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AMERICAN PSYCHIATRIC ASSOCIATION

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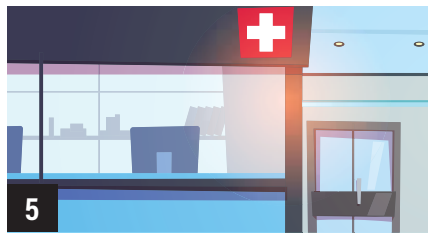
APA's 2018 IPS: The Mental Health Services Institute got under way just as this issue was going to press; coverage will begin in the next issue. Gathering for a photo after the Opening Session with APA President Altha Stewart, M.D. (third from right), were (from left) Meryl Camin Sosa, executive director of the Illinois Psychiatric Society; Glenda Wrenn, M.D., chair of the IPS Scientific Program Committee; Saul Levin, M.D., M.P.A., APA CEO and medical director; Camara Phyllis Jones, M.D., Opening Session speaker; and Bruce Schwartz, M.D., APA president-elect.



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Cannabidiol may normalize brains of people at risk of psychosis.

APA Joins Lawsuit Against Trump's 'Skimpy' Plan Rule

APA joins a coalition to file suit against the administration's new rule that expands short-term, limited duration health plans. ***BY LINDA M. RICHMOND***

APA joined a coalition of mental health and health advocacy groups last month to file a federal lawsuit to invalidate a new Trump administration rule that expands short-term, limited-duration health plans, dubbed "skimpy" plans for the sparse coverage they provide.

The coalition argued in its complaint that the final rule, which took effect October 2, violates the plain-English meaning of "short term" by allowing the sale of plans providing up to one year of coverage instead of the current three months and "limited duration" by allowing renewals for up to three years instead of one. The plans were originally intended to fill short-term gaps in coverage, such as when individuals are between jobs, and were permitted for sale for up to only three months at a time, with renewals of up to one year.

The coalition also argued that the rule creates an unauthorized alternative to plans that comply with the Affordable Care Act (ACA) and undercuts such plans, making them increasingly unaffordable. APA was joined in the lawsuit by the National Alliance on Mental Illness, Mental Health America, National Partnership for Women & Families, Association for Community Affiliated Plans, AIDS United, and Little Lobbyists.

"This rule jeopardizes the insurance coverage of many Americans with complex medical needs that require strong, predictable insurance protection and care," said APA President Altha Stewart, M.D. "Without this coverage, patients with complex medical needs will suffer and often end up in emergency rooms, raising health care costs. We call upon the administration to drop this rule

see **Lawsuit** *on page 13*

PERIODICALS: TIME SENSITIVE MATERIALS

N.C. Medicaid Begins Using Collaborative Care Codes

APA's website offers guidance on how to advocate for Medicaid reimbursement of the collaborative care model.
BY MARK MORAN

State Medicaid programs are beginning to adopt reimbursement codes for collaborative care, including payment for psychiatrists who contract with primary care centers as consultants.

This month the state of North Carolina joined Washington State in allowing primary care practices to submit reimbursement codes to treat Medicaid patients using the collaborative care model (CoCM). The collaborative care codes were first developed by the Cen-

see **N.C.** *on page 22*

PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Diversity and Inclusion Matter In Continuing Education Efforts

BY ALTHA STEWART, M.D.

As part of my overall commitment to creating an environment of diversity and inclusion in APA and the profession of psychiatry, this column is devoted to providing an update on the work of one member and two APA components regarding the education and training of future psychiatrists, our members, and the patients we serve.

In the fall of 2017, Francis Lu, M.D., initiated an action item advocating for a diversity/inclusion accreditation standard in graduate medical education. This action item addressed the Accreditation Council of Graduate Medical Education (ACGME) revised Common Program Requirements (CPR) for both residency and fellowship that were released June 29 and will go into effect on July 1, 2019 (https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements). Supported by both the Council on Minority Mental Health and Health Disparities and the Council on Medical Education and Lifelong Learning, the APA Board voted to lead this effort, joining other organizations including the Association of American Medical Colleges (AAMC) and the American Association of Directors of Psychiatric Residency Training (AADPRT), in advocating for this new accreditation standard. Until now, ACGME has had no diversity/inclusion accreditation standard. This action closes the gap between the 2009 LCME accreditation standard on diversity/inclusion for U.S. and Canadian medical schools and the ACGME accreditation standards for all residencies and subspecialty fellowships in the United States.

The specific diversity/inclusion requirement is included under "Oversight" and appears on page 5 of both the residency and fellowship CPR documents, as follows:

"I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community.

Background and Intent: It is expected that the Sponsoring Institution has, and that programs will implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c)."

I encourage leaders in psychiatry's residency and fellowship programs to prepare by partnering and aligning with their sponsoring institution's relevant policies and procedures and, when institutional improvement is needed, contributing their expertise. Training programs should also consider working with the designated institutional officer (DIO), associate or assistant deans of diversity and inclusion, the chief diversity officer, and designated institutional officers of

see **From the President** *on page 23*

IN THIS ISSUE

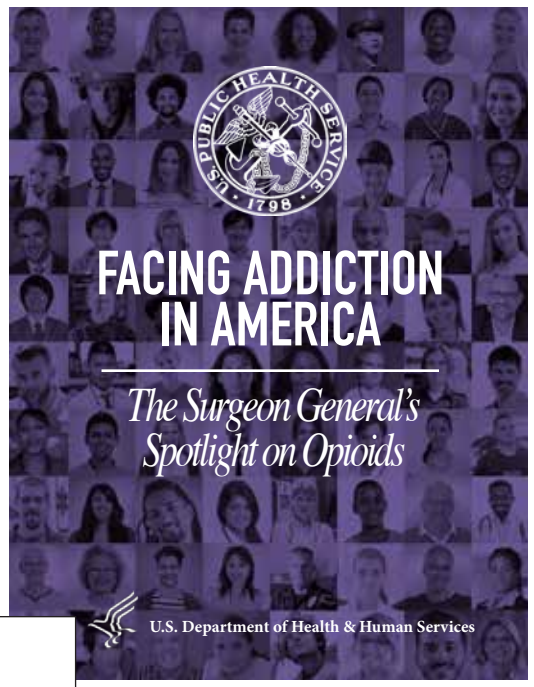
DEPARTMENTS

Get Ready for San Francisco!

APA's 2019 Annual Meeting combines a fabulous location with the celebration of a major APA milestone: its 175th anniversary. Attendance is expected to break records, so make your hotel reservations now at psychiatry.org/annualmeeting. The meeting will be held from **May 18** to **22.**

Surgeon General's Report on Opioids Emphasizes 'Gold Standard' Treatment

While the surgeon general's report notes that effective treatment exists for opioid use, one psychiatrist points out that more funding is needed to make treatment more available. **BY LINDA M. RICHMOND**



The U.S. surgeon general issued a report last month calling for a "cultural shift in the way Americans talk about the opioid crisis." He also called for health care professionals to become qualified to prescribe buprenorphine, follow "the gold standard" for treatment, and address substance use with the same sensitivity as other chronic health conditions.

"Addiction is a brain disease that touches families across America, including my own. We need to work together to put an end to stigma," wrote U.S. Surgeon General Jerome M. Adams, M.D., M.P.H., in the report's preface.

His family experience with addiction involved his brother. His brother's illness started with untreated depression, which led to opioid misuse. Like many individuals with co-occurring substance use and mental illness, his brother cycled in and out of correctional institutions.

The report, titled "Facing Addiction in America: The Surgeon General's Spotlight on Opioids," was prepared by the surgeon general's office in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA). The intent behind the report is to allow people from a broad range of backgrounds to obtain opioid-related information cited in the surgeon general's previous report on addiction, "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health," in one document.

In 2017, overdose deaths climbed to more than 72,000, a nearly 10 percent rise from the previous year, according to provisional government estimates issued in August. More than two-thirds of those deaths involved opioids. The surgeon general's report attributed the rise to three trends: an uptick in prescription opioid overdose deaths, a fourfold increase in heroin overdoses since 2010, and a tripling of the death rate from synthetic opioids such as fentanyl since 2013.

Despite the existence of effective treatments and the promise of integrated care to reach more individuals, only 1 in 4 people receives treatment for opioid use disorder (OUD). The report pointed out why that's the case: "The substance use disorder treatment system is underprepared to support care coordination; the primary care system has been slow to implement medication-assisted treatment (MAT) a as well as prevention, early identification, and other evidence-based recommendations; the existing health care workforce is already understaffed and often lacks the necessary training and education to address substance use disorders; and the need to protect patient confidentiality creates hurdles for sharing of information."

"Now is the time to work together and apply what we know to end this epidemic once and for all," wrote Elinore McCance-Katz, M.D., Ph.D., assistant secretary for mental health and substance use in the Department of Health and Human Services, in the report's foreword. "Medication-assisted treatment, combined with psychosocial therapies and community-based recovery supports, is the gold standard for treating opioid addiction."

In a section on treatment and management of opioid use disorders, the report noted that treatment is effective and improves an individual's productivity, health, and overall quality of life. "Incorporating treatment for multiple substance use disorders could also be beneficial." For example, integrating tobacco-cessation programs into substance use disorder (SUD) treatment is associated with a 25 percent increase in the likelihood of maintaining long-term substance abstinence, the report explained.

The report listed the "components of care" as follows: personalized diagnosis, assessment, and treatment planning; long-term disease management; administration of FDA-approved medications; behavioral interventions delivered by trained professionals; coordinated care for co-occurring disorders; and recovery support services.

Andrew J. Saxon, M.D., chair of APA's Council on Addiction Psychiatry, praised the report overall, calling it a "positive, strong, and important report that codifies some of the most important aspects of opioid use disorder treatment." However, he said, while the report enumerates the gold standard "components of care," it falls short of explaining how patients can access this type of comprehensive treatment, which would cost at minimum $10,000 to $15,000 per patient per year.

"I wish every patient, every person in the country with OUD could get this kind of health care. But how is this all going to be paid for?" Saxon asked. "I worry that the way this is pitched in the report, primary care physicians may say, 'My practice can't

continued on next page

Components of Care for Opioid Use Disorder Treatment

Personalized diagnosis, assessment, and treatment planning; one size does not fit all.
Long-term disease management/outpatient care.
Access to FDA-approved medications.
Effective behavioral interventions delivered by trained professionals.
Coordinated care for co-occurring diseases and disorders.
Recovery support services—such as peer support and ongoing community programs.

Source: Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016

continued from previous page

provide all that, so I'm not going to do it at all.' "

Saxon advises physicians who cannot provide all the elements to at least offer MAT and meet with patients regularly, citing several recent studies showing that buprenorphine treatment alone provided in a primary care setting can be just as effective for many patients, even without additional counseling and services.

Substance users face many barriers to care, including a shortage of treatment providers and the reimbursement policies of many state Medicaid plans; most do not cover all of the FDA-approved medications for treating OUD. Saxon called on the federal government to begin providing physicians incentives to take on the complicated work of providing MAT by offering higher compensation and by taking action to eliminate the myriad prior authorizations that prescribers must fight through to get patients the medication they need.

"Ultimately, the federal government should call on private insurers to step up to this crisis and cover MAT and reimburse providers who use these medications at a higher rate," he said.

Saxon said he is also concerned that the federal mental health parity law—on the books now for 10 years—is still not being well enforced. "We need government support and intervention to reduce the stigma surrounding substance use disorder in practical ways. One way to do that is to enforce parity laws," he said. The administration's expansion of "skimpy," short-term, limited duration health plans that took effect October 1—a move the APA is fighting in federal court—is an affront to that, he said, and will most likely strand more individuals with no coverage for OUD treatment (see story on page 1).

The report also highlighted the proven benefits of "harm reduction strategies," such as outreach and education programs, needle/syringe exchanges, overdose prevention education, and access to naloxone to reverse potentially lethal opioid overdoses. But Saxon pointed out that needle exchange programs are not supported by the federal government. In addition, the Justice Department has threatened to prosecute the state or city officials who open "safe injection sites," a harm reduction strategy now being contemplated across the country to prevent overdose deaths and disease transmission. **PN**

"Facing Addiction in America: The Surgeon General's Spotlight on Opioids" is posted at https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf.

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Report Shows Number of Hospital Suicides Lower Than Estimated

The Joint Commission's new, much lower estimate of annual inpatient suicides should have important implications for how resources are allocated to prevent suicide. **BY MARK MORAN**

Between 48.5 and 64.9 hospital inpatient suicides occur each year in the United States, according to a report in the September *Joint Commission Journal on Quality and Patient Safety.*

That's "far below the widely cited figure of 1,500 per year," wrote lead author Scott Williams, Psy.D., director of the Department of Research at The Joint Commission, and colleagues.

"The results from this study provide a more reliable benchmark of the national inpatient suicide rate for policymakers, regulators, accrediting organizations, health care providers, and researchers to use when making decisions regarding allocation of resources and implementation of specific requirements to prevent inpatient suicides," they wrote.

The authors analyzed data from 27 states reporting to the National Violent Death Reporting System (NVDRS) for 2014 to 2015 and from hospitals reporting to The Joint Commission's Sentinel Event (SE) Database from 2010 to 2017. The Centers for Disease Control and Prevention established the NVDRS in 2002 as a population-based surveillance system to quantify deaths by violence and categorize them by cause.

Deaths due to violence are defined by the World Health Organization as "the intentional use of physical force or power against oneself, another person, or against a group or community."

The sentinel event (SE) database includes data on the suicide of patients who received care in a setting that is staffed around the clock or who died by suicide within 72 hours of discharge, including from the hospital's emergency department (ED).

Reports to the SE database include coded information about the method of suicide (asphyxiation, hanging, gunshot, drug overdose, jumping from a

see **Hospital Suicides** *on page 16*

APA Wins Award From CMS to Develop Quality Measures

APA is one of seven organizations to receive an award from the Centers for Medicare and Medicaid Services (CMS) to help develop mental health and substance use quality measures for CMS's Quality Payment Program (QPP).

The award is a $5.38 million grant over three years. APA will help develop mental health and substance use quality measures in the domains of measurement-based care, early psychosis, opioid misuse, suicide risk, and patient care experiences.

The QPP is the updated reimbursement system for CMS that was established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA authorized CMS to provide incentives that encourage physicians to focus on quality, value of care, and patient health. QPP consists of two participation pathways for doctors and other clinicians—the Merit-based Incentive Payment System (MIPS), which measures performance in four categories to determine an adjustment to Medicare payment, and Advanced Alternative Payment Models, or Advanced APMs, in which clinicians may earn an incentive payment through sufficient participation in risk-based payment models.

APA will work with the National Committee for Quality Assurance, a nonprofit organization that is experienced at developing quality measures. A goal will be to minimize the burden of measurement by eliminating redundancies and low-value quality measures from the QPP. In a statement announcing the award, CMS said it had removed or proposed to eliminate reporting requirements for 105 measures across the agency's programs, saving health care professionals $178 million over the next three years.

APA will use its PsychPRO registry to test these quality measures. PsychPRO is a CMS-certified Qualified Clinical Data Registry.

"APA is proud to take a leading role in shaping quality measures for our field," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "This grant will help us ensure that patients are receiving the highest standards of psychiatric care and that providers can easily report and be reimbursed for providing high-quality services."

The other six organizations receiving awards and their specialty areas of measurement development are Brigham and Women's Hospital, orthopedic surgery; American Society for Clinical Pathology, pathology; the Regents of the University of California, San Francisco, radiology; the University of Southern California, mental health and substance use; Pacific Business Group on Health, oncology; and the American Academy of Hospice and Palliative Care, palliative care.

More information about PsychPRO and how to join is posted at https://www.psychiatry.org/registry.

Hospital Chain Switches to Telepsychiatry For E.R., Inpatient Psych Consults

A new telepsychiatry service in the emergency department and on the medical floors at Sutter Health hospitals allows psychiatrists to reach rural locations not before served.

BY LINDA M. RICHMOND

Tim Jones, N.P., appears on one of the workstation monitors being used for telepsychiatry for all emergency room and inpatient psych consults at 13 hospitals at Sutter Health in Northern California.

Sutter Health, a Northern California hospital system, is gradually rolling out a telepsychiatry program at all 24 of its locations to better meet patients' needs and solve their psychiatrist shortage problem, especially at their most rural hospitals.

Now, with the service in operation at 13 of their hospitals, telepsychiatrists access patients via a workstation that can be wheeled into the patient's room. The board-certified psychiatrists are based all over the country and spend about 45 minutes with each patient from their home office.

"A number of our hospitals are in rural areas and had no psychiatry services or had very limited pockets when a psychiatrist was available," explained Tim Jones, N.P., Sutter Health's telepsychiatry program manager. "But psychiatric care emergencies occur 24-7, and we wanted to make sure we had robust acute care in our emergency rooms and on our medical floors that meets patients' needs."

While in many emergency rooms across the country, wait times for patients who need to see a psychiatrist range from several hours to several days, Sutter Health patients who need a psychiatric consult in the emergency department or on their medical floors can often be seen within an hour of a provider's request to a central call center.

The participating psychiatrists are all licensed to work in California and hired by Virtual Medical Staff, an Atlanta-based company that has been providing telepsychiatry services to hospitals for the past seven years. The psychiatrists go through a credentialing process and get privileges at each hospital in which they practice. They are given real-time access to the patients' electronic health records so they can order labs, tests, or medications and enter treatment notes.

Virtual Medical Staff's telepsychiatrists are issued enhanced audiovisual equipment, and the live feed between the patient and the physician is protected with (128-bit) encryption technology and is HIPAA compliant, explained Jack Williams, president of Virtual Medical Staff.

The company provides telepsychiatry services for about 350 hospitals nationwide. For about half of them, it provides 24-7 coverage, like at Sutter Health, and for half its patients, it supplements an in-house psychiatry service by covering the night shifts, 7 p.m. to 7 a.m.

For clinicians, the telepsychiatry setup gives them work flexibility and the ability to reach a broader population than would otherwise be possible if they had to drive to various locations throughout the state, Williams said. "They really like the technology because it allows them to see more patients faster and without having to physically travel," he said. "They are able to make a bigger impact than they would if they were just working at one location."

"This is another way for them to extend their practices," Jones said. "For patients, it helps clarify their diagnoses: Is this delirium, dementia, or new-onset psychosis? Psychiatrists help us clarify these 'gray area' presentations we often find."

One task the telepsychiatrists can't do is complete a California 5150, an involuntary hold that requires on-site clinician involvement. "They can recommend it, but by law the applications must be completed by on-site staff," Jones explained.

More than 1,500 telepsychiatry consults have been completed within Sutter Health since the launch of the program last fall, and the service will be rolled out to all of its hospitals by the end of the first quarter of 2019, Jones said.

At this time Sutter Health is not passing along the cost of the program to its patients "because we believe this is the right thing to do for our patients. They need this level of care and service, and by actively treating their psychiatric symptoms, we can reduce their length of stay and in many instances reduce their need for higher levels of care like psychiatric hospitalization." **PN**

APA's Telepsychiatry Toolkit, developed by the APA Work Group on Telepsychiatry, is posted at https://www.psychiatry.org/telepsychiatry.

Patients Connect From Home for Appointments

Psychiatrists and their patients in a large, integrated health system in California will soon be able to meet for appointments via smartphone or tablet and leave behind the hassles of traffic jams and parking-space hunts.

Telepsychiatry is already well established for emergency department care, outpatient clinical work, and even inpatient psychiatric unit work, as telepsychiatrists "make rounds" with patients via computers, explained Jack Williams, president of Virtual Medical Staff, an Atlanta-based company that provides telepsychiatry services to some 350 hospitals nationwide.

But one of Virtual Medical Staff's clients will soon launch a new program that will allow both the psychiatrist and the patient the option of meeting virtually. "It is now very easy for both physicians and patients to quickly initiate a live, secure, HIPAA-compliant video encounter," he said. "And these offerings are very popular with patients."

The program will allow for follow-up psychiatric care and medication management. "Patients can connect from home by simply installing on their tablet or smartphone the mobile app for Vidyo. It's about that simple," Williams said. Final details of the program are still being hammered out; one issue is ensuring patients aren't participating in their psychiatry appointments while driving down the interstate, Williams said.

While every state has its own laws and every hospital its own bylaws governing telepsychiatry and its reimbursement, rules are starting to shift in favor of this type of telepsychiatry, Williams added.

Tracy Stegall with Jackson Healthcare

CDC Releases Suicide Prevention Guide For States, Communities

Psychiatrists and mental health clinicians may have an especially important role in counseling patients and family members about safe storage of medications, firearms, and other household items that may be used in suicide. **BY MARK MORAN**

Christine Moutier, M.D., urges psychiatrists to seek extra training in suicide risk assessment and treatment.

The Centers for Disease Control and Prevention (CDC) has published a "technical package" of suicide-prevention strategies that can be used at the state and community levels as well as by psychiatrists and mental health professionals.

The 67-page document, titled "Preventing Suicide: A Technical Package of Policies, Programs and Practices," describes a select group of strategies based on the best available evidence. These strategies are described in seven chapters that cover the topics of strengthening economic supports, strengthening access and delivery of suicide prevention care, creating protective environments, promoting connectedness, teaching coping and problem-solving skills, identifying and supporting people at risk, and lessening harms and preventing future risk.

"States and communities already engaged in suicide prevention can use this technical package to assess their activities and see if there are areas in which to expand their efforts," said Deb Stone, Sc.D., M.S.W., M.P.H., in comments to *Psychiatric News*. She is a behavioral scientist in the Division of Violence Prevention at the CDC's National Center for Injury Prevention and Control. "For states and communities who have not begun work in the area of suicide prevention, this technical package can help guide decision making and prevention planning."

The strategies in the package include those with a focus on preventing suicide and reducing risk as well as approaches to lessen the immediate and long-term harms of suicidal behavior for individuals, families, communities, and society at large.

Although primarily intended for policymakers, the technical package can be used by psychiatrists and mental health clinicians. "Psychiatrists may be able to use the package in several ways—by working with their local community organizations to make sure that evidence-based programs are being implemented and helping to raise awareness about the programs and policies described in the technical package," Stone said. "The broad range of strategies in the technical package requires collaboration across community sectors. Psychiatrists and other health and mental health professionals are critical to the implementation of evidence-based treatments and practices such as Collaborative Assessment and Management of Suicidality, dialectical behavior therapy, and other forms of cognitive-behavioral therapy."

Among the experts who reviewed the CDC document was APA member Christine Moutier, M.D., chief medical officer of the American Foundation for Suicide Prevention (AFSP).

In comments to *Psychiatric News*, Moutier said the technical package builds on a similar document produced by the AFSP's Action Alliance, "Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention." The latter outlined very broad public health strategies—planning, communication with stakeholders in the community, aligning activities to the local culture, and ensuring sustainability for long-lasting change.

She said the CDC technical package is a more detailed "toolkit" describing specific strategies that have been shown to reduce suicide.

see **Guide** *on page 11*

WHY I ASPIRED TO BE A PSYCHIATRIST

Patients' Stories Led to Unusual Career Path

BY JOHN LUO, M.D.

John Luo, M.D., is a health science clinical professor in psychiatry and director of the psychiatry residency program at the UC Riverside School of Medicine. He is also an expert on psychiatry and informatics and a member of APA's Council on Communications.

Reflecting on how I became a psychiatrist, there were a series of opportunities as well as interactions with mentors who have helped shape my career. I first attended the California Institute of Technology with the goal of getting a Ph.D. in biology and pursuing research in immunology. Suffice it to say, after two summers spent doing research, I decided I wanted more human interaction and less lab bench time, so I transferred to UCLA with the plan to go to medical school.

I thought that I would follow in my father's footsteps and become a primary care provider. I saw how much he had sacrificed time with the family to provide comprehensive care for his patients, whether seeing them at his clinic or at the hospital and rounding on them on the weekends. What impressed me was how much they appreciated his dedication to their care, and I wanted to have that same experience. I also wanted to have a better work-life balance, since I remember all too well the many weekends waiting for hours in the hospital parking lot for my father to finish rounding on his patients. Keep in mind, this time was well before the advent of smartphones and portable gaming systems to keep me entertained!

At the University of Texas Medical Branch, it was during my third-year clerkship in psychiatry on the consultation-liaison service that I discovered why I aspired to become a psychiatrist. Even though I was a medical student, just by listening to my patients and having empathy with their stories, I was able to have a significant impact. I learned that for patients with severe mental illness, a psychiatrist is often their primary care provider, and I found the relationship with my patients as engaging and rewarding as my father had with his patients. My choice to pursue a psychiatry residency was also influenced by the need to reduce the stigma of mental illness in Asian communities.

It was during residency that I was fortunate to be an APA-Center for Mental Health Services Minority Fellow, which provided the next fork in the eventual path of my career. As a resident member of the Committee of Asian-American Psychiatrists, I served on the Committee on Information Systems. My initial plan was to create a webpage of resources in 1996 to help address the access issue to mental health services for minority populations, but I learned that many of my resident colleagues, faculty, and APA members didn't even know what the internet was back then. I realized that my technical skills and early adoption of various technologies could help improve patient care by educating my colleagues on how to use technology appropriately in the practice of psychiatry.

I feel very fortunate in this journey to become a psychiatrist, informaticist, and educator. My goal has been to provide excellent patient care just like my father, yet I discovered my own path. It has been a privilege to provide care to my patients as well as educate my colleagues to enable them to use the various technology tools in patient care. As I reflect on my career so far, I couldn't imagine it to be any better! **PN**

Psychiatric News **invites you to share your story of why you chose a career in psychiatry. If interested, please send an email to cbrown@psych.org.**

Medicaid Expansion Improves Access to Depression Care

Adults with depression have better health care access in Medicaid expansion states, but the imposition of new work and other eligibility requirements threatens to reverse the progress. **BY LINDA M. RICHMOND**

The expansion of state Medicaid coverage was associated with a 23 percentage point increase in health insurance among adults with depression, as well as decreased cost-related delays in obtaining health care or medication, according to a study posted on August 28 in *Psychiatric Services.*

Medicaid expansion was also associated with an 11 percentage point boost in respondents who have a personal doctor and a reduction in the number of people who delayed care (16 percentage points) or skipped medications (18 percentage points) because of cost, according to authors Carrie E. Fry, a Ph.D. health policy student at Harvard, and colleagues.

The study involved surveys of nearly 5,000 low-income adults who screened positive for depression from three southern states: Arkansas and Kentucky, both of which expanded their Medicaid program, and Texas, which has a similar demographic makeup but did not expand. Researchers conducted phone surveys before the Medicaid expansion in 2013 and after states' expansion (from 2015 to 2016) and compared them.

Under the Affordable Care Act, states could expand Medicaid eligibility to residents with incomes of up to 138 percent of the federal poverty level, granting new coverage to nearly 12 million people in the 34 states that expanded, according to the Kaiser Family Foundation (KFF). In these states, individuals can earn just under $16,800 a year and still qualify for Medicaid, up from $12,100 a year in states that did not expand.

Prior to expansion, only about half of eligible adults were enrolled in Medicaid. "Eligibility for Medicaid doesn't automatically result in coverage, and the enrollment process can be especially burdensome for individuals with depression or other mental health or substance use disorders," Fry told *Psychiatric News.* "Continued threats to Medicaid expansion will likely result in reduced access to health care services for people who need care the most, including adults with depression."

The findings come as a number of states are seeking to restrict Medicaid eligibility with never-before-tried approaches such as work requirements, drug screening and testing, eligibility time limits, and cost-sharing premiums. Some states are seeking to have these restrictions applied only to their expansion populations, but some are seeking to apply them to their poorest Medicaid populations as well.

Three states—Arkansas, Kentucky, and New Hampshire—received approval from the Centers for Medicare and Medicaid Services (CMS) to require beneficiaries to work as a condition of enrollment, and 10 states now have applications with CMS pending to do the same, KFF reported.

Indiana was one of the first states to add cost-sharing premiums. Within the first two years, more than half (55 percent) of enrollees required to pay premiums failed to do so, resulting in negative consequences. Nearly 287,000 of the states' poorest residents were moved to a more limited benefit package for failure to pay. In addition, some 60,000 expansion enrollees were either never enrolled or lost coverage. The top reasons cited by enrollees were lack of affordability and confusion over the payment process.

In Arkansas, nearly 4,400 low-income individuals were dropped from Arkansas' Medicaid rosters last month for failure to work or report their work or community engagement activities under a restriction that began in the spring, according to a statement from Gov. Asa Hutchinson. Those individuals are now ineligible for coverage for the remainder of the calendar year.

"Personal responsibility is important," Hutchinson said. "We will continue to do everything we can to ensure those who qualify for the program keep their coverage, but it is equally important to make sure those who no longer qualify are removed."

Arkansas' provision is now being challenged in court, and a similar work provision in Kentucky was invalidated by a federal district court in June and sent back to the Department of Health and Human Services to reconsider. **PN**

"Effect of Medicaid Expansion on Health Insurance Coverage and Access to Care Among Adults With Depression" is posted at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201800181.

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Activists demonstrate in India in support of gay rights. Last month, India's Supreme Court overturned a law criminalizing homosexuality, ending 150 years of oppression.

Psychiatrists Welcome India's Historic Ruling on Homosexuality

Psychiatrists in India and around the world helped promote the culture change that allowed for the decriminalization of homosexuality. **BY LINDA M. RICHMOND**

Ending more than 150 years of oppression, the Supreme Court of India last month resoundingly struck down a law criminalizing gay sex, giving rise to a culture shift now under way in the world's second most populous country and giving hope that other human rights such as gay marriage and same-sex adoption will follow.

The long-held belief in the psychiatric community that homosexuality is a normal variation of human sexuality was cited by the justices as influencing their unanimous ruling. They also cited individual autonomy, equality for all without discrimination, and recognition of identity and privacy as overarching ideals underpinning their decision.

"What nature gives is natural," the justices wrote. "History owes an apology … for the delay in providing redressal for the ignominy and ostracism that [homosexuals] have suffered through the centuries," Justice Indu Malhorta wrote in a separate concurring judgment.

The ruling will likely influence many of the 70 countries and territories worldwide that continue to criminalize same-sex relationships; eight of them still impose the death penalty for violations.

"The decision not only affects the people of India, but it also will have an influence on many non-Western countries that still have laws criminalizing homosexuality," said Jack Drescher, M.D., a clinical professor of psychiatry at Columbia University and a member of the World Health Organization's Working Group on the Classification of Sexual Disorders and Sexual Health. "I think it will have an impact on countries that see acceptance of homosexuality as a primarily Western idea. This is a game changer."

The ruling "is a huge step forward in removing discrimination against homosexually oriented persons," said Ajit V. Bhide, M.D., president of the Indian Psychiatric Society (IPS). "It allows them freedom from stigma that is long overdue, but there is indeed a large conservative section in Indian society who will take a long time to come to grips with the altered legal status."

Om Prakesh Singh, M.D., a professor of psychiatry at West Bengal Medical Education Service and editor of the IPS's *Indian Journal of Psychiatry*, agreed. "Because India is a developing country with a traditional outlook—and deep cultural and educational ties to similar countries—this acceptance of homosexuality will influence their thinking," Singh said.

India's law, known as Section 377, was introduced in the 1860s by British colonists. It made it a crime to voluntarily have "carnal intercourse against the order of nature" and carried a punishment up to life in prison. Although seldom enforced by the country's criminal justice system, the law created a climate allowing beatings, blackmail, and other exploitation of gays, who suffered in silence for fear that reporting any crimes would result in their own criminal prosecution—or worse—by law enforcement.

A Delhi High Court briefly invalidated Section 377 in 2009, but the anti-sodomy law was restored four years later after a two-judge Supreme Court panel reinstated it. It ruled at the time that India's homosexuals were a "miniscule fraction of the country's population"—too small to warrant protection.

"I welcome this first step toward humanity and reform in criminal laws in India," said Dilipkumar Patel, M.D., president of the Indo-American Psychiatric Association and an adjunct assistant clinical professor of psychiatry at Morehouse School of Medicine. "Though the law has decriminalized the sexual act, acceptance of gay or lesbians has a long way to go in Indian society in general. India needs to fully embrace the evolving standards of global society—and the rights of everyone regardless of their sexual identity or gender identity."

An IPS task force to legalize homosexuality held conferences in cities across India, bringing together psychiatrists and members of the community

see **India** *on page 10*

APA Paved the Way for Changes in U.S. Laws on Homosexuality

A research paper explaining how APA depathologized homosexuality by removing it from its *Diagnostic and Statistical Manual* in 1973 was cited by the Indian Supreme Court in its 495-page ruling to decriminalize homosexuality.

Psychiatrists learning about the stigma caused by the homosexuality diagnosis and gay activists were major catalysts for APA's decision 45 years ago, as well as the realization that homosexuality was a diagnosis—unlike other mental disorders—not associated with social impairment or subjective distress, wrote Jack Drescher, M.D., in a 2015 paper. Drescher is a clinical professor of psychiatry at Columbia University and a member of the World Health Organization's Working Group on the Classification of Sexual Disorders and Sexual Health.

"I personally believe APA's decision in 1973 to remove homosexuality from *DSM* set in motion a culture change, not just confined to the United States, but that spread to the rest of the world and served to increase acceptance of homosexuality," Drescher told *Psychiatric News.* "These changes paved the way for the World Health Organization's removal of homosexuality from its ICD [International Classification of Diseases] codes in 1990," he added.

Although APA threw out the diagnosis some 45 years ago, it took until 2003 for the U.S. Supreme Court to declare unconstitutional a Texas same-sex sodomy law, invalidating similar laws in the dozen or so states that still retained them. It ruled that private sexual conduct is protected by the liberty rights implicit in the due process clause of the United States Constitution.

Three years ago a U.S. Supreme Court decision struck down state bans on gay marriage, legalizing it throughout the country and its territories. Other human rights have yet to be won: the United States has no federal law outlawing discrimination against LGBTQ individuals, leaving residents of some states unprotected against discrimination in employment, housing, and private or public services.

"Out of DSM: Depathologizing Homosexuality" is posted at https://www.mdpi.com/2076-328X/5/4/565/pdf.

Access to Quality MH Care Does Not Equate To Use by Black Immigrants

BY JENNIFER SEVERE, M.D.

Immigration history and status remain fundamental elements of black immigrants' sense of belonging and perceived experiences with discrimination, marginalization, threats to family, education, employment, and health care services. Access to high-quality and affordable care does not equate with use of that care despite the need for it. Many individuals are afraid to seek out care or fully engage with treatment due to their concern that it might impact their immigration status. This fear pervades throughout the African diaspora, touching individuals who are permanent residents, temporary residents (students, professionals), and humanitarian migrants (refugees), to name a few.

I remember Nugo, from Nigeria, who required psychiatric hospitalization for an acute decompensation.

Jennifer Severe, M.D., is a clinical assistant professor of psychiatry at the University of Michigan and a consultant to APA's Council on International Psychiatry.

While he was grateful that his condition improved, he was frightened that "this type of incident" would interfere with the renewal of his student visa, and as a result, he firmly declined any future care. With the stress of trying to create a new life and assimilate into a new culture, Nugo had an entrenched fear that if he did not play by the rules and "be mentally well," his visa might be in jeopardy.

To what extent does immigration history and status deter black immigrants from appropriately using health care services? This is the issue I brought to the 48th Annual Legislative Conference last month in Washington, D.C., Organized by the Congressional Black Caucus Foundation (*Psychiatric News,* https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2018.10a22). It was sponsored by Rep. Daniel K. Davis (D-Ill.), who has a long interest in the health and well-being of black immigrant families. I joined a panel of black leaders and advocates.

Having a front-row seat in the black immigrant community to learn their strengths, cultural traditions, and cumulative local experiences, I found this opportunity was timely to increase awareness, educate the public, and inform policy on the deterrent effect of immigration issues on mental health service use. It also created momentum to recognize and amplify existing endeavors and accomplishments in the field of psychiatry aimed at addressing immigrant issues through expanding cultural competency training, which improves the effectiveness of psychiatric treatment for immigrant and ethnic minority patients—building a culture of diversity, equity, and inclusion, which has multiplicative effects on the workforce, the people we train, and the communities we serve; and advocating for better health insurance coverage, which promotes equitable access to care.

While psychiatry has become increasingly sophisticated in its approach to culturally sensitive care and stigma reduction, we still have a long way to go to create systems that are welcoming to fully engage those who are in need of our services but are afraid to seek help.

At the clinician level, we need to explore not only immigrant patients' symptoms, but also their narratives around immigration issues. Building and maintaining trust while assuring them of confidentiality remain central to this rewarding effort. **PN**

Rising Temperatures and Suicide

BY ROBIN COOPER, M.D.

Suicide deaths have received a lot of public and professional attention recently after the Centers for Disease Control and Prevention reported a 30 percent increase in the number of suicides in the United States between 2000 and 2016. Coincidentally, information about the link between heat and suicide was published in the July *Nature Climate Change.* This is information that all psychiatrists should note.

The authors of this study report that a 1 degree Celsius increase in average monthly temperature increased suicide rates 0.7 percent in the United States and 2.1 percent in Mexico. In a separate interview, the lead author—Marshall Burke of Stanford University—acknowledged the multifaceted contributions to suicide; however, this new study is remarkable and stands out from previous studies reporting linkage between heat and suicide by controlling for a multitude of confounding variables. These include gender, time of year, rural or urban residence, regional poverty and income levels, location effects such as daylight exposure, gun availability, and access to air-conditioning.

The study by Burke and colleagues is the first to look at rates in North America; other reports linking climate change and suicide have had more limited scope and have looked at rural farmers in India and in Australia.

Robin Cooper, M.D., is a member of the Steering Committee of the Climate Psychiatry Alliance and an assistant clinical professor of psychiatry at the University of California San Francisco. She is also a private practitioner in adult psychiatry.

The effects described in the Burke study hold true whether in cooler or hotter climates, and over decades, indicating that there is no adaptation to warming temperatures over time. The authors highlight the contribution of improved general health to economic development (lessened environmental exposures, greater access to air-conditioning) but find no such adaptation for the relationship between increased temperature and suicide. "Even once you control for income, you still don't see air-conditioner use come through as a factor. Suicide is a fundamentally different animal from these other types of mortality, like cardiac mortality, that you see in the literature" said Burke in the July 23 *Atlantic.*

In addition to reviewing suicide data, the authors analyzed over 600 million social media communications and found an increase in depressive language and suicidal ideation correlated with increased temperatures.

Given their results, the authors made a startling projection about the future impacts of climate change and global warming. They estimated that by 2050, assuming no reduction in greenhouse gas emissions, there will be 14,020 excess suicides in the United States and 7,460 excess suicides in Mexico. These rates are comparable to the effects on suicide incidence due to economic recessions and unemployment, celebrity suicides, gun restriction laws, and suicide prevention programs, according to the report.

Although the underlying biological and physiological mechanisms remain to be elucidated, there is some speculation on the role of serotonin. Additional research is clearly needed. The authors end their article with a final call for implementing "policies to mitigate future temperature rise."

The urgency to control climate change is clear: we must use our leverage to limit global warming and advocate for policies that protect our communities and promote mental well-being. **PN**

"Higher Temperatures Increase Suicide Rates in the United States and Mexico" is posted at https://www.nature.com/articles/s41558-018-0222-x. "Climate Change May Cause 26,000 More U.S. Suicides by 2050" is posted at https://www.theatlantic.com/science/archive/2018/07/high-temperatures-cause-suicide-rates-to-increase/565826/. "Climate and Conflict. Annual Review of Economics" is posted at https://www.annualreviews.org/doi/10.1146/annurev-economics-080614-115430.

India

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to create awareness and better understanding of the plight of the LGBT community. "The public stance of the IPS has without a doubt helped shape the new, healthy outlook that the Supreme Court has validated," Bhide said.

There is much reason now for hope: with the Supreme Court ruling, the IPS policy statement, and the surrounding publicity has come greater acceptance of the LGBTQ community, said Singh. "Many articles are being published by business professionals and others who openly declare their homosexuality. It has increased acceptance," he said. "Parents are also realizing the biological nature of homosexuality and are more supportive."

"The fight has not been easy," Bhide said, summing up years of activism by Indian psychiatrists and others. But he is quick to credit another group as well. "The perseverance of the LGBT community leaders of course needs the greatest applause." **PN**

India's Supreme Court decision is posted at https://www.sci.gov.in/supremecourt/2016/14961/14961_2016_Judgement_06-Sep-2018.pdf.

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Perimenopausal Depression Guidelines Released

Antidepressants and psychotherapy are the frontline treatments for women transitioning to menopause, but hormonal therapy can be effective and should be considered if menopausal symptoms are severe.

BY NICK ZAGORSKI

Clinicians have known for a while that the risk of depression in women increases with the onset of perimenopause—a transitional period characterized by biological changes in hormone levels. However, there has been less consensus on how to properly identify and treat depression that arises during this period.

An expert panel last month released the first-ever guidelines for the evaluation and treatment of perimenopausal depression. The guidelines, jointly published September 5 in the journals *Menopause* and the *Journal of Women's Health*, address five clinical topics: the epidemiology of depressive symptoms in perimenopausal women; the clinical presentation of perimenopausal depression; the effects of antidepressants; the effects of hormone therapy; and the effects of other interventions such as psychotherapy, exercise, and natural products.

The 11-member expert panel was convened by the North American Menopause Society and the National Network on Depression Centers Women and Mood Disorders Task Group. Panel members were divided into subgroups based on their expertise into one of these five topic areas. Each subgroup reviewed the available literature for their topic and drafted a set of recommendations. Each subgroup was also assigned to review the recommendations of one of the other topic areas. The two panel co-chairs then prepared the final guidelines based on the collected feedback.

"The reason these guidelines are needed is because depression during the perimenopausal phase occurs alongside other menopausal symptoms," said panel co-chair Pauline Maki, Ph.D., a professor of psychology and psychiatry at the University of Illinois at Chicago College of Medicine, in a statement. These symptoms include sleep problems, sexual dysfunction, fatigue, and difficulty concentrating.

"These perimenopause symptoms can co-occur with and complicate the presentation of depression, and it can be challenging to disentangle the symptoms and diagnoses," said panel co-chair Susan Kornstein, M.D., a professor of psychiatry at Virginia Commonwealth University. "Clinicians should also be aware of the unique psychosocial stressors for women during midlife, such as caring for both children and elderly parents, death of parents, children leaving home, career and relationship shifts, and personal and family illness."

As noted in the guidelines, there are no menopause-specific mood-disorder scales available, but general depression screening tools such as the Patient Health Questionnaire (PHQ-9) can be used. Validated scales for menopause symptoms, such as the Menopause Rating Scale (MRS) or Menopause-Specific Quality-of-Life Scale (MENQOL), also include measures related to mood, which may assist in clarifying the contribution of menopause to the patient's overall symptom profile.

Once a depression diagnosis is made, the treatment options are similar to those used with other patients with depression. According to the guidelines, antidepressants and psychotherapies (particularly cognitive-behavioral therapy) remain the frontline choices for treating major depressive episodes during perimenopause.

> "Perimenopause symptoms can co-occur with and complicate the presentation of depression."
> —Susan Kornstein, M.D.

Among antidepressants, the serotonin-norepinephrine reuptake inhibitor (SNRI) desvenlafaxine has the most clinical evidence to support its use in perimenopausal women. Two large randomized clinical studies have demonstrated that desvenlafaxine improves mood symptoms in perimenopausal women relative to placebo. Smaller clinical studies have also suggested that other SNRIs, selective serotonin reuptake inhibitors (SSRIs), and the tetracyclic antidepressant mirtazapine are effective at improving mood and other perimenopausal symptoms.

"Since desvenlafaxine is the only antidepressant that has been studied in large placebo-controlled studies in peri- and post-menopausal women, I would consider it a frontline choice," Kornstein told *Psychiatric News*. "However, other factors need to be considered, such as previous antidepressant response in women with prior episodes of depression."

Depending on the exact profile and severity of symptoms (for example, if mood changes are predominantly due to menopausal vasomotor symptoms such as hot flashes or night sweats), estrogen replacement therapy is another pharmacological option. Multiple studies have found that hormone therapy has antidepressant effects when administered to perimenopausal women. Additional research also suggests that estrogen therapy can augment the effect of antidepressants.

Nonetheless, the guidelines recommend that a combination strategy of antidepressants plus estrogen should be used with caution and preferably limited to patients with strong somatic symptoms like vasomotor problems.

"On the whole, the guideline conclusions are a fair and accurate summation of the published literature," said David Rubinow, M.D., the Assad Meymandi Distinguished Professor and Chair of Psychiatry and director of the Center for Women's Mood Disorders at the University of North Carolina.

He added that while the guidelines emphasize the role of a history of depression as an important risk factor for perimenopausal depression, he cautioned that many women enter midlife with no prior depression. "[P]ractitioners need to remain vigilant no matter the woman's history." **PN**

"Guidelines for the Evaluation and Treatment of Perimenopausal Depression: Summary and Recommendations" is posted at https://www.liebertpub.com/doi/10.1089/jwh.2018.27099.mensocrec and https://journals.lww.com/menopausejournal/Documents/MENO-D-18-00170%20FINAL%20(2).pdf.

Guide

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Moutier highlighted the need to reduce access to lethal means among people at risk for suicide. In the chapter titled "Create Protective Environments," the technical package outlines the importance of safe storage of medications, firearms, and other household products that can be used in suicide.

"Such practices may include education and counseling around storing firearms locked in a secure place (e.g., in a gun safe or lock box), unloaded and separate from the ammunition; and keeping medicines in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts," according to the technical package.

Moutier said psychiatrists and other physicians have a critical role in providing such counseling. "If we educate all gun owners that the presence of a gun in the home increases the risk of suicide and we also teach them basic prevention strategies such as safe storage, we have a logical reason to believe it will reduce suicide in the population," she said.

She urged psychiatrists to seek out extra training in suicide risk assessment and evidence-based treatments and to familiarize themselves with the CDC technical package.

"It really represents how far we have advanced in community-based suicide prevention," Moutier said. **PN**

"Preventing Suicide: A Technical Package of Policies, Programs, and Practices" is posted at https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf. "Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention" is posted at https://theactionalliance.org/sites/default/files/transformingcommunitiespaper.pdf.

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TBI Associated With Increased Risk For Suicide, Study Finds

Clinicians are advised to ask patients about their history of head injuries. **BY RICHARD KAREL**

A Danish retrospective study of more than 34,000 people who died from suicide found that the suicide rate was nearly double among those diagnosed with traumatic brain injury (TBI) compared with those without a TBI diagnosis.

The study was conducted by psychiatric epidemiologist Trine Madsen, Ph.D., and colleagues including psychiatrist Michael Benros, M.D., Ph.D. The authors are affiliated with the Danish Research Institute of Suicide Prevention and Copenhagen University Hospital in Denmark. Benros is a senior researcher and clinician with expertise in psychiatric epidemiology.

In total, the researchers assessed data on more than 7.4 million people aged 10 and older living in Denmark from 1980 to 2014. During this period, approximately 7.6 percent—nearly 568,000 people—had a medical contact for TBI. Among those with TBI, the suicide rate was 41 per 100,000 versus 20 per 100,000 for those without a TBI diagnosis.

Although the incidence of post-TBI suicide was only a fraction of the total number of people who experienced

FROM THE EXPERTS

The Origins of Black Mental Health

BY EZRA E.H. GRIFFITH, M.D., BILLY E. JONES, M.D., M.S., AND ALTHA STEWART, M.D.

We have been good friends and colleagues for decades, and we have had careers rooted in university and public settings. We've been students of black-white interactions, sensitive to policy developments in the public sector and to the racialized ambience of the inner city. We always followed the happenings in American psychiatry because of our active membership in key psychiatric organizations.

In late 2016, there was a buzz in the air. Donald Trump had won the election. The post-Obama era was on its way, and as public mental health figures, we were beginning to worry about the effects and possible damage of policy changes. Public intellectuals were decrying the overt manifestations of racism that were becoming more blatant than usual, even at the highest levels in society. The deadly reactions of law enforcement officers to the misunderstood behavior of black men made us pause. Then there was the sad passing of some of our black leaders in psychiatry, like Phyllis Harrison Ross and Chester Pierce. We worried about what to do and say, and where and when to say it. Talk about the mental health concerns of the black community came to the fore, but in a sputtering sort of way.

However, it became clear that members of APA, the Black Psychiatrists of America (BPA), and the National Medical Association were engaging in discussions about what appeared at first to be a bleak period in these professional health societies. These organizations had found ways of conversing about certain topics of significance to the maintenance of the health and mental health of blacks in this country. For example, there was ongoing discussion about the significance of social determinants of mental illness, intersectionality (as seen with black women and black LGBTQ persons), and the presence of multiple medical problems in black elderly patients. Plus, there was talk about how blacks were incarcerated at more than five times the rate of whites.

With these exchanges in the background, we attended a symposium at

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Ezra E.H. Griffith, M.D., is professor emeritus of psychiatry and deputy chair for diversity and organizational ethics in the Yale School of Medicine Department of Psychiatry. Billy E. Jones, M.D., M.S., is a clinical professor of psychiatry at NYU School of Medicine, former president of the Black Psychiatrists of America, and former commissioner of the New York City Department of Mental Health. Altha Stewart, M.D., is APA president and director of the Center for Health in Justice Involved Youth at the University of Tennessee Health Science Center in Memphis. They are the co-editors of *Black Mental Health: Patients, Providers, and Systems*. APA members may purchase the book at a discount at https://www.appi.org/Black_Mental_Health.

TBI—0.62 percent—any factor that increases suicide risk warrants concern, commented Jennifer Coughlin, M.D., an assistant professor of psychiatry at Johns Hopkins School of Medicine. She has studied the impact of concussions on National Football League athletes using neuroimaging to evaluate the molecular changes that follow brain trauma. She noted that the study finding are consistent with prior findings.

"We need to be asking our patients about history of TBI, and for those who report TBI, we need to ask about psychiatric symptoms and suicidal ideation," Coughlin said. "These data suggest that the impact of that practice alone may be lifesaving."

The researchers also found that the more severe the TBI, the greater the risk of suicide, and that suicide risk was most elevated in the six months following initial medical contact for TBI. This suggests that both patients and clinicians need to be particularly focused on treatment during this critical period, said Benros.

Regarding treatment, Benros said, the evidence supporting an approach specifically for post-TBI psychiatric disorders is inadequate. The absence of treatment details and the absence of data on the particular psychiatric disorders that were associated with TBI were among the study's key limitations and represent critical areas for further research, he said.

There was one paradoxical finding—in those with a pre-TBI history of either a psychiatric diagnosis or deliberate self-harm, TBI was associated with a *lower* risk of suicide than among those who had *only* a psychiatric diagnosis or had engaged in deliberate self-harm.

"That finding emphasizes what we [already know]—that psychiatric illness and deliberate self-harm are the main risk factors for suicide," said Benros. It is possible that because risk in this subpopulation is already so elevated, there may be "a ceiling effect," he noted, and it is also possible that increased medical attention after TBI may be a protective factor for those with pre-TBI psychiatric diagnosis and history of self-harm.

"We found that the suicide rate was nearly doubled after a TBI."
—Michael Benros, M.D., Ph.D.

Jonathan Silver, M.D., is a clinical professor in the NYU School of Medicine Department of Psychiatry and the lead author of an article in the journal *Brain Injury* on the association between head injuries and psychiatric disorders.

The Danish study highlights an important issue, said Silver, but clinicians need to remember that there is an "enormous association" between TBI and a range of serious psychiatric disorders, he told *Psychiatric News*. In a commentary for the *New England Journal of Medicine's* "Journal Watch," Silver wrote, "Preventing suicide is important; education of clinicians regarding assessment and treatment of common neuropsychiatric disorders in people with TBI would have even greater impact."

The study was funded by the Mental Health Services Capital Region Denmark and an unrestricted grant from the Lundbeck Foundation. **PN**

"Association Between Traumatic Brain Injury and Risk of Suicide" is posted at https://www.ncbi.nlm.nih.gov/pubmed/30120477. "The Association Between Head Injuries and Psychiatric Disorders: Findings From the New Haven NIMH Epidemiologic Catchment Area Study" is posted at https://www.tandfonline.com/doi/abs/10.1080/02699050110065295.

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APA's Annual Meeting in May 2017. The occasion was an academic event in honor of Chester Pierce, M.D., marking his death and celebrating his contributions to American psychiatry. The APA meeting was brimming with promise and hope for the future. The election of one of the authors of this article—Altha Stewart, M.D.—as the first black president had shattered the ceiling above us. The organization's election news was a validation, not only of Dr. Stewart's outstanding abilities and accomplishments, but also a statement that black members could belong fully to the organization.

We also recognized that the BPA would be 50 years old in 2019. The BPA was born out of the protest of senior black psychiatrists at APA's 1969 Annual Meeting in Miami. The primary focus of the protest was for greater and more open involvement in APA of black members. Not only had that been achieved, it had opened the door for other minority and underrepresented groups.

These events, when linked to our memories of the 1999 text by Jeanne Spurlock, M.D. (*Black Psychiatrists and American Psychiatry*), helped us understand that we had to respond to this confluence of forces that were so insistently calling on us. We decided quickly that we would produce a new book, which we decided to title *Black Mental Health: Patients, Providers and Systems.* It is now available from American Psychiatric Association Publishing. We wanted to combat the nihilistic feelings and the morbid preoccupations by talking about how far we had come over the last 50 years in the domain of mental health care for blacks in the United States.

Our book consists of about 400 pages broken into 28 chapters written by 48 authors; it is organized into four main sections: "Reflections," "Patient Care," "Training of Black Mental Health Care Providers," and "Psychiatric Research and Blacks." We think of this text as an exemplar of communication: between us and our authors, and especially between the authors and the broader audience of readers.

We know there is a need for special knowledge when treating black patients. For example, our authors argue that practitioners should have some understanding of black children and their families and of their values and lifestyles, as well as the general health and behavioral impediments they face when seeking mental health treatment. Our authors point out that research findings indicate that black youth as young as 10 to 12 years old are significantly more likely to receive harsher judgments and punishments when compared with their white peers exhibiting similar behaviors. The authors recommend the use of evidence-based assessment tools that are useful in providing information about a black child's or adolescent's functioning. They caution, however, that clinicians should be aware that the reliability and validity of these measures with black youth vary from poor to superior. There is caution, too, about avoiding the unconscious bias that may intrude when we interact with minority groups.

In the conversation we intend in this text, we emphasize that racial discrimination is a public health pollutant with malignant effects on U.S. society, both whites and blacks. Its impact extends to all the spaces that we inhabit, and the resultant trauma include psychological and somatic health disorders. We hope this new text will push the conversation further about this important subject and will catalyze a new look at black mental health. **PN**

Lawsuit

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and enforce the protections of the Affordable Care Act."

The plans are sold in the individual market, representing about 10 percent of health insurance plans sold, and are bought by people without employment-based or government-sponsored insurance. With efforts to repeal and replace the ACA having failed so far, this rule is purportedly aimed at providing more affordable consumer choices.

Short-term health plans are typically less expensive than comprehensive plans, but they are not required to cover the ACA's required "essential benefits," such as mental health and substance use disorder services, prescription drugs, hospitalization, emergency services, or maternity care. Similarly, short-term plans are not subject to consumer safeguards or antidiscrimination rules that the ACA requires. For instance, insurers can deny coverage for preexisiting conditions; set higher premiums based on age, sex, or health status; retroactively cancel coverage; and deny renewals. Short-term plans may also increase uncompensated care for health care providers, the coalition wrote.

The exclusions and lack of safeguards can lead to disastrous results and bankruptcy for consumers, the coalition said. For example, one man in Washington, D.C., purchased a short-term plan with a stated maximum payout of $750,000 and thought that he was well covered. When he filed a claim for a hospitalization bill that topped $211,000, however, the plan reimbursed him just $11,780 and denied the rest, in part due to his father's medical history.

The final rule threatens the lives of Americans by taking away needed treatment, said Paul Gionfriddo, president and CEO of Mental Health America. "At a time when suicide and overdose deaths have hit epidemic levels and continue to rise, the last thing we need is a rule that confuses consumers and offers worse mental health and substance abuse benefits."

The National Alliance on Mental Illness (NAMI) is concerned that expanding skimpy health plans will result in excluding people with mental health conditions from care. "For the past 20 years, NAMI has fought for parity—the fundamental tenet that mental health care is just as important as physical health care," said Mary Gilberti, CEO of NAMI. "This rule change rolls back the clock on Congress' bipartisan efforts to ensure patient protections and fair insurance coverage of mental illness." **PN**

The coalition's statement is posted at http://apapsy.ch/ShortTermPlanRule. The Short-Term, Limited-Duration Insurance Final Rule is posted at https://www.cms.gov/newsroom/fact-sheets/short-term-limited-duration-insurance-final-rule.

Large Study of Black Adults Points To Strategy to Slow Dementia

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A clinical study in older black adults found that using behavioral activation to reinforce healthy living could slow cognitive decline over a two-year period. **BY NICK ZAGORSKI**

Encouraging older black adults with mild cognitive impairment (MCI) to increase their cognitive, physical, and/or social activities may help to slow cognitive decline, according to a study posted on September 10 in *JAMA Neurology*.

This study is not the first to suggest that staying mentally, physically, and socially active can help slow down cognitive decline; however, previous population studies in the United States have not included significant numbers of black individuals, so it was not known whether the cognitive benefits of staying active generalized to blacks.

This new study, led by investigators at Sidney Kimmel Medical College of Thomas Jefferson University in Philadelphia, enrolled 221 black adults aged 65 and older with MCI. The participants were randomly assigned to receive either behavioral activation or supported therapy over a two-year period. Behavioral activation uses strategies like setting goals and making action plans to reinforce a healthy lifestyle, while supportive therapy involves structured, empathic discussions with people about the experience of aging and memory loss but does not include any behavioral reinforcement strategies.

Participants in both groups received five in-home, hour-long treatment sessions over the first four months, followed by six in-home, hour-long follow-up sessions over the next 20 months. The sessions were administered by trained community health workers.

The participants were given cognitive tests and asked about their cognitive, physical, and social activities every six months. There were no significant differences in cognitive performance between the groups at six months, but in the subsequent follow-ups, the adults receiving behavioral activation began to perform better than those in the supportive therapy group.

The primary measurement was the number of participants whose scores on the Hopkins Verbal Learning Test (which tasks people to learn a set of words and then remember them after 20 to 25 minutes) declined by at least six points from baseline. Only 1 percent of the behavioral activation group had a significant decline after 24 months, compared with 9 percent in the supportive therapy group.

Lead study investigator Barry W. Rovner, M.D., a professor of psychiatry and neurology at Thomas Jefferson University, told *Psychiatric News* that using a preset cutoff on the Hopkins test could be seen as arbitrary; people might have dropped 4 or 5 points on their cognitive test scores and not be considered as showing a decline. To account for this, the investigators used additional statistical methods to compare cognitive decline.

"We found that if you looked at overall test performance over the two years, the participants in the behavioral activation group were half as likely to show any decline on the cognitive test at any given time point," Rovner said.

In discussing why behavioral activation showed such significant results, Rovner noted that social determinants of health such as environment or income play a significant role in the dementia risk of blacks.

"Starting from conception, a time during which black mothers have higher rates of stress, poor nutrition, and less access to quality medical care, blacks face tremendous health disparities that break down their cognitive reserve and double their risk of dementia," he said. "This study showed that if

Late-Life Anxiety Linked to Cognitive Decline

More research is needed to determine whether late-life anxiety might be a prodromal form of dementia or if anxiety is causally related to neurodegeneration. **BY MARK MORAN**

Symptoms of anxiety in women over 50 appear to be associated with a decline over time in executive function—the ability to plan ahead and organize one's thoughts, according to a report published September 14 in the *American Journal of Geriatric Psychiatry*.

Among both men and women 65 years and older, anxiety appears to predict a decline in verbal memory, which refers to the ability to remember words.

Lead author Sebastian Köhler, Ph.D., an associate professor of neuroepidemiology at Maastricht University, told *Psychiatric News* that the findings support some research suggesting that anxiety in older adults could be a sign of dementia yet to come.

"Anxiety symptoms in older adults are associated with a faster memory decline, and among women anxiety is also associated with decline in non-memory functions," Köhler said. "High late-life anxiety symptoms might be an at-risk state for dementia. If causal, adequate treatment of anxiety symptoms might lower the risk for further cognitive deterioration."

Köhler and colleagues analyzed data on 918 participants who were 50 years of age or older in the Maastricht Aging Study, a longitudinal population-based study of factors associated with cognitive aging in the Netherlands.

They measured anxiety at baseline using the anxiety subscale of the Symptom Check List-90 (SCL-90). The participants were asked to answer 10 questions, rating the degree of a specific anxiety symptom on a five-point scale.

The total score was calculated by adding up the individual scores per question. For the purposes of the analysis, Köhler and colleagues tallied the results in two ways: as a continuous score of severity and as a dichotomous score (high anxiety/no high anxiety), with high anxiety defined as being the highest quartile on the severity scale.

The participants also underwent neuropsychological testing, which measured executive function, memory, speed of information processing, and verbal fluency. The neuropsychological tests were repeated every three years during a 12-year follow-up. (Köhler said anxiety symptoms were also measured throughout the 12-year follow-up, but for the purposes of this analysis, the researchers looked only at the relationship of baseline anxiety to cognitive decline.)

If late-life anxiety can be shown to be causal for dementia, treatment could lower the risk for cognitive decline, says Sebastian Köhler, Ph.D.

Overall, being in the highest quartile of anxiety symptoms ("high anxiety") did not predict a faster decline in executive functioning over time in men and women. However, among women, higher anxiety on the continuous measure of severity was associated with a worse cognitive trajectory. A similar sex-specific effect was found for processing speed and verbal fluency.

In contrast, faster decline in verbal memory was associated with "high anxiety" irrespective of sex but was more pronounced in those 65 years and older.

Köhler and colleagues speculate that the stronger association of anxiety with cognitive decline in women may indicate that women experience a more severe form of anxiety. That theory is borne out by the fact that women in the Maastricht Aging Study have a

continued on next page

we intervene in that socioeconomic context and enrich these adults' environments in a culturally sensitive way, we can overcome that adversity."

Translating these controlled study findings to a real-world setting is challenging, Rovner admitted. Study participants received continual behavioral reinforcement from trained community workers, and many older black adults do not have access to such personnel in their communities. But that's where family members can step in, he said. "That's the way we can scale this up to the community level."

Rovner said that the behavioral strategies employed do not even have to be very detailed if that proves difficult for family members. He noted that while behavioral activation is superior, the 9 percent decline in the supportive therapy group was encouraging. Epidemiological studies have suggested that up to 20 percent of black adults with MCI show significant cognitive decline over two years. That indicates that even a little bit of support and social interaction can benefit this population, he said.

This study was supported by a grant from the National Institute on Aging. **PN**

"Preventing Cognitive Decline in Black Individuals With Mild Cognitive Impairment: A Randomized Clinical Trial" is posted at https://jamanetwork.com/journals/jamaneurology/fullarticle/2698824.

continued from previous page

higher prevalence and higher severity of symptoms than men. "Previous research has also shown an increased risk for coronary heart disease in women with anxiety symptoms," Köhler and colleagues wrote. "Since the vascular disease burden could potentially mediate the association between anxiety and deterioration of executive function, this may explain these sex-specific findings as well."

Köhler and colleagues noted that it is unclear whether late-life anxiety might be a prodromal form of dementia or causally related to neurodegeneration. "A recent meta-analysis found suggestions for anxiety as a prodromal symptom of neurodegenerative diseases," they wrote. "Anxiety could then be a consequence of diminished cognitive capacities which are only experienced on a subjective level. . . . Further longitudinal research is needed to fully understand the relationship between anxiety and cognition including potentially mediating mechanisms." **PN**

"Anxiety as a Risk Factor for Cognitive Decline: A 12-Year Follow-Up Chort Study" is posted at https://www.ajgponline.org/article/S1064-7481(18)30483-4/fulltext.

Number of Americans in Treatment For OUD Grows, Survey Suggests

Even as the overall use of heroin and other opioids in the United States fell between 2016 and 2017, illicit drug use by adults aged 18 to 25 climbed, the 2017 National Survey on Drug Use and Health found. ***BY NICK ZAGORSKI***

Over the past few years, studies and media reports have painted a grim picture of the opioid epidemic in the United States. But the latest results of an annual survey by the Substance Abuse and Mental Health Services Administration (SAMHSA), released in September, show signs of progress in reducing opioid use.

The 2017 National Survey on Drug Use and Health (NSDUH) found that the number of people who started using heroin dropped by more than 50 percent between 2016 and 2017 (from about 170,000 to 81,000). In addition, people receiving specialty treatment for heroin use rose significantly between 2016 and 2017, from about 235,000 to 358,000. The survey defined specialty treatment as substance use treatment at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center.

The increase in people seeking help for heroin problems was part of a larger trend, as the number of people receiving specialty treatment for any opioid use disorder (OUD) rose sharply as well, from 453,000 (21.1 percent of all people with an OUD) in 2016 to 603,000 (28.6 percent) in 2017.

These positive developments are due in part to several initiatives implemented by SAMHSA over the past year in response to the 2016 NSDUH, according to Elinore McCance-Katz, M.D., Ph.D., assistant secretary for mental health and substance use in the Department of Health and Human Services. Among other items, the previous NSDUH reported rises in heroin use, use of fentanyl-laced compounds, and opioid overdose deaths.

Some of these new initiatives included establishing a state-targeted response program for the opioid crisis. Through this program, addiction professionals in each U.S. state and territory will receive SAMHSA support to help provide technical assistance and training to communities. SAMHSA has also changed its grant guidelines so that grantees can provide substance use services to incarcerated individuals prior to their release from prison.

The findings speak "to the emphasis that this administration has placed on addressing the opioid epidemic and to the focus that states and communities have had on making sure the needs of their people with opioid use disorder are being met," McCance-Katz said in a recorded presentation of the latest data.

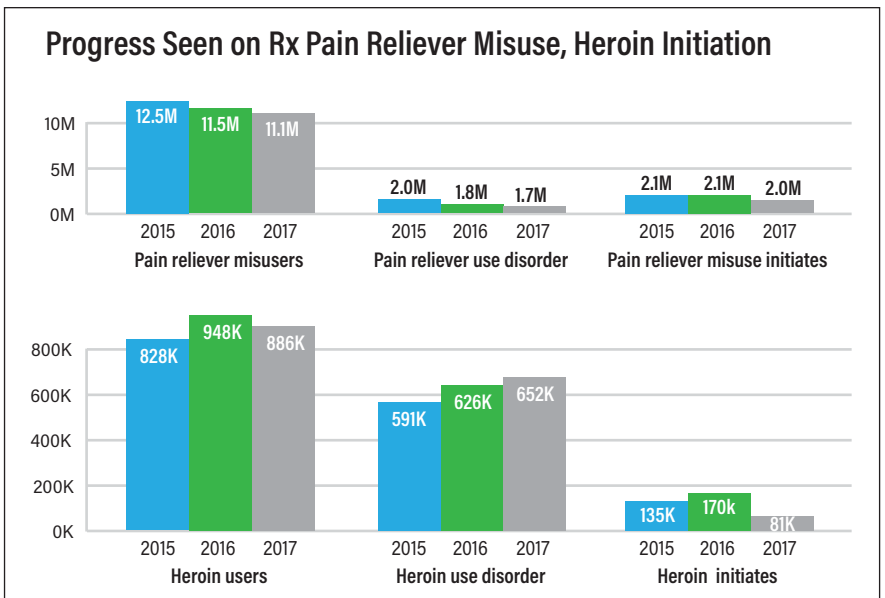
McCance-Katz cautioned that despite these positive signs, the burden of opioid use remains large. Deaths related to heroin use spiked in 2017: there were 15,549 heroin-related deaths reported in 2017, compared with 13,219 in 2016 and 13,101 in 2015. Additionally, McCance-Katz noted, heroin use represents only a small proportion of problem opioid use. The majority of the 11.4 million people in the United States with an OUD misuse prescription pain medication.

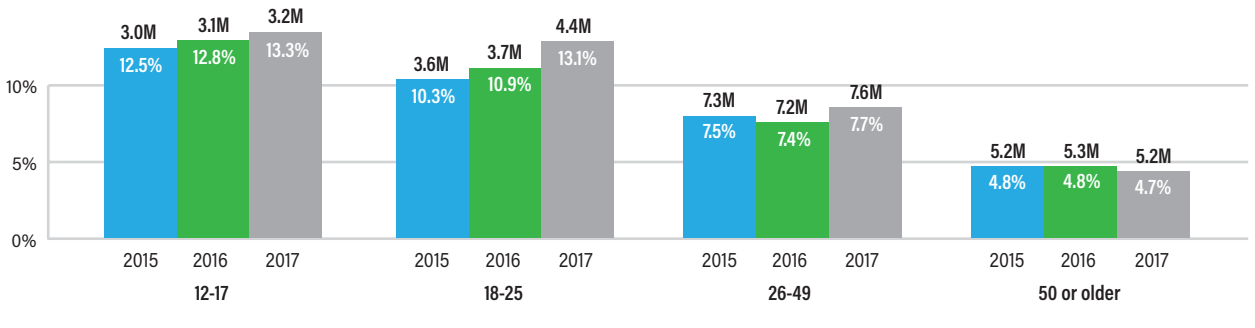
Substance Use Remains Source of Concern for Young Adults

The 2017 NSDUH also revealed an uptick in substance use by adults aged 18 to 25. Over the past two years, the rates of alcohol, cigarette, cocaine, methamphetamine, and LSD use have increased in this age bracket, whereas rates in younger (aged 12 to 17) and older (26 and up) individuals have remained relatively stable.

The number of adults aged 18 to 25 diagnosed with a major depressive episode (MDE) or serious mental illness also rose in 2017; 13.1 percent of adults aged 18 to 25 experienced an MDE in 2017 compared with 10.9 percent in 2016, while the prevalence of serious mental illness in this age

see **OUD** *on page 17*





First Trimester Exposure to Quetiapine Appears to Be Safe

The findings came from an ongoing study at Massachusetts General Hospital on the reproductive safety of second-generation antipsychotics. **BY MARK MORAN**

Use of the antipsychotic quetiapine during pregnancy does not appear to increase the risk of major malformations in offspring, according to a report published August 16 in *AJP in Advance*.

A comparison of offspring born to a small sample of women who were using the antipsychotic in the first trimester of pregnancy with those of women unexposed to quetiapine indicated no increased risk of major malformations.

"Given the considerable use of quetiapine among women of reproductive age across multiple indications, it is critical to have better information regarding the potential risks of fetal exposure to this medication so that women can make informed treatment decisions consistent with their personal wishes and the severity of their underlying psychiatric disorder," wrote Lee Cohen, M.D., of Harvard Medical School and colleagues. "The study results suggest that quetiapine is not a major teratogen."

Cohen is the director of the Center for Women's Mental Health at Massachusetts General Hospital and the Edmund and Carroll Carpenter Chair in Psychiatry in Women's Mental Health at Harvard Medical School.

The team analyzed data from the National Pregnancy Registry for Atypical Antipsychotics (NPRAA) to quantify the relative risk of major malformations associated with first-trimester exposure to quetiapine compared with women with psychiatric disorders not taking second-generation antipsychotics.

As part of participation in the registry, pregnant women aged 18 to 45 with a history of psychiatric illness were interviewed across pregnancy and the early postpartum period by telephone. Obstetric, labor, and delivery medical records and medical records from the first six months of life were screened for evidence of major malformations.

Of 152 women exposed to quetiapine during the first trimester, three gave birth to twins, resulting in 155 exposed live births. Among the 205 control women with available data, five sets of twins were born, resulting in 210 live births.

The primary outcome was the presence of a major malformation identified within six months of birth. A major malformation was defined as a structural abnormality with surgical, medical, or cosmetic importance.

Two major malformations were reported among infants with exposure to quetiapine: one infant with transposition of the great arteries and one infant with pulmonary stenosis due to dysplastic pulmonary valve. In the control group, three major malformations were reported: one infant with midshaft hypospadias requiring surgical repair, one infant with isolated cleft lip and palate, and one infant with a thickened pulmonary valve associated with mild pulmonary stenosis.

Lee Cohen, M.D., director of the MGH Center for Women's Mental Health, says that the study results confirm previous research showing no strong association between SGA exposure and major birth defects.

"The data from this analysis are consistent with the existing literature, which does not suggest a strong association between fetal exposure to second-generation antipsychotics and an increase in the rates of major malformations," Cohen and colleagues wrote.

The NPRAA at Massachusetts General Hospital was established in 2008 to increase the availability of systematically gathered reproductive safety data for second-generation antipsychotics. The primary aim of the NPRAA is to delineate the risk of major malformations following in utero exposure to second-generation antipsychotics compared with a control group of women with psychiatric disorders who did not use agents in this drug class during pregnancy.

Analysis of reproductive safety data is timely given recent changes in Food and Drug Administration (FDA) regulations governing product labeling incorporated as part of the Pregnancy and Lactation Labeling Rule. That rule, which went into effect in 2015, requires narrative explanations of pregnancy risks associated with a medication with supportive data. (The previous labeling involved a grading system that was regarded as simplistic and misleading.) The regulations apply to new medications as well as approved products as new information becomes available.

"These findings represent preliminary yet important data with profound clinical implications for pregnant women and women of reproductive potential," Cohen and colleagues wrote. "It is imperative that research efforts continue to focus on the reproductive safety of psychiatric medications that are commonly used by women during their childbearing years." **PN**

"Risk of Major Malformations in Infants Following First Trimester Exposure to Quetiapine" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.18010098.

Hospital Suicides

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height, jumping in front of a vehicle, laceration, other). Narrative descriptions from the NVDRS were reviewed and classified using the same categories, whenever the method was clearly indicated in the report.

Here are the report's main findings:

- From the states reporting to the NVDRS in 2014, there were 16 inpatient suicides, 11 of which were associated with psychiatric hospitalization. In 2015 there were 30 inpatient suicides reported, 23 of which were associated with psychiatric hospitalization.

- Extrapolating from the 18 states that reported to the NVDRS in 2014, representing 33 percent of all hospital admissions, the authors estimated that 48.5 inpatient suicides occurred in the United States. Based on the larger set of data available from 27 states in 2015, representing 46.2 percent of all hospital admissions, they estimated that 64.9 inpatient suicides occurred in the United States.

- A total of 174 inpatient suicides were reported to the SE Database from 2010 to 2016.

- Hanging was by far the most common method of inpatient suicide in the NVDRS and SE databases (71.7 percent and 70.3 percent, respectively).

"This study provides the first data-driven estimate of the number of inpatient suicides per year in hospitals in the United States," Williams and colleagues wrote. "The estimated range of 48.5 to 64.9 inpatient suicides per year is vastly lower than the most widely quoted figure of 1,500 per year, which appears to have been based on speculation. … This new, lower estimate of the rate of suicides in hospitals has important implications for the allocation of resources to address suicide prevention within health care and the broader population.

"Because the vast majority of suicides continue to be by hanging, with the most common ligature fixation points being a door, door handle, or door hinge, hospitals should conduct careful environmental assessments to ensure that door handles and door hinges are 'ligature resistant.' "

Last year administrators at many hospitals expressed concern about increased monitoring and enforcement of citations by the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission around elimination of ligature risks that were costing facilities exorbitant amounts of money. At the July meeting of the APA Board of Trustees, APA CEO and Medical Director Saul Levin, M.D., M.P.A., reported that APA had surveyed 88 facilities in 34 states and the District of Columbia between April and June. Of the 55 that responded, 10 had closed inpatient beds due to the assessment of fines for ligature risks, and 14 had closed psychiatric beds. Twenty-three facilities reported paying fines between $100 and $6 million.

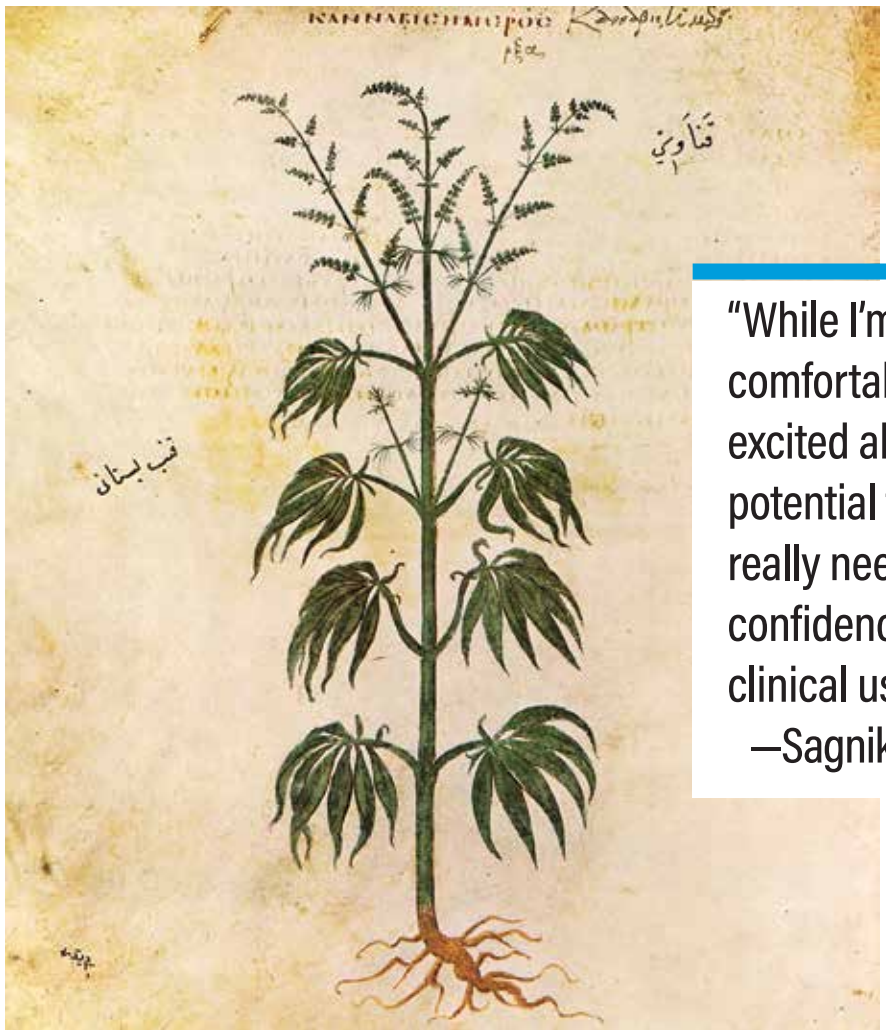
Levin said that APA is continuing to work with CMS and The Joint Commission on the issue. **PN**

"Incidence and Method of Suicide in Hospitals in the United States" is posted at https://www.jointcommissionjournal.com/article/S1553-7250(18)30253-8/fulltext.

Pilot Study Suggests Cannabis Compound May Improve Brain Function in Psychosis

The diverse effects of cannabidiol may stabilize the brain and, in some people, protect against psychosis.

BY RICHARD KAREL



A study from King's College in London has for the first time identified how cannabidiol (CBD), a compound in cannabis, alters brain function in ways that may correlate with improvement in psychotic symptoms. The research, by psychiatrist Sagnik Bhattacharyya, M.D., Ph.D., and colleagues, was published online in *JAMA Psychiatry* on August 29.

Prior research has suggested that CBD may help reset brain function in people with or at high risk of psychosis, but the specific mechanisms have remained speculative (*Psychiatric News*, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2017.pp9b1). Although the new study, which used brain imaging to observe brain activity, did not definitively link the observed changes to clinical improvement, they are consistent with known mechanisms of psychosis, according to Bhattacharyya.

"This is just a single dose," said Bhattacharyya. "So while the findings are promising because the effects are in key brain regions linked to psychosis, in the absence of clinical correlates—that is, correlation with effects on symptoms, we can't be sure," he added.

The study used 33 subjects clinically at risk for psychosis, divided into a group receiving a single 600 mg dose of CBD and a group receiving placebo. The brains of another 19 healthy subjects were imaged under otherwise identical conditions without either CBD or placebo to establish a comparative baseline. Imaging of the brains of the high-risk group receiving CBD showed a dramatic change toward healthy brain function—although CBD did not fully normalize brain function.

Bhattacharyya and colleagues have received a grant for a clinical trial involving 300 patients with multiple dosing over a sustained period of time. "Within that study, we will also look at the mechanism question again, and we will really have the numbers to systematically relate the brain effects to the effects on symptoms," Bhattacharyya said.

In contrast to current antipsychotic medications, CBD is well tolerated, said Bhattacharyya. The prospect of a relatively benign, effective antipsychotic medication is extremely encouraging, he said.

A cautionary note is that the dominant psychoactive compound in cannabis, tetrahydrocannabinol (THC), can worsen or even precipitate psychosis in at-risk individuals, Bhattacharyya commented. "While I'm very comfortable and very excited about the potential for CBD, we really need larger trials to have confidence as to its potential clinical use."

In the meantime, it is critical that the public understand that cannabis contains many active compounds and that recreational use of cannabis should not be equated with the eventual use of a clinically approved medication.

Donald Goff, M.D., is the vice chair for research in psychiatry at New York University and author of a review article on the risks and benefits of cannabinoids and schizophrenia. He is also the recipient of the APA Research Award and Kempf Award for Mentorship in Biological Psychiatry.

"Cannabidiol is a very promising drug from which we may learn a lot about better ways to treat psychosis, but this particular study is only one piece of a very complicated puzzle," Goff commented. "It is widely believed that it is reversing THC, which acts primarily through the CB1 receptor, but it is much more complicated than that. In fact, cannabidiol has minimal affinity for the CB1 receptor, so its mechanism is via other effects."

CBD elevates a molecule called anandamide, which some believe is the brain's endogenous antipsychotic, and as anandamide levels rise with CBD treatment, that tends to correlate with antipsychotic response, Goff noted. CBD, however, also acts on about 10 other receptors, all of which correlate to some extent with stress response and pathways linked to brain equilibrium. These diverse effects may stabilize the brain and, in some people, protect against psychosis, Goff said.

> "While I'm very comfortable and very excited about the potential for CBD, we really need larger trials to have confidence as to its potential clinical use."
>
> —Sagnik Bhattacharyya, M.D., Ph.D.

Britta Hahn, Ph.D., is a behavioral pharmacologist and an associate professor of psychiatry at the University of Maryland School of Medicine. Earlier this year she published an article on therapeutic potential of CBD for cannabis users with recent-onset psychosis.

Hahn echoed concerns about the public embracing the potential benefits of CBD while minimizing the risks of THC in people at risk for or diagnosed with psychosis. "THC will increase the risk of developing psychosis and also has a detrimental effect on prognosis," she commented. Hahn would like to see research that identifies the specific receptor populations affected by CBD and how they correlate with clinical efficacy.

This study was supported by grants from the Medical Research Council of the United Kingdom. Bhattacharyya's work was supported by the UK National Institute for Health Research Clinician Scientist Award when this work was carried out. **PN**

"Effect of Cannabidiol on Medial Temporal, Midbrain, and Striatal Dysfunction in People at Clinical High Risk of Psychosis: A Randomized Clinical Trial" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2697762. "The Potential of Cannabidiol Treatment for Cannabis Users With Recent-Onset Psychosis" is posted at https://academic.oup.com/schizophreniabulletin/article-abstract/44/1/46/4080751.

OUD

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group rose from 5.9 percent in 2016 to 7.5 percent in 2017. The number of youth receiving treatment for SMI also rose between 2016 and 2017, from 50.7 percent to 57.4 percent. "But, that still means 42.6 percent are getting no treatment, and that is unacceptable," said McCance-Katz. "We will continue to focus on this issue, particularly as it relates to young adults."

The NSDUH is an annual nationwide survey on the use of legal and illicit drugs and prevalence of mental disorders that has been conducted by the federal government since 1971. The NSDUH surveys approximately 67,500 civilian, noninstitutionalized Americans ages 12 and older every year through face-to-face interviews. The survey is designed to have the participants be representative of the whole nation as well as individual states and the District of Columbia. **PN**

The 2017 NSDUH report is posted at https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH.

Drops in Blood Pressure, BMI Common Prior to Dementia Diagnosis

A study that tracked seniors over 14 years is one of the first to explore how temporal changes in metabolic risk factors affect dementia risk. **BY NICK ZAGORSKI**

iStock/Sasha_Suzi

Metabolic problems are a known risk factor for dementia, but studies examining the association between metabolic status at certain ages and dementia risk have found varied results. High blood pressure and low blood pressure at certain ages have both been linked with dementia risk, as have obesity and being underweight.

In a study published in *JAMA Psychiatry*, researchers at the University of Bordeaux in France described how rather than examining the relationship between metabolic status at a specific age and dementia risk, they tracked the trajectories of these risk factors. They found evidence to suggest that exaggerated drops in body mass index (BMI) and blood pressure could signify oncoming dementia. They also reaffirmed that high blood glucose in older age is a significant dementia risk factor.

The findings were based on analysis of health data from nearly 4,000 individuals who were part of the Three-City (3C) study. The study followed adults aged 65 and older in three French cities (Bordeaux, Dijon, and Montpelier) for 14 years to ascertain connections between heart disease and dementia.

The research team identified 841 people in the 3C cohort who developed dementia at some point during the study (the average length of time to diagnosis was about eight years). The researchers then tried to match each person with dementia with four control individuals with similar demographics at the time of diagnosis; they successfully matched 785 dementia cases with 3,140 controls for the final analysis.

The researchers then plotted out all prior assessments of BMI; systolic and diastolic blood pressure; and high-density and low-density lipoprotein cholesterol (HDL-C and LDL-C), triglyceride, and blood glucose levels for these 3,925 people.

The metabolic trajectories revealed that people who developed dementia showed much steeper declines in BMI in the years preceding their diagnosis, with the most rapid weight loss starting at about seven years before diagnosis. Over the 14-year period, the average BMI of dementia patients dropped from 26.1 to 24.8, whereas BMI in controls only dropped from 25.7 to 25.3.

People who developed dementia also experienced a greater drop in blood pressure over time compared with controls. Although both groups of patients experienced rising blood glucose level with age, those with dementia had consistently higher glucose levels over the 14-year period.

Lead study author Maude Wagner, M.P.H., of the University of Bordeaux said that the changes seen in dementia patients likely represent reverse causation—that is, subtle cognitive decline may be accelerating normal metabolic changes. In the case of BMI, early dementia may cause someone to eat less, which would increase age-related weight loss. Likewise, some research has suggested that early-stage dementia disrupts brain processes involved in blood pressure regulation.

Because low blood pressure reduces the delivery of oxygen to the brain, Wagner and colleagues noted that it is also possible that lower blood pressure contributes to dementia.

"This study reinforces that the relationship between metabolism and dementia is complex and highly dependent on timing," Gary Small, M.D., director of geriatric psychiatry at the David Geffen School of Medicine at the University of California, Los Angeles, told *Psychiatric News*. Even so, he cautioned that it's too soon for clinicians to make predictions using these measures.

"We need more longitudinal studies to try to tease out this gray area of what changes are cause versus effect," he said.

The 3C is conducted under a partnership agreement between the Institut National de la Santé et de la Recherche Médicale (INSERM), the University of Bordeaux, and Sanofi. **PN**

"Evaluation of the Concurrent Trajectories of Cardiometabolic Risk Factors in the 14 Years Before Dementia" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2694709.

Escitalopram May Reduce Risk of Heart Problems

In addition to improved depression symptoms, patients who took 24 weeks of escitalopram after a heart attack or unstable angina had a reduced risk of additional heart attacks during an eight-year follow-up. **BY NICK ZAGORSKI**

iStock/Eraxion

Many people develop depression in the aftermath of a heart attack or unstable angina. Although studies have shown that depression can lead to poorer outcomes in patients following such acute coronary syndrome (ACS) events, few studies have examined the long-term effects of antidepressants on this patient population.

A study published in the July 24/31 issue of *JAMA* provided some of the first experimental evidence that treating patients with depression following an ACS event with escitalopram can reduce the risk of heart problems.

Jae-Min Kim, M.D., Ph.D., of Chonnam National University Medical School in the Republic of Korea and colleagues tracked the long-term outcomes of 300 patients who had received 24 weeks of escitalopram (flexibly dosed at 5 mg to 20 mg/day) or placebo following an ACS event.

As the researchers initially reported in the *Journal of Clinical Psychiatry* in 2015, patients who took escitalopram had lower depressive symptoms than those who took placebo at 24 weeks. For this new study, they continued to monitor the cardiovascular health of these patients for an additional eight years on average.

At the end of the follow-up period, 61 patients (40.9 percent) in the escitalopram group and 81 patients (53.6 percent) in the placebo group experienced a major cardiac event. Major events were defined as cardiac-related death; death from any cause; heart attack; or having a percutaneous coronary intervention (PCI), a medical procedure to open narrow arteries.

When looking at individual cardiac events, the researchers found a significant reduction in the occurrence of heart attacks: 8.7 percent of patients in the escitalopram group had a heart attack compared with 15.2 percent in the placebo group, a greater than 40 percent reduction. There were no statistical differences in mortality or rates of PCI between the groups.

Two previous randomized clinical studies had failed to find any long-term cardiovascular benefits to post-ACS antidepressant therapy. The researchers noted, however, that one of these studies followed patients for only about 18 months, which may be too short a time. The other study followed patients for nearly seven years but only measured differences in mortality in patients who received antidepressants with those who did not. As was seen in this study, mortality was not found to be different between the two groups.

"This is the strongest evidence so far that antidepressants might improve cardiovascular prognosis in addition to depressive symptoms," said Peter Shapiro, M.D., a professor of psychiatry and director of the Consultation-Liaison Psychiatry Service at Columbia University Medical Center.

Shapiro told *Psychiatric News* that it is premature to interpret these findings to mean that selective serotonin reuptake inhibitors such as escitalopram should be the preferred option for ACS patients who have depression.

For one, the study did not compare patient outcomes after receiving escitalopram therapy with other treatment options like a stepped care approach

see **Escitalopram** *on page 24*

Adolescents With Depression Less Likely To Post Symptoms on Social Media As They Age

Youth need to be told that they should talk to a responsible adult when feeling troubled.

BY CAROL SORGEN

iStock/Mixmike

Adolescents with a diagnosis of depression may feel less stigmatized when describing their depressed mood on social media than previously believed, according to a study presented at the Pediatric Academic Societies 2018 Meeting in Toronto. The study further found, however, that at-risk adolescents are less likely to post about depressive symptoms on social media as they age.

The purpose of the longitudinal study was to analyze the patterns of social media posting describing depressive symptoms among an at-risk group of adolescents at two different points in their lives—at age 13 and then again between the ages of 18 and 20. "This research doesn't speak to the effect of social media on teens," lead author and pediatrician Kathleen Miller, M.D., told *Psychiatric News*. "Rather, we focused on looking at how teens use social media to express their symptoms."

The study measured Facebook posts made by approximately 80 participants, both as adolescents and as young adults. In analyzing the content, Miller and her colleagues applied the *DSM* criteria for depression to identify displayed depression symptoms on Facebook.

The authors found that the average number of references to depression among those who posted was 9.30 as adolescents and 4.94 as young adults, showing a dramatic decrease in posts between the time frames. The average number of references to suicide or self-harm was 0.34 as adolescents and 0.08 as young adults.

Miller, who is a fellow in adolescent medicine at the University of Minnesota, said that the reduced expressions about depressive symptoms may be related to the development of the prefrontal cortex and the role it plays in inhibiting impulsive decisions.

Posts that referred to depression included such statements as "Basically at the point of giving up" and "Feeling the worst right now, just wanting to cry."

Before analyzing the data, the researchers thought they would find that youth were posting about vague symptoms such as fatigue and difficulty sleeping, and not symptoms that could be considered stigmatizing, such as mentioning depression outright, Miller said.

"I was surprised to find that the teens—especially in the younger age group—used phrases like 'I'm depressed" much more often than I would have thought," she said. "In a way, that could be interpreted as positive, because this younger generation might not feel that depression is as

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JOURNAL DIGEST

BY NICK ZAGORSKI

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Patients May Benefit From Humor During Psychotherapy Sessions

The use of humor in psychotherapy sessions may be associated with positive outcomes in individual patients, according to a study in the *American Journal of Psychotherapy*.

The study, conducted by researchers in Belgium, focused on 110 adults who had attended at least 10 psychotherapy sessions. These adults were all treated by the same therapist and were participating in therapy for a range of disorders, including depression, panic disorder, and substance use disorder. The participants and therapist reported on the frequency and intensity of humorous events at their sessions, as well as perceived therapy effectiveness, therapeutic alliance, hope, and pleasure in participating in therapy sessions.

The researchers found a strong positive correlation between humor and all four of these domains of satisfaction, from both the patient and therapist perspectives. The association between humor and therapy effectiveness held true even for clients with more severe illness, although these clients reported less overall humor in their therapy sessions.

Greater use of humor was also associated with mood improvements in the patients, as measured by changes in Clinical Global Impressions scores over the 10 sessions.

"This study was limited by its global assessment of humor, without regard for the specificity of humorous interventions," the authors noted. "Clinical interventions, whether humorous or not, need to be specific for the actual situation, perspective, therapeutic alliance, and process of each client."

Panichelli C, Albert A, Donneau AF, et al. Humor Associated With Positive Outcomes in Individual Psychotherapy. *Am J Psychother*. September 12, 2018. [Epub ahead of print] https://psychotherapy.psychiatryonline.org/doi/10.1176/appi.psychotherapy.20180021#

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Urine Test Developed For Depression, Anxiety Found Fairly Accurate

A research team at Chongqing Medical University has developed a urine-based test that can identify patients with comorbid depression and anxiety with over 90 percent accuracy, according to a study published in *Translational Psychiatry*.

The team collected urine samples from 48 patients with major depression and an anxiety disorder (39 with general anxiety disorder and nine with panic disorder) as well as 48 matched controls without depression or anxiety. A range of metabolomic assays were performed on 32 patients and 32 controls, which identified 20 urinary biomarkers that were differentially expressed in patients with depression and anxiety. Of these, a panel of four biomarkers was most strongly associated with depression and anxiety: aminomalonic acid, azelaic acid, hippuric acid, and N-methylnicotinamide.

The researchers then evaluated these four biomarkers in the remaining 16 patients and 16 controls. The panel was able to discriminate between the two groups with about 93.4 percent accuracy overall; the sensitivity was 100 percent (no false negatives), while the specificity, or ability to eliminate false positives, was 81.2 percent. The authors found no significant differences in the metabolite readings when comparing patients taking antidepressants with those who were not taking antidepressants. This suggests that antidepressant use does not interfere with the urinary biomarkers.

Chen JJ, Bai SJ, Li WW, et al. Urinary Biomarker Panel for Diagnosing Patients With Depression and Anxiety Disorders. *Transl Psychiatry*. 2018; 8(1):192. https://www.nature.com/articles/s41398-018-0245-0

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Escitalopram May Help Lessen Mood Symptoms In Women Undergoing IVF

Studies have found that women undergoing in vitro fertilization (IVF) have elevated risks of mood and anxiety problems. A clinical study published in *Archives of Women's Mental Health* suggests that giving escitalopram to women undergoing IVF can prevent the worsening of mood and anxiety symptoms during IVF treatment.

Researchers at Tel Aviv University in Israel randomized 41 women who were diagnosed with an adjustment disorder and about to start IVF to receive either 10 mg/day escitalopram (n=22) or a placebo pill (n = 19) for eight weeks. The medication treatment began six weeks prior to the embryo transfer.

At the start of the study, both groups had similar depressive and anxiety symptom scores, as measured by the Center for Epidemiologic Studies Depression scale (CES-D) and Zung Self-Rating Anxiety scale. On the day of embryo transfer, though, average CES-D and Zung scores for the escitalopram group were 6.40 and 27.47, respectively, compared with 15.83 and 33.17, respectively, for the placebo group.

"Short-term treatment with an SSRI may serve as a prophylactic treatment against the perpetuation and possible worsening of depressive and anxiety symptoms in women undergoing IVF treatments," the authors wrote. "Further studies concerning pharmacological interventions in larger samples and studies addressing screening for psychological stress indicators in this population are warranted."

Aisenberg Romano G, Fried Zaig I, Halevy A, et al. Prophylactic SSRI Treatment for Women Suffering From Mood and Anxiety Symptoms Undergoing in Vitro Fertilization—A Prospective, Placebo-Controlled Study. *Arch Womens Ment Health*. September 17, 2018. [Epub ahead of print] https://www.ncbi.nlm.nih.gov/pubmed/30225529

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Age, Sex May Impact Use Of Alternative Therapies For Chronic Pain

As part of an effort to reduce dependence on opioid painkillers, the Veterans Health Administration (VHA) began offering evidence-based complementary and integrative health (CIH) therapies such as yoga to treat chronic pain. An analysis of CIH use among veterans by race, age, and sex suggests some patients may be more likely to use CIH than others.

Researchers at the University of Massachusetts Amherst and colleagues examined electronic health record data from about 470,000 military personnel aged 18 to 54 with chronic musculo-

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stigmatizing as older generations do."

Since the group of youth studied had already been identified as suffering from oppositional defiant disorder and/or depression, Miller doesn't think the absence of posts about depression says much about whether depressive symptoms eased up as the youth got older.

"Most of the kids in this study were suffering from mental health concerns," said Miller. "The fact that many of them didn't post depressive symptoms at all shows that not everyone suffering will post on social media. So kids can definitely have social media accounts that look bright and cheerful while they're struggling—just like adults."

According to Miller, the take-away message from the study is not necessarily that teens are less depressed as they get older, but rather that they're not sharing it with their entire social media audience.

"In some ways," Miller said, "this might be a good thing, because it's showing that they're a little more selective about who they share personal information with, especially since some of their Facebook settings were set to public. On the other hand, we still want to encourage kids to reach out, and we certainly don't want to further stigmatize mental health or depression.

"The message I would like to send to teens," Miller continued, "is that they should make sure to reach out—in person—and talk to a responsible adult about their symptoms if they're struggling. This study provides some insight on how teens use social media to communicate their symptoms, but social media doesn't replace concerned adults who can help and support in real time."

The study was funded from multiple sources, including the National Institutes of Health. **PN**

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ters for Medicare and Medicaid Services (CMS), with strong backing from APA, in 2016 and were adopted for patients in the Medicare program in 2017.

Anna Ratzliff, M.D., associate director for education at the University of Washington's AIMS (Advancing Integrated Mental Health Solutions) Center, told *Psychiatric News* that the movement by states to adopt collaborative care for their Medicaid populations will extend mental health care and psychiatric expertise to many who are not currently receiving it.

"The reimbursement codes offer payment for some core pieces of collaborative care that are not currently covered in traditional fee-for-service models—especially the work of psychiatric consultants," she said. "The model allows psychiatrists to partner with primary care and spend a small amount of their time to have a large population impact."

The state of Washington was the first to adopt the codes for use in the Medicaid program. Several other states are considering adoption of the codes.

"It's an exciting opportunity, but it does require some time for primary care practices to build the systems necessary for delivering the core components of the collaborative care model that allow them to bill for these services," Ratzliff said.

The North Carolina Medicaid program, which serves some 2 million people, began using three collaborative care codes on October 1. It is the result of vigorous advocacy by the North Carolina Psychiatric Association (NCPA) and APA. Also vital was the CoCM training that APA provided as a Support and Alignment Network in CMS's Transforming Clinical Practice Initiative.

To date, APA has trained more than 150 physicians in North Carolina (127 psychiatrists and 29 primary care physicians) in collaborative care. APA is partnering with a number of North Carolina–based provider groups to continue to provide trainings and resources, such as Community Care of North Carolina, the North Carolina Academy of Family Physicians, and the North Carolina Pediatric Society.

"The Medicaid coverage of the collaborative care model in North Carolina will greatly expand access to mental health and substance use disorder treatment in the state," said APA CEO and Medical Director Saul Levin, M.D., M.P.A. "The collaborative care model has been proven to effectively provide mental health services to primary care patients. We encourage other states to

follow North Carolina's lead in adopting Medicaid codes for this method of health care delivery."

NCPA President-elect Jennie Byrne, M.D., called the state's adoption of the CoCM codes an important development for patients in North Carolina. "The collaborative care model is our best, evidence-based model for psychiatrists to deliver population-based mental health services. It has a demonstrated return on investment and is an opportunity to provide value when psychiatrists are in scarcity. The model allows psychiatrists to be 'workforce multipliers,' teaching our primary care colleagues and serving a larger population than we can see one on one."

Byrne and NCPA Executive Director Robin Huffman emphasized that psychiatrists in the state do not have to be Medicaid provider participants to contract with a primary care center as a psychiatric consultant. The codes are submitted by the primary care practice, which receives a monthly lump-sum payment per patient. Psychiatric consultants are paid by the primary care center on a contractual basis.

"Our Medicaid system has been under reform for years," Byrne told *Psychiatric News*. "Behavioral health has been carved out with a totally separate utilization review method that has caused a lot of psychiatrists to drop out. But we have psychiatrists in solo private practice who are interested in this model because it allows them to do more than one thing and engage a population of patients they would not otherwise be able to treat."

Ratzliff said that the rules for submitting the codes and receiving payment under the Medicaid program differ from state to state. In Washington state, for instance, primary care practices must submit an "attestation form" stating that they will provide the core components of collaborative care—use of a care manager and psychiatric consultant, a registry to track patients over time, and "treatment-to-target." (The latter refers to using validated instruments, such as the PHQ-9, to track patient progress in reaching designated target scores for recovery.)

Ratzliff said the movement toward adoption of the reimbursement codes by state Medicaid programs means that more and more pediatric practices—which have a high proportion of Medicaid patients—will begin to develop the components of collaborative care.

She urged psychiatrists in states that have not yet adopted collaborative care reimbursement codes for their Medicaid programs to convince their legislators to do so. Guidance on how to do so can be found on the APA webpage titled "Making the Case: Medicaid Payment for the Collaborative Care Model" at http://apapsy.ch/MakingTheCase.

"There is an important role for psychiatrists in advocating for collaborative care," Ratzliff said. "Psychiatrists made a significant contribution to North Carolina Medicaid's adopting the codes for collaborative care. That's a really powerful message of the kind of impact psychiatrists can have." **PN**

Information about APA's CoCM training is posted at https://www.psychiatry.org/TCPI.

From the President

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the AAMC's Group on Diversity and Inclusion (GDI) and Group of Women in Medicine and Science (GWIMS).

Finally, departments of psychiatry should create an internal diversity advisory committee, chaired by a senior faculty member who has received training or with experience in the area of diversity and inclusion and reports directly to the department chair. That individual must be charged with developing and implementing policies and procedures of recruitment and retention for a diverse and inclusive workforce of trainees, faculty, and staff. This advisory committee should work closely with other GME programs and faculty search committees to establish guidelines to ensure diverse and inclusive recruitment on residency and fellowship selection committees and faculty search committees, including internal support systems to assure they are successful in their work. The identification and development of needed supports (including the appropriate mechanisms for expressing and addressing concerns, complaints, and challenges) is critical to the recruitment and retention of a diverse and inclusive workforce in psychiatry and the rest of medicine. By adopting these practices, we assure that the field moves closer to the goal of recruitment and retention of a diverse and inclusive workforce of residents, fellows, faculty members, key administrative staff, and other relevant members of the medical academic community.

Let me hear from you on how the APA can help! **PN**

Thanks to Drs. Francis Lu and Mary Kay Smith for their suggestions and assistance in writing this column.

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skeletal pain who received VHA-provided care between 2010 and 2013.

Overall, more women (36 percent) than men (26 percent) with pain used CIH therapies, though there was a wide range of prevalence depending on race/ethnicity and age. Among women, younger white and Hispanic/Latino veterans (age 18 to 44) were similarly likely to use CIH therapies. Black women were found to be least likely to use CIH therapies regardless of age. Among men, white and black veterans were less likely to use CIH therapies than Hispanic/Latino men. Among younger men (aged 18 to 44), black veterans were least likely to use CIH therapies.

"These differences in CIH therapy use are important because they might be partially contributing to existing disparities in pain and opioid use," wrote the authors in the article, published in *Women's Health Issues*. "Our findings suggest that VA clinicians might want to tailor their CIH engagement efforts to be sensitive to gender, race/ethnicity, and age."

Evans EA, Herman PM, Washington DL, et al. Gender Differences in Use of Complementary and Integrative Health by U.S. Military Veterans With Chronic Musculoskeletal Pain. *Women's Health Issues*. 2018; 28(5):379-386. https://www.whijournal.com/article/S1049-3867(18)30187-7/fulltext#sec5

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Brief Mild Exercise Boosts Memory

Participating in a few minutes of light intensity exercise may lead to memory improvements, suggests a study published in *PNAS*.

The study, by researchers at the University of Tsukuba in Japan, involved 36 healthy young adults (aged 18 to 23). Participants were asked to perform a memory task while at rest and again 45 minutes after a 10-minute session of light exercise on a recumbent bicycle. The task involved discriminating images they had seen during a memorization session from new but sometimes similar-looking images.

On average, the participants performed better on the memory discrimination task following exercise, especially for images that were highly similar to previously viewed ones.

The researchers also analyzed MRI scans of the brains of 16 participants following rest and exercise sessions. Participants showed increased neural connections between the dentate gyrus (a portion of the hippocampus involved in memory processing) and parts of the frontal cortex following exercise compared with resting levels. The authors found that the magnitude of the increased connectivity between these regions predicted the extent of memory improvement in the study participants.

"Taken together, we suggest that these brain regions play a role in representing high-precision memories, and enhanced communication with the [dentate gyrus] may contribute to improved memory discrimination," the authors wrote. **PN**

Suwabe K, Byun K, Hyodo K, et al. Rapid Stimulation of Human Dentate Gyrus Function With Acute Mild Exercise. *Proc Natl Acad Sci USA*. September 24, 2018. [Epub ahead of print] http://www.pnas.org/content/early/2018/09/19/1805668115

Escitalopram

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that starts the patient with brief psychotherapy and careful monitoring.

Second, while Shapiro noted this study provided the strongest data to date, it still had limitations. The study size of 300 was a bit small, and since all the participants were Korean, the findings may not be applicable to other populations. Shapiro also said the screening procedure was unusual; this study recruited patients who were hospitalized up to two weeks following an ACS. He noted that it would be rare to have someone in the United States be an inpatient that long after a heart attack.

This study was funded by the National Research Foundation of Korea. H. Lundbeck A/S provided the escitalopram for the study. **PN**

"Effect of Escitalopram vs. Placebo Treatment for Depression on Long-Term Cardiac Outcomes in Patients With Acute Coronary Syndrome" is posted at https://jamanetwork.com/journals/jama/fullarticle/2688569. "Escitalopram Treatment for Depressive Disorder Following Acute Coronary Syndrome: A 24-Week, Double-Blind, Placebo-Controlled Trial" is posted at http://www.psychiatrist.com/jcp/article/pages/2015/v76n01/v76n0110.aspx.