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AMERICAN PSYCHIATRIC ASSOCIATION

PSYCHIATRIC NEWS

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Join your colleagues in Chicago next month for APA's fall meeting, IPS: The Mental Health Services Conference, from October 4 to 7. See page 8 for stories on two sessions you won't want to miss.

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Long-time APA member named to American Hospital Association board.

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NIMH director explains role of targets in advancing the field.

2019 Fee Schedule Proposes Flat Rate for E/M Services

Many changes proposed by the Centers for Medicare and Medicaid Services should simplify documentation requirements, but the effects of the proposed flat rate for evaluation and management (E/M) services will vary according to physician practice. ***BY MARK MORAN***

The Centers for Medicare and Medicaid Services (CMS) has released the proposed 2019 Physician Fee Schedule, including proposals to reduce documentation burdens associated with evaluation and management (E/M) services and to substitute a single "flat rate" payment for some E/M services for Medicare patients.

The proposed changes apply only to those E/M codes billed in an office setting for new and established patients (99202-99205 and 99212-99215).

The changes to documentation requirements, if finalized, would allow physicians to choose from three possible documentation methods:

- Documenting on the basis of current guidelines (but physicians would only need to meet requirements for a level 2 service);
- Documenting on the basis of face-to-face time only (CMS has not yet determined the exact minimum time required);
- Documenting by medical decision making only (physicians would only need to meet requirements for a level 2 service).

Jeremey Musher, M.D., APA's advisor to the Current Procedural Terminology (CPT) Panel and RVS Update Committee (RUC), said the proposed changes should simplify documentation for billing purposes. But he noted that physicians would still be required to provide documentation to clarify medical necessity or for other clinical purposes.

The proposed single flat rate would take the place of the different levels of

see **Flat Rate** *on page 19*

Trump Expands Low-Cost, Short-Term Health Plans

Patient and consumer advocates warn that encouraging short-term health plans, which are sparse on coverage, may leave consumers open to financial ruin when care is needed and raise premiums for those with preexisting health conditions.
BY LINDA M. RICHMOND

The Trump administration issued a final rule last month encouraging the sale of short-term, inexpensive health plans that offer minimum coverage to individuals.

Short-term health plans were designed to fill temporary gaps in coverage, such as when changing jobs or graduating from college. The administration's new rule will allow the purchase of these short-term policies for

see **Health Plans** *on page 17*

PERIODICALS: TIME SENSITIVE MATERIALS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Your APA: The First 100 Days

BY ALTHA STEWART, M.D.

As I approach the end of the first 100 days of my presidency, I want to share some of the activities in which I have been involved on behalf of APA. My year started at the end of the Annual Meeting with representing APA at the National Children's Mental Health Awareness Day event alongside first ladies from a half dozen states that support creating a more trauma-informed children's mental health system (see https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2018.6b17).

At the end of May, I joined other mental health and substance use professionals on Capitol Hill for a congressional briefing on mental health and criminal justice (see https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2018.6b30). In June I was invited to share APA's vision for psychiatry's future hopes and challenges at the Psychiatry in 2018 Conference sponsored by McLean Hospital and Harvard Medical School.

Along with members of the APA administration, I then traveled to Japan and the United Kingdom, where I spoke about women in leadership positions in psychiatric associations and strategies being used around the world to support children in need of mental health care and their families.

In July, we had the first full Board of Trustees meeting of my presidency and addressed a wide range of issues. Among the highlights:

- Update on APA's survey of the economic impact of The Joint Commission's ligature risk and self-assessment standards on psychiatric facilities and workforce.

- Update on APA's statements on psychological harm done to the approximate 3,000 undocumented children separated from their families because of the Department of Justice's "zero-tolerance" policy. APA was one of the first medical associations to publicly oppose the policy of separating children from their parents and led 17 other mental health organizations in sending a letter to the Department of Justice, Department of Homeland Security, and Department of Health and Human Services urging the Trump administration to end its policy of separating children from their parents.

- Update on APA's continued advocacy for passage of the Overdose Prevention and Patient Safety (OPPS) Act, which aligns 42 CFR Part 2 with HIPAA requirements. The legislation would allow physicians to view a patient's substance use record to facilitate quality care, supporting care coordination, the integration of treatment, and improved patient outcomes. It would also decrease stigma by allowing mental health and substance use disorders to be treated like any other illnesses.

Two other important issues consistent with my commitment to early career members were addressed: (1) the Board revised and approved an Assembly action paper on medical school repayment subsidies for psychiatrists practicing in community mental health centers, state psychiatric facilities, and correctional facilities and

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

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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 8.


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Revised ICD-10-CM Codes to Take Effect October 1

A crosswalk between the new ICD codes and DSM-5 *codes is posted on APA's website in a printable format that can be used for easy reference.*

Revised ICD-10-CM codes for 2019, released by the National Center for Health Statistics (NCHS), take effect on October 1. The list includes new, updated, or deleted codes for diagnoses in ICD-10-CM, including some 65 codes related to mental health conditions in *DSM*-5. All practitioners and payers must use the codes.

Coding updates are typically made to provide greater diagnostic specificity, which in turn impacts reimbursement levels.

NCHS is a federal agency within the Centers for Disease Control and Prevention, which oversees the ICD-10-CM. The ICD-10 Coordination and Maintenance Committee, a federal committee co-chaired by a representative from NCHS and from the Centers for Medicare and Medicaid Services, approves proposed changes to ICD on a yearly basis.

The diagnoses are listed alongside two columns—one column lists the codes that can be used through September 30, and the other column lists the new codes that become effective October 1. Two versions of the table are provided—one listing the codes in numerical order and the other listing them in the order in which they appear in *DSM*-5.

This year's coding changes impact two diagnostic categories in *DSM-5:* (1) factitious disorder in the somatic symptom and related disorders and (2) substance withdrawal in the substance-related and addictive disorders. Overall, these changes allow clinicians to provide a greater level of specificity. The details of these changes are presented below, as explained by Michael First, M.D. He is a professor of clinical psychiatry at Columbia University and a research psychiatrist in the Division of Clinical Phenomenology at the New York State Psychiatric Institute. Additionally, he is a member of the *DSM* Steering Committee, the editorial and coding consultant for *DSM-5,* and the chief technical and editorial consultant on the World Health Organization's ICD-11 revision project.

Factitious disorder involves falsification of medical or psychological signs and symptoms or induction of injury or disease associated with identified deception. *DSM-5* introduced new subtyping: factitious disorder imposed on self vs. factitious disorder imposed on another. Prior to this coding change, clinicians did not have an option to code subtypes because the only available code was F68.10. While F68.10 will remain in use for factitious disorder imposed on self, the new code, F68.A factitious disorder imposed on another, allows the clinician to make the distinction between these two subtypes. Of note, factitious disorder imposed on another is diagnosed in the perpetrator, not the victim.

The coding change specific to substance withdrawal reflects the need to differentiate between individuals who experience substance withdrawal in the presence of a use disorder and individuals who experience substance withdrawal while taking medications as prescribed and under appropriate medical supervision.

Given that substance withdrawal typically occurs in the context of a moderate to severe substance use disorder, the *DSM-5* coding note for substance withdrawal only offers the ICD-10-CM code for substance withdrawal occurring in the context of a comorbid moderate or severe substance use disorder. For example, the coding note for opioid withdrawal instructs the clinician to use F11.23, noting that "the ICD-10-CM code indicates the comorbid presence of a moderate or severe opioid use disorder, reflecting the fact that opioid withdrawal can only occur in the presence of a moderate or severe opioid use disorder" (*DSM-5,* page 548). Substance withdrawal, however, commonly occurs in individuals taking medications exactly as prescribed. Because the *DSM-5* substance use criteria reflecting the development of tolerance and withdrawal are not considered to be met for individuals taking such substances solely under appropriate medical supervision, these individuals are not considered to have a diagnosis of a substance use disorder unless at least two of the other substance use criteria are met. Thus, the diagnostic codes indicated in the coding note do not apply.

The omission is being corrected in *DSM-5* so that the diagnostic codes for substance withdrawal that develops in individuals taking medications under appropriate medical supervision no longer indicate that there is a comorbid moderate or severe substance use disorder. The new codes for substance withdrawal that are being added for cases of withdrawal with no comorbid use disorder include F11.93 for opioid withdrawal; F12.93 for cannabis withdrawal; F13.939 for sedative, hypnotic, or anxiolytic withdrawal without perceptual disturbances; F13.932 for sedative, hypnotic, or anxiolytic withdrawal with perceptual disturbances; F13.931 for sedative, hypnotic, or anxiolytic withdrawal delirium; F15.93 for amphetamine withdrawal; and F19.939 for other substance withdrawal. Additionally, the code for cannabis withdrawal occurring in the context of moderate or severe cannabis use disorder will change from F12.288 to F12.23.

In addition to coding changes in ICD-10-CM, the *DSM* Steering Committee recently corrected the omission of "no diagnosis" category in *DSM-5*. This category was approved for inclusion in May and corresponds to the existing ICD-10-CM code Z03.89. It is available for immediate use. **PN**

The *DSM-5* recommended ICD-10-CM coding changes appear in a table posted at https://www.psychiatry.org/psychiatrists/practice/dsm/updates-to-dsm-5/coding-updates.

Harsh Trivedi, M.D., Named to AHA Board

AHA represents nearly 5,000 hospitals, health care systems, networks, other providers of care, and 43,000 individual members.

Harsh Trivedi, M.D., M.B.A., president and chief executive officer of the Sheppard Pratt Health System, has been named to the Board of Trustees of the American Hospital Association (AHA). He begins a three-year term on January 1, 2019.

At Sheppard Pratt, Trivedi is head of the largest private, nonprofit provider of mental health, substance use, special education, and social support services in the country. He is also a clinical professor of psychiatry at the University of Maryland School of Medicine and editor of *Psychiatric Clinics of North America*. A longtime member of APA, Trivedi is the chair of the APA Council on Healthcare Systems and Financing. He is also an alternate delegate to the AMA Section Council on Psychiatry.

The AHA Board of Trustees is the highest policymaking body of the AHA, representing nearly 5,000 hospitals, health care systems, networks, other providers of care, and 43,000 individual members.

"I am honored to serve on the AHA Board of Trustees as we work to advance the health of individuals and communities across the nation," said Trivedi. "I firmly believe that our best solutions come from the input of many. Together, we can identify solutions to meet the needs of our diverse hospitals and health systems, as well as the unique needs of those we serve."

APA leaders said that having a psychiatrist on the board of the influential hospital association will advance patient care. "We congratulate Dr. Trivedi on this distinguished accomplishment," said APA President Altha Stewart, M.D. "The APA Board of Trustees looks forward to working with him in this new role with the shared goal of improving care and access for our patients."

"We are delighted to see one of our leaders placed on the AHA board," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "He is one of the top leaders in the field of psychiatry, and his insight and expertise will be a tremendous asset to the AHA board."

Trivedi also serves on the Executive Committee of the Maryland Hospital Association and the board of the National Association for Behavioral Healthcare. Trivedi, a graduate of the Mount Sinai School of Medicine, completed his general psychiatry residency at the Zucker Hillside Hospital/Albert Einstein College of Medicine. He completed his child and adolescent psychiatry training at Children's Hospital Boston/Harvard Medical School and his M.B.A. at the University of Tennessee Haslam School of Business. **PN**

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Psychiatric Educators Issue 'Call to Action' on Climate Change

Some of the nation's leading academic psychiatrists describe why and how the psychiatric profession should respond to climate change. **BY MARK MORAN**

Climate change, caused by human activity, is "an indubitable scientific fact," say seven psychiatric educators in a "call to action" published in the most recent edition of *Academic Psychiatry*.

"Climate change has the potential to catastrophically impact planetary and public health," wrote lead author John Coverdale, M.D., a professor of psychiatry and behavioral sciences at Baylor College of Medicine, and colleagues. "Psychiatric professional organizations and psychiatric departments and every single member of the psychiatric profession have fiduciary obligations to the public. We and our departments and organizations are trusted and influential role models. We should therefore embrace with enthusiasm this critical opportunity for leadership in attending the very serious threats posed by climate change."

Coverdale is deputy editor of *Academic Psychiatry*.

The call to action is a striking statement by some of the nation's leading academic psychiatrists, including Richard Balon, M.D., director of the adult psychiatry training program at Wayne State University; Eugene Beresin, M.D., senior educator in child and adolescent psychiatry at Massachusetts General Hospital for Children; Adam Brenner, M.D., director of psychiatry training and vice chair for education at the University of Texas Southwestern Medical Center; Anthony Guerrero, M.D., chair of psychiatry at the University of Hawaii; Alan Louie, M.D., director of education in the Department of Psychiatry and Behavioral Sciences at Stanford University; and Laura Roberts, M.D., chair of the Department of Psychiatry and Behavioral Sciences at Stanford and editor in chief of the APA Publishing Books Division.

The call to action outlines scientific data on climate change; mental health effects of climate change; and clinical, administrative, research, and educational initiatives that psychiatry can undertake.

It is accompanied in the journal by a commentary by APA President Altha Stewart, M.D. "APA recognizes the importance of working in this area [of climate change] and will co ntinue these efforts through its existing components, as well as through alliances with other organizations," Stewart wrote. "If indeed climate change is the biggest global health threat of this century, then we have an obligation to make concerted efforts to mitigate its effects."

John Coverdale, M.D., says it is not known the extent to which discussion of the effects of climate change on health and mental health have penetrated medical school curricula.

In comments to *Psychiatric News*, Coverdale said he believes psychiatrists, and especially psychiatric educators, have a critical opportunity to act as leaders in responding to the threats associated with climate change. "Yet there has been a perplexing general lack of attention on climate change in psychiatry publications," he said. "The journal *Academic Psychiatry* is perfectly poised for this leadership role because the associated challenges relate to the journal's mission including to improve knowledge in and stimulate evidence-based advances in key domains such as education, leadership, finance and administration, career and professional development, ethics and professionalism, and health and well-being."

Elizabeth Haase, M.D., says the challenge of climate change may require psychiatrists and APA to make dramatic changes to practice and professional activities.

Coverdale told *Psychiatric News* that medical schools and academic medical centers can create pathways for select members of the profession to specialize in the study of climate change including its psychological, psychiatric, and social aspects. "It might be of value for medical schools to employ climatologists to assist in meeting these goals," he said.

Psychiatrists concerned about climate change say that the call to action is timely and that medical schools and residency programs have a special responsibility to respond. "Putting climate health into our medical school and residency curriculae is as important as teaching young physicians about the impact of tobacco, diabetes, or hypertension and should be rapidly implemented by the ACGME [Accreditation Council for Graduate Medical Education]," said Elizabeth Haase, M.D., an associate professor of psychiatry at the University of Nevada at Reno School of Medicine.

Haase is on the steering committee of Climate Psychiatry Alliance (CPA), a group of APA members that have coalesced around the issue of climate change and mental health (see box above). She is also chair of the Group for the Advancement of Psychiatry (GAP) Climate Committee.

She said the urgency of climate change calls for radical measures. "If we know that giving a patient an electric bicycle improves both their immediate health and the long-term viability of their environment, should we not be able to write a prescription for an electric bike? How do we reward sustainable health measures in a disease-based profit model?

see **Climate Change** *on page 18*

Climate Psychiatry Alliance Grows

The Climate Psychiatry Alliance (CPA) is growing.

Members of the alliance were instrumental in advocating for a position statement adopted by APA last year on climate change. The position states: "APA recognizes that climate change poses a threat to public health, including mental health. Those with mental health disorders are disproportionately impacted by the consequences of climate change. APA recognizes and commits to support and collaborate with patients, communities, and other health care organizations engaged in efforts to mitigate the adverse health and mental health effects of climate change."

A similar statement was also adopted by the American Association of Community Psychiatrists. CPA members also advocated successfully for the formation of a climate psychiatry caucus within the Committee on Disaster Psychiatry.

CPA will be convening two panel discussions at next month's IPS: The Mental Health Services Conference in Chicago and is submitting proposals for six panel discussions at APA's 2019 Annual Meeting in San Francisco. CPA members are offering talks on climate change around the country in the coming months and are attending the Climate Summit in San Francisco this month.

More information about CPA is posted at https://www.climatepsychiatry.org/.

Data Mining May Help Identify Suicide Risk

By analyzing hundreds of pieces of medical, behavioral, and demographic information using advanced software programs, researchers try to identify people at greatest risk of suicide.

BY NICK ZAGORSKI

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As highlighted by data released this summer by the Centers for Disease Control and Prevention, U.S. suicide rates have climbed steadily over the past decade. Despite this uptick in suicides, however, suicides remain rare overall. Even within populations considered vulnerable for suicide, such as individuals hospitalized for a psychiatric condition, most people will not attempt suicide.

To better target suicide prevention efforts to those in greatest need, researchers must first find better ways to identify patients who might be truly at risk.

Some researchers believe people with suicidal ideation may leave clues to their future intent each time they visit a doctor—akin to a trail of clinical "bread crumbs." These investigators are turning to sophisticated software programs to mine electronic health records for patterns that indicate a forthcoming suicide attempt.

The measures scanned by these programs include known suicide-associated variables such as history of mental illness and/or history of self-harm, along with prescription drug history, demographic information, and scores on clinical assessments such as the 9-item Patient Health Questionnaire (PHQ-9).

The programs scan through a patient's medical history and use an algorithm to develop a risk score. These scores are then used to stratify patients into suicide risk categories. Such information could help clinicians initiate conversations with patients at highest risk of suicide earlier in treatment.

Developing algorithms most likely to identify people who may attempt suicide is not a one-formula-fits-all approach. Colin Walsh, M.D., an assistant professor of psychiatry and biomedical informatics at Vanderbilt University Medical Center who has developed programs to assess suicide risk in adults and adolescents, noted each program has its own distinct parameters. His adolescent risk algorithms, for example, consider childhood attention-deficit/hyperactivity disorder and defiant disorders as part of the suicide risk profile, whereas these disorders are not used in adult algorithms. Ronald Kessler, Ph.D., the McNeil Family Professor of Health Care Policy at Harvard Medical School, has been exploring the potential of suicide risk algorithms in military personnel. His programs include combat-specific information such as how much time soldiers have between deployments.

More research is needed before these algorithms can be routinely used in practice. In a report appearing in the *American Journal of Psychiatry* in May, Gregory Simon, Ph.D., and his colleagues at Kaiser Permanente described an algorithm they used to predict suicide attempt and suicide death following an outpatient visit. They found that among patients in the top 5 percent of risk scores, just 5.4 percent attempted suicide and 0.26 percent died by suicide in the 90 days following their outpatient visit.

"Some critics have raised concerns that these outcomes are not common enough to warrant intense interventions, even among this high-risk group," said Kessler. However, he countered

see **Data Mining** *on page 19*

ETHICS CORNER

Electronic Medical Records and the Dehumanization of Medicine

BY CLAIRE ZILBER, M.D.

Claire Zilber, M.D., is a psychiatrist in private practice in Denver, a faculty member of the PROBE (Professional Problem Based Ethics) Program, and chair of the Ethics Committee of the Colorado Psychiatric Society. She is the co-author of *Living in Limbo: Creating Structure and Peace When Someone You Love Is Ill,* the winner of a 2017 Silver Nautilus Book Award.

The popular narrative about the electronic medical record (EMR) is that it makes a patient's health care information more accessible across providers; allows medical history, diagnoses, problem lists, and medications to be tracked and reconciled to increase accuracy; and results in improved quality of care.

The reality is that the Affordable Care Act mandated the EMR for all of the above reasons and to serve as a billing platform. All of the EMR's purported benefits, including accurate and efficient billing, are laudable; however, it has had unintended and devastating consequences. These include reduced face-to-face time between clinicians and their patients, a note cluttered with meaningless information because of excessive reliance on checkboxes, reduced clarity of communication because the cluttered notes make it hard to find the most important pieces of information, and diminished job satisfaction for health care professionals. In addition, there are some potential ethical concerns regarding the EMR, including a loss of the virtues inherent in professionalism.

A Google Scholar search for "electronic medical record and burnout" limited to articles published since 2017 results in 5,160 published articles. The findings include that primary care physicians spend more than half of their 11 hours of daily clinical work interacting with the EMR. One review article *Current Opinion in Anaesthesiology* concludes, "In multiple recent studies, electronic health records have been shown to decrease professional satisfaction, increase burnout, and the likelihood that a physician will reduce or leave clinical practice." Many articles concern improving work-life balance through physician self-care, and others describe assigning a clerical scribe to each health care professional to reduce time spent directly interacting with the EMR. Those suggestions are good, but they are not good enough.

What the data fail to capture is the dehumanization of health care professionals in an increasingly corporate, market-driven world. In the effort to track meaningful quality improvement data, the EMR has shifted the focus from the patient to metrics. Physicians feel like cogs in the wheel of the billing-and-reimbursement machine, our service reduced to billable units.

This is not what motivated any of us to attend medical school. Virtues such as altruistic service, compassion, diligence, and communication with patients are not supported by typing and clicking on a computer for six hours a day. The requirement to have notes entered in a timely fashion elevates other virtues, such as efficiency, but perhaps not the ones patients and their families care most about. When the values that motivate us to work hard in service of our patients are subverted by administrative mandates, we may feel diminished and demoralized. Our demeanor at work may shift, and our professionalism may suffer.

APA's *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (2013) exhorts the physician to respect the law and "recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient" (Section 3). If psychiatrists find that the EMR in its current incarnation is compromising the best interests of the patient, it is our ethical duty to seek changes. Furthermore, Section 4, Article 1, acknowledges, "Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard."

To preserve the healing nature of the doctor-patient relationship we must protect our ability to spend time talking face to face with our patients, and we must practice in a way that feels true to the values that brought us into this healing profession. Individual psychiatrists cannot achieve this kind of systemic change on our own. We need the organizational capacity of APA, AMA, and other professional advocacy groups to work with the federal government, health care systems, and insurers to promote deep shifts in health care business practice. Unless we find a way to rehumanize the profession, we will be reduced to mere technicians in the medical industrial complex. **PN**

Risk Management Considerations When Treating Violent Patients

Always be prepared to deal with the potential that a patient may become violent and take steps to minimize legal risks.

BY KRISTEN LAMBERT, J.D., M.S.W., L.I.C.S.W.

There may be times in your practice when you have a patient who expresses violence toward others or when you may be concerned that a patient has the potential to commit a violent act. Given some of the large-scale violent incidents that have occurred, I thought it would be important to outline some of the major issues to consider when treating patients who are or may be violent.

If your patient expresses that he or she wants to harm others, you may need to consider your duty to warn (see https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.1b1). If able, first obtain advice on whether disclosure would be permissible under the circumstances notwithstanding your patient confidentiality obligations. However, you may have an extremely urgent issue arise. It is always best to err on the side of caution and safety versus maintaining patient confidentiality.

The best strategy to minimize risk is to document your risk assessment thoroughly. Additionally, APA's Resource Document on Psychiatric Violent Risk Assessment may be helpful in assessing risk. Briefly, your risk assessment should include documentation of the following:

- Risk factors.
- Specific threats (imminent or not).
- Ability to follow through.
- Thought process on hospitalization.
- Why hospitalization is recommended or not.
- When indicated, discussion with family members or significant others.

If your patient engages in a high-profile violent act, it is preferable not to communicate with others. Your inclination may be to talk with other treatment providers, family members, or even the media. However, prior to doing so, obtain advice on steps to take to ensure you are in compliance with state law in maintaining patient confidentiality.

When a patient has a history of expressing homicidal ideation or has been violent previously, you should

Kristen Lambert, J.D., M.S.W., L.I.C.S.W., is vice president of the Psychiatry and Professional Lines Group of AWAC Services Company, a member company of Allied World.

document, in every subsequent session, whether the patient admits or denies homicidal ideation. When the patient expresses homicidal ideation, document what he/she expressed and the steps you did or did not take in response and why. Should an incident occur, your documentation will play an important role in defending your actions.

Despite taking precautions, your patient may still commit a violent act. The following are some strategies that may minimize your risk.

- Conduct complete timely/thorough risk assessments.
- Document, including the reasons for taking and not taking certain actions.
- Understand your state's law on duty to warn. Be aware of the language in the law on whether you have a mandatory, permissive, or no duty to warn/protect.
- Understand your state's laws regarding civil commitment.
- Understand your state's laws regarding disclosure of confidential information and when you can do so.
- Understand your state's laws regarding discussing firearms ownership and/or possession with patients.
- If you have questions, consult an attorney or risk management professional. **PN**

APA's Resource Document on Psychiatric Violence Risk Assessment is posted at https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/rd2011_violencerisk.pdf.

VIEWPOINTS

How to Be an Advocate

BY MARY C. VANCE, M.D.

Tired of your patients being treated as second-class citizens by the health care system? Tired of *you* being treated as a second-class citizen by insurance companies? Frustrated at how few beds are available for individuals with mental illness? All psychiatrists have stories to tell about the daily injustices we face while trying to care for our patients. Most of us have gone as far as to muse, "Someone needs to do something about this." And a few of us—though the number is growing every day—have realized that that someone is *us*.

It's not easy to become an advocate, but given the current political situation and upcoming elections, it's important to get outside your comfort zone and get involved. It may be hard to find time to advocate, and mentors in advocacy may be few and far between. Does this mean we should just go back to our desks and stop trying? No—it means there is an unmet need. Here's a short, step-by-step guide to help you on your way.

Mary C. Vance, M.D., is a research fellow with the National Clinician Scholars Program at the University of Michigan and the VA Ann Arbor and a consultant to APA's Council on Advocacy and Government Relations. She is the lead editor of *A Psychiatrist's Guide to Advocacy*, to be available from APA Publishing in 2020.

- **Step 1: Tap into your moral outrage.** Yes, there is a name for that flash of anger you experience when you see a patient or colleague being treated unjustly by the powers that be. It's moral outrage, a term that my first mentor in advocacy taught me and that captures the essence of what drives many people to advocate. We all have an innate ability to detect unfairness and inequality. What matters is what we do when we come across it. By paying attention to what sparks your moral outrage, you can identify the advocacy areas that you care about most. Focus your energy on these areas, and your moral outrage will be your fuel when you advocate.
- **Step 2: Find your crowd.** As another one of my mentors would say, "Advocacy is a team sport." The bigger the problem you're trying to fix, the more boots on the ground you'll need to fix it. You need to surround yourself with like-minded people and work together to achieve a mutually agreed-upon goal. This is called coalition building, and it's a vital skill for an advocate to have. By building—or joining—a group that is advocating for issues you care about, you'll start to build the strength in numbers you need to succeed. In addition, the connections you make will provide you with invaluable mentorship and resources.

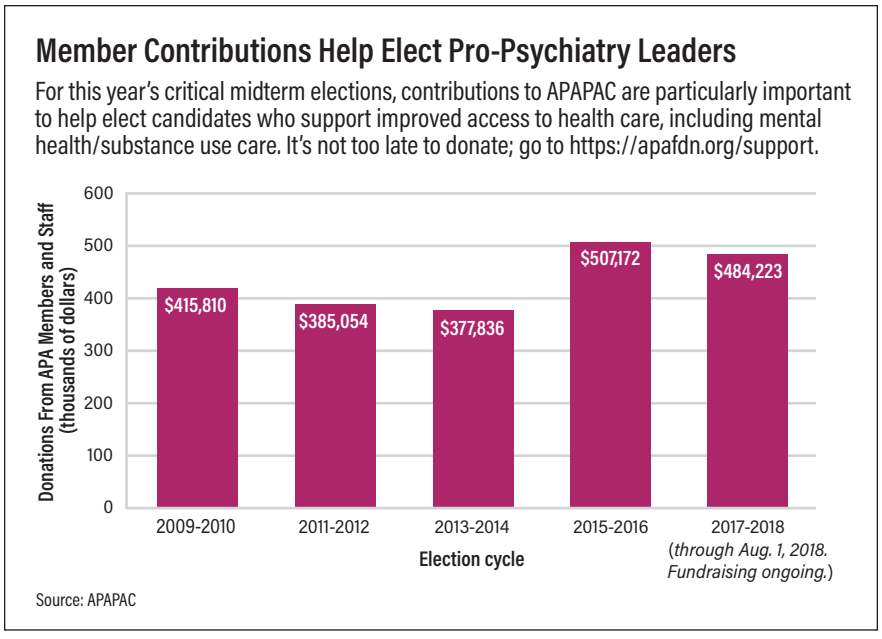
  Not sure how to find or build that coalition? Start locally. Ask around in your hospital or practice about who has interest in advocacy. You may be surprised to find how many fellow advocates are out there! Also, APA and the National Alliance on Mental Illness (NAMI) are both excellent starting points. Connect with your APA district branch at https://www.psychiatry.org/about-apa/meet-our-organization/district-branches and with your local NAMI chapter at https://www.nami.org/Find-your-local-nami.
- **Step 3: Be specific.** Many would-be advocates falter not from lack of enthusiasm, but from lack of direction. Because the definition of advocacy is broad, and because there is so much to advocate for, it's easier to be passionate about the general idea of advocacy than to pick a particular topic on which to work.

continued on next page

APAPAC Plays Key Role Advancing Psychiatry During Elections

The APA political action committee (APAPAC) raises funds from members to support those running for federal office who have demonstrated a commitment to advancing psychiatry.

BY LINDA M. RICHMOND



With so many congressional seats up for grabs this November, APA's political action committee (APAPAC) is working behind the scenes to shape the outcomes in a number of critical federal races.

There are 35 U.S. Senate and 435 House seats up for reelection, with as many as 55 of them considered toss-ups that could be won by either candidate.

What role does APAPAC play? Put simply, it seeks out viable candidates who are supportive of psychiatry, cultivates relationships with them, and helps them get elected to federal office. The goal is to build champions for psychiatry in Congress.

Some of the issues APAPAC works to advance include improving patient access to psychiatrists, fighting for funding for mental health programs and research, and treating the opioid epidemic. Another major concern is ramping up the psychiatry workforce by securing more residencies for medical students.

"We provide support to candidates who are pro mental health and who are interested in championing our issues: promoting access to high-quality, evidence-based psychiatric care and in promoting psychiatry overall," said child and adolescent psychiatrist Debra Koss, M.D., a member of APA's Council on Advocacy and Government Relations and APAPAC consultant. Koss said that through her work with APAPAC, she has been able to share anecdotes of her clinical experiences and patients' attempts to access care with lawmakers. "These are much more compelling to lawmakers than mere statistics," Koss added.

"Historically, psychiatry is near the bottom of the pack of physician specialties in terms of money raised to

see **APAPAC** *on page 17*

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But the more specific you can be about the change you want to see, the more likely you are to succeed in making change happen—both because you (and your coalition) can better focus your efforts, and because policymakers respond best to direct, actionable, and specific guidance.

- **Step 4: Make your voice heard.** Once you've completed the steps above, you're ready to get your message out to the public. To figure that out who your audience is, identify the stakeholders for your issue—the individuals and groups who have a vested interest in that issue. Of course, psychiatrists and patients will be among them, but so might legislators, insurers, administrators, and others. How you craft and where you deliver your message will differ depending on who your target audience is. For example, telling personal stories ("In my practice, I often experience …") may be compelling for policymakers, and this may take the form of meeting with them at the state house or giving congressional testimony. In contrast, a board of trustees may be most interested in hearing about ideas that advance its organization's mission, and your best access to these leaders may come in the form of working with a committee that reports to the board.

Even if you don't have much time to devote to advocacy, writing to your congressional representatives is a good first step to making your voice heard. Find out who they are and sign up for alerts from APA's Advocacy Action Center (http://cqrcengage.com/psychorg/home) or your district branch to stay informed on current advocacy priorities.

And finally, the work of an advocate is never done, but even small actions make a difference. As psychiatrists, we are privileged to be thought leaders in mental health. We should use that influence to continually improve the care of our patients. **PN**

2019 **APA** Election

Nominations Invited for APA's 2019 Election

All APA members are invited to submit nominations for APA's 2019 election for the offices of president-elect and secretary. APA members in Areas 3 and 6 are also invited to submit nominations for trustees in their respective Areas. Resident-fellow members are invited to submit nominations for resident-fellow member trustee-elect. APA is also accepting nominations for the minority/underrepresented (M/UR) trustee. Nominees must self-identify as American Indian/Alaska Native/Native Hawaiian; Asian American; black; Hispanic; LGBTQ; international medical graduate; and/or woman to qualify for election to this position. Nominations should include the full name of the APA member and the corresponding office(s) for which the individual is being nominated and be sent by October 1 to election@psych.org.

Session to Separate Fact From Fiction On Gun Violence, Mental Health Link

Marc Manseau, M.D., M.P.H., will discuss the common media misconceptions about mental illness and give messaging tips so psychiatrists can be more effective advocates for gun reform. **BY NICK ZAGORSKI**

iStock/Onandter_sean

Mark Manseau, M.D., M.P.H., hopes that his session on gun violence and mental illness will help psychiatrists provide better public messaging as well as improved dialogue with their patients about firearms.

The spate of mass shootings in the United States has brought the topics of gun violence and mental illness into the public spotlight.

"After every mass shooting, people will come on television and say that it's a mental health problem and that if we had better mental health services, we could prevent these tragedies," said Marc Manseau, M.D., M.P.H., a clinical assistant professor of psychiatry at NYU Langone School of Medicine.

Some psychiatrists might view these moments as an opportunity to obtain more resources for mental health care, but Manseau believes it's more important to correct the flawed—and stigmatizing—perception that people with mental illness are more prone to carry out violent acts.

That mischaracterization will be one of the topics that Manseau will cover at his session at this year's IPS: The Mental Health Services Conference in Chicago: "Mental Illness and Gun Violence in the United States: Facts and Messaging Tips for Psychiatrists."

Manseau will highlight that, contrary to popular belief, research has shown that people with mental illness are only slightly more likely than the general population to commit gun violence against others, with factors such as illness severity or comorbid substance use influencing the increased risk. The pressing gun problem associated with mental illness is not homicide, but rather suicide, which accounts for approximately two-thirds of all nonaccidental gun-related deaths.

The other major theme Manseau will tackle is gun policy. Universal background checks and assault-weapon bans are commonly proposed ways to reduce

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Psychiatrists Can Help Train Police in Crisis Response

Getting involved in Crisis Intervention Training (CIT) for police officers is an important way psychiatrists can help at-risk patients in their communities. **BY LINDA M. RICHMOND**

Police departments across the United States are increasingly being called to serve as first responders for people experiencing mental health crises.

Tragically, these encounters too often result in arrests, injury, or far worse. Of the 987 people shot to death by police officers in 2017, mental illness was known to have played a role in one quarter of these incidents, according to an ongoing national study by the *Washington Post*.

"What training, if any, do police officers have in interactions with people experiencing mental illness?" asked Chandan Khandai, M.D., a consultation-liaison psychiatry fellow at the University of Washington School of Medicine. "Often they say 'I don't know what to do. I was never trained for this. I'm just trying to do my job.'" Khandai hopes that more police officers will receive Crisis Intervention Training, also known as CIT, and that psychiatrists will assume a bigger role in shaping these programs.

Khandai will be participating in the session "Law Enforcement-Mental Health Interactions and the Crisis Intervention (CIT) Model" at IPS: The Mental Health Services Conference, which is being held October 4 to 7 in Chicago.

"This is an easy, concrete way of helping our patient population by getting involved in this," he said. "The more partners we can develop outside of the traditional medical and mental health care setting, the better off our patients will be."

Khandai, himself a native Chicagoan, attended CIT training this past May with the Chicago Police Department and was one of the first psychiatrists to attend the program. "It was quite an eye-opening experience," he said. "I never fully appreciated the difficulties that officers face when trying to handle mental health–related calls—not having a medical background, having incomplete information, having to balance doing what's best for the individual with keeping the community safe."

Chandan Khandai, M.D., hopes that more police officers will receive Crisis Intervention Training, also known as CIT.

Research has demonstrated that CIT helps both officers and patients: it boosts police officers' knowledge of mental health issues and de-escalation techniques, raises referrals of people with mental illness to treatment venues, and lowers the likelihood of arrest and incarceration for individuals experiencing a crisis, he said.

In Chicago, the training takes place in studios that are designed to look like houses or bars, and with individuals who have experienced mental illness acting out scenarios with police trainees. Both police officers and the "actors" benefit. "This allows them to reenact their bad experiences with police officers and get a better outcome," he said. The police officer who heads Chicago's CIT training will also be speaking at the session.

For now, Chicago police officers who take the 40-hour CIT training do so on a voluntary basis, Khandai said. "But we are trying to make it required for everyone going forward. The more officers who are trained in CIT techniques, the deeper the pool will be of officers who are able to go and de-escalate interactions with individuals with mental illness." **PN**

"Law Enforcement–Mental Health Interactions and the Crisis Intervention (CIT) Model" will be held Thursday, October 4, 1 p.m. to 2:30 p.m.

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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gun violence, and while Manseau believes they are necessary, they are not sufficient. Moreover, they will not effectively address the risk of suicide among people with mental illness. Extreme risk protection orders, in which officials can temporarily remove guns from people who display "red flag" suicidal behaviors, have been shown to be more effective, and Manseau will discuss these.

"Of course, another important consideration is the influence of the gun lobby," Manseau told *Psychiatric News*. "It doesn't matter what policies might work if we cannot get any laws passed or agencies like the CDC cannot do gun-related research."

There are many layers to go through in the gun debate, Manseau said, adding that his IPS presentation will just scratch the surface. However, he hopes attendees will learn enough to be able to provide more nuanced and contextually correct messages when discussing the intersection of mental illness and gun violence.

While proper messaging is important when advocating on behalf of people with mental illness, it is also critical when talking with patients.

"Psychiatrists should be able to discuss gun ownership with their patients, be aware of how access to firearms affects a patient's risk for violence and suicide, and be knowledgeable on what they can do to separate patients from their guns if necessary," he said. **PN**

"Mental Illness and Gun Violence in the United States: Facts and Messaging Tips for Psychiatrists" will be held Friday, October 5, 8 a.m. to 9:30 a.m.

Prenatal Folic Acid Associated With Lower Psychosis Risk

Analysis of hundreds of MRI scans shows that children born before the United States started fortifying grains with folic acid experienced earlier cortical thinning—a process implicated in schizophrenia. **BY NICK ZAGORSKI**

In 1996, the United States began requiring that enriched grain products (refined grains such as white flour or white rice with nutrients added back) be fortified with folic acid to help prevent neurological birth defects such as spina bifida. Numerous studies over the years have also suggested that children who were exposed to folic acid in utero have lower risks of other neurodevelopmental problems, including language delays and autism.

A study published July 3 in *JAMA Psychiatry* provides the first biological evidence to support the idea that folic acid may also mediate schizophrenia risk. Researchers compared MRI brain scans of children who were born before, during, and after the full implementation of folic acid fortification of U.S. grain products (1996-1998). They found that increased gestational exposure to folic acid was associated with positive

changes in childhood brain development and reduced the occurrence of psychotic symptoms later in life.

"With schizophrenia, as with any illness, you want to identify modifiable risk factors that might help prevent or delay symptoms," said lead author Joshua Roffman, M.D., an associate professor of psychiatry at Harvard Medical School.

"We've known for a while that complications during pregnancy and childbirth increase schizophrenia risk, but it's not like you can tell women to not have a complicated birth," he continued. "You can help them make choices that will enhance resilience during pregnancy, and one way is to remind them that there is a global recommendation that pregnant women take 400 to 800 micrograms of folic acid daily because it has neuroprotective effects."

Roffman, who also heads the Brain Genomics Lab at Massachusetts General Hospital, and colleagues first analyzed 292 MRI scans taken of children aged 8 to 18 at Massachusetts General Hospital. This group included 97 children born before folic acid enrichment, 96 born during the rollout (partially exposed to folic acid), and 99 born after the fortification was implemented nationwide.

They used the scans to measure the thickness of the cortical mantle (the outer layer of the brain's cerebral cortex) in the children. This region gradually thins as children mature, reflecting the carefully regulated pruning of excess neuronal connections to make the brain more efficient. If neuron pruning starts too early, though, it can increase the risk of disorders such as schizophrenia.

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The analysis by Roffman and colleagues showed that the brains of children exposed to folic acid exhibited slower age-related cortical thinning than children who were not exposed, with the partially-exposed children falling somewhere in between. These findings were confirmed in two additional batches of MRI images made available by the University of Pennsylvania (UPenn) and the National Institutes of Health (NIH), respectively. The UPenn study included 861 children born across the folic acid rollout timeframe (1992-2003) while the NIH study was exclusively composed of 217 children born before the fortification requirement was made (1983-1995).

The overall data suggested thinning begins shortly after age 13 in folic acid–exposed children, and about a year earlier in non-exposed children.

As part of the UPenn study, the children who received MRIs also underwent clinical tests to assess potential psychiatric conditions, including early psychosis symptoms. The investigators found that the children who had delayed thinning were at less risk of having psychosis symptoms.

Does this mean we might soon see a lower prevalence of psychotic disorders like schizophrenia as folic-acid fortified children start reaching adulthood?

"That would be encouraging, but we have to remember that there are many other risk factors for schizophrenia that can emerge between birth and adulthood. So, it's not necessarily a direct correlation," Roffman told *Psychiatric News*.

Roffman noted that the United

States is imperfect when it comes to nationwide monitoring of mental illness rates and trends. And unfortunately, the places that track health information the best—Northern European countries including Sweden and Denmark—do not mandate folic acid fortification. He said he hopes that studies like his might persuade U.S. authorities to improve mental health surveillance while also convincing other countries to join the 81 nations already fortifying foods with folic acid.

Camille Hoffman-Schuler, M.D., a psychiatrist and obstetrician at Colorado University Anschutz Medical Center, said the findings of the study by Roffman and colleagues affirm the U.S. decision to fortify foods with folate.

"If future studies fall along the same lines and show an association between prenatal folic acid and reduced risk of schizophrenia and other mental illnesses, then the population impact could be huge," Hoffman-Schuler said.

She noted that folic acid supplementation during the first trimester of pregnancy reduces the risk of neural tube defects (which are rare to begin with) by a factor of 10. If folic acid had anywhere close to that effect on schizophrenia, which is much more common, it would be a tremendous public health impact.

This study was funded by MQ: Transforming Mental Health, with additional support from the National Institute of Mental Health. **PN**

"Association of Prenatal Exposure to Population-Wide Folic Acid Fortification With Altered Cerebral Cortex Maturation in Youths" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2686139.

Genetic Variant May Foretell Cognitive Response to Antipsychotics

People with schizophrenia who have a certain variant of the dysbindin-1 protein perform better on cognitive tasks after taking antipsychotics than those without the variant.

BY NICK ZAGORSKI

Antipsychotics are known to be effective at managing positive symptoms of schizophrenia (hallucinations and delusions), but these medications can be unpredictable when it comes to alleviating symptoms of social withdrawal and cognitive deficits.

A study published in June in *Nature Communications* suggests that the dysbindin-1 protein may be a biomarker to identify which patients are most likely to show cognitive improvements on antipsychotics.

Dysbindin-1 regulates the recycling of dopamine D2 receptors—the targets of antipsychotics. A variant in the dybindin-1 gene known as T-A-A results in the production of less dysbindin-1 protein. Less dysbindin-1 means less recycling of dopamine receptors, which leads to excess dopamine signaling. This overactivity can affect thinking, and studies in both humans and mice have shown that reduced dysbindin-1 impairs cognitive flexibility, or the ability to easily modify one's thinking as circumstances change.

A team of researchers from Europe and the United States analyzed genetic data from 259 patients with chronic schizophrenia, all of whom were taking antipsychotics. As part of the study, the patients completed the Wisconsin Card Sorting Task, which measures cognitive flexibility. The researchers found that individuals who had the T-A-A variant performed better on average in the card task than patients without the variant.

The researchers conducted a second test with 45 patients with first-episode psychosis who had been exposed to antipsychotics for only four weeks. As with the other study group, patients who had the T-A-A variant did better on the card-sorting task.

The researchers acknowledged that a placebo group for comparison would be valuable to confirm the improved performance in patients with T-A-A was due to antipsychotic therapy. However, they noted that it would be ethically challenging to withhold medication from some patients. Instead, the authors used mice engineered to produce less dysbindin-1. These mice performed worse on a flexible-thinking task than normal mice, but after two weeks of antipsychotic treatment, their performance improved. Mice given placebo injections did not improve after two weeks.

Lead study author Francesco Papaleo, Ph.D., a researcher at the Department of Neuroscience and Brain Technologies and the Italian Institute of Technology in Genoa, said that this finding brings researchers one step closer to precision medicine for schizophrenia.

The "findings highlight one of the mechanisms that could be used to identify a subset of patients with schizophrenia whose executive functions are likely to respond better to antipsychotics," Papaleo and colleagues wrote. "Ultimately, these results might be potentially applied to increase the effectiveness of antipsychotics and reduce the duration of the empirical testing often required to select appropriate medication or doses of antipsychotic drugs."

Papaleo cautioned that while the Wisconsin Card Sorting Task measured only one component of cognition (flex-

see **Genetic Variant** *on page 17*

NIMH Experimental Therapeutics Paradigm Seeks to Revitalize Intervention Research

Under a new experimental paradigm, NIMH is requiring researchers to demonstrate that an intervention they want to test has an effect on some measurable target mechanism of the disorder under investigation.

BY MARK MORAN

Joshua Gordon, M.D., Ph.D., says the experimental platform will ensure that intervention studies advance the field regardless of whether the intervention shows a clinical benefit.

More than 50 years ago, biophysicist John Platt published in the journal *Science* a seminal article titled "Strong Inference," asserting that the greatest advances in science derive from hypothesis-falsifying experiments—studies designed to exclude, or falsify, one or more hypotheses and then are replicated to winnow out remaining hypotheses.

In this way, a study with a negative result can be enormously clarifying, forcing progressive changes and refinements in theory.

It is a process exactly the opposite of the way that much research on schizophrenia, especially drug discovery research, has been undertaken. What has been lacking in many of these studies is a testable hypothesis about how a molecule might affect a biological target related to schizophrenia.

The National Institute of Mental Health (NIMH) wants to change that. The experimental therapeutics paradigm, initiated under former Director Thomas Insel, M.D., requires that researchers seeking NIMH support for clinical trials in any area, including schizophrenia, demonstrate that the intervention they want to test—whether a drug, a psychosocial intervention, or a somatic therapy—has an effect on some measurable target mechanism believed to be relevant to the disorder being studied.

"We remain deeply committed to intervention research, particularly in areas like schizophrenia where there is tremendous need," said Joshua Gordon, M.D., Ph.D., who succeeded Insel as NIMH director in 2016. "But we have spent a great deal of money on 'me too' studies of interventions that didn't work, producing negative result after negative result, while never scientifically ruling out or confirming an underlying hypothesis. We were throwing money down the drain."

It doesn't have to be that way. As Gordon pointed out in an interview with *Psychiatric News*, even studies that produce negative results can be powerfully informative if researchers measure some biological target related to the disorder of study.

As an example, stress is known to play a role in psychiatric illness. A researcher might test an antagonist to the corticotrophin-releasing factor (CRF) system (known to be involved in the release of the stress hormone cortisol in the bloodstream), with the hypothesis that doing so will prevent or reduce the severity of depression. If the experimental drug has been shown to blunt the release of cortisol, the researcher can then test the molecule, at a variety of doses, in individuals with depression.

Even if the study is negative, showing no effect on depression, the study will have revealed something vital: blocking CRF is not a mechanism crucial to preventing or reducing depression. "If you show engagement of a biological target with your treatment and prove it doesn't produce a clinical effect, then you have evidence against the target as a mechanism in the disease," Gordon said.

The crucial question is, what constitutes a "measurable target"?

"We have been fairly explicit that the measurable target should be as close as possible to the actual posited mechanism of the drug or psychosocial intervention," Gordon said. "That is, if you are using a drug in a clinical study that binds a particular receptor, the best possible measurement demonstration would be receptor binding. We want the measure to be as proximal as possible to the target."

However, when it is not possible to assess whether the precise hypothesized target has been engaged, a secondary or downstream effect might be acceptable as a measure, Gordon said. For instance, a researcher who is testing a glutamate receptor agonist but is unable to directly measure receptor binding may, alternatively, show that activation of this receptor (through a downstream pathway) enhances a physiological measure of brain activity, such as the strength of gamma oscillations. (When neurons synchronize their firing, the rhythm of that firing is reflected as brain oscillations; a gamma oscillation is a neural oscillation of a particular frequency that is believed to be involved in cognition.)

"Quantifying gamma oscillations would be a potentially acceptable measure of target engagement in that case," Gordon said.

Gordon said the institute has never and would never require that treatment or other studies focus only on genes, or, in particular, only on single genes for treatment targets. "We fund plenty of work on pathways that may yield novel treatments. "

What is crucial, he said, is that investigators targeting those pathways be able to demonstrate that they have successfully engaged them so that the study is informative regardless of whether the results are positive or negative.

How can researchers seeking NIMH support for testing psychosocial interventions identify a measurable target?

Gordon pointed out that the majority of clinical trials at the institute are testing psychosocial strategies. "Part of the reason for this is that the psychosocial research community has bought into the idea of target measurement more rapidly than the psychopharmacological community," Gordon said.

He said a biological, brain-based target mechanism is preferable, but isn't always possible. What's crucial is that the researcher identify some measurable target mechanism by which the underlying hypothesis of the study can be tested.

For example, the institute is funding several studies looking at the effect of cognitive-enhancement training for high-risk youth on real-world functional outcomes in schizophrenia. In each case, the measurable targets include adoption of specific cognitive and/or social skills; if the researcher can show that the skills are adopted, then the hypothesis will be reliably tested, whether the actual effect on functional outcomes is positive or negative. The institute is also funding studies of technological interventions for the treatment of schizophrenia (see box at left).

Gordon emphasized that the institute remains committed to intervention research and to drug development for schizophrenia. And he offered some advice—and a challenge—to those seeking NIMH support: "Work with your program officer to figure out what would be an appropriate target measure. If you can't define one, I want to hear about it. It's possible we are preventing meaningful clinical trials because there isn't an appropriate target to measure, but so far no one has taken me up on the challenge."

He added, "The experimental platform is a way to ensure that the studies we conduct on interventions are rigorous science that will advance the field regardless of whether the experimental intervention shows a clinical benefit." **PN**

Psychosocial Intervention Studies Measure Target Mechanisms

The following NIMH-funded studies are looking at the effect of technological interventions on clinical outcomes in schizophrenia:

"Texting for Relapse Prevention: Improving Outcomes for People With Schizophrenia" is evaluating the impact that text messages have on the following targets: medication adherence and patient-provider communication.

"Mobile After-Care Support Intervention for Patients With Schizophrenia Following Hospitalization" is testing an app to improve outcomes. Targets include adherence to keeping appointments after hospitalization and self-coping mechanisms.

"Effectiveness of a Mobile-Texting Intervention for People With Serious Mental Illness" is also testing the effects of a text-based app. Targets include measures of how well patients adopt new strategies for managing their own illness.

Education Can Reduce Antipsychotic Polypharmacy

Providing community clinics with educational sessions about antipsychotic prescribing practices can change physician behaviors and reduce risky overprescribing. **BY NICK ZAGORSKI**

A study published June 8 in *Psychiatric Services in Advance* found that providing prescribers at a clinic with educational briefings coupled with feedback of the clinic's prescribing trends—academic detailing and auditing—can reduce the number of patients taking multiple antipsychotics concurrently.

Led by investigators at Dartmouth University, this study analyzed prescribing practices at eight community mental health clinics across New Hampshire over a period of two years. Educators who were experienced psychiatrists led academic detailing and audit sessions at the clinics at the start of the study and then again one month, 11 months, and 23 months later.

As lead author Mary Brunette, M.D., described, academic detailing involves educating medical staff about the benefits, risks, and alternatives to medications. Auditing provides the clinic with details about how their prescribing practices compare with others in the state and feedback on how their practice has changed over time.

Using available Medicaid data, Brunette and her team saw that the overall prevalence of polypharmacy among patients who filled prescriptions for antipsychotics dropped a little over 2 percent after the second year of the detailing and auditing intervention from 13.1 percent to 10.9 percent of patients.

The investigators also explored whether the clinics were reducing their use of antipsychotics with a high risk of cardiometabolic side effects such as weight gain and diabetes. They found that while overall prescribing rates of high-risk antipsychotics did not change statistically over two years, there were some positive trends. There was a reduced use of high-risk antipsychotics among Medicaid beneficiaries with psychotic and bipolar disorders, and increased use of low-risk antipsychotics among individuals without hospital or ED visit—a group considered to be more stable.

Mary Brunette, M.D., believes academic detailing and auditing is a straightforward yet engaging approach to reduce psychiatric polypharmacy while letting clinicians retain control of prescribing decisions.

"Compared with other studies that have assessed academic detailing for other health practices, our results were right in the middle, which was encouraging," Brunette said. "It can be difficult for physicians to change medications in people with a serious mental illness, and they do so very cautiously."

Study co-author Robert Cotes, M.D., an assistant professor of psychiatry at Emory University, agreed. "Two percent doesn't sound like much, but if you can get this drop across a state or across the country, it can make a big public health difference."

Brunette added that polypharmacy rates might have dropped even further as time went on and the physicians became more accustomed to new prescribing behaviors. Incorporating additional detailing sessions might also have lowered polypharmacy further, but that also brings about additional cost and time considerations.

"This is an appealing approach to improving health care practice and I hope clinics will consider implementing it," Brunette said. She acknowledged it might be challenging since many places that see a lot of Medicaid patients have set up contracts with managed care companies. These companies have their own approach to reducing polypharmacy, such as requiring prior authorization

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FROM THE EXPERTS

Psychiatrists Need to Prepare to Care for Gender-Variant Patients

BY ERIC YARBROUGH, M.D.

The concept of gender, or what people generally think of as the state of being male or female, is something that is so deeply engrained in our culture that attempts to even bend it are met with hostility from individuals and groups, both political and religious. Given our society's appreciation of individual freedom, it has never made sense to me that the presentation of someone's gender outside the expected upsets so many.

The number of trans-identified individuals seeking care for gender-affirming services has increased dramatically over the past few years. This could be due in part to the depathologizing language change from gender identity disorder to gender dysphoria in *DSM-5*. This change communicated a shift in psychiatric thinking regarding gender diversity, which provided a metaphorical welcome sign to those who previously felt uncomfortable or unsafe seeking psychiatric care. The increase in gender-diverse people seeking services could also be due to insurance coverage of gender-affirming treatments such as hormone therapy and surgical procedures.

As more transgender and gender-nonconforming patients are coming out and making new patient demands, the psychiatric community must be prepared to care for more gender-diverse individuals. The first step in the process includes examining how we think about gender.

I work at an LGBTQ clinic in New York City, and dealing with the many identities on the gender spectrum is a regular part of my work day. The idea that "male" and "female" are not a dichotomy but can exist simultaneously or not at all is part of an assumed position when working at a place like Callen-Lorde. When I speak at schools, clinics, and hospitals, it is generally about LGBTQ mental health and more recently about transgender mental health. Part of my introduction to the topic is discussing the gender spectrum, and I ask clinicians to think about what parts of their presentation are typically masculine and feminine. Surprisingly, mental health professionals—those who are thought to be the most in tune with their ideas and emotion—are sometimes defensive about the notion that their gender might be more complicated than the single identifier onto which they have held so closely since childhood.

Eric Yarbrough, M.D., is director of psychiatry at Callen-Lorde Community Health Center in New York City and president of AGLP: The Association of LGBTQ Psychiatrists. At APA, he is vice chair of the Council on Minority Mental Health and Health Disparities and a member of APA'S LGBTQ Caucus. He is the author of *Transgender Mental Health* from APA Publishing. APA members may purchase the book at a discount at https://www.appi.org/Transgender_Mental_Health.

It is good practice for all psychiatrists to be aware of their own gender and to examine the spectrum that exists within their own identity. When psychiatrists are open to exploring their own gender and gender expression, it is easier for them to approach gender-diverse patients as individuals and provide the best care. Letting go of the conventional definitions of masculinity and femininity is the first step to moving past the old gender dichotomy. Being self-aware will keep in check our own gender stereotypes and help us pay attention to the automatic assumptions that influence our daily thinking.

What is considered to be masculine and feminine behavior, attitudes, and fashion are cultural stereotypes that have been engrained in us from an early age. While some stereotypes might have biological roots, the majority are probably societal inventions. With the emergence of hormone and surgical treatment options for gender dysphoria, we are in a unique place to examine and deconstruct some of the core concepts of what makes up gender.

Through supervising other clinicians who work with individuals with gender dysphoria and exploring my own experience, I know that there are so many automatic reactions, thoughts, and ideas that require significant additional introspection. It is best that we start having conversations about them to free us up to provide sensitive and quality care. And as we do so, we will likely learn just as much about our changing society and our culture as about ourselves. **PN**

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to ensure that specific conditions are met before a second antipsychotic will be reimbursed.

Both methods can work, but Brunette feels clinicians would prefer academic detailing and feedback as it gives clinicians more control to use their own judgment; it's also more engaging. "I've found clinicians like the auditing and feedback information," she said. "They like to see how they compare with their peers."

She said that she hopes that a future study might directly compare detailing and prior authorization, to get better information on the cost-effectiveness of the two interventions.

Cotes said that he is also interested in attempting a similar study in Atlanta to see how academic detailing might work at a big city hospital that sees thousands of outpatients daily. "These results have given me optimism that changing physician behavior is possible with a low-intensity intervention," he said.

This study was funded by a grant from the National Institute of Mental Health. **PN**

"Use of Academic Detailing With Audit and Feedback to Improve Antipsychotic Pharmacotherapy" is posted at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700536.

Genetic Variant

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ibility), people with schizophrenia typically have broad cognitive deficits. He told *Psychiatric News* that his team is currently collecting other cognitive data from people with the dybindin-1 T-A-A variant to see if they also show signs of other cognitive improvements while taking antipsychotics.

Papaleo noted that the T-A-A variant was not one of the 108 genetic variants implicated as being associated with schizophrenia risk in a landmark genome-wide analysis (*Psychiatric News*, September 5, 2014). "Oftentimes genes important in drug response have no connection to the underlying disorder," he said.

He added that more research is needed to explore the connection between dysbindin-1, dopamine receptors, schizophrenia, and cognition.

This study was supported by the Italian Institute for Technology, the Marie Curie FP7-Reintegration-Grant, the Italian Ministry of Health, the Brain and Behavior Research Foundation, and the Compagnia di San Paolo. **PN**

"Variations in Dysbindin-1 Are Associated With Cognitive Response to Antipsychotic Drug Treatment" is posted at https://www.nature.com/articles/s41467-018-04711-w.

Health Plans

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12 months at a time, up from three months, with extensions possible for up to three years. Under prior rules, such policies were not renewable.

These low-cost plans may attract young and healthy working people who do not qualify for government subsidies under the Affordable Care Act (ACA). But health advocacy organizations are concerned the plans' sparse coverage and lack of required transparency about coverage gaps may result in financial ruin for some consumers when care is needed.

The short-term plans will "expose those younger, healthier individuals to the significant risk that their health plan will fail to cover critically necessary care if they fall ill," according to a joint statement by some 25 health care advocates representing 100 million consumers with health conditions, including the National Alliance on Mental Illness.

Mental Health, Substance Use Benefits Not Required

Rates vary widely, but monthly premiums for healthy people buying short-term health insurance can be less than one-fifth of a comprehensive plan, according to a Kaiser Family Foundation review of two large online private insurance marketplaces. However, these plans are not subject to ACA requirements; they are not required to cover its "essential health benefits" such as mental health and substance use disorder services, prescription drugs, hospitalization, or emergency services.

Of the 24 short-term plans listed in two online marketplaces examined by Kaiser, none provided maternity care, 38 percent covered treatment for substance abuse, and 57 percent covered mental health services.

In June, the Trump administration issued another final rule making it easier to sell association health plans to small businesses and allowing them to be sold for the first time to people who are self-employed. Like the short-term plans, they are not required to cover essential health benefits.

In addition to the lack of ACA essentials, short-term plans are exempt from other important market rules governing individual plans. Some examples: plans are free to deny coverage or charge higher premiums for older or less healthy applicants, retroactively cancel a consumer's coverage, deny renewals for enrollees who become ill, and subject enrollees to cost sharing in excess of $20,000 per person, per policy period, the Kaiser report noted.

Frederick Isasi, executive director of Families USA, a health care consumer advocate, called the short-term plans "junk plans." And "sadly, many people who buy a short-term plan will have the rug pulled out from under them when they need coverage the most: when they have a medical issue and learn they've been tricked," he said.

HHS: Plans Provide 'More Affordable Option' for Some

"These plans aren't for everyone, but they can provide a much more affordable option for millions of the forgotten men and women left out of the current system," said Health and Human Services (HHS) Secretary Alex Azar.

Comprehensive plans can range from about $300 to $500 per month for the lowest cost, least coverage ("Bronze" category) plans, according to the Kaiser Family Foundation.

While enrollment has been stable in the subsidized exchanges created under the ACA, the administration said enrollment has dropped 20 percent in the non-subsidized market in 2017, while premiums rose 21 percent, according to HHS.

There will no longer be a tax penalty for uninsured individuals—or for individuals who purchase skimpy plans—starting January 1, 2019, due to changes enacted in the Republican tax bill. About 3 million are expected to drop coverage as a result, and the number of uninsured people under age 65 is expected to rise to 32 million next year, according to Congressional Budget Office and Joint Committee on Taxation estimates.

Health care organizations are concerned encouraging short-term plans will cause higher price spikes for those who buy comprehensive coverage. "This rule will siphon younger and healthier individuals out of the individual market risk pool, forcing patients with preexisting health conditions to pay far higher costs for the comprehensive coverage they obtain through the insurance marketplaces." **PN**

The final rule on short-term plans is posted at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16568.pdf. The report by the Kaiser Family Foundation, titled "Understanding Short-Term Limited Health Insurance," is posted at https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

APAPAC

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support candidates, but that is gradually changing as APA members recognize its importance," said APAPAC Director Ashley Mild. "We are gaining strength. With nearly $485,000 raised from members so far through August 1, we're on track to exceed our 2016 election cycle fundraising numbers."

With the midterm elections just around the corner, the future of mental health policy may hang in the balance. APAPAC has contributed to 111 congressional races so far in the 2017-2018 election cycle.

Mental health issues are bipartisan, so APAPAC supports legislators on both sides of the aisle. "We may not agree with the legislators' opinions on every single topic, but when we advocate through the PAC, our focus is on mental health, and on those issues, we align," Koss explained.

Helping to overcome the stigma against psychiatry and mental illness is another role of APAPAC. "People have the idea that treatment doesn't work. They see homeless people on the street or read a headline about a tragic shooting," said APAPAC Chair R. Scott Benson, M.D., a child and adolescent psychiatrist in Pensacola, Fla. Benson noted that many patients he sees respond to treatment and go on to live healthy lives.

APAPAC aims to educate lawmakers on the realities of mental illness and the importance of providing resources to care. The group also works with legislators to block legislation that would be detrimental for psychiatrists and their patients, Benson said. For instance, whenever a mass shooting happens, a lawmaker floats the idea of creating a mass database of every psychiatric patient—to track them or make sure they don't own guns. "That would be an invasion of privacy," he said. "The people making these decisions are not necessarily psychiatrists, so we need that voice in the legislative process."

Koss, who has spent more than a decade working in political advocacy for mental health, explained what keeps her involved: "I realized it's a way to have a direct impact on legislation that affects our patients and affects our profession. There are many special interest groups out there meeting with legislators, trying to sway their thinking on issues. That's why it's imperative that we as psychiatrists remain committed to the process of advocacy and on building relationships with our lawmakers. At the same time, it's important that we contribute to the APAPAC."

Benson echoed that sentiment. "We as citizens and psychiatrists have to recognize that much as we dislike it, elections run on money." **PN**

"Members can make contributions to the APAPAC at https://www.psychiatry.org/psychiatrists/advocacy/apapac.

Study Explores Effects of Hypnotics on Suicidal Ideation

The findings suggest that adults thinking of suicide can participate safely in randomized clinical trials. **BY LYNNE LAMBERG**

Suicidal, depressed adults with insomnia who took fluoxetine alone or in combination with either blinded zolpidem or placebo in a randomized, controlled clinical trial slept better and experienced less depression and hopelessness, fewer nightmares, and better quality of life at the end of the eight-week study than at the outset.

Investigators reported results from their multisite study, Reducing Suicidal Ideation Through Insomnia Treatment (REST-IT), at the annual meeting of the American Academy of Sleep Medicine and the Sleep Research Society in Baltimore earlier this summer.

REST-IT, funded by the National Institute of Mental Health, is the first study to explore whether treating patients with depression, insomnia, and suicidal ideation with both an antidepressant and a hypnotic medication decreases intensity of suicidal ideation.

Two prior pilot studies found that treating patients with depression and insomnia with both fluoxetine and a hypnotic led to a higher rate of resolution of depression than fluoxetine alone. Suicidal patients were excluded from those studies.

While REST-IT study findings provided only a weak signal that zolpidem controlled release (CR) reduced suicidal ideation more than an SSRI alone, "I wouldn't call it a negative study," said W. Vaughn McCall, M.D., REST-IT's principal investigator. McCall is the chair of the Department of Psychiatry and Health Behavior and executive vice dean at the Medical College of Georgia at Augusta University.

All patients had active suicidal ideation at baseline with no statistically significant differences between groups. Based upon preliminary analyses, McCall said, the zolpidem CR group had a marginally significant advantage during treatment on the Columbia Suicide Severity Rating Scale (C-SSRS) at p=0.057.

Among patients using zolpidem CR, sleep improved, and depression did not worsen. A different hypnotic, one with a longer half-life, may have shown greater benefit, McCall posited. The investigators originally had planned to use eszopiclone as the hypnotic. Because it was available as brand-name only at the time, McCall said, the NIMH asked the investigators to substitute a similar medication. They chose zolpidem CR.

More than 60 epidemiologic studies suggest insomnia predicts suicidal ideation and suicide death, McCall noted. The REST-IT study's findings, he said, show it's possible to conduct a double-blind, randomized, controlled trial of insomnia therapies and possibly other treatments in actively suicidal patients.

"While safety concerns usually prompt exclusion of people with suicidal ideation from randomized clinical trials, psychiatrists have an obligation to conduct such research," McCall told *Psychiatric News*. "We need generalizable results for this population," he said.

Researchers sought to include patients who had clinically relevant suicidal ideation (had thought of suicide but had no specific intent or plan to end their lives) and were not so ill they needed hospitalization, said REST-IT co-investigator Andrew Krystal, M.D., a professor of psychiatry and behavioral science at the University of California San Francisco School of Medicine.

The study's safety features, Krystal said, follow the 2001 National Institutes of Health guidelines for intervention research with people at high risk of suicide.

Patients had to forgo psychotropic medications for seven days before baseline evaluations. Researchers assessed patients at baseline and over the study with self-report and clinician-rating tools, including the C-SSRS and Beck Scale for Suicide Ideation. Researchers encouraged patients to bring significant others to the first visit and to involve them in the study, Krystal said.

Courtesy of W. Vaughn McCall, M.D.

Researchers interviewed 1,348 potential participants to find the 103 adults enrolled in the REST-IT study, W. Vaughn McCall, M.D., the study's principal investigator, reports.

The study enrolled 103 adult outpatients (64 women, 39 men) aged 18 to 65 years who met criteria for major depressive disorder complicated by insomnia and suicidal ideation. All patients received open-label fluoxetine, 20 mg/day. This dose could be increased to 40 mg/day at the end of four weeks if the patient's score on the Hamilton Rating Scale for Depression-24 was 15 or higher. The 5 percent of patients who could not take fluoxetine received a different SSRI (sertraline, 50 mg/day; paroxetine, 20 mg/day; or citalopram, 20 mg/day).

In addition to taking the SSRI, all patients were randomized to receive either blinded zolpidem CR, 6.25 mg/day, or blinded placebo for eight weeks. The dose could be increased to 12.5 mg/day at the end of week 1 if a patient had experienced little or no improvement in insomnia symptoms and had no side effects.

Participants were asked to wear wrist activity monitors, or actigraphs, throughout the eight-week treatment to record their sleep/wake patterns. They were seen in clinic visits at 1, 2, 4, 6, and 8 weeks post-randomization. To minimize overdose risk, researchers provided only enough of the study drugs at each visit to last until the next scheduled visit, plus an extra three days' dose.

The researchers routinely called the participants midway between scheduled visits. "The calls might be seen as potentially having a placebo effect," Krystal said, "but these were sick people."

As soon as patients entered the study, investigators talked with them about plans for care after the study's end. At that point, they gave patients enough SSRI medication to last until their first follow-up visit and checked in weekly by phone for two weeks to confirm patients were in treatment.

Of the 103 enrollees, 82 completed the study, McCall reported. None of the participants made suicide attempts or needed hospitalization.

REST-IT study findings still are being analyzed, McCall said. Further research is needed, he said, to clarify the relationship between insomnia and suicidal risk and to determine whether other treatments for insomnia, or for factors that may contribute to insomnia such as hyperarousal, can reduce that risk.

The study was conducted at the Medical College of Georgia at Augusta University and medical schools of Duke University, Wake Forest University, and the University of Wisconsin-Madison. **PN**

More information on the trial is posted at https://clinicaltrials.gov/ct2/show/NCT01689909.

Climate Change

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Why not promote industries like bike manufacturing in our health care expenditure, instead of drugs for obesity?"

Haase said APA needs to provide leadership on how to lower the carbon footprint of the profession without compromising care. "Altha Stewart in her editorial and others highlight that telepsychiatry and decreasing the number of professional conferences are ways to lower fossil fuel use," Haase said. "How should clinicians balance the sustainability costs of maintaining a heated staffed facility against the possibility of suicide for an acute patient? Will an online consultant, an app, or some other means of contact do just as well?"

Medical consensus around the critical nature of climate change appears to be growing. How would Coverdale respond to those who insist that climate is outside the purview of psychiatrists and psychiatry?

"The medical and mental health effects associated with climate change are serious and potentially catastrophic," he said. "Especially vulnerable populations include the homeless, the poor, the mentally ill, children, and the elderly. Climate change should therefore be very high on the agenda of our academic missions."

He added, "We need to be developing the policies of our professional societies and academic departments to support initiatives that counter climate change. We all should think about how we can lower our own carbon footprints and recognize that as role models we have an opportunity to influence others' behaviors. Moreover, we should learn how to effectively communicate the key issues at stake to members of the public including politicians and patients." **PN**

"Climate Change: A Call to Action for the Psychiatric Profession" is posted at https://link.springer.com/article/10.1007/s40596-018-0885-7. "Psychiatry's Role in Responding to Climate Change" is posted at https://link.springer.com/article/10.1007/s40596-018-0909-3.

Flat Rate

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complexity (2 through 5) currently reportable by clinicians. That means physicians would be paid the same rate in the outpatient setting for E/M services regardless of the complexity of the work a patient requires.

The effect of this single flat rate for E/M services will be highly variable, depending on the mix and complexity of patients seen in a physician's practice.

"The administration has proposed significant changes to how E/M services are to be documented and paid," Musher said. "Some of the proposed changes will be seen as welcome relief from onerous documentation burdens, but the associated flattening of the payment would adversely affect physicians who work with more complex patients and bill more of the high-level codes. APA is working collaboratively with other physician organizations and coalitions, including the American Medical Association, to understand the impact of what has been proposed and provide thoughtful recommendations to the administration. The common, consistent theme among the physician organizations has been to ensure that all patients have access to appropriate care and that physicians are paid appropriately for their work."

According to an initial estimate by AMA, psychiatry would see a small increase in payment for E/M services if the proposed flat rate is made final. But certain subspecialists and physicians who treat more complex patients would likely see a decrease in overall payment. For example, payments to addiction medicine physicians and geriatric psychiatrists for E/M services are estimated to drop by 2 percent and 3 percent, respectively. Rates may or may not be offset by payments for other billed services or by the anticipated time savings associated with reduced documentation requirements, Musher said.

Some early responses to the proposed rule by APA members have emphasized the possible effect on access to care for the most seriously mentally ill. One member wrote in an email to APA staff, "It seems that the E/M service collapse will result in a financial incentive for psychiatrists to not see the more complicated patients. And despite very conscientious psychiatrists out there, this will be the result. I believe this is a disaster in the making, as it will likely result in more patients becoming destabilized and resulting in more psychiatric hospitalization, driving up costs."

Additionally, CMS is proposing a number of new CPT codes, including a "shorter" prolonged service code that captures additional work beyond the typical E/M visit and a code that describes the technology-based, or "virtual" check-in for E/M services. The administration is also soliciting comments on whether and/or how to create an episode-based, bundled medication-assisted treatment (MAT) service. Creating such a bundle would "provide opportunities to better leverage services furnished with communication technology while expanding access to treatment for SUDs [substance use disorders]," according to CMS. **PN**

The proposed rule for the 2019 Medicare Fee Schedule is osted at https://www.regulations.gov/document?D=CMS-2018-0076-0621. APA members who need assistance with practice management issues may contact APA's Helpline at practicemanagement@psych.org or (800) 343-4671.

Fee Schedule Proposes Changes to Quality Reporting, EHR Requirements

The annual Medicare fee schedule now also includes numerous proposals affecting various aspects of the Quality Payment Program (QPP). The QPP is the "value-based" payment system designed to reimburse physicians on the quality and value—as opposed to volume—of services they provide.

These include proposals affecting the quality measures physicians are required to report as part of the Merit-Based Incentive Payment System (MIPS), as well as requirements around electronic health records (EHRs).

The following are some proposed changes around quality reporting that may affect psychiatrists:

- **CMS is proposing that all MIPS participating clinicians submit quality data on six measures from medical specialty–specific quality measure sets.** If finalized, this proposed change would mean that physicians cannot select measures from different specialty sets. However, psychiatrists do not have to select from the proposed Mental/Behavioral Health Specialty Measure Set if there is another set that better meets their patients' needs. Once a psychiatrist selects a particular measure set, he or she must use that set for the remainder of the MIPS performance year.
- **CMS is proposing to incrementally remove process measures that they determine are "low value" from the quality performance category.** This is intended to allow room for quality measures that provide greater meaning to patients and their providers. However, it could be problematic for psychiatrists if a number of measures deemed to be low value are ones that psychiatrists commonly use. Included among those proposed for removal is one that measures the percentage of patients with depression or bipolar disorder assessed for substance use disorder. Should this measure be removed from the Mental/Behavioral Health Specialty Measure Set, the set will not include any measures that address substance use other than alcohol and opioids.

The following are some proposals affecting use of health IT in the Quality Payment Program:

- **All eligible professionals (EPs) must now use 2015 Edition Certified Electronic Health Record Technology (CEHRT).** This is a change from the first two years of the program that allowed eligible providers to use 2014 CEHRT or a combination of 2014 and 2015 CEHRT. Psychiatrists should check with their EHR vendor to ensure that they meet the 2015 standard. There are already a limited number of psychiatry-specific, certified EHRs available (for a complete list, visit the ONC's Certified Health IT Product List https://chpl.healthit.gov/#/search), so limiting participants in MIPS to 2015 products may reduce reporting options for reporting year 2019.
- **The "Advancing Care Information" category of MIPS (formerly known as the "Meaningful Use" program) has been renamed "Promoting Interoperability."** For reporting year 2019, CMS proposes requiring fewer measures under this category. Also, the scoring methodology has been changed to eliminate reporting thresholds and, instead, uses one that is performance based. This will give psychiatrists participating in MIPS greater flexibility in reporting under this category and will help to avoid a downward payment adjustment in 2021.
- **CMS proposes two new measures for the Promoting Interoperability: Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement.** If included in the 2019 MIPS Final Rule, these measures would be optional under the e-prescribing measure, and reporting on them would earn MIPS participants up to 5 bonus points for each measure.

Data Mining

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that the predictive value of these algorithms is on par with other established risk calculators, including the Framingham Risk Score, which predicts people at high risk of a heart attack.

More importantly, Kessler noted that his research shows that patients at high risk of suicide tend to be at a greater risk of other associated health problems than those at a lower risk of suicide. "About 1 in 3 high-risk patients will experience an outcome like an accidental death, nonfatal but serious self-harm, or severe depressive disorder," he said. "Our interventions for suicide also treat all these other possibilities."

There are still other roadblocks before these suicide risk programs can be routinely used in practice. First, the nature of these "big data" tools means they would be limited to places that have a large clinical database, such as Kaiser Permanente or the Veterans Administration. Even in these health systems, it's not yet known whether these risk programs are cost-effective.

Then there's an important consideration at the level of the individual, Kessler said. Since these suicide screening algorithms piece together so much nuanced information, the patients themselves may not be fully aware of their suicidal ideations. "How do you elicit suicidality from those who don't want to admit it?" Kessler asked. "Is it even the job of the health care system to make someone admit they have a problem, or is that asking too much?"

Walsh agrees that turning research into practice will be challenging, "but this is where pragmatics and partnerships come into play." He told *Psychiatric News* that such risk-screening tools could be valuable if selectively implemented in emergency departments (EDs), where many suicidal patients find themselves in the weeks and months before a suicide attempt. EDs, especially ones affiliated with academic centers, have the robust records to enable these screening algorithms to work, as well as the needed staff to administer questionnaires such as the PHQ-9 before discharge.

As for patient discussions, he thinks these algorithms can be valuable if seen as conversation starters rather than a lab result. "When you see a person's score, and the main items that contribute to that score, it may help guide your discussion," he said. "I think we still have to be direct with patients about what the risk programs reveal, but we can be respectful and compassionate as well." **PN**

"Predicting Suicide Attempts and Suicide Deaths Following Outpatient Visits Using Electronic Health Records" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.17101167.

MED CHECK

BY NICK ZAGORSKI

FDA Releases Guidance On OUD Medications

The FDA in August issued new recommendations aimed at encouraging more robust development of novel medications to assist in the treatment of opioid use disorder (OUD).

Clinical trials evaluating the effectiveness of medication-assisted treatment for the purposes of FDA approval have to date generally used reduction in drug use as an endpoint. The new draft guidance outlines additional ways for drug developers to measure clinical outcomes demonstrating a drug's effectiveness; these include endpoints centered around adverse outcomes including overdose mortality/overall mortality, the frequency of emergency medical interventions, or acquisition of injection-related infections. Other potential outcomes include real-world improvements such as the ability to resume work or school.

"[T]he agency recognizes that evaluating [these outcomes] could require larger trials than those usually conducted for marketing approval. To that end, the FDA is encouraging sponsors to discuss their plans with the agency early in the drug development process," the agency said in a statement. "The agency is also committed to providing assistance to sponsors interested in developing a validated measurement of patient-reported experiences, such as 'craving' or 'urge to use' opioids, which make it difficult for patients with OUD to sustain recovery."

Risperidone LAI Receives FDA Approval

Perseris, a once-monthly form of ***risperidone***, has been approved by the FDA for the treatment of schizophrenia in adults. Perseris uses an extended-release delivery system that allows patients to achieve clinically relevant levels of the drug after the first injection without the need for a loading dose or supplemental oral risperidone.

According to Indivior, the manufacturer of Perseris, the efficacy of this long-acting injectable was demonstrated in a phase 3 randomized, double-blind, placebo-controlled, eight-week study of 354 patients with schizophrenia. The study found a statistically significant improvement in the primary clinical endpoint (Positive and Negative Syndrome Scale total score) at the end of the trial. The improvement in Clinical Global Impression Severity of Illness (CGI-S) was also statistically significant at the end of the trial.

The safety profile of Perseris was consistent with that of oral risperidone. The most common systemic adverse reactions in the phase 3 trial were increased weight, sedation/somnolence, and musculoskeletal pain. Prescribing information including a boxed warning is online at http://www.indivior.com/wp-content/uploads/2018/07/FDA-Label-revised.pdf.

Sandoz Issues Recall Of 470K Blister Packs

In July, Sandoz, a division of Novartis Pharmaceuticals, implemented a voluntary recall of over 470,000 blister packages of medications after discovering that some blister packs did not meet U.S. child-resistant packaging requirements.

Twelve medications were affected by the defective packages, including the psychiatric medications ***donepezil***, ***haloperidol***, ***imipramine***, ***perphenazine***, and ***risperidone***. Consumers should immediately secure their blister packs out of the sight and reach of children, and contact Sandoz to request a resealable, child-resistant pouch.

The company said that there are no safety or quality issues with the medications themselves, and any tablets of these medications provided in bottles are not affected by the recall. A full list of affected packages including lot numbers is available at https://www.us.sandoz.com/patients-customers/product-safety-notices.

Phase 3 Trial Of Cyclobenzaprine For PTSD Halted

Tonix Pharmaceuticals announced in late July that it is halting its phase 3 study of ***Tonmya (cyclobenzaprine HCl sublingual tablets)*** as a treatment for military-related posttraumatic stress disorder (PTSD). After 12 weeks, participants taking Tonmya (5.6 mg at nighttime) did not show any statistical improvements in their PTSD symptoms compared with people taking placebo. PTSD symptoms were measured by the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5).

While Tonmya did not achieve its primary endpoint, the company noted that the people taking Tonmya did show significant improvements over placebo in both CAPS-5 and Clinical Global Impression–Improvement scores after four weeks. **PN**

Fom the President

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(2) the Board approved an amendment to APA's Operations Manual that prohibits members from serving on APA components while a member of the Board of Trustees (except appointments to those components that are specifically required to include members of the Board of Trustees).

I can't take credit for either of these actions: they were already in motion when I became president. But I am proud that in my first 100 days as president, actions occurred that address issues I consider extremely important to securing a strong future for our profession—assisting early career psychiatrists with their significant debt load and assuring there is a place at the organizational table for them to share their interests, energy, and innovative ideas while some of those more seasoned members are available to mentor them.

Finally, in July we achieved the highest fundraising total ever in support of our APA Foundation at an APA Board of Trustees meeting—$6,000! To be able to say that APA's top leadership has invested in the Foundation is important as its staff reaches out to organizations and individuals to seek support for our work to create a mentally healthy nation and share the success stories from our many signature programs. By the way, I hope you will all consider making an annual contribution so that we can continue APA's excellent work to educate, inform, and empower the public and the profession and overcome the stigma, bias, and lack of accessible information associated with mental health issues. (Please visit https://apafdn.org/support for more information.)

As I recalled the above activities, I was reminded of a former president who said her term as president was like "drinking from a firehose." I can honestly say I now know what she meant, and the solution seems to be to stay focused on the mission and make sure every action relates to that. And as always, I encourage you to send your suggestions on how we can continue to support increased involvement of members in the important work of our Association. **PN**

LETTERS TO THE EDITOR

Changes Recommended to Better Support Veterans With PTSD Symptoms

Forty-five years ago, I began my career as a psychiatrist for the Veterans Administration (VA). Now at the end of my career, I am again working for the VA. I am treating a lot of veterans for posttraumatic stress disorder (PTSD). Some of these veterans have service-connected PTSD and some do not. Those who are not fall into one of three categories: (1) they have not applied for treatment of a service-connected disability because they did not know how to apply or did not have someone to guide them through the process; (2) even though they had symptoms of PTSD, the evaluator did not think that they had enough symptoms to qualify; or (3) they are like the case I saw this morning in which the evaluator documented that the veteran met all of the criteria for PTSD but diagnosed him as having something else because the evaluator didn't think that the patient had enough "clinically significant distress or impairment in social, occupational, or other important areas of functioning" to qualify despite his traumatic nightmares and thrashing around in his bed at night.

We do not have this limiting criterion in many other areas of psychiatric diagnosing. In major depression we recognize mild, moderate, and severe levels, and if patients with mild or moderate depression still work out of personal fortitude or economic necessity, we do not say that they are not depressed. Similarly, in other areas of medicine we do not say that patients do not have cancer because they are not bedridden yet. I believe that psychiatry needs to correct this diagnostic limitation for the sake of our veterans and our patients in general.

K-LYNN PAUL, M.D.
Fort Meade, S.D.

Melding Psychotherapy Approaches

This letter is in response to the article in the July 6 issue by Dr. Frederic Busch titled "Psychodynamic Approaches to Behavioral Change."

Dr. Busch's article is very relevant and timely. While various psychotherapy modalities have been developed over the past few decades, one point that we need to keep in mind is that each modality has something to gain from the other.

Sadly, psychotherapists tend to restrict themselves to a certain approach, at times to the point of dismissing the value of a psychotherapy modality that is different from what they believe in or have been trained in. This can be detrimental to patient care as well as to the future generations of psychotherapy practitioners. Dr. Busch's article beautifully delineates examples of how psychodynamic therapy may benefit from behavioral approaches and vice versa.

Due partly to more research supporting behavioral approaches, psychodynamic psychotherapy has been relegated somewhat to the background in recent years, such that many newer psychiatrists and psychologists are not fully aware of what psychodynamic psychotherapy has to offer. Certain factors may be contributing to this situation, but Dr. Busch aptly suggests that the psychodynamic approach may also benefit from incorporating elements from the behavioral one. I've even encountered many therapists holding a negative bias toward certain major forms of psychotherapy.

The same way in which just a biological approach or a purely psychological approach would not provide a patient with the most optimal or comprehensive treatment, a psychotherapy approach that is purely of one type runs the risk of missing important elements of treatment, treatment resistance, and, eventually, understanding the patient as a whole.

RICHA BHATIA, M.D.
San Mateo, Calif.