VOLUME 53, NUMBER 16, AUGUST 17, 2018

AMERICAN PSYCHIATRIC ASSOCIATION

# PSYCHIATRIC NEWS

PSYCHNEWS.ORG

ISSN 0033-2704

David Hathcox

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**APA's Board of Trustees** addressed a number of major issues in psychiatry during its meeting last month at APA's new headquarters in Washington, D.C. See page 8.

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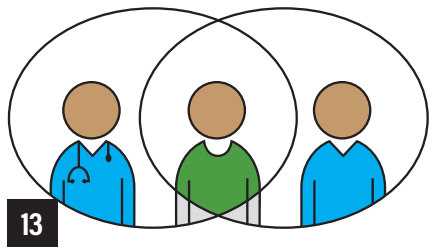
Incarceration of a woman after a drug relapse elicits differing opinions.



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The first of a series of articles on C-L psychiatry is launched in this issue.

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Genetic study finds connection between psychiatric disorders.

## Minority Fellowship Program Wins Doubled Funding

*The $7.1 million grant will help develop psychiatrists who can become leaders in serving minority and underrepresented populations.* **BY LINDA M. RICHMOND**

APA was awarded a grant totaling $7.1 million over the next five years by the Substance Abuse and Mental Health Services Administration (SAMHSA) to not only continue but to expand its Minority Fellowship Program (MFP), an amount nearly double its previous award.

The grant continues the 44-year tradition of the program at APA, which has trained more than 500 minority and underrepresented (M/UR) psychiatry residents—as well as those interested in serving M/UR populations—to teach, administer, conduct services research, and provide culturally competent mental health care to M/UR populations.

The current grant had been set to expire July 31, and President Donald Trump's requested budget had called for an elimination of its funding. APA lobbied aggressively to raise the profile of the program and secure a renewal by meeting with appropriations committee leaders and encouraging members to send action alerts.

"Addressing racial disparities in health care is a core part of the APA strategic plan and a specific focus in my presidential term," said APA President Altha Stewart, M.D. "The increased funding will allow us to expand the work of the fellows and support training that will impact the ability of all our members to provide culturally appropriate care and improve outcomes for all patients, especially those in minority and underserved communities."

The funding boost will allow the program to support up to 30 new psychiatry fellows each year, up from the 20 fellows. The program will also support up to 60 medical students and undergraduates to encourage them to pursue a career in psychiatry, with a focus on serving racial/ethnic and underserved populations.

*see* **Fellowship** *on page 25*

## Five States Pass Laws to Improve Compliance With MH Parity Laws

*The new laws will help enforce federal and state mental health parity requirements. The hope is that many more states will follow their lead.* **BY LINDA M. RICHMOND**

APA and its district branches were instrumental in pushing through mental health parity reporting bills in five states—Colorado, Delaware, Illinois, New York, and Tennessee—in their latest legislative sessions to hold insurance companies accountable for ensuring mental health benefits are comparable to those for medical and surgical care.

In New York, Barry Perlman, M.D., longtime chair of the Legislation Committee of the New York State Psychiatric Association (NYSPA), worked closely with lobbyists and other mental health

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PERIODICALS: TIME SENSITIVE MATERIALS

PSYCHIATRIC NEWS

***Psychiatric News,*** ISSN 0033-2704, is published biweekly on the first and third Friday of each month by the American Psychiatric Association. Periodicals postage paid in Washington, D.C., and additional mailing offices. Postmaster: send address changes to Psychiatric News, APA, Suite 900, 800 Maine Avenue, S.W., Washington, D.C. 20024. Online version: ISSN 1559-1255.

**SUBSCRIPTIONS**
U.S.: individual, $151. International: APA member, $205; nonmember, $227. Single issues: U.S., $26; international, $45. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or email institutions@psych.org.



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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

# APA Leads the Way!

***BY ALTHA STEWART, M.D.***

In my first column I wrote about one of the three areas I discussed in my Opening Session speech. In this column I want to discuss another—those activities that are often described as "social" issues that impact mental health and how organized psychiatry can and should respond in these situations. However, when I addressed this topic at the Annual Meeting, I had no way of knowing I would soon have the opportunity to advocate for just such an issue as part of a growing national crisis.

Within three weeks of assuming the presidency, we again learned how important APA's advocacy efforts are in changing policy that can effect a change in practice. You may recall that was when the administration began its practice of separating children from their parents at the U.S. southern border. I immediately heard from several members with suggestions regarding how APA might respond in this situation. Ultimately it led to one of my first presidential actions, the approval and release on May 30 of the APA Statement Opposing Separation of Children From Parents at the Border (https://www.psychiatry.org/newsroom/news-releases/apa-statement-opposing-separation-of-children-from-parents-at-the-border).

APA was one of the first medical associations to speak out against this harmful policy. And when the administration reversed that policy and ordered the reunification of families, we again went on record supporting that it be done as quickly as possible and that it include access to services and supports needed to minimize the likely trauma suffered by the children and their parents. In our most recent communication (http://alert.psychnews.org/2018/07/apa-joins-in-urging-house-senate-to.html), we called upon Congress to fully examine the harmful practice of separating families so that it doesn't occur again and that the children who remain in custody are returned to their parents and receive the care they need.

Also included in that statement were options for how interested psychiatrists could volunteer their services to assist these individuals. I am pleased to announce that since publication of that notice, we have received additional information from another organization—our long-time partner, Give an Hour. Some APA members may remember that through the APA Foundation, we partnered with Give an Hour years ago to offer our members an opportunity to join its network of volunteer providers of mental health treatment for returning military personnel, veterans, and their families. During this latest national crisis Give an Hour has joined groups like Lutheran Family Services, Catholic Charities, and Physicians for Human Rights to assure pro bono psychiatric services are available to immigrant families as they are being reunited. As we hear from more organizations engaged in this work, we will make that information available to you. And you will find more details about how you can help on APA's website at http://apapsy.ch/Help_Families.

Other ways you can become involved and make your voice heard include speaking out on social media about the lifelong health and mental health consequences of the separation practice—use the following hashtags #FamiliesBelongTogether and #EndFamilySeparation. Or you can write the administration urging that services be available for these children and their families. The APA Division of Communications

*see* **From the President** *on page 4*

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### DEPARTMENTS



### Build Your Clinical Skills

Register now for APA's fall meeting, IPS: The Mental Health Services Conference. This year's meeting will be held October 4 to 7 in Chicago. For more information, see page 10.


iStock/tankbmb


Above is a scene from a video that provides information on PsychPRO and explains how psychiatrists can benefit from joining. To view it, go to psychiatry.org/registry.

# PsychPRO Invites New Participants As APA Registry Reaps Success

*Many PsychPRO participants, ranging from solo practitioners to large hospital systems, qualified for CMS bonuses. The deadline to sign up for the registry to meet the 2018 reporting requirements is October 1.*

As of this past May, over 400 clinicians—including solo practitioners, members of group practices, and physicians in large health systems—were fully integrated into PsychPRO, APA's new mental health registry.

That surpasses the number of participants who were expected to join when the registry was created by more than 100 percent. APA also worked to get the new registry approved as a Centers for Medicare and Medicaid Services (CMS) Qualified Clinical Data Registry (QCDR) a year ahead of schedule.

"By getting this cutting-edge technology built expeditiously to achieve QCDR certification one year ahead of schedule, the registry was able to help participants who were integrated into PsychPRO to avoid a penalty, and most scored high enough to be eligible for bonuses under the Merit-Based Incentive Payment System [MIPS]," said APA CEO and Medical Director Saul Levin, M.D., M.P.A.

PsychPRO (Psychiatric Patient Registry Online) was launched in May 2017 to help members achieve the following:

- Avoid payment penalties and earn bonuses for meeting quality reporting requirements while minimizing the burden of data collection.
- Achieve optimal patient outcomes through tools to measure, chart, and benchmark clinical care.
- Automatically obtain MOC Part IV credit for quality improvement.
- Develop better ways to treat and prevent psychiatric illnesses and help the field of psychiatry develop and test its own quality measures.

MIPS began with the 2017 performance year, and the first payment adjustments will be in 2019. There are four MIPS performance categories: quality, advancing care information, cost, and improvement activities.

A total MIPS score of 70 or greater qualified a practice to receive possible bonus money on its 2019 Medicare reimbursements. Not reporting anything at all meant a practice would receive a 4 percent penalty. (For an overview of the Quality Payment System, go to APA's Payment Reform Toolkit at https://www.psychiatry.org/paymentreform.

Because the MIPS program was in its first year, CMS allowed practices to submit a minimum of one quality measure or one improvement activity to avoid the penalty. Many PsychPRO participants, ranging from solo practitioners to large hospital systems, did far better than this by meeting full CMS requirements and scoring 70 or greater out of a total score of 100. Four practices achieved a score of 100.

APA members who have used the registry for reporting say PsychPRO is a game changer. David Brodie, M.D., of New York called the registry "one of the best member benefits that APA has ever offered." Alvaro Camacho, M.D., who practices with a small Federally Qualified Health Center in the San Diego area, said, "PsychPRO has been an invaluable resource for reporting our outcomes."

Richard Ownings, M.D., a practitioner with Psychiatric Associates of Arkansas, concurred. "I enthusiastically endorse the PsychPRO program. I had actually given up on succeeding at MIPS, because the undertaking seems too onerous. . . . I can see how the PsychPRO interface will enable collection of the data that we need in order to report. I very much appreciate APA creating this solution for me and the other busy practitioners." **PN**

**If you wish to sign up for the registry to meet the 2018 reporting requirements, you must do so by October 1. For more information, go to psychiatry.org/registry.**

## From the President

*continued from page 3*

can assist you if needed. This is one of those "social" issues I mentioned in which I think APA can serve as a role model for how to deal with these challenges when they arise. I realize that the 37,000-plus members of APA may not agree on all aspects of the nation's immigration policies, but I believe that as physician experts in mental health, we understand the serious medical and health consequences of the stress and trauma experienced because of the separation policy. And I hope we can all agree that it is our professional responsibility to lead the way in advocating for how the nation should respond in such situations. I look forward to hearing from you as this issue continues to unfold. **PN**

### Nominations Invited for APA Presidential Appointments

APA President-elect Bruce Schwartz, M.D., invites APA voting members to indicate their interest in serving on APA components. Members who are willing to share their expertise and make a significant time commitment to serve APA, the field of psychiatry, and patients are asked to submit their names or nominate a colleague. Schwartz seeks APA members who represent the varied demographics of APA's member and patient populations. Please send the name of the component(s) along with a one-page description of the nominee's background, experience, and qualifications to appointments@psych.org.

### How to Code for Stable Psychotherapy Patient

***BY ELLEN JAFFE***

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

**Q:** I see a young patient every two weeks for 50 minutes, primarily for psychotherapy, and she is stable on her medication. I would like to know the most appropriate code(s) to use:

- Just 90834, since I'm primarily doing psychotherapy
- 99213 and 90836
- 99212 and 90836

**A:** Since you are monitoring the patient's reaction to her medication as well as providing psychotherapy, it could be appropriate for you to bill for the E/M as well as the psychotherapy. Since the patient is primarily presenting for psychotherapy and is stable, and you are not considering a change in medications or other management options, you probably are doing no more than a 99212 level of E/M. In this scenario, 99212 and 90836 appear to be the appropriate choice.

***APA members who have questions about reimbursement, coding, documentation, and other related practice issues may contact the Practice Management HelpLine at practicemanagement@psych.org or (800) 343-4671.***

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

# Capitol Hill Forum Seeks to 'Demystify' Gender Identity Dysphoria

*The minority stress model describes how individuals in any minority category can be subject to social stressors, including prejudice, that result in mental illness.* **BY MARK MORAN**

"Gender dysphoria" may someday go the way of homosexuality as a diagnosis in the *DSM*.

So said psychiatrists and other clinicians at a forum titled "Demystifying Gender Dysphoria," held last month in the Rayburn House Office Building on Capitol Hill. The forum was sponsored by APA and the American Psychological Association.

Eric Yarbrough, M.D., vice chair of APA's Council on Minority Mental Health and Health Disparities and a member of APA'S LGBTQ Caucus, recounted the evolution of diagnoses related to gender identity within *DSM*: it began as a category of "sexual deviations" and later "psychosexual disorders." Today's diagnosis of "gender dysphoria" describes a condition of "marked incongruence between one's experienced/expressed gender and assigned gender" along with "clinically significant distress or impairment in social, occupational, or other important areas of functioning."

Yarbrough said this evolution roughly mirrors the history of homosexuality in *DSM*. Homosexuality was listed as a disorder in *DSM-I* and *DSM-II* and dropped from *DSM-II* in 1973. In *DSM-III,* the diagnosis of "ego-dystonic homosexuality" was included to denote individuals who were distressed about their sexual orientation. This diagnosis was dropped with the publication of *DSM-III-R*. (Yarbrough noted that the diagnosis was sometimes used to justify reparative therapy.)

Similarly, gender dysphoria may some day be taken out of *DSM* as well. "Many gender-affirming psychiatrists would like to see it removed entirely from *DSM*," Yarbrough said.

Michael Hendricks, Ph.D., a psychologist with the Washington Psychological Center, outlined the "minority stress model," which seeks to explain how individuals in any minority category—including transgender and gender noncomforming (TGNC) people—encounter social and environmental stress that can result in mental illness.

"TGNC people, like all people, encounter general life stressors that can result in a wide range of reasons for needing psychological care," he said. "However, beyond these general stressors, TGNC people are subjected to excessive rates of discrimination, violence, and rejection related to their gender identity or expression. It is to these experiences that we attribute a potentially greater need for mental health services."

Hendricks said "minority stress" is understood to be additive to general stressors experienced by all people, chronic, and related to relatively stable underlying social and cultural structures. "There are a number of pathways to increased pathology, including substance use/dependence, mood disorders, and suicidal behaviors," he said.

But Hendricks added that experiencing prejudice and routine insults can also lead to coping and resilience. "Coalescing around minority identity produces group solidarity and cohesion that serve as protective factors. The minority stress model proposes that exposure to and engagement with others of one's own minority status lead to development of a minority identity, which ultimately lead to increased self-esteem and psychological health. It also contributes to a sense of belonging, which satisfies a basic psychological need."

Eric Yarbrough, M.D., says that many gender-affirming psychiatrists would like to see "gender dysphoria" removed from *DSM*.

He added, "Thwarted belongingness has been strongly implicated in negative mental health outcomes and suicide."

Hendricks cited a number of professional standards, competencies, and guidelines that can guide clinical care for TGNC people. These include Standards of Care of the World Professional Association for Transgender Health, Guidelines for Psychological Practice With Transgender and Gender Nonconforming People of the American Psychological Association, and Endocrine Treatment for Gender Dysphoric/Gender Incongruent Persons of the Endocrine Society.

APA's "Guide for Working With Transgender and Gender Nonconforming Persons" can be accessed by APA members at https://www.psychiatry.org/home/search-results?k=transgender.

For TGNC individuals seeking medical care, Hendricks said that "the key is in finding providers who are both knowledgeable about gender diversity and gender-affirmative approaches and who have developed the skills to deliver these approaches." **PN**

# Two States Pass Laws to Mandate Student MH Education

*The laws are intended to enable students in New York and Virginia to recognize mental health problems in themselves and others.* **BY LINDA M. RICHMOND**

Mental health education laws took effect last month in two states—New York and Virginia—that require their schools to provide mental health instruction for students as part of the health curriculum.

A small number of states have laws requiring mental health education or training, but only for teachers. New York was the first state to pass a law mandating mental health instruction for students. The Mental Health Association in New York State Inc. (MHANYS) led a six-year lobbying effort for the measure, explained John Richter, MHANYS director of public policy.

New York's law is meant to improve the mental health literacy of youth so that they can prevent, recognize, and seek help for mental health problems in themselves and others. While students there are already taught about such mental health concerns as alcohol, drug, and tobacco use, the bill noted, "Equally critical, but missing from current law and often the classroom, is the recognition that mental health is as important to health and well-being as physical health."

A recent CDC report underscores the urgency of boosting the mental health literacy of students: the U.S. suicide rate increased 30 percent over the past 15 years. A particularly troubling trend emerged for young girls: while it still represents a small number, there was a 300 percent increase in the suicide rate for girls aged 10 to 14 and an 80 percent jump for girls aged 15 to 24 during that time, the CDC reported. Half of all chronic mental illnesses begin by age 14.

The law does not mandate specific topics or material to be taught, but rather provides flexibility to New York school districts to develop their own curriculum. The new instruction standard applies to all elementary, middle, and high school students, and it applies to all schools under the purview of the State Education Department, both public and private.

MHANYS received a $1 million appropriation in the state budget to establish a School Mental Health Education Resource and Training Center, which will help school districts implement the law. The center will hold a series of in-person summits for educators, as well as offer webinars, free teacher training, and lesson plans.

## Virginia Law Spearheaded by High Schoolers

The Virginia law requires schools to recognize the multiple dimensions of health by including mental health and the relationship of physical and mental health in its instruction. The law also directs the state's Board of Education to review and update its Health Education Standards of Learning for students in the ninth and 10th grades to include mental health, in consultation with mental health professionals.

"Health education that respects the importance of mental health and the challenges of mental illness will help young people and their families feel more comfortable seeking help, improve academic performance, and save lives," according to the legislation.

Virginia's law was spearheaded by three high school seniors: Lucas Johnson, Alexander Moreno, and Choetsow Tenzin. Although each attended a different high school in Albemarle County, they "clicked instantaneously" after meeting at a student leadership institute and realizing they were all "very passionate on the issue of mental health," Johnson told *Psychiatric News*. For all three students, the issue was personal: Johnson said a good friend "out of the blue" told him she wanted to die by suicide, despite having a long list of academic and extracurricular successes.

"It really hit home for me how little I knew about the issue of depression or mental illness and how little I knew about how to help," he said. "I resolved that not only would I learn what to do

*see* **Laws** *on page 10*

# Resource Document Offers Clinicians Guidance On Risk-Based Gun Removal Laws

*Several states have enacted or are considering legislation that allows clinicians and family members to initiate the temporary confiscation of guns from individuals who pose a danger to themselves or others.* **BY REBECCA GREENBERG**

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In the wake of a series of mass shootings around the country, a resource document has been developed by APA's Council on Psychiatry and Law to provide guidance for members on how risk-based gun removal laws may be used to prevent future tragedies. The document, which expresses the views of the authors, was approved in June by APA's Joint Reference Committee.

"One of the strategies for gun violence prevention has been to develop risk-based gun removal laws," said council Chair Debra Pinals, M.D., a clinical professor of psychiatry and director of the Program of Psychiatry, Law, and Ethics at the University of Michigan. "These laws offer families and others the opportunity to have a firearm removed from someone who may be at risk to themselves or others."

Reena Kapoor, M.D., the lead author and an associate professor of psychiatry and associate program director of the forensic psychiatry fellowship at Yale School of Medicine, noted that as of late April, eight states had passed gun removal laws, and roughly 20 others were considering legislation.

Also referred to as "gun violence restraining orders," or more loosely as "red flag laws," risk-based gun removal laws are designed to address crisis situations. For example, a parent can ask police to remove firearms from the home if a teenager is threatening suicide. After a period of restriction, the individual can petition the court to have the firearms returned.

"Policies and practices vary significantly among states with gun removal laws regarding who can initiate the gun removal process, whether a warrant is required, what factors the court must consider before ordering firearm removal, what must be proven in court, how the firearms are restricted, and what process is used to restore the individual's firearm access," the authors wrote.

When the document was being drafted last year, four states—California, Connecticut, Indiana, and Washington—had enacted laws that allowed clinicians and family members to initiate gun removal regardless of the individual's diagnosis or whether the individual had been diagnosed with a mental illness. The authors used these states as case examples.

The resource provides a "succinct" document for clinicians who may not be aware of how these laws operate in their respective states, Kapoor said. State psychiatry societies or individual psychiatrists can share it with legislators and policymakers to show them how these laws work, she added.

In 2014, APA published a resource document that addressed the complex relationship between firearms, mental illness, suicide, and violence. It highlighted the limitations of using registries such as the National Instant Criminal Background Check System

*see* **Gun Removal** *on page 21*

# Parity

*continued from page 1*

advocates for several years championing New York's parity reporting bill that passed there. "This is clearly one of the most consequential pieces of legislation undertaken by NYSPA, and one that will advance the goal of fully implementing the spirit and intent of the federal and New York's parity law that we all fought so hard to enact 12 years ago," Perlman said.

The new laws vary by state (see box), but all require insurers to demonstrate how their care management practices for mental health and substance use treatment are no more restrictive than those for medical care.

"We are hoping that these are the first of many states to pass comprehensive parity reporting bills, because without this level of transparency and accountability on the part of insurers, we will never achieve full implementation of mental health parity laws," said Tim Clement, APA's Northeast regional field director of state government affairs.

It has been 10 years since the Mental Health Parity and Addiction Equity Act of 2008 required health insurers to provide the same level of benefits for mental health/substance use treatment as for medical or surgical care. That law has been largely successful in equalizing more straightforward "quantitative" mental health benefits for patients, such as number of covered visits per year and copay amounts.

But parity in how insurers design their more complicated managed care practices has not followed suit. Part of the problem is the complexity of overseeing parity for what are known as nonquantitative treatment limits (NQTLSs), such as prescription drug formulary design, prior authorization rules, network adequacy, provider reimbursement rates, or step therapies, Clement said.

"Unfortunately, the end result is that some people are denied coverage of mental health and addiction care when continued treatment is needed, and they subsequently suffer or even die from overdoses or suicides," Clement said.

For example, insurers continue to apply far more stringent network

*continued on next page*

## Five States Pass Parity Reporting Laws

Mental health parity reporting laws were passed in five states this past legislative session. Although the specific provisions in the laws vary, they will help enforce existing mental health parity laws by requiring health plans to improve their reporting practices on the subject.

- **Colorado HB 18-1357** was signed into law May 24. It requires the commissioner of insurance to report on compliance with mental health parity laws, establishes an office of the ombudsman to assist state residents in accessing behavioral health care, and appropriates $94,000 to implement the bill.
- **Delaware SB 230** sets annual reporting requirements for insurance carriers on their coverage for serious mental illness and drug and alcohol dependence, including for recipients of public assistance. At press time, it was awaiting signature by Gov. John Carney (D), who is expected to sign it.
- **Illinois SB 1707** requires health plans to submit parity compliance analyses to the Illinois Department of Insurance and the Illinois Department of Healthcare and Family Services, which will be made available on a public website. It requires the departments to perform market-conduct examinations and parity compliance audits and report on their enforcement activities annually to the General Assembly. It also requires expanded access to substance use disorder treatment and closes a loophole in Illinois law that allowed school district health plans to discriminate against mental health and substance use disorders. As of press time, the bill was still awaiting signature by Gov. Bruce Rauner (R), who is expected to sign it.
- **New York A3694A** requires insurers and health plans to submit certain data to its Department of Financial Services (DFS) so it can evaluate their compliance with federal and state mental health and substance use parity laws. Network adequacy, cost sharing, rates of appeals, and reimbursement rates for both in-network and out-of-network mental health providers are among a list of items to be evaluated. DFS will use the data to prepare an annual mental health parity report for consumers.
- **Tennessee Public Chapter 1012** requires its Department of Commerce and Insurance to implement and enforce mental health and substance use parity and prohibits any nonqualitative treatment limitations that apply to mental health or alcohol/substance use benefits that do not apply to medical and surgical benefits. It requires individual health policies to follow the same parity rules as group health policies. It also requires "drug and alcohol dependency treatment" be covered under parity rules and prohibits insurers from using any additional criteria for benefit determination for such benefits, aside from evidence-based clinical guidelines. The bill takes effect January 1, 2019.

# Court Finds Substance Users Can Be Jailed For Relapsing While on Probation

*Incarcerating an individual on probation after relapse for SUD appears to be a punishment for having an illness—or it could be a life-saving measure when inpatient treatment is not available.* **BY LINDA M. RICHMOND**

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Judges in Massachusetts may order individuals with a substance use disorder (SUD) who commit a crime to remain "drug free" as a condition of probation and may revoke probation for those who fail to remain abstinent, the state's highest court ruled last month.

The judge in this case did not abuse his discretion in concluding the defendant violated her probation when she tested positive for an illegal drug during a random drug test, the Massachusetts Supreme Judicial Court ruled. Furthermore, judges may jail defendants while they are awaiting probation violation hearings, the court ruled.

As the opioid crisis worsens across the country, the case had been closely watched by patient advocacy groups, many of whom weighed in with friend-of-the-court briefs. One urged the court to consider "the scientific consensus that substance use disorder is a chronic disease of the brain" and that relapse is a symptom of the disorder that is not effectively managed by incarceration or the threat of it, according to a brief filed on behalf of the Massachusetts Medical Society and joined by six other patient advocates including the American Academy of Addiction Psychiatry.

The case underscores that much more funding is needed for treatment of opioid use disorder. "It's a chronic issue and a sad situation where it looks like jail is the default option because we don't have a bed to treat someone," said John Renner, M.D., a professor of psychiatry at the Boston University School of Medicine and a member and former chair of APA's Council on Addiction Psychiatry. "In most places, the prison system is not designed or equipped to treat people with SUD."

Although courts have a very important role to play in holding people for what can be lifesaving treatment, Renner said, the ruling may set a troubling precedent. "I'm concerned about patients who are doing well in treatment but have a slip and then get pulled out of the community and put in jail for six months—where they will receive no treatment," he said.

### Defendant Tests Positive 11 Days After Initial Hearing

In this case, defendant Julie A. Eldred admitted in August 2016 to stealing jewelry from the home of a client and said she had sold it to support her heroin use. A judge imposed a one-year probation with special conditions that required her to remain drug free, submit to random drug screens, and attend outpatient treatment three times a week.

Eldred began outpatient treatment at a hospital, including medication-assisted treatment. But 11 days after her initial hearing, Eldred tested positive for fentanyl during a random drug test. She declined inpatient treatment, so her probation officer took her into custody. At a detention hearing, the judge said she took into consideration that the patient's family—her support network—was out of town and that it was the start of the holiday weekend when few treatment resources would be available. She ordered Eldred to be jailed until placement in an inpatient treatment facility became available. Eldred was jailed for 10 days—receiving no substance use treatment during that time—before a bed opened up.

The defendant's lawyer argued that since Eldred had been diagnosed with SUD, she was incapable of remaining drug free, setting her up for unconstitutional cruel and unusual punishment when the inevitable relapse occurred. Her lawyer also argued the drug-free requirement was an outdated moral judgment about an individual's SUD and that the decision to detain her constituted a punishment for her relapse.

"The judge was faced with either releasing the defendant and risking that she would suffer an overdose and die or holding her in custody until a placement at an inpatient treatment facility became available," the Supreme Judicial Court wrote in its decision. "Detaining a defendant may be permissible to protect the public and the defendant."

### 'People Do Respond to Consequences'

Ultimately, the decision affirming the constitutionality of court-imposed abstinence and treatment protects one of its most important tools—to deliver effective treatment to drug-using offenders, said past APA President Paul Appelbaum, M.D., the Dollard Professor of Psychiatry, Medicine, and Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University.

"Many courts, including more than 3,100 drug courts in this country, routinely impose conditions of supervision or probation that require SUD treatment and abstinence," Appelbaum said. "Studies of drug courts have found this approach reduces relapse to drug use, criminal recidivism, and overall costs."

Laurence Westreich, M.D., an associate professor of psychiatry at New York University's School of Medicine and past president of the American Academy of Addiction Psychiatry, noted that the judge in this case had a thoughtful response to the defendant's relapse—acting much like a drug court would have.

"People do respond to consequences," he added. "While revoking probation should be viewed as a last resort, jailing someone short term for a relapse may be necessary. Judges can be much more persuasive than clinicians in leading people to get help. In this case, it may have saved the defendant's life."

Westreich pointed out most individuals who enter SUD treatment are coerced in some way, either because their spouse is threatening to leave, their public assistance payments are going to be cut off, or they are being threatened with incarceration. "However, when we get someone in the door, whether they enter treatment voluntarily or are coerced, we know that treatment absolutely works, and that a large percentage of people get better." **PN**

**The Massachusetts Supreme Judicial Court's decision in *Commonwealth v. Julie Eldred* is posted at https://www.mass.gov/files/documents/2018/07/16/12279.pdf.**

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admission standards for mental health professionals, with more documentation required and fewer patients admitted, Clement said. Reimbursement for mental health professionals is lower too: an examination of claims data from preferred provider organizations for 42 million patients revealed that behavioral care services were paid 21 percent less than claims for primary care, a Milliman study found in December 2017.

New York's bill had faced vigorous opposition from managed care and behavioral health care organizations but was finally pushed through the Senate on the last day of the session, explained NYSPA's Perlman. As director of psychiatry at a large hospital for 35 years, Perlman said he witnessed the continued and disparate hurdles faced by individuals with mental health and substance use disorders when trying to obtain coverage for their care. "We were continuously in conflict with managed care companies," he added. Much of the responsibility for enforcement of parity laws has come down to the states.

Prior to the passage of the Illinois bill, the Illinois Department of Insurance was tracking compliance with existing parity laws mainly by tallying how many complaints it received from the public, said Meryl Sosa, executive director of the Illinois Psychiatric Society (IPS). "But most people don't know anything about parity and don't know enough to file a complaint. We're very happy about getting this bill passed."

The results of a statewide survey by the Kennedy Forum of Illinois mental health and substance use professionals, including IPS members, helped to sway the assembly, Sosa said. The survey revealed that clinicians have had problems getting a variety of behavioral health services covered by both Medicaid managed care organizations and commercial insurers. For example, more than half of providers surveyed reported that commercial health plans denied coverage for acute behavioral health services for their patients sometimes (41 percent), often (9 percent), or always (5 percent), because they were deemed "not medically necessary."

Anna Weaver-Hayes, executive director of the Colorado Psychiatric Society, said it strongly supported the passage of House Bill 18-1357. "It is often difficult to access care and even more so during a mental health/SUD crisis. This bill benefits the people of Colorado, our mental health and substance use disorder treatment providers, and the state."

APA has written a compliance guide for state regulators to use when evaluating parity compliance. It also has worked on model legislation other states can adopt. **PN**

**For help with passing parity legislation in your state, contact Tim Clement at tclement@psych.org.**

David Hathcox

Left: Resident-Fellow Member Trustee Tanuja Gandhi, M.D., comments on the report of the Work Group on Psychiatrist Well-Being and Burnout. The work group will continue as a standing committee of the Council on Medical Education and Lifelong Learning. Right: APA President Altha Stewart, M.D., reports on her meeting with leaders of the Japanese Society of Psychiatry and Neurology.

# APA to Advocate for Loan Repayment Aid To Psychiatrists in Public Settings

*Medical school loan repayments was just one of a number of issues that the Board addressed at its July meeting.* **BY MARK MORAN**

APA's Board of Trustees has approved a policy to advocate for state and federal legislation to provide funds to help repay loans for psychiatrists in community mental health centers, state psychiatric hospitals, and correctional facilities and for those using telemedicine to treat patients in these facilities.

The decision stemmed from an Assembly action paper approved by the APA Board of Trustees at its meeting last month in Washington, D.C. It was among a number of issues addressed by the Board, including ligature risk in hospitals, weapons use in inpatient facilities, solitary confinement of juveniles, and physician burnout.

The action paper addressing loan repayment for psychiatrists working in certain public settings was sponsored by Mary Jo Fitz-Gerald, M.D., and Mark Townsend, M.D., both representatives from the Louisiana Psychiatric Association. It was cosponsored by 17 other Assembly representatives.

The action paper noted that a 2012 report by the Association of American Medical Colleges indicated that some 86 percent of graduates have medical school debt, and the average debt for medical students across the country in 2011 was more than $160,000.

Meanwhile, the projected need for psychiatrists is greatly outpacing the current supply. The Department of Health and Human Services reports about 4,000 areas where there is only one psychiatrist for 30,000 or more individuals. More than 45 percent of psychiatrists are over age 60.

The action paper also emphasized that there is precedent for federal subsidies of medical school loans. The Clay Hunt Suicide Prevention for American Veterans Act (Clay Hunt SAV Act), signed into law by President Barack Obama in 2015, established a pilot project encouraging more psychiatrists to choose a career with the Veterans Health Administration (VHA) by offering medical school loan repayments on par with other government agencies and private practices.

Trustees also approved a position statement from the Council on Psychiatry and Law on the use of weapons in dealing with patient violence in hospitals (see box on facing page). The statement asserts that routine management of patient violence risk "is a clinical task that should be properly resourced" and that "weapon use is not part of routine clinical management."

The position statement also includes recommendations for hospitals to reduce weapon use overall by staff in hospitals when dealing with behaviorally disturbed patients.

## Other Reports and Actions

- **Ligature risks:** Trustees heard a report from APA CEO and Medical Director Saul Levin, M.D., M.P.A., about the issue of ligature risks in inpatient psychiatric facilities. Last year administrators at many hospitals expressed concern about the increased monitoring and enforcement of citations by the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission around elimination of ligature risks that were costing facilities exorbitant amounts of money (*Psychiatric News,* December 1, 2017). Levin said that APA is continuing to work with CMS and The Joint Commission about the issue. Meanwhile, he said that APA had surveyed 84 facilities in 34 states and the District of Columbia between April and June. Of the 55 that responded, 10 had closed inpatient beds due to the assessment of fines for ligature risks, and 14 had closed psychiatric beds. Twenty-three facilities reported paying fines between $100 and $6 million.

- **Physician burnout**: Trustees approved the formation of the Committee on Well-Being and Burnout under the Council on Medical Education and Lifelong Learning. The committee represents a continuation of the Ad Hoc Work Group on Well-Being and Burnout, appointed by then APA President Anita Everett, M.D.

- **Discrimination against religious minorities:** The Board voted to approve a position statement condemning acts of discrimination against any religious minority and affirming findings in the literature that isolation of religious minorities in the United States exacerbates negative mental health effects resulting from religious discrimination. Further, the statement urges practicing psychiatrists to reach out to and support

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Margaret Dewar

APA CEO and Medical Director Saul Levin, M.D., M.P.A., presents a gift to Theresa Miskimen, M.D., as a memento of her participation in the Grand Opening ceremonies of APA's new headquarters in March, which occurred while she was speaker of the APA Assembly. The presentation took place when the Assembly Executive Committee met last month at APA headquarters. With them are (from left) current Assembly Speaker James (Bob) R. Batterson, M.D., Speaker-elect Paul O'Leary, M.D., and Recorder Seeth Vivek, M.D.

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patients and communities of religious minority groups in this country.

• **Solitary confinement of juveniles**. Trustees approved a position stating that "solitary confinement of juveniles (also referred to as restrictive housing or segregation), with rare exceptions, should be avoided due to the potential for harm to the juveniles." In the rare case that a juvenile must be placed in solitary confinement, meaningful access to mental health care, medical care, education, and recreation should be provided to minimize the potential for psychological harm. Solitary confinement should never be used for punitive purposes, according to the statement. It was written by the Council on Psychiatry and Law; the Council on Children, Adolescents, and Their Families; and the Council on Minority Mental Health and Health Disparities. **PN**

**Position statements approved by the Board of Trustees can be accessed https://www.psychiatry.org/home/policy-finder. Archived summaries of Board actions can be accessed at http://apapsy.ch/Archives.**



## How to Minimize Weapon Use in Hospitals

A position statement on weapons use in hospitals approved by APA's Board of Trustees last month includes the recommendations below to reduce weapon use by staff in hospitals when dealing with behaviorally disturbed patients. "Weapons" include, but are not limited to, pepper spray, mace, nightsticks, Tasers, cattle prods, stun guns, and pistols.

Hospitals should minimize the unauthorized presence of weapons on their premises. As appropriate, these steps should include screening patients for weapons before admission to psychiatric emergency rooms and/or psychiatric inpatient units and screening patients assessed to be at high risk to others prior to admission to nonpsychiatric inpatient units.

Patients who pose a risk of harm to others should be managed by clinical staff using clinical approaches. These usual clinical approaches typically involve psychological interpersonal interventions and may include, when less-restrictive alternatives fail, the use of involuntary emergency medication, physical seclusion, and physical or mechanical restraint following guidelines issued by The Joint Commission and the Centers for Medicare and Medicaid Services.

Hospital clinical and security staff acting under the supervision of clinical staff should receive regular training in safely managing the risks posed by patients who present with agitation and are disruptive and engaging in escalating behavior.

Hospital administrations should ensure that clinical staffing levels are sufficient to facilitate proper clinical approaches to the management of patient violence risk that are sufficient to resolve the great majority of behavioral incidents.

Weapons should never be used by clinical staff or hospital security staff acting in a clinical capacity as a means of subduing a patient, placing a patient in restraint or seclusion, or otherwise managing violence risk.

Hospitals should have a policy in place to define when clinical control of a situation involving patient violence is being ceded to law enforcement or hospital security staff acting in a law enforcement capacity.

***"Weapons Use in Hospitals and Patient Safety" is posted at http://apapsy.ch/Patient_Safety.***

### Register Now!

Advance registration rates are now in effect for IPS: The Mental Health Services Conference. Register online at psychiatry.org/IPS, where you will also find information about housing and the full scientific program.

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# Symposia to Examine Complex Issues Of Workforce Diversity, Microaggressions

*APA's fall meeting, IPS: The Mental Health Services Conference, will be held October 4 to 7 at the Palmer House in Chicago. Advance registration fees are in effect. This year's theme is "Reimagining Psychiatry's Impact on Health Equity."* **BY MARK MORAN**

Enhancing diversity of the psychiatric workforce and countering prejudice in the community will be topics of discussion at this year's IPS: The Mental Health Services Conference in Chicago.

"Workforce Inclusion: Roadblocks and Relevance of Black Men in Psychiatry" will look at how increased diversity within a physician workforce can help address health disparities in minority and underserved communities. One topic is APA's Black Men in Psychiatry Pipeline Program, which seeks to recruit undergraduate black men who are thinking about medical school.

The symposium will be co-chaired by Chicago community psychiatrist Carl Bell, M.D., and Rahn Bailey, M.D., the APA Assembly representative from the Caucus of Black Psychiatrists.

Bell told *Psychiatric News* that black and other minority psychiatrists of his generation know the obstacles that stand in the way of greater diversity in medicine.

He related his own experience as an undergraduate with a plan to graduate early from college and attend medical school. "I told my plan to a college advisor who happened to be a white male," Bell said. "He suggested that I go for something more reasonable like auto mechanics. I tore up his suggestions as soon as I left his office and took the courses that ultimately helped me to finish college in two years and go to medical school.

"He was the antipathy of workforce inclusion, not to mention perpetrating a microaggression that would have kept me from medical school," Bell said.

According to the Association of American Medical Colleges (AAMC), black men make up 2.6 percent of the nation's psychiatric workforce compared with 36 percent for white men. From 1978 to 2014, the number of black men matriculating into U.S. medical schools decreased by 5 percent.

The symposium will address the social and academic support systems needed to recruit black men into psychiatry and support them while highlighting APA programming that addresses their shortage in the profession. In unpacking APA's fourth strategic initiative—"Supporting and increasing diversity within APA"—this session will draw on the experiences and insight of black men who are in the psychiatric workforce and the challenges they have encountered. The format will encompass role playing, lectures, and other interactive strategies to facilitate the development of practical solutions.

Included among the speakers at the symposium is Norman Harris, a student at Howard University who is in APA's Black Men in Psychiatry Pipeline Program (*Psychiatric News,* May 4). The program grew out of the AAMC's 2015 report "Altering the Course: Black Males in Medicine." It began as a pilot at Howard University and has been expanded to other colleges and universities; it now includes seven men.

As a participant in the program, Harris receives mentoring (from APA President Altha Stewart, M.D.) and has attended the annual meetings of APA and the American Academy of Child and Adolescent Psychiatry, as well as the meeting of the Black Psychiatrists of America in Memphis in April.

The IPS will also feature the symposium "Microaggression and Strategies to Overcome Prejudice," co-chaired by Bell and Ranna Parkekh, M.D., director of APA's Division of Diversity and Health Equity. In 1970, psychiatrist Chester Pierce, M.D., coined the term "microaggression" to describe an everyday, subtle form of discrimination experienced by African Americans. The term now applies to all minorities and marginalized groups.

Bell and Parekh will outline various types of microaggressions and their impact on the treatment of patients and on working with minority medical professionals. And they will offer strategies to overcome prejudice. The panel will provide real-life examples and effective practices to eliminate and combat bias. **PN**

**IPS registration and housing information is posted at https://www.psychiatry.org/ips. The site also contains full descriptions of all sessions.**

## Laws

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in these situations, but I realized that this is something that really needs to change for all students."

For Moreno, a student one grade ahead at his school had died by suicide, and he'd seen many other classmates battling mental health issues too, he said. A close relative had also suffered from depression and found it difficult to obtain help.

All three students were rising seniors and each had a decade of health classes under their belts when they began researching the issue of mental health education in Virginia.

"None of us really remembered any discussion around mental health during our health classes," Johnson said.

When the trio reviewed Virginia's health education standards, they found that there was no section dedicated solely to mental health, and although there were snippets scattered throughout the curriculum, "there was no cohesive and coherent message on mental health," Johnson said.

Albemarle schools provided information sheets called "stall talks" posted in the high school bathroom stalls about subjects such as relationship problems, substance use, and mental illness, Moreno said. "But when you're having a crisis at 1 o'clock in the morning, you're not going to be able to run to the school bathroom stall." The students impressed upon the school board that more resources were needed and won more online mental health resources, as well as $160,000 in next year's budget for dedicated mental health counselors to serve the student body.

Buyoed by this success, they then met with Virginia state Sen. Creigh Deeds, who decided to sponsor the students' mental health education bill at the state level. The students testified in front of the state's House and Senate education committees, sharing their personal stories and research. Eventually, they returned for the bill signing ceremony.

Unlike the New York bill, the Virginia bill requires a change in the curriculum only for ninth and 10th graders, but the students hope the effort will be expanded to other grades.

"We're trying to make mental health education a rite of passage for all Americans," Johnson said. **PN**

**New York's law is posted at http://apapsy.ch/NewYorkParityEnforcement. Virginia's law is posted at https://lis.virginia.gov/cgi-bin/legp604.exe?181+ful+CHAP0392.**

VIEWPOINTS

# Global MH: Clinical and Research Implications in India, Africa, and the Diaspora

***BY SAM O. OKPAKU, M.D., PH.D.***

Sam O. Okpaku, M.D., Ph.D., is president of the Black Psychiatrists of America and president and founder of the Center for Health, Culture, and Society in Nashville.

The subcontinent of India is a land of temples, fragrances, and mysticism. A visit there is bound to conjure up exotic and romantic images. There is the Taj Mahal in its splendor and the attractions of the Crystal City. In addition, there are inward-facing aspects of the culture that have produced yoga and, more recently, mindfulness, which is sweeping the West with its philosophical foundations and healing applications. So it did not take much effort to rationalize the choice of New Delhi as a venue for a conference of the Black Psychiatrists of America (BPA) last November with the theme stated in the title of this article.

The BPA has two annual conferences: one is a transcultural conference held outside the United States, and the other is a domestic conference held in the spring. The choice of New Delhi for the BPA's 2017 transcultural conference last November was based on a variety of factors, some historical and others contemporary. In the United States, a good percentage of mentally ill patients of African origin are treated by psychiatrists of Indian background. Therefore, BPA members thought that a conference in India bringing together psychiatrists of Indian and African origin could be productive in an era of globalization.

This sentiment was enhanced for me by the discovery of a major exhibition at the famous Schomburg Center for Research in Black Culture in New York. The exhibition illustrated the long history of blacks in India. Blacks occupied a variety of wide-ranging positions including courtiers, army generals, counselors, and indentured servants. Today, aspects of African culture can be found in India in music, food, and dance. Also, India and many African nations share a common history of a colonial past and trade.

The New Delhi conference brought me to India for a third time, and each visit gave me a different view and perspective on the culture. The circumstances of this last visit reminded me of an earlier historic conference—a joint meeting of the Association of African Psychiatrists, the BPA, and APA in Nairobi, Kenya, in 1986. As an African and member of the three organizations, I was asked by several of my African colleagues why there is a separate association for black psychiatrists. I told them that the BPA was formed in 1968 against the backdrop of the U.S. civil rights movement. Many African-American psychiatrists were dissatisfied with APA because of its lack of support and insensitivity toward their goals and needs.

The New Delhi conference was as successful as it was instructive. The plenary lecture was given by Dr. Thara Rangaswamy, the director of the Schizophrenia Research Foundation in Chennai, India. The lecture, titled "Delivering Mental Health Care to Millions—Meeting the Challenge," was very well received. I was interested in the social security systems in India. At a World Psychiatric Association conference in Greece several decades ago, I made a presentation on the participation of mentally ill individuals in the social safety-net programs. At that conference an Indian colleague told me that he feared that the U.S. system would not work in India because the benefit payments would be a disincentive to return to work.

One highlight of the trip was a visit to the psychiatry department of the All Indian Institute of Medical Sciences. We were intrigued by the large caseloads of our colleagues. We also found it impressive that hospitalized patients are required to have a family member available on the ward at all times. The tour of the psychiatric wards was followed by a discussion period during which the questions on both sides were frank. The Americans asked about the caste system, the treatment of women, and the abuse and harassment of African students and diplomats. The plight of victims of the Dalit is well known, and some suicides have been attributed to the system.

Another highlight of the trip was my visit to the Raj Ghat, the place where Mahatma Gandhi was assassinated and buried. Coincidentally, this year's BPA spring conference was held in Memphis, Tenn., where the Rev. Martin Luther King Jr. was assassinated at the Lorraine Motel.

My report would be incomplete without reference to the major advances that India has made industrially and agriculturally, such as the green revolution. Moreover, India has been contributing to the theories and practices of global health and mental health. While these efforts are most welcomed, I cannot fail to mention the smog conditions in New Delhi during our visit. It indeed posed a threat to our visit as some participants feared being exposed to the air. The mental health consequences of climate change are becoming more apparent, and I hope that our Indian colleagues will devote more energy to issues related to climate change as they also advocate for gender and ethnic equality.

I and my colleagues at the BPA hope that the New Delhi meeting is the first of many contacts with our Indian colleagues. I, on behalf of the BPA, wish to thank them for their kindness, generosity, and openness, and we hope that in the not-too-distant future, we will have the opportunity to reciprocate. **PN**

Sam O. Okpaku, M.D., Ph.D. (with a marigold garland), is photographed with other participants of the BPA's meeting in New Delhi last November. Among them are Patricia Newton, M.D. (in black and white dress), BPA's CEO and medical director; and Altha Stewart, M.D. (in pink jacket), then president-elect of APA.

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# Psychiatric Treatment in Organ Transplant Patients

*This article is one of a series coordinated by APA's Council on Consultation-Liaison Psychiatry and the Academy of Consultation-Liaison Psychiatry.* **YELIZAVETA SHER, M.D.**

Consultation-Liaison PSYCHIATRY

Transplant psychiatry is a key area of focus within consultation-liaison (C-L) psychiatry. In the United States, 34,770 solid organ transplants were performed in 2017. While pretransplant psychosocial assessment is an important role, the transplant psychiatrist also provides support to patients through the challenges posed by transplantation, from end-stage organ disease to posttransplant adaptation.

The following case illustrates the full scope of C-L psychiatrists' transplant care: C-L psychiatry was consulted to see Mr. J, a 55-year-old man with cystic fibrosis, due to anxiety related to respiratory failure and placement on the lung transplant waiting list.

- **Pretransplant anxiety secondary to medical condition:** Mr. J described anxiety precipitated by any movements making him feel short of breath and developed worried anticipation of any future physical activity. He was assessed to be an appropriate transplant candidate from a psychiatric perspective. He was diagnosed with anxiety due to a general medical condition and was treated with a combination of mirtazapine, gabapentin, guanfacine, and supportive psychotherapy. However, his respiratory failure progressed, and he required intubation and placement on extracorporeal membrane oxygenation.

Yelizaveta Sher, M.D., is a clinical assistant professor of psychiatry and associate director of the Psychosomatic Medicine Fellowship at Stanford University. She is a member of the Transplant Psychiatry Special Interest Group of the Academy of Consultation-Liaison Psychiatry.

- **Postoperative delirium:** Two months after he was initially seen by psychiatry, Mr. J underwent bilateral lung transplantation. Postoperatively, he became confused, disoriented, and paranoid. He believed that his hand was cut off and that his nurse was trying to kill him and remove his organs. Extreme restlessness necessitated soft restraints. Haloperidol was added for treatment of delirium, which subsided within a week. Subsequently, guanfacine and haloperidol were tapered off, and he was discharged one month after his transplantation.

- **Acute stress disorder/posttraumatic stress disorder related to transplant (PTSD-T):** During outpatient follow-up a week after discharge, Mr. J shared experiencing haunting images dating back to his delirium experiences. He avoided certain shows on TV that made him feel claustrophobic. He thought of future hospitalizations with terror. He initially declined required bronchoscopy due to his new fears and anxiety, but he was able to complete this procedure with psychological support from psychiatry and pretreatment with lorazepam before the procedure.

- **Posttransplant depression:** Two months after his transplant, Mr. J felt depressed and hopeless and had decreased enjoyment of any activity. In fact, he wished at times he had not elected lung transplant. His mirtazapine was increased and bupropion started while psychotherapy continued. Within several months, his depression subsided, procedures became easier, and he eventually had resolution of PTSD-related flashbacks.

- **Discussion:** This case highlights the scope and important role that C-L psychiatrists play in patients' transplant journey. Anxiety is common in patients awaiting lung transplantation, due to a combination of physiological changes (that is, hypercapnia, hypoxemia) and psychological/existential reactions to the transplant experience. Data suggest that almost 40 percent of patients undergoing lung transplant evaluation have an anxiety disorder. While anxiety disorders are typically not a contraindication to transplantation, they can have significant impact on the transplant course, and effective interventions from the transplant psychiatrist can facilitate the process. When treating this medically vulnerable population, psychiatrists need to have expertise in selecting efficacious psychiatric treatments, while also mitigating potential adverse effects of psychotropic agents and drug interactions. For example, benzodiazepines are often avoided in the peritransplant period due to risks of respiratory depression and cognitive side effects. Therefore, Mr. J was treated with a combination of mirtazapine, gabapentin, and guanfacine to avoid use of benzodiazepines for his anxiety.

Posttransplant, Mr. J developed delirium, which occurs in approximately 40 percent of lung transplant recipients. C-L psychiatrists working in transplant psychiatry must be able to untangle the multiple factors contributing to delirium in transplant recipients in addition to their surgery status and prolonged hospital stay, including high-dose immunosuppressants (for example, steroids, calcineurin inhibitors), use of opiates, the presence of primary graft dysfunction, posttransplant renal insufficiency, or syndromes such as posterior reversible encephalopathy syndrome.

Mr. J also developed symptoms of PTSD-T, which afflicts approximately 15 percent of transplant recipients. The experience of end-stage disease, a prolonged hospital stay before and after transplant, surgery itself, and multiple painful experiences and interventions are certainly traumatic. Delirium and his memory of his psychotic experiences might have also been additional risk factors for Mr. J. Therefore, C-L psychiatrists must be well versed in assessing these multiple factors precipitating and perpetuating PTSD-T and effectively treat these distressing symptoms often interfering with posttransplant care.

Depression is even more common, occurring in 25 to 30 percent of patients within two years of cardiothoracic transplantation. Posttransplant depression not only severely affects

*see* **Transplant Patients** *on page 24*

## IN MEMORIAM

APA honors members whose deaths were reported to APA from April 1 to June 30, 2018. See https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2018.6b51.

# Study Examines Connections Between Psychiatric, Neurological Disorders

*A comparative analysis of the genes of patients with 10 psychiatric and 15 neurological disorders shows that, among other findings, schizophrenia is related to numerous other psychiatric conditions.*

**BY NICK ZAGORSKI**

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Numerous genetic studies over the years have shown that people with different psychiatric disorders share similar genetic risk factors.

A study published June 22 in *Science* has now amplified this existing genetic knowledge to new heights. Making use of over two million DNA samples from across the globe, a research consortium has highlighted the shared heritability of 25 psychiatric and neurological disorders.

The results of this massive effort validate that psychiatric disorders share a lot of underlying risk factors, whereas neurological disorders are more distinct from each other.

That difference highlights how valuable it is to have specific biological abnormalities linked to a disease, said study co-author Benjamin Neale, Ph.D., an assistant professor of medicine at Harvard Medical School. Neale is also a member of the Analytic and Translational Genetics Unit at Massachusetts General Hospital.

Neale and his colleagues with the Brainstorm Consortium conducted a genome-wide association study of DNA samples from 265,218 patients with one of either 10 psychiatric disorders or 15 neurological disorders and 784,643 healthy controls.

Among the most striking findings was the correlation between schizophrenia and six other varied psychiatric disorders: attention-deficit/hyperactivity disorder (ADHD), anorexia nervosa, autism spectrum disorder, bipolar disorder, major depression, and obsessive-compulsive disorder. (Anxiety disorder, posttraumatic stress disorder [PTSD], and Tourette's syndrome were the other three psychiatric disorders analyzed in this study.)

"This makes sense as schizophrenia touches on so many different components of how the brain works," Neale said. He noted that the shared genetics of schizophrenia and ADHD might seem somewhat unexpected, but it likely reflects that both disorders involve problems with executive function.

On the other end of the spectrum was PTSD, which had no significant genetic correlation with any other psychiatric disorder. Neale noted that the number of PTSD samples was low (about 2,000), which may have limited the ability to detect shared connections. However, it may also reflect that this disorder, which is tied to some precipitating event, has unique characteristics.

Interestingly, neurological problems also showed very little overlap with psychiatric disorders, even though behavioral symptoms are common in disorders such as Alzheimer's disease and Parkinson's disease. The one exception was migraines, which shared risk factors with ADHD, major depression, and Tourette's syndrome.

"This was surprising. If I had to pick ahead of time, I would have said migraine would share the most genetics with bipolar disorder, since there is epidemiological evidence that people with bipolar disorder have much higher rates of migraine," Neale said.

As for depression and ADHD (and Tourette's, which is often comorbid with ADHD), Neale said he believes the connection with migraine may be related to pain sensitivity. That people with depression tend to be more sensitive to pain is known, but there is early evidence that children with ADHD also are more sensitive to their surrounding environment.

But the unexpected genetic connections between migraine and psychiatric disorders, as well as some other surprises such as no connection between Tourette's and epilepsy, underscores the need to conduct such large genetic studies.

"We are not done with the yeoman's work on brain genetics," Neale said. "And as we learn more, some of our implied considerations about how these disorders relate will be tested."

This project was funded by the National Institute of Mental Health, the Orion Farmos Research Foundation, and the Fannie and John Hertz Research Foundation. **PN**

**An abstract of "Analysis of Shared Heritability in Common Disorders of the Brain" is posted at http://science.sciencemag.org/content/360/6395/eaap8757.long.**

PSYCHIATRY & INTEGRATED CARE

# Integrated Care: Perspectives From A Behavioral Health Consultant

**BY JENNIFER NOONAN, L.C.S.W.**

*Integrated care requires a team of professionals with complementary skills who work together to care for a population of patients with common mental health problems. It involves a shift in how medicine is practiced, the creation of new workflows, and the addition of new team members beyond the primary care provider and the patient. In this issue, we hear from Jennifer Noonan, L.C.S.W., a behavioral health consultant who works alongside psychiatrists on an integrated care team.*

*—Jürgen Unützer, M.D., M.P.H.*

I have worked at a local community mental health center for the past 23 years in a variety of positions—inpatient case manager, crisis intervention specialist, group home supervisor, day treatment/clubhouse supervisor, outpatient therapist, and, for the past 10 years, a behavioral health consultant on an integrated care team. Of all of the roles I've had, working on an integrated care team has been the most effective in bringing about change and improving patients' lives. I cannot imagine going back to providing traditional services. I don't think my experiences are unique, and I offer the following reasons why providing mental health services on an integrated care team is truly rewarding.

- **Timely access to care:** The ability to provide services in an integrated setting speeds up the process significantly for both the mental health and physical health sides. If there are untreated/uncontrolled medical issues or immediate referrals for specialty care (neurology, endocrinology, and so on) or labs/diagnostic studies, those can be coordinated the same day and vice versa—if the primary care providers have someone in crisis, I can meet with them and get services started or coordinate more intensive services if need be (inpatient psych or substance use treatment).

Jennifer Noonan, L.C.S.W., is an employee of Regional Mental Health in Merrillville, Ind. She is contracted to provide behavioral health services at Northshore Health Clinics at its Lake Station office. Jürgen Unützer, M.D., M.P.H., is a professor and chair of psychiatry and behavioral sciences at the University of Washington and founder of the AIMS Center, dedicated to "advancing integrated mental health solutions."

- **Less paperwork:** The amount of paperwork is much less than I had previously, which allows me to provide services more quickly. I am not bogged down by notes, treatment plans, and so on. I also do concurrent documentation so I am mostly finished with paperwork by the end of the day. This also means I have time to have lunch instead of catching up on paperwork.

- **Effective therapy:** We continue to offer therapy in the primary care setting, including behavioral activation therapy, cognitive-behavioral therapy, and motivational interviewing techniques, but we are not tied down to the "hour." I have seen more of my patients move forward in an integrated care setting than I had when I worked in a regular outpatient setting. I believe that the old way of doing therapy created a dependency and kept people in a "patient" role longer. There are times a patient has to be referred out—usually patients who are not responding to medications, have extensive trauma histories, or have ongoing addiction issues—but

*continued on next page*

# SGAs Increase Teens' Abdominal Fat, Decrease Insulin Sensitivity

*The three medications studied quickly led to changes that increase the risk for metabolic disorders and diabetes.*

**BY MARK MORAN**

Treatment with certain second-generation antipsychotic (SGA) medications in SGA-naïve youth for disruptive behavior disorders appears to result in increases in abdominal fat and reductions in insulin sensitivity within just 12 weeks of treatment, according to a report posted June 13 in *JAMA Psychiatry*.

All three of the antipsychotic medications compared in the study—aripiprazole, olanzapine, and risperidone—resulted in significant increases in whole body and abdominal fat. Further, when results for the entire cohort were pooled, treatments with these drugs resulted in reductions in insulin sensitivity in a remarkably short period.

"We have known for a while that antipsychotics cause weight gain, and we have known for a while that in large epidemiologic samples—such as studies of Medicaid patients—antipsychotic exposure was associated with increased risk for diabetes," said principal investigator and senior author John Newcomer, M.D., a professor of integrated medical science at the Charles E. Schmidt College of Medicine at Florida Atlantic University.

"The usual pathway to developing diabetes is to have increased abdominal fat mass, which a vast amount of evidence has shown increases the risk for insulin resistance," he said. "When your body develops insulin resistance, that's when you develop the risk for type 2 diabetes. What we were trying to do in this study is identify in antipsychotic-naïve young people if antipsychotic exposure increased body fat, if the increase occurred in the abdominal compartment, and whether treatment also led to a decrease in insulin sensitivity. That's exactly what we saw."

> "The results of the study call into question the off-label use of antipsychotics in adolescents."
>
> —John Newcomer, M.D.

Newcomer and colleagues recruited young people from the St. Louis metropolitan area between June 2006 and November 2010 whose clinicians and parents had already decided to initiate antipsychotic treatment, so that participation in the study offered safety monitoring not typically available in clinical practice. Researchers enrolled 144 antipsychotic-naïve youth aged 6 to 18 years; all participants had one or more Axis I *DSM IV-TR* diagnosis and clinically significant aggression defined by a score of at least 18 on the irritability subscale of the Aberrant Behavior Checklist.

The youth were randomized to receive aripiprazole, olanzapine, or risperidone for 12 weeks. Primary outcome measures were treatment effects over 12 weeks on total body fat, measured by dual-energy X-ray absorptiometry (DXA), as well as insulin sensitivity at muscle (glucose disposal). Secondary outcomes included effects over 12 weeks on abdominal fat and insulin sensitivity, measured by magnetic resonance imaging (MRI) at the liver (glucose production) and adipose tissue (lipolysis).

Newcomer and colleagues found that the primary outcome of mean percentage total body fat increased significantly during 12 weeks for all study treatments. The largest increase was for olanzapine (4.12 percent) followed by aripiprazole (1.66 percent) and risperidone (1.18 percent). When results for the entire cohort were pooled, insulin sensitivity decreased significantly during the 12 weeks, and there was no significant difference between treatments.

The secondary outcome of abdominal fat measured by MRI increased significantly in visceral and subcutaneous compartments, with a similar mean increase in visceral fat during all treatments, but greater subcutaneous mean fat increase with olanzapine.

"Olanzapine led to more fat," Newcomer said, "but all three drugs produced significant increases. But to me, the really important observation is that all three drugs increased visceral abdominal fat and that treated youths on average experienced decreases in insulin sensitivity."

Newcomer noted that off-label prescribing of antipsychotics for children and adolescents for behavioral disorders is far higher in the United States than in other parts of the world, while psychotherapy or cognitive-behavioral therapy are vastly underused.

"Medications have become the easy go-to fix," he said.

He said that although the risks of weight gain and metabolic disease have been relatively well known and publicized, clinicians may have believed they could make a rapid clinical intervention with antipsychotics to improve behavior without significant risk to metabolic health and that they could switch to lower-risk medications over the long term. The results of the *JAMA Psychiatry* study call those assumptions into question.

"An important finding from the study is how quickly the mechanism that leads to risk for diabetes kicks in," he told *Psychiatric News*. "The take-home message for clinicians is that the decision to prescribe antipsychotics in the first place is as important as the drug you choose. We've been telling clinicians to choose the lower-risk agent, but maybe for off-label uses, the risk-benefit equation is different when you are treating schizophrenia or bipolar disorder. In the instance of disruptive behavior disorder, when there are other nonpharmaceutical options, perhaps we should be rethinking the decision to go down this road at all."

In an editorial accompanying the study, Belgian researchers Marc De Hert, M.D., Ph.D., and John Detrax, M.Psy., wrote that despite the existing guidelines and recommendations that highlight the importance of monitoring for metabolic abnormalities, glucose and lipid-monitoring rates continue to be "disappointingly low" in children and in adults.

"In the case of off-label prescribing, psychosocial interventions should be tried before initiating antipsychotic medication," they wrote. "If antipsychotic medication is started, psychoeducation and health lifestyle advice are essential and can be helpful."

The study was supported by grants from NIMH and NIH. **PN**

**"Metabolic Effects of Antipsychotics on Adiposity and Insulin Sensitivity in Youth: A Randomized Clinical Trial" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2683878.**

*continued from previous page*

we can help the vast majority of patients at the clinic.

- **Increased knowledge:** The knowledge base I have gained from working directly with psychiatrists and other medical professionals has increased my ability to be a better and more effective practitioner. This is particularly true when working with patients who have bipolar disorder or other mood disorders. The psychiatrists teach me to watch for possible medical situations that might be impacting or interfering with a patient's mental health. When we can attack mental and physical health conditions at the same time in a coordinated way, we get faster results.

- **Less stress:** My stress level is almost nonexistent, and I have a distinct separation between work and home. My sleep has been the best it has ever been since becoming a behavioral health consultant. I don't dread getting up when the alarm goes off.

- **More variety:** There is a lot of variety that keeps me on my toes. I have been exposed to more interesting situations and histories in the integrated care setting than ever have before, which continues to challenge and expand my knowledge base. Many of the patients in a primary care setting have never talked to anyone in the mental health field.

- **Compassionate care:** My ability to handle grief with patients has also improved. I am called in to appointments in which people receive devastating medical diagnoses, women who experienced stillbirths and miscarriages, and so on. I am able to forge a partnership immediately rather than having to tell them to go to a mental health center and start services with another agency.

- **Happy doctors:** The majority of the doctors with whom I work welcome the fact that my colleagues and I are there to help address their patients' mental health issues. We've built up an incredible amount of trust within the integrated care team. Everyone relies on and trusts each other's knowledge and expertise.

Of course, not every job is perfect, and I do face some challenges, particularly in the area of service coordination. But the rewards more than make up for the setbacks. Working on an integrated care team has been the most rewarding job I've ever had, and it's given me an enormous amount of personal and career satisfaction. **PN**

# Suicide Prevention Program to Get Test Run This Fall

*With suicide rates on the rise, a county in New York is introducing a pilot program that will focus on patients at high risk for suicide.* **BY REBECCA GREENBERG**

A new suicide prevention model that has shown promise in Switzerland will be tested this September in the United States. The treatment is called Attempted Suicide Short Intervention Program (ASSIP). It will be implemented in Onondaga County, N.Y., as part of a statewide suicide prevention effort funded through a $3.5 million federal grant from the Substance Abuse and Mental Health Services Administration.

People who have attempted suicide are known to be the most likely to die by suicide. An estimated 1.3 million adults aged 18 or older attempted suicide in 2016, according to the National Institute of Mental Health.

ASSIP targets patients who have recently attempted suicide. It consists of three 60- to 90-minute face-to-face sessions followed by regular, personalized letters sent to patients over two years. Konrad Michel, M.D., a professor emeritus at the University Hospital of Psychiatry in Bern, and colleagues developed the program.

Konrad Michel, M.D., works with patients to identify signs that they might be feeling suicidal as well as strategies they can use to stay safe.

Michel coauthored a study in *PLOS Medicine* in March 2016 that showed that ASSIP was associated with an 80 percent reduction in repeat suicide attempts among 120 patients admitted to the emergency unit of the Bern University of General Hospital after a suicide attempt.

Half of the patients were randomly selected for treatment as usual, which included a single clinical interview in the emergency unit followed by a risk assessment summary that was sent to the patients' outpatient providers. The other half received treatment as usual plus ASSIP. During the 24 months of follow-up, five repeat suicide attempts were recorded in the ASSIP group, and 41 repeat suicide attempts were recorded in the control group. One person died by suicide in each group.

For the first session, which is videotaped, a patient tells the therapist how he or she reached the point of wanting

to die by suicide. In the second session, the patient and therapist review the tape together. In the final session, the therapist and patient identify signs that the patient may be feeling suicidal, as well as strategies the patient can use to stay safe. These are printed on a card that the patient carries at all times, along with a list of emergency numbers. Over the next two years, therapists send patients a series of personalized letters reminding them of the risk of experiencing a suicidal crisis and the importance of using safety strategies at those times.

Suicide has less to do with a patient's psychiatric diagnoses and more to do with each patient's inner experience and narrative, Michel told *Psychiatric News*. "The patient is in the expert position, which gives the patient insight into his or her own suicidal crisis."

Michel said that the process allows patients to feel heard and understood, which creates trust—the basis of a strong therapeutic alliance. Creating that alliance is key to ASSIP's patient-centered, collaborative approach.

The authors noted that if ASSIP achieves similar results in the United States, the program may one day become a common evidence-based follow-up treatment that could reduce the number of deaths by suicide.

"ASSIP fulfills the need for an easy-to-administer, low-cost intervention," the authors concluded. **PN**

**"A Novel Brief Therapy for Patients Who Attempt Suicide: A 24-Months Follow-Up Randomized Controlled Study of the Attempted Suicide Short Intervention Program (ASSIP)" is posted at http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001968.**

# Bullying Linked to Depression in Youth With Autism

*Children with autism are often the target of bullying, which can contribute to the development of depression.* **BY REBECCA GREENBERG**

By age 10, children with autism spectrum disorder (ASD) or autistic traits have more symptoms of depression than their peers, according to a study published June 13 in *JAMA Psychiatry*. Irrespective of genetic factors, the researchers found that depressive symptoms worsened up to the end of the study as the adolescents reached age 18 and were exacerbated by bullying.

"[F]urther research into the role of traumatic experiences, such as bullying, and the utility of interventions to reduce bullying or address its adverse effects could have the potential to reduce the burden of depression in this population," wrote lead author Dheeraj Rai, Ph.D., a senior lecturer in psychiatry at the University of Bristol, and colleagues.

For the study, the authors relied on data from the Avon Longitudinal Study of Parents and Children. The Avon study collected data from 1990 to 1992 on more than 15,000 parents and children from pregnancy through childhood in the Bristol area from self-report questionnaires; clinical assessments; biological samples; and birth, medical, and

educational records.

The final dataset for the study included 8,087 children. Five groups were identified as either having ASD or symptoms of ASD. Of this group, 96 were diagnosed with ASD, 546 had social communication impairments, 526 had problems with speech coherence, 419 displayed repetitive behaviors, and 801 had poor social temperament with overlap between the groups.

Participants with ASD and the four autistic traits had higher depression scores than the general population, as assessed by the Short Mood and Feelings Questionnaire (SMFQ) and the computerized version of the Clinical Interview-Revised, a psychiatric interview widely used in community samples. Their scores continued to rise over time. The SMFQ was administered at six points between ages 10 and 18 via mailed questionnaires or in clinics. Data analysis was conducted from January to November 2017.

At age 10, the children with ASD or autistic traits who reported being bullied had the highest average SMFQ scores; likewise, youth with social communication impairments who reported being bullied in childhood or adolescence were more likely to have a diagnosis of depression at age 18.

"It is possible that children with social communication problems, who may not have developed a good understanding of social rules and how to fit in, may be targets for bullies," Rai told *Psychiatric News*. "Many of the autistic people I have worked with over the years have mentioned that the awareness of being excluded or targeted because of being perceived as different was particularly traumatic."

"These findings add to the evidence highlighting a higher burden of depression and also suggest a potentially modifiable pathway, through bullying," the authors wrote. "However, gaps remain in our understanding of the measurement and phenomenology of depression in individuals with autism, which could be a priority for future research. Further work could also focus on improvements in psychological and pharmacological management of depression in ASD."

A systematic review of nearly 8,000 research articles in the March issue of the *Journal of Abnormal Child Psychology* reported that people with ASD are four times more likely to experience depression in their lifetime than people without ASD.

Rai noted that depression can be more difficult to detect in these patients because they may not recognize or be able to describe their mood states. For clinicians, Rai said the study shows that many young people and adults with depression have also had a history of trauma.

"[T]hese findings suggest that focusing on the role of traumatic experiences such as bullying and interventions targeting these could be important and may have the potential to make a real difference in the well-being of autistic people," he said in a press release from the University of Bristol.

The study was funded by the Baily Thomas Charitable Fund. **PN**

**"Association of Autistic Traits With Depression From Childhood to Age 18 Years" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2683880. "Prevalence of Depressive Disorders in Individuals With Autism Spectrum Disorder: a Meta-Analysis" is posted at https://link.springer.com/article/10.1007/s10802-018-0402-1.**

## Gun Removal

*continued from page 6*

to identify individuals at risk of harming themselves or others. The authors argued that background checks could unfairly stigmatize people with mental illness. As an alternative, the authors recommended risk-based firearm removal laws. The 2018 resource document summarizes research related to implementation of these laws.

"One of the things APA supported in the 2014 resource document is that there are risk factors for violence that are separate from mental illness, for example, anger or frustration," Pinals said. While suicide risk is associated with firearms, she noted that numerous studies have shown that mental illness is not a risk factor for firearm violence against others.

"Most of the people whose guns were taken away in this manner have not received mental health treatment or been identified as having a major mental illness. They are people in crisis," Kapoor said. "Family members, neighbors, and friends are the ones calling the police to say, 'I am concerned about this person having a gun right now.' Most of the time they are concerned because the person is a threat to themselves, not to others." **PN**

**"Resource Document on Risk-Based Gun Removal Laws" is posted at http://apapsy.ch/Gun_Removal. Resource documents express the views of the authors and do not necessarily represent the views of APA's officers, trustees, or other members.**

FROM THE EXPERTS

# A Language of Hope: The Top 10 Solution-Focused Translations

***BY ANNE BODMER LUTZ, M.D., B.S.N.***

Conversations that allow clients to access possibility lead to amplified self-agency and a realization that goals are realistic and attainable.

Anne Bodmer Lutz, M.D., B.S.N., is director of the Institute for Solution-Focused Therapy and an assistant professor at the University of Massachusetts. She is the author of *Learning Solution-Focused Therapy: An Illustrated Guide* from APA Publishing. APA members may purchase the book at a discount at https://www.appi.org/Learning_Solution-Focused_Therapy.

Solution-Focused Brief Therapy (SFBT) is an evidence-based approach that builds on client's strengths, enhances positive emotion, instills hope, explores past successes, and allows clients to understand that they have the necessary resources to act on their own behalf.

Learning this therapy is not unlike learning a new language. A completely new set of skills requires the therapist to "speak" in a way that focuses on solutions rather than our "first" language, which tends to focus on problems.

The following is a list of the top 10 solution-focused questions and the intent behind the language:

10 *The indirect compliment: How did you do it?*

The indirect compliment is most often posed in the form of a question. "How did you do it?" The question is not "Did you do it?" but instead *"How* did you do it?" "Did" (past tense) conveys the client has indeed done it already. Noticing what the client has already done successfully enhances a sense of self-efficacy. Solving problems (challenges) requires action, which is the reasoning behind using the verb "do" (present tense). The goal of the therapist is to listen for opportunities that will allow the client to recognize past strengths that can be used in future situations.



9 *What are your best hopes?*

This is the solution-focused translation of the chief complaint (What brought you here?). The question is not "Do you have hopes?" but rather "What are your best hopes?" It is future directed and helps to create a narrative of competence.

8 *What else? How else? Who else?*

Effective solution building requires getting as many details as possible about prior successes. These questions leave no potential strength uncovered and are the metaphorical "language shovels" that dig for the details of success. What else are you good at? How else did you do it? How else was it helpful? Who else is most important to you?

7 *Who are the most important people in your life, and what do you most appreciate about them?*

Mapping out a client's social context is critical in understanding and assisting them in building solutions. Viewing their life from other perspectives allows clients to see a broader array of possibilities. This question also reinforces positive supports.

6 *What do you know?*

"What do you know?" conveys that clients already have the knowledge and understanding of what is important in their lives. For example, asking clients what they know about marijuana, medications, or their diagnosis attests to their competence. One of my favorite questions is to ask parents "What do you know about your child that tells you he or she will succeed in life?" It continually amazes me to learn that parents are always able to answer this question, regardless of how desperate they might be feeling in the moment.

5 *Have you ever had to cope with trauma, domestic violence, hurricanes, homelessness, mudslides, poverty, loss, or death?*

Incorporating the one-word "cope" within the question demonstrates a confidence that your client has coped—has already been successful. I follow up this question with "How have you coped?," which magnifies their success. And remember that cope is one letter away from hope.

*see* **Translations** *on page 25*

# JOURNAL DIGEST

BY NICK ZAGORSKI

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## Adjunctive *Withania Somnifera* May Reduce Some Schizophrenia Symptoms

Patients with schizophrenia who continue to experience symptoms while taking antipsychotics may benefit from adjunctive treatment with a standardized extract of *Withania somnifera*, suggests a small clinical trial. *Withania somnifera* (Ashwagandha)—a plant traditionally used in Indian medicine—is known to have anti-inflammatory and immunomodulating properties.

Researchers at the University of Pittsburgh assigned 66 adult patients with schizophrenia to take *Withania somnifera* capsules (initially 250 mg then titrated up to 500 mg) or placebo pills twice daily in addition to their antipsychotic medication for 12 weeks.

Beginning at week 4 and continuing until the end of treatment, patients in the group taking *Withania somnifera* capsules showed significantly greater reductions in negative symptoms (such as emotional or social withdrawal), general psychological symptoms (such as anxiety or impulse control), and stress compared with participants in the placebo group. The groups demonstrated no differences in positive symptoms.

The *Withania somnifera* capsules were well tolerated, and they did not cause any weight or metabolic problems for the participants.

The study was published in the *Journal of Clinical Psychiatry*.

**Chengappa K, Brar JS, Gannon JM, Schlicht PJ. Adjunctive Use of a Standardized Extract of *Withania somnifera* (Ashwagandha) to Treat Symptom Exacerbation in Schizophrenia: A Randomized, Double-Blind, Placebo-Controlled Study. *J Clin Psychiatry.* 2018; 79(5): 17m11826. http://www.psychiatrist.com/JCP/article/Pages/2018/v79/17m11826.aspx**

iStock/RossHelen

## Study Points to Connection Between Sleep Deprivation, Alcohol Intoxication

People who are sleep deprived exhibit similar behaviors to people who are drunk. A study published in *PNAS* has found a biological connection between sleep deprivation and alcohol intoxication.

Researchers in Germany and colleagues compared attention and reaction time in 49 young adults (average age 26) following alcohol intake (to reach a blood alcohol level of around 0.07), one night of total sleep deprivation, or one night of partial sleep deprivation. The study was designed so that each participant was exposed to all three scenarios, with recovery time in between.

The researchers found that participants who performed better on these cognitive tests following alcohol intake were also more likely to do better on the tests following sleep deprivation.

The researchers next compared PET scans of 10 other healthy adults who had consumed alcohol or water. They found that alcohol intake was associated with more adenosine in several brain regions. Previous research has linked sleep deprivation with increased levels of adenosine in the brain. Too much adenosine blocks the activity of cholinergic neurons that promote wakefulness.

The study authors wrote that showing the effects of sleep deprivation and alcohol intoxication may originate with the same biological process could have important ramifications.

"Reports indicate that young drivers believe driving drowsy is less of a serious problem than driving under the influence of alcohol," they wrote. "Our finding of a shared physiological basis raises awareness for the still underestimated danger of driving while sleep impaired."

**Elmenhorst E, Elmenhorst D, Benderoth S, et al. Cognitive Impairments by Alcohol and Sleep Deprivation Indicate Trait Characteristics and a Potential Role for Adenosine A1 Receptors. *Proc Natl Acad Sci USA*. July 16, 2018. [Epub ahead of print] http://www.pnas.org/content/early/2018/07/10/1803770115.long**


iStock/Hailshadow

## Modified Botox Found To Reduce Pain in Animals

Synthetic versions of botulinum toxin, also known as Botox, may offer long-term pain relief, suggests an animal study by investigators at the University of Sheffield in England.

The researchers modified Botox to block either the neurokinin-1 receptor (NKIR, which sends pain signals from the spinal cord to the brain) or the mu opioid receptor (the target of morphine and related opioids).

A single injection of either molecule into the spinal cords of mice provided pain relief for up to 22 days without causing any neuronal death. The two molecules had no effect when injected in mice that lacked the relevant receptor (NKIR or mu). This indicates that these botulinum constructs specifically target these receptors, which lowers the risk of unwanted side effects.

These two modified Botox molecules did not provide stronger pain relief if given together. This suggests the NKIR and mu opioid receptors are part of the same pain network.

These findings were published in *Science Translational Medicine*.

**Maiarù M, Leese C, Certo M, et al. Selective Neuronal Silencing Using Synthetic Botulinum Molecules Alleviates Chronic Pain in Mice. *Sci Transl Med*. 2018; 10(450). eaar7384. http://stm.sciencemag.org/content/10/450/eaar7384.short**

iStock/pjohnson1

## Nitrates May Be Associated With Manic Episodes

Exposure to nitrates—chemicals found in processed meats such as hot dogs and beef jerky—might contribute to manic episodes, reports a study from researchers at Johns Hopkins University.

The researchers first made the connection after analyzing dietary questionnaires from about 700 psychiatric patients who were receiving care at Baltimore's Sheppard Pratt Health System. They found that patients treated for mania were about 3.5 times more likely to report a history of consuming nitrate-containing meat products than patients with other mental illness or healthy controls. Other food categories including undercooked meat or raw fish were not associated with mania.

Next, the research team conducted laboratory studies in which rats were fed either a regular diet, a regular diet supplemented with dried beef, or a regular diet supplemented with nitrate-free dried beef. After two weeks, the rats who ate regular dried beef appeared to be more hyperactive during behavioral tests and slept less than those on the regular diet or nitrate-free beef diet.

Analysis of the rats' fecal samples revealed that eating the nitrates changed the complexion of the rats' gut microbiome. These changes in intestinal bacteria might be contributing to the manic behavior, the researchers suggested.

*see* **Journal Digest** *on page 26*

## Transplant Patients

*continued from page 13*

patients' quality of life, but also has a negative effect on clinical outcomes, including decreased patient survival.

C-L psychiatrists are well positioned to consider the potential impact of various medications used in transplant patients. The neuropsychiatric effects of immunosuppressants and potential effects of other medications used in transplant, such as pain medications and antibiotics, can further contribute to psychiatric sequalae in transplant patients. C-L psychiatrists caring for transplant patients are constantly anticipating the effects of psychiatric medications on immunosuppressant levels, which may increase the risk of rejection (if levels are decreased) or adverse side effects (if levels are increased). Furthermore, transplant medications may also alter levels of some psychotropic medications, thus limiting the efficacy of psychiatric treatment posttransplant or causing side effects. In liver and kidney transplant recipients, functioning of the new graft may vary, and psychiatrists must consider the metabolism route of the medications when using psychotropic medications. Mr. J's psychiatrist considered these factors during the posttransplant phase and optimized his treatment in response to these factors.

In summary, this case illustrates the critical role C-L psychiatrists have in the acute and long-term care of transplant patients. Specialized psychiatric care for this patient population is needed to better support patients and to treat emerging psychiatric comorbidities during the pre- and posttransplant journey. **PN**

# Fellowship

*continued from page 1*

"The fact that SAMHSA nearly doubled the annual funding shows the importance and value of this effort, and we look forward to this APA program supporting our work to achieve mental health equity," Stewart added.

Ranna Parekh, M.D., APA deputy medical director and director of the Division of Diversity and Health Equity, served as principal investigator of the grant. "While serious mental illnesses occur in all racial/ethnic and socioeconomic classes, minorities tend to be overrepresented among those most vulnerable to mental illness and in need of psychiatric care," explained Parekh. "Yet the nation's health care system does not have enough psychiatrists who are trained to provide culturally competent care."

As part of the program, fellows receive mentorship from experts in psychiatry, establish relationships with peers from other academic institutions, serve on APA councils, participate in presentations at the Annual Meeting, and may have the opportunity to sit for a year on the APA Board of Trustees. The projects they establish serve minority and underrepresented groups.

Applicants for the program must be members of a racial/ethnic minority or have an interest in reducing mental health disparities. Each fellowship is for one to two years, and each fellow is awarded $25,000 for a research project in addressing mental health disparities. Applications will be accepted starting in November. **PN**

**More information about the APA SAMHSA Minority Fellowship Program is posted at http://apapsy.ch/MFP.**

## Former MFP Fellows Continue to Serve Underrepresented Populations

*Psychiatric News* caught up with a few recent alumni of the SAMHSA Minority Fellowship Program (MFP) to learn about some of the work they are doing to improve mental health services for minority and underrepresented populations.

Vanessa Torres-Llenza, M.D., now an assistant professor of psychiatry at George Washington University, held workshops for hospital staff during her MFP fellowship to teach cultural competency and improve the recognition of delirium in minority patients who are medically ill. Studies have shown that delirium is often missed in patients whose primary language is not English, boosting their risk for medical adverse events. "It's very important to have a translator for patients to get the best care, but too often that does not happen," she said.


Dimas Tirado-Morales, M.D.

Torres-Llenza, who is from Puerto Rico, went on to do a "mental health awareness tour" on the island to encourage medical students to consider careers in psychiatry to alleviate the shortage of psychiatrists there. Another fellowship awardee from Puerto Rico, Hector Colon-Rivera, M.D., now an attending psychiatrist at the University of Pennsylvania and Veterans Administration, joined forces with her, and together they became active in community outreach mental health efforts in Puerto Rico (*Psychiatric News,* March 2).

They worked to integrate care on Vieques, a small island off the coast of Puerto Rico with no psychiatrists to serve its 9,000 residents (*Psychiatric News,* June 17, 2016). They empowered primary care providers with psychiatric assessment tools, such as the PHQ-9, to identify and address anxiety and depression earlier in the illness.

Colon-Rivera then launched a mental health radio show for Puerto Rican residents at the urging of community leaders. What began as a 10-minute monthly radio program delving into topics such as sex education for high schoolers, suicide prevention, mindfulness, anxiety, and trauma has proved so popular that he has since expanded it into a weekly 30-minute format. It is still going strong, he said. "In the end, it's all about improving mental health and taking care of yourself."

Since Hurricane Maria devastated Puerto Rico in fall 2017, a group of five former MFP fellows have traveled to the island more than half a dozen times to assist residents and support the mental health professionals who serve them. They have done mental health first-aid training as well as resiliency workshops to combat burnout among providers. "It's become part of our mission," Colon-Rivera said. "And without that fellowship experience, we wouldn't be where we are right now."

Colon-Rivera said the MFP fellowship gave him the opportunity to travel internationally on aid missions, give presentations at national psychiatry meetings, publish numerous papers, and serve on the APA Board of Trustees. "I owe 99 percent of my career to the SAMHSA Minority Fellowship because it opened so many doors for me, and it opened them fast."

Once their fellowships are completed, awardees tend to keep giving back to minority populations. For instance, Torres-Llenza now works at a hospital in Washington, D.C., serving predominantly African-American patients, many of whom are low income. She also works weekly at a free clinic for refugee patients who are immigrants and refugee asylum seekers, many of whom are survivors of torture or domestic violence.

Other notable alums include Patrice Harris, M.D., M.A., AMA president-elect; Mindy Fullilove, M.D., a research psychiatrist at New York State Psychiatric Institute and a professor of clinical psychiatry and public health at Columbia University; and Tiffany Ho, M.D., behavioral health medical director at Santa Clara Valley Health and Hospital System and winner of APA's 2017 Jeanne M. Spurlock Minority Fellowship Achievement Award.

# Translations

*continued from page 23*

**4** *You must have a good reason?*

Asking clients about their reasons for harmful behaviors can reveal how clients view these behaviors as beneficial. The question does not condone the behavior; rather, it helps clients to understand their own motivation. This recognition leads to what they could do differently.

**3** *Was it different for you?*

Noticing positive differences, also known as exceptions, are times when an expected problem could have occurred but didn't. This leads to uncovering past successes.

**2** *On a scale from 1 to 10, where 10 is most satisfied and 1 is the opposite, where are you on the scale?*

Solution-focused scaling questions are constructed in a way to highlight things such as satisfaction with relationships, confidence in the ability to keep safe, or helpfulness of medications. Asking what keeps the number from being lower uncovers strengths the client might not have even been aware of. Other helpful scaling questions: What is the highest the number has ever been? What would be a good enough number? Where would your VIPs rate the number? How would you recognize when the number increases? How confident are you that you could raise the number by one point?

**1** *What are you good at, and what do you enjoy?*

This question invites the client to talk about aspects of their life that are working and reinforces that they are more than their "presenting problem." Focusing on their accomplishments expands the narrative of their abilities and enhances engagement in treatment. **PN**

# Journal Digest

*continued from page 24*

This study was published in *Molecular Psychiatry*.

**Khambadkone SG, Cordner ZA, Dickerson F, et al. Nitrated Meat Products Are Associated With Mania in Humans and Altered Behavior and Brain Gene Expression in Rats. *Mol Psychiatry.* July 18, 2018. [Epub ahead of print] https://www.nature.com/articles/s41380-018-0105-6**

iStock/LightFieldStudios

## Therapy Dogs Found to Improve ADHD Symptoms In Children

A randomized clinical study from researchers at the University of California, Irvine, School of Medicine has found that exposure to therapy dogs can be effective at reducing the symptoms of attention-deficit/hyperactivity disorder (ADHD) in children.

The study, which was published in *Human-Animal Interaction Bulletin*, involved 88 medication-naïve children aged 7 to 9 with ADHD. The participants received either conventional psychosocial training (concurrent child social skills training and behavioral parent training) or psychosocial training plus canine therapy for 12 weeks.

At the end of the study, parents in both groups reported an overall reduction in ADHD symptoms in their children; however, by week 8, the improvements became more significant in the group also receiving canine therapy. The differences of canine therapy were more evident in inattentive symptoms and social skills, and less so in hyperactivity symptoms.

These positive results suggested families now have another viable option when looking for a therapy to accompany or replace ADHD medications, said lead author Sabrina E.B. Schuck, Ph.D., in a press release. **PN**

**Schuck S, Emmerson NA, Abdullah MM et al. A Randomized Controlled Trial of Traditional Psychosocial and Canine-Assisted Interventions for Children With ADHD. *Hum Anim Interact Bull.* 2018; 6(1): 64-80. https://www.apa-hai.org/human-animal-interaction/haib/a-randomized-controlled-trial-of-traditional-psychosocial-and-canine-assisted-interventions-for-children-with-adhd/**