 3 Rep Joseph Napoli, M.D., Secretary/Treasurer Charles Blackinton, M.D., Trustee Debra Koss, M.D., and Assembly Area 3 Deputy Rep William Greenberg, M.D.

OVERCOMING BURNOUT



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Taking Steps to Avoid Isolation Is Key to Preventing Burnout

This is the first in a series of articles on physician wellness and burnout that will run throughout the term of APA President Anita Everett, M.D. **BY RICHARD SUMMERS, M.D.**

The stress of changing jobs. The anxiety, sadness, or sense of loss that may accompany aging. The frustration associated with wanting to make changes in practice that are stymied by bureaucratic systems. The feelings of alienation working as a minority psychiatrist in community settings, or the conflict between the mission and the difficulty of meeting immense community needs with so few resources.

Sound familiar?

We psychiatrists are a community, and this was strikingly evident at APA's 2017 Annual Meeting at the session titled "Physician Wellness and Burnout: A Town Hall Discussion With APA Leadership," where these and other difficulties were expressed by clinicians wrestling with the challenges of being a physician today.

With standing room only, and many members willing to contribute their thoughts, observations, and raw emotion, it was clear that the struggle to feel balanced, well, and focused in our work is something we share.

The town hall began with remarks by then incoming APA President Anita Everett, M.D., who emphasized the organization's commitment to addressing members' well-being and the problem of burnout as a central theme of her presidential year. She asked attendees to let her and APA leaders know what they feel they need in this area. Saul Levin, M.D., M.P.A., CEO and Medical Director of APA, echoed these sentiments. I described the Work Group on Psychiatrist Well-Being and Burnout's primary deliverables this year: creation of an online portal to allow members to conduct a self-assessment and receive direction to meaningful online resources; a toolkit to help psychiatrists serve as Well-Being Ambassadors in their home organizations, highlighting psychiatry's special role among the medical specialties; and a set of educational, programmatic, and policy recommendations for APA.

More than 35 members spoke over the next hour about their experiences with well-being, burnout, and depression and shared personal crises, adaptations, solutions, and responses. The feeling in the room was of intense engagement and concern for one another, with areas of agreement and of conflict about the key drivers of stress and burnout.

Can APA help define "career milestones" to help people through important career transitions? Should APA help members explore unionization as a way of dealing with changes in the workplace? What about telemedicine? Can it help give physicians a greater sense of autonomy and control over their schedule and interactions with patients?

We know that isolation is a serious problem for physicians and an important cause and effect of burnout, and the experience of being in a large room filled with colleagues connecting with one another was affirming and fulfilling.

Probably the central theme was of the importance of physicians connecting with one another through peer supervision, discussion groups, early recognition of peers who are struggling, and the development of more effective state physician health programs. Although burnout and depression are important issues among psychiatrists, we are at lower risk than many other medical specialists, and there were several comments about how we can help colleagues in the rest of medicine. Concerns about overly demanding practice environments, insufficient autonomy, burdensome paperwork, and cumbersome electronic health records were frequent topics.

Many comments addressed the nature of well-being, burnout, and depression. Attendees shared personal experiences, including descriptions of strategies to enhance well-being, and reflected on the role one's clinical setting, family, and age may play in vulnerability to burnout, or in resiliency.

Participants called on APA to develop models for best practices in staffing policies, contribute to the development of a better electronic medical record system, and develop benchmarks for psychiatrist productivity. Suggestions in the educational realm included curriculum development to support trainees' awareness of career transitions, initiatives regarding medical student debt, and mentorship for career transitions.

Many expressed a strong feeling that the town hall discussion was an important first step in addressing the problem of burnout and hoped that it would be the beginning of many conversations. We promise that it will be. **PN**

WHY I ASPIRED TO BE A PSYCHIATRIST

Youthful Exposure to Psychiatry Set My Career Path

BY STEPHEN C. SCHEIBER, M.D.

Stephen C. Scheiber, M.D., is the former executive vice president of the American Board of Psychiatry and Neurology.

I believe that factors on career choice are multi-determined. In my case I can identify two significant factors. The first is reading the works of Sigmund Freud in high school and the second was noting close family members who had been treated for mental illness with good results.

When I attended the Putney School in Putney, Vt., for my last two years of high school, I discovered works written by Freud in the school library. I was fascinated by his work and thought that he was a genius. In a naïve fashion, I wondered how I could become someone like him. As part of my explorations, I came to realize that he was a physician and that I should consider a course as a pre-medical student when I went to college.

The other early influence was that in my early teens my mother was hospitalized in the New York Hospital Westchester Division in my home town for almost a year. I was told that she was treated for depression with electroconvulsive treatments. I was not astute enough to know that she was depressed but was so informed by my family. I did note that she was much improved after discharge and that she continued to see Dr. Curtis Prout, a senior staff psychiatrist, as an outpatient for a number of years and that she thrived after her discharge from the hospital and suffered no recurrences. Looking back, I believe that

continued on facing page

National Academies Report Offers Strategy To 'Unravel' Opioid Epidemic

Preventing overdose deaths and other opioid-related harm should be elevated immediately to a public health priority, the report states. **BY JOANN BLAKE**

The all-out effort to reduce opioid use nationwide is a balancing act that requires collaboration across federal agencies, educational and professional organizations, insurance companies, and health care practitioners, according to Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA).

Commenting on a report on pain management and the opioid epidemic released July 13 by the National Academies of Sciences, Engineering, and Medicine, Volkow told *Psychiatric News*, "On the one hand, there is the need to change the culture of opioid prescribing—already the focus of various initiatives by government and professional medical associations. On the other hand, we must ensure that patients who need these medications for severe pain conditions can still get them."

The 380-page report—which describes the state of the science on pain research, care, and education and offers recommendations for future steps to stem the opioid epidemic—was written by a committee of 18 experts convened by the National Academies at the request of the Food and Drug Administration (FDA).

To improve awareness of the risks and benefits of opioids, the National Academies committee recommended enhanced education for both health professionals and the public. The report outlines several strategies, including requiring that all health care professionals receive basic training in the treatment of opioid use disorders and training for prescribers and pharmacists so that they know how to recognize and counsel patients at risk for opioid use disorder or overdose.

Drug overdose, driven primarily by opioids, is now the leading cause of unintentional injury deaths in the United States, and trends indicate that premature deaths associated with the use of opioids are likely to climb, according to the report.

As of 2015, at least 2 million people in the United States were estimated to have an opioid use disorder involving prescription opioids and almost 600,000 have an opioid use disorder involving heroin. While the annual number of deaths from prescription opioids remained relatively stable between 2011 and 2015, overdose deaths from illicit opioids—including heroin and synthetic opioids such as fentanyl—nearly tripled during this period. Part of this was due to a growing number of people whose use began with prescription opioids.

"The report focuses on many factors that contribute to this epidemic such as inadequate coverage by insurance companies of comprehensive multimodal pain management, inadequate access to treatments of substance use disorder, and lack of access to naloxone and safe injection equipment," psychiatrist Patrice A. Harris, M.D., immediate past chair of the American Medical Association's Board of Trustees and chair of AMA's Task Force to Reduce Opioid Use, told *Psychiatric News*.

To begin to stem the epidemic, the report cautions that efforts to reduce access to opioids should be coupled with investments in treatment. The committee recommended that states—with assistance from relevant federal agencies, particularly the Substance Abuse and Mental Health Services Administration (SAMHSA)—provide universal access to evidence-based treatment for opioid use disorder in a variety of settings, including hospitals, criminal justice settings, and substance use–treatment programs.

The committee also recommended that states implement laws and policies that improve access to the medication naloxone, which blocks or reverses the effects of opioids, as well as safe injection equipment to reduce transmission of infectious diseases. For example, offering prescribers immunity from civil liability or criminal prosecution for prescribing, dispensing, or distributing naloxone, and laypersons immunity for possessing or administering it could help reduce the harms of opioid use and death, the group noted.

The report suggests that the FDA also take actions to change how it approaches prescription opioid products and approval decisions.

"The FDA traditionally has taken a product-specific approach to drug approval decisions... While this approach works well in most cases, the committee believes it is necessary to view regulatory oversight of opioid medications differently from that of other drugs because these medications can have a number of consequences not only at the individual level but also at the household and societal levels," the report stated.

"The broad reach of the epidemic has blurred the formerly distinct social boundary between prescribed opioids and illegally manufactured ones, such as heroin," said committee chair Richard J. Bonnie, professor of medicine and law, and director of the Institute of Law, Psychiatry, and Public Policy at the University of Virginia, Charlottesville, in a press release. "We want to convey a clear message about the magnitude of the challenge. This epidemic took nearly two decades to develop, and it will take years to unravel."

> "This epidemic took nearly two decades to develop, and it will take years to unravel."
> —Richard J. Bonnie

The committee recommended several additional strategies:

- The FDA should complete a review of the safety and effectiveness of all approved opioids.
- Public and private payers should develop reimbursement models that support evidence-based and cost-effective comprehensive pain management, including both drug and non-drug treatments for pain.
- The Department of Health and Human Services, in concert with state organizations, should conduct or sponsor research on how data from prescription drug monitoring programs can be better leveraged to track opioid prescribing and dispensing information.
- The National Institutes of Health, SAMHSA, the U.S. Department of Veterans Affairs, and industry should invest in research that examines the nature of pain and opioid use disorder, as well as develop new non-addictive treatments for pain. **PN**

The report "Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use" is posted at https://www.nap.edu/catalog/24781/pain-management-and-the-opioid-epidemic-balancing-societal-and-individual.

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my mom had an involutional depression and that four of her siblings had been treated for psychiatric conditions that likely included agoraphobia, posttraumatic stress disorder, and postpartum depression. They too seemed to benefit from therapy.

To test my own interest in going to medical school, I worked summers in the same hospital as a laboratory technician and as an orderly on one of the male inpatient wards. In the laboratory I recall testing urines on patients for bilirubin. I was told that 5 percent of patients who had been prescribed the then-recently approved phenothiazine antipsychotics such as Thorazine and Stelazine had abnormal liver studies. I also did white blood counts to check for leukopenia. As an orderly, I assisted in such procedures as ECT, insulin shock treatments, hot tub treatments, and cold pack treatments. I was impressed with the care and attention given to the patients. I also spent a summer working in the laboratory at the Strang Prevention Clinic of the Memorial Hospital in New York City to solidify my interest in medicine.

I was not disappointed in my choice of psychiatry when I was a medical student at the University of Buffalo. I thought that one of the best lecturers in my first two years of medical school was Dr. S. Mouchly Small. He gave weekly lectures on personality development and psychopathology in our second year. He taught us psychiatric interviewing at the Buffalo State Hospital; he conducted interviews on chronic patients followed by groups of four of us going to the bedside to jointly interview patients.

To my surprise, I also liked clerkships in other disciplines in medicine, particularly internal medicine, but it was clear that my first love was psychiatry and continues to be so, 53 years after graduating from medical school. **PN**

APA President Anita Everett, M.D., invites you to write a brief article about why you aspired to be a psychiatrist. If you are interested in doing so, please contact Dr. Everett at aeverett@psych.org or Cathy Brown at cbrown@psych.org.

AADPRT Curriculum on Professionalism Teaches Wise Use of Digital Technology

As digital technology continues to evolve rapidly, the AADPRT curriculum is being updated to include teaching vignettes about the use of mental health apps. **BY MARK MORAN**

"The current generation of learners relates to the internet more as an extension of themselves than as an external resource."

—2012 AADPRT Task Force Report on Professionalism and the Internet in Psychiatry: What to Teach and How to Teach It

The digital revolution and social media are having a profound effect on medicine and patient care, and as the statement from the AADPRT task force report suggests, young physicians in training are likely to approach the use of these tools much differently from more senior doctors.

"When we talk to trainees about digital technology, it's very clear that many of them view their online and social media presence on LinkedIn, for instance, as an extension of their identity, not just as a vehicle for communication," said Sandra DeJong, M.D., president of the American Association of Directors of Psychiatric Residency Training (AADPRT). "People are curating their identities on social media sites, but for physicians, that can mean some interesting things in terms of challenging conventional boundaries around professional identity versus private identity, as well as challenging the traditional framework for professional space and time.

"We used to set up appointments for 45 minutes, but now there is the expectation that you are available almost 24/7," DeJong said. "This disruption of the conventional treatment frame has an impact on the psychiatrist-patient relationship and raises all kinds of new questions."

For example, DeJong asks, "Is it OK for a physician to follow his or her patient on Twitter?"

(During a symposium at this year's Annual Meeting in San Diego titled "Patient Targeted Googling: Oh! What a Tangled Web We Weave, When First We Practice to Deceive," psychiatrist Lilya Gershengoren, M.D., presented results from a pilot survey showing that more than 80 percent of resident trainees at a large academic medical center had Googled the name of a patient, and nearly all of them had at least considered doing so. (*Psychiatric News*, July 7).

"All of these traditional parameters are being challenged by digital technology," DeJong said. "This has required medical educators to think about how we talk to trainees and fellows about the wise, responsible, and ethical use of digital tools."

Moreover, technology is constantly evolving. LinkedIn and Facebook became popular more than a decade ago, but it is only very recently that mental health apps, some of which can track patient symptoms in real time, have begun to be marketed.

Sandra DeJong, M.D., says digital technology can change the way clinicians and patients interract—for good or for ill.

For that reason, AADPRT is updating its Curriculum on Professionalism and the Internet, first developed in 2010 by a task force under then-AADPRT President Sheldon Benjamin, M.D., and released in 2012. The original curriculum was also accompanied by a task force report, published in *Academic Psychiatry* in September 2012.

"We made a commitment when we issued the curriculum to keep it current as needed," DeJong said. "This subject of digital technology is a moving target, so this really needs to be a dynamic document. We are in the process of updating the teaching vignettes to include some about the use of apps."

The original 2010 curriculum is comprehensive, including 36 vignettes describing situations in which digital technology or social media impact the clinical setting. An example of one of the more basic teaching vignettes for discussion is the following:

A psychiatrist has just had her third visit with a patient. About this time the psychiatrist is "friended" on Facebook by an old high school classmate. However, the communications from the "classmate" do not appear to be genuine; in fact, this person appears to be an imposter. The psychiatrist is able to ascertain from the person's Facebook page that the friend is actually the new patient who had located the psychiatrist's high school year book online.

see **AADPRT** *on page 13*

FRESH TALK

How to Beat the Advocacy Blues

BY KRISTIN S. BUDDE, M.D., M.P.H.

Kristin S. Budde, M.D., M.P.H., is a PGY-4 psychiatry resident at Yale University.

I realized two things recently.

First, the political situation in the United States has made me want to be a better advocate for my patients. Second, I have no idea how to do that.

I was used to calming distress with therapy, medication, a helping hand. But this seemed so different. There was no Stahl's, no NICE guidelines to show me the way.

So first I tried the Internet. A quick search offered a definition of advocacy: "Public support for or recommendation of a particular cause or policy." Then I spent half an hour (OK, an hour) in a rabbit hole about famous marches throughout history. Not so productive.

Then I remembered an advocacy talk I'd heard last year at APA's September Components meeting, where councils and committees gather to develop ideas and work with the APA leadership. This seemed like a better bet. To my surprise, I found quite a few resources on the APA website. More importantly, I found pathways to action. Here's an admittedly abridged list, with some lessons I took away from my search.

Open your browser and type in https://www.psychiatry.org/psychiatrists/advocacy. You'll find the main APA advocacy page and a link to APAPAC, APA's political action committee. This group works to ensure that psychiatrists have a say in legislation that will affect our work (think parity, health care reform, Medicare, and research). Working with APA's staff, APAPAC members know how to navigate the legislative system and campaign for policies that will help our patients. Your voice is needed!

An important resource on the APA advocacy page is the Congressional Advocacy Network Guide, posted at https://www.psychiatry.org/psychiatrists/advocacy/congressional-advocacy-network/resources. This 22-page guide offers a wide range of advocacy advice. It ranges from the basics (for example, how federal advocacy works and how to call your members of Congress) to more advanced ways to get involved (for example, conducting tours and hosting candidate fundraisers). It can help demystify the world of federal advocacy, which to me seemed totally overwhelming.

And don't stop there. Consider going a step further and joining APA's Congressional Action Network, APA's political grassroots network. Advocates serve as "key contacts" for their members of Congress so that when an important issue comes up before the U.S. Congress (like Medicare and Medicaid reimbursement for physicians and comprehensive mental health reform), APA can quickly get its message to members of Congress. Learn more at https://www.psychiatry.org/psychiatrists/advocacy/congressional-advocacy-network//join.

The Federal Affairs page, https://www.psychiatry.org/psychiatrists/advocacy/federal-affairs, links to APA resources on a number of major mental health topics, including mental health reform, parity, public health, and military and veterans affairs. Why does this matter? Well, in my case deciding what I wanted to focus on was part of my problem. Here I found a bird's-eye view of a number

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We Look Forward to Welcoming You in New Orleans!

BY GLENDA L. WRENN, M.D., M.S.H.P., AND MICHAEL T. COMPTON, M.D., M.P.H.

As chair and vice chair of the Scientific Program Committee of the 2017 IPS: The Mental Health Services Conference, we are pleased to have worked hard to assemble an outstanding conference program around the theme of "Enhancing Access and Effective Care." We look forward to seeing many old friends and colleagues, making new friends and colleagues, and hearing the great array of speakers in the program.

Glenda L. Wrenn, M.D., M.S.H.P., and Michael T. Compton, M.D., M.P.H., are chair and vice chair, respectively, of the Scientific Program Committee for IPS: The Mental Health Services Conference. Wrenn is director of the Kennedy-Satcher Center for Mental Health Equity in the Satcher Health Leadership Institute at Morehouse School of Medicine. Compton is professor of clinical psychiatry at Columbia University and medical director for adult services in the New York State Office of Mental Health.

The IPS has always been a preeminent gathering of clinical psychiatrists, community psychiatrists, and others working in public-sector mental health settings. Here are a few aspects of the conference that we are most excited about.

First, we have a number of great courses for which you can register on the topics of office-based use of buprenorphine, telepsychiatry, marijuana and mental health, integrated care, child psychopharmacology, and a psychiatry board review course. We're also excited about the topics being presented in our lectures, symposia, workshops, and other conference formats. They are of great relevance to clinical psychiatrists, such as the modern and optimal use of clozapine, long-acting injectables, ECT, telepsychiatry, motivational interviewing, and measurement-based care.

Other presentations are on unique and cutting-edge topics; you won't want to miss them! They include

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sessions on medical-legal partnerships, the mental health consequences of climate change, the ECHO model, the ongoing opioid epidemic, and many others.

In light of the urgent and increasing need for political advocacy, there are a number of sessions on physician legislative and policy advocacy. Here are some of the session titles: "Big Goals, Small Steps: The Psychiatrist's Journey to Advocate," "Psychiatrists as Allies: Navigating Power and Privilege in Psychiatry," "Cultivating Physician Advocacy: Opportunities and Challenges in Training and Beyond," and "Advocacy Skills for Psychiatrists: From the Clinic to the Capitol." You won't find those learning experiences at any other conference. And did we mention the two-day Medical Director's Boot Camp?

We're also very pleased with the line-up of heavy-hitter speakers, including Drs. Ben Druss, Michael Flaum, Steve Goldfinger, Helena Hansen, Patrice Harris, Brian Hepburn, Charles Kellner, Ken Minkoff, Phil Muskin, Joe Parks, David Pollack, Kerry Ressler, Ruth Shim, and many others.

In addition to these extremely talented speakers, we are fortunate to have with us APA President Dr. Anita Everett and retired U.S. Army Lt. Gen. Mark Hertling, who will be giving the lecture at the opening session. Perhaps most importantly, the IPS is a great way to get to know the experts, spend time with colleagues, and enjoy the great city of New Orleans and everything it has to offer.

Stop us in the lobby, hallways, or Exhibit Hall of the Hilton New Orleans Riverside to give us your feedback! We look forward to welcoming you in New Orleans. **PN**

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of topics important to psychiatry and our patients. Each topic heading includes APA position statements, fact sheets, and more, and helped me narrow my focus.

The State Affairs page, https://www.psychiatry.org/psychiatrists/advocacy/state-affairs, addresses matters affecting your town, county, and state. Although the legislative agenda in each state varies widely, some topics (for example, Medicare and the Affordable Care Act) are relevant regardless of your location.

Another place to find out what's going on in your state is to become involved in your local district branch. (Contact information for district branches can be accessed on APA's website at https://www.psychiatry.org/about-apa/meet-our-organization/district-branches.) My branch, the Connecticut Psychiatric Society, has monthly meetings at which we discuss the current legislative session or events or bills that affect our patients. Much of the legislation up for debate this year has concerned the opioid epidemic. These meetings have been a great way to meet other psychiatrists in my area who want to get involved.

So what's actually keeping us from getting involved? One concern I've had is that some of our colleagues may not have a complete understanding of the Goldwater Rule. (The latest ethics opinion on the rule is posted at https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/APA-Ethics-Committee-Goldwater-Opinion.pdf.) The bottom line is that psychiatrists should not diagnose people they haven't evaluated. But following the Goldwater Rule doesn't mean you can't get involved in politics. There's nothing preventing psychiatrists from contacting lawmakers about legislation, educating the public about mental illness, or getting involved in political campaigns.

Here's what I've learned. Avoid search-engine rabbit holes by relying on APA's website for the advocacy information you need to know. If you find you have questions, don't hesitate to contact the staff of APA's Department of Government Relations. Use the advocacy guide to learn how to contact legislators and get involved. And finally, talk to people! Most of my tips have come from friends and colleagues finding their way along a new advocacy path.

Being an active advocate can feel overwhelming, but we need informed practitioners to speak up about what needs to happen. Your opinion matters.

Now get out there and advocate! **PN**

Advertisement

Can Childhood Infections Trigger Mental Disorders?

Understanding the role post-infectious autoimmunity plays in a large spectrum of psychiatric symptoms could lead to new avenues for the treatment and prevention of childhood mental illness. **BY JOANN BLAKE**

The latest and largest-scale study to test the pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection (PANDAS) hypothesis supports the curious role of infections in the development of mental illness.

Strep infection such as strep throat or scarlet fever has been linked with obsessive-compulsive disorder (OCD) and tic disorders, a controversial concept first defined by Susan Swedo, M.D., then a pediatrician-researcher at the National Institute of Mental Health (NIMH). Dramatic symptoms appear suddenly after the infection, and may include motor or vocal tics, obsessions, compulsions, and anxiety attacks.

Almost 20 years ago, Swedo and colleagues published a study about the first PANDAS cases they identified, "Pediatric Autoimmune Neuropsychiatric Disorders Associated With Streptococcal Infections: Clinical Description of the First 50 Cases" (*American Journal of Psychiatry*, 1998). Since then, numerous research groups have tried to prove or disprove the hypothesis.

The 2017 Danish study, "Association of Streptococcal Throat Infection With Mental Disorders: Testing Key Aspects of the PANDAS Hypothesis in a Nationwide Study," published online in *JAMA Psychiatry* May 24, shows that children with preceding strep throat infections did indeed have an elevated risk of mental disorders, particularly OCD and tic disorders. However, the study also found non-streptococcal throat infection to be associated with increased risks, though to a lesser degree. This finding may support a more recent broader concept called pediatric acute-onset neuropsychiatric syndrome (PANS).

Sonja Orlovska, M.D., says one of the main findings from the recent Danish research study testing the PANDAS hypothesis is "the connection between somatic and mental illness."

"Our study contradicts the PANDAS hypothesis to some extent," wrote first author and co-researcher Sonja Orlovska, M.D., affiliated with the Mental Health Centre Copenhagen and the University of Copenhagen, Denmark, in an email to *Psychiatric News*. "Still, the risk of OCD remained highest after a step versus non-strep throat infection, pointing to a specific association between strep infection and OCD, in line with PANDAS."

Swedo, now director of the Pediatrics and Developmental Neuroscience Branch at NIMH, called the Danish study an important addition to the growing body of PANS/PANDAS literature. "Their finding of increased rates of *any* mental disorder following strep infection suggests that post-infectious autoimmunity may play a role in a large spectrum of psychiatric symptoms, which could lead to new avenues for treatment and prevention of childhood mental illness," she said in a statement to *Psychiatric News*.

The Danish researchers concluded that their results may favor the essential elements of PANS, because it offers an alternative to PANDAS with wider diagnostic criteria and without the restriction of streptococcal infection.

Data Specifics From the Danish Study

This PANS/PANDAS population-based cohort study used data from 1,067,743 individuals under 18 years of age in the nationwide Danish

see **Infections** *on page 19*

Advertisement

New Treatment Guidelines Set for PANS/PANDAS

Recommendations from experts focus on psychiatric and behavioral interventions, immunomodulatory therapies, and treatment and prevention of infections that underlie neuropsychiatric conditions. **BY JOANN BLAKE**

In July, Susan Swedo, M.D., director of the Pediatrics and Developmental Neuroscience Branch of the National Institute of Mental Health (NIMH), along with a national panel of experts, published comprehensive treatment recommendations for Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS) and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infection (PANDAS), now considered a subset of PANS, in the *Journal of Child and Adolescent Psychopharmacology*.

PANS/PANDAS are characterized by an unusually abrupt onset of symptoms of obsessive-compulsive disorder (OCD), tics, or restricted eating, and presumed to be triggered by a throat infection or other disease mechanisms.

A work group of experts reviewed the published literature on PANS/PANDAS and drew upon their combined clinical experience with more than 1,000 children with PANS/PANDAS to develop the recommendations. The group decided that treatment of PANS should involve a three-pronged approach that uses psychiatric medications when appropriate to provide symptomatic relief, antibiotics to eliminate the source of neuroinflammation, and anti-inflammatory and immune modulating therapies to treat immune system disturbances.

The treatment guidelines are divided into three clinical focus areas:

- Psychiatric and behavioral interventions to address OCD symptoms, eating restrictions, anxiety, irritability, and more.

- Immunomodulatory therapies, such as oral corticosteroids, that target the neuroinflammation and post-infectious autoimmunity commonly seen in PANS/PANDAS.

- Treatment and prevention of the streptococcal and other infections that underlie these neuropsychiatric conditions.

PANDAS is set in motion by antibodies directed toward the streptococcal bacteria that mistakenly cross-react with the basal ganglia of the brain. This misdirected immune response produces an abrupt onset of neuropsychiatric symptoms, according to NIMH researchers who first proposed the hypothesis in the early 1990s.

A more recently defined condition (2012), PANS includes a range of triggers and multiple etiologies, not just strep infection, as in PANDAS. Still, in cohorts of well-characterized PANS patients examined by these experts, evidence of post-infectious autoimmunity or neuroinflammation was found in more than 80 percent of the cases, according to the new guideline report.

The unusual and startling behaviors associated with PANDAS and PANS often prompt parents to ask for a referral to a psychiatrist or psychological services, said Margo Thienemann, M.D., clinical professor of psychiatry at Stanford Medical School and co-director of the PANS Program at Stanford Children's Health. Children may become overly irritable and have mood swings, sleep disturbances, anxiety attacks, urinary problems, attention and concentration difficulties, or regress into "baby talk."

Susan Swedo, M.D., continues her pioneering work on PANS/PANDAS by joining experts across the country in publishing comprehensive treatment guidelines for clinical practitioners.

Thienemann, a co-author of the new guidelines, told *Psychiatric News*, "These patients should receive a thorough medical evaluation and certainly, a throat culture. We should remind ourselves that mental illnesses are also medical illnesses."

Along with a complete medical and psychiatric history and physical exam, clinical assessment should include laboratory testing of blood and possibly cerebrospinal fluid, and selected imaging procedures, according to the guidelines. Even in children without symptoms of pharyngitis, a throat culture should be obtained to exclude the possibility of an occult strep infection as the inciting agent, Swedo told *Psychiatric News*.

"If the culture is positive, a course of antibiotics should be given immediately to clear up the infection and the symptoms will subside. Meanwhile, the clinician may prescribe NSAIDs or prednisone to calm down the immune system. Some children may also need psychotherapy while they're getting better," Thienemann advised.

Physicians should note that PANS/PANDAS is a diagnosis of exclusion. "The diagnosis should be made only when symptoms are not better explained by a known neurological or medical disorder, such as Sydenham chorea, autoimmune encephalitis, neuropsychiatric lupus, central nervous system vasculitis, and others," according to the guidelines.

This research was funded by Auspex Pharmaceuticals, NIMH, Shire Pharmaceuticals, Pfizer Inc., F. Hoffmann-La Roche Ltd., AstraZeneca Pharmaceuticals, Centers for Disease Control and Prevention, Massachusetts General Hospital, Sunovion Pharmaceuticals, Neurocrine Biosciences, Psyadon Pharmaceuticals, the PANDAS Network, the International OCD Foundation, and the Tourette Syndrome Association. **PN**

The guidelines, "Clinical Management of Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS)," appear in three parts: "Part I–Psychiatric and Behavioral Interventions" is posted at http://online.liebertpub.com/doi/full/10.1089/cap.2016.0145; "Part II—Use of Immunomodulatory Therapies" is posted at http://online.liebertpub.com/doi/full/10.1089/cap.2016.0148; and "Part III—Treatment and Prevention of Infections" is posted at http://online.liebertpub.com/doi/full/10.1089/cap.2016.0151.

AADPRT

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Many other vignettes describe more complex situations involving nuanced decision making around patient care and professional ethics and include annotated references to guide learners. All of the vignettes are grounded in the real experiences of psychiatrists working with patients.

"Even before the task force was created, we held a workshop at an AADPRT annual meeting where it became clear there was a huge need for education in this area," DeJong said. "At that workshop and subsequent ones, we collected material in the form of stories people submitted to us and developed these teaching vignettes based on actual clinical experience."

It is not known how widely the AADPRT curriculum is being employed at institutions around the country, but DeJong said that anecdotally the level of consciousness among educators about issues relating to digital technology and medical professionalism has dramatically increased. "Many of the changes that are happening in medical education are happening at the institutional level rather than the training-program level."

She continued, "I think technology is going to become an increasingly important part of all health care, and that will be true for mental health care as well. Somehow we have to find a balance between making sure our graduates have the necessary skills to function and use these new tools skillfully, while also helping them develop the thought process that allows them to pause, think about the ramifications of these tools, and remember the important tenets of psychiatric professionalism.

"Moreover, I think psychiatry is different in that our patients are vulnerable in a variety of ways, and the kind of information we are privy to is especially intimate. I think that places on psychiatrists a higher obligation to pay attention to the core ethical values of our profession." **PN**

APA offers a course based on the AADPRT curriculum titled "Professionalism and the Internet." It can be accesed at https://education.psychiatry.org/Users/ProductDetails.aspx?ActivityID=445. An abstract of "Professionalism and the Internet in Psychiatry: What to Teach and How to Teach It" is posted at https://link.springer.com/article/10.1176/appi.ap.11050097.

Social Skills Therapy for ASD Shows Modest Benefits in Routine Settings

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A clinical trial of youth aged 8 to 17 carried out in 13 outpatient behavioral clinics has found some improvements in parental reports of autism symptoms. **BY NICK ZAGORSKI**

Social skills training (SST) is one of the most common therapies provided to children and adolescents with autism spectrum disorder (ASD), yet there is sparse evidence to show how well it works. There have been clinical studies suggesting SST—which incorporates behavioral training, role-playing, and social activities to improve communication, interaction, and confidence—is modestly effective, but these have been conducted in controlled environments.

A study published in the July issue of the *Journal of the American Academy of Child and Adolescent Psychiatry* provides some of the first real-world data on SST. Researchers reported that this approach provides some benefit, but it is inconsistent. SST also seems to be more effective in adolescents, particularly adolescent females.

The novel finding regarding gender is important, noted lead investigator Sven Bölte, Ph.D., a professor of child and adolescent psychiatry at Stockholm's Karolinska Institutet, and colleagues. Previous clinical studies have involved almost entirely male participants, making gender effects difficult to parse out.

Elizabeth Laugeson, Ph.D., an assistant clinical professor of psychiatry and biobehavioral sciences at the University of California, Los Angeles, found the gender differences curious, since her own research (she co-developed a social skills program known as PEERS, as described in the October 2, 2015, issue of *Psychiatric News*) has not seen such differences.

"This phenomenon needs further examination, but it is quite encouraging, since the female population has been largely overlooked in autism research," Laugeson told *Psychiatric News*.

The results showing better adolescent performance were less curious, Laugeson added, since the intervention the authors used was not parent assisted. While adolescents have more independence, younger children need parental involvement to gain the most benefit.

In addition, the study intervention, which is called KONTAKT, was set up so adolescents received 90-minute sessions each week compared with 60-minute sessions for children, so they were getting more therapeutic time as well.

As a whole, though, this study was welcome news as it provides some positive data backed by the rigor of a randomized, placebo-controlled trial and the applicability of a naturalistic study, she said.

For this study, Bolte and his colleagues recruited 296 youth (88 female) aged 8 to 17 with ASD and no underlying intellectual disability. The participants were divided to receive either 12 weeks of KONTAKT in addition to their standard care (which could include psychotherapy, speech therapy, and/or other interventions depending on need) or standard care alone. KONTAKT is a structured program that incorporates cognitive-behavioral therapy (CBT), computer-based training programs, behavioral activation, and other educational elements in a group-based session.

The sessions were carried out across 13 outpatient child psychiatry clinics in Sweden by the regular staff. The primary outcome measure was changes in the parent and teacher reports of the Social Responsiveness Scale (SRS), which assesses social communication ability. Parents, teachers, and the session trainers also provided reports for several secondary outcomes, including the children's overall functioning, ASD symptom severity, and parental stress.

At the end of the intervention period, there were no significant differences between the SST and standard care groups among children aged 8 to 12. However, adolescents receiving KONTAKT had around an 8-point positive change in parental SRS scores; this improvement persisted at a three-month follow-up visit.

When assessing by gender, the authors found no differences between the groups among males, but females in the KONTAKT group had about a 9-point improvement in their parental SRS scores compared with females in the standard care group at the end of the study; however, these improvements were no longer evident at the three-month follow-up.

Among the secondary outcomes for all ages, SST moderately improved adaptive functioning scores as reported by parents and symptom severity as reported by the trainers. Analysis of the teacher reports did not indicate any difference between the groups, but the authors did report that the response rate from teachers was fairly low. At the same time, they acknowledged that the parents and trainers knew which intervention the children were receiving, so there might have been some bias in their reporting.

"If there's a take-home message for social skills practitioners, it's that using an evidence-based curriculum is very important," Laugeson said. "It's not just what you teach, it's how you teach. Many programs try to build social skills just by doing group activities or trying to create friendships like a shared-interest group would. Autism is not a shared interest." **PN**

"Social Skills Training for Children and Adolescents With Autism Spectrum Disorder: A Randomized Controlled Trial" is posted at http://www.jaacap.com/article/S0890-8567(17)30202-2/fulltext. "Program Teaches Social Skills to Adolescents With Autism" is posted at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2015.9a12.

Many Prescription Opioids Go to Adults With Depression, Anxiety

An estimated 18.7 percent of adults with a mood or anxiety disorder filled multiple prescriptions for opioids in the past year, compared with only 5 percent of adults without such a diagnosis. **BY NICK ZAGORSKI**

There is a strong and reinforcing relationship between mental illness, pain, and the pain relief offered by opioids. Several studies have pointed to a higher use of opioids among people with a mental disorder, but this use has not been thoroughly examined.

A study published in the July issue of the *Journal of the American Board of Family Medicine* now suggests that over half of all opioid prescriptions for adults in the United States each year go to people diagnosed with a mood or anxiety disorder.

When extrapolated to the national population, these findings estimate that adults with a mood or anxiety disorder receive 60 million of the 115 million opioid prescriptions distributed annually.

"It's important to state that this study looked at legal prescriptions; it did not assess or make any suggestions about mental illness and opioid abuse," said lead investigator Matthew Davis, Ph.D., M.P.H., an assistant professor in the Department of Systems, Populations, and Leadership at the University of Michigan School of Nursing.

"But these prescriptions are how opioids get into society, so it's important for us to quantify prescription flow at the national level to help guide clinical guidelines and policy decisions," he told *Psychiatric News*.

Davis and his colleagues performed their analysis using data from the 2011 and 2013 Medical Expenditure Panel Survey (MEPS), a national survey conducted by the federal Agency for Healthcare Research and Quality that gathers extensive information on a person's overall health, what health care services they use, and how much they pay.

The final sample consisted of responses from 51,891 adults in the

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Experts Discuss What Psychiatrists Need to Know About Medicinal Cannabis

Clinicians considering recommending cannabis for patients should be sure they know the laws of their state and have obtained a written statement of informed consent. **BY NICK ZAGORSKI**

Twenty-nine states and the District of Columbia have legalized medical cannabis, with more potentially on the way. As psychiatric disorders are among conditions for which cannabis might be recommended, psychiatrists throughout the country are or could soon be engaged in discussions about medicinal marijuana with their patients.

There are a few steps clinicians can take to prepare for such conversations, according to a group of experts who participated in a session on medicinal cannabis at APA's 2017 Annual Meeting.

One of the first important facts about medicinal cannabis, noted David Gorelick, M.D., Ph.D., a professor of psychiatry at the University of Maryland, is that psychiatrists and other physicians cannot technically "prescribe" it. Cannabis is classified as a Schedule 1 controlled substance by the Federal Controlled Substances Act; the Schedule 1 category includes drugs considered to have a high potential for abuse and no currently accepted medicinal value and therefore cannot be prescribed. Instead, physicians can "recommend" or "certify" that a patient could benefit from incorporating medical cannabis into their treatment plan.

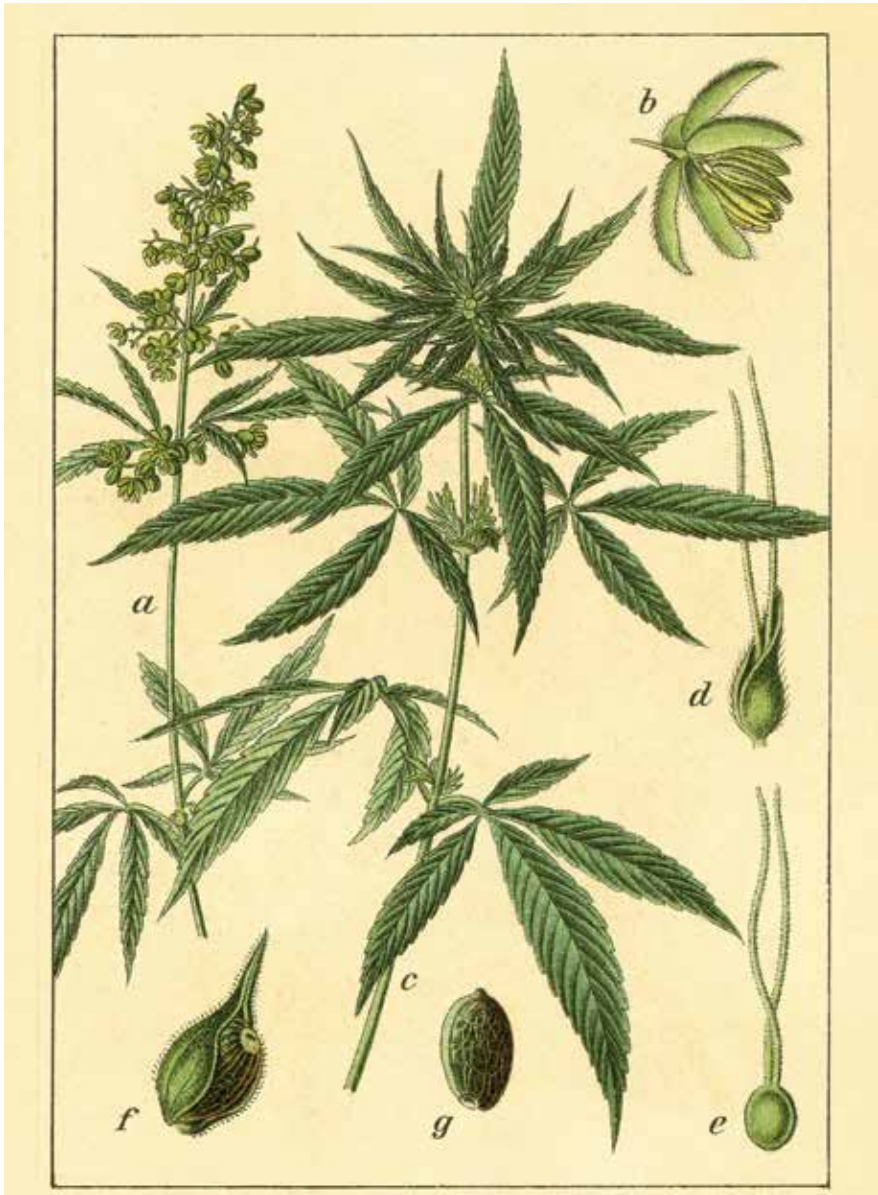
There are currently 53 medical conditions that qualify for medicinal cannabis in at least one state, but each state has its own list of acceptable conditions, explained Kevin Hill, M.D., an addiction psychiatrist at McLean Hospital in Boston. For example, posttraumatic stress disorder is considered a qualifying condition in New Jersey, but not in neighboring New York.

"There is a big difference, though, between what the laws say and what the science says," Hill said. He highlighted the recent 2017 report from the National Academies of Science, Engineering, and Medicine on the therapeutic evidence for cannabis or cannabis-derived products as a good resource to see which conditions have some science behind therapeutic claims (*Psychiatric News*, May 19, 2017).

Before recommending cannabis for a patient, John Halpern, M.D., director of the Boston Center for Addiction Treatment, said clinicians should first obtain a written statement of informed consent. He recommends that such consent forms include the following terms:

- Patient will store medicinal cannabis in a secure lockbox.
- Patient will not divert supply to anyone else.
- Patient will keep a regular appointment schedule.
- Patient will agree to submit to urine drug testing, if requested.
- Patient will keep a log of cannabis intake that includes information such as date and place of cannabis purchase, amount used per session and route of administration, as well as symptom improvements or side effects.
- Confirmation that patient is aware of all relevant cannabis regulations in their state.
- Patient will not bring cannabis to states where it is illegal, nor violate any state laws such as driving under the influence.
- Patient agrees that failure to take these steps could result in a loss of the physician recommendation.

Halpern then discussed the tricky proposition of discussing with patients how and when to use cannabis so it's most effective. Unlike pharmacies that dispense medications with standard doses, every dispensary has its own strains of cannabis and every strain has different levels of chemicals. Halpern said that vaporization/volatilization of cannabis is the preferred intake method to get a therapeutic dose with the lowest risk of adverse effects, while edible forms pose the most risks. Also, strong versions of cannabis like hashish should be avoided, especially in people who are drug naïve, he said. Lastly, Halpern said that patients taking medical marijuana should do so in the company of a support person not taking the drug. **PN**



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United States. The authors then used both the respondents' self-reports as well as clinical and pharmacy data to identify depression and/or anxiety diagnoses, opioid prescriptions, and the conditions associated with that prescription.

To examine the relationship between mood and anxiety disorders and prescription opioid use, the researchers focused on "opioid users"—individuals who had filled at least two opioid prescriptions in a year.

The authors found that 18.7 percent of adults with a mood or anxiety disorder filled multiple prescriptions for opioids in the past year, compared with only 5 percent of adults without such a diagnosis. After adjusting for sociodemographic and health factors, adults with a mood or anxiety disorder had 2.08-fold greater odds of being classified as opioid users.

This elevated risk of opioid use for adults with a mood or anxiety disorder was evident when looking at various subgroups of patients. Adults with a mood or anxiety disorder were more likely to be prescribed opioids for mild, moderate, or severe pain, as well as for different types of pain such as pain from cancer or a musculoskeletal condition. For instance, those with a mood or anxiety disorder and severe pain were nearly twice as likely to be opioid users as those without a mood or anxiety disorder diagnosis (45.3 percent compared with 24.1 percent, respectively).

"The overlap between depression and chronic pain is well known. Once patients are given an opioid, they may notice a reduction in pain and an improvement in mood and then may be very resistant to stopping the opioid. Patients may not even be conscious of the improved mood, but they are more likely to try to continue the medication," said John Renner, M.D., a professor of psychiatry at Boston University School of Medicine and vice chair of APA's Council on Addiction Psychiatry.

"I do not think that physicians deliberately prescribe an opioid because of the presence of mental illness; data seem to suggest that many primary care physicians aren't screening for psychiatric symptoms."

The study authors did not report any funding for this research. **PN**

"Prescription Opioid Use Among Adults With Mental Health Disorders in the United States" is posted at http://www.jabfm.org/content/30/4/407.

Sergey Ivanov

Could Later School Start Times Improve Adolescent Health?

National conference draws coalition of medical professionals, parents, educators, and others aiming to improve adolescent health by starting middle and high schools at 8:30 a.m. or later. **BY LYNNE LAMBERG**

Ah, Fall. Yellow school buses swarm streets, often while it's still dark, a glum reminder that most of the nation's middle and high schools start too early for most teenagers.

Pubertal delays in the biological clock make it hard for most teenagers to fall asleep before 11 p.m. Most need nine hours of sleep for optimal alertness and health. When schools start early, few get it.

Insufficient sleep boosts teens' risk of depression, use of alcohol and other substances, suicidal thoughts and attempts, and overall mortality, Wendy Troxel, Ph.D., an adjunct assistant professor of psychiatry and psychology at the University of Pittsburgh School of Medicine, said at the nation's first national conference on adolescent sleep, health, and school start times earlier this year in Washington, D.C.

Troxel, also a senior behavioral and social scientist at the RAND Corporation, was one of 30 speakers from a broad range of disciplines at the two-day conference that examined how sleep and educational system research could be used to inform public policy on school start times and promote healthy adolescent development. Other speakers included sleep specialists, psychiatrists and other physicians, psychologists, school counselors, other health professionals, students and parents, school superintendents and teachers, school board members, legislators, economists, transportation experts, and community activists.

A 2009 survey of 27,939 middle- and high-school students in Fairfax County, Va., where high schools started at 7:20 a.m., found high school students averaged only 6.5 hours of sleep on school nights, Troxel said, about an hour less than middle schoolers. More than 20 percent of high school students slept less than five hours on average on school nights. Only three percent reported sleeping at least nine hours per night.

Even among students averaging nine hours of sleep per night, 19 percent reported feeling sad and hopeless, 8 percent had considered suicide, and 1.8 percent had attempted suicide. Among students averaging only five hours sleep, a startling half reported having made a suicide attempt, according to an analysis of survey data by Adam Winsler, Ph.D., a professor of applied developmental psychology at George Mason University in Fairfax, and colleagues.

Medical Groups Advocate for Later School Start Times

Changes in the biological clock at puberty program teenagers to sleep from roughly 11 p.m. to 8 a.m. The CDC reports that the nation's 39,700 public middle, high, and combined schools start on average at 8:03 a.m., which often requires students to rise at 6 a.m. or earlier. Only about one in six of these schools starts at 8:30 a.m. or later.

The CDC together with the American Medical Association, American Academy of Pediatrics, American Academy of Sleep Medicine, and other groups have endorsed starting middle and high schools at 8:30 a.m. or later.

Each hour of missed sleep also increased students' odds of using tobacco, alcohol, marijuana, and/or illicit/prescription substances. The less sleep students got, the higher their risks overall, Winsler's team reported in the *Journal of Youth and Adolescence* in 2015. The corollary also is true, Winsler told *Psychiatric News*. For each additional hour of sleep, students reported less hopelessness and suicidal ideation, and fewer suicide attempts, regardless of whether researchers compared six hours of sleep to five, or eight hours to seven.

The study's findings helped spur the Fairfax County School Board to change its middle and high school start times from 7:20 a.m. to 8 a.m. or 8:10 a.m., starting in 2015, said Sandy Evans, school board chair, and co-founder of the advocacy group SLEEP in Fairfax. Fairfax County plans to study the impact of the delay, and to continue to explore the possibility of still later start times.

Aborting sleep after only five or six hours eliminates a significant amount of rapid eye movement (REM) sleep, noted Charles Czeisler, M.D., Ph.D., Baldino Professor of Sleep Medicine at Harvard Medical School. REM sleep, highest in the latter third of the night, is critical for learning, memory consolidation, and emotional processing. Sleepiness increases distractibility, and disrupts the ability to focus, Czeisler said, sometimes triggering a misdiagnosis of attention-deficit/hyperactivity disorder.

Can sleeping two hours later on Saturday and Sunday fully restore sleep-deprived students' ability to focus? "The answer appears to be 'No,'" said Dean Beebe, Ph.D., a professor of pediatrics at the University of Cincinnati, and director of Cincinnati Children's Hospital's neuropsychology program.

His research and that of others suggests two nights of recovery sleep improves mood in sleep-deprived students, he said, but that may not be enough to return students' levels of alertness and sustained attention to those obtained when they were fully rested.

Sleepy people often fail to recognize how sleepy they are, Beebe noted, a finding with direct implications for drivers, particularly those who are young and inexperienced.

In weighing school start time delays, parents and educators initially worried that if schools started later, students would stay up later. That fear proved groundless. When school starts later, students typically go to bed at the same time, and sleep longer, said Kyla Wahlstrom, Ph.D., a senior research fellow at the University of Minnesota. Wahlstrom conducted some of the first studies on the impact of school start time changes in the 1990s.

Every minute of delay helps, Wahlstrom said. When students get more sleep, she noted, their grades improve, attendance increases, tardiness falls, sports injuries drop, and rates of driving crashes decline.

Low achievers may benefit even more than high achievers from school start time delays, said Terra Ziporyn Snider, Ph.D., co-founder and executive director of Start School Later, a nonprofit organization advocating adoption of school start times that foster student health and safety. When struggling students get more sleep, she reported, they are more apt to go to school, arrive on time, pay attention, and graduate.

The Centers for Disease Control and Prevention (CDC) recommends that the nation's middle and high schools start at 8:30 a.m. or later. *Healthy People 2020*—the CDC's blueprint for improving the nation's health—includes the goal of increasing the proportion of students in grades 9 through 12 who get sufficient sleep (defined as eight or more hours of sleep on an average school night), said Anne Wheaton, Ph.D., an epidemiologist in CDC's Division of Population Health. In 2009, only 30.9 percent of U.S. students in grades 9 through 12 met that objective. In 2015, only 27.3 percent did so. The CDC seeks to raise that figure to 33.1 percent by 2020.

The adolescent sleep, health, and school start times conference was sponsored by the RAND Corporation, Yale School of Medicine Department of Pediatrics, Robert Wood Johnson Foundation, and Start School Later. **PN**

An abstract of Winsler's report, "Sleepless in Fairfax: The Difference One More Hour of Sleep Can Make for Teen Hopelessness, Suicidal Ideation, and Substance Use," is posted at https://www.ncbi.nlm.nih.gov/pubmed/25178930. *Healthy People 2020* is posted at https://www.healthypeople.gov/node/3506/objectives#5260.

JOURNAL DIGEST

BY NICK ZAGORSKI

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Transgender Students May Think About Suicide More Than Peers

Using data from a representative sample of U. S. youth, researchers have found that transgender teens have nearly three times the odds of suicidal ideation as their peers. The findings provide the first information on gender identity–related disparities in suicidal ideation, as well as some potential factors that may contribute to this disparity.

This study, a joint effort of Columbia University and the University of Texas, was published in the *Journal of the American Academy of Child and Adolescent Psychiatry*.

The data were derived from high school students who participated in the 2013-2015 California Healthy Kids Survey and the biennial California Student Survey; the final sample included over 600,000 students.

The study authors found that prevalence of past 12-month self-reported suicidal ideation was nearly twice as high for transgender youth compared with non-transgender youth (33.73 versus 18.85 percent), which calculated to 2.99-fold higher odds of suicidal ideation for transgender youth after adjusting for other variables.

The higher prevalence of depression and/or school-based victimization among transgender youth partially accounted for the association between gender identity and suicidal ideation; however, the study authors estimated that these factors only explained approximately 14 percent to 17 percent of the association.

"This underscores the need for future scholarship to assess additional social and structural factors—such as state-level legislation that promulgates stigma against transgender youth—that may explain why transgender youth are at heightened risk for suicidal ideation relative to non-transgender youth," they wrote.

Perez-Brumer A, Day J, Russell S, Hatzenbuehler M. Prevalence and Correlates of Suicidal Ideation Among Transgender Youth in California: Findings From a Representative, Population-Based Sample of High School Students. *J Am Acad Child Adolesc Psychiatry*. July 4, 2017. [Epub ahead of print] http://www.jaacap.com/article/S0890-8567(17)30316-7/fulltext

Schacher Lab/Columbia University

Study Suggests Memories Can Be Selectively Erased

A study in the marine snail *Aplysia* suggests that negative memories may be able to be erased without interfering with other, positive memories, even if they are part of the same neuronal circuit.

The findings, published in *Current Biology*, suggest that it may be possible to develop medications that specifically target maladaptive memories that trigger anxiety or posttraumatic stress disorder without affecting other memories.

For this study, researchers at Columbia University Medical Center and McGill University designed a simple brain circuit in which two *Aplysia* sensory neurons were connected to a single motor neuron. One sensory neuron was stimulated to induce an associative memory and the other to induce a non-associative memory.

The investigators found that each connection with the sensory neurons was maintained by a different form of a protein known as protein kinase M (PKM) in the motor neuron; PKM Apl III was expressed at the synapse of the associative memory while PKM Apl I was at the non-associative synapse.

These two variants of PKM are produced by two different enzymes. The researchers found that each memory could be erased by blocking one of the two PKM molecules, thus removing one memory without affecting the other.

The findings offer "a cellular basis for developing therapeutic strategies for selectively reversing maladaptive memories," the researchers reported.

Hu J, Ferguson L, Adler K, et al. Selective Erasure of Distinct Forms of Long-Term Synaptic Plasticity Underlying Different Forms of Memory in the Same Postsynaptic Neuron. *Curr Biol.* July 2017; 27(13):1888-1899.e4. http://www.cell.com/current-biology/fulltext/S0960-9822(17)30647-4

Goldwater Rule

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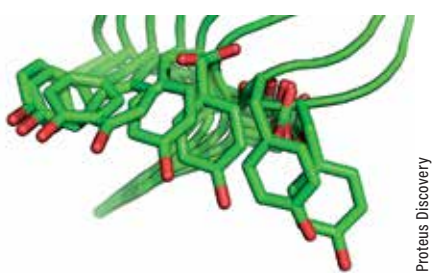
Voters get to decide who governs them, said Brendel in an interview. "The 25th Amendment [covering presidential disability and succession] addresses a president's ability to govern, but a public figure can't be diagnosed from afar."

APsaA issued a clarifying statement on July 25: "In an email to association members, our leadership did not encourage members to defy the 'Goldwater Rule' … Rather, it articulated a distinct ethics position that represents the viewpoint of psychoanalysts. The field of psychoanalysis addresses the full spectrum of human behavior, and we feel that our concepts and understanding are applicable and valuable to understanding a wide range of human behaviors and cultural phenomenon."

Wolfe said she found the whole uproar to be puzzling.

"Maybe there was some hope that someone would have something to say that would change the political situation," she said. "But this is a political issue, not a mental health issue, and the solutions need to be political, not based on commentary by mental health professionals." **PN**

The American Psychoanalytic Association statement on the Goldwater Rule is posted at http://www.apsa.org/content/american-psychoanalytic-association-statement-%E2%80%9Cgoldwater-rule%E2%80%9D. APsaA's position statement from 2012 regarding commenting on public figures is posted at http://www.apsa.org/sites/default/files/2012%20Position%20Statement%20Regarding%20Psychoanalysts.pdf.



Proteus Discovery

Protein Provides Link Between Parkinson's, Alzheimer's Disease

A study from a research team at Singapore's National Neuroscience Institute has uncovered a novel connection between Parkinson's and Alzheimer's disease.

The connection involves a protein known as leucine-rich repeat kinase 2 (LRRK2); mutations that over-activate LRRK2 are associated with about 40 percent of inherited forms of Parkinson's.

Using mouse models, the investigators found that mutant LRRK2 can modify the Alzheimer's-associated amyloid precursor protein (APP) in dopamine-producing neurons.

Once modified, the APP gets chewed up by enzymes, and a resulting fragment known as the APP intracellular domain travels to the nucleus and alters the expression of important genes related to cell structure and apoptosis (programmed cell death); this eventually triggers the death of the neuron.

The researchers found that LRRK2 inhibitors could prevent this cell death in both their mouse models and neurons cultured from human Parkinson's patients.

These findings, which were published in *Science Signaling*, "link LRRK2 and APP, two important proteins involved in two of the most common neurodegenerative diseases," which may open up new possibilities for future therapies for both disorders, the authors wrote.

Chen Z, Zhang W, Chua L, et al. Phosphorylation of Amyloid Precursor Protein by Mutant LRRK2 Promotes AICD Activity and Neurotoxicity in Parkinson's Disease *Sci Signal.* Jul 18, 2017; 10(488). pii: eaam6790. http://stke.sciencemag.org/content/10/488/eaam6790

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Increasing Marijuana Use In Adolescence Said to Be Risk Factor for Psychosis

Adolescents who transition from occasional marijuana use to more frequent marijuana use appear to be more likely to experience recurrent psychotic-like experiences, according to researchers at the University of Montreal.

The findings, published in the *Journal of Child Psychology and Psychiatry* in July, were based on an analysis of a cohort of 2,566 adolescents in the Montreal area. The adolescents, aged 13 to 16, completed computerized questionnaires that assessed substance use, psychiatric symptoms,

see **Journal Digest** *on page 18*

Area 5 Announces Winners of Resident Poster Competition

Four residents from Area 5 were among the winners of APA's 2017 Resident Poster Competition. They are (from left) Samantha Saltz, M.D., Zelde Espinel, M.D., Capt. Joseph Mansfield, and Joan Deng, M.D., Ph.D. The competition seeks to recognize exemplary research work by psychiatry residents and fellows. The winning posters were selected from more than 70 submissions. The award included a plaque and $300.

"These RFMs have put a lot of work into their research that appropriately is recognized at the national APA level," said Scott Benson, M.D., then Area 5 trustee. "But Area 5 realized that it is important for these future leaders to connect with their Area Council, and through the Area Council they connect back with the district branch. Such connections are important for their future work, whether they decide to work in Area 5 or move to another part of the country. APA is all about making valuable connections."

- **Huiqiong "Joan" Deng, M.D., Ph.D.,** PGY-3 psychiatry resident at the University of Texas Health Science Center, Houston: "Moderation of Buprenorphine Therapy Efficacy for Cocaine Dependence by Variation of the Preprodynorphin Gene"
- **Zelde Espinel, M.D.,** PGY-4 psychiatry resident at Jackson Memorial Hospital/University of Miami: "Global Mental Health Outreach, Screening, and Intervention for Highly-Traumatized Colombian Women: "Victims of the Armed Conflict"
- **Capt. Joseph Mansfield,** PGY-1 psychiatry resident at University of Texas Health Science Center, San Antonio: "Inpatient Psychiatric Admission Rates in a U.S. Air Force Basic Military Training Population"
- **Samantha Saltz, M.D.,** a child and adolescent fellow at Jackson Memorial Hospital/University of Miami: Cyberbullying and Its Effect on Adolescent Mental Health"

Journal Digest

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and performance on cognitive tasks annually for four years.

The researchers first identified three trajectories of psychotic-like experiences in the group: about 84 percent of teens had a low frequency of events that decreased over time, 8 percent had more frequent events that decreased over time, and 8 percent experienced an increase in the frequency of psychotic-like experiences.

A steeper growth in cannabis use from ages 13 to 16 was associated with a higher likelihood of being assigned to the increasing psychotic-like experience trajectory (odds ratio, 2.59); this association was partially explained by growth in depression symptoms among frequent cannabis users, but not anxiety symptoms or changes in cognitive functioning, the authors reported. **PN**

Bourque J, Afzali M, O'Leary-Barrett M, Conrod P. Cannabis Use and Psychotic-Like Experiences Trajectories During Early Adolescence: The Coevolution and Potential Mediators. *J Child Psychol Psychiatry*. July 5, 2017. [Epub ahead of print] http://onlinelibrary.wiley.com/doi/10.1111/jcpp.12765/full

Advertisement

ACA

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Susan Collins (Maine), Lisa Murkowski (Alaska), and John McCain (Ariz.) joining all 48 Democrats in opposing it. Among other provisions, the bill would have repealed the individual mandate to buy insurance and the employer mandate that requires businesses with 50 or more full-time-equivalent employees to provide health insurance to at least 95 percent of their full-time employees and dependents up to age 26; failure to do so results in a penalty. The bill also would have eliminated guaranteed coverage of essential health benefits, including mental health benefits.

The "skinny" bill was the latest—and possibly the last—effort by Congressional Republicans to do away with, or substantially revamp, the signature achievement of the Obama presidency.

The legislative odyssey began with passage by House Republicans of the American Health Care Act (AHCA) in May. The Congressional Budget Office estimated that the AHCA would result in 14 million more people uninsured in 2018 than under current law, and 23 million more people without insurance by 2016. The bill would have eliminated the extension of Medicaid to individuals at or below 138 percent of the federal poverty level (a key provision of the ACA that provided millions with new insurance) and would have instituted a system of per capita caps on Medicaid payments.

In June, Senate Republicans crafted a bill (the Better Care Reconciliation Act, or BCRA), modeled on the AHCA, that never made it to the floor for a vote—largely because of the intransigence of Collins and Murkowski. The following month Republicans tried again with a re-tooled BCRA that was introduced after Senate Majority Leader Mitch McConnell (R-Ky.) announced he was delaying the start of the August recess by two weeks to allow more time to address the legislation.

The re-tooled BCRA retained deeply problematic provisions including steep Medicaid cuts and elimination of essential health benefits. When that bill also failed to advance on the floor, Republicans opted for the "skinny" repeal, hoping that a House-Senate conference would later work out a more comprehensive repeal of the ACA.

In a dramatic ending, the skinny bill was defeated in an early morning vote when McCain, who had returned from Arizona following surgery for a blood clot and a diagnosis of brain cancer, cast the deciding vote.

APA has taken a leadership role in consistently opposing the efforts to repeal and replace the Affordable Care Act. APA leaders and staff have engaged Capitol Hill lawmakers and staffers; worked as a leader in coalitions, including the Mental Health Liaison Group (a group of medical and advocacy organizations that focuses on mental health issues); and facilitated "fly-ins" with leaders coming to Washington, D.C., to advocate on Capitol Hill and participate in press conferences with other major medical specialty groups.

Following the July 28 vote on the skinny bill, Levin said, "This is a significant victory for the nation, APA's members, and their patients. We now anticipate there will be hearings and bipartisan discussions about legislation to stabilize the individual market when Congress returns from the August recess. APA stands ready to work with members of Congress on sustainable solutions so that every American has access to quality health care, including mental health care." **PN**

Medicare

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treated by mental health professionals; adoption of new CPT codes for collaborative care services, as well as a proposal to pay for these services in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs); and a call to revise the Evaluation and Management Guidelines as a way to reduce administrative burdens to physicians.

APA staff will be reviewing the rule in detail and drafting comments with input from APA components and member experts sometime later this month. However, initial analysis indicates that the schedule includes several proposed changes that represent potential increases in reimbursement for psychiatrists and other mental health practitioners.

Here are the key proposals related to payments to psychiatrists:

- CMS proposes increasing indirect Practice Expense (PE) values for about 50 codes with very low direct PE. This proposal positively impacts services "primarily furnished by behavioral health professionals." The incremental increase will be spread over four years and amounts to $40 million a year for all 50 services for four years. Mental health professionals collectively are projected to see an increase in allowed payments of over $1 million a year.

- CMS also proposes adding new codes under telehealth services: Crisis Codes (90839, 90840) and an Interactive Complexity add-on code (90785).

- CMS plans to adopt CPT codes for Collaborative Care Model (CoCM) services and Behavioral Health Integration (BHI) services (99xx5) to replace the current temporary codes (G0502, G0503, G0504, and G0507).

- CMS is proposing to allow FQHCs and RHCs to receive separate payment for CoCM and BHI services starting January 1, 2018.

- CMS proposes to include payment for the CoCM and BHI services in the definition of "primary care services" leading to assignment of beneficiaries to a Medicare Accountable Care Organization (ACO). This may help encourage ACOs to adopt CoCM.

- CMS has proposed the adoption of codes that describe the work involved in implanting or removing buprenorphine subdermal implants for treatment of patients with opioid or other substance use disorders. CMS is also interested in strategies to incentivize organizations and professionals "to provide screening, assessment, and evidence-based treatment for individuals with opioid use disorders and other substance use disorders." This includes examples of potential reimbursement methodologies, systems integration, and care coordination among other things.

With regard to CoCM codes, CMS has indicated it will accept most of the valuation recommendations from the AMA/Specialty Society RVS Update Committee. Adoption of the recommended values means an increase in payment due to an increase in the practice expense component—approximately $18.00 and $2.50 more for the initial and subsequent months of care, respectively.

APA was instrumental in developing both the CPT codes and the recommendations adopted by the RVS Update Committee.

Additionally, CMS has called for a multi-year process to review the documentation guidelines for evaluation and management services in an effort to reduce the administrative burden on practitioners. Specifically, they will be considering redesigning the requirements with greater importance on medical decision making. APA will be working with a small coalition of other physician organizations to better understand the impact of this potential change.

The final rule is expected to be issued in November. **PN**

Information about the proposed rule is posted at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-2.html.

Infections

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registers between January 1, 1996, and December 31, 2013, with up to 17 years of follow-up. The Danish National Health Service Register provided information on individuals with the registration of a streptococcal test. Data analysis was conducted from January 1, 2016, to February 28, 2017.

Of the children included in the study (519,821 girls and 547,922 boys), 638,265 received a streptococcal test, 349,982 of whom had positive test results at least once.

Children with positive streptococcal test results had an increased risk of any mental disorder (n = 15,408; IRR, 1.18), particularly of OCD (n = 556; IRR, 1.51) and tic disorders (n = 993; IRR, 1.35), compared with individuals who had never been tested for streptococcal infection, according the study. Furthermore, the risk of any mental disorder and OCD was more elevated after a streptococcal throat infection than after a non-streptococcal infection.

Nonetheless, individuals with a non-streptococcal throat infection also had an increased risk of any mental disorder (n = 11,315; IRR, 1.08), OCD (n = 316; IRR, 1.28), and tic disorders (n = 662; IRR, 1.25).

The study was supported in part by grants from the Lundbeck Foundation and the Program for Clinical Research Infrastructure established by the Lundbeck Foundation and the Novo Nordisk Foundation. **PN**

An abstract of "Association of Streptococcal Throat Infection With Mental Disorders: Testing Key Aspects of the PANDAS Hypothesis in a Nationwide Study" is posted at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2629065. "Pediatric Autoimmune Neuropsychiatric Disorders Associated With Streptococcal Infections: Clinical Description of the First 50 Cases" is posted at http://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.155.2.264?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.

Board

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members, residents, medical students, and other physicians.

- **Resources:** Recommend resources other than education to support members' mental health, wellness, and satisfaction. This will include resources for vulnerable psychiatrists and opportunities to provide support to other medical membership organizations regarding physician well-being and burnout.

- **Communications:** Work with staff in the Divisions of Communication and Publishing to develop recommendations for a communications strategy that will promote these products and opportunities.

"So much of this problem has to do with professional isolation," Summers said.

Trustees agreed that burnout is a problem affecting all medical specialties at every career stage and that psychiatry's response to the crisis can benefit the entire medical community.

David Hathcox

APA President Anita Everett, M.D., said Maintenance of Certification is an issue affecting professional satisfaction, contributing to physician burnout.

Future of *DSM* Discussed

The Board heard a report from past APA President Paul Appelbaum, M.D., chair of the *DSM-5* Steering Committee. Since a web portal on the APA website was opened in January for the submission of proposals to revise or update the diagnostic manual, the committee has received just two relatively minor proposals: a correction to the criteria for acute stress disorder and the addition of ICD-10-CM codes for substance use disorder in remission.

Appelbaum said *DSM-5* was envisioned as a "living document," drawing on digital technology to update the manual incrementally, in place of the expensive and time-consuming effort to rewrite the *DSM* wholesale that has characterized revisions in the past. In 2013, then APA President Jeffrey Lieberman, M.D., appointed the Work Group on the Future of *DSM*, with Appelbaum as chair. The work group developed a report, approved by the Board in 2014, that outlined a process for iterative, online updating of the manual.

At last month's meeting, Appelbaum said the updating process was guided by two overarching, competing principles: the need for stability so that changes are not made too rapidly and the need for revisions that keep up with evolving knowledge and research.

Due to the small number of proposed changes so far, Appelbaum said that in the coming months, the steering committee will be revisiting the process to determine whether the threshold for making changes should be lowered and/or whether an effort to better publicize the web portal is necessary.

"For much of the year, the phone has been silent," Appelbaum said. "Is it because people are unaware of the process or are the criteria for making changes too rigorous?"

For more information about the update process, see an upcoming edition of *Psychiatric News*.

Other Actions

Trustees also approved several new policies including, among others, resolutions in the following areas:

- **APA elections:** The Board approved four recommendations of the Ad Hoc Work Group on Election Violation Issues for mediating and resolving allegations of election rule violations (see box on page 3).

- **Referenda:** Trustees approved a policy stating that if a majority of members approve an issue in a referendum, but the minimum requirement of 40 percent of the voting eligible membership does not participate, the issue will be brought before the Board as an action item for a vote.

- **IMGs:** Trustees approved the retention of a 1994 position statement opposing restrictions on the number of IMGs entering graduate medical training with a minor revision. The revised statement reads: "The American Psychiatric Association firmly opposes any arbitrary ceiling restriction on the number of International Medical Graduates entering graduate medical training."

- **Pharmacists altering of prescriptions:** The Board approved a position stating the following: "APA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a pharmaceutical product, to dispense a medication containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution). Physicians' prescriptions should not be overruled or substituted without prior physician approval and should recognize patient preference."

- **Mental health care for displaced people:** Trustees approved policy stating the following: "American psychiatrists have broad skill sets for relieving suffering inflicted upon immigrants and refugees by displacement from and within their home countries and can provide direct psychotherapeutic and psychosocial interventions, as well as programmatic leadership, for the care of persons suffering posttraumatic symptoms and other migration-related syndromes of distress. **PN**

Summaries of Board actions are archived at https://www.psychiatry.org/about-apa/meet-our-organization/governance-meetings/governance-meeting-archives.


David Hathcox

Mary Vance, M.D., M.P.H., who is the APA/American Psychiatric Foundation Public Psychiatry Fellow, urged the Workgroup on Physician Wellness and Burnout to consider issues at the "systems" level, where policies are formulated that affect physician professional satisfaction.

From the President

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Center for Workplace Mental Health, which provides it cost-free to interested employers.

Right Direction was developed by the Center in partnership with Employers Health CoalitionInc. and is a first-of-its-kind program designed to give employers the tools they need to address depression in the workplace.

Many employers who work with the center share their success stories with these and programs of their own design in the form of case studies that can be found on the center's newly designed website (http://www.workplacementalhealth.org/Case-Studies). These in-depth stories are an excellent way to see how varying approaches to ensuring the mental health and well-being of employees achieve effective results in a range of industries.

I have enjoyed watching the evolution of the Center for Workplace Mental Health over the years and the realization by many employers that investing in employees to help them be healthy and happy is key to creating a productive and successful workplace. The Center for Workplace Mental Health does a great job of highlighting this truth to employers, and I look forward to seeing what they are able to accomplish as time goes on. **PN**