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AMERICAN PSYCHIATRIC ASSOCIATION

PSYCHIATRIC NEWS

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AP Photo/Matt Rourke

SEE STORY ON PAGE 13

A person pauses in front of Stars of David with the names of those killed in the shooting at the Tree of Life Synagogue in Pittsburgh in October. Area psychiatrists counseled survivors and are assisting in the community's long-term recovery.

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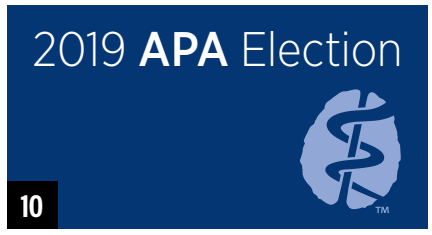
FDA's plans to curb vaping among youth may not go far enough.



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Learn about the 15 candidates in APA's 2019 election. Your vote matters!

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An exhibit memorializes the many victims of opioid overdose.

2019 Medicare Fee Schedule Drops Proposal to Collapse E/M Payments

In addition, CMS has made several changes to documentation requirements for which APA had advocated to reduce the administrative burden on physicians. ***BY MARK MORAN***

For 2019, the Centers for Medicare and Medicaid Services (CMS) has reduced administrative burdens associated with documentation while preserving separate payments for each of the individual levels of evaluation and management (E/M) services used to describe care for new and established patients in office or other outpatient settings.

Those decisions are reflected in the final rule on the 2019 Medicare Physician Fee Schedule, which CMS released in early November. In August, CMS had proposed a single "flat payment rate" for level 2 through level 5 E/M services provided in outpatient settings, which would have resulted in physicians being paid a single rate for those services regardless of the complexity of care patients require.

CMS delayed the implementation of the simplified payment structure until 2021 and modified its original proposal. In 2021, CMS plans to collapse the payment for levels 2 through 4 for outpatient visits but will retain a separate payment amount for level 5 services. CMS has also proposed for 2021 an add-on code for complex, specialty E/M visits that can be billed by psychiatrists and others.

APA expects that this special add-on code could bring the payment amount closer to what psychiatrists now receive for code 99214. That code, which is the current level 4 E/M code, is indicated for an "office or other outpatient visit for the evaluation and management of

see **Medicare** *on page 21*

PERIODICALS: TIME SENSITIVE MATERIALS

FDA Approves Powerful Opioid Amid Controversy

Critics warn of diversion and potential for lethal accidental overdose. ***BY TERRI D'ARRIGO***

On November 2, the Food and Drug Administration (FDA) approved Dsuvia (sufentanil sublingual tablet, 30 mcg) for managing acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. The decision came amid controversy over the risks of potential diversion and accidental exposure. Sufentanil is 10 times more potent than fentanyl and 1,000 times more potent than morphine.

Tensions flared over the drug on October 12, when the FDA's Anesthetic and Analgesic Drug Products Advisory Committee voted 10-3 to recommend approval. Six days later, the commit-

see **Dsuvia** *on page 23*

PSYCHIATRIC NEWS

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AMERICAN PSYCHIATRIC ASSOCIATION

FROM THE PRESIDENT

Why You Should Vote in APA's 2019 Election

BY ALTHA STEWART, M.D.

It's that time again: the APA election season is under way. The longstanding tradition of getting ready for the holidays and the coming new year also means that the candidates for the next group of APA's elected leaders have begun campaigning hard for our vote. And despite that inevitable activity, here comes the now perennial question: why do so few APA members vote each year?

In preparing this column, I took a moment to review columns on APA's election by several of my predecessors that appeared around this same time in their presidency. Each used a different approach to discuss the election, but the conclusion always seemed to be the same—APA members care about the organization, the profession and the issues we face, and those we serve. Nonetheless, it's been over three decades since at least half the members voted in an election, and we have been trying to figure out why this is so. This is a particularly poignant concern this year because of the recent national midterm elections. At a time when our country is severely polarized and approaching problem solving from a partisan perspective, we saw an increase in the number of citizens exercising their right to vote for those to represent and lead them for the next few years. With regard to APA elections, clearly there must be a "tipping point" where members decide they can no longer sit on the sidelines and want to use their voice to accomplish the changes they wish to see. Maybe this will be the year.

Voting in APA elections is now easier than ever—click on a link in an email that APA will send to you in early January, vote for the candidates of your choice, and you're done. To ensure you'll get the email, make sure your contact information is up to date in your APA member profile. And if you don't have an email address on file with APA, make sure your mailing address is correct so you'll get a paper ballot (see instructions on how to access your profile at the end of this article).

This issue of *Psychiatric News* provides information about APA's 2019 election, including the candidates' names, photos, member class, and website addresses (see pages 10 and 11). Want to learn more about a candidate and his or her views on issues of importance to psychiatry? Visit that candidate's website and read the candidate's biographical and candidacy statements on APA's election website. You can also watch video interviews of the candidates for president-elect and secretary. Take the time to learn about the candidates' priorities and ask them about issues that are important to you. Moreover, most of the allied psychiatric associations invite candidates to write statements about issues of importance to their members or subspecialty concerns and publish them widely. And while we no longer have the candidate debates of years ago, many district branches and state associations invite candidates to speak at their meetings during the campaign season, and that's also a good way to hear directly from each one.

The times in which we live and work demand that we become more involved in the process of selecting our future leaders. These are the folks that will help us shape and implement the

see **From the President** *on page 15*

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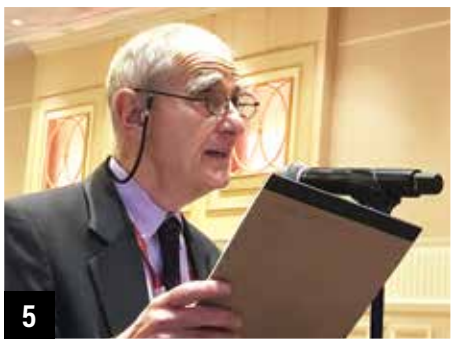
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DEPARTMENTS

Register Now!

Registration is now open for APA's 2019 Annual Meeting in San Francisco, which will be held **May 18** to **22**. A gala to celebrate a major milestone in APA's history—its 175th anniversary—will be held in San Francisco City Hall. For meeting and gala details, see the ad on page 14.

AMA Acts on Treatment of Children at Border, Gun Violence, Pediatric Decision Making

The AMA took action on a wide range of issues at its Interim Meeting last month. **BY MARK MORAN**

At last month's Interim Meeting of the AMA House of Delegates at National Harbor in Washington, D.C., delegates overwhelmingly approved a resolution objecting to policies that separate children and guardian parents seeking entry to the United States at the border.

Delegates also approved a resolution stating that the AMA will support the practice of administering psychotropic drugs to immigrant children only "when there has been evaluation by appropriate medical personnel and with parental or guardian consent or court order, except in the case of imminent danger to self or others." The House also passed a resolution urging continuity of care for all migrant children released from detention facilities.

(A further resolution objecting to policies prohibiting unaccompanied, undocumented minors access to the United States was referred to the AMA Board of Trustees for a decision.)

Debate at the House on the policies related to immigration took place in the context of reports that migrant children are being given psychotropic medication after being separated from parents and the Trump administration's efforts to modify the *Flores* settlement. *Flores* is the 1997 legal settlement of lawsuits filed against what was then known as the Immigration and Naturalization Service (INS) for alleged maltreatment of migrant children. The settlement requires the government to release children from immigration detention without unnecessary delay to their parents, other adult relatives, or licensed programs. It also requires immigration officials to provide detained minors a certain quality of life, including food, drinking water, and medical assistance in emergencies.

Mark Moran

David Fassler, M.D., tells delegates that AACAP opposes the excessive or indiscriminate administration of psychotropic medication to children in the absence of comprehensive evaluations, accurate diagnoses, individualized treatment plans, and appropriate informed consent.

(Last month APA submitted public comments to the administration regarding its proposed rule change to the Flores settlement. "The proposed rule seeks to amend the [settlement] to allow the Department of Homeland Security to keep 'families who must or should be detained together at appropriately licensed family residential centers for the time needed to complete immigration proceedings,'" APA wrote. "This vague guidance about how long families may be detained is concerning and has the potential to impose long-lasting trauma on detained children and their parents.")

Speaking for the Academy of Child and Adolescent Psychiatry, David Fassler, M.D., a delegate from the academy and a member of the AMA Section Council on Psychiatry, told the House that the academy opposes all policies that attempt to deter immigration by separating children from their parents.

"Separation places already vulnerable children at increased risk for traumatic stress reactions, psychiatric disorders, and other adverse medical outcomes," Fassler said. "We also oppose the excessive or indiscriminate administration of psychotropic medication to these kids, in the absence of comprehensive evaluations, accurate diagnoses, individualized treatment plans, and appropriate informed consent. Children who've been separated from their parents as a result of our immigration policies are frightened and alone. Many have prior histories of trauma and abuse. As physicians, we have an obligation to speak out and advocate on their behalf."

He added, "We also support the language and protections of the existing *Flores* agreement."

Gun Violence

The plight of migrant children at the border was only one of the high-profile issues addressed by the House. Just weeks following the shooting at a Pittsburgh synagogue where 11 people were killed (see page 13), the House also approved a report to the Board of Trustees calling for a variety of measures to prevent or reduce gun violence. The House also debated, but did not approve, a report from the Council on Ethical and Judicial Affairs on the contentious topic of physician-assisted suicide (see facing page).

"The House passed excellent policy that will help protect our patients and our practices on a variety of topics at this meeting," said Jerry Halverson, M.D., chair of the AMA Section Council on Psychiatry. "Gun control, opioids, and suicide continue to be hot topics on the minds of physicians of all specialties, and strong AMA policy, influenced by psychiatrists, on these topics will help to change laws."

The gun violence report from the AMA's Board of Trustees, approved by the House, advocates and supports, among other actions, the following:

- A waiting period and background check for all firearm purchasers; legislation that enforces a waiting period and background check for all firearm purchasers; and legislation to prohibit the manufacture, sale, or import of lethal and nonlethal guns made of plastic, ceramics, or other nonmetallic materials that cannot be detected by airport- and weapon-detection devices.

- Requiring the owners and purchasers of firearms to obtain a license or permit, complete a safety course, and register all firearms.

- Gun violence restraining orders for individuals arrested or convicted of domestic violence or stalking, and extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence.

- Increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging physicians to inquire about the presence of household firearms as a part of childproofing the home and encouraging state medical societies to work with other organizations to increase public education about firearm safety.

see **AMA Acts** *on page 25*

AMA Debates Council Report on Physician-Assisted Suicide

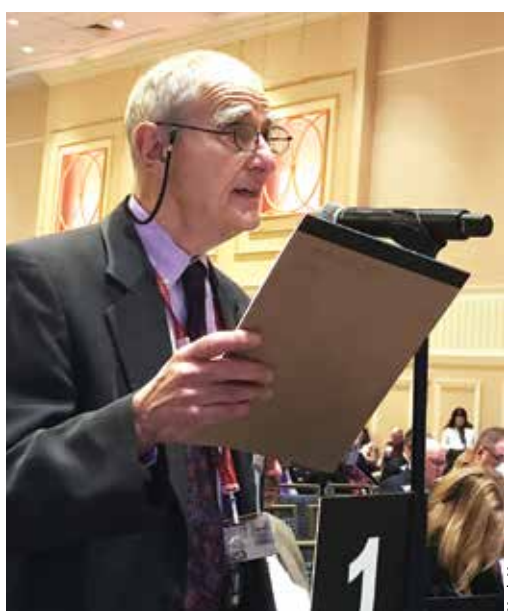
The report, which was referred back for further work, asserted that the Code of Medical Ethics provides ethical guidance to physicians who both oppose and support physician-assisted suicide. ***BY MARK MORAN***

A report by AMA's Council on Ethical and Judicial Affairs (CEJA) on physician-assisted suicide (PAS), or medical aid in dying, was not approved by the House of Delegates at its Interim Meeting last month and was referred back to CEJA by a narrow margin for further work.

The report asserted that the AMA's existing code of medical ethics should not be amended and that it provides ethical guidance and support to those who oppose PAS as well as to those who support the practice in states where it is legal.

Psychiatrist Jim Sabin, M.D., who is chair of the council, testified during hearings on the report that AMA's Principles of Medical Ethics, as currently written, "conveys balanced respect for the moral integrity of both sides."

A foundational principle of the CEJA report was that physicians approach the subject of PAS with "irreducible differences" of opinion, such that both sides share a common commitment to "compassion and respect for human dignity and rights" (as stated in Principle I of the AMA Principles of Medical Ethics) but draw different moral conclusions from these shared commitments. (At last year's Interim Meeting of the House of Delegates in Honolulu, CEJA sponsored an open forum on the subject of PAS where widely divergent views were expressed by physicians.)



Mark Moran

"Physicians who both oppose and support PAS," says Jim Sabin, M.D., "base their opinion on the first principle of medical ethics, which calls on doctors to demonstrate 'compassion and respect for human dignity and rights.'"

In testimony during reference committee hearings on the report, Sabin noted that Section 5.7 of the code states that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." Meanwhile, Section 1.1.7 (known as the conscience code) preserves the right of physicians to practice according to their conscience.

(The conscience code notes, in part, that "physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. … Preserving opportunity for physicians to act or to refrain from acting in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely.")

The CEJA report stated, "For some physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to abandon the patient preclude the possibility of supporting patients in hastening their death. For others, not to provide a prescription for lethal medication in response to a patient's sincere request violates that same commitment and duty. Both groups of physicians base their view of ethical practice on the guidance of Principle I of the AMA Principles of Medical Ethics."

In comments during reference committee hearings on the report, Sabin

see **Assisted Suicide** *on page 22*

Robinowitz Honored as Long-Time Leader and Mentor in AMA House

Over the years, Robinowitz has witnessed and helped to shape the evolution of the AMA House into a far more diverse body with a renewed focus on public health concerns, medical education, and physician performance and satisfaction. ***BY MARK MORAN***

Carolyn Robinowitz, M.D., a longtime AMA member and immediate past chair of the AMA Section Council on Psychiatry, was honored with a special reception at this year's Interim Meeting of the AMA House of Delegates at National Harbor outside of Washington, D.C.

Robinowitz is a former APA president, APA senior deputy medical director, and director of APA's Division of Education. She is also a former dean of the Georgetown University School of Medicine and held leadership positions in many psychiatric organizations. She has been a member of the AMA House of Delegates since 1975, when there were no more than a dozen women in the House, and has held numerous AMA leadership positions, including chair of the AMA's Council on Science and Public Health.

AMA leaders, including AMA President-elect Patrice Harris, M.D., APA leaders, and other members of the psychiatric delegation, hailed her tireless energy and dedication to advancing the interests of psychiatry within the AMA and her mentoring of many psychiatrists who have risen to positions of leadership in the AMA.

"Carolyn has been a role model and an example of leadership in organized medicine for all of us," said Harris.

Over the years, Robinowitz has witnessed and helped to shape the evolution of the AMA House into a far more diverse body with a renewed focus on public health concerns, medical education, and physician performance and satisfaction. "This is definitely not your grandfather's or even father's organization," Robinowitz said.

At the reception and in comments to *Psychiatric News* after the meeting, Robinowitz spoke of the enormous success of the AMA Section Council on Psychiatry and the larger psychiatric delegation within the AMA.

"I am proud of the successes of psychiatry in the AMA and the House of Medicine," she said. "Our results have been the culmination of more than a decade of work beginning with a strategic planning process initiated by [past APA President and former section council member] Joe English, M.D., who held us to maintaining a focus on goals and priorities."

The AMA Section Council on Psychiatry is composed of delegates from

Mark Moran

APA CEO and Medical Director Saul Levin, M.D., M.P.A., presents Carolyn Robinowitz, M.D., with a plaque in recognition of her long service at the AMA that helped elevate the profile of psychiatry in the AMA House of Delegates.

APA, the American Academy of Child and Adolescent Psychiatry, the American Academy of Psychiatry and the Law, and the American Association of Geriatric Psychiatry. Additionally, there are psychiatrist members of most state delegations to the AMA House.

Psychiatrists currently occupy seats and leadership positions on virtually all of the AMA councils. For instance, psychiatrist Jim Sabin, M.D., is chair of the influential Council on Ethical and Judicial Affairs, and psychiatrist Al Herzog, M.D., is chair of the AMA Council on Long-Range Planning and Development. Within the last decade, two psychiatrists have been elected president of the AMA—Jeremy Lazarus, M.D., who was president in 2012-2013, and Harris, whose presidential year will commence next June.

see **Robinowitz** *on page 24*

MHA Ranks States on Prevalence Of MH Disorders, Access to Care

The report concluded that far too many people are not receiving the services they need to live healthy and productive lives.

BY LINDA M. RICHMOND

The states that ranked highest overall on access to mental health care—with the lowest prevalence of mental illness—were Minnesota, Maine, Massachusetts, New Jersey, and Vermont, according to the "State of Mental Health in America 2019" report by Mental Health America (MHA).

States were assigned an overall mental health ranking based on 15 measures involving prevalence of mental illness, including serious thoughts of suicide and substance use disorder, and access to care, including health insurance status, mental health coverage, and mental health workforce availability.

The state that ranked lowest was Nevada, followed by Idaho, Oregon, Mississippi, and Alaska.

Now in its fifth year, the annual report provides a snapshot of mental health status and access to care among youth and adults and monitors trends.

The report analyzes national survey results from all 50 states and the District of Columbia from the Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, as well as other state and federal sources.

The report also ranked states based on their availability of "mental health providers," defined as psychiatrists, psychologists, social workers, counselors, marriage/family therapists, and advanced practice nurses specializing in mental health care. In the top-ranked states, the ratio of state residents to mental health providers was close to 200 to 1 (Massachusetts, District of Columbia, Maine, Oregon, and Vermont), but in the lowest-ranked states there were at least four to six times as many residents for every provider (Alabama, Texas, West Virginia, Georgia, and Arizona).

KEY POINTS

Other findings in the Mental Health America report "State of Mental Health in America 2019" include the following:

- Adults with any mental health illness: 18 percent
- Adults with any mental illness who are uninsured: 12 percent
- Adults with a severe mental illness: 4 percent
- Adults with serious thoughts of suicide: 4 percent
- Adults who reported a past-year substance use disorder: 8 percent
- Youth who reported a past-year substance use disorder: 5 percent

The shortage of mental health providers has resulted in many individuals not accessing care or relying on emergency room services for psychiatric care. More than half of psychiatrists will reach retirement age within seven years, which could exacerbate the shortage if many of them decide to retire.

"Integrating primary care and behavioral health services is key for early identification and intervention but is only part of the solution. Primary care providers cannot fill the void created by a lack of psychiatrists," the MHA report noted.

Twenty percent of adults with any mental illness were not able to receive the treatment they needed, and this number has not declined since 2011, MHA reported. Some barriers included cost of care, lack of insurance or limited coverage of mental health services, and a shortage of mental health providers.

The report showed alarming increases in serious suicidal ideation

see **MHA** *on page 24*

PSYCHIATRY & INTEGRATED CARE

Suicide Prevention in Integrated Care: Opportunities to Provide Advocacy, Education

BY ANNA RATZLIFF, M.D., PH.D.

Psychiatrists and other behavioral health care providers have an enormous potential to help prevent suicides by working in collaboration with primary care providers. This month's author, Anna Ratzliff, M.D., Ph.D., provides some concrete actions we can take to help people who are struggling with thoughts of suicide.

—Jürgen Unützer, M.D., M.P.H.

Psychiatrists working in integrated care settings have an important role to play in suicide prevention. Nearly 50 percent of people who die by suicide will have seen their primary care physician in the month before they die, and 83 percent will have seen a medical professional in the past year. If you are a psychiatrist working in a primary care setting, I encourage you to take action to address this public health crisis in one of the following ways: provide education to primary care teams, support protocol development, and/or expand access to the Collaborative Care Model.

Anna Ratzliff, M.D., Ph.D., is the director of the Advancing Integrated Mental Health Solutions (AIMS) Center and the Integrated Care Training Program at the University of Washington, Department of Psychiatry and Behavioral Sciences. Jürgen Unützer, M.D., M.P.H., is a professor and chair of psychiatry and behavioral sciences at the University of Washington and founder of the AIMS Center, dedicated to "advancing integrated mental health solutions."

- **Provide education to primary care teams:** By leveraging your relationship with a primary care team, you can provide education in the core skills of recognizing and managing patients at risk for suicide in primary care and other medical settings. Core training goals include making sure all medical professionals know the suicide prevention hotline number—(800) 273-TALK—and are able to ask directly about suicide, use standardized tools such as the Columbia Suicide Severity Rating Scale, and implement decision aids such as the SAFE-T to manage patients at risk. Knowing how to deliver effective educational messages, such as how to safely store medications (the most commonly used method for suicide attempts) and firearms (the most commonly used lethal means for suicide), to different kinds of audiences can make communities safer by increasing public awareness.

- **Support protocol development:** You may work closely on protocol development for a variety of clinical conditions, and suicide prevention should be a primary target of this work. One of the best places to start when working in a new clinic is to ask about the suicide prevention and crisis protocols that are already in place. Some clinics will have well-developed protocols, and your role may be as simple as supporting effective application of these protocols. Other practices may not have any standardized approach, and you may be able to provide leadership to develop one. There are national resources to assist with this work including free materials available from Zero Suicide (https://zerosuicide.sprc.org/) and specific materials for primary care from the Suicide Prevention Resource Center (http://www.sprc.org/settings/primary-care/toolkit).

- **Implement collaborative care:** A common risk factor for suicide is depression, and working to increase access to effective treatment needs to be part of suicide prevention. Implementing collaborative care is an important strategy to address this need. In the IMPACT study, the largest trial of collaborative care to date, patients were twice as likely to have a reduction in depression symptoms and a demonstrated reduction in suicidal ideation. APA

continued on facing page

Experts Call For More Action to Thwart Youth Vaping 'Epidemic'

The FDA plans to ban traditional menthol cigarettes but retain current sales practices for menthol- and mint-flavored e-cigarettes. Experts say more action is needed to keep e-cigarettes out of the hands of youth. **BY LINDA M. RICHMOND**

iStock/mauro_grigollo

As use of e-cigarettes by youth reaches epidemic levels, the Food and Drug Administration (FDA) announced several planned regulatory actions, but health experts are concerned the proposals do not go far enough to reverse the alarming trend.

More than 1 in 5 high schoolers reported past-month use of e-cigarettes in 2018. That represents an increase of e-cigarette use by nearly 80 percent among high schoolers and 50 percent among middle schoolers since last year, according to the 2018 National Youth Tobacco Survey (NYTS) issued last month.

In response, the FDA announced it will seek to ban the sale of traditional menthol cigarettes and restrict access to certain flavors of e-cigarettes—but not all—to specialized stores and online retailers that can verify a purchaser's age.

"Sales restrictions on some flavors simply does not go far enough in responding to this public health epidemic," said American Lung Association President and CEO Harold P. Wimmer. He called for the FDA to remove all flavored tobacco products from the marketplace, including all flavored e-cigarettes. "This is an all-hands-on-deck moment for our nation: urgent action is needed at all levels of government."

Douglas Ziedonis, M.D., M.P.H., associate vice chancellor for health sciences and a professor of psychiatry at the University of California, San Diego, believes that even further limits than have been proposed are warranted.

"I'm concerned that adolescents see e-cigarettes as a safer alternative than they probably are," he said, adding that for youth, use of e-cigarettes has been shown to be "a gateway to other substance problems." Whether and when clear evidence will emerge that e-cigarettes cause long-term cell damage and health consequences similar to combustible cigarettes, only time will tell, he said.

The considerable rise in e-cigarette use among young people reversed a recent decline in overall youth tobacco use, driving it instead to a seven-year high, according to the NYTS report. More than one-quarter of high schoolers reported current use of any tobacco product—a 38 percent increase from 2017. E-cigarettes—electronic cigarettes—or "vaping" involve battery-powered devices that heat and vaporize a liquid containing nicotine derived from tobacco.

The rise in e-cigarette use by youth is led by the popularity of "pod mod" cartridge-based e-cigarettes, such as JUUL, according to the NYTS report. They are slim and shaped like a USB flash drive and, with disposable, pre-filled cartridges that can be popped in and out, are far easier to use—and conceal—than previous e-cigarettes. The pods are sold in flavors that appeal to youth, and each contains as much nicotine as a pack of cigarettes. Since launching in 2015, JUUL Labs Inc. has garnered more than 70 percent of the U.S. e-cigarette market share, now valued at $15 billion.

E-cigarettes were introduced to the U.S. marketplace in 2007, and by 2014, they became the most commonly used tobacco product among U.S. youth. There is substantial evidence that vaping is a gateway to combustible cigarettes. An *American Journal of Medicine* study in 2017 found that young nonsmokers were four times more likely to begin smoking combustible cigarettes after vaping for about 18 months.

"These new data show that America faces an epidemic of youth e-cigarette use, which threatens to engulf a new generation in nicotine addiction," said Health and Human Services (HHS) Secretary Alex Azar of the NYTS report.

FDA Commissioner Scott Gottlieb, M.D., said he plans to direct the FDA Center for Tobacco Products (CTP) to

see **Vaping** *on page 23*

continued from facing page

offers a variety of training opportunities and resources to support implementation of collaborative care.

Last year, I helped develop and launch a suicide prevention training program (All Patients Safe) for the University of Washington and Seattle Children's Hospital in response to Washington state legislation that requires suicide prevention training for all health care professionals. Over 1,000 people have completed the training so far, and we are beginning to see its positive impact. For example, a recent trainee reported that after completing the training, he had the tools and skills to complete a safety plan with two patients the next day in his clinic.

Seeing this success has inspired me to seek additional opportunities as a psychiatrist to provide advocacy and education in suicide prevention. I hope you can find inspiration in these ideas, bring them to your integrated care work, and help address the public health crisis of suicide. **PN**

More information on integrated care and APA's free trainings can be accessed at psychiatry.org/TCPI.

Can E-Cigarettes Help Your Patients Quit Smoking?

Research by the Centers for Disease Control and Prevention (CDC) shows that the use of e-cigarettes to quit smoking has become a far more popular means of quitting smoking among adults than the use of FDA-approved methods such as nicotine patches, nicotine gum, or smoking-cessation medications. But does it work?

E-cigarettes are not approved by the FDA as a smoking-cessation aid, and the few studies on this issue have shown mixed results. "We don't yet know if e-cigarettes can be effective in helping adults reduce their use of traditional, combustible tobacco cigarettes," said Douglas Ziedonis, M.D., M.P.H., associate vice chancellor for health sciences and a professor of psychiatry at the University of California, San Diego. "There is a need for research studies to evaluate the safety and long-term efficacy of e-cigarettes in this role. But even if such initial studies were carried out, they would not likely include individuals with neuropsychiatric disorders."

It turns out that adults with mental health conditions are even more likely to try e-cigarettes, be current users of e-cigarettes, and be susceptible to future use of e-cigarettes than adults without such conditions, and they smoke them for many of the same reasons other adults do—because they wish to cut back on smoking or because of the stigma associated with smoking, a study published in *BMJ* found.

The lifespan of people with severe mental illness is 26 years shorter than the general population, and this enormous health disparity is greatly influenced by their smoking, Ziedonis said. "It's great that psychiatrists are becoming more aware of the huge negative impact smoking is having on their patients and that more are integrating treatment for tobacco use disorders into their practices."

While the CDC found that 30 percent of e-cigarette users were former smokers who had transitioned off combustible cigarettes, it is not known whether the use of e-cigarettes helped them quit. Moreover, 60 percent of e-cigarette users were found to be "dual users"—that is, they continue to smoke both.

"Dual use is not an effective way to safeguard your health," the CDC wrote. More troubling was that among young people (aged 18 to 24), 40 percent of e-cigarette users had never smoked, suggesting that for young people at least, e-cigarettes may be more of a gateway to smoking than anything else.

For adult patients who smoke, there are seven FDA-approved products that can increase the chances of successful quitting. Of the agents studied, varenicline was most effective in helping smokers achieve abstinence, outperforming bupropion, placebo, and nicotine patch. In addition, a study in 2016 found that use of varenicline or bupropion by people with psychiatric disorders did not increase neuropsychiatric adverse events.

"Balancing medication with psychosocial interventions can further boost success rates," Ziedonis pointed out. Methods with the strongest evidence involve face-to-face psychotherapy, such as cognitive-behavioral therapy and group therapy, as well as state-operated quit lines (accessed by calling 1-800-QUIT-NOW).

FDA Clears First Direct-to-Consumer Pharmacogenetic Test

23andMe's Personal Genome Service now offers data on an individual's ability to metabolize drugs, which may or may not be useful in clinical decision making.

BY NICK ZAGORSKI

23andMe

In October, the Food and Drug Administration (FDA) authorized the DNA-testing company 23andMe to begin marketing the first direct-to-consumer pharmacogenetic test. This clearance marks another major advance in the field of personal genomics, but some experts caution that such tests may offer very little medical value.

Unlike DNA tests that assess patients for genetic variants linked with risk of getting a disease—such as the BRCA gene and breast cancer—pharmacogenetic tests indicate a person's ability to metabolize medications; that is, do they stay in their body longer or shorter than average?

Specifically, 23andMe's Personal Genome Service Pharmacogenetic Reports test looks for 33 possible variants among eight genes that encode metabolic proteins. The list includes four members of the cytochrome P450 family—a group of enzymes that does the lion's share of the body's drug metabolism duties. Many psychotropic drugs, including commonly prescribed antidepressants and antipsychotics, are targets of P450 proteins.

The FDA authorization allows 23andMe "to provide customers with information on whether they are predicted to be fast or slow metabolizers based on their genetics, but does not describe associations between any detected genetic variants and any specific medication," the company noted in a press release.

This is an important distinction, said Anne-Marie Dietrich, M.D., a private practice psychiatrist in Alexandria, Va., who uses pharmacogenetics in her practice. (Tests designed for physicians have been available for years). "[T]hese tests can tell someone only how they are going to metabolize a medication, not how they will respond to a medication."

Still, even though the information is limited, Dietrich told *Psychiatric News* that these consumer tests can provide useful information to psychiatrists.

"If a patient provided me with their pharmacogenetic profile, I would look at it alongside other lab tests, patient and family history, and a patient's previous medication trials when making a decision," she said. "And I have adjusted patient medications based on pharmacogenetic data. It is important that physicians do not put too much stock in these tests [alone]."

Charles Nemeroff, M.D., Ph.D., a professor of psychiatry at the Dell Medical School at the University of Texas at Austin, told *Psychiatric News* that the potential risks of 23andMe's test lie in patients' deciding to alter their adherence to medication based on the genetic information. Some people who order the tests may interpret test results to mean they should stop or increase their medications based on their results, he explained.

As part of the marketing clearance,

see **Pharmacogenetic Test** *on page 25*

Physicians Oppose Government Efforts To Undercut Women's Contraceptive Care

The Trump administration issued rules allowing more employers to opt out of providing no-cost birth control and at the same time proposed a new rule that would effectively end abortion coverage by individual plans. **BY LINDA M. RICHMOND**

APA joined four other physician organizations last month to urge the Trump administration to rescind its new final rules to restrict women's access to birth control.

The organizations spoke out after the Trump administration issued a pair of final federal rules the day after the midterm elections that allow many more employers to deny coverage for FDA-approved birth control coverage on religious or moral grounds.

"By undercutting women's access to contraception, a key preventive service, at no out-of-pocket cost in private insurance plans, the final rules conflict with our firmly held belief that no woman should lose the coverage she has today," the frontline physicians said.

A federal court issued an injunction halting similar interim rules the administration issued one year ago awaiting the outcome of litigation.

The administration also proposed a new rule that same day that would add substantial payment burdens for individual health plans that cover abortion, making it nearly impossible for such plans to continue to cover abortion care. The rule would effectively end abortion coverage for nearly 1.3 million consumers who buy health insurance under the marketplace created by the Affordable Care Act.

"This is a tragic decision. It hurts women and families. Women want to be able to have babies when they can take care of them," said Nada Stotland, M.D., M.P.H., former APA president and an expert on reproductive psychiatry. "We know that when women's access to contraceptive coverage is curtailed, the birth rate goes up and the abortion rate goes up."

Final Rules Allow Opt-Outs for Contraceptive Coverage

The Obama administration deemed FDA-approved methods of birth control an essential health benefit under the Affordable Care Act, requiring most employers' health plans to provide coverage for them with no out-of-pocket cost. Later, houses of worship were completely exempt from providing this benefit to employees. Nonprofits with religious affiliations and "closely held" for-profit companies could choose an "accommodation" whereby they did not pay for contraception directly, but their health plans were still required to provide it for covered employees for no copay.

The Trump administration's new rule on religious objections significantly expands the range of employers that can claim religious exemptions, looping in more nonprofit and for-profit employers, including publicly traded companies and private higher educational institutions that issue student health plans. Employers with religious exemptions—and their health plans—are no longer required to provide contraceptive care to females and dependents.

The rule covering moral objections also permits employers to terminate coverage for birth control, but it does not allow publicly traded companies or government entities to claim the moral exemption.

"This interferes in the personal health care decisions of our patients and inappropriately inserts a patient's employer into the patient-physician relationship," the frontline physicians cautioned. Additionally, the rules also "open the door to moral exemptions for other essential physician-recommended preventive services, such as immunizations."

Joining APA in the frontline physician group were the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American College of Physicians.

The final rules are set to take effect mid-January, but they are likely to face legal challenges. When the Trump administration issued interim versions of the rules last year, they triggered lawsuits waged by nonprofit advocacy groups and a number of state attorneys general, which are now awaiting appeals. In the cases led by California and Pennsylvania, the federal courts issued preliminary injunctions one year ago, blocking the enforcement of the interim regulations pending the outcome of the litigation.

The frontline physicians also warned of the harmful effects of reducing women's access to contraceptives on public health. "We know that when women have unintended pregnancies, they are more likely to delay prenatal care, resulting in a greater risk of complications during and following pregnancy for both the woman and her child. The final rules reject these facts and the corresponding recommendations of the medical community, jeopardizing many women's ability to maintain a vital component of their health care," they said.

Restrictions on Abortion

The rules come as conservative lawmakers are seeking to restrict women's access to reproductive health care. At least six states have just one abortion clinic remaining, due to passage of laws restricting abortion clinics, according to the American Civil Liberties Union. The U.S. abortion rate is down 26 percent in the past decade, the lowest level since the Centers for Disease Control and Prevention began monitoring it.

"There has been a concerted effort to roll back abortion rights," Stotland said, "and not as concerted an effort to preserve them. Abortion is frowned upon and stigmatized, and since the 1973 *Roe v. Wade* ruling, many women take it for granted. … It's up to all of us to make sure all women have access to that vital care so we're not back to coat hangers and women having babies they can't take care of." **PN**

The frontline physicians' statement is posted at https://www.psychiatry.org/newsroom/news-releases/america-s-frontline-physicians-oppose-the-administration-s-decision-to-jeopardize-access-to-women-s-preventive-care.

Pa. Secretary of Health Wins APA's Javits Award

Tim Clements

Rachel Levine, M.D. (second from right), was presented with APA's 2018 Javits Award at a ceremony last month in Lafayette, Pa. She is the Secretary of Health for the Commonwealth of Pennsylvania and a professor of pediatrics and psychiatry at the Penn State College of Medicine. The ceremony was held during the Pennsylvania Psychiatric Society (PPS) Patient Safety and Risk Management Conference. With her are (from left) Rajnish Mago, M.D., chair of the PPS State Educational Committee; Anita Everett, M.D., chief medical officer of the Substance Abuse and Mental Health Services Administration and immediate past APA president; and Deborah Ann Shoemaker, M.D., executive director of the PPS.

The Javits Award is given to a public servant who has made significant contributions to the field of mental health and worked to better the lives of people with mental illness and underserved populations. The award honors the legacy of U.S. Sen. Jacob K. Javits of New York, who achieved many successes during his long Senate career on behalf of those with mental illness and on matters related to substance use disorders.

Levine was nominated by the PPS for, among other reasons, her leadership in combatting the opioid epidemic. She signed a standing order for naloxone, enabling pharmacies in Pennsylvania to dispense this life-saving treatment to thousands, and headed efforts to establish opioid prescribing guidelines and prescribing education for medical students.

In addition, noted Everett in her opening remarks, "Dr. Levine is a leading force in the fight for recognition of the toxic effects of bias in all aspects of health care, particularly as it pertains to the LGBTQ community. As part of the governor's office's efforts to educate the medical community and configure LGBTQ-inclusive programs and processes, she has traveled throughout the state to lecture and ensure a visible presence regarding the importance of the provision of fair and equitable health care services."

Levine was recently recognized as one of NBC's Pride 30, a national list of 30 people who are both members of and making a difference in the lives of the LGBTQ community.

Past winners of the Javits Award include Sen. Harry Reid; Sen. Gordon Smith; Sen. Olympia Snowe; Judge Stephen V. Manley, J.D., of the Superior Court of Santa Clara County, Calif.; and Dave Jones, California insurance commissioner.

Meet the Candidates in APA's 2019 Election

Voting begins on Tuesday, January 2, 2019, and ends on Wednesday, January 31, 2019.

There are 15 candidates vying for national and Area office in this year's election. Here are their photos, membership class, and, for those who would like more information about the candidates directly from them, the addresses of their personal websites.

Ballots will be emailed on Wednesday, January 2, to all APA voting members who have a valid email address on file with APA. Those who do not will receive a mailed paper ballot.

Voters may also go to the homepage of APA's website and use their member login information to access their electronic ballot.

To help APA members select the candidates they believe are best

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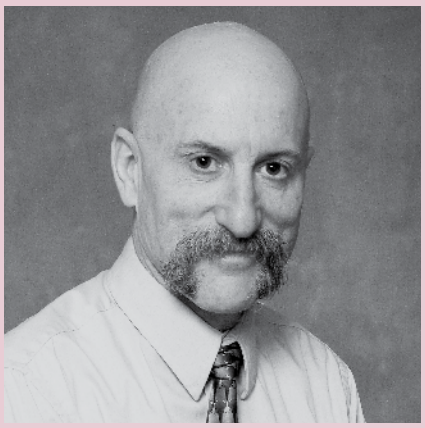
PRESIDENT-ELECT



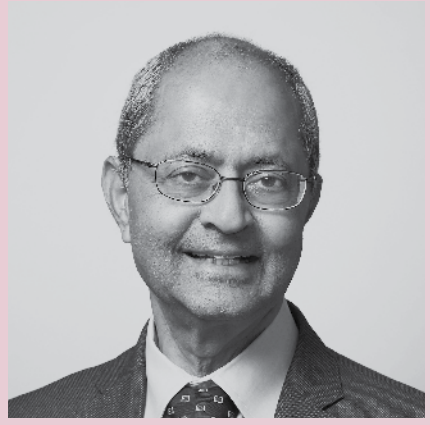
Jeffrey Geller, M.D., M.P.H.
Distinguished Life Fellow
https://suemp2.wixsite.com/jeffreygeller

Theresa Miskimen, M.D.
Distinguished Fellow
https://drmiskimen.com/

SECRETARY

Jeffrey Akaka, M.D.
Distinguished Life Fellow
www.jeffreyakaka.com

Sandra DeJong, M.D., M.Sc.
Distinguished Fellow
www.DeJongforAPASecretary.org



Ramaswamy Viswanathan, M.D., D.M.Sc.
Distinguished Life Fellow
https://rviswa.com/

MINORITY/UNDERREPRESENTED (M/UR) TRUSTEE

Rahn Kennedy Bailey, M.D.
Distinguished Fellow
www.baileypsych.com

Robert Cabaj, M.D.
Distinguished Life Fellow
http://www.robertcabaj.com/

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qualified for office, candidates' biographical and position statements will be posted on the APA election website by the end of this month at psychiatry.org/election. A booklet containing the same information will be mailed with the paper ballots.

Members can also view videos of the candidates for president-elect and secretary as they respond to a series of questions posed by APA's Election Committee. The videos will be posted on the APA election website by the end of this month.

For Area trustee, members can vote only in the race for their Area, and only resident-fellow members (RFMs) can vote for RFM trustee-elect.

Requests for replacement paper ballots must be emailed by Friday, January 15, to election@psych.org. The deadline for online voting and receipt of paper ballots is Thursday, January 31, 2019, at 11:59 p.m. EST.

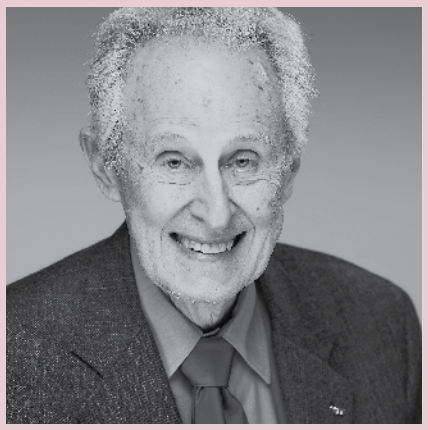
APA members wishing to campaign on behalf of a candidate are asked to review the APA Election Guidelines, which can also be accessed at psychiatry.org/election.

Those with comments or questions about the election should email them to election@psych.org. **PN**

AREA 3 TRUSTEE

Kenneth Certa, M.D.
Distinguished Life Fellow
kencerta.com

Barry K. Herman, M.D., M.M.M.
Distinguished Life Fellow
www.voteforbarry.com



Roger Peele, M.D.
Distinguished Life Fellow
RogerPeeleMD.com

AREA 6 TRUSTEE

Barbara Yates Weissman, M.D.
Distinguished Fellow
http://barbaraweissman.com

Melinda Young, M.D.
Distinguished Life Fellow
https://www.melindayoungmd.com

RESIDENT-FELLOW MEMBER TRUSTEE-ELECT (RFMTE)

Lisa Harding, M.D.
Resident-Fellow Member
http://www.drlisaharding.com/

Daniel Hart, M.D.
Resident-Fellow Member
www.VoteWithYourHart.com

Michael Mensah, M.D., M.P.H.
Resident-Fellow Member
mensah4apa.com

Stepping Up Initiative

How One County Is Stepping Up to Keep People With Mental Illness Out of Jail

Across the United States, counties are joining the Stepping Up Initiative to implement ways of diverting people with mental illness from overcrowded jails to more appropriate treatment settings. ***BY AARON LEVIN***

It's become a cliché to say that the institution that houses the most individuals with mental illness is the county jail, not the local hospital. The problem is that it's a fact, not a cliché.

However, a combination of diversion away from the criminal justice system, treatment, and wraparound social services offers a chance to alleviate that problem. The Stepping Up Initiative, a national movement led by the National Association of Counties, the Council of State Governments, and the APA Foundation, is working to implement that process in America's 3,007 counties.

Alamance County, N.C., provides a good example of how a step-by-step approach can make Stepping Up work. In North Carolina, 11,000 people with serious mental illness end up in local jails, even though most are accused of minor crimes and present a small threat to public safety. The costs for those prisoners of cycling in and out of the criminal justice system are twice those of prisoners without mental illness.

The toll on individuals is even greater, said Robin Huffman, executive director of the North Carolina Psychiatric Association (NCPA) and a volunteer with the Alamance County Stepping Up program.

"They may lose their job, their chance at future employment, their housing, their Medicaid, and often their dignity and self-respect," said Huffman. "People are serving life sentences, 30 days at a time."

A group from Alamance County attended the national Stepping Up kickoff conference in Washington, D.C., in April 2016. The problem was clear. When outside alternatives for care of the mentally ill shrink, there are two default options: jail or the emergency department. The question was how to put solutions into practice, said Huffman.

The most important element for success may be connecting everyone with a place in the system—police and sheriff's departments, local elected officials, patient advocates, and social service and mental health professionals.

To get things rolling, more than 200 representatives from around the state gathered in May 2017, said Huffman. "The counties wanted help to develop tools for screening people brought into jails and then find local resources for diversion, treatment, re-entry back into the community, plus analyzing the data the system would generate." Stepping Up provided them with the guidelines to do just that.

The county moved ahead on several fronts. The sheriff's department recategorized two staff positions to permit hiring a coordinator for the program and a social worker for the jail (now named a "detention center"). The seven law enforcement agencies in the county committed to giving all officers 40 hours of crisis intervention training to better prepare them for encounters with people with mental illness.

"We're creating a new case manager position for people awaiting trial to assess the likelihood of their showing up for trial and not committing a crime in the interim, even if they don't have enough money for bond," said Robert Byrd, a former county commissioner and a retired administrator at a local hospital.

"We're also working on creating a 24-hour diversion center staffed by mental health professionals to eliminate taking people with misdemeanor charges to jail," said Byrd. They have the building, but renovation and staffing are still needed. He wants to create a mental health court to shift the emphasis from the criminal justice system to one that contracts with people to get and stay in treatment.

A key element in the process is avoiding the arrest of people whose only problem is having a mental illness.

"We want to divert right from the beginning and not run the person through the booking process," said W. James Ryan, M.D., a semi-retired psychiatrist in private practice and the former medical director of a hospital in Burlington, N.C.

Ryan saw getting involved with Stepping Up as a way to combat the detrimental effects on people who should be patients but who had ended up in jails, prisons, and emergency rooms. Diversion makes it more likely that the individual will be connected first with evaluation and treatment while minimizing the chance of a stigmatizing criminal record. Ryan has contributed his psychiatric expertise at several levels, from managing agitated patients to anticipating patient flow problems once the diversion center is up and running.

"We have also made sure that there is a mental health screening for everyone who comes into the jail and have increased treatment opportunities, including having a psychiatrist who can prescribe medications," he said. "I

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BPA President Honored by World Association of Cultural Psychiatry

Roberto Lewis-Fernández, M.D. (left), presents Samuel Okpaku, M.D., Ph.D., with the World Association of Cultural Psychiatry's (WACP) 2018 Pioneering Work in Cultural Psychiatry Award. He received the award in recognition of his groundbreaking contributions to cultural psychiatry. Lewis-Fernandez is the outgoing president of the WACP.

Okpaku is president of the Black Psychiatrists of America and the president and founder of the Center for Health, Culture, and Society in Nashville, Tenn. The center is dedicated to improving access to mental health services in Africa as well as conducting collaborative research. He is the former chair of the Department of Psychiatry at Meharry Medical College and clinical professor at Vanderbilt School of Medicine and has held fellowships at the World Health Organization and National Institute of Mental Health. Among his numerous publications is *Clinical Methods in Transcultural Psychiatry* by APA Publishing.

The WACP is an independent, international academic organization whose main objective is to promote the exchange of science and educational information and the progress of international activity in the field of cultural psychiatry across the world.

Shootings at Pittsburgh Synagogue Raise Anxiety Over More Hate Crimes

The Pittsburgh Psychiatric Society is working with local psychiatrists to reach out to those who have been impacted by the October 27 shootings at the Tree of Life synagogue. **BY EVE BENDER**

Most of the storefronts in the business district of Squirrel Hill, a largely Jewish neighborhood in the east end of Pittsburgh, advertise that the area is "Stronger Than Hate" with a placard featuring the Star of David incorporated into the Pittsburgh Steelers' iconic three-star logo.

The shootings that left 11 people dead and six injured at the Tree of Life synagogue in Squirrel Hill on October 27 have unified many in the city—including the city's psychiatrists, who are offering their services to those who have been impacted by the shootings.

The suspect in the shooting, Robert Bowers, faces 44 federal charges in a rampage that left the historic Jewish neighborhood and the rest of the nation stunned. The attack is believed to be the deadliest on the Jewish community in U.S. history, the Anti-Defamation League said in a statement.

At press time, a list of more than 30 psychiatrists, therapists, and licensed social workers from Allegheny Health Network (AHN) who are willing to donate their services to those affected by the shootings has been submitted to the Pittsburgh Psychiatric Society and to the Governor's Office of Victim Services and its Victims Services Advisory Committee. The list will be distributed to crisis centers locally, according to Pittsburgh Psychiatric Society (PPS) President Amit Chopra, M.D.

"We have provided resources to the current PPS members to help them with general tips on dealing with people who may be affected by this tragedy and are arranging for more formal disaster mental health training for providers at AHN to be better able to deal with those affected by this trauma," he said.

Chopra, along with Ahmad Hameed, M.D., president of the Pennsylvania Psychiatric Society, issued a press release stating, "Traumatic events affect survivors, emergency workers, and the friends and relatives of victims who have been involved. As psychiatrists, we understand the attack may cause significant distress and pose potential threats to the mental health of all those involved. It is important for everyone to know that help is available, and treatment does work."

AP Photo/Gene J. Puskar

Rabbi Chuck Diamond, a former rabbi at Tree of Life synagogue, leads a Shabbat morning service outside the synagogue where 11 people were killed and six wounded a week earlier during a service.

The release offered tips on how to cope in the aftermath of the shooting, including avoiding overexposure to media coverage of the event and seeking help from a psychiatrist or other mental health professional if overwhelmed with feelings of anxiety or sadness.

Immediately following the shooting, John Rozel, M.D., who is medical director for resolve Crisis Services and an associate professor of psychiatry at the University of Pittsburgh, assisted those impacted by the shooting as part of the Critical Incident Stress Management Team that is run by UPMC Western Psychiatric Hospital. Rozel is also president-elect of the American Association for Emergency Psychiatry.

Team members provided immediate support to survivors of the shooting at the family reunification support center at the Jewish Community Center, which was only a few blocks from the synagogue. Support, according to Rozel, included psychological first aid and critical incident stress management. The team reunited survivors with their loved ones, reviewed self-care plans with them, and ensured that survivors' basic needs were being addressed in the first hours following the event.

In some cases, he said that it is not uncommon for those impacted by a traumatic event to continue experiencing eating or sleeping problems, tearfulness, and intrusive memories a month afterward. "But this is around the time when we expect people who are going to get better on their own to start showing some improvement." People who feel that their symptoms are not getting better or are getting worse should reach out for more support, he said.

Pittsburgh-area psychiatrist Ken Thompson, M.D., has been working with survivors of disasters since 1994, when USAir Flight 427 crashed near Pittsburgh International Airport. He also worked with survivors of the 1995 Oklahoma City bombing and the September 11 World Trade Center attack.

The attack on Tree of Life synagogue was different in that the disaster became personal for him, Thompson told *Psychiatric News*. His dentist, colleague, and friend at the Squirrel Hill Health Center, Richard Gottfried, 65, was among the 11 people killed in the shootings.

"Rich had only a week before placed two crowns in my mouth and was talking about his plans for retirement," Thompson recalled.

The health center receives federal funds and maintains a refugee program under which refugees receive comprehensive health services. "The guy who committed this horrible act was targeting exactly the kind of patients we treat—and Rich was there with us treating them."

Thompson noted that these patients, who are grieving Gottfried's loss, are fearful that they, as immigrants, could also be targeted by a hate crime.

"We have held debriefings and gatherings of mutual support, and are helping the patients work through their fears—when and where will this happen again?"

While he was helping to support health center patients, Thompson noted that his own experience of the shooting "has been visceral, and I'm still not out of the shock or disbelief stage yet."

Thompson said he will also be working with the Israeli Trauma coalition to help survivors of the shooting. The organization began in 2002 in Israel and now sends professional teams all over the world to train local officials and clinicians to manage trauma and promote rehabilitation after a disaster. A day after the Tree of Life shooting, members of the coalition were on the ground in Pittsburgh, Thompson noted.

The psychiatric response to the trauma caused by the shooting at Tree of Life has just begun. "After an event like this, you have repercussions that continue for a long time," he said. "Grief is not a solitary event, and it lasts for a while. The impact of the loss doesn't fully reveal itself, nor does the impact of the violence fully reveal itself, immediately"Unfortunately, we will be dealing with this tragedy for a long time to come." **PN**

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was surprised by one thing, and that was the support not only by people in the community but also by the police and the sheriff's department. The culture has changed. Every single one supports this initiative because they see that it works."

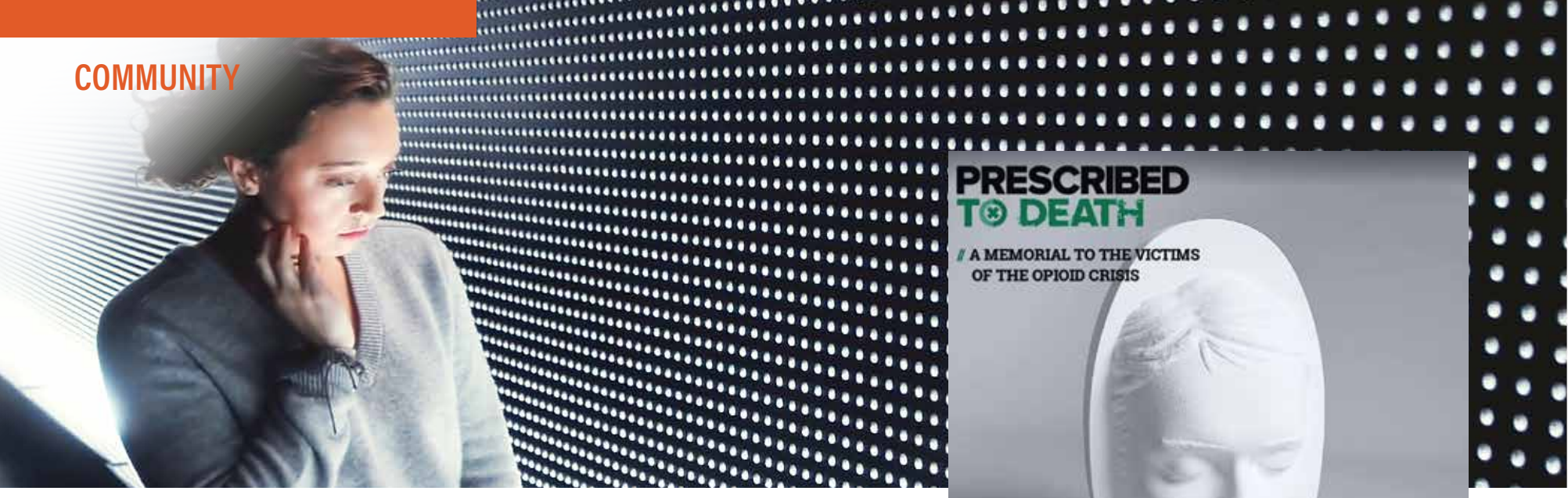
So far, 30 of the 46 North Carolina counties that have passed resolutions committing to the Stepping Up Initiative still need help getting the program off the ground. However, counties like Alamance are taking the "Johnny Appleseed" approach, sending out newly experienced staff and volunteers to contribute their hard-won experience, said Huffman. "We [NCPA] could leverage our statewide relationships to expand the program."

Putting her executive director hat back on, Huffman said that APA district branches can contribute to the Stepping Up Initiative by talking at the state level about the re-entry into society of inmates released from prison. "We've created a state coalition of elected officials, law enforcement, corrections officials, mental health professionals, consumer advocates, local public-sector mental health entities, the sentencing commission, and others who've pledged to find solutions to this problem." **PN**

More information on Stepping Up is posted at https://apafdn.org/impact/justice/the-stepping-up-initiative.

Your Help Wanted

APA invites psychiatrists to help develop meaningful quality measures through participation in the PsychPRO registry. For more information, see the ad on page 17 and look for an in-depth interview with project leadership in the January 4 issue.



A woman gazes at the centerpiece of the National Safety Council's opioid memorial exhibit, a massive wall of perfectly spaced white pills. Onto each pill has been carved the face of an individual who lost his or her life to the opioid epidemic.

National Safety Council

At the National Safety Council's opioid memorial exhibit, a computer-driven engraving machine continuously carves a face onto a little white pill every few minutes to signify another life lost to the opioid epidemic. The CDC reported there were nearly 49,000 opioid overdose deaths in 2017.

Prescribed to Death: Memorial Strives to Put a Face On Opioid Overdose Statistics

A traveling memorial seeks to honor victims of prescription opioid overdose and motivate visitors to action to stop the worst drug crisis in American history. **BY LINDA M. RICHMOND**

As the nation grapples with the worst drug crisis in United States history, the National Safety Council (NSC) wants to put a face on the toll it has taken. NSC's exhibit "Prescribed to Death: A Memorial to the Victims of Opioid Crisis" is traveling around the country and may be coming to a city near you. It seeks to personalize the data points and drive its visitors to action.

One in four Americans has been directly impacted by the opioid crisis, yet NSC poll data show that 40 percent still do not consider it to be a threat to their own family. "The most important thing about this crisis is not the statistics, but the faces," explained NSC President and CEO Deborah A.P. Hersman. NSC is a nonprofit that works to eliminate preventable deaths. "The Prescribed to Death memorial not only brings visitors face to face with this everyday killer, but also encourages actions that will help us eliminate these preventable deaths."

The centerpiece of the exhibit is a black wall of pills, row after row, with each pill intended to represent one of the 22,000 individuals lost to prescription opioid overdose in 2015—the year the memorial was conceptualized. Onto each pill has been carved the face of an individual who lost his or her life to the opioid epidemic.

Infinity mirrors affixed to both ends of the wall make it appear to go on forever, reminding visitors that the opioid crisis, too, will continue "unless we do something about it," said Maureen Vogel, an NSC spokesperson.

Messaging added onto the sides of the wall explains to visitors that the opioid overdose death toll has tragically continued since the memorial's inception: of the 42,000 individuals who died from opioid overdoses in 2016, about 40 percent (17,000) involved prescription opioid analgesics.

When NSC unveiled the memorial at its Chicago headquarters in 2017, a computer-driven engraving machine worked nearby, continuously carving a new face onto a pill every few minutes and dropping it onto a table to signify another life lost. "Now, it's every 12 minutes that someone is overdosing on opioids in our country," Vogel said.

A separate installation adjacent to the memorial wall invites visitors to enter the recreated personal space of one individual lost to opioid overdose or one who battled opioid use disorder. Each installation contains personal artifacts: handwritten journal entries; a specially knitted blanket; a card a son had left his mother just prior to his overdose, telling her how much he loved her.

"We want to make sure people understand the opioid crisis is human. It's not just data points," Vogel said. "These are real people, just like you and me. They had real relationships … and they're not here anymore because of something we know how to stop."

Visitors to the memorial receive a special envelope to allow for safe disposal of unused opioid pills in their homes and an "Opioids: Warn Me" label to affix to their insurance cards, empowering them to discuss with prescribers the risks of taking opioids—and explore whether other pain relief options are available.

The exhibit traveled to six additional cities throughout the country in 2018: Fayetteville, Ark.; Pittsburgh; Atlanta; Buffalo, N.Y.; Houston; and Washington, D.C., where it was displayed in a tent on the Ellipse in President's Park at the White House. NSC spent more than $1 million to create the exhibit and is seeking sponsors to help bring it to other locations and events in 2019. **PN**

View the "Prescribed to Death" memorial online at https://www.youtube.com/watch?v=0jmDHoPUGKI.

From the President

continued from page 3

national agenda to address the challenges facing psychiatry. From the overreaching regulations regarding programs, policy, and payments to achieving full mental health parity, reducing stigma, and educating the rest of medicine and the public about the significant scientific progress related to more effective therapeutic interventions, we have a lot of work facing us. Additional challenges related to the social determinants of mental health, impact of public unrest, climate change, association of mental illness with continuing acts of violence, and the impact of these traumas on overall health and well-being suggest that the need for psychiatric services may be greater now than ever before.

So, join with me and make your voice heard by voting in APA's election. What you think is best for psychiatry's future matters, so stand up, click (or check the box on the paper ballot), and be counted. We know that now, more than ever, every single vote is important. **PN**

To check your member profile, go to psychiatry.org, log in, click on the arrow to the right of your name, and select "Member Profile."

APA Foundation Cohosts Panel Discussion On Philanthropy and Social Narratives

BY TERRI D'ARRIGO

On November 13, 140 nonprofit, fundraising, and communications leaders gathered at the National Press Club in Washington, D.C., for a panel discussion about how community philanthropy can help counter the ill effects of divisive national discourse. The APA Foundation, Graham-Pelton Consulting, and public relations firm Fenton sponsored the discussion, with APA Foundation Executive Director Daniel H. Gillison Jr. and Graham-Pelton President and CEO Elizabeth Zeigler moderating.

The discussion featured five panelists from disparate philanthropic organizations: Delia de la Vara of UnidosUS, Nona Evans of the Whole Kids Foundation, Sheryl Hughes of the Chicago Community Trust, Will Shafroth of the National Park Foundation, and Lilly Weinberg of the Knight Foundation. Panelists spoke of how community-based philanthropy can help heal the wounds of a society polarized by opinion bombardment in social media and other communications channels. They emphasized that relationship-building and seeking out commonalities within communities, among neighborhoods, and between individuals can counter the divisiveness of national and political discourse.

Gillison noted key statements Shafroth made during the discussion.

"To Will's point, when you go to a park, you don't know if the other people there are Democrats, Republicans, or Independents. But you do know they are there to enjoy the park. This was about what we have in common with one another, rather than our differences," Gillison said.

"To create change, you have to do it at the local level. You can't control what's happening at the national level," Gillison added. "This event was for not-for-profits looking to make a difference where people live, learn, work, and worship. They were there to collect insight into what they could be doing more of and taking the time to learn and hear." **PN**

Terri D'Arrigo

APA Foundation Executive Director Daniel H. Gillison Jr. encourages panelists to share their experiences in community philanthropy.

Cardioprotective Treatments After Heart Attack Increase Lifespan of Patients With Schizophrenia

Psychiatrists can play a role in making sure patients with schizophrenia and severe mental illness live longer following a heart attack.

BY LINDA M. RICHMOND

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The increased risk of mortality in patients with schizophrenia following a heart attack can be reduced with cardioprotective medications, such as antiplatelets, β-blockers, and statins, suggests a study posted October 28 in *JAMA Psychiatry*.

Patients with schizophrenia worldwide die 15 years younger on average—and have worse outcomes from coronary artery disease—than those in the general population, previous studies have found. This study suggests that poor quality medical care after myocardial infarction (MI) may play an important role in the excess mortality among this population.

"We found that patients with schizophrenia were significantly less likely to receive prescriptions for cardioprotective medications after MI than people from the general population," lead author Pirathiv Kugathasan, M.D., of Aalborg University in Denmark, told *Psychiatric News* via email. Such patients were nearly nine times more likely to die compared with the general population treated, he noted. When patients with schizophrenia received any cardioprotective medication, this risk dropped to twofold.

"Cardioprotective medication after myocardial infarction should be carefully managed to improve prognosis," Kugathasan and colleagues wrote.

The researchers studied adults aged 30 and older who were treated in Denmark public hospitals with first-time MI over a 20-year period. This group included more than 105,000 individuals; nearly 700 patients (0.7 percent) had a prior diagnosis of schizophrenia. Patients were followed about six to eight years on average.

During the follow-up period, 45 percent of patients with schizophrenia and 27 percent of the other patients died. Most of the deaths in both groups (66 percent) were caused by cardiovascular disease.

The researchers examined the prescriptions for antiplatelets, vitamin K antagonists, β-blockers, angiotensin-converting enzyme inhibitors, and statins received by patients during the follow-up period. They noted the use of monotherapy (treatment with one medication group), dual therapy (use of two), or triple therapy (use of three or more) and compared their use with all-cause mortality during the follow-up.

The triple therapy provided the greatest benefit for all patients. In fact, when patients with schizophrenia received three or more cardioprotective medications in any combination, their mortality risk dropped to about the same as that of the general population who received the same treatment.

Patients with severe mental illness are less likely to take cardioprotective medication after MI because of their poor insight into physical illness, negative attitudes toward medication, and lack of understanding of the purpose of the medications, the authors noted. "These contributing factors may be even worse for patients with schizophrenia, who have cognitive impairment, which has been linked to reduced medication adherence in general."

Other studies have found that patients with schizophrenia may also be less likely to receive specialist care and cardiac procedures following cardiac events. Even for those who do, cardiologists may not have the extra time it takes to care for patients with schizophrenia, Benjamin G. Druss, M.D., M.P.H., professor and Rosalynn Carter Chair in Mental Health at the Rollins School of Public Health of Emory University, told *Psychiatric News*.

> "The study highlights the cracks in the health care system that exist for disadvantaged patients, particularly those with severe mental illness."
>
> —Benjamin G. Druss, M.D., M.P.H.

"This study highlights the cracks in the health care system," Druss added. "With disadvantaged patients, such as those with severe mental illness, we need to have even more systems in place to ensure they receive good quality care."

In an editorial Druss wrote accompanying the study by Kugathasan and colleagues, he added, "these results indicate a critical need to implement population-level approaches to improve uptake of those treatments among individuals with schizophrenia."

Effective efforts to narrow the mortality gap for patients with severe mental illness in the United States have included providing primary care physicians on site at mental health clinics and training peer workers in assisting with the management of chronic medical illness, he said.

But there is much psychiatrists can do. "They need to become thoughtful about the medications they're prescribing, because many have metabolic side effects and must be carefully managed," Druss continued. "Psychiatrists can also ensure regular screenings are performed, including blood-pressure monitoring and bloodwork to detect cardiovascular problems." For patients who have had MI, who are at highest risk, "the psychiatrist needs to work closely with patients to ensure they're getting appropriate medical treatment and to coordinate with their cardiologist to make sure both illnesses are being managed."

No outside funding was used to support this study. **PN**

"Association of Secondary Preventive Cardiovascular Treatment After Myocardial Infarction With Mortality Among Patients With Schizophrenia" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2707998. The accompanying editorial, "Can Better Cardiovascular Care Close the Mortality Gap for People With Schizophrenia?," is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2707998.

LAI Naltrexone May Help More Patients With OUD Stay in Treatment

Patients who received long-acting injection naltrexone had twice the rate of treatment retention at six months compared with those taking oral naltrexone.

BY NICK ZAGORSKI

The opioid receptor antagonist naltrexone is a proven treatment for opioid use disorder (OUD), but the clinical usefulness of oral naltrexone has been limited by poor adherence. A study published October 19 in *AJP in Advance* now suggests that patients with OUD may be twice as likely to stay in therapy if they receive monthly injections of extended-release naltrexone (XR-naltrexone) following opioid withdrawal compared with daily oral naltrexone.

"These study findings have immediate clinical relevance for treatment of opioid use disorder at a time when an opioid epidemic continues unabated in the United States," wrote Maria Sullivan, M.D., Ph.D., of Columbia University and colleagues. "Given that post-detoxification outpatient treatment without pharmacotherapy yields poor completion rates, high (60 percent to 90 percent) relapse rates, and heightened risk of overdose and death, XR-naltrexone may be a viable alternative to prevent relapse in patients seeking treatment for opioid use disorder who do not prefer an agonist approach [such as methadone or buprenorphine]."

Sullivan and colleagues randomized 60 adults aged 18 to 60 who met *DSM-IV* criteria for opioid dependence to receive either 50 mg/day oral naltrexone (32 patients) or 380 mg of monthly XR-naltrexone (28 patients) for 24 weeks. All the participants received one 50 mg naltrexone pill at the start of the study to make sure they could tolerate naltrexone.

The study participants were asked to visit the clinic three times a week for the first two weeks and then twice weekly for the remainder of the 24-week study. During each clinic visit, the patients took a urine test, discussed any recent substance use, and took part in a behavioral therapy session. The goal of the behavioral therapy, which included both individual and family sessions, was to educate, motivate, and support patients through the process of opioid detoxification, naltrexone induction, and successful naltrexone maintenance. To encourage attendance at clinic appointments, patients were entered in a drawing for the chance to win gift vouchers after each session they attended.

see **LAI Naltrexone** *on page 21*

'Lazy Eye' May Affect How Children Perceive Certain Competencies

The lower self-perception of children with amblyopia is tied to slower reading speed and worse motor skills. **BY TERRI D'ARRIGO**

iStock/FatCamera

Some children who have amblyopia, or "lazy eye," may think of themselves as less able to do well in school, have a good social life, and play sports, according to a study posted November 15 in *JAMA Ophthalmology.*

Amblyopia is a condition in which one eye has poor or blurry vision, and the poor vision is not caused by a problem with the eye's health and cannot be corrected with lenses.

Eileen E. Birch, Ph.D., of the Retinal Foundation of the Southwest in Dallas and colleagues assessed self-perception in 81 children aged 8 to 13 years. The children were divided into three groups: the amblyopia group, the nonamblyopia group, and the control group. There were 50 children in the amblyopia group. The 13 children in the nonamblyopia group had mild strabismus (eye misalignment), anisometropia (unequal focus between eyes), or both. Nearly all of the children in the first two groups wore eyeglasses. The 18 children in the control group had no vision or eye problems, and none wore eyeglasses.

Birch and her colleagues assessed the children's self-perception using the Self-Perception Profile for Children, which covers five domains: scholastic, social, and athletic competence; physical appearance; and behavioral conduct. It also includes a separate measurement of children's overall sense of their worth as a person. The researchers also evaluated reading and motor skills in the amblyopia group. They did not test these skills in the nonamblyopia group because of time constraints, Birch said, noting that the tests take about an hour per child.

Scores for physical appearance, behavioral conduct, and global self-worth did not differ significantly among all three groups. However, compared with the control group, children in the amblyopia group had significantly lower self-perception of their scholastic, social, and athletic competence. The researchers found that the slower the children's reading speeds were, the lower their scores were on self-perceived scholastic competence. They also found that the less accurate the children were at aiming and catching, the lower their scores were on self-perceived scholastic, social, and athletic competence.

Like the children in the amblyopia group, the children in the nonamblyopia group had significantly lower scores for social and athletic competence than the children in the control group. However, unlike the amblyopia group, their scores for scholastic competence did not significantly differ from those of the control group.

> "The abnormal binocular vision may contribute to lower self-perceptions of social and athletic competence than children with normal vision."
>
> —Eileen E. Birch, Ph.D.

Birch said that her team's prior research may help explain why only children in the amblyopia group had more negative views of their scholastic competence.

"We have shown that amblyopia, but not nonamblyopic strabismus or anisometropia, is associated with slower reading speed, and that this is related to [the] abnormal eye movements and unstable fixation associated with amblyopia. We have also shown that amblyopic children are slower at completing Scantron answer sheets," Birch said.

The abnormal binocular vision inherent in amblyopia, strabismus, and anisometropia may explain why children in both the amblyopia and nonamblyopia groups had lower social and athletic scores than the control children, Birch told *Psychiatric News.*

"Amblyopic children have impaired vision in the affected lazy eye and also have abnormal binocular vision. Either or both of these may cause the lower self-perception scores we observed. [But] nonamblyopic children with strabismus or anisometropia [also have] abnormal binocular vision," Birch explained.

"Because both the amblyopic and nonamblyopic children had lower scores on the social and athletic scales, it suggests that these scales may be influenced by the binocular vision deficit, while the scholastic scale changes appear to be the results of the reduced visual acuity and resultant fixation instability associated with amblyopia," Birch said.

In their paper, Birch and her colleagues also noted that wearing eyeglasses could also contribute to altered self-perception of social and athletic competence in the amblyopic and nonamblyopic groups.

FROM THE EXPERTS

Brief Update and Review on Treating Eating Disorders

BY JAMES LOCK, M.D., PH.D.

Eating disorders are common mental disorders that can lead to serious psychiatric, medical, and social disabilities. However, many psychiatrists and other mental health professionals have limited knowledge to assess and treat eating disorders. This article briefly reviews current information about assessing and treating these disorders with the aim of helping increase the knowledge of nonspecialists to identify and treat more patients with these problems.

Problematic eating can be identified by asking screening questions such as these: Are you satisfied with your eating pattern? Do you ever eat in secret? Does your weight affect the way you feel about yourself? Have any members of your family had an eating disorder? Do you have or have you had an eating disorder?

Anorexia nervosa (AN), an eating disorder with a high mortality rate and characterized by low body weight and extreme fear of weight gain, has a prevalence of approximately 1 percent. Unfortunately, medications and psychosocial treatments such as cognitive-behavioral therapy (CBT) have only limited effectiveness in adults with AN.

James Lock, M.D., Ph.D., is a professor of psychiatry and behavioral science at Stanford University School of Medicine. He is the editor of *Pocket Guide for the Assessment and Treatment of Eating Disorders* by APA Publishing. APA members may order the book at a discount at https://www.appi.org/Pocket_Guide_for_the_Assessment_and_Treatment_of_Eating_Disorders.

Treatments are more effective for younger patients with short-duration AN. Family-based treatment (FBT) helps parents learn to be effective in combating behaviors that maintain low weight and overexercise. In contrast, adolescent-focused therapy (AFT) targets developmental issues related to maturity, social and family relationships, and self-esteem as underlying AN behaviors. Approximately 30 percent to 45 percent of AN patients can fully recover using these approaches.

Bulimia nervosa (BN) has a prevalence rate of about 3 percent and, like AN, is much more common in women than men. People with BN are highly invested in their appearance and weight. The disorder often begins in the context of dieting. As a result of undereating, urges to eat increase and ultimately lead to binge-eating episodes and feelings of being unable to control eating. These episodes are followed by guilt and worry about weight gain; thus, strategies to compensate for the increased intake through purgative behaviors such as vomiting and laxative use begin.

Depression and substance use and abuse commonly co-occur in patients with BN. The most effective treatment for BN in adults is CBT, which focuses on using behavioral and cognitive-skill development to challenge the maintenance of behaviors that lead to binge eating and purging. About 30 percent

continued on next page

In a commentary on the study, Joseph L. Demer, M.D., Ph.D., noted that the treatments for amblyopia may contribute to events that influence how children with amblyopia perceive themselves.

Demer noted that amblyopia treatment with eyeglasses and patches may provoke stigmatization and being bullied, but that the treatment with atropine eyedrops may relieve some of the psychological burden on the child.

Demer added that while treating amblyopia may be helpful, particularly when a child's amblyopia improves from profound to mild, in some cases the adverse psychosocial effects of treatment may outweigh the benefits. "This may argue for a careful balancing of the family and psychosocial burdens of treatments, such as patching, against the likely improvements that can be obtained by prolonging such treatments."

This study was supported by the National Eye Institute and the Thrasher Research Fund. **PN**

"Self-Perception of School-Aged Children With Amblyopia and Its Association With Reading Speed and Motor Skills" is posted at https://jamanetwork.com/journals/jamaophthalmology/fullarticle/2714699. "Childhood Self-Perceptions in Children With Amblyopia: Is the Problem the Disease or the Treatment?" is posted at https://jamanetwork.com/journals/jamaophthalmology/fullarticle/2714697.

Youth With Early-Onset Depression Have Higher Rates of ADHD

Children who develop depressive symptoms by the age of 13 often have problems with language and social communication as well. **BY NICK ZAGORSKI**

Youth who experience depression before turning 13 frequently show several traits associated with attention-deficit/hyperactivity disorder (ADHD), according to a study published October 14 in *JAMA Psychiatry*.

This study, conducted by Frances Rice, Ph.D., of the Cardiff University in the United Kingdom and colleagues, made use of data available from the Avon Longitudinal Study of Parents and Children (ALSPAC). ALSPAC is a large, ongoing research study of nearly 15,000 women in the United Kingdom who gave birth between 1991 and 1992, and their children.

The children in the study answered short depression-related questionnaires several times between the ages of 10 and 18. Most respondents (73.7 percent) had persistently low depression symptoms throughout adolescence; 17.3 percent of the youth had later-onset depression, in which elevated depression symptoms first appeared when they were about 16.5 years old; and 9 percent had early-onset depression that typically appeared when the youth were about 12.5 years old.

A closer look at the two groups of youth who developed depression showed some significant differences in how the symptoms presented. Youth with early-adolescent depression had higher rates of ADHD than the late-onset group (6.3 percent versus 0.9 percent), and they were about five times more likely to have problems with social communication and pragmatic language skills (for example, understanding what is appropriate to say and when it is appropriate to say it).

Rice noted that she was surprised to find that more than 70 percent of the youth in the early-onset depression group were girls. While depression is more common in women when looking at adults, studies have found that adolescent girls and boys tend to have similar rates of depression. Additionally, given the connection between early-onset depression and ADHD—which occurs at a higher rate in boys—one might expect a higher ratio of males with early depression.

Cardiff University

Frances Rice, Ph.D., believes that the high co-occurrence of developmental symptoms like language deficits in children with early-onset depression stems from both genetic factors and social/cultural stressors.

Studies have found that boys with neurodevelopmental problems such as ADHD or autism tend to underreport their symptoms, so Rice said it is possible that the participant questionnaires used in the study failed to capture some of the boys with early-onset depression. It is also possible that girls with symptoms of ADHD may face additional stressors because parents and teachers tend to be more accepting of such social problems in boys. These societal pressures might trigger depression, Rice said.

Rice said that she believes that understanding more about these two possible subtypes of depression in adolescents can help with developing better ways of supporting these young people and their families.

This study was supported by grants from the UK Medical Research Council (MRC). The ALSPAC is jointly supported by the MRC, Wellcome Trust, and the University of Bristol. **PN**

References for this article are posted at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2018.12b0.

"Characterizing Developmental Trajectories and the Role of Neuropsychiatric Genetic Risk Variants in Early-Onset Depression" is posted at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2707727.

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to 35 percent of patients with BN recover with CBT. Interpersonal psychotherapy (IPT) is also effective but focuses on changing interpersonal relationships rather than binge eating or purging directly. While IPT is effective, it is slower in accomplishing its effects. Antidepressant medications also decrease binge eating and purging but are most useful as adjunctive treatments to CBT. For younger patients, CBT is also effective, but FBT works more quickly.

Binge-eating disorder (BED) is a new diagnosis in *DSM*. BED has a prevalence rate of about 3 percent and is equally common in both men and women. Patients with BED binge eat but do not adopt compensatory behaviors. Nonetheless, BED is associated with significant emotional distress, physical, or social impairment; depression, anxiety, and substance use disorders commonly co-occur. With ongoing BED, weight gain is inevitable and often accompanied by the medical consequences of obesity including hypertension, diabetes, sleep disorders, and joint problems. There are several effective treatments for BED including CBT, IPT, and dialectical behavioral therapy (DBT).

The specific form of DBT used for BED targets binge eating as a maladaptive attempt to cope with emotional states. Although a number of medications may be helpful with BED, only lisdexamphetamine dimesylate, a stimulant originally indicated for attention-deficit/hyperactivity disorder (ADHD), is approved by the Food and Drug Administration. Unfortunately, although patients may improve using these approaches, weight loss remains very limited.

Another eating disorder that is new in *DSM* is avoidant restrictive food intake disorder (ARFID). Unlike AN or BN, eating behavior is not based on worries about appearance, weight, or shape, and weight loss is not intentional. However, individuals with this disorder can experience nutritional deficiencies, severe malnutrition, and behavioral, emotional, and psychological problems. Patients can develop ARFID at any time, but it is most common in school-aged children. Some present with highly selective or picky eating, others develop extreme fears about eating related to anxiety about choking or swallowing, and others are not motivated to eat enough due to low interest in eating or low appetite. No evidence-based treatments have been identified for ARFID yet; therefore, most treatments are individualized and aimed at achieving normal eating patterns to promote health and social development.

Through brief screening, a basic understanding of the main types of eating disorders, and familiarity with effective treatment approaches, psychiatrists and other mental health professionals can successfully treat these patients. For more complex cases, referral to specialty treatment may be indicated. Resources are available to learn CBT, IPT, and FBT through published manuals and training events. The prevalence and clinical needs of patients with eating disorders far exceed the capacities of specialty centers. Thus, more community-based psychiatrists and other mental health professionals are needed to identify and treat these common disorders. **PN**

Therapy Targeting Cognitive Biases Reduces Delusions in Psychosis

Metacognitive therapy targets cognitive biases, such as the tendency to jump to conclusions not supported by evidence, that are linked to delusional beliefs in patients with schizophrenia. **BY MARK MORAN**

Participating in a brief course of individualized metacognitive training—a psychotherapy designed to specifically target delusional beliefs—can reduce the severity of delusions and positive symptoms in patients with schizophrenia, according to a study posted October 30 in *Schizophrenia Bulletin*.

The study found that patients who received metacognitive training (MCT) had significant reductions in delusional thinking compared with patients who received cognitive remediation, a program designed to improve cognitive abilities. These improvements were maintained at six months.

The findings "suggest that even brief psychotherapy can help to ameliorate the symptoms of psychosis," Ryan P. Balzan, Ph.D., of Flinders University in Adelaide, Australia, and colleagues wrote.

MCT is a manualized, group-based program that targets the cognitive biases that have been shown by research to be linked to the formation and maintenance of delusional beliefs. These biases include overconfidence, inflexibility of beliefs, and a bias toward jumping to conclusions not supported by evidence. MCT encourages participants to "think about their thinking," raising metacognitive awareness of these biases and planting "seeds of doubt," Balzan and colleagues wrote.

For the purposes of the study, a specialized therapy—MCT-plus (MCT+)—was developed combining metacognitive training with elements of individual cognitive-behavioral therapy.

The researchers recruited patients with a schizophrenia spectrum diagnosis and current delusions. To be eligible, participants were required to be between ages 18 and 65 years; diagnosed with a schizophrenia spectrum disorder; and have a current delusional belief, defined as a score of 3 or greater on the "delusions" item of the Positive and Negative Syndrome Scale (PANSS).

Of the 54 patients included in the trial, 52 were taking antipsychotic medications; these patients continued to receive their medication throughout the study.

The patients were randomly assigned to MCT+ or cognitive remediation. Patients in the MCT+ group completed four two-hour sessions with a therapist over one month. Patients in the cognitive remediation group completed four therapist-led, 90-minute to two-hour sessions over the same timeframe, during which they focused on improving working and verbal memory, processing speed, problem solving, and attention—cognitive domains commonly impaired in patients with schizophrenia.

The researchers assessed the patients' delusions, positive symptoms, performance in several cognitive domains, and clinical insight (awareness of and attitudes toward mental illness) at the start of the trial, following the completion of the four therapy sessions, and six months later. Two patients did not complete the six-month assessment.

Patients in the MCT+ group showed significant reductions in delusional and overall positive symptom severity and improved clinical insight relative to patients in the cognitive remediation group. There was a large reduction in the delusions score on PANSS from baseline to posttreatment following MCT+, and a further small, significant improvement from posttreatment to follow-up at six months.

Compared with those in the metacognitive training group, patients in the cognitive remediation group showed moderate improvement in problem-solving ability but in no other cognitive domains. The authors wrote that this suggests "more CR [cognitive remediation] might be required to be effective in these domains."

"Despite the brevity of the active treatment condition, the findings suggest that MCT+ led to strong and significant improvements in delusional severity and overall positive symptomology, which were maintained at six-month follow-up," the authors wrote. "While both interventions were observed to improve general psychopathology and illness insight, MCT+ appeared to have a stronger and longer-term influence. Although previous trials have also shown that MCT can improve clinical insight, this was the first trial to show that improvements could be maintained long term."

They added that the MCT+ program includes content aimed at reducing self-stigma and improving self-esteem, which may have contributed to these findings.

In conclusion, the authors wrote, "While larger multisite trials investigating MCT+ are warranted, the present study adds to the growing literature that psychological interventions can be effective in people with psychosis."

This research was supported by Flinders University and the Trevor Prescott Freemasons Memorial Scholarship. **PN**

"Individualized Metacognitive Training Reduces Delusional Symptoms in Psychosis: A Randomized Clinical Trial" is posted at https://academic.oup.com/schizophreniabulletin/advance-article-abstract/doi/10.1093/schbul/sby152/5146645?redirectedFrom=fulltext.

Fears of Losing Mental Control in Psychosis Linked to Suicide

Psychiatrists should emphasize a recovery-focused approach and an optimistic outlook when working with people with psychosis. **BY MARK MORAN**

Negative thoughts about psychotic experiences and fears of losing mental control may heighten the risk of suicide in patients with psychosis who were not taking antipsychotics, suggests a report posted November 2 in *Schizophrenia Bulletin*.

"Overall, our findings emphasize the importance of clinicians promoting a recovery-focused and appropriately optimistic outlook when working with people with psychosis, taking care to avoid providing information that might heighten negative illness appraisals and/or fears of losing mental control," wrote Paul Hutton, Ph.D., of the Edinburgh Napier University in the United Kingdom and colleagues.

They analyzed data on the effect of "metacognition" on suicidal thinking. Metacognition refers to knowledge and beliefs relating to the structure and integrity of the self and one's own cognitive processes.

In their report, they noted that estimates of suicide rates among individuals diagnosed with schizophrenia spectrum disorders range from 5 to 10 percent, making it a leading cause of premature death in this population.

"Given antipsychotics have their strongest effects on the positive symptoms of psychosis, it is plausible that individuals not taking this medication may have greater positive symptom severity than those who do—and that this accounts for their increased suicide risk," Hutton and colleagues wrote. Yet the researchers said evidence on the contribution of positive symptoms to suicide risk remains unclear, with some studies suggesting no association.

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Other studies, however, have found that the way a person interprets or "appraises" their psychotic experiences may be more important than symptom severity for predicting suicidal behavior. For instance, a review published in the *British Journal of Psychiatry* in 2005 found that people with psychosis who die by suicide were more likely to have "fears of mental disintegration" than those with psychosis who did not die by suicide.

In their report, Hutton and colleagues described analyzing data on 68 patients enrolled in the ACTION trial, a pilot trial designed to assess the effects of cognitive therapy on individuals with schizophrenia who had not taken antipsychotics for at least six months. At the start of the study and follow-ups at nine and 18 months, the researchers measured the patients' psychotic symptoms using the Positive and Negative Symptom Scale; they also measured negative beliefs and attitudes using the Personal Beliefs About Experiences Questionnaire and the Metacognitions Questionnaire-30.

The researchers found that symptoms of psychosis were more likely to be linked to suicidal thinking at nine to 18 months when the patients held negative thoughts and fears. Negative thoughts and fears about consequences of symptoms leading to loss of mental control accounted for 37 percent of the association between those symptoms and suicidal thinking, according to the report.

They wrote, "The emergence of suicidal ideation can be conceptualized as not only a response to symptoms and related perceptions of defeat and entrapment, but also as attempts at

see **Psychosis** *on page 22*

Medicare

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an established patient, which requires at least two of the following three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity."

In the meantime, CMS has adopted several of the documentation changes for which APA had advocated in comments it submitted on the proposed rule. Beginning on January 1, 2019, CMS will no longer require physicians to document medical necessity for treating patients in their home rather than in the office; will no longer require physicians to re-record history and exam elements for established patients when there is documentation that those items have been reviewed and updated; and will allow physicians to indicate they have reviewed and verified information that is already recorded by ancillary staff or the patient regarding the patient's chief complaint and history.

Physicians should continue using either the 1995 or 1997 guidelines for documentation and E/M code selection.

Jeremy Musher, M.D., APA's advisor to the Current Procedural Terminology (CPT) Panel and RVS Update Committee, said the effect of the collapsed payment for levels 2 through 4 E/M visits will be highly variable, depending on the patient mix and level of care that patients require.

"APA is working collaboratively with other physician organizations and coalitions, including the AMA, to understand the impact of what has been proposed for 2021 and provide thoughtful recommendations to the administration," Musher said. "The common, consistent theme among the physician organizations has been to ensure that all patients have access to appropriate care and that physicians are paid appropriately for their work."

As an outgrowth of the SUPPORT for Patients and Communities Act (that is, the "opioid bill/package"), the final fee schedule waives certain rules regarding the location that Medicare beneficiaries must go to receive telehealth services for a substance use disorder or a substance use disorder and a co-occurring mental illness. These changes will allow patients to be seen in their home regardless of whether they are in a federally designated rural area, whereas previously they would have had to go to a qualified "originating site," such as a hospital or physician's office, for telehealth services. These new rules go into effect July 1, 2019.

APA strongly advocated for this change and will continue to support the waiver of restrictions that apply only to patients receiving care for mental illness or substance use disorders.

The fee schedule also includes important changes to requirements regarding electronic health records, the Merit-Based Incentive Payment System (MIPS), and the use of quality measures. The following are some of the most important updates in the fee schedule (see box for updates on quality measures):

- The Advancing Care Information performance category of MIPS has been renamed Promoting Interoperability.

- Many burdensome measures that required patients to interact with their record have been eliminated.

- Clinicians must now use 2015 Edition Certified Health Record Technology. Those using 2014 technology need to make the transition and can search for options in the Office of the National Coordinator's Certified Health Product List at https://chpl.healthit.gov/#/search.

- Clinicians must now report to *two* different public health agencies or clinical data registries. APA's PsychPRO registry counts as one of them.

- Two new measures focusing on opioid prescribing are included as potential bonuses for the 2019 reporting year.

MIPS is the government's payment system that seeks to reward physicians for the value—as opposed to the volume—of services they provide. For 2019, the low-volume threshold has been revised so that physicians will be exempt from MIPS reporting under these conditions:

- They have allowed charges for covered professional services less than or equal to $90,000.

- They provide covered professional services to 200 or fewer Medicare Part B-enrolled individuals.

- They provide 200 or fewer covered professional services to Medicare Part B-enrolled individuals.

Physicians will have the choice of opting in to MIPS reporting if they meet or exceed one or two (but not all three) of the low-volume threshold criteria. Finally, the MIPS Cost category will count as 15 percent of a physician's overall score in performance year 2019. (The cost category weighs the cost of services provided by a physician compared with peer physicians providing similar services.) **PN**

Information about the fee schedule is posted at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html. Members who have questions can email APA at qualityandpayment@psych.org or call the Practice Management Helpline at (800) 343-4671. A summary of the fee schedule is posted on APA's website at http://apapsy.ch/FeeSchedule.

Administration Updates Quality Reporting

For the 2019 program year (year 3 of the Quality Payment Program), the Quality Performance Category will make up 45 percent of the total Medicare-Based Incentive Payment System (MIPS) composite score, rather than 50 percent as it did in 2018. Measures available for 2019 include up to 25 quality measures that psychiatrists should be able to report on.

CMS has streamlined the terminology and defined the amount of data required for MIPS participants according to data collection type.

CMS is continuing to help small practices (solo physicians or practices with 15 or fewer eligible practitioners reporting as a group under a single tax identification number) by increasing the small-practice bonus to six points, but including it in the Quality Performance Category score of clinicians in small practices instead of as a standalone bonus; continuing to provide small practices with the option to participate in MIPS as a virtual group; and giving eligible physicians who meet one or two elements of the low-volume threshold the choice to participate in MIPS (referred to as the opt-in policy). There is a selection of non-claims-based measures available and reportable through certified electronic health records systems or through APA's Qualified Clinical Data Registry, PsychPRO, the mental health registry (see https://www.psychiatry.org/psychiatrists/registry).

CMS announced that it will incrementally remove measures identified as being of low value to patient care, including "process-based" measures. (They measure the intermediary steps toward achieving a desired outcome.) APA will work with CMS to ensure measures pertinent to psychiatrists are retained, at least until more meaningful tools will replace them, or advocate for reduced measure-reporting criteria.

LAI Naltrexone

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After four weeks, four of the 28 (14.3 percent) patients receiving XR-naltrexone had dropped out of treatment, compared with 12 of 32 (37.5 percent) patients receiving oral naltrexone. By the end of the 24-week study, 12 of the 28 (43 percent) patients receiving XR-naltrexone had dropped out of treatment, compared with 23 of 32 (72 percent) patients receiving oral naltrexone.

"[T]his trial shows that even in the presence of an intensive behavioral regimen aimed at supporting medication adherence, oral naltrexone is an inferior treatment and should be avoided clinically, other than perhaps for very select cases with a high likelihood of adherence," Sullivan and colleagues wrote.

There were no significant differences in side effects between the two groups, other than a higher rate of insomnia among patients taking oral naltrexone. There were nine serious adverse events, but only one was found to be related to medication: one patient receiving XR-naltrexone developed allergic hives and was removed from the study.

"Ever since extended-release naltrexone was approved for opioid use disorder back in 2010, experts in the field have been saying it should be the formulation of choice when treating patients with naltrexone," said Andrew Saxon, M.D., a professor of psychiatry and behavioral sciences at the University of Washington and director of the Center of Excellence in Substance Abuse Treatment and Education at the VA Puget Sound Health Care System. "These findings now provide experimental data to back up this consensus." Saxon, who is also the chair of the APA Council on Addiction Psychiatry, was not involved in the study.

Because prize drawings to encourage attendance would be hard to implement at many community drug centers, Saxon said that the treatment retention rates seen in this study may not be as high in a real-world setting.

Initiating naltrexone use following opioid withdrawal remains a significant challenge, Saxon told *Psychiatric News*; induction requires about seven to 10 days of opioid detoxification to make sure all opioids have left the patient's system. In this study, 110 patients enrolled in the opioid withdrawal program, but only 60 were able to complete it and transition onto naltrexone therapy.

This study was supported by grants from the National Institute on Drug Abuse. **PN**

"A Randomized Trial Comparing Extended-Release Injectable Suspension and Oral Naltrexone, Both Combined With Behavioral Therapy, for the Treatment of Opioid Use Disorder" is posted at https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.17070732.

MED CHECK

BY NICK ZAGORSKI AND TERRI D'ARRIGO

Phase 2 Study Suggests Adjunct Pimavanersin Improves MDD Symptoms

Acadia Pharmaceuticals in October announced that ***pimavanserin*** was effective at reducing depressive symptoms when given as an adjunct treatment to adult patients with treatment-resistant depression. Pimavanserin, which is a selective serotonin inverse agonist, is FDA approved for the treatment of Parkinson's disease psychosis.

The findings came from a phase 2 study that involved 207 adult patients with major depressive disorder and an inadequate response to first-line therapy with a selective serotonin reuptake inhibitor (SSRI) or serotonin norepinephrine reuptake inhibitor (SNRI).

The participants were randomly assigned to receive either 34 mg pimavanserin (n=51) or placebo (n=156) daily in addition to their existing SSRI/SNRI therapy for five weeks. After five weeks, the 58 patients in the placebo group who did not show a treatment response were re-randomized to receive pimavanserin or placebo for a second five-week period.

After the first five-week stage, pimavanserin was superior to placebo at reducing depressive symptoms, as measured by the 17-item Hamilton Depression Rating Scale. Pimavanserin was also superior to placebo for several secondary endpoints, including sleepiness, impulsiveness, and sexual functioning. The stage 2 results showed no difference between pimavanserin and placebo.

Pimavanserin was generally well-tolerated, and minimal serious adverse events were reported. Discontinuations due to adverse events were 1.2 percent for pimavanserin and 3.2 percent for placebo.

Pfizer Creates Company For CNS Drug Development

Pfizer has followed through on its plan to exit neuroscience research. The company announced in October that it was creating a new biopharmaceutical company called Cereval to continue to investigate several Pfizer compounds designed to target central nervous system (CNS) disorders. Pfizer will retain 25 percent equity in Cereval as part of the spinoff.

The most advanced drug in the pipeline of newly formed Cerevel is ***PF-06649751***, a dopamine 1 receptor modulator that will be tested in a phase 3 study for the treatment of Parkinson's disease next year. Cereval has also obtained two drugs ready to start phase 2 clinical trials: an acetylcholine receptor modulator being tested for psychosis and a GABA receptor–targeting drug for epilepsy.

The remainder of Pfizer's donated assets are all in the preclinical stage and include additional drug candidates for the treatment of Parkinson's and psychosis, as well as molecules for treating substance use disorder and neuroinflammation.

Schizophrenia Drug Has Favorable Weight Profile In Phase 3 Trial

In November Alkermes announced the results from ENLIGHTEN-2, a phase 3 trial of its investigational schizophrenia drug ***ALKS 3831***. Patients with schizophrenia who took ALKS 3831—a combination of ***olanzapine*** and the opioid receptor antagonist ***samidorphan***—for six months did not gain as much weight as those taking olanzapine alone.

The trial involved 561 patients with stable schizophrenia and was designed to compare weight gain with ALKS 3831 with that of olanzapine alone over six months.

Patients in the ALKS 3831 group met both primary endpoints for the trial: they had a lower mean percent weight gain at six months compared with those in the olanzapine group, and a lower proportion of patients who gained 10 percent or more of their baseline body weight at six months.

The difference in weight gain between the two groups became apparent after the fourth week, and their rates of weight gain continued to diverge for the study's remainder. At the sixth week, weight stabilized in the ALKS 3831 treatment group and remained flat for the rest of the study period.

Alkermes plans to submit a New Drug Application to the Food and Drug Administration in 2019.

Congress Passes Bills Banning Pharmacy 'Gag Clauses'

Congress in October passed two laws that ban pharmacy "gag clauses," which health insurers use to prevent pharmacists from informing patients how they can pay less for prescription drugs.

The pharmacy gag clauses were previously included in contracts between pharmaceutical benefit managers and drug companies, who work together to negotiate drug prices on behalf of insurance companies and other health care payers. In some cases, the out-of-pocket price of the drug is less than a patient's insurance copayment, but the gag clauses prevent pharmacies from disclosing this information.

The Patient Right to Know Drug Prices Act and the Know the Lowest Price Act prohibit the use of such clauses in pharmaceutical agreements. The Patient Right to Know Drug Prices Act applies to people covered by private health insurance and is already in effect; the Know the Lowest Price Act applies to patients on Medicare and will go into effect in January 2020. **PN**

Assisted Suicide

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said the report was the result of debate that reflected "the best of the democratic process" on a highly contentious issue.

"We believe the code as it exists gives excellent moral guidance to our profession," Sabin told delegates. "The existing opinion on PAS [5.7] expresses the value of opponents of PAS in an eloquent way, and the conscience opinion [1.1.7] expresses the ethical rationale for supporters in states where it is legal.

"This has been a long slog," he continued. "The debate has been civil, thoughtful, and respectful on a topic that if not handled well could split the association."

That the CEJA report was referred back to the council is hardly unusual; CEJA formulates AMA ethical principles around topics that are often among the most difficult issues in modern medicine, and it is not uncommon for reports to be referred back for numerous iterations before they are finally approved.

But PAS appears to be uncommonly fraught, with even the name for the practice being a subject for debate. (The CEJA report found "physician-assisted suicide" to be the most precise term and urged AMA to adopt the term.)

Opponents of the report argued that its conclusions were not supported by much of the text in the report and that the code as written could be used against physicians who participate in PAS in states where it is legal.

Psychiatrist Beth Morrison, M.D., said, "The code can be weaponized against physicians who practice aid in dying by stating that it is 'fundamentally incompatible with a physician's role as healer.'"

Supporters of the CEJA report disputed that claim, saying physicians practicing in states that have legalized PAS cannot be found unethical. Meanwhile, they argued that PAS was not a subject about which the AMA could afford to be neutral.

"Neutrality is not neutral," said Daniel Sulmasy, M.D., Ph.D., senior research scholar at Georgetown University's Kennedy Institute of Ethics, who argued in favor of approving the report.

He said that if the AMA were to declare itself neutral on the issue, "the flood gates would open" and PAS would quickly become legal in more than the six states and the District of Columbia where it is already permitted. He said the CEJA report "stands for integrity." **PN**

Psychosis

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cognitive control, motivated by worry about the uncontrollability and danger of worry itself."

Hutton and colleagues called for more randomized, controlled trials to examine the effect of special therapies that address negative cognitive beliefs, such as metacognitive therapy, metacognitive reflection and insight therapy, and cognitive analytic therapy on suicidal thinking.

"Consistent with previous findings that fears of mental disintegration are strongly associated with suicide in psychosis, our results suggest that the way people appraise their symptoms and their consequences, including whether they [have] heighten[ed] concerns about losing mental control, may partly determine whether [their symptoms] lead to thoughts of suicide," Hutton and colleagues wrote.

The study was a secondary analysis of a trial funded by the British National Institute for Health Research under its Research for Patient Benefit program. **PN**

"Suicidal Ideation in People With Psychosis Not Taking Antipsychotic Medication: Do Negative Appraisals and Negative Metacognitive Beliefs Mediate the Effect of Symptoms?" is posted at https://academic.oup.com/schizophreniabulletin/advance-article/doi/10.1093/schbul/sby153/5155459. An abstract of "Schizophrenia and Suicide: A Systematic Review of Risk Factors" is posted at https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/schizophrenia-and-suicide-systematic-review-of-risk-factors/11D5E79A12C190B39A069AEAEF22B9FB.

Dsuvia

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tee's chair, Raeford E. Brown Jr., M.D., who was unable to attend the committee's vote, co-signed a strongly worded letter that the nonprofit consumer advocacy group Public Citizen sent to FDA officials to oppose approval.

In the letter, Brown, a professor of anesthesiology and pediatrics at the University of Kentucky College of Medicine in Lexington, lambasted current efforts at ensuring public safety with respect to opioids. "Briefly stated, for all of the opioids marketed in the last 10 years, there has not been sufficient demonstration of safety, nor has there been postmarketing assessment of who is taking the drug, how often prescribing is inappropriate, and whether there was ever a reason to risk the health of the general population by having one more opioid on the market," he wrote.

"The agency feels that there is a capability, so far not demonstrated, to regulate [Dsuvia] so that it is used only in closely controlled settings. In order to have this happen, the education of all prescribers would need to be guaranteed. This has not been demonstrated with any other opioid, and given the lack of teeth in the current risk evaluation and mitigation strategies [REMS] for opioids, there is currently no educational nor regulatory scheme that will guarantee that this drug will be used only as described in the label," he added.

In a statement released on November 2, FDA Commissioner Scott Gottlieb, M.D., sought to address concerns over the FDA's decision. He explained that Dsuvia will not be available for home use, should be used for 72 hours only, and should be administered only by a health care professional. To reduce the risk of exposure, Dsuvia is delivered through a disposable, single-dose applicator, he added.

Gottlieb also noted that Dsuvia could be used on the battlefield and said that the Department of Defense (DoD) "worked closely with the sponsor" on the drug's development.

"This opioid formulation, along with Dsuvia's unique delivery device, was a priority medical product for the Pentagon because it fills a specific and important, but limited, unmet medical need in treating our nation's soldiers on the battlefield," Gottlieb said, adding that the advisory committee discussed the DoD's needs.

"The FDA has made it a high priority to make sure our soldiers have access to treatments that meet the unique needs of the battlefield, including when intravenous administration is not possible for the treatment of acute pain related to battlefield wounds," Gottlieb said. "The military application for this new medicine was carefully considered in this case. We understand the concerns about the availability of a high-potency formulation of sufentanil and the associated risks. The FDA has implemented a REMS that reflects the potential risks associated with this product and mandates that Dsuvia will only be made available for use in a certified, medically supervised heath care setting, including its use on the battlefield."

Andrew J. Saxon, M.D., chair of APA's Council on Addiction Psychiatry, expressed doubt over whether Dsuvia will add extra value to battlefield medicine.

"Accidental contact with the tablet could potentially [cause] harm by causing an unexpected overdose."
—Andrew J. Saxon, M.D.

"Intramuscular morphine has been used successfully on the battlefield for many years with no evidence that poor pain control contributes to battlefield mortality," Saxon said.

Saxon stressed the risks of accidental exposure to the drug, regardless of setting.

"There is the potential for lost or dropped tablets when the tablets are not administered properly," Saxon said. "If this situation occurs, accidental contact with the tablet could potentially [cause] harm by causing an unexpected overdose."

Saxon said that based on trials that tested Dsuvia's use in bunionectomy, outpatient abdominal surgery, emergency room trauma, and postoperative pain management, he doesn't see a compelling need for a potent, sublingual opioid.

"I do not believe a high-potency opioid would be needed in relatively minor surgery [like bunionectomy]. In [the remaining] settings, the vast majority of patients would need intravenous access established for other reasons beyond administration of opioid analgesics," he said. "Once intravenous access is established, it becomes unclear what the need for a sublingual opioid analgesic would be since sufentanil, the active compound in Dsuvia, could be administered intravenously, as could a number of other potent opioids."

Although Saxon believes that some Dsuvia will be diverted, he said its impact on the opioid crisis remains to be seen.

"All controlled substances are prey to diversion, and even with the controls on Dsuvia, some diversion will inevitably occur. However, the streets of our communities are already awash in heroin and illicit fentanyl, with high rates of overdose and other complications, so a small amount of Dsuvia on the streets is unlikely to make the situation much worse," Saxon said. "We will really only know the definitive answer when we actually see how events unfold and what the ultimate impact of Dsuvia turns out to be." **PN**

An FDA press release on the approval of Dsuvia is posted at https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=BasicSearch.process. Gottlieb's November 2 statement is posted at https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm624968.htm.

Vaping

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revisit the compliance policy for flavored e-cigarette products, with one big exception carved out: mint and menthol flavors. Specifically, Gottlieb is seeking to restrict the sale of flavored e-cigarettes to age-restricted, specialty locations, such as vape shops, and online retailers under heightened practices for age verification. However, menthol and mint e-cigarettes would be exempt from these new rules and still be permitted to be widely distributed and sold.

"This reflects a careful balancing of public health considerations," Gottlieb said. He wants the FDA to strike a balance between "closing the on-ramp for kids to become addicted to nicotine" but still maintaining the on-ramp to e-cigarettes for adult smokers seeking to quit regular cigarettes.

The FDA also plans to issue an advanced rulemaking proposal seeking to ban menthol in traditional combustible cigarettes and cigars, Gottlieb announced. More than half of youth who smoke traditional cigarettes use menthol-flavored ones. Such a ban would likely take several years to advance. **PN**

The NYTS report, "Notes from the Field: Use of Electronic Cigarettes and Any Tobacco Product Among Middle and High School Students—United States, 2011–2018" is posted at https://www.cdc.gov/mmwr/volumes/67/wr/mm6745a5.htm?s_cid=mm6745a5_w.

MHA

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among adults and major depression among youth. The number of adults reporting serious thoughts of suicide was more than 9.8 million (4 percent nationwide) this year, an increase of 200,000 people since 2017. Among young people, nearly 13 percent of youth had at least one past-year major depressive episode, up from 9 percent in 2017.

"Despite mental health being something that more and more people are talking about, far too many people are still suffering," said Paul Gionfriddo, MHA president and CEO. "People are simply not receiving the treatment they need to live healthy and productive lives—and too many don't see a way out."

When it comes to unmet mental health needs, there was a wide disparity between the highest ranked states (Hawaii, Alabama, Texas, Nebraska, and Maine), where nearly 16 percent to 17 percent of adults reported unmet mental health care needs, and the lowest ranked states (Nevada, New Hampshire, Oregon, and Idaho) and the District of Columbia, where 25 percent to 26 percent did not receive needed services.

The report also uncovered some good news: Under the Affordable Care Act, the U.S. continues to see a decline in the number of Americans who are uninsured, with a nearly 3 percent reduction from last year. In fact, 46 states reported a reduction in the number of adults with any mental illness who lack insurance. The largest reductions were seen in South Carolina, Missouri, Arkansas, and Arizona, all of which had a 6 percent to 7 percent decline in adults with mental illness who had no insurance coverage.

Youth with mental illness seemed to fare far worse than adults when it came to access to care: Close to two-thirds of youth with major depression (62 percent) did not receive any mental health treatment, MHA reported. Only one-quarter of youth with severe depression receive consistent treatment, defined as seven to 21 visits in a year. Late recognition of mental illness in primary care settings and limited coverage of mental health services often prevent youth from receiving timely and effective treatment.

Nationwide, less than 1 percent of students (0.8) were identified as having an Individual Education Program (IEP) for emotional disturbance (ED). "If states were doing a better job of identifying whether youth had emotional difficulties that could be better supported through an IEP, the average rate would be closer to 8 percent instead of 0.8 percent," MHA wrote. "Early identification for IEPs is critical. IEPs provide the services and support students with ED need to receive a high-quality education." The top five states (Vermont, Minnesota, Massachusetts, Wisconsin, and Pennsylvania) identified 15 students to 27 students per 1,000 as having an IEP for ED, and the lowest-performing five states (Alabama, Arkansas, Louisiana, Utah, South Carolina) identified 2 students to 4 students per 1,000. **PN**

The report, "The State of Mental Health in America 2019," can be accessed at http://www.mentalhealthamerica.net/download-2019-state-mental-health-america-report.

Robinowitz

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"Not only have psychiatrists been elected to major leadership positions, but our delegation and more importantly our issues—especially parity for mental illness and substance use disorders—have been endorsed and promoted by colleagues throughout the House," Robinowitz said. "We have worked to educate colleagues and to strengthen alliances for the benefit of our profession and the patients whom we serve.

"It takes considerable time to build trust and respect at the AMA," Robinowitz said. "I am so proud that our delegation and the Section Council on Psychiatry have been recognized as an important, trustworthy, and reliable participant."

Current section council chair Jerry Halverson, M.D., echoed those comments. "The AMA House of Delegates is a great model of how psychiatrists can work with other physicians to push common-sense policies that will help improve the lives of our patients and our practices," he said. "This works at the national level and the state and local levels. One of the most effective ways for a psychiatrist to engage in this type of advocacy is to work with our other colleagues at the national level and the state and local levels by engaging in our state and county medical societies along with our state psychiatric organizations."

After many years practicing psychiatry in the Washington, D.C., area, Robinowitz and her husband, Max Robinowitz, M.D., a pathologist, recently moved to San Francisco to be near children and grandchildren. **PN**

AMA Acts

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• The enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS) and federal funding to provide grants to states to improve NICS reporting.

Pediatric Decision Making

Delegates also approved a report from the Council on Ethical and Judicial Affairs on pediatric decision making in cases of children with differences of sex development. The report provides guidance to physicians on delivering compassionate care to all pediatric patients, while negotiating with parents or guardians to develop a shared understanding of the patient's medical and psychosocial needs and interests.

The report received support from a number of patients and parents of patients with congenital adrenal hyperplasia (CAH), who testified that surgery is a vital option that should be preserved as part of shared decision making. At reference committee hearings, they refuted claims by what they called "anti-surgery activists" who assert that surgery is medically sanctioned violence. (CAH is a group of rare inherited autosomal recessive disorders characterized by a deficiency of one of the enzymes needed to make specific hormones, which may result in abnormal genital development.)

One mother of an 11-year-old girl with CAH told the House of Delegates, "Parents and families have a right to choose what is best for their child."

Delegates also approved the following:

• A resolution supporting the right of federally certified Opioid Treatment Programs (OTPs) to be located within residential, commercial, and other areas where there is a demonstrated medical need.

• A resolution supporting legislation and federal funding for evidence-based training programs by qualified professionals aimed at educating corrections officers in effectively interacting with people diagnosed with a mental illness in federal prisons and detention and correction facilities.

• A resolution calling for advocacy for the Accreditation Council for Graduate Medical Education (ACGME) to collect data on the suicide deaths of medical students, residents, and fellows to identify patterns that could predict suicidal behavior. **PN**

Highlights of the House's actions are posted at https://wire.ama-assn.org/ama-news/highlights-2018-ama-interim-meeting. APA's response to the administration's proposed rule change to the *Flores* settlement is posted at https://www.psychiatry.org/File%20Library/Psychiatrists/Advocacy/Federal/APA-Comments-DHS-Flores-Proposed-Rule-11062018.pdf.

Pharmacogenetic Test

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the FDA established some special requirements to ensure patient safety, including that the test's label include appropriate warning statements that medication changes should only be made after discussing test results with a licensed health care professional who can confirm the results with a clinical test. As part of the clearance requirements, 23andMe reported that 97 percent of customers understood the caveats about pharmacogenetic testing.

Even if used properly, these tests do not yet make much economic sense in psychiatric practice, Nemeroff continued.

"The FDA approval was focused on the genetic tests being helpful in preventing potential adverse drug effects," he said, noting that understanding a patient's metabolic information could prevent doctors from dosing patients too high. "This is not really an unmet need when prescribing drugs like antidepressants. By starting with a low dose and gradually increasing it, we avoid side effects in patients who cannot tolerate higher doses."

The more pressing need is getting information that may help physicians to pick which antidepressant might provide the best chance of response, Nemeroff said. But as APA's Task Force for Novel Biomarkers and Treatments, which is chaired by Nemeroff, noted earlier this year (*Psychiatric News*, https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2018.pp6b1), current pharmacogenetic tests fall short in that regard.

"If a patient wants to get one [a personal genomics test], they certainly can as an independent consumer, but I would recommend they bring the results to an experienced psychopharmacologist to help with the interpretation," he said. **PN**